Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 28 November 2023 at 10.00am

(Day 002)

Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning. Yes, Mr Glover.
2
3 MR GLOVER: Thank you, Commissioner.
4
5 This morning, and during the course of today we have,
6 as Mr Muston flagged yesterday, evidence from Dr Lyons,
7 Dr Chant and Ms Willcox. They will be appearing as
8 a panel. We might have them sworn or affirmed and then
9 we'll go from there.
10
11 **<NIGEL JOSEPH LYONS, sworn: [10.01am]**
12
13 **<KERRY CHANT, affirmed: [10 .01am]**
14
15 **<DEBORAH WILLCOX, affirmed: [10.01am]**
16
17 MR GLOVER: Dr Lyons, if I can start with you, could you
18 state your full name, please.
19
20 DR LYONS: Nigel Joseph Lyons.
21
22 MR GLOVER: You are currently a specialist adviser to the
23 office of the secretary for the ministry of health?
24
25 DR LYONS: That's correct.
26
27 MR GLOVER: What are your responsibilities in that role?
28
29 DR LYONS: I've been contracted to provide support for the
30 Special Commission of Inquiry but also to undertake
31 a number of activities that are of strategic interest for
32 the secretary, so I've been involved in establishing the
33 Health System Advisory Council, which I think we'll hear a
34 little bit more about probably during these hearings, which
35 is around giving clinicians a greater voice in the
36 ministry, and most recently have been involved in looking
37 at how we can free up clinicians at the frontline from some
38 of the administrative tasks that are taking them away from
39 patient care, so it's a project called "Time to Care".
40
41 MR GLOVER: And you've been in that role since September
42 2022?
43
44 DR LYONS: Correct.
45
46 MR GLOVER: And prior to that you were deputy secretary
47 health systems, strategy and planning, from October 2016?

1
2 DR LYONS: That's correct.
3
4 MR GLOVER: Prior to that, you were the chief executive of
5 the Agency for Clinical Innovation?
6
7 DR LYONS: That's correct.
8
9 MR GLOVER: All right. Dr Chant, if I can come to you.
10
11 DR CHANT: Yes.
12
13 MR GLOVER: You are currently the chief health officer
14 and deputy secretary population and public health?
15
16 DR CHANT: That's correct.
17
18 MR GLOVER: You've been in that role since about April
19 2009?
20
21 DR CHANT: That's correct.
22
23 MR GLOVER: In general terms what are your
24 responsibilities in these roles?
25
26 DR CHANT: I have portfolio responsibility for dental,
27 drug and alcohol, up until recently Aboriginal health, and
28 also the Centre for Epidemiology and Evidence, so
29 surveillance systems, data systems, data linkage
30 capabilities.
31
32 I also have broad roles within the health protection
33 remit, environmental health, immunisation and protection of
34 communicable diseases.
35
36 We also have the population health programs areas
37 which particularly focus on tobacco, obesity and other,
38 most recently, an emphasis on e-cigarettes.
39
40 MR GLOVER: We might explore some of those areas during
41 the course of the day.
42
43 Ms Willcox, if I can come to you. Your substantive
44 role is deputy secretary health systems strategy and
45 patient experience; is that right?
46
47 MS WILLCOX: That's correct.

1
2 MR GLOVER: I understand you are currently the acting
3 secretary; is that right?
4
5 MS WILLCOX: That's correct.
6
7 MR GLOVER: And you have been in that role since
8 September 2022?
9
10 MS WILLCOX: Yes.
11
12 MR GLOVER: Prior to that you were chief executive of the
13 Northern Sydney Local Health District; is that right?
14
15 MS WILLCOX: That's correct.
16
17 MR GLOVER: Each of you have - I will have to do this one
18 at a time, so I will go back in reverse order. Ms Willcox,
19 you have participated in the preparation of a joint report
20 for the purpose of these hearings?
21
22 MS WILLCOX: I have indeed, thank you.
23
24 MR GLOVER: That's the document at [MOH.9999.0001.0001]
25 I'll just have that brought up on the screen. The matters
26 that are expressed in it reflect your views, do they?
27
28 MS WILLCOX: Yes, they do.
29
30 MR GLOVER: Dr Chant?
31
32 DR CHANT: Yes, they do.
33
34 MR GLOVER: Dr Lyons?
35
36 DR LYONS: They do.
37
38 MR GLOVER: Commissioner, I propose to tender the report
39 at the moment, and if convenient, to do a bulk tender of
40 a number of documents. Some of those documents are
41 referred to in the report. Some of them are what I will
42 call foundational documents that were referred to in
43 opening yesterday.
44
45 We've done it by way of list. If I can hand two
46 copies, one, a working copy, for you. I propose to tender,
47 if it is convenient each of those --

1
2 THE COMMISSIONER: I should say, I can obviously still
3 stand but my hearing is not - I don't know whether it is
4 the acoustics in here, which I think are pretty dodgy, but
5 you will all need to keep your voices up for me to hear,
6 thanks.
7
8 Does that report need to be given a number now?
9
10 MR GLOVER: Yes, notionally on the list, Commissioner,
11 you'll see we have applied exhibit numbers for all of them
12 and the report is --
13
14 THE COMMISSIONER: I see. It is already exhibit A1.
15
16 MR GLOVER: A1. The way we propose to handle tenders
17 throughout the hearings is to do them by reference to the
18 hearing block. This being the first, it is A. The next
19 will be B and so on, if convenient.
20
21 THE COMMISSIONER: All right.
22
23 **EXHIBIT #A1 JOINT REPORT OF DR LYONS, DR CHANT AND**
24 **MS WILLCOX [MOH.9999.0001.0001]**
25
26 MR GLOVER: For the purposes of giving your evidence,
27 I understand that between you, you have arranged for one of
28 you to be the lead for particular topics.
29
30 What I propose to do is direct the questions on those
31 topics to the nominated lead, but I'm interested to hear
32 from all of you, so if, at any stage, any of you wish to
33 add to an answer that has been given, in case I forget to
34 ask, please feel free to do so.
35
36 Dr Lyons, we're going to start with you and we're
37 going to start with the topic under question 2 of the
38 report, that starts at paragraph 33 and following.
39
40 In paragraph 34, reference is made to the need to
41 balance:
42
43 *... efficiencies which may be gained from*
44 *centralised delivery and governance against*
45 *the need for local management responsive to*
46 *the varying needs of [the] different*
47 *communities.*

1
2 Do you have that passage?
3
4 DR LYONS: I do, indeed.
5
6 MR GLOVER: Can you just explain to me what is the balance
7 and why is it an important one to be struck?
8
9 DR LYONS: Certainly. I think the balance here refers to
10 a range of factors. The first of those is that under the
11 devolved governance arrangements, where we have local
12 health districts being responsible for providing the
13 services for their local community and population, we have
14 the ministry, which is the role as system manager but
15 providing a whole range of support functions for the whole
16 of the system. It's about where we decide the balance
17 needs to be in relation to either a service that's provided
18 or a decision that needs to be made in relation to service
19 delivery, or in relation to how the services are
20 configured. And so there is always a balance to be struck
21 around those, depending on what the service is or what the
22 issue is as to where the best place for that decision to be
23 made is.
24
25 Under our arrangements, that balance is struck with
26 the centre deciding on policy, overarching funding and
27 strategy, overarching system planning, and also providing
28 those support services on a statewide basis that we can
29 reference, but there are a number of them.
30
31 Then at the local health district level it is around
32 having that focus on delivering the services through the
33 hospitals and community health services that the local
34 health district is responsible for; making decisions that
35 put policy into practice at the local level, that
36 distribute the resources that are provided to the local
37 health district in a way that gets the best service
38 delivery for the local community across the range of
39 different services; and providing support for clinicians
40 who are delivering those services locally as well as
41 involving the community as much as possible and consumers
42 in decisions around the services that they receive.
43
44 MR GLOVER: Why is it important for matters of the kind
45 you have just been describing to be dealt with at the local
46 level rather than the central level?
47

1 DR LYONS: We have found that over the years - and we've
2 been through various governance arrangements in New South
3 Wales with things more centralised and then decentralised
4 in terms of decision-making - there is a strong sense from
5 our communities and consumers of health care, and from our
6 clinicians and staff, that decisions that are made as close
7 as possible to where patients receive their care or where
8 communities receive a service are seen to be better
9 decisions because people can be involved in those
10 decisions, can understand them, be involved in processes
11 that support the decision-making, and understand who is
12 making the decision again, and can ask why.
13
14 When the decision is made a long way away, that is
15 more difficult to achieve, and so for those matters that
16 are directly relevant to service provision and care, having
17 those decisions being made locally is a better outcome in
18 terms of that communication, support and engagement with
19 the community and clinicians involved.
20
21 MR GLOVER: Ms Willcox, did you wish to add anything to
22 Dr Lyons' answer?
23
24 MS WILLCOX: No. I think Dr Lyons has summarised it well.
25
26 MR GLOVER: Dr Chant?
27
28 DR CHANT: I suppose just to say that also the greater
29 understanding of the service configuration locally, the
30 relationship to other service providers, is held locally,
31 and for much of our care, it is around how we work in
32 partnership with those other service providers, be that
33 primary care, aged care sector or other non-government
34 organisations.
35
36 MR GLOVER: We'll definitely come back to that later in
37 the morning.
38
39 Below paragraph 34, Dr Lyons, there is an
40 organisational chart and we'll get into the pillars and the
41 statewide services, et cetera, in a moment, but just in
42 terms of the specialist networks, can you just briefly
43 explain the two specialist networks and how they operate
44 within the wider system?
45
46 DR LYONS: Sure. So the two specialist networks are not
47 geographically based but have functions that are very

1 important to the state. So the Sydney Children's
2 Hospital's Network is the configuration of the children's
3 hospitals at Randwick and Westmead. They provide the
4 highly specialised paediatric services that are required to
5 support care of children, and that's connected through the
6 children's services and all the other local health
7 districts, but all those higher levels of care are provided
8 through the Sydney Children's Hospital's Network at those
9 two hospitals and their associated services.
10
11 And Justice Health and Forensic Mental Health Network
12 has the responsibility of providing care for people who are
13 in custody across the state in prisons and also has
14 responsibility for forensic mental health and the care of
15 people who are in that system as well, in terms of their
16 mental health and physical health, and that is a statewide
17 service as well.
18
19 MR GLOVER: I take it that they're structured in that way
20 because services of those kinds are better delivered on
21 a statewide rather than local basis; is that right?
22
23 DR LYONS: That's correct, and they are highly specialised
24 and concentrated, so that's why they are configured that
25 way.
26
27 MR GLOVER: If we can have document [SCI.0001.0042.0001]
28 displayed on the screen.
29
30 Commissioner, this is in volume 6 at tab A46 of the
31 hard copy tender bundle.
32
33 This is the ministry of health organisation chart.
34 I just want to get a brief description of each of the
35 divisions, Dr Chant, we heard from yours.
36
37 I might ask you, Ms Willcox, to do this, given your
38 current role as acting secretary. If you wouldn't mind
39 just giving us a brief overview of each of the divisions
40 within the structure and what their responsibilities are,
41 please.
42
43 MS WILLCOX: Certainly. Kerry has outlined her role as
44 chief health officer. The deputy secretary financial
45 services and asset management and chief financial officer,
46 Mr Alfa D'Amato, is responsible for the oversight of the
47 budget and funding systems and processes across the entire

1 system. The areas around asset management go to issues
2 around all the capital and equipment that are used in the
3 health system and how they are managed in the accounting
4 sense, so that is the remit of the chief financial officer.
5
6 Mr Minns is deputy secretary, people, culture and
7 governance. Mr Minns is responsible for industrial
8 relations policy, workforce policy, organisational, talent
9 development, and learning and workforce culture and
10 development issues, statewide training and the like.
11
12 The deputy secretary systems, sustainability and
13 performance, Mr Matthew Daly, oversees some of the key
14 access areas around emergency departments, elective
15 surgery, importantly has remit of sustainability in the
16 system, looking at climate change and the impacts on the
17 system, and has an analytics and data function and the
18 chief custodian of data for NSW Health.
19
20 Deputy secretary regional health, Mr Luke Sloane,
21 recently appointed to oversee and support and coordinate
22 health service delivery in our rural, regional and remote
23 local health districts to give a greater emphasis to the
24 policy and service issues that are relevant to those
25 communities who have quite different health service
26 settings and needs to our metropolitan --
27
28 MR GLOVER: Just before you go on, is that a relatively
29 recent addition to the structure?
30
31 MS WILLCOX: Yes, that is, just in the last month, that
32 appointment. Mr Sloane held the role of the regional
33 health coordinator. That role has been in place, I would
34 have to double-check, but it's more than a year, but just
35 recently the title has been changed to deputy secretary.
36
37 MR GLOVER: And I take it that elevating it to deputy
38 secretary reflects the significance of the role within the
39 organisation?
40
41 MS WILLCOX: Yes. No doubt you will be aware of a rural
42 health inquiry that was held with a suite of
43 recommendations and one of them was about giving profile
44 within the ministry to the needs of rural, regional and
45 remote communities, and so Mr Sloane's position is being
46 created in that regard. He has travelled to around,
47 I don't know, over 100 facilities across the state, meeting

1 with communities and clinicians so we can strengthen our
2 understanding of the needs and ensure that our policy and
3 strategy response is in alignment with what we are hearing.
4
5 MR GLOVER: Please continue.
6
7 MS WILLCOX: Deputy secretary clinical innovation and
8 research and chief executive, Agency for Clinical
9 Innovation, Dr Jean-Frederic Levesque - this too is
10 a relatively recent deputy secretary position. The intent
11 of this one is to oversee medical research and innovation
12 within the New South Wales health system. There is an
13 Office for Health and Medical Research that reports in to
14 Dr Levesque.
15
16 The aim of this role is to again increase profile
17 connectivity with clinicians and researchers and the
18 academic partners across the system so that New South Wales
19 can strengthen its research activities and its dominant
20 place in this regard, in clinical trials innovation.
21
22 The Agency for Clinical Innovation has been
23 a longstanding part of the health system, that Dr Levesque
24 was the chief executive, and that involves - largely works
25 with clinicians that work on refreshing models of care and
26 guidance around clinical variation, and those two positions
27 have come together under his leadership.
28
29 The state health services functional area coordinator,
30 Mr Wayne Jones, that position has been created in response
31 to our response to COVID, looking at our disaster and
32 emergency preparedness and how we can take the learnings
33 from COVID to strengthen our response, along with the other
34 emergency disaster impacts that occur, unfortunately, from
35 time to time, such as floods.
36
37 MR GLOVER: Dr Chant, I think you said in an answer
38 earlier that Aboriginal health used to be within your
39 division.
40
41 DR CHANT: Yes. So just recently Aboriginal health was in
42 my division, but in recognition of the importance of that,
43 now there is a direct report of the Centre for Aboriginal
44 Health to the secretary, and that reflects the emphasis
45 that we, as leaders of the health system, want to see
46 Aboriginal health placed.
47

1 MR GLOVER: What role does that centre have?
2
3 DR CHANT: That centre provides a coordination. We really
4 want to embed the concerns around Aboriginal health and
5 addressing health differences or inequalities in health
6 between Aboriginal and non-Aboriginal people across all our
7 program areas. The centre provides a coordination
8 mechanism, it provides advice, leadership at a state level.
9
10 MR GLOVER: Thank you.
11
12 Dr Lyons, if you can just have a look at paragraph 36
13 of the report. There you describe the role of the ministry
14 for health as "system manager". By that, is that
15 a reference to the role of the ministry that you described
16 in perhaps your first answer today around policy, strategy
17 and those centralised matters?
18
19 DR LYONS: It is but it goes beyond that. It has
20 a particular reference in the context of the National
21 Health Reform Agreement as well, in that the states and
22 territories are the system managers for the services in
23 each of their jurisdictions, so they have overarching
24 responsibility for the delivery of services through all of
25 the different health services within the states and
26 territories.
27
28 As system manager, we're responsible for ensuring that
29 we deliver on the requirements of National Health Reform
30 Agreement but also support that effective delivery through
31 the local health district. That is done through a range of
32 different processes, part of which is the service
33 agreements which are struck between the ministry and each
34 of the local health districts, which define what will be
35 delivered by the local health district, what will be
36 delivered centrally, and the relationship between both the
37 centre and the district.
38
39 Also, the performance levels that are required in
40 terms of levels of service delivery and the sorts of
41 performance indicators that will be used to measure whether
42 or not the districts are effectively delivering within the
43 service agreement arrangements.
44
45 MR GLOVER: That's done through the service agreements and
46 the performance framework, is it?
47

1 DR LYONS: That's correct.
2
3 MR GLOVER: We'll come back to that later today.
4
5 Also in paragraph 36 there's reference to public
6 hospitals, but also community health and other public
7 health services. What is within the description of
8 "community health and other public health services"?
9
10 DR LYONS: I think within New South Wales, historically,
11 our local health districts, area health services in the
12 past, have had responsibility not just for the hospitals
13 and the services that they provide but for a range of
14 services that are delivered in to the community through
15 community health and through other services like our
16 community mental health, through arrangements with
17 non-government organisations in relation to delivering
18 certain types of services through the non-government
19 organisations as well.
20
21 These are usually more outside of the hospital walls
22 and are around how we provide supports to keep people well
23 and healthy within a setting in the community, and that can
24 be delivered through child and family nurses; through aged
25 care; through community nurses who would be out providing
26 support for people who have conditions that need ongoing
27 treatment for a period of time; through our community
28 mental health teams. So there are a range of different
29 services that exist and are operating in the community
30 alongside other community services, including primary care,
31 which is delivered outside of NSW Health. So those are
32 very important distinctions.
33
34 Some other states and territories are focused around
35 hospitals, but we are much broader in terms of the services
36 that our local health districts are responsible for.
37
38 MR GLOVER: Thank you.
39
40 DR LYONS: That would include drug and alcohol and other
41 services as well. There are a range of different
42 services - dental which is also a very important service
43 that we are responsible for at the local level.
44
45 MR GLOVER: In paragraph 37, reference is made to the
46 ministry guiding the development of services and
47 investments in the New South Wales public health system.

1 How does it go about doing that?
2
3 DR LYONS: It goes about it in a range of different ways
4 but primarily through the development of policy, the
5 development of centralised planning approaches and the
6 reflection of those into the arrangements we have with the
7 service providers, usually communicated through the annual
8 service agreement.
9
10 But if I give you an example, we have a 10-year future
11 health strategy, which has clearly defined the directions
12 that we want to see in the New South Wales health system
13 for the next 10 years. That has guiding, overarching
14 strategies and objectives that will then flow through into
15 plans but also will flow through into the arrangements we
16 strike with all of the service providers, whether that's
17 the central agencies and the pillars, the statewide
18 services, or whether that's through the local health
19 districts. What we look at is how we take that plan and
20 deliver it in terms of the actions and activities that we
21 want each part of the system to play and how we ensure that
22 we do achieve those directions through the arrangements in
23 the service agreements or the things that we purchase or
24 supply. That's one way.
25
26 Then the other is reflecting it in policy and
27 strategy, which will be reflected through the different
28 divisions that the ministry has responsibility for and
29 ensuring that those are then reflected in the activities
30 that are undertaken through the system.
31
32 MR GLOVER: How does the ministry take into account what's
33 happening on the ground, if I can call it that, in the
34 districts in that process?
35
36 DR LYONS: A really important point. To take as an
37 example, even in the development of our future health
38 strategy, which is a 10-year strategic plan, we were
39 heavily involved in consulting with our local health
40 districts and partners, and even through to consumers
41 directly, and clinicians directly, to ensure that we were
42 able to feed in the issues as they saw them, as well as the
43 things that were driving the need for change at a system
44 level and bringing the two together to ensure that the
45 strategy we came up with was informed by people who were
46 involved in delivering care and receiving care, as well as
47 for people who are responsible for policy, strategy and

1 ensuring that the government priorities are delivered on.
2
3 MR GLOVER: Dr Chant do you wish to add anything to that?
4
5 DR CHANT: No, I think that Dr Lyons has covered it.
6 I suppose just one component was we also do monitor data,
7 so we use data to inform where there might be gaps in
8 service provision, we look at variations in access and
9 uptake and outcomes, and so a lot of the planning is also
10 informed by changes in the demographics of the population.
11 So the data assets that we have at a statewide level inform
12 some of that local - clinical services plans and the local
13 decision-making.
14
15 MR GLOVER: Ms Willcox?
16
17 MS WILLCOX: Dr Chant covered off on the planning component
18 I was going to mention, but in addition, there are clinical
19 councils that are in our hospitals and at the district
20 level who connect with the executive teams and can raise
21 issues that they think are relevant to their community and
22 their service needs, and that's a frequent pathway for
23 identification of change or new models of care or
24 innovation that might be required at a local health
25 district and that may equally be required across a number
26 of districts or, in fact, become statewide.
27
28 MR GLOVER: Are they the clinical councils that flow from
29 the model by-laws for example?
30
31 MS WILLCOX: There are medical staff councils that are
32 part of the by-laws and an executive medical staff council
33 that sits, which are the chairs of each of the medical
34 staff councils of the hospitals that sit on that with the
35 chief executive and other members of the district executive
36 team. But the clinical councils are broader than our
37 medical colleagues; they include nursing and allied health
38 and local management.
39
40 MR GLOVER: Thank you.
41
42 One aspect of the system which isn't in the structural
43 diagram are the affiliated health organisations. We might
44 just bring up the list so those who are following online
45 can know what we're talking about. [SCI.0002.0004.0001] at
46 pages 125 and 126. This is schedule 3 to the Health
47 Services Act which lists the affiliated organisations. If

1 we just scroll down, that's the introduction, and then over
2 the page, please, and there's the list.
3
4 I don't need to go through the list, Dr Lyons, but
5 just in general terms, how do the affiliated health
6 organisations plug into the system?
7
8 DR LYONS: Very, very closely, is the answer. For all
9 intents and purposes, they are providing the same types of
10 services as our publicly funded health services. They are
11 affiliated under the old schedule 3, due to the fact that
12 they were historically run by and owned by charitable
13 organisations, and have a very important role in health
14 service delivery locally. So that when the state resumed
15 responsibility for providing services for public hospitals,
16 those relationships were enshrined in the Act.
17
18 Those services usually have a very close relationship
19 with the local health district, except for St Vincent's,
20 which is its own local health district network in its own
21 right, given its role and important role with some very
22 highly specialised services that it operates. But those
23 services are undertaken with the local health district
24 working in partnership to ensure that those affiliated
25 healthcare organisations receive resources that they need
26 to deliver those services and that there's highly
27 integrated care between what they do and what's provided
28 through the other services in the local health district.
29
30 MR GLOVER: When you say they work in partnership, is it
31 the responsibility of the health district to, effectively,
32 manage and monitor the services being provided by the
33 affiliated health organisations?
34
35 DR LYONS: That's correct. So in the structures that
36 exist within the local health districts, they will ensure
37 that the people who are operating those affiliated
38 healthcare organisations are a part of the discussions, as
39 are the management of the other hospitals in the local
40 health district or other services, to ensure that there is
41 a good connection between how those services are delivered
42 at the local level.
43
44 MR GLOVER: We'll come back to funding later, but in
45 general terms, how are those organisations funded for the
46 services that they do provide?
47

1 DR LYONS: It's the position of the ministry that they
2 should be treated in exactly the same way as the other
3 facilities within the local health district - they should
4 receive similar funding for the similar services that are
5 provided, and that any access to activity based funding
6 that relates to service provision should flow through to
7 those hospitals the same as it does for the other hospitals
8 in the local health district.
9
10 MR GLOVER: When you say "it's the position of the
11 ministry", does that mean it doesn't always work that way?
12
13 DR LYONS: We do hear from time to time at the centre that
14 there may be an issue with an affiliated healthcare
15 organisation not receiving resources they believe they
16 should have received, and that advocacy can occur up
17 through the district or through the Health Services
18 Association, which is, I think, the peak group of the
19 affiliated healthcare organisations in the state, and we
20 are always very receptive to addressing those issues when
21 they are asked.
22
23 MR GLOVER: Are there, for want of a better term, services
24 type agreements between the local health districts and the
25 affiliated health organisation in their region?
26
27 DR LYONS: There should be formal agreements around the
28 service level that is provided, that is consistent with the
29 service agreements we strike with the local health district
30 to reflect those and to have similar levels of performance
31 required for the resources that they receive in delivering
32 those, yes.
33
34 MR GLOVER: You mentioned that St Vincent's was slightly
35 different. In what way?
36
37 DR LYONS: It is considered to be a local health district
38 in its own right from the point of view of the way we
39 interact with St Vincent's. So the chief executive of
40 St Vincent's is considered the same as the chief executives
41 of all the other local health districts and we would strike
42 an agreement with St Vincent's which is direct from the
43 ministry through our service agreements with them directly,
44 rather than through another local health district entity.
45
46 MR GLOVER: Why have they been treated as that network?
47

1 DR LYONS: I think historically - and there was
2 a governance review around 2011 and I think there had been
3 some issues with St Vincent's feeling that the resources
4 they were receiving for the role they played, while they
5 were embedded within an area health service, wasn't
6 a satisfactory arrangement, so for the purposes of ensuring
7 that there were direct relationships with the centre, they
8 were pulled out and created as a local health district in
9 their own right, so there was that direct relationship with
10 the ministry.
11
12 MR GLOVER: Ms Willcox?
13
14 MS WILLCOX: I would probably add an example to exemplify
15 how we operate with our AHOs. The Royal Rehab service, for
16 instance, has an arrangement with Northern Sydney Local
17 Health District to provide care to spinal injury patients.
18 Rural Rehab are designated in the service level agreement
19 of Northern Sydney, so as a true service partner, and we
20 would have regular performance meeting with the executive
21 team at Royal Rehab, monitor activity and manage any issues
22 that were emergent. So it is a very true and real
23 partnership.
24
25 MR GLOVER: Dr Chant?
26
27 DR CHANT: No I think it has been adequately covered.
28
29 MR GLOVER: Back to the report, if that can be brought up
30 on the screen, thanks, operator, and to paragraph 39.
31
32 This has been touched on already, Dr Lyons, but
33 reference is made there to the LHDs and their boards being
34 charged with responsibility for determining how they
35 deliver their services, et cetera. Do I take it that,
36 based on your earlier answer, that is a prime example of
37 devolved responsibility and the LHDs have a high level of
38 autonomy in doing that?
39
40 DR LYONS: It is. They have responsibility within the
41 policy and strategy of NSW Health - so the future health
42 strategy that I outlined earlier applies to all of the
43 local health districts there. Their role is to translate
44 those directions, that strategy and those directions, to
45 what that means in terms of the local health district's own
46 strategic direction and its clinical service plans.
47

1 So at the local level, they will look at what the
2 state is saying needs to be delivered and where the state
3 is heading with its health services, and think about what
4 that means for the way they are currently operating and
5 what needs to change to reflect that, and they will develop
6 their own strategy and their own clinical service plans,
7 which should reflect the directions that have been outlined
8 in the statewide strategic plans.
9
10 MR GLOVER: Although they're developed at the local level,
11 is there any statewide, or perhaps lesser regional
12 coordination, to ensure that the needs of the population
13 that may straddle areas are being fully met?
14
15 DR LYONS: We have responsibility for services that are
16 above local health districts. So there are a range of
17 services that are not provided just within a local health
18 district, because they might be more highly specialised and
19 need to be concentrated in a lesser number of sites, for
20 instance. We call those supra local health district
21 services. They're usually highly specialised and there's
22 usually an arrangement struck with the hosts of those
23 services, so the local health district that is hosting that
24 service will have in its service agreement a recognition
25 that they are providing a statewide or supra LHD service,
26 and reflected in their agreement that that is for residents
27 that are outside of their local health district.
28
29 There are examples of things like burns, which is
30 provided in one or two sites across the state; spinal cord
31 injury that Ms Willcox just mentioned is actually provided
32 only on a couple of sites in the state. These are highly
33 specialised services, so there is a concentration of
34 expertise around those. But there are other examples.
35
36 For treatment of stroke, we have a statewide stroke
37 service. It's hosted out of Prince of Wales Hospital but
38 there are a number of sites that provide endovascular clot
39 retrieval, which is a very highly specialised treatment
40 where we're able to have interventional specialists put
41 a catheter up into the vessels in the brain and extract
42 clots for some people who have appropriate strokes.
43
44 So those are concentrated to only three or four sites
45 across the state, so there are arrangements for networking
46 of services for access for residents anywhere from across
47 the state into those services, and it's reflected in the

1 agreements and the resources that are provided and deployed
2 that those districts have responsibility to provide that
3 service on a statewide basis.
4
5 MR GLOVER: For those highly specialised services, why are
6 they concentrated to one, two or three sites?
7
8 DR LYONS: For a range of factors. The primary driver of
9 those, though, is that there are small numbers of those
10 procedures done proportionally and there is a need to
11 concentrate, usually highly specialised skills, in a site
12 that enables that service to be available 24/7, 365 days
13 a year. It wouldn't be possible to replicate that service
14 over a number of sites, and nor would it be appropriate to
15 try and provide it and maintain quality services, when
16 there's only a few of those cases likely to be appearing at
17 a site if it was devolved out.
18
19 It's better to concentrate - there's a lot of evidence
20 in the literature around a volume outcome relationship
21 where, for those highly specialised procedures, you
22 concentrate the volume into one or two sites and you get
23 better clinical outcomes because people do more of those
24 procedures, the team around them and supporting them do
25 more of those procedures, so they are able to provide the
26 highest quality care.
27
28 MR GLOVER: Dr Chant, did you wish to add anything to that
29 answer?
30
31 DR CHANT: Probably just a reflection that we do look at
32 access and equity across the state in terms of who is using
33 those services that are procured on a statewide basis, and
34 if there are services that span multiple districts, we do
35 attend to the fact that we do look at which populations are
36 accessing those services for that sort of equity and
37 discussions across the districts.
38
39 MR GLOVER: The terms "access" and "equity" are referred
40 to in a number of places in the report, so what do you mean
41 by those terms when you use them?
42
43 DR CHANT: Look, I think when I'm using the term "access",
44 I mean that the services are able to be accessed, and that
45 doesn't just mean the services being there - the services
46 being culturally competent, people feeling comfortable to
47 use the services. So I use "access" in a more global term

1 than just the presence or absence of the services.
2
3 The issue of equity, I think you'll see a theme in the
4 report where we do highlight that we acknowledge that some
5 community members, for a variety of reasons, have more
6 difficulty accessing our system, and we were happy to
7 explore that further, but it's probably a very big
8 discussion, which is what are the drivers for that
9 inequity?
10
11 But clearly, we do take that view that we want to, as
12 a system, address those inequities, and that would be about
13 addressing access, but it will also be broader work in a
14 more whole of government to support and address those
15 essential determinants of health.
16
17 MR GLOVER: We'll explore that a little bit further during
18 the course of the evidence, but in terms of addressing
19 equity challenge, does it require targeted responses
20 depending on where the particular segment of the population
21 is?
22
23 DR CHANT: Look, it requires - it's a really complex
24 system and to tackle equity requires action at all levels.
25 So I've just described the fact that we do look at data and
26 see the differential uptake of the data, but we also need
27 to map that with the underlying need of the population. So
28 for some population groups, we would actually expect them
29 to have fourfold or tenfold greater presentations because
30 of their underlying health need.
31
32 So in those circumstances, we would expect to see very
33 high levels of hospitalisation high levels of access to our
34 services commensurate with their need. It's a big
35 discussion about equity but happy to drill down.
36
37 DR LYONS: Could I expand on that?
38
39 MR GLOVER: Yes.
40
41 DR LYONS: It goes the other way as well, which is we also
42 need to be conscious of the fact that we don't provide all
43 services for all people. In fact, some people are able to
44 access services through other means, whether they have
45 private health insurance or the ability to pay for that
46 service outside of the services we offer.
47

1 Our job is to be the safety net for all of the
2 community, but there are, of course, many people who can
3 access health care through other means. It is then
4 a balancing act of ensuring that we're providing the
5 appropriate resources in the right places to adjust for
6 that, and that's an important factor that we constantly
7 monitor as well, because of the intersection between our
8 services and other service sectors. So primary care,
9 specialist care in private hospitals, aged care - all of
10 those have impacts and we need to be constantly monitoring
11 those impacts on our services.
12
13 DR CHANT: I suppose just to take it back one step, what
14 we are wanting to do is have the same outcomes. For the
15 same underlying health need, we want the same outcomes and
16 we know that the approach will have to be different to
17 achieve that. But that's ultimately what equity we want.
18
19 MR GLOVER: Thank you.
20
21 Ms Willcox?
22
23 MS WILLCOX: Just in terms of the statewide approach to
24 planning in your original question, apart from what would
25 be the supra LHD services that Dr Lyons talked about, we
26 also have policy frameworks at a ministry level, for
27 instance, for multicultural health or youth health that
28 give a framework to the LHDs around the considerations when
29 planning services for your local community. We have some
30 statewide demographic data that would support providing the
31 types of services or models of care that might be
32 appropriate. But that information then is for the local
33 health district to configure and provide in accordance with
34 their local needs and their own local planning and data
35 information so the two come together.
36
37 MR GLOVER: Paragraph 41 of the report, Dr Lyons, we see
38 reference to the Health System Advisory Council that you
39 mentioned earlier. I take it that is a relatively recent
40 innovation, if I can call it?
41
42 DR LYONS: It is. It has come about, I think, as a result
43 of our experience during the pandemic, actually, where, in
44 response to some of the challenge we faced in response to
45 meeting the needs of our services, we established a COVID
46 clinical council, which meant we had a direct voice from
47 frontline clinicians who were dealing with caring for

1 patients in that context, and felt the value of that voice
2 directly to the ministry which hadn't been present
3 previously.
4
5 The secretary and the minister are both very
6 supportive of establishing a central clinical voice,
7 multidisciplinary, so it's doctors, nurses, allied health,
8 some local management, people who are working in oral
9 health, as well as our other clinical services. They've
10 now come together with defined terms of reference and are
11 meeting - they've met three or four times now - and will be
12 continuing to support us with advice around the sorts of
13 things that will be very important for the system, not just
14 now but into the future.
15
16 MR GLOVER: How does that advice feed in to overall
17 planning at the ministry level?
18
19 DR LYONS: As I said, it's early days, but it's going to
20 be really critical that we establish effective pathways.
21 The deputy secretaries from all of the divisions in the
22 ministry are a part of the Health System Advisory Council,
23 as is the secretary. They are part of the discussions that
24 are being held and will hear directly from the clinicians
25 around how they see particular issues that might be brought
26 before the council and the advice that they would want to
27 provide around how the ministry could best support any
28 changes in service delivery, introductions of new
29 treatments.
30
31 We had a good discussion at the last meeting around
32 the impact of artificial intelligence on health service
33 delivery. So that will then inform the policy position we
34 take and the priorities around how we start to introduce
35 that type of change into the system.
36
37 MR GLOVER: So is it intended to function that this group
38 will take issues up to ministry level or that it will
39 provide advice on issues coming down or a two-way exchange?
40
41 DR LYONS: Two-way. So it is our view that the ministry
42 will have issues that they would like to seek advice from
43 the Health System Advisory Council about; equally, we want
44 to hear issues that are confronting our clinicians at the
45 front line, and this is an opportunity for them to have a
46 direct voice to the ministry on those matters.
47

1 MR GLOVER: At paragraph 43 of the report, reference is
2 made to the by-laws and some of the structures that are put
3 in place. Ms Willcox, I think we had an exchange about
4 some of them earlier.
5
6 MS WILLCOX: Yes.
7
8 MR GLOVER: Could I just ask you to explain in brief terms
9 each of those structures and their role in the system?
10
11 MS WILLCOX: Certainly. The medical staff executive
12 councils, as I mentioned, sit at the district level and
13 they are comprised of the chairs of each of the medical
14 staff councils that are in the hospitals and services, and
15 would have members of the - usually the chief executive and
16 members of the executive district team would be a part of
17 that meeting.
18
19 Medical staff councils are local medical staff
20 councils. Medical practitioners from across the variety of
21 departments belong to a medical staff council, meet around
22 monthly, have minutes that would be shared with the
23 hospital executive from time to time to help resolve
24 issues.
25
26 The mental health medical staff council, or an
27 approved alternative engagement mechanism, is a relatively
28 new medical staff council to bring our mental health
29 practitioners closer in. There's a number of other
30 mechanisms that some LHDs have, so we didn't want to say
31 "Dispense with that one and create this one", hence the
32 statement around "approved alternative".
33
34 Local health district/specialty health network
35 clinical councils - again, district level roles would have
36 representation from all disciplines and sit with the
37 district executive or network executive. There would be
38 a monthly meeting or two-monthly, with a structured agenda,
39 performance reporting, topical issues, quality and safety,
40 and things that the executive wanted to bring forward to
41 get guidance, and certainly for the clinicians to bring
42 forward those issues they're looking for support on.
43
44 The hospital clinical councils are a subset of that
45 group. They are at each of the hospitals and again would
46 have hospital executive teams on that and be
47 representatives from all disciplines in the hospital, and

1 it tends to follow, so that members or the lead on the
2 hospital clinical council would be the representative on
3 the district-wide clinical council, so there's a connection
4 of information to and from the local group through to the
5 district group and back.
6
7 MR GLOVER: Paragraph 44, Dr Lyons, reference is made to
8 the need to create a "patient-centred, effective and
9 equitable healthcare systems". What does that mean?
10
11 DR LYONS: A very laudable aim. It means that when we are
12 making decisions around how we should provide health care,
13 we should involve patients, carers and families in the
14 design of those services to ensure that they meet their
15 needs. This is an ever-challenging area of focus. I mean,
16 historically, there has not been as much involvement of
17 patients, carers and families in deciding how services
18 would be delivered, and increasingly, we are requiring
19 a concept of co-design, which is having the consumer or
20 patient voice very directly involved in decisions around
21 how we should deliver that service, to ensure that it is
22 actually going to meet the needs of the patient who will
23 receive that care.
24
25 We have tended in the past, I think historically, to
26 be a little focused around how we think that care should be
27 delivered, because we know how care should be delivered,
28 but increasingly, we are seeing the importance of this in a
29 whole range of areas, that patients should be directly
30 involved in decisions around how that care is provided as
31 well as being responsible with us for how those services
32 are delivered.
33
34 MR GLOVER: Why is that important in care planning and
35 delivery?
36
37 DR LYONS: Because we can assume things about what we
38 believe are best for patients, but unless we hear directly
39 from them, we may not be meeting their needs, and so it's
40 really important that we understand their needs and are
41 ensuring that the services that we provide will be best set
42 up to meet their needs. We'll get better outcomes for the
43 patients, there will be a better experience for the
44 patients, there should actually be the better experience
45 for the clinicians and teams involved in providing that
46 care as well, because it will be meeting the needs of the
47 patients, and there will be fewer concerns and complaints

1 from our patients around the service they receive because
2 it will be designed to meet their needs in the first place.
3
4 MR GLOVER: One of the other benefits of that referred to
5 in that paragraph is it drives greater innovation in
6 healthcare delivery. How does it do that?
7
8 DR LYONS: I think innovation has a whole range of
9 different contexts, but innovation at its core is around
10 doing things differently that might reflect different
11 circumstances, whether that's a growth in knowledge or
12 technology that's available or a treatment that wasn't
13 previously available, or it might be the context in which
14 it's being delivered, the service is being delivered.
15
16 We see lots of innovation in our system, particularly
17 where the system is challenged to provide a service and it
18 looks for different ways to deliver that care, and so we
19 see lots of innovative practice in the rural parts of our
20 system, because there may not be the same levels of
21 staffing or the types of staff available to do certain
22 things. There are different ways found to provide that,
23 and that's innovation, an example of innovation.
24
25 But having the patients, carers and families directly
26 involved in that ensures that that innovation will be
27 underpinned by the needs of those patients, no matter what
28 the setting.
29
30 MR GLOVER: Ms Willcox, did you wish to expand on that?
31
32 MS WILLCOX: Yes, thank you very much. Dr Lyons's
33 comments are very true, and I think the system has evolved
34 considerably over the last decades. I mean, principally,
35 our hospitals were designed for the staff that worked in
36 them, as opposed to the patients and families that were
37 coming into our care, and I think we're seeing
38 a considerable shift in that regard.
39
40 We've generated a document that's noted in
41 paragraph 45, called "All of Us", and it's a toolkit, for
42 want of a better term, to help our staff better connect
43 with patients and consumers and carers and help to redesign
44 and reconfigure how they go about their work. Dr Lyons's
45 point about it giving greater satisfaction to our staff to
46 be able to take the time and listen to patients and to
47 build that rapport is a much more rewarding experience than

1 going from task to task, which is not what they are trained
2 to do, nor do they intuitively want to do.
3
4 Just with the connection to the Health System Advisory
5 Council, as noted in paragraph 46, we're in the process of
6 developing a consumer council, which will be a statewide
7 peak consumer group in parity with the Health System
8 Advisory Council, so our consumers will be able to give
9 input up to us, give us guidance, and similarly we can talk
10 to them about those issues that we need them to work with
11 us on.
12
13 MR GLOVER: Is that a body that is in development, if
14 I can put it that way?
15
16 MS WILLCOX: Yes, in development currently. There are
17 many models from around the world, different jurisdictions.
18 I won't go through them all now, but there are many
19 configurations. We want to explore all the evidence from
20 other jurisdictions and we're working - obviously our
21 consumers are co-producing this with us.
22
23 MR GLOVER: Dr Chant, did you have anything further?
24
25 DR CHANT: No, I think that has covered that.
26
27 MR GLOVER: Dr Lyons, a couple of references have been
28 made already to the services agreements, and we might just
29 go to one by way of example. This is [SCI.0002.0013.0001].
30 For those working off hard copy, it is in volume 6 at
31 tab A47. Hopefully, you can all see the screen. Dr Chant,
32 there's a hard copy there.
33
34 DR CHANT: Thank you.
35
36 MR GLOVER: Volume 6, tab A47, Commissioner.
37
38 This is the "Service Agreement 2022-23" between the
39 secretary and the Northern Sydney Local Health District, by
40 way of example.
41
42 As a general matter, do they take a similar format
43 across the districts?
44
45 DR LYONS: They do.
46
47 MR GLOVER: If I can just start on page 6 - Commissioner,

1 I'm going to use the coded page numbers for the operator to
2 put it on the screen, so the top of the page.
3
4 THE COMMISSIONER: Got it.
5
6 MR GLOVER: Reference is made there in paragraph 2.1 to
7 the "Future Health Strategic Framework". Is it against
8 that framework that the key performance indicators are set?
9
10 DR LYONS: It is. It's a work in evolution, because the
11 future health strategy has only recently been adopted, and
12 so what we are doing is translating all of those key
13 performance indicators to reflect the strategic objectives.
14 Now, that's a process that is being worked through, so I'm
15 not sure it's as complete, yet, as it can be, but it is
16 a commitment that the strategic objectives and the future
17 health should drive what is actually being delivered and
18 how the services will be held to account. So the alignment
19 is very important.
20
21 MR GLOVER: Is that to ensure that across the state,
22 although they are dealing with local issues, the system is
23 pulling in one direction, if I can put it that way?
24
25 DR LYONS: Absolutely. Absolutely. That's the purpose of
26 it all and I think it has created that structure and the
27 processes around it to support that being a very
28 disciplined approach across the whole of the system. It is
29 one of the strengths, I believe, of the New South Wales
30 health system in regards to the centre being strong around
31 those things, the services at the local level understanding
32 their context and doing the things that are needed to be
33 done, but that strong connection and alignment between
34 where we need to go as a system as well as understand the
35 local needs.
36
37 MR GLOVER: If we go forward in that document to page 21,
38 here we see the key performance indicators set out in more
39 fulsome terms. Again, do I understand it that each of the
40 service agreements look fairly similar in this regard?
41
42 DR LYONS: They do.
43
44 MR GLOVER: The first one refers to "Overall Patient
45 Experience Index" and "Patient Engagement Index". What's
46 within those measures?
47

1 DR LYONS: These are parts of the surveys that are done on
2 a statewide basis that look at both the experience that
3 patients report on receiving care in our services, and the
4 engagement index is around whether they would recommend
5 that service. It's another type of question, so it's
6 around how they felt the experience was and whether or not
7 they felt they were part of their care and would recommend
8 it to others who were receiving care there. There are some
9 definitions around that but they're both defined and
10 they're part of a statewide survey which is consistently
11 applied.
12
13 MR GLOVER: Do those measures take into account outcomes
14 that those patients have received?
15
16 DR LYONS: Not so much clinical outcomes but experience,
17 we believe, is a very important outcome, so we would hold
18 experience and clinical outcome as very important
19 components of the care that is delivered, and both should
20 be measured to ensure that they are being delivered
21 effectively within the reported needs of the patient.
22
23 MR GLOVER: How is clinical outcome measured at the
24 moment?
25
26 DR LYONS: That's the challenge. I think we are all
27 challenged by clinical outcomes and we are working through
28 how we define those clinical outcomes in a way that is
29 meaningful for patients and for the clinical teams, and
30 that varies depending on the type of care and the type of
31 patient.
32
33 We have established through the Agency for Clinical
34 Innovation, and are now looking to implement, measures, and
35 we've got a system called the health outcomes and patient
36 experience data collection system. Developed clinical
37 systems around the world in developed countries are all
38 struggling with how to measure outcomes in a way that is
39 meaningful for patients and clinical teams but doesn't
40 burden the clinical team or the patient with extra data to
41 collect. It is a real balance and getting the sweet spot
42 is hard. So we're looking at how we can do that
43 effectively and do it in a way that is sustainable, and
44 that gives us the right measures that are meaningful to
45 clinical teams as well as to patients, carers and families,
46 and that's a work in progress. There's lots more work to
47 be done on that but we're well advanced in our thinking

1 around that.
2
3 DR CHANT: Perhaps if I could just add a few components.
4 In some domains we actually have very good outcomes. For
5 instance, in the cancer remit, we monitor survival,
6 five-year survival rates. We monitor - for many other
7 program areas, we have very good outcome.
8
9 I think what Dr Lyons is reflecting is that the
10 outcome data returning to the clinicians in an acute sense
11 is more challenging, but certainly we do monitor as
12 a health system how we're working in terms of mortality
13 outcomes.
14
15 We also have sentinel events systems that pick up when
16 things perhaps don't go well and there are opportunities
17 for systems learnings. So there is a framework where we
18 collect data. I think it is really in relation to the
19 timeliness of that back to clinicians.
20
21 We do measure a lot of process indicators as well, and
22 we know that for many of our programs, there's such good
23 strong evidence that if you do something, the outcome in a
24 population level for that clinical cohort will be very
25 good. So for many of our systems, we're also looking at
26 how we embed those process measures, which are easier to
27 capture, and return that information to clinicians in a
28 more timely manner.
29
30 MR GLOVER: What would be an example of the process
31 indicator that you've just described?
32
33 DR CHANT: So for process indicators, some of that would
34 be things - I'll choose maternity as an example. We ask
35 questions around have pregnant women taken iodine
36 supplementation and folic acid; are women breastfeeding
37 after delivery; immunisation, have they been immunised, we
38 know that will often protect the baby, if we are talking
39 about influenza and whooping cough vaccination. By knowing
40 that we actually have those systems in place, we can
41 actually be confident that we are supporting the mums and
42 bubs to be healthy in that critical period.
43
44 THE COMMISSIONER: Whose perspective is outcome judged
45 from? It could be objective or subjective. Is it hard
46 because great care can be provided but the patient doesn't
47 feel as though the outcome was as good as they were

1 expecting from the particular procedure they had?
2
3 DR CHANT: That's the really valid question. There's the
4 outcome from the clinician perspective and the outcome from
5 the patient perspective and that's why it's important to
6 measure both. But there would be shared indicators that
7 people would value - for instance, cancer survival,
8 disease-free intervals, not experiencing recurrent
9 hospitalisations, you know, periods of hospitalisations, if
10 you have chronic disease, if we have managed to maintain
11 you at home. For some indicators there is a general
12 alignment with what --
13
14 THE COMMISSIONER: Sure. If you have a complete cure and
15 you were treated with respect, the clinician and the
16 patient are going to think, "Fantastic outcome". But
17 I suppose if you went in for a hip replacement and it was
18 done perfectly but you thought you would be running within
19 four weeks and running really quickly, the clinician and
20 the patient might have different ideas.
21
22 DR LYONS: Commissioner, I think that's a really important
23 point. Patient reported outcome measures are a very
24 important component of the outcomes. They're not just the
25 clinical outcomes as defined by the clinical teams; it's
26 important that we understand and collect information around
27 the patients' outcomes - what they're expecting from the
28 treatment, first and foremost, and whether or not it
29 actually meets their expectations after the event. So
30 those are components of the data collection systems that
31 I said we are starting to develop more fulsomely and are
32 not yet available. But that's the direction we absolutely
33 need to go.
34
35 In terms of the data that Dr Chant has been talking
36 about, at the population level and in relation to large
37 services, we have very good, hard measures around mortality
38 and morbidity. What I was alluding to is probably more
39 refined outcome measures that relates to the care received
40 at an individual patient level and within a clinical team
41 where it is really important for the clinical team to
42 understand and be fed back the outcomes. We don't
43 routinely do that for many of the things that we do.
44
45 DR CHANT: Commissioner, I think you make a really valid
46 point in the sense that what we would really want the
47 system to be is much more shared transparent

1 decision-making, and for us, the fact that someone's
2 expectations were different to what the clinical treating
3 team - that's actually not good patient care. So we do
4 need that very clear --
5
6 THE COMMISSIONER: That's a communication problem, maybe,
7 yes.
8
9 DR CHANT: We really do want to see that sort of shared
10 decision-making, clarity about options and choices and
11 making sure the patients are fully informed about the range
12 of options. We know, for instance, some other
13 interventions, which are non-surgical interventions, can
14 give people good outcomes and improved mobility. So all of
15 the full range of options need to be discussed --
16
17 THE COMMISSIONER: Or just reduce pain, I imagine, too.
18
19 DR CHANT: Yes, reduce pain. So the full suite of options
20 really needs to be discussed, and that's what we would see
21 as patient-centred care.
22
23 THE COMMISSIONER: This is obviously important to everyone
24 in the health system, but the terms of reference keep
25 talking about "best health outcomes", but it doesn't define
26 what that term means, so we have to be sure we know what
27 we're talking about. It's not an absolutely
28 straightforward concept.
29
30 MS WILLCOX: Commissioner, if I could just add, in
31 relation to the patient report experience measures and
32 outcome measures that Dr Lyons referred to, they are
33 gathered in real time, and they enable patient and
34 clinician to have a discussion around what that experience
35 or outcome looks or feels like, so it actually builds that
36 communication and enables the clinician then to adapt what
37 care or treatment they are providing to meet what the
38 experience and outcomes noted by the patient are.
39
40 MR GLOVER: Just building from that, when you say "they
41 are gathered in real time", how, in practice, does that
42 happen?
43
44 DR LYONS: I will give you an example. So we're moving to
45 an online data collection system, so with validated tools
46 that actually collect information that can be used
47 objectively to measure the performance of that service and

1 look at things over time.
2
3 A lot of these are now online and the system we've
4 developed is actually available for patients to put input
5 into that system, either on a device in their own home in
6 advance of the clinical consultation, or if they don't have
7 access to those, in a clinical consult, before they see the
8 team, paper-based or device-based. But then if it's on the
9 system it can be used at the time of the consultation to
10 have that discussion with the patient about the things that
11 they're expecting to receive from the treatment, the
12 outcomes they're looking for, what's important to them.
13
14 MR GLOVER: Then is there a step post treatment to gather
15 further data from the patient?
16
17 DR LYONS: It's ongoing. So for chronic conditions, it
18 continues on over time, so that you can see and track over
19 time whether or not the experience and the outcomes are
20 improving through the treatments that are being received,
21 and if they're not, then you can tailor the treatment to
22 make sure it's starting to address the issues that the
23 patient sees as important.
24
25 So I think it's an advance which we're very pleased
26 that we're implementing. It now needs to be scaled up and
27 used more widely.
28
29 MR GLOVER: And that's a process that will touch a great
30 variety of patients from different backgrounds and
31 different life experiences with different levels of health
32 literacy. How does the system take that into account to
33 ensure it's getting the best possible data?
34
35 DR LYONS: It's being done in a way that's using tools
36 that have been used internationally and have been validated
37 as being appropriate questions and applied in the contexts
38 that we're delivering them. I think that will be a process
39 of continual refinement, based on our experience and
40 feedback from our patients as well.
41
42 MR GLOVER: How long has this system been up and running?
43
44 DR LYONS: Two or three years, I think it has been in
45 place, and we've piloted it in a range of different
46 clinical services.
47

1 Ms Willcox will be aware because, one of the services
2 we piloted it in was in Northern Sydney, in
3 musculoskeletal, I think, but it is not widespread yet, so
4 it has to be scaled up and broadened in terms of its
5 application.
6
7 MR GLOVER: I see. So this isn't a system-wide process?
8
9 DR LYONS: Not yet, not yet.
10
11 MR GLOVER: Recognising from the answers that have been
12 given in this last little passage the difficulty in
13 measuring clinical outcomes, how, if at all, are those
14 clinical outcomes taken into account in performance
15 management and KPIs for LHDs and specialty health networks?
16
17 DR LYONS: I think there's probably more of a focus on
18 process measures, to be fair at the moment. I think that
19 would be where the focus is, on the basis that if those
20 care processes are in place and delivered effectively, the
21 outcomes will be positive.
22
23 But we're not routinely collecting in a way that
24 reports back through the service agreements outcomes. Some
25 of the reason for that is that some of those outcomes can
26 be over a longer period of time so they're difficult to
27 relate to a service agreement annual cycle. The other
28 component of it is that it's not just what we do.
29 Particularly for people who've got chronic conditions, they
30 receive treatment in a whole range of different settings.
31 A lot of that will be in settings that we're not directly
32 responsible for. So what happens in those settings can
33 have a direct bearing on their outcome, so attribution of
34 that is a challenge as well.
35
36 I think we will be moving more towards outcome
37 measurement but we need to be very careful about how we
38 introduce it to ensure that we're holding the right people
39 accountable for those outcomes and that we're able to
40 report back in a way which is meaningful to the clinical
41 teams and to the patients.
42
43 DR CHANT: I suppose, Dr Lyons might want to touch on the
44 fact that there are some clinical quality outcomes related
45 to it, so that's sentinel events, falls in hospital or
46 bloodstream infections. So there are some clinical
47 components that are suitable for feedback for --

1
2 DR LYONS: For all patients.
3
4 DR CHANT: -- all patients, but suitable to reflect in a
5 cycle of a service agreement.
6
7 MR GLOVER: Is that because those types of things are a
8 little bit more readily measurable?
9
10 DR LYONS: That's correct. Things like hospital-acquired
11 infections, falls, the things that Dr Chant has outlined,
12 are measured all the time, now, in the system and are able
13 to be reported back directly and they are part of the
14 service agreement indicators around quality.
15
16 MS WILLCOX: I was just going to add that the
17 information around length of stay, the hospital-acquired
18 complications, people having unplanned readmission in a
19 short period of time, those measures which sit in the
20 service agreement can be seen by broader department level,
21 so clinicians are able to see their results with teams, and
22 have discussions around these things and it means the
23 executive and clinicians can work, if they are seeing some
24 variation of there. Variation of itself is not a negative
25 thing, but it is always worth inquiring. So they are
26 process measures but they do allow for good engagement at
27 a local ward or unit level to have a look at their patient
28 care.
29
30 MR GLOVER: Is the effect of those combined answers that
31 it may be easier to measure where things haven't gone quite
32 to plan than when they've gone well?
33
34 DR LYONS: It's more a reflection, I think, of what the
35 process measures are, the things that we are able to easily
36 measure, so that's what we tend look at. Particularly
37 where there are things that lead to an adverse outcome, we
38 want to focus on those to ensure they don't occur, so I
39 think that has been the process we've followed with the
40 quality care indicators particularly in inpatient settings.
41
42 MR GLOVER: Can we go ahead in that document to page 28,
43 please. This sets out a number of key deliverables under
44 the heading "Performance Deliverables". Again are these
45 relatively uniform across the service agreements?
46
47 DR LYONS: They are.

1
2 THE COMMISSIONER: Is that page 27?
3
4 MR GLOVER: It's 28 at the top.
5
6 THE COMMISSIONER: Yes. Sorry, my fault.
7
8 MR GLOVER: Are these individual deliverables or statewide
9 or a mix?
10
11 DR LYONS: Could you just explain that question?
12
13 MR GLOVER: Yes. How are they set, is probably a better
14 way to put it?
15
16 DR LYONS: Okay. So they're set on a statewide basis and
17 reported on by the districts in relation to their own
18 performance.
19
20 MR GLOVER: Is this an example of something coming from
21 the centre, to pick up a phrase that you used earlier?
22
23 DR LYONS: That's correct, yes. So it's about what is
24 defined as a level of performance we would want to see
25 consistent across the system, and then each of the
26 districts will report against their own performance in
27 relation to that.
28
29 MR GLOVER: Thank you. That document can be taken down
30 and we will go back to the report, please.
31
32 In paragraphs 48 through to 54, reference is made to
33 the pillars. Ms Willcox, I might ask you. We have some
34 general descriptions in those paragraphs about what the
35 responsibilities of each of the pillars are, but perhaps
36 some practical examples might assist in the work that
37 they're doing on the ground. If we start with the Agency
38 for Clinical Innovation and then take each in turn?
39
40 MS WILLCOX: Thank you. The Agency for Clinical
41 Innovation, one of their great strengths is the clinical
42 networks that are established as part of them. So for
43 specialty areas, it might be maternity, orthopaedics,
44 anaesthetics, critical care, there will be a group of
45 clinicians from local health districts and networks who
46 come together to look at clinical variation, to look at
47 models of care, innovation, look at data from other

1 jurisdictions as well as local, and help guide
2 evidence-based best practice for the system. Their work is
3 then shared across the local health districts for local
4 implementation, if it's agreed it would form the basis of
5 a statewide model, for instance.
6
7 MR GLOVER: Just a couple of terms you used there -
8 "clinical variation", what does that mean?
9
10 MS WILLCOX: There would be, for particular surgical
11 procedures, for instance, an expectation that a person
12 would have a particular length of stay, you know, be able
13 to do certain things at the end of that hip replacement,
14 for want of a better - I'm just trying to think of
15 a practical example.
16
17 If we're seeing variation, ie, extended lengths of
18 stay or hospital-acquired infections in surgical sites,
19 you'd have to say that might be a variation that was
20 a problem and worth delving into.
21
22 But other variation in other facilities with very
23 short lengths of stay may be very positive. One example of
24 that is that Royal North Shore, and I think also Lismore
25 Hospital and perhaps others now, are doing hip replacements
26 and/or knee replacements in a day. So it's about gathering
27 the evidence and having a look at contemporary models of
28 care and seeing what we can do to learn and improve and
29 spread that evidence base across the system, so it's not
30 pocketed in particular hospitals or services.
31
32 MR GLOVER: "Models of care" was the very next one I was
33 going to ask you about. What do you mean by "models of
34 care" when you use that phrase?
35
36 MS WILLCOX: A model of care - it is a term used broadly,
37 but essentially a model of care is how we can provide some
38 consistency in the care of an individual, noting every
39 individual has their own particular needs and complexities,
40 but how that care or that service care should be provided
41 in our hospital or service. So there would be an
42 expectation prior to surgery that you would be seen
43 pre-admission and have a particular round of tests, things
44 done to check on your pre-surgical condition; the day
45 you've come into hospital, the day of surgery, what you
46 required, did you need to stop your medications, where you
47 would go, what you could expect in terms of your surgical

1 procedure, where you would wake up, what you can expect
2 with drips and drains, and the like. So the model is
3 really describing the process of care that we're going to
4 provide.
5
6 THE COMMISSIONER: A clinical pathway is what you're
7 describing?
8
9 MS WILLCOX: A clinical pathway is probably a tighter way
10 of describing it, yes.
11
12 THE COMMISSIONER: I'm known for my efficiency.
13
14 MR GLOVER: Please continue.
15
16 MS WILLCOX: Thank you.
17
18 So Bureau of Health Information - Bureau of Health
19 Information has been, I think, at least a decade in
20 existence, it's an independent report on our health
21 performance. They have generated a range of surveys over
22 that period of time to measure access performance,
23 including emergency department, how long it takes to
24 receive care; surgical performance, is it done in a timely
25 way; in relation to our ambulance performance and our
26 safety and quality. So they extract data from across the
27 system and run quite a rigorous methodology across those
28 datasets to give what would be a statewide view of what
29 performance is relative across the system, depending upon
30 the complexity of the patients.
31
32 The Cancer Institute. The Cancer Institute is created
33 by legislation to provide particular expertise in the care
34 of individuals with cancer. As Dr Chant commented, one of
35 the great things that the Cancer Institute has developed
36 over time is looking at survival rates and mortality rates
37 for different types of cancers in patients so that we can
38 maximise their survival outcomes and their quality of life
39 outcomes, identifying hospitals that might perhaps be
40 providing only very low volumes of a particular type of
41 cancer care or surgery and ensuring that those procedures
42 are done in centres that are multidisciplinary with enough
43 volume and the requisite infrastructure and services to
44 give the very best survival and mortality outcomes for
45 patients.
46
47 They also provide a lot of preventative advice around

1 skin cancer care, tobacco, and the like, and a research
2 profile as well.
3
4 The Clinical Excellence Commission is really our peak
5 part of the system that guides safety and quality across
6 the system, heavily led by clinician engagement as well and
7 evidence bases from around the world and locally, in order
8 to drive safe quality care and consistency across the
9 system, so develop policies and guidelines to enable that
10 so that we all have the same approach to infection control,
11 sepsis, a deteriorating patient, and other significant
12 events.
13
14 They are also responsible for looking into adverse
15 events that may occur in the system to give an independent
16 view of how care is being approached and what might be the
17 learnings or changes that need to occur as a result.
18
19 The Health Education and Training Institute
20 essentially coordinates, as paragraph 54 says, the training
21 and education across the system. Training and education is
22 part of the DNA of our healthcare services. It happens at
23 every interaction, every point, pretty much, in the system,
24 but HETI supports that by working with the colleges and
25 other training providers, stands up modules around
26 mandatory training, whether that be for respecting the
27 difference, for fire training - there's a myriad of
28 training modules that HETI provides because they're the
29 ones that, across the state, all staff, all clinical staff,
30 would be required to do.
31
32 THE COMMISSIONER: Did you say "fire training"?
33
34 MS WILLCOX: Yes, fire and safety training.
35
36 THE COMMISSIONER: What, being a fire warden?
37
38 MS WILLCOX: Say again?
39
40 THE COMMISSIONER: Being a fire warden?
41
42 MS WILLCOX: No, it's so that staff have basic skills in
43 attending to - in the event there were a fire in a ward or
44 a unit, they would know how to respond.
45
46 THE COMMISSIONER: I've got it, yes.
47

1 MR GLOVER: How are they funded?
2
3 MS WILLCOX: So all of the pillar agencies are funded out
4 of the health budget and allocated that on a base budget
5 that would be reviewed annually to see if there are
6 additional programs or activities they're required to do
7 that require supplementation.
8
9 MR GLOVER: In the following paragraphs, 55 through to 57,
10 reference is made to "statewide services". What are the
11 benefits of these services being provided on a statewide
12 basis as opposed to being provided at a local basis?
13
14 MS WILLCOX: Do you want to talk to health protection? We
15 might do them one --
16
17 MR GLOVER: Yes.
18
19 MS WILLCOX: Just in a general comment, both ambulance and
20 pathology and health protection are fundamental service
21 activities that all parts of the health system require. So
22 having a statewide approach in order - how an ambulance
23 service is run, where paramedics are, how they're
24 dispatched and how that's managed as a system, there's an
25 efficiency around that as well as a quality control around
26 that, because it's statewide; people don't live and require
27 services within a geographical area alone.
28
29 Pathology, there was a large body of work, and
30 Dr Lyons actually led this organisation so can talk to it
31 more fulsomely, but again pathology and having consistency
32 around how pathology is collected, the results, the sorts
33 of infrastructure you require to manage a complex health
34 system that has simple blood tests right through to some of
35 the most complex DNA and genomic testing, having
36 a statewide approach to how those services are networked is
37 efficient and adds to capability.
38
39 I will let Dr Chant speak to health protection because
40 that's in her bailiwick.
41
42 DR CHANT: Health Protection NSW is a statewide service
43 that is reporting into me as the chief health officer. It
44 is headed by Dr Jeremy McAnulty, our public health
45 physician.
46
47 We also have a network of public health units which

1 are located in local health districts. Some of those
2 public health units bridge two local health districts such
3 as Western NSW is hosted across both - covers Far West; in
4 general, Murrumbidgee and Southern is also a shared public
5 health unit, and for Northern and Mid North Coast there is
6 a collective public health unit.
7
8 The most critical element of the public health units
9 is that they're embedded within the local health district
10 and report up through the local health district reporting
11 structures. But the benefits of having this networked
12 system means that we have on the ground people to follow up
13 infectious diseases, but we can then centralise that
14 intelligence. As you know, people move around the state,
15 and so it makes no sense for communicable diseases to be
16 looked at within the confines of the local health district.
17
18 We then report up into a national surveillance system,
19 so there still might be the need to work in other
20 jurisdictions, with the Commonwealth, with the Therapeutic
21 Goods Administration, with other national stakeholders, and
22 so we do that work at the centre.
23
24 We also work across government, and our local public
25 health units then connect with government locally and all
26 the other services that they're embedded within.
27
28 MR GLOVER: Dr Lyons, did you wish to add anything?
29
30 DR LYONS: Only to say that, at a high level, these are
31 services which, on balance, providing them across the state
32 provides a better service delivery model through economies
33 of scale efficiencies, standardisation of practice, getting
34 a consistent approach in terms of the way those services
35 are delivered. So that's where the services have been
36 delivered on a statewide basis, the benefits of doing so
37 have been achieved and why they've been picked out to be
38 delivered as statewide services.
39
40 MR GLOVER: Are there any limitations in delivering them
41 on a statewide basis?
42
43 DR LYONS: I think it's always about that relationship
44 with the services at the local level, because they are part
45 of the system so there's a requirement for all of these
46 services to have an effective working relationship with our
47 clinical services right across the state, and so those are

1 ongoing and are important, but I think they're being
2 delivered in a way that is - the feedback from the
3 customers is able to be received and fed back into the way
4 they're operating.
5
6 DR CHANT: I would like to highlight that health
7 protection is probably slightly different, because it's
8 really embedded within the local health district and we
9 have the networked arrangement to the state, and I think
10 that benefits very much from the local knowledge, the local
11 operating context and how important and critical that is;
12 but also the opportunity that the public health units have
13 to leverage off the broader assets within the local health
14 district, so, for instance, community health nurses or
15 other professionals that they require to do their response.
16
17 MS WILLCOX: If I perhaps could just add in relation to
18 pathology, just as another example, pathology departments
19 exist in most of our hospitals, and those relationships are
20 integral with our clinical teams in order to ensure that
21 we've got the tests that are required and the capability to
22 care.
23
24 For instance, if you're at a Royal Prince Alfred or a
25 Royal North Shore, with very sick patients, the types of
26 pathology services you might need might be different to
27 somewhere in a small rural community, but those services
28 are networked. The local health districts have regular
29 meetings with their New South Wales pathology partners,
30 they are divided into networks across the state, so it is
31 again a very embedded relationship with the sharing of data
32 and information to make sure the services they're
33 providing, even though statewide, are working locally with
34 the teams.
35
36 MR GLOVER: The concept of networked services comes up in
37 a few places. What does it mean at a practical level?
38
39 MS WILLCOX: In a practical level, it goes to the point
40 that for some things - for instance, Dr Lyons referred to
41 clot retrieval in stroke patients. It's not conceivable
42 that you could have that capability infrastructure and
43 multidisciplinary team in every hospital or service across
44 the state. Decisions are made around the location for
45 that, based on all those things I just outlined, and then
46 the networking is done to enable that accessibility and
47 equity issue that we've talked about also, so that if

1 a person is in a different area, that there's a
2 communication pathway, clinician to clinician, so those
3 services are then networked to enable the access that that
4 person might require, even if they're not on that
5 particular location.
6
7 So networking is about ensuring capability is in the
8 right places, it's about ensuring we maximise the spread of
9 our services, so they have greater access to our community.
10
11 At a local health district level, those services will
12 be networked between, frequently, a flagship hospital and
13 a smaller, less complex hospital. If I take Sydney Local
14 Health District, for example, they have Royal Prince Alfred
15 and they have Balmain and Concord and Canterbury, all very
16 different in terms of what they provide. But if you're in
17 that area and need to come into care for that, your care
18 will be attended to at the right level of hospital with the
19 right capability, and that networking of services enables
20 that geographical spread and that improved access for
21 patients.
22
23 MR GLOVER: That straddles local health districts?
24
25 MS WILLCOX: Yes, it does.
26
27 DR LYONS: Indeed it does. In fact, it is very defined.
28 We have what is called a role delineation which includes
29 defining the level of service that is provided, quite
30 explicitly, and each of the hospitals or services within
31 the state will define what role they play and then how it
32 relates to another service, so that if they can't provide
33 that service locally, what the connection is to ensure that
34 a patient who needs that can be cared for appropriately by
35 referral on.
36
37 MR GLOVER: When you say "role" and "service", you mean
38 the treatment that can be delivered in that context?
39
40 DR LYONS: Yes. It defines what resources are available
41 locally, how that relates to the lowest level of service
42 that could be potentially provided, to the highest level
43 across the state. I think there are six levels, six being
44 the highest, zero being no service at all, so each of the
45 services would define what level they are and how that
46 creates a network either within the district or across the
47 state for that service.

MS WILLCOX: One example would be an intensive care service that is now networked between Royal Prince Alfred Hospital and Broken Hill Hospital. It's a virtual model that enables the clinicians at both sites to connect, for the clinicians at RPA to observe a patient in Broken Hill and assist those local clinicians to make the appropriate decision of care. That may be to transfer a patient out, but it may be that that care can be managed locally.

So there's the networking within a district, there's the network at state level for the sorts of services that Dr Lyons described, but there might even be networks of the nature which are a more innovative nature, to continue to ensure that we can improve access: no matter where you live, you can get access to these particular services.

MR GLOVER: Dr Chant, did you wish to add anything?

DR CHANT: I suppose just in drug and alcohol, we've seen the advantages of telemedicine in addressing some of the equity of access issues. For example, there are hubs out of both Hunter New England Area Health Service and also St Vincent's that actually support rural/regional through a telemedicine hub.

So again, these are just innovative ways in which our services are networked. So the networking probably happens seamlessly, there are also referral pathways - many of our clinicians travel to rural/regional, so at all levels there's networking.

MR GLOVER: So there is some organic networking as well as defined --

DR CHANT: That's correct. Defined and structured networking.

MR GLOVER: Lastly on this topic, in paragraph 58, reference is made to the stability of the governance framework over the last decade, although there's an opportunity to assess the balance between centralised decision-making and devolution. What are the opportunities that you each see in that area?

DR LYONS: I think it's constantly under review, but if I use the example of planning, and we've talked about

1 planning a little bit during the course of this morning's
2 conversation, we have, under our devolved arrangements,
3 left most of the decisions around planning of services and
4 in particular the planning of new hospitals, to the local
5 health districts, and in the course of the last 10 years,
6 what we have identified is that perhaps we are planning for
7 more of the same with our hospitals; we are focusing on
8 delivering bigger and better, and more beds. If you look
9 at what the directions are in the future health strategy
10 and the needs of our community, perhaps our focus needs to
11 be more out of hospital. While hospitals are very
12 important and we need to maintain their expertise and
13 support that, the balance might be that we have more
14 investment in community-based services rather than
15 continually building bigger and larger hospitals with more
16 beds.
17
18 So on balance, the governance arrangements, it might
19 be an opportunity to start to say, "Well, in terms of
20 planning those facilities, perhaps we bring some of the
21 planning oversight around the building of new capital to be
22 more closely scrutinised by the centre, before final
23 decisions are made around what will be built", to challenge
24 some of that thinking and to think about, you know, perhaps
25 what might be different rather than building more of the
26 same. That's an example of that balance, and where,
27 historically, we might have had more centralised decisions
28 that have been devolved, now we're saying that what we're
29 experiencing is perhaps that we need to bring some of that
30 closer to the centre so that we get a better outcome in
31 terms of resources.
32
33 THE COMMISSIONER: That's to get the capital expenditure
34 aligned with the health services that are likely to be
35 needed to be delivered?
36
37 DR LYONS: That's correct, Commissioner. What we're
38 seeing is that with the capital builds and the operating
39 costs of those, if you map those out into the future, it's
40 going to be a real challenge for us to do that within the
41 budget we have available. So it is about starting to think
42 about what's the better alignment of capital build
43 resources and how they are deployed to get the best balance
44 of service delivery.
45
46 MR GLOVER: Dr Chant, do you see any opportunities in
47 relation to the balance between centralised and devolved

1 decision-making?
2
3 DR CHANT: I think Dr Lyons reflected that that's
4 continually under question, which services can deliver the
5 same patient connection and meet the needs of clinicians,
6 and the question is clearly the centralised approach to
7 health pathology - I would like to do a big callout,
8 I think that has been a really amazing success and
9 supported a lot of the health protection and other areas in
10 my portfolio, but are there other services that would
11 similarly, because of the investment in technology --
12
13 MR GLOVER: Radiology, for example?
14
15 DR CHANT: There would be a range of things that could
16 be - the question needs to be asked, which things need to
17 be centralised. But I think the key component is --
18
19 DR LYONS: And why.
20
21 DR CHANT: And why. But the key component to that is
22 a recognition, though, that we need to support the patients
23 and the clinicians at the coalface. So any decisions
24 around centralisation need to still be very connected and
25 embedded and meeting service needs, because ultimately we
26 deliver health care, and that's a very human experience for
27 patients and the clinicians involved. But there may well
28 be some services that we consider would benefit from
29 a greater statewide governance, and that's continually
30 under review.
31
32 MR GLOVER: Ms Willcox, do you wish to add anything?
33
34 MS WILLCOX: I think this debate, we have to have with our
35 communities as well. The comments that Dr Lyons made
36 around the capital planning are absolutely correct, and
37 I think there's an opportunity to test some of the
38 assumptions that we think - what we need in terms of built
39 form and what does community want and expect. We know
40 that --
41
42 THE COMMISSIONER: It's not just building more
43 infrastructure; it's also whether you hold on to some
44 infrastructure?
45
46 MS WILLCOX: Yes, that's right.
47

1 THE COMMISSIONER: Which is where the community and
2 politics might all come into play.
3
4 MS WILLCOX: Yes, and there's no question that the
5 community have had an expectation that they have a hospital
6 in their community and they expect that it may be rebuilt
7 or renovated at particular points and they need additional
8 things, and that's all absolutely appropriate. But I think
9 it's about having a discussion around the community-based
10 care, some of the other options. There's no doubt that
11 during COVID the evolution of doing things differently has
12 really accelerated and our own planning processes have not
13 accelerated at the same rate, not surprisingly because we
14 were dealing with COVID, but it is something that we do
15 need to attend to and work with the community on.
16
17 MR GLOVER: Thank you.
18
19 Is that a convenient time.
20
21 THE COMMISSIONER: Mr Glover, no-one can grab your gown
22 and give it a tug, but I think your co-counsel wanted to -
23 perhaps you can do it over the break.
24
25 MR GLOVER: We can do that over the break.
26
27 THE COMMISSIONER: You can do it over the break.
28
29 MR CHENEY: Commissioner, might I inquire whether there is
30 any difficulty with my team speaking with the witnesses
31 during these breaks?
32
33 THE COMMISSIONER: No, not at all. I don't think they are
34 being cross-examined in an adversarial setting, so that's
35 fine. But have a conversation with Mr Glover as well about
36 what the discussion is about. But otherwise, yes, that's
37 fine.
38
39 We will break until 5 to 12.
40
41 MR GLOVER: Thank you.
42
43 **SHORT ADJOURNMENT**
44
45 THE COMMISSIONER: Can I just ask a question first?
46
47 MR GLOVER: Of course you can.

1
2 THE COMMISSIONER: When we were talking about patient
3 outcomes and - sorry, health outcomes and getting feedback
4 from patients, were any of you referring to HOPE? Sorry,
5 that was part of the workshop we had on - that was the
6 program that was being --
7
8 DR LYONS: It's health outcomes and patient experience,
9 Commissioner.
10
11 THE COMMISSIONER: Yes, thank you.
12
13 MS WILLCOX: It is the ICT platform that's used to
14 develop --
15
16 THE COMMISSIONER: Yes, all right. I think the way it was
17 described to us, apart from giving direct feedback from
18 patients about what their experience was, it's - I think it
19 was explained to us that it can be also a means of
20 identifying low value care. One of the notes I made was -
21 for example, the note I made was, "I've had an arthroscopy.
22 My knee is no better". If that's the feedback multiple
23 times, then it's a means of identifying low value care as
24 well.
25
26 Okay, thanks. Go ahead.
27
28 MR GLOVER: Thank you.
29
30 Just before we move to funding, in terms of the
31 balance between centralised decision-making and devolved
32 decision-making, is one of the challenges the sharing of
33 information or innovations between districts?
34
35 DR LYONS: That is an ongoing challenge.
36
37 MR GLOVER: How is it addressed?
38
39 DR LYONS: We have established a range of mechanisms to
40 assist in that regard. You would have heard of the role of
41 the Agency for Clinical Innovation - that is one example.
42 But all of the pillar organisations have been established
43 to have a statewide remit but have a presence in the local
44 health districts in clinical services as well, through our
45 directors of clinical governance in relation to the
46 Clinical Excellence Commission, who have a relationship
47 with the Clinical Excellence Commission, through the

1 clinicians who are part of the clinical networks and the
2 Agency for Clinical Innovation.
3
4 Health, Education and Training Institute have
5 a connection with the local health districts through the
6 education practitioners within the districts. So all of
7 them have been established to try to ensure that there is
8 an opportunity, where there are pockets of excellence or
9 better practice or innovations that have potential to
10 benefit the whole system, that they are able to be
11 acknowledged, but then shared through those mechanisms.
12
13 Now, that isn't always easy to achieve, because, what
14 might be a priority for one local health district in their
15 context and the things they are dealing with, may not
16 necessarily be a priority for another. And equally, as we
17 have tried to share some of these examples of better
18 practice, the way services are delivered in one context is
19 not always the same as they're delivered in another by
20 nature of the fact of the way the services are offered, the
21 staff that are in those services, the experiences that they
22 have - like, their qualifications and experience might be
23 difference and the mix of staff might be different.
24
25 It is not as easy as just taking what is happening
26 here and saying it now has to happen over there. It needs
27 to always be contextualised and supported, and the other
28 issue is that the skills in managing change are a skill set
29 which need to be supported in their own right.
30
31 So issues around how you redesign a clinical service,
32 how you embed and sustain those changes in clinical
33 practice, is a specific skill set with evidence around it,
34 and not all of our staff have had access to that evidence
35 base or that education and training.
36
37 So those organisations are not just looking for those
38 opportunities but are also involved in providing that
39 education and training and that skill set development
40 across the system.
41
42 It is a really important area of focus. It is
43 sometimes simplistically thought that, well, if it is
44 happening over there, why doesn't everyone just do it?
45 There are a whole range of reasons why that is not always
46 possible, but our role is to facilitate support, and if it
47 is necessary, ultimately, to mandate a change because it is

1 of such value and so important that we address it as
2 a priority across the whole health system, to do that as
3 well.
4
5 DR CHANT: Could I add with the research lens how we also
6 enable this. I think Dr Lyons has talked about how we use
7 clinical networks, and those could be through the ACI but
8 also through other program areas.
9
10 The next way we do it is through supporting research,
11 because obviously one of the first steps before you might
12 scale an initiative is generating the evidence that it
13 meets the outcomes, it's effective. So we have a program
14 that is run by Jean-Frederic Levesque's area in the Office
15 of Science and Medical Research, which is called the
16 Translational Research Grants Scheme.
17
18 This enables districts to put up projects which they
19 actually think have the potential to scale and it provides
20 funding very often and a proper evaluation of that. That's
21 also reviewed by experts, but people within the ministry
22 who can also look at those issues that Dr Lyons spoke
23 about: is this something that truly could be scalable,
24 because of the context, and perhaps even in the development
25 of those research projects, bring in other districts, so
26 that it's not just one district that starts off, we
27 actually partner with another, we might want to test across
28 a rural/regional and say, "Could you find a rural partner
29 to demonstrate the scalability of this initiative". So
30 that's just another example, and there is also a report
31 that's been completed on how those initiatives have been
32 implemented and scaled.
33
34 MR GLOVER: Ms Willcox, before the break we were
35 discussing networks, both organic and policy based, if
36 I could put it that way. To the extent that they are
37 centralised in terms of design, how are they designed to
38 ensure that they're effective and there are no gaps across
39 those networks?
40
41 MS WILLCOX: If I take an example of intensive care
42 services, ensuring that within a local health district - so
43 if we talk within the geographical confines of a district -
44 reference to the clinical service planning and the role
45 delineation of the hospitals within that district will be
46 relevant to how and where they network their critical care
47 services. So it might be the major flagship hospital will

1 have all of the complexity of critical care that you might
2 expect, with ventilation support and blood pressure and
3 heart and a range of things, but a smaller hospital in the
4 district will provide some sort of lower-level coronary
5 care monitoring - oxygen and the like.
6
7 So the aim is to look across the local health
8 district, understand your role delineation, the capability,
9 workforce and infrastructure resources, and to cross-check
10 that, within a defined area, you have the capability to
11 care for people if they come into your care or cross your
12 border into your geographic boundary into care.
13
14 When it comes to the larger services that I think
15 Dr Lyons referred to previously, such as burns and spinal,
16 that lifts up to another level and ensuring that patients
17 who require that complex burns service or trauma care, it's
18 about including communication with clinicians with our
19 ambulance services, our aeromedical retrieval and our other
20 emergency responders, so that there is a knowledge and
21 a protocol that identifies the appropriate location for an
22 individual to go, depending on their needs.
23
24 MR GLOVER: The more organic networks, do they develop
25 through relationships between clinicians in different
26 areas?
27
28 MS WILLCOX: Yes, I think that that is true. For a large
29 system, there is a high level of connectivity between our
30 clinical staff. People work and collaborate across
31 boundaries, they research together, they do clinical trials
32 together, they do studies together. The Agency for
33 Clinical Innovation, as mentioned earlier, the broad and
34 vast representation of clinicians across those networks is
35 another way in which information is shared.
36
37 Now, some of that will be formally propagated across
38 the state or across particular local health districts, but
39 some of that information sharing will just come back from
40 an individual back into their service and generate
41 discussion and potential change and redesign.
42
43 MR GLOVER: Do those more informal networks sometimes
44 develop into formal networks to ensure that the benefit of
45 them continues even if the personalities change?
46
47 MS WILLCOX: Yes, I'd hark back again to the Agency for

1 Clinical Innovation really as being the engine room for
2 that to occur. There are other things that we do, however,
3 in the system, such as recognising innovation through local
4 awards and for staff to present at forums, for those things
5 to come forward to the senior executive forum - that all
6 the chief executives of the pillared, shared services and
7 special networks attend every month - and again, it may
8 appear informal in a sense but these things are quite
9 deliberate, that we encourage staff to tell the story
10 around how they've designed a particular service, we're
11 very focused on the outcomes and the evaluation of things,
12 and that is shared amongst colleagues and promoted from
13 various means of communication, whether it be websites or
14 newsletters, through the secretary's message out to the
15 system.
16
17 MR GLOVER: I'm going to move on to the topic of funding.
18 Again, I think, Dr Lyons you've been nominated as the lead
19 for this series of questions.
20
21 THE COMMISSIONER: Just before you do, you asked some
22 questions about paragraph 58 of the report.
23
24 MR GLOVER: Yes.
25
26 THE COMMISSIONER: Can I just ask any of the witnesses -
27 I think you were asking Dr Lyons, but it doesn't matter -
28 Mr Glover asked, "What did you mean by 'opportunity to
29 assess the balance between centralised decision-making and
30 devolution?'" The paragraph is in the context of the
31 pandemic. Is relevant to that the review that I think was
32 called "As one system" and some of the findings in relation
33 to that, or was that more specific to a public health
34 crisis rather than something broader?
35
36 DR CHANT: I think that probably the linkage to the
37 pandemic just reflects on the fact that the pandemic
38 implemented a range of systems which demonstrated different
39 ways of working, many of which were effective and very
40 acceptable to communities. So I think the link to the
41 pandemic was not really the one systems review. It was
42 more reflecting that the pandemic led to a number of
43 innovations, probably e-prescribing, electronic
44 prescribing, the growth of telemedicine.
45
46 There has also been a lot of evidence generated
47 through that period with different modalities where we can

1 be more confident that they are acceptable to patients and
2 deliver the outcomes, however - you know, a perspective on
3 outcomes.
4
5 I think that that reflects the opportunity to, even
6 within a district, potentially do more centralisation,
7 particularly if you are scrabbling with workforce
8 shortages, and so I think it just is that opportunity. The
9 governance - the devolution could be within a district, to
10 a more centralised structure, and then also reflecting from
11 the districts to the state. So I think it was really the
12 terminology, at least from my perspective, was in
13 reflection of the pandemic and how it had opened up
14 different possibilities of service delivery configuration.
15
16 DR LYONS: I think to expand on that a little bit,
17 Commissioner, the other comments around the pandemic
18 response was that the way we were structured enabled us to
19 respond quite rapidly to the crisis of the pandemic, and
20 there were a number of decisions that were made centrally.
21 We had a regular assessment of the level of risk in our
22 facilities and agreed on a ratings scale of risk, and what
23 that meant in terms of PPE use right across the system,
24 which was consistent, being set up with the CEC and with
25 the structures that we had enabled us to do that.
26
27 Equally, the deployment of personal protective
28 equipment through procurement through HealthShare meant
29 that we made sure we had availability of PPE right across
30 the system and that we never ran out because of the
31 centralised approach.
32
33 Pathology was another example of where we were able to
34 set up testing and be really flexible about that and ensure
35 that access to testing was maintained right through right
36 across the state. I think what we have reflected on is
37 that the benefits of some of these system-wide and
38 statewide services within the context of local
39 decision-making as well, on reflection, has provided us
40 a very good system and we need to continually assess. It
41 depends on our context as well in relation to a crisis, you
42 centralise a lot of things because you have to, but it also
43 allows us that assessment of, well, what do we need to keep
44 centrally, what do we continue to allow local
45 decision-making on and making sure we continually assess
46 that?
47

1 THE COMMISSIONER: Sure. Thanks.
2
3 MR GLOVER: We move to the general topic of funding, and
4 that is dealt with in paragraphs 4 and following of the
5 report.
6
7 Just to set some context, Dr Lyons, the funding of the
8 public hospital services is a shared responsibility between
9 the Commonwealth and the state and territory governments;
10 is that right?
11
12 DR LYONS: That's correct, under the structure systems and
13 processes of the National Health Reform Agreement.
14
15 MR GLOVER: And those structures evolved from reforms in
16 about 2011, and commenced in 2012; is that right?
17
18 DR LYONS: That's correct.
19
20 MR GLOVER: What was the approach to funding of public
21 hospital services before those reforms?
22
23 DR LYONS: So before 2011 the state funding was
24 distributed to the area health services, as they were then,
25 on the basis of a population-based approach, which was
26 called the resource distribution formula, which had as the
27 primary driver of the allocation of resources the
28 population that the area was responsible for, but with
29 a number of adjustors that reflected the different contexts
30 that services were being delivered into.
31
32 For instance, there was an adjustor for rurality to
33 reflect the fact that services would be dispersed and
34 provided in a less concentrated way which had certain costs
35 attached to it. There was an adjustor for the proportion
36 of your population of Aboriginal and Torres Strait Islander
37 background, because that was important to acknowledge, that
38 there might be specific needs that needed further resources
39 for that particular population group and ensuring their
40 outcomes were improved.
41
42 There was an adjustor for private health insurance,
43 which was reflective of the fact that within a district or
44 a health service at that stage, a certain proportion of the
45 population could access services, if they were insured
46 privately, through the private hospital sector, so that
47 would take some of the burden off some of the public

1 services. That's an example of how it was distributed but
2 primarily the driver was population.
3
4 MR GLOVER: How it's currently distributed is now very
5 different; is that right?
6
7 DR LYONS: That's correct. There was a historical base,
8 so it's important to reflect that we've started from
9 somewhere. We started in 2012, when we introduced the new
10 arrangements, with the funding that the health services
11 already received as a base, and then under the National
12 Health Reform Agreement, funding for growth is now
13 determined around purchasing activity through an
14 arrangement where the system manager, by agreement with the
15 service providers, the local health districts, strikes
16 a level of activity to be delivered, and so the resources
17 then flow based on the level of activity, and that is
18 defined through the arrangements in the NHRA, and the
19 Commonwealth contributes a proportion of that, which is
20 45 per cent of growth.
21
22 MR GLOVER: We'll come to that, but just in terms of
23 structure, under the current arrangements, the Commonwealth
24 contributes on an activity basis, on a block basis and some
25 what's described as public health funding; is that right?
26
27 DR LYONS: That's correct. There are a range of different
28 components of the Commonwealth funding.
29
30 MR GLOVER: And there's also the ability of the states and
31 territories to enter into bilateral agreements for other
32 funding from the Commonwealth; is that also right?
33
34 DR LYONS: That's correct.
35
36 MR GLOVER: Now, just before I interrupted you, you were
37 explaining what is sometimes referred to as the growth
38 model of the Commonwealth's contribution. What does that
39 mean in practice?
40
41 DR LYONS: So under the National Health Reform Agreement,
42 the Commonwealth has agreed to fund 45 per cent of the
43 growth in activity that the states and territories
44 undertake in terms of service provision. So that's for all
45 new activity over and above the base at the time of the
46 agreement being struck, and within a defined scope of
47 services.

1
2 That defined scope of services is often referred to as
3 the "general list". It defines those services that the
4 Commonwealth considers to be in scope for its contribution.
5 That 45 per cent growth is contributed based on an
6 annualised level of activity for the state, which is then
7 distributed across to all of the local health districts and
8 service providers as part of those service agreement
9 arrangements that we've talked about previously.
10
11 MR GLOVER: Is the Commonwealth's contribution under those
12 arrangements subject to a cap each year?
13
14 DR LYONS: It is. It is.
15
16 MR GLOVER: What's the cap?
17
18 DR LYONS: The cap is 6.5 per cent per annum cap, and
19 that's a national cap and that's a hard cap. So if one of
20 the states or territories had growth which was
21 significantly greater than one of the others, but it meant
22 that the Commonwealth contribution would be breached at the
23 6.5 per cent, then the cap is held for everybody at that
24 point, irrespective of where they are in relation to their
25 growth.
26
27 MR GLOVER: Has it ever been reached?
28
29 DR LYONS: No.
30
31 MR GLOVER: Does the cap apply to each of the funding
32 sources under the NHRA?
33
34 DR LYONS: It's primarily related to the activity, because
35 potentially activity is open ended, however we would say
36 that activity is not open ended because it's actually
37 defined by the level of funding which the state provides to
38 the health system, and that dictates the level of service
39 that we can negotiate with the district to provide within
40 the resources that we have. So there is a notional
41 allocation, which is annualised and which defines the level
42 of activity which can be afforded, and it's driven by the
43 state budget, with the Commonwealth funding flowing based
44 on the activity that's delivered.
45
46 MR GLOVER: In paragraph 10 of the report, reference is
47 made to the fact that state public health services are

1 provided free, and then the observation is made that:
2
3 *As individuals do not incur any*
4 *cost ... this unintentionally drives*
5 *activity to the public health system.*
6
7 What did you mean by that?
8
9 DR LYONS: So we are the safety net for everybody. Our
10 services are always available and open, and if people
11 attend our services then, under the health agreement, we
12 are obliged to treat them and provide them appropriate
13 care.
14
15 Now, in our system, the access is primarily in terms
16 of undifferentiated or un-arranged access, through the
17 emergency departments. So what we're seeing through our
18 emergency departments across the state is ever-increasing
19 levels of activity over and above what would be expected
20 with just purely population growth.
21
22 At the same time, we're hearing that issues around
23 access to general practice and primary care in parts of our
24 state are challenging, because providers are not available
25 or, if they are available, they may not be operating at
26 certain hours of the day or days of the week, or
27 alternatively, they may be charging patients at the point
28 of care to an extent where people are choosing to go where
29 they can seek treatment at no cost. That's something which
30 we believe we are seeing as a result of some of the changes
31 that are occurring in other parts of the system - so
32 patients attending our services for those treatments,
33 through emergency departments as an example.
34
35 Another example would be through our specialist
36 outpatient clinics where our specialist outpatients clinics
37 are seeing increasing numbers of referrals of people who
38 might otherwise have been seeking treatment through
39 specialists in private practice - that is, because we
40 believe there's an issue around cost and access related to
41 availability of practitioners and also to the level of out
42 of pocket costs for patients at the point of care.
43
44 MR GLOVER: By that, do I take it that the unintentional
45 driver is that these are patients who would otherwise be
46 seen in what's described as the primary care system but,
47 for reasons of access or affordability, they are finding

1 their way into the public hospital system; is that right?
2
3 DR LYONS: That's our contention, yes.
4
5 THE COMMISSIONER: Don't take this as a criticism, either
6 counsel or witnesses, but we went past the resource
7 distribution formula, without me fully understanding how it
8 worked, which I will take responsibility for, but do
9 I understand it that allocation of funding based on
10 resource distribution formula which would have been to the
11 health areas before, the LHDs, right --
12
13 DR LYONS: Yes.
14
15 THE COMMISSIONER: -- is based on population, population
16 growth and certain demographics or the region or area?
17
18 DR LYONS: That's correct, Commissioner.
19
20 THE COMMISSIONER: So were there CEs of the areas back
21 then?
22
23 DR LYONS: There were.
24
25 THE COMMISSIONER: If I was the CE of the local health
26 area, I would get funding based on how many people are in
27 my area, what's the predicted growth of the population and
28 do I have, for example, lots of people with complex chronic
29 disease in my area?
30
31 DR LYONS: The adjustors dictated. So they were primarily
32 around things like rurality, Aboriginal population, private
33 health insurance status, and the ability to have substitute
34 services available. They were the primary things that
35 I can recall at that stage as being part of it.
36
37 THE COMMISSIONER: Is that how both the ministry funded
38 local health areas and also how the Commonwealth, based on
39 the same formula, provided money to the State of New South
40 Wales, or --
41
42 DR LYONS: So my understanding of the Commonwealth at that
43 stage is that it was primarily population with an increment
44 each year reflective of increasing costs. So it was just
45 a --
46
47 THE COMMISSIONER: CPI?

1
2 DR LYONS: --- CPI type arrangement on a block arrangement
3 to the state at a certain level which was dictated by the
4 Commonwealth and purely population driven with that
5 increment.
6
7 THE COMMISSIONER: Please don't hesitate to say I should be
8 asking someone else about this, but the shift away from
9 resource distribution formula to activity based funding was
10 because obviously there was a drive by the Commonwealth
11 that it wanted to do it this way, but what was the
12 reasoning?
13
14 DR LYONS: Well, it was a requirement under the National
15 Health Reform Agreement, so we had to.
16
17 THE COMMISSIONER: Yes, but there must have been a debate
18 about whether it was a good idea?
19
20 DR LYONS: There was. I think at that stage my
21 recollection - and it is my recollection - is that there
22 was a concern that the Commonwealth could not see, from the
23 investment they made, where that investment was going to,
24 because there was no ability to see --
25
26 THE COMMISSIONER: So better transparency.
27
28 DR LYONS: So greater transparency.
29
30 THE COMMISSIONER: If I'm the Commonwealth, I'm saying
31 it's more transparent to have you supply all your activity
32 costs and we can work out the funding and we know what
33 we're paying for?
34
35 DR LYONS: That's correct. So they could have
36 transparency, visibility of where their investment went and
37 what it led to as a result, and seeing that directly was
38 very important.
39
40 I think there was a lot of feedback from the system at
41 that stage, or concern, that potentially the Commonwealth
42 investment was not necessarily flowing through to the
43 services, it might have been going somewhere else, and so
44 that direct relationship was of comfort to the Commonwealth
45 so they could see that.
46
47 And I think there was a view that the system was not

1 necessarily as efficient, technically, as it could be, and
2 so - and looking at the variation in cost across the
3 nation, different states were costing different amounts,
4 the Commonwealth wanted to standardise its contribution and
5 to drive that efficiency of service delivery.
6
7 THE COMMISSIONER: And the view was that ABF, at least in
8 the public hospital system, would drive efficiency better
9 than the current funding was?
10
11 DR LYONS: That's my understanding, Commissioner.
12
13 THE COMMISSIONER: Do either of you want to add to --
14
15 MS WILLCOX: Perhaps just to comment on the resource
16 distribution formula. It was a state government initiative
17 back in around the mid '90s or slightly thereafter, in
18 order to try and use some levers to improve equity of
19 services, so there wasn't a domination of funding into the
20 cities and to try and push money out into the area health
21 services.
22
23 THE COMMISSIONER: I think it has been described to us as
24 to ensure that the loudest voices didn't prevail, but the
25 data that said, "This is what is actually needed in these
26 health areas to have equitable health funding" --
27
28 MS WILLCOX: Yes, that's correct.
29
30 DR LYONS: Commissioner, the debate about equity is
31 prevalent no matter what basis of distribution is used.
32
33 THE COMMISSIONER: Yes, sure.
34
35 DR LYONS: I'm sure you'll hear similar issues around
36 equity.
37
38 THE COMMISSIONER: Okay, thanks.
39
40 MR GLOVER: Just before I leave paragraph 10, did either
41 of Dr Chant or Ms Willcox wish to add to Dr Lyons' answer
42 about the drivers of activity to the public health system?
43
44 MS WILLCOX: No, I think Dr Lyons summarised it well,
45 thanks.
46
47 DR CHANT: No, thank you.

1
2 MR GLOVER: In paragraph 11, reference is made to the
3 National Health Funding Body. That's one of at least two,
4 maybe three, bodies set up under the National Health Reform
5 Agreement. What are the others?
6
7 DR LYONS: There is the funding administrator, who is
8 responsible for administering how the funds are
9 distributed. There is the Australian Commission on Quality
10 and Safety in Health Care, which is responsible for
11 oversight of the clinical quality and safety of patients
12 cared for across the system. There's the Independent
13 Health and Aged Care Pricing Authority, which is - I always
14 stumble over the aged care because that has been added in
15 most recently.
16
17 MR GLOVER: It used to be the Independent Hospital Pricing
18 Authority.
19
20 DR LYONS: Yes, so it has the responsibility for
21 undertaking the costing methodology, so understanding what
22 the cost of providing services across the country in the
23 hospitals that are in scope are and then defining the
24 national efficient price and agreeing on the basis on which
25 the Commonwealth's contribution to the 45 per cent growth
26 will be delivered to the states.
27
28 MR GLOVER: I just want to break that up a little bit.
29 I'll use the acronym IHACPA. It has the function of
30 setting or determining the national efficient price;
31 correct?
32
33 DR LYONS: That's correct.
34
35 MR GLOVER: The national efficient cost?
36
37 DR LYONS: Correct.
38
39 MR GLOVER: And what is considered to be in-scope
40 activity; is that right?
41
42 DR LYONS: Correct.
43
44 MR GLOVER: What's the national efficient price?
45
46 DR LYONS: The national efficient price is determined as
47 a result of gathering information from all the states and

territories who provide those services, and the costs of doing so, relating it to case mix activity that is reported through and coming up with the cost of providing care for those patients for those classifications that are in scope across the country.

Out of that, then the national efficient price is determined based on all of the inputs from all of the states and territories and that distribution across, and it is the average, I understand, of all of those costs that becomes the national efficient price.

MR GLOVER: So it is one number?

DR LYONS: It is one number.

MR GLOVER: What does it seek to represent?

DR LYONS: It seeks to represent what should be the cost of providing care if care is delivered efficiently according to the costing approach. So it defines in the Commonwealth contribution, because they only want to contribute to efficient care, so if a state or territory is over the cost, the Commonwealth contribution will be pegged at the national efficient price, even though their costs of delivering care are higher.

MR GLOVER: When you say "the efficient cost of delivering care", what's the unit of care against which the price is applied?

DR LYONS: The national weighted activity unit.

MR GLOVER: What's that?

DR LYONS: That is a unit that is derived out of primarily the classification systems that define categories of care - they are like streams of care or service delivery components - and they are based on a classification methodology: for inpatients it is the diagnostic related groups, which has been a case mix instrument for many, many years and there is an Australian version of that. It reflects the complexity or resource consumption for delivering care for certain types of patients, depending on the complexity of the care that is needed.

So for a simple patient who doesn't need a lot of

1 care, it might be around 1, as defined under the national
2 weighted activity unit. For a more complex patient, or
3 a less complex patient, the relativities are defined around
4 that one activity unit reference point.
5
6 MR GLOVER: Do I take it that one NWAU, if we use the
7 acronym, is the average inpatient episode of care?
8
9 DR LYONS: Not necessarily the average. It is defined as
10 the unit that reflects the base on which everything else is
11 referenced. I think that's probably the better way to
12 reflect it, because then the complexity of care that is
13 delivered for, say, a heart transplant will be relative to
14 that NWAU of 1, as will somebody who comes in for a hip
15 replacement. It is referenced against that one resource
16 consumption unit.
17
18 MR GLOVER: And it is referenced as either a fraction of 1
19 or multiples of 1; is that right?
20
21 DR LYONS: That's correct. So if it is an outpatient
22 clinic it might be a fraction, because the complexity is
23 low and the episode is short.
24
25 MR GLOVER: Dr Chant, did you wish to add anything to
26 that?
27
28 DR CHANT: No - I don't want to confuse the issue with
29 DWAUs, which are dental weighted activity units. It is
30 a similar principle. They are just multiples. It is just
31 like a generic coin and then some procedures are more
32 complex and that will be multiple, and then we use it as
33 a way of what we expect would be the cost inputs in an
34 efficient environment.
35
36 MR GLOVER: And the national efficient cost - what's that?
37
38 DR LYONS: That is the cost as reported by the entities
39 that report through. So it should have a direct
40 relationship to the national efficient price.
41
42 I am not a technical expert to define how they relate,
43 but one is the cost of actually delivering those services
44 and the other is the price that is then struck as being the
45 national efficient price. That would be a very good
46 question for IHACPA to talk about.
47

1 MR GLOVER: They may well get the opportunity. Is the
2 national efficient cost used for block funding?
3
4 DR LYONS: That is, I think, the primary driver for the
5 block funding, because it reflects the cost of delivering
6 those services, yes, and it can't be related to activity.
7
8 MR GLOVER: In terms of IHACPA's role in terms of
9 determining what is in scope, how does it go about doing
10 that and is it an ongoing process?
11
12 DR LYONS: It is an ongoing process. When the agreement
13 was first struck, there was a certain agreement about the
14 services that were provided by hospitals that the
15 Commonwealth would define as being the services they would
16 contribute to, and there is a list, actually, of all those
17 services.
18
19 IHACPA has also the responsibility for assessing
20 requests from the states and territories, or even from the
21 Commonwealth, for that matter, about changes to that
22 general list that might reflect changes in practice or the
23 way services are delivered. But it has to be around
24 hospital or hospital substitution, because it has to be
25 hospital-like care. That's I think a prerequisite or
26 requirement. And for it to be considered, it has to be
27 demonstrated that there is actually some evidence that this
28 new way of delivering care is appropriate and
29 cost-effective, before the IHACPA will consider it to be
30 added to the list.
31
32 MR GLOVER: Is that a lengthy process?
33
34 DR LYONS: It is a very lengthy process. We have had
35 examples of submissions that have been made through to
36 IHACPA that have either been rejected or have been asked
37 for further information, and that is an annual cycle
38 process, so it can go through at least a couple of annual
39 cycles before a decision is made as to whether or not those
40 services would be agreed to be on the list.
41
42 MR GLOVER: And are there some activities undertaken in
43 public hospitals that aren't within scope?
44
45 DR LYONS: Increasingly so. I think we have talked about
46 the role that our local health districts have which goes
47 beyond the bounds of a hospital into the community, and

1 increasingly what we've observed with this increase in
2 activity and demand coming through to our services is
3 a need to think about how we might deliver care in a way
4 that prevents people needing to come to hospital. So we've
5 increasingly invested in programs that are not funded
6 through those arrangements of the general list or the
7 Commonwealth contribution, into things like integrated care
8 strategies or a program that we have called "collaborative
9 commissioning", which is I think over the last five years
10 or so around about a $20 million per annum contribution
11 across the state, to define different ways of delivering
12 care that drive innovation and integration of the system,
13 both of which are very important and desirable, which is
14 connecting the system up more effectively and providing new
15 ways of delivering care that might take the pressure off -
16 provide better care for patients, first and foremost;
17 involve primary care and community-based providers in
18 delivering that care more effectively as part of the team;
19 and ultimately taking the pressure off our hospital
20 services.
21
22 MR GLOVER: Is that what you mean by "integrated care" -
23 that is, crossing the spectrum between in-hospital and
24 primary care settings?
25
26 DR LYONS: We would use that as one example of integration
27 but it is not the only example, but certainly integration
28 between parts of the system that are different
29 responsibilities and don't automatically connect, is where
30 we're looking at integration.
31
32 So other boundaries would be aged care and the state
33 health system interface. Another boundary example would be
34 the National Disability Insurance Scheme and care for
35 people under that scheme and its relationship to health
36 care delivery on the state side too.
37
38 MR GLOVER: We might explore some of those arrangements a
39 little later.
40
41 THE COMMISSIONER: Are you talking about trials under the
42 National Health Reform Agreement or something broader than
43 that?
44
45 DR LYONS: These are not trials under the National Health
46 Reform Agreement, they are before that point, Commissioner.
47 So it is about us, the state, investing in new ways of

1 doing things to test whether they have an impact and
2 whether there is an argument that should be put forward
3 about them being scaled.
4
5 THE COMMISSIONER: And when you say "the state investing",
6 it's the state's money because they are not coming up as
7 activities that ABF relates to?
8
9 DR LYONS: That's correct. In fact, we've now had some
10 response from the Commonwealth around some of those
11 programs to say that they would be interested in
12 considering them for funding. So it's important that we do
13 drive these innovations and look for new ways and look for
14 ways to get those contributions in for those changes.
15
16 MR GLOVER: Dr Chant, did you wish to add anything?
17
18 DR CHANT: Probably not at this point, but I suppose just
19 to reinforce that one of the components probably just to
20 touch on briefly is the fact that perhaps the current
21 pricing system doesn't reflect the full cost of perhaps
22 preventative care in all of its elements, and also those
23 equity dimensions by which we know that to achieve those
24 same outcomes, we may need to provide more intense or
25 wrap-around services, and those services that many of our
26 local districts incorporate are not adequately reflected in
27 the current funding models.
28
29 MR GLOVER: What is it about the current funding models
30 that doesn't pick those activities up, or at least well?
31
32 DR CHANT: I think Dr Lyons is more familiar with the
33 intricacies of it - so please jump in - but I think ABF
34 drives more for technical efficiency, and not all things --
35
36 THE COMMISSIONER: So ABF is like funding what I think
37 what is called a case mix; the MBS funds fee for service,
38 but chronic conditions might require a cycle of care that
39 isn't quite picked up in either funding model.
40
41 DR CHANT: And what we know is to achieve outcomes in many
42 areas, we need much more multidisciplinary teams, and to
43 achieve some outcomes we actually need to work effectively
44 across government agencies and non-government organisation
45 sector. All of that is resource intensive, but in order to
46 achieve the same outcomes for that individual we need to
47 work in that way, and that isn't reflected in some of the

1 current funding programs.
2
3 It is from the state, the state does institute some of
4 the programs to address that, but it isn't reflected in
5 probably the Commonwealth-state funding arrangements.
6
7 THE COMMISSIONER: Is that where we talk about things like
8 bundled payments or blended - is there a difference between
9 bundled and blended?
10
11 DR LYONS: A bundling could be within our system and we
12 pay for all of it; blended would be where we would seek
13 a component across the boundaries of MBS and - so I think,
14 Commissioner, you are absolutely right. There has been
15 a mid-term review of the National Health Reform Agreement
16 just recently that you are aware of, I'm sure.
17
18 THE COMMISSIONER: I'm aware of the review, not of any
19 outcomes from it.
20
21 DR LYONS: They will be published, I understand, soon.
22 But our submission to that review process was that the
23 funding arrangements do need to be altered to reflect the
24 need for greater flexibility and responsiveness to requests
25 for service change, and for the need to drive that
26 integration across the boundaries of the current service
27 systems - in particular, the MBS system and primary care in
28 particular, and the services that we're responsible for.
29 There is a real need for us to explore different ways to
30 support those changes in clinical care, because our
31 reflection would be that activity based funding has driven
32 activity within the services that are funded under those
33 arrangements, and that is driving activity into hospitals,
34 and that is not necessarily the best place for providing
35 care given the demography of our population now,
36 particularly with the increasing occurrences of chronic
37 conditions and people living in the community and trying to
38 keep them well in those settings. So we need to shift the
39 focus and change the axis of care to be more around what's
40 available in the community, rather than - I mean, the
41 hospitals are still very important and we need to maintain
42 those, but we need to start to shift the focus to that care
43 being provided differently.
44
45 THE COMMISSIONER: And fee for service or activity based
46 funding works perfectly well, in fact really well, for
47 certain conditions or injuries or types of acute care, but

1 not necessarily for the sorts of things you were describing
2 where people might have complex care needs and
3 comorbidities and need integrated care and a range of
4 different medical health professionals assisting them with
5 their condition, whatever it may be, to get the best health
6 outcome for everyone and keeping them out of the hospital
7 system.
8
9 DR LYONS: That's absolutely correct, Commissioner.
10 Activity based funding and fee for service is more around
11 episodic care. We're now talking about ongoing care, not
12 just by an individual but by a multidisciplinary team.
13
14 So it is not just the funding. We would argue there
15 is a whole range - policy needs to change; information
16 systems need to be connected up to allow that to occur much
17 more effectively. So there is a range of things that need
18 to be all in place to support that shift.
19
20 DR CHANT: Even, for instance, in an episodic dimension of
21 care, we may need to provide more wrap-around services for
22 someone even in that single episode of care.
23
24 THE COMMISSIONER: Yes, I might have come in for an acute
25 condition, I have a toe infection, but the toe infection is
26 because I'm obese and I can't bend over --
27
28 DR CHANT: That's right, and you have no-one coming in to
29 give your food, you are food insecure, we need to arrange
30 Meals on Wheels or family supports; we need to get you
31 connected in community; we need to understand your context.
32 So if we are truly going to address it equity wise, those
33 intangibles - the light is not shone on that important work
34 that is done often in our health systems to support those
35 outcomes.
36
37 THE COMMISSIONER: Yes, so - no doubt this happens all the
38 time - you could go into hospital because there is
39 a particular problem you have that needs acute care, but
40 there still might be aspects of treating that patient that
41 are preventative as well.
42
43 DR CHANT: That's correct. That's correct. And I think
44 you have probably read, through our submission, that we
45 really support a competent and comprehensive primary care
46 system, but for some of the patients that are connecting
47 with us, they perhaps at that point in time haven't got

1 a primary care provider, and we do need to stabilise them,
2 work with it and then put effort in connecting them to the
3 right primary health care provider for them, and that again
4 takes time.
5
6 THE COMMISSIONER: That's a big gap for preventative care
7 because it can't all be the public hospital system that is
8 engaged in preventative care. Ideally, it's actually
9 probably more the majority either GPs, primary care, or
10 community health centres or whatever.
11
12 DR CHANT: That's correct. General practice is probably
13 where we would see the bulk of prevention happen, in that
14 sort of primary/secondary prevention. However, we know
15 that we have an important enabling role in that and there
16 will be some patient groups that have very close ties to us
17 or are seeing us because they feel safe, and we do need to,
18 in the end, link them to primary care. That would be our
19 objective. But we may need to provide more comprehensive
20 care to them during that journey of connection.
21
22 MR GLOVER: In paragraph 12, Dr Lyons, in the second
23 sentence, just by way of clarification, it says:
24
25 *ABF uses a unit price ...*
26
27 Is that the national efficient price that is being referred
28 to there?
29
30 DR LYONS: The national efficient price is for the funding
31 received from the Commonwealth. There is also a state
32 efficient price.
33
34 MR GLOVER: We will come to that.
35
36 DR LYONS: So in relation to the funding from the state to
37 our local health districts for their hospital services,
38 it's determined by the state efficient price.
39
40 MR GLOVER: But at the Commonwealth to state level, it's
41 the national efficient price; is that correct?
42
43 DR LYONS: Correct.
44
45 MR GLOVER: In paragraph 13, the concept of the NWAU is
46 introduced, that we have discussed, but reference is made
47 to a range of adjustments that are applied to account for

1 the relative cost of treating patient, and some examples
2 are given. How are those adjustors determined?
3
4 DR LYONS: They are determined by IHACPA again. They are
5 the people who determine the adjustors and level of the
6 change that is appropriate, and that's based on evidence
7 that needs to be put before IHACPA to demonstrate that
8 increased cost, and that's reflective of a certain patient
9 group.
10
11 MR GLOVER: And are they under constant review?
12
13 DR LYONS: They are. They are able to be reviewed. We
14 can put forward for consideration what we believe might be
15 certain patient cohorts that are increased cost to us.
16
17 For instance, I think six or seven years ago we put
18 forward that there were a lot of culturally and
19 linguistically diverse patients that we were caring for,
20 and I think there was a joint submission from New South
21 Wales and Victoria who both were of the view that they were
22 seeing increased costs for providing for those patient
23 groups.
24
25 IHACPA considered it but declined to make an
26 adjustment because they didn't believe there was enough
27 evidence to quantify the impact, but there is an
28 opportunity for us to continually reassess those and make
29 further submissions around different groups as we see the
30 need.
31
32 MR GLOVER: Building perhaps from that last answer, how
33 effective are the adjustors in capturing the relative costs
34 in those circumstances?
35
36 DR LYONS: I think they reflect the additional costs. For
37 instance, for children, there is an adjustor for children,
38 for care for children, and we know that there is increased
39 cost in providing care for children, just by the nature of
40 the way the care needs to be provided. So there are always
41 arguments that they don't go far enough, but I think they
42 reflect that there is increased resource consumption in
43 providing for different patient groups and it is considered
44 appropriate that they be adjusted to reflect that.
45
46 MR GLOVER: Although I take it, based on the submission
47 made a few years ago, the view would be that there should

1 be perhaps some others added to the system; is that right?
2
3 DR LYONS: There are always groups that our services will
4 argue cost them more to provide care for, so it is about
5 looking at what level of evidence we have for that and
6 making appropriate adjustments based on the evidence that
7 we have.
8
9 MR GLOVER: Ms Willcox, did you wish to add anything?
10
11 MS WILLCOX: I think probably the other, dare I say,
12 barrier around some of this work is - I mean, it is very
13 complicated and technical, but there is also a long lag
14 time for some of this work, which, when you are working
15 with clinicians and they are innovating and changing models
16 of care and we are under constant pressure and demand and
17 managing our resources the best we can, having a more
18 expedited mechanism to capture data and make the necessary
19 changes - there will always be debate and negotiation,
20 I expect, between an organisation like IHACPA and the
21 states and territories to strike the right balance of what
22 is in scope and what isn't. But I think from our
23 perspective, there is a limiting factor around the
24 innovation, models of care, hospital avoidance and the
25 things that we're doing outside of the walls of the
26 hospital, as Dr Lyons said, that they are not able to
27 capture and attend to at the pace that probably the states
28 and territories would desire.
29
30 MR GLOVER: Is that a lag through the application process
31 to IHACPA or gathering the data necessary internally in
32 NSW Health?
33
34 MS WILLCOX: I'm probably not best placed to answer all
35 the technical steps, but I think it is probably
36 a combination of what data is required and then time taken
37 to evaluate and assess and test internally for IHACPA,
38 I expect.
39
40 DR LYONS: Yes.
41
42 MR GLOVER: Just before we move on, Dr Lyons, I would just
43 like to step through, in general terms, the process that is
44 undertaken that leads to the determination of the
45 Commonwealth funding contribution in any given year. So
46 how does that process start from the state level? What
47 information has to be given and how does it flow through to

1 a funding flow from the Commonwealth?
2
3 DR LYONS: It comes from decisions that the state makes
4 about how much activity it can deliver within the resources
5 that it has available to deliver those and through the
6 distribution of those in relation to hospital services
7 versus public health versus dental care or whatever. So
8 those decisions are made. They are historically based,
9 usually, so it's usually based on what has occurred the
10 previous year and then adjustments that are reflective of
11 input from the districts around where they see service
12 changes occurring that might drive activity; population
13 growth that we can determine, in terms of population
14 projections; new capital builds, which might have an
15 implication for the amount of service that is provided and
16 the cost of providing that service. Those are all fed into
17 a process of consideration.
18
19 There is a process that we undertake with the local
20 health districts that occurs from around November through
21 to February/March of each year in the lead-up to the state
22 budget, where those negotiations and discussions are had.
23
24 As we get closer to the budget and are clear around
25 what budget we receive for our state health budget, those
26 agreements firm up and the level of activity is agreed for
27 the next year. So it is an annualised agreement of
28 activity. That then feeds into information that is
29 provided to the Commonwealth.
30
31 MR GLOVER: Just before you go on to that step, those
32 activity levels are reflected in the service agreements,
33 are they?
34
35 DR LYONS: They are, and they're rolled up to the state
36 level and they'll be in the service streams of emergency
37 department activity, acute admissions, inpatient activity,
38 sub-acute and non-acute activity, for things like
39 rehabilitation, palliative care, and so forth. So there
40 are a range of service streams that all bundle up and have
41 their own different classification systems.
42
43 MR GLOVER: Are they expressed as multiples of NWAU?
44
45 DR LYONS: They are, indeed. So once that is struck and
46 agreed at the state level and rolled up, it is then
47 provided to the Commonwealth as the basis on which the

1 Commonwealth contribution will be provided to the state and
2 to the local health districts.
3
4 MR GLOVER: At that stage, they're still estimates because
5 we're looking forward?
6
7 DR LYONS: They are estimates that are agreed. What
8 happens is that the Commonwealth pays on the basis of those
9 estimates, as does the state. So we don't pay on actuals
10 during the course of the year. The districts receive the
11 funding flow based on the assessment of what the annualised
12 target will be, and then there's a reconciliation at the
13 end of the year around the actuals.
14
15 MR GLOVER: What happens as part of that reconciliation
16 process?
17
18 DR LYONS: That reconciliation process takes some time
19 because it relies on coded information around all of the
20 activity within that financial year being made available,
21 then being assessed by the funding administrator and the
22 national funding body, and any technical adjustments being
23 made and agreements what the Commonwealth is then in-scope
24 for to be provided to the state. So it can be actually
25 12 months after the end of the financial year, and that
26 then is either a positive contribution from the
27 Commonwealth to the state for that activity, if it was over
28 what the assessment was and it is still within the
29 6.5 per cent cap, or it will be a requirement to provide
30 funding back to the Commonwealth because we were under
31 target.
32
33 MR GLOVER: If there is an adjustment that sees funding
34 going back, is it actually a transfer of funds or is it
35 merely taken into account in the next funding cycle?
36
37 DR LYONS: It is not a transfer of funds from the health
38 system because that financial year has well and truly gone.
39 So it would be between treasury, if there is an exchange -
40 and I'm not an expert in how that occurs and to what extent
41 it occurs, so --
42
43 MR GLOVER: That's fine. In that answer you referred to
44 provision of coded activity. What is that?
45
46 DR LYONS: That's the activity that has been undertaken
47 but we're required to clinical code it so that it can be

1 classified appropriately under the arrangement for
2 classification system. So DRGs for diagnostic related
3 groups for inpatient care, but there are a range of
4 different classification systems for emergency department
5 activity and for sub-acute, non-acute care - they all
6 needed to be coded and that gives the appropriate weighting
7 of that activity so that it reflects the resources
8 consumed.
9
10 MR GLOVER: What you're describing there is records of
11 actual activity undertaken in the relevant services; is
12 that right?
13
14 DR LYONS: That's correct, and we need to have evidence of
15 that and be able to have it audited so that it has actually
16 been delivered.
17
18 MR GLOVER: Is that an important function within the LHD
19 or specialty health network?
20
21 DR LYONS: It is an important function, a very important
22 function, to make sure that we capture activity, first and
23 foremost, for all of those things that we do, but then
24 accurately code the activity to ensure that we're getting
25 the appropriate funding for the resources that are consumed
26 in delivering that care.
27
28 MR GLOVER: When you say "accurately code", why is that
29 a particularly important piece of the puzzle?
30
31 DR LYONS: Because that determines what funding we receive
32 not only out of the state pool but also the Commonwealth
33 pool, and it appropriately reflects, then - it should
34 appropriately reflect the cost of delivering that care as
35 well. So if it's not coded effectively, then there may
36 have been more resources consumed in delivering that care,
37 but the funding received won't match the care delivered.
38
39 MR GLOVER: In paragraph 14, you describe what I might
40 call the cut-off for eligibility for activity based
41 funding, and the process that you've just described,
42 Dr Lyons, that relates to activity based funding; is that
43 right?
44
45 DR LYONS: That's correct.
46
47 MR GLOVER: Block funding is dealt with slightly

1 differently?
2
3 DR LYONS: It is.
4
5 MR GLOVER: We'll come that that. The cut-offs, that is
6 3,500 total NWAU per annum or 1,800 admitted patient NWAU
7 per annum - is there a difference between a total NWAU and
8 an admitted patient NWAU?
9
10 DR LYONS: The rural hospitals might have a range of
11 different services being provided within that hospital, so
12 it might be a combination of inpatient NWAU, outpatient
13 NWAU, emergency department NWAU, sub-acute NWAU. So the
14 total is looked at for those. In the metropolitan
15 hospitals it has to be admitted patient NWAU.
16
17 MR GLOVER: Are these NWAU levels the only measure for
18 determining whether a facility would be block funded or
19 funded under ABF-type arrangements?
20
21 DR LYONS: Not the only consideration. I think we have
22 a couple of specialty hospitals that because of the
23 discrete nature of the services they provide are considered
24 not to be appropriate for activity based funding, because
25 what they provide is very narrow. I'm thinking of the
26 Sydney Eye Hospital as an example, because it is primarily
27 around a certain type of patient. It's not considered that
28 it would be appropriate to fund that under an activity
29 based funding model because it doesn't have the range of
30 patients. It's very discrete and defined about what it
31 does.
32
33 But most of the hospitals, what has been done is an
34 assessment around the cut-off between when activity based
35 funding - that there's enough activity to cover the costs
36 of keeping that service open, so the fixed costs of
37 providing that service, and the level of activity going
38 through it that will enable it to be supported for its
39 fixed cost and the activity, versus a hospital where the
40 fixed costs are such that if you paid them under activity
41 they wouldn't get enough money to keep the service
42 operating. There's a technical process that's done to
43 assess that across the state.
44
45 MR GLOVER: Do the particular districts in which those
46 facilities sit - are they involved in that process?
47

1 DR LYONS: Absolutely. The information comes from them.
2
3 MR GLOVER: Can they make a submission or an argument as
4 to which funding model should be adopted?
5
6 DR LYONS: They can, and I think that's a process that has
7 been undertaken between the ministry and the local health
8 districts and we've struck these definitions based on the
9 feedback and the assessments.
10
11 MR GLOVER: And do facilities that receive ABF funding
12 also receive block funding?
13
14 DR LYONS: They may receive block funding for certain
15 programs. It depends on what they provide. I think if you
16 look at our state budget, I think around 70 per cent of the
17 total budget we provide is in the activity based funding
18 category, around 20 per cent I think is in block. Then
19 there's some other components around different programs,
20 health protection, public health, those sorts of things,
21 that might be independent of that again. So you can
22 actually receive activity based funding and block funding
23 for certain things, depending on what service you're
24 providing, what programs, and what we are asking to be
25 delivered from those sites.
26
27 MR GLOVER: Ms Willcox, do you wish to add anything?
28
29 MS WILLCOX: I might just go back to the matter of
30 clinical coding to elaborate on what Dr Lyons said. We are
31 very reliant on our clinical staff who are attending to the
32 medical records, they're seeing the patient and they're
33 documenting what care or intervention they've undertaken.
34 And part of the technical complexity of this work is from
35 time to time the language that is required changes, so you
36 need to refresh the education and work with your
37 clinicians. For instance, it may be that someone with
38 a low potassium, if it's written as "low potassium",
39 doesn't attract the same amount of NWAU as if you write
40 "hyperkalaemia", which is the technical term for low
41 potassium. So these definitional changes can impact on
42 what amount of activity is actually gathered to truly
43 reflect the patient episode of care that is being provided.
44
45 So a lot of our hospitals have clinical-coding people
46 that go around and work with medical officers in
47 particular, JMOs, to assist them to appropriately document

1 what work they're doing with a patient so that we optimise
2 what we capture. As Dr Lyons said, the process by our
3 coders is they run through the medical records and gather
4 all of that, check back with clinicians if they have
5 questions, and it's audited on a regular basis to make sure
6 that that's all being done appropriately. But I think it's
7 important to know that the JMO, the clinical nurse
8 consultant, the allied health professional, all the way
9 through, are entering records, contributing to this body of
10 work and for us to optimise the capture.
11
12 MR GLOVER: Thank you.
13
14 In paragraph 16, block funding is described. And in
15 the second sentence, block funding is informed by health
16 service costing data plus escalation. Can you just
17 describe that process, please, Dr Lyons?
18
19 DR LYONS: In identifying the block funding, we go through
20 a costing process each year to assess the cost of providing
21 a service in different settings. That's where this issue
22 around the thresholds for block funding for activity for
23 the hospitals is struck, based on the different levels of
24 activity and the costs of providing that care. Then if
25 there's a decision made that block funding is appropriate
26 for that service, rather than having a process with
27 negotiation around that, the previous block funding is
28 provided plus an appropriate escalation that reflects the
29 escalation of what might go into ABF. So if there's
30 increase for salaries and wages, that goes in at the
31 percentage increase for salaries and wages. If there's an
32 increase for goods and services at a certain level, then
33 that flows through in the block funding as it would in the
34 ABF.
35
36 MR GLOVER: And again at the Commonwealth to state level,
37 subject to the Commonwealth growth cap?
38
39 DR LYONS: That's correct.
40
41 MR GLOVER: Picking up on your last point, Ms Willcox, if
42 a facility received entirely block funding, so a small
43 rural facility, does it still need to capture its activity
44 in that coding mechanism?
45
46 MS WILLCOX: I might need to confer. Dr Lyons, I presume
47 it does.

1
2 DR LYONS: It does. Yes, it does. That's how we come up
3 with the thresholds. It is still required to capture
4 activity.
5
6 MR GLOVER: Is that a convenient time, Commissioner?
7
8 THE COMMISSIONER: It is, yes. We will adjourn until
9 2 o'clock.
10
11 **LUNCHEON ADJOURNMENT**
12
13 THE COMMISSIONER: Yes, Mr Glover.
14
15 MR GLOVER: Ms Willcox, just before lunch you were making
16 reference to the importance of coding and the involvement
17 of a number of coders and clinicians in that process.
18 I take it that across the state there is a need for that
19 process to be undertaken at a consistent level, would that
20 be right?
21
22 MS WILLCOX: That would be right, yes.
23
24 MR GLOVER: Is there anything that either is being
25 undertaken or can be undertaken from the ministry level to
26 ensure that that happens?
27
28 MS WILLCOX: I think the education and training of staff
29 is something that we can assist from, from the centre, and
30 I may have this correct, that HETI, I do think, undertakes
31 some clinical coding training modules that are available
32 for staff.
33
34 There are always difficulties in more rural and remote
35 areas in terms of acquiring people with the requisite
36 skills, so I think as much support as we can give from the
37 centre is very, very important
38
39 The clinical coding workforce itself tends to be
40 a fairly sparse, they're a hard group to recruit to, it's
41 a very specialist set of skills. The people who do coding
42 are often very highly sought after by insurance companies
43 and medical defence unions and the like, so competing with
44 the private sector remains an ongoing challenge for the
45 health system.
46
47 We've looked at some workforce opportunities for

1 clinical coding staff, opportunities to work from home,
2 which now is not such a feature at all since COVID, but
3 prior to that it probably was a fairly novel flexibility in
4 the workplace that wasn't commonly used. So I think in
5 summary, there's probably some workforce support and some
6 training and education that, from the centre, we can assist
7 those staff who are providing that service.
8
9 MR GLOVER: Does the ministry undertake any assessment of
10 how well activity is captured across the network?
11
12 MS WILLCOX: Dr Lyons might assist me with this, but the
13 audit process is a key one to make sure that what is being
14 captured in the record is being accurately represented in
15 the coding that is then submitted as part of our funding
16 submissions.
17
18 The clinical coding support teams that are present in
19 a number of hospitals - I wouldn't say they were in all
20 hospitals but many of our larger hospitals - are there to
21 provide that support and education, in particular to our
22 junior medical staff, and that would contribute to ensuring
23 some consistency and a bit of standardisation of how things
24 are reported and recorded in the record.
25
26 MR GLOVER: Dr Lyons?
27
28 DR LYONS: I have nothing further to add.
29
30 MR GLOVER: If we can go back to the joint report, please,
31 and in particular, paragraph 18, there reference is made to
32 some time-limited national partnership agreements. Can you
33 give me an example of such an agreement, Dr Lyons?
34
35 DR LYONS: Certainly. So there are agreements in place at
36 the moment, for instance, there's a bilateral around mental
37 health, that the Commonwealth indicated that they would
38 provide some additional funds to the state for specific
39 components of delivering different mental health services.
40 So that's an example of a national partnership or
41 a bilateral agreement. Some of them are bilateral, some of
42 them are multilateral; it depends on how they're
43 negotiated. But usually the Commonwealth tries to get as
44 much consistency across the states and territories as it
45 possibly can.
46
47 Some other examples are palliative care. We've had

1 a national partnership agreement for palliative care. And
2 dental services is one that has historically been in place.
3
4 The issue with these, when they are time limited, they
5 create a problem because as we come towards the end of the
6 agreement, there is no certainty of ongoing funding. So
7 then it becomes an issue around how are those services,
8 which are often very important services delivering care,
9 going to be maintained if they are not going to be
10 continued to be supported by the Commonwealth through
11 a partnership arrangement?
12
13 What we have flagged under the previous National
14 Health Reform Agreement negotiations is there needs to be
15 a negotiation in advance, a very clear warning around
16 what's happening with these partnership agreements as they
17 come to their conclusion, to give certainty to the states
18 and territories around how they continue to provide those
19 services.
20
21 MR GLOVER: When you speak of "time limited", what sort of
22 periods do these agreements cover?
23
24 DR LYONS: Five years is usually the sort of historical
25 arrangement.
26
27 MS WILLCOX: Three to five, yes.
28
29 DR LYONS: Three to five, yes.
30
31 MR GLOVER: Is the funding provided under them quarantined
32 in some way - that is, it must be spent on the purpose?
33
34 DR LYONS: It is. It needs to be directed towards the
35 specific requirements that are documented within the
36 agreement around the services that they're directed to.
37
38 MR GLOVER: How is that administered by the ministry?
39
40 DR LYONS: The ministry will receive the partnership
41 agreement then, through the same process we use for
42 services with the districts, decide on how that is to be
43 split and how to be allocated across the local health
44 districts. That then becomes part of the budget that's
45 allocated to the districts to provide their services.
46
47 DR CHANT: Perhaps I could just clarify in relation to

1 dental, there have been periodic national partnership
2 agreements related to dental, and just to echo Dr Lyons'
3 comments, that it does introduce many inefficiencies, if we
4 cannot recruit long-term staff, particularly into our rural
5 and regional. It provides a challenge for ongoing
6 retention; when there's uncertainty, staff will leave and
7 move. So really having that sustainable funding.
8
9 From a policy perspective, we also see dental as
10 a core component of health services. We provide a safety
11 net service and provide services to those that are
12 eligible, which is largely pensioners and those that are
13 health care card holders, but we do see the Commonwealth
14 having a key role in partnering with us in terms of that
15 safety net system for dental.
16
17 Under the NPA, they will set a particular activity
18 target and this is probably an example where I mentioned
19 before a dental weighted activity unit.
20
21 MR GLOVER: Yes.
22
23 DR CHANT: That's a similar premise to the NWAU, where
24 it's basically saying one episode, it might be it's 1, and
25 then if it's more complex, it's 1.5. They specify the
26 amount of activity lift they want to see from the states,
27 so there's a baseline, they want to see an activity lift
28 and a demonstration of that, and then we get paid if we
29 achieve those activity targets.
30
31 We distribute that activity in a service agreement, so
32 it will be reflected in the service agreement to each of
33 the local health districts, and then we monitor that
34 centrally. We have a statewide data system called
35 Titanium, and we're able to track that activity by our
36 districts through the performance structures.
37
38 MR GLOVER: Ms Willcox, do you wish to add anything?
39
40 MS WILLCOX: No, I don't think so, thank you.
41
42 MR GLOVER: The other type of funding, if I can describe
43 it as that, under the NHRA, is labelled "public health
44 funding". What sort of initiatives or activities does that
45 funding relate to?
46
47 DR CHANT: There is some particular partnership agreement,

1 such as for the NPA for immunisation, so the Commonwealth
2 procures vaccines on behalf of the states and territories
3 and the states then do the distribution. That distribution
4 occurs to pharmacies and general practice and also then to
5 our own health district distributions. So that's an
6 example of an NPA in that public health stream.
7
8 Then there has also been - you would have to help me
9 here, Nigel - historically, some rolled funding around
10 prevention that has come to the states from the
11 Commonwealth.
12
13 DR LYONS: I can't remember the details specifically but,
14 yes, it has been rolled up.
15
16 DR CHANT: Then there's particular funding for different
17 programs, which sits outside the national partnership
18 agreements around Breast Screen and some of the other
19 Commonwealth screening programs.
20
21 MR GLOVER: Thank you. Paragraphs 19 to 31 of the report
22 deal with the allocation of funds within the state - that
23 is, by treasury and then the ministry out to the services;
24 is that right?
25
26 DR LYONS: That's correct.
27
28 MR GLOVER: In paragraph 23 - and all these questions in
29 this little section are in that context, that is, this is
30 the allocation of the state funding - it's referred to as
31 a "growth funding model", and it's described as being put
32 in place to provide greater funding certainty and improve
33 the sustainability of growth. How does that model achieve
34 that outcome?
35
36 DR LYONS: It provides certainty about likely budgets to
37 be allocated to health from the state. So there's the
38 annual budget cycle where it's firmed-up, but then in the
39 forwards, the outer years of the budget cycle, there's an
40 indication of the budget that will be received by health,
41 and it's reflected in the past, that historical 4 to
42 5 per cent growth over the last eight, 10 years, and that
43 has given certainty because what it has allowed the health
44 system to - while it's always to be firmed-up the next
45 year, it's not absolute, it gives a likely indication of
46 the ongoing funding to flow and allows the state to be
47 confident that the services it initiates reflecting the

1 budgets that are allocated this year will be able to be
2 sustained into the future. Because if there was growth
3 that was a smaller amount than perhaps salaries and wages
4 agreements in terms of increments, or the likely CPIs,
5 further savings would need to be found that might then
6 impinge on the ability to deliver services.
7
8 So it gives that sense of certainty around what is
9 likely to flow and allows the confidence in the system to
10 establish services on a sustainable footing, because one of
11 the worst things that can happen in health is trying to
12 establish a service with a lack of certainty about ongoing
13 funding. It's a challenge to recruit and retain the staff
14 with the appropriate skills and the right environments to
15 deliver those services if there's no certainty about
16 ongoing employment.
17
18 MR GLOVER: One of the challenges that we've heard about
19 at district level is related to that - that is, the yearly
20 funding cycle presents some challenges in forward planning.
21 Does what you've described go some way to meeting those
22 challenges?
23
24 DR LYONS: In part, and what follows from that is if the
25 state system has got the certainty about likely future
26 allocations, the districts should have confidence that the
27 allocations they receive should be at least in the ballpark
28 to maintain, if not grow, services over time. And it gives
29 the districts that certainty as well.
30
31 It's important, though, to reflect that sometimes, we
32 are asked to look at efficiencies, because the demand that
33 comes to our services and the cost of providing those
34 services can grow at a rate which is higher than the funds
35 that are received, and, in fact, demand and complexity of
36 care and the workforce costs can outstrip even the increase
37 in funds that are coming. So most managers who work in
38 public health are always looking for better and more
39 efficient ways of delivering care, to look at ways that
40 savings can be delivered safely at high quality so they can
41 continue to meet the demands on their service.
42
43 That's an ongoing cycle that you see across all of
44 public health, and it has been the same for as long as
45 I have worked in public health; it's always there. There's
46 an underlying requirement really that we're always looking
47 to do things differently and better to make the best of the

1 resources we receive and optimise the care we can provide.
2
3 MR GLOVER: Moving ahead to paragraph 29 in the report,
4 it's stated there that market trends indicate a growing
5 requirement to move asset acquisitions to long-term service
6 delivery arrangements, and that "this is significant change
7 with capital budgets being transitioned to operating
8 budgets". What do you mean by that?
9
10 DR LYONS: Examples of this would be major capital
11 equipment, so things like large pieces of diagnostic
12 imaging that traditionally may have been bought through
13 capital but are now through operating leases, and there's
14 an ongoing requirement then that funds are found out of the
15 operating budget.
16
17 The other examples are in ICT. That's an increasing
18 trend in information technology and software to move from
19 purchasing it outright to having an ongoing arrangement for
20 annual payments. So those are both big shifts in terms of
21 movements that were historically capital based into the
22 operating budgets, which then is a challenge for the
23 districts to find, with all of the other pressures, because
24 it's additional over and above what they're used to paying
25 within their operating expenses.
26
27 MR GLOVER: Paragraph 30 and the diagram immediately
28 below - do I understand that to be describing the process
29 of setting the targets and budgets within the service
30 agreement process between the ministry - sorry, the
31 secretary and the LHDs and specialty networks; is that the
32 flow?
33
34 DR LYONS: That's correct.
35
36 MR GLOVER: How, at a general level, are the activity
37 targets in that process developed and worked out at the
38 individual LHD level?
39
40 DR LYONS: As it says in the baseline there, the starting
41 point is the previous year, and it is the previous year's
42 actuals, not the previous year's target. However, the
43 target that was set for that year will be looked at in the
44 context of if the activity wasn't met, there would need to
45 be an explanation around the circumstances and why that
46 wasn't met.
47

1 What would be looked at there is the performance of
2 the district as well in terms of some of the other
3 components that relate to activity being delivered. So,
4 for instance, were emergency departments performing well in
5 terms of access? Were electives, the booked surgery
6 targets, the planned surgery targets, met for different
7 categories of patients? Because if the activity wasn't
8 performed, that can flow through into poorer performance on
9 some of the KPIs. So that would be looked at.
10
11 Then on the basis of the actuals, there will be
12 a discussion around what is the forecast for the next
13 12 months? So a lot of that is input from the districts
14 around the things that they see are likely to be changing
15 for them, and that would include population trends,
16 demographic changes, service delivery changes, in
17 particular if they've a new capital development coming
18 online, and what that would mean in terms of activity. So
19 that becomes the baseline negotiations and that's
20 a discussion that is had.
21
22 Then there are issues around the growth component, and
23 that comes out of the submissions that the district makes,
24 and the ministry assesses those as well and assesses across
25 the state to look at those trends and what it means in
26 terms of the total budget that's likely to be available and
27 then looks at addressing any issues around equity, so are
28 there some factors that are put forward and can be
29 evidenced that demonstrate that there is an issue around
30 equity in terms of the ability for groups to be able to
31 access care? Population, ageing trends, all those
32 demographic trends that we said before, all factor into the
33 growth. Then the adjustors get looked at and those are the
34 things that might then ameliorate the growth in some way.
35 For instance, unplanned re-admissions - that is an example
36 of where, depending on the rate of re-admissions that are
37 not expected for services in that district, if they're
38 higher than the state would anticipate, there may be an
39 incentive to the district to try and reduce those unplanned
40 re-admissions, because that's not good quality care; it
41 suggests that when the patient has been discharged from the
42 hospital, the transfer of care into the community hasn't
43 been supported adequately and they haven't been maintained
44 adequately because they have deteriorated and needed to be
45 readmitted.
46
47 MR GLOVER: How is that incentive delivered through this

1 process?
2
3 DR LYONS: So that can be through purchasing adjustors.
4 For instance, the ministry might say, "We are not prepared
5 to pay for all of your unplanned re-admissions, because
6 there's a need for you to reduce those, so some of them may
7 not be in the activity targets." Other solutions need to
8 be found around how the re-admissions are reduced and there
9 might be an agreement about what needs to be put in place
10 and how that is supported. But that is an example of where
11 there's a shift through the negotiation to say, "Well,
12 something needs to change, and we're not prepared to
13 continue to pay for things that are unplanned and should be
14 cared for in other ways.
15
16 So again another area is potentially preventable
17 hospitalisations. There's a series of clinical conditions
18 where there is a view that care for those conditions is
19 appropriate in the community and they should not need to be
20 admitted to hospital. If they are being admitted to
21 hospital, why is that? Why are we paying for them to be
22 admitted to hospital? Perhaps there's a process around how
23 the adjustments to activity are made to reflect that that
24 shift needs to occur.
25
26 MR GLOVER: So they might be adjustments down?
27
28 DR LYONS: They may be adjustments down.
29
30 MR GLOVER: Are there adjustments that might be upward?
31
32 DR LYONS: Yes, there might be; there might be agreements
33 around the establishment of a new service. So we've talked
34 about virtual care and telehealth. There may be an
35 agreement that we're going to move and shift a service from
36 being delivered in a certain way to another way, and
37 certainly moves to deliver care in community settings are
38 very strongly supported because that's in line with the
39 future directions of health in taking pressure away from
40 hospitals. So if the districts have initiatives around
41 service changes they want to make that reflect those care
42 changes that are in line with where the system would see
43 those important changes occurring as well, they may be
44 supported by additional activity being purchased to reflect
45 that new service delivery model.
46
47 MR GLOVER: Is it really through these adjustors that

1 incentives to drive strategy developed by the centre are
2 implemented through the networks, the districts and the
3 networks?
4
5 DR LYONS: They are certainly one of the levers.
6 Purchasing can be one of the levers to support that, along
7 with planning and policy and other data and information
8 KPIs. So, yes, absolutely, it is one of the levers the
9 centre has to negotiate those shifts in the way care is
10 delivered.
11
12 MR GLOVER: The last factor in that diagram is the
13 specific factors, and we've heard some evidence about supra
14 LHD services. What other types of matters are taken into
15 account at that level?
16
17 DR LYONS: Supra LHD are services that might be provided
18 for a number of different local health districts. The
19 statewide services is where a district hosts, say, service
20 for the whole of the state, so they're the two distinctions
21 there, and both have different appropriate funding provided
22 to support their activity.
23
24 Highly specialised services might be services that are
25 consolidated in only a certain number of places around the
26 state because they're very expensive and because the
27 capability of the staff to provide those and the teams and
28 the technology to support them can't be replicated
29 everywhere.
30
31 MR GLOVER: Some of the examples of highly specialised
32 care you gave earlier today.
33
34 DR LYONS: Yes, yes. So those are examples of where there
35 would be specific things that would be included into the
36 service agreement, and then all of those are added
37 together, and you can see the pluses or minuses on the
38 adjustors and specific factors there.
39
40 MR GLOVER: Yes.
41
42 DR LYONS: Then, ultimately, the activity targets are
43 struck and the budget that will be provided to deliver
44 those is agreed, and that becomes the basis of the service
45 agreement.
46
47 MR GLOVER: And those activity targets, as we discussed

1 earlier, are the ones that are fed into the Commonwealth
2 funding arrangements as part of the overall state activity
3 estimate; is that right?
4
5 DR LYONS: That's correct.
6
7 MR GLOVER: Ms Willcox, did you have anything to add to
8 that?
9
10 MS WILLCOX: No, I don't think so. I think that's fine,
11 thank you.
12
13 MR GLOVER: Those activity targets or arrangements having
14 been set in the service agreement, what would happen if the
15 district exceeded them in any given year?
16
17 DR LYONS: I think there's a tolerance of 2 per cent on
18 the service agreements, so if a district was tracking
19 towards being over that, I mean - so it is not a "set and
20 forget" arrangement, there is ongoing discussion between
21 the ministry and the district; at least quarterly meetings,
22 depending on the level that the district - that is in the
23 performance framework; they may be more frequent than that
24 if there are concerns around performance. Those issues are
25 monitored very closely and if there is a material change
26 likely, then discussions would be had around what's the
27 basis for that, if there's an explanation for it - is it
28 able to be supported, is there action required to change
29 it, if that's possible to do? So those are ongoing
30 discussions between the ministry and the district.
31
32 MR GLOVER: When you say "is it able to be supported",
33 does that mean in a funding sense?
34
35 DR LYONS: Correct.
36
37 MR GLOVER: We might just have a look at an example of how
38 this is expressed in the service agreement.
39
40 This is document [SCI.0002.0013.0001] Commissioner.
41 In the hard copy, you'll find it in volume 6 at tab 47. It
42 is the one we went to earlier. If we can go to page 13 of
43 the document - the coded page 13 - so this is headed "State
44 Outcome Budget Schedule". Is this where we see these
45 targets, at least in summary form --
46
47 DR LYONS: It is.

1
2 MR GLOVER: -- being expressed?
3
4 DR LYONS: It is.
5
6 MR GLOVER: Then a reference you made earlier to the state
7 efficient price is at the top of that table there?
8
9 DR LYONS: That's correct.
10
11 MR GLOVER: What is the purpose of the state efficient
12 price in this process?
13
14 DR LYONS: So the state efficient price is the level of
15 funding that the state sets for funding to the districts
16 for the activity that's purchased. It's a reflection of
17 the cost of providing services in New South Wales, and if
18 you look at the comparisons on the basis of NWAU and the
19 cost of delivering those NWAU across the country, there's
20 variations I talked about before.
21
22 New South Wales is probably I think the second most
23 efficient, I think, in terms of price. Now, to continue to
24 drive efficiency within the system and to maximise the
25 amount of treatment we can provide within the resources we
26 have, the state sets a state efficient price which looks to
27 drive the best, most optimal amount of volume of activity
28 we can purchase within the resources we have. So it looks
29 to set the state efficient price under the national
30 efficient price, and actually under the average - that is,
31 the cost of providing services across the state. It looks
32 at where care is being delivered most optimally within the
33 resources and tries to drive the system towards that.
34
35 MR GLOVER: How does that affect those parts of the state
36 that have challenges like regionality or remoteness in
37 delivery of care?
38
39 DR LYONS: They have adjustors that give them a higher
40 level of funding to reflect those challenges, and that's
41 agreed, because there's an agreement that those costs are
42 there and aren't able to be delivered. But the state
43 efficient price is there to really support and drive as
44 much activity as we possibly can within the resources we
45 have available and the adjustors for the places that can't
46 achieve that are added on so that they reflect the
47 additional costs.

1
2 MR GLOVER: Earlier in your answer you said one of the
3 purposes of it was to drive efficiency.
4
5 DR LYONS: Yes.
6
7 MR GLOVER: How does the use of the state efficient price
8 drive efficiency?
9
10 DR LYONS: The funding that's being received - it's part of
11 this challenge we have in public health of how do we
12 provide as much care as we possibly can within the
13 resources? So by setting the state price at an efficient
14 level, the volume of activity expected is higher than what
15 would be under the national efficient price, and it allows
16 the system to deliver more care and potentially meet those
17 higher demands that we see coming through our system each
18 year. So it's an attempt of using funding as one of the
19 levers to support people looking for new ways and
20 innovative ways to deliver services, maintain their quality
21 at the highest possible level and keep that sustained, but
22 look for more efficient and effective ways of delivering
23 that treatment.
24
25 MR GLOVER: How well does it operate in practice?
26
27 DR LYONS: Well, if you look at the state health system by
28 comparison with any of the other state and territory health
29 systems, we are highly performing, I think, in terms of the
30 measures that are looked at nationally; in terms of access,
31 in terms of emergency department throughput; in terms of
32 emergency and planned surgery activity within the clinical
33 category waiting times; the cost of care; the adverse
34 events - all of those we perform at a very high level and
35 at second-lowest cost.
36
37 The BHI - I think we provided this in one of our
38 submissions earlier - did an assessment of all the
39 developed health systems around the world in the OECD and
40 looked at the per capita cost of delivering services and
41 potential life years lost by the community in those
42 settings and those countries, and New South Wales and
43 Australia performed very well, but New South Wales performs
44 exceedingly well when you look at the per capita spend and
45 the potential life years lost for people from dying early
46 from conditions that they otherwise might be treated for.
47

1 So that gives us a sense, when you do those
2 comparisons, that the system is actually operating very
3 well. It's maintaining services and doing that efficiently
4 and effectively, and the outcomes for our community, at
5 least at that highest level, are very good.
6
7 Now, that doesn't mean that there aren't issues within
8 different cohorts and populations that we need to continue
9 to strive to address, and we are committed to do that, but
10 when you look at the system in totality, it performs very
11 well.
12
13 MR GLOVER: If we can go ahead to page 16 in that
14 document.
15
16 THE COMMISSIONER: The per capita spend and the state
17 efficient price, one of the inputs in that is what health
18 workers are paid; right?
19
20 DR LYONS: Partly. That is one of the drivers. Certainly
21 that would explain, Commissioner, the difference between
22 some of the other jurisdictions about the relative rates of
23 pay, but not just the rates of pay, it will be the
24 industrial arrangements and how staffing is organised.
25
26 THE COMMISSIONER: Yes.
27
28 MR GLOVER: Page 16, just by way of clarification, is this
29 the summary of the estimates for the Commonwealth funding
30 purpose? That is, this is the estimate that feeds in to
31 the overall state estimate for the purpose of determining
32 the Commonwealth funding contribution?
33
34 DR LYONS: That's correct.
35
36 MR GLOVER: We see there in relation to this LHD, in-scope
37 for Commonwealth and state NHRA contributions total - the
38 Commonwealth contribution is about 39.5 per cent, in the
39 middle there, overall?
40
41 DR LYONS: Yes.
42
43 MR GLOVER: Has any assessment been done as to the level
44 of Commonwealth contribution overall to public hospital
45 services in the state?
46
47 DR LYONS: It has, and when we first started, if my memory

1 serves me correctly, I think we were around about
2 38 per cent Commonwealth contribution when NHRA was
3 introduced and activity based funding was introduced. So
4 that was the base. And with the 45 per cent contribution
5 on growth, I think we're up to 42 - 38.6, sorry, 38.6, I've
6 just been corrected by my colleague, who has the most
7 recent information. So we are slowly increasing, but given
8 that the 45 per cent contribution is only on growth and the
9 base is unaddressed, it will take many years for us to get
10 to a higher level of contribution from the Commonwealth.
11
12 THE COMMISSIONER: It takes 80 years to get to
13 45 per cent, I think, Commonwealth contribution. That's
14 what I have read somewhere, I'm sure.
15
16 DR LYONS: That's correct, Commissioner. I think the
17 assessment is it will be about 80 years to get to the
18 45 per cent.
19
20 THE COMMISSIONER: What was the breakdown before - and if
21 you don't know, it doesn't matter, but what was the
22 breakdown before ABF was introduced?
23
24 DR LYONS: I think it was around 38 per cent. That's my
25 recollection. I will have that confirmed but I think it's
26 in that ballpark.
27
28 MR GLOVER: Just going back to an answer you gave earlier
29 about the adjustors in this process, and you used
30 hospital-acquired complications as one, if that's an
31 adjustor that may see a downward effect on the funding that
32 is received by the LHD, might that, on one view, pose some
33 difficulties in the district in actually addressing that
34 issue, that is, the hospital-acquired complications issue?
35
36 DR LYONS: Yes, I mean, the hospital-acquired
37 complications one is one that is a national agreement,
38 because the Commonwealth doesn't pay for hospital-acquired
39 complications either, so it's a reflection of the national
40 funding arrangements, flowed through to the districts.
41
42 Absolutely, you could argue that if you're providing
43 less money, perhaps it's difficult, but in totality these
44 are not huge adjustments to the budgets, but they are to
45 reflect that price signal around quality that the
46 Commonwealth would like to see flow through to the
47 hospitals.

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1
2 DR CHANT: Perhaps it's important to say that you're
3 looking at it from a funding stream concurrent with the
4 fact that hospital-acquired infections might be higher in a
5 particular district, that will be picked up under the
6 performance review; the Clinical Excellence Commission
7 sits on the - our CEC sits on the performance reviews and
8 there will be a program of work designed to work and
9 support the district to understand what's driving those
10 infections or other complications and what has worked in
11 other districts and really sharing, to actually support the
12 district. That's one of the key roles of the pillar
13 organisations, and particularly our Clinical Excellence
14 Commission, in the domain of quality and safety.
15
16 MR GLOVER: Ms Willcox?
17
18 MS WILLCOX: Dr Chant really said what I was intending to
19 say. I think it's important to note that these are
20 discussions that happen at a formal performance level and
21 the frequency of those will be determined in terms of the
22 relative performance of the district. But if an LHD is
23 concerned about particularly a quality and safety measure,
24 it's frequent that those teams would escalate and have some
25 discussions with the Clinical Excellence Commission, for
26 one, but most certainly as part of our due diligence in the
27 ministry, we would then ask the appropriate representative
28 from the ministry to attend the performance meeting with
29 that district. Suitable papers would be sent in advance so
30 that there would not be a blind-siding of colleagues but
31 really to trigger the discussion and to provide guidance
32 and support around how we might assist them to improve that
33 performance, say it's a hospital-acquired complication or
34 the like.
35
36 So, yes, it is an iterative process with an approach
37 to support and decisions around - to Dr Lyons's point,
38 it's not like a hard end with a lot of money taken away
39 from an LHD. We would do a lot of work and try to mitigate
40 that impact, but also to note that the care that is causing
41 complications, whether it's sepsis or longer lengths of
42 stay, is also more expensive, so there is an incentive
43 there to want to do the right thing by the patient, but
44 it's also an optimisation of the district.
45
46 MR GLOVER: As part of this process is there a focus on
47 reducing low value care?

1
2 DR LYONS: Not explicitly. It's being incorporated in
3 more to the discussions now, but the low value care relies
4 on there being good evidence for the care not to be
5 effective or to be consuming resources but of limited value
6 to the patient in terms of better outcomes, or to have good
7 and effective ongoing outcome measurement systems as we
8 talked about earlier.
9
10 So where there are explicit things - arthroscopies for
11 arthritis of the knee, for instance - the system is not
12 purchasing that activity anymore for patients on a planned
13 surgery basis, because that is low value care. But other
14 examples of where we might make service change, it is not
15 just around the purchasing. As colleagues have indicated,
16 purchasing is one lever but it's not left to just the
17 purchasing. It needs to be supported by a whole range of
18 other policy, support for change in practice, discussions
19 with clinicians about alternatives, getting those services
20 arranged and set up to support the patients to make sure
21 their needs are being met. So it's not done as a blunt,
22 just not going to purchase; it's got a whole strategy
23 around it usually.
24
25 MR GLOVER: And having used the term myself, what is
26 within the concept of low value care?
27
28 DR LYONS: Low value care, by definition, is care that is
29 consuming resources, healthcare resources, but without
30 delivering significant benefit to the patient in terms of
31 clinical benefit or outcome.
32
33 THE COMMISSIONER: A simple example might be giving
34 antibiotics to someone who has a virus.
35
36 DR LYONS: Correct. That's correct, Commissioner. And
37 another example might be ordering tests like vitamin D on
38 a frequent basis, where it's not going to change care. So
39 there are myriads of examples of things that are being
40 done.
41
42 THE COMMISSIONER: It has to be a lot more complex than my
43 example.
44
45 DR LYONS: There are plenty of them that are more complex.
46 But the whole concept of value based care is certainly well
47 and truly embedded in the developed healthcare system world

1 now, out of concepts that came out of the US, but value
2 based care is really around looking at the resources that
3 are consumed and what's the clinical outcome, the
4 healthcare outcome for the patient as a result of that and
5 making sure that we're optimally using the resources we
6 have to get the best possible outcome and, if not,
7 adjusting it.
8
9 MR GLOVER: Ms Willcox, you described some of the
10 performance framework in terms of assisting an LHD to
11 correct an issue. It is convenient to take you to the
12 health performance framework at that time. The document is
13 [SCI.0001.0007.0001]. Commissioner, you will find this in
14 volume 2 behind tab A11.
15
16 Is this the framework that you had in mind when
17 answering those questions a little earlier?
18
19 MS WILLCOX: Yes.
20
21 MR GLOVER: If we go to page 10 in that document? There
22 is a description of the performance levels that I think you
23 mentioned.
24
25 MS WILLCOX: Mmm.
26
27 MR GLOVER: Just in general, practical terms, how does
28 this process play out?
29
30 MS WILLCOX: So as part of the reporting that local health
31 districts undertake, they capture performance across
32 finance performance, as in surgery, emergency departments
33 and clinical performance, as well as quality and safety and
34 some workforce measures as well. The ministry has an
35 executive team that is chaired by the secretary with the
36 support of finance and the performance teams who collate
37 responses to the districts' performance inputs, so that we
38 can collectively form a view as to what level a local
39 health district is sitting at or if we have concerns around
40 performance.
41
42 Just to note, though, that there are ongoing
43 discussions with LHDs. This is a quarterly meeting that
44 occurs and not the sum total of dialogue that would be had
45 around a district's performance, particularly if a district
46 was struggling - anything, you know, really from 2, 3, 4,
47 they would find themselves having increased interaction

1 with the ministry.
2
3 That scaling or escalation table that's described
4 there outlines or gives a framework for what is the level
5 of intervention from the ministry or not. So if you are
6 performing on level zero - it's a bit counterintuitive -
7 you're performing the best. People like Kerry, Nigel and
8 I stay clear of you, allow you to get on in your devolved
9 system and do your good work and report as required and
10 escalate as required. Then the hierarchy, as you can see,
11 gets right up to a level 4, where previous attempts to
12 support an LHD have potentially been unsuccessful, recovery
13 is incomplete and that leaves the performance level in a
14 pretty dire situation that may require a more extreme
15 response.
16
17 MR GLOVER: Over the page, please. Here we have a general
18 description of the performance recovery process. Does that
19 process involve what you described earlier - that is,
20 engaging with some of the pillar organisations to support
21 the LHD through what it needs to do to recover?
22
23 MS WILLCOX: Yes, there could be a potential for a variety
24 of scale of activities that we may implement to support
25 a district. The one that I previously referred to probably
26 is more aligned to a specific change in the - for instance,
27 a health-acquired complication that you've got in that
28 month's report and that you're going to have a discussion
29 with the Clinical Excellence Commission particularly on
30 that measure and implement something directly to deal with
31 it.
32
33 As we get into these performance levels in this
34 quarterly response, you get into a more holistic, I guess,
35 view of where a district is sitting across a range of
36 areas. It's not just about finance, it's not just about
37 quality, it's not just about performance, it's about the
38 totality because we treat all things as equal. So the
39 interventions then may require a pillar to come in to
40 assist, may require somebody external to come in and review
41 the financial operations. Yes, it could be any manner of
42 things, or it might be a combination of events, or in fact
43 might require a team to go in and to actually take a much
44 more interventionist role in the LHD.
45
46 MR GLOVER: Thank you.
47

1 We'll move now to part 3 of the report, or question 3.
2 That commences at paragraph 59. I think Ms Willcox you
3 have been nominated for these questions. Dr Lyons can
4 relax for a little while
5
6 MS WILLCOX: I'm sure he'll want to contribute.
7
8 MR GLOVER: In paragraph 62, it states:
9
10 *NSW Health undertakes a comprehensive,*
11 *evidence based clinical services planning*
12 *to ensure current and future services meet*
13 *the needs of the NSW population.*
14
15 Can you just describe that process?
16
17 MS WILLCOX: Yes, certainly. The planning for the New
18 South Wales health system happens at a number of levels.
19 At a state level, we have planning teams within the
20 ministry and within my division who would look at
21 a population, look at the demographic, ageing, housing, you
22 know, new housing estates, public transport, a whole lot of
23 macro government measures that are occurring that will
24 impact on where a population is and how they may be
25 situated.
26
27 They would also connect very strongly with people in
28 Kerry's team, looking at priority populations and some
29 other - I guess we go back to the point of equity, we're
30 looking at some population need issues that would overlay
31 that macro planning.
32
33 At a local health district level, all our local health
34 districts undertake a level of population health planning
35 and clinical service planning. They use data from the
36 ministry to support that, they would use Australian Bureau
37 of Statistics data, local government, a range of inputs, to
38 plan for their local population and understand how they
39 need to - where their services need to be developed, either
40 location or complexity, to do that networking of services
41 that we discussed earlier so that they can actually have
42 the best ability to care for their population, noting that
43 people will flow in to particular districts for particular
44 supra LHD services, but if we just talk locally.
45
46 Hospitals and services themselves will then also plan.
47 They will make operational plans out of these more

1 strategic plans that overlay them locally and from the
2 state level, and they will use that information, drill down
3 in terms as to how they determine how they run their
4 operational services in a community health centre or in a
5 hospital, so that that is supporting the population needs
6 that are being described at a macro level, that that is
7 translating on to the ground with services that are
8 actually being provided. So it's a macro, district, and
9 then a local planning exercise.
10
11 MR GLOVER: In that answer you referred to "priority
12 populations". What did you mean by that?
13
14 MS WILLCOX: Dr Chant may like to add to this, but we
15 would identify those priority populations who one may be -
16 their access may be impeded, there may be language
17 barriers, socioeconomic settings, lack of access to primary
18 care, perhaps transport is an issue, where populations are
19 more marginalised, their ability to access care routinely
20 is limited. We know that in our Aboriginal population
21 there's increased co-morbidities and shorter life
22 expectancy, and so we would also, in areas where there was
23 large Aboriginal populations, ensure that those services
24 and partnerships with our Aboriginal controlled health
25 organisations were in place to manage those or support
26 those and partner with those communities. Those would be
27 some of the headline areas.
28
29 MR GLOVER: Dr Chant, to you have anything to add to that?
30
31 DR CHANT: I think probably just to frame it that priority
32 populations can be probably looked at, at a macro level,
33 and then also related to each disease or condition stream,
34 we might have priority populations. But overall we're
35 looking at populations for which we know the outcomes are
36 not the same, so there are disparities. For instance, it
37 might be homelessness, it may be Aboriginal populations, it
38 may be our prisoner populations. So for those individuals,
39 we might need to add on additional components to their
40 clinical care pathways to achieve those same outcomes. We
41 might have to make sure that the front end of our services
42 are very appropriate and tailored to the needs.
43
44 We might have to help people connect services. They
45 might have barriers such as transport or be concerned about
46 payment or racism or discrimination. So for many of our
47 populations, we look at our data very closely to determine

1 who is missing out, where are the gaps, and then do what we
2 can to put in those models of care to support them.
3
4 And then we use the term "priority populations" also
5 where we know that the burden of illness is different
6 across our population. For instance, with conditions such
7 as tuberculosis or conditions such as hepatitis B, we know
8 that people coming from culturally and linguistically
9 diverse countries will have a higher burden of that
10 disease. So when we're designing services, we need to have
11 a particular focus on newly arrived migrants or people who
12 have been born in countries overseas. That's more the
13 demographic of trends associated with the nature of those
14 diseases, the epidemiology of those diseases.
15
16 MR GLOVER: Is that more done at the macro level or the
17 local level?
18
19 DR CHANT: At the macro and the local level. We would
20 have a suite of - many of our program areas would have
21 a range of strategies and those planning documents - I can
22 name a few - we have our hepatitis B plan, our HIV, our STI
23 plan, and each of them will look at where the burden of
24 disease is, where the groups are that particularly might be
25 emerging issues, and that will target our strategies to
26 those responses. But that will require us to identify our
27 priority populations, where we're going to work and,
28 importantly, who we're going to work with and what are the
29 communities we're going to work with. It will be at
30 a macro level but it will also be very much at a local
31 health district level as well.
32
33 MS WILLCOX: Probably one simple example of that might be
34 if we look at transport services at a state level to
35 identify where housing might be built or transport runs
36 that might be near our hospitals and services, we also
37 partner with NGOs that provide community transport. So
38 perhaps in a community that we know is a little
39 marginalised, one option to assist them and support access
40 to care would be to partner with an NGO community transport
41 provider to collect those people perhaps from the housing
42 estate, or wherever they're located, to bring them into
43 a community health centre. That's where the macro meets
44 the local.
45
46 MR GLOVER: As part of that overall process is there
47 community consultation undertaken?

1
2 MS WILLCOX: Yes. I mean, I think our capability in
3 community consultation is certainly something that's
4 evolved for the better over the past years. In fact,
5 there's almost nothing you would do in public health these
6 days that would not involve the community. Our consumers -
7 we say these things and it's not intended to be a glib
8 comment - are truly our partners in what we do.
9
10 COVID taught us many things, but that connection with
11 community, I think, was one of the most profound things
12 that emerged, in terms of knowing our communities,
13 understanding many of the cultural groups that perhaps we
14 didn't have inroads with or relationships with. So
15 building these partnerships enables us to go to community
16 and talk about what they want and how we build services
17 around them and with them.
18
19 In the rural and regional, some of the place-making
20 work that has been done in a number of our rural
21 communities is also showing great gains, and that's working
22 with community leaders, local government, community and
23 NGOs and health and making decisions around what types of
24 services do you need in this area, you know.
25
26 MR GLOVER: Did you describe that as "place-making work"?
27
28 MS WILLCOX: Yes.
29
30 MR GLOVER: What does that mean?
31
32 MS WILLCOX: It is not intended to be jingoistic, but it's
33 about really bringing who are all the relevant people in a
34 community together to collectively make decisions around
35 what sorts of health services they're going to need now and
36 into the future. It's not a funding body; it's
37 a consultative arrangement to help design and then forward
38 that information into the clinical plans for the local
39 health districts, so as they bring activity and resources
40 on, they've got a very clear and signed-up plan with the
41 community as to what they want to bring online.
42
43 DR CHANT: I'll give you probably an example of how that
44 can happen in a macro level and then it happens at a local
45 level. HIV has probably been a longstanding example where,
46 at a peak level, we would have our New South Wales users
47 group, NUAA, sitting down with us alongside our academic

1 partners in the Kirby, alongside ACON, Pos Life and other
2 NGOs that are working in that sector and sitting down and
3 looking at the data and what are the concerns, what are the
4 gaps, what are the threats, and planning together - data
5 informed, evidence informed, what are the innovations that
6 are being used overseas, what is the new evidence that is
7 emerging? And we have general practice, we have drug and
8 alcohol, sexual health, representatives from our local
9 health districts.
10
11 Those linkages will then play out differently but
12 depending on the geography, the nature of the risks in
13 particular areas, that will be a focus of activity of the
14 local health district as well, but informed up and down
15 from intelligence, because we recognise the importance of
16 local intelligence as well as engaging statewide. But our
17 partners have been critical at keeping us informed and
18 grounded about what our services need to look like.
19
20 MR GLOVER: Thank you. In paragraph 64, something called
21 a "whole of person integrated care model" is described.
22 What does that mean?
23
24 MS WILLCOX: We talked briefly earlier around integrated
25 care, and that is about providing care that is seamless for
26 the person who is requiring the services so they can move
27 between primary care, community services, hospital
28 admission potentially, and each part of the system that
29 they move through understands them, knows them, has
30 information about them, allows that person to move through
31 in a connected way.
32
33 Now, we know this is not perfect at the moment, you
34 know, you ask any patient - "Mum, how many times did I have
35 to describe my situation to any number of people?" - that
36 is, when they enter the health system. But our aim is to
37 mitigate these interface issues that happen between primary
38 care and the state system so that we can join up our
39 activities, certainly data sharing and medical records,
40 models of care that show a continuation of care for
41 a person, also in the vein of keeping them optimally well
42 in the community and not requiring them to come into
43 hospital, and you have a much greater chance of that if
44 that care pathway for them is continuous and there is
45 a sharing and understanding of their needs across all of
46 the professions that may be caring for them in primary
47 through to acute.

1
2 The interface, I think, with primary care, aged care,
3 these are all the things that we are working around, and
4 there are many things. I think some of them are captured
5 in the submission that we may come to about how we can
6 actually improve that and create true integration.
7
8 NSW Health has done a number of very good flagship
9 integrations under Dr Lyons's leadership, but it is not
10 a universal way of providing care as yet. It's still in
11 targeted areas and taking considerable effort in order to
12 create a setting that means a person can move seamlessly
13 across care.
14
15 MR GLOVER: Why is it important for someone to be able to
16 move seamlessly across care in the way you've described?
17
18 MS WILLCOX: I think, firstly, for the person the
19 experience is better. They move from professional to
20 professional and people know them and understand them.
21 They can develop trust in their care providers. If you are
22 changing practitioners constantly, there's a vulnerability
23 there for you.
24
25 It's better for the clinicians who are providing the
26 care because they're getting better information about
27 a person, they're getting more informed information from
28 the patient as well, so they're getting the total picture
29 of what's going on with a person. It goes to some of those
30 outcome and experience measures we talked to earlier. It
31 will probably be more efficient in terms of a funding - you
32 know, funding arrangements, because we're likely to
33 actually manage somebody better in the community and make
34 better decisions about when they might need to come to
35 hospital. If it's fragmented, we end up being the
36 default and --
37
38 THE COMMISSIONER: It's care that's for the whole of the
39 person's health needs, or all of their health needs is
40 integrated care, which might - we were talking about this
41 at lunch - involve multidisciplinary care because a whole
42 of a person's health needs might require different health
43 professionals that have different areas of expertise.
44
45 MS WILLCOX: That's correct, Commissioner. And one of the
46 things that, out of the Strengthening Medicare Taskforce
47 that Dr Lyons was a participant on, the Commonwealth

1 Government has provided some funding to make it easier for
2 general practice to employ nurses and allied health
3 professionals within a practice. That goes to your point,
4 because rarely does a person have one need; they will have
5 multiple needs.
6
7 The patient reported experience measures and output
8 measures that we talked about earlier are also important in
9 that regard, because a patient will sometimes report
10 themselves about just not feeling okay or feeling anxious.
11 That may not be something that comes up in a dialogue in a
12 clinic, but if it can be captured in those measures and a
13 clinician's aware of it, that question may well be asked
14 and additional supports provided to an individual.
15
16 THE COMMISSIONER: And you can have multidisciplinary care
17 needs out of the hospital system, but integrated care might
18 require treatment in a hospital for some acute part of your
19 healthcare needs, but referral outside of the hospital
20 system for assistance from a different healthcare
21 professional for prevention or ameliorating the symptoms
22 from what was the acute condition.
23
24 MS WILLCOX: Yes, that's absolutely right. There would be
25 some community settings - an outpatients clinic would be
26 one area. People go to a pain clinic, for instance. There
27 are many elements to pain. It may be a particular back
28 issue or a nerve issue, there will be some psychosocial
29 component, pain is a terribly distressing thing. Having
30 a psychologist as well as a neurologist in that
31 consultation may be more beneficial than a neurologist
32 alone.
33
34 Is there anything you want to add?
35
36 DR LYONS: I'd just say I think this is the nub of where
37 the system needs to change.
38
39 THE COMMISSIONER: Does this get back to where, perhaps,
40 the funding models don't respond best to the kinds of care
41 we've just discussed?
42
43 DR LYONS: In part, but I would add to that that I think
44 the success of the acute care system over the last 20 or
45 30 years has got us to the point where we've got deep
46 knowledge around specialties, which are disease and system
47 focused, primarily.

1
2 THE COMMISSIONER: And technically efficient care in
3 hospitals.
4
5 DR LYONS: And technically very efficient. However, when
6 you are a person who has multiple problems and are aged and
7 frail, your needs may not be best met by just one of those
8 specialties alone. You need access to a number of them for
9 your holistic care and to get the best outcome.
10
11 I think the challenge for us is how we re-orient the
12 system, because at the moment it's still very much geared
13 up around - these specialties and sub-specialities are so
14 important, they've given us the outcomes we now have which
15 are great outcomes, and they're keeping people alive a lot
16 longer than they would otherwise have been, but we now have
17 this situation where their needs are not being met best by
18 the way we are organising and delivering care. It's
19 fragmented, it's siloed. Even within the acute care
20 settings, it's a challenge to deliver holistic care, let
21 alone transitioning outside, and how you support that
22 change happening as a system is the issue that we are all
23 grappling with, about how you support that change to occur,
24 and particularly across the boundaries that exist between
25 the state, the Commonwealth and other service providers.
26
27 DR CHANT: I think that's a really important segue,
28 because the system that we have in Australia is premised on
29 the general practitioner, who is a specialist - general
30 practice is a specialty - who is the integrator. Then,
31 technically, the other specialists, the non-GP specialists,
32 have become so super specialised that we so much need that
33 integrator to do that integrated care, and then in the
34 absence of that strong grounding, our services are picking
35 up some of that requirement to integrate. Technically, we
36 should be integrating back to the primary care, this really
37 strong --
38
39 THE COMMISSIONER: When you say "our services".
40
41 DR CHANT: I mean the services that NSW Health is
42 providing.
43
44 Now, there will always be some circumstances where
45 people are not in a stable condition to be dealt with and
46 they may be hospitalised or they may require a lot more
47 support than even a well-funded, well-integrated general

1 practice could do, and then again, that's a role for us.
2
3 So I really think that this has to be thought of in
4 terms of, you know, our respective roles and
5 responsibilities and to some extent, the integration and
6 what that looks like for us depends on the partners we've
7 got to integrate with. But ultimately, I think the
8 majority of people would see a very strong primary health
9 care sector, multidisciplinary, as the integrator, with us
10 making sure we do our part in transferring medical records,
11 that we link in, we give responsiveness to that primary
12 care practitioner. But there are challenges, and I suppose
13 we're operating in - that's part of the reason you have got
14 this special commission.
15
16 THE COMMISSIONER: What you've all said today and just
17 then has, in one way or another, been said in multiple
18 reviews - everything we've been talking about.
19
20 DR LYONS: Yes.
21
22 THE COMMISSIONER: But we're here.
23
24 MS WILLCOX: We've used the term "workarounds", and
25 I don't mean that in a pejorative sense, but some of the
26 things that we've done at a state level have really been in
27 a positive sense, "What are the workarounds we can do
28 within the structures and the funding models that we exist
29 in that are the best thing for patients?" So Kerry's
30 point about how people with multiple chronic conditions,
31 how they manage themselves, having a chronic care navigator
32 is a service that a number of districts would do, and that
33 enables someone to have a go-to person to help them work
34 through where they need to be and help to manage themselves
35 at home.
36
37 We try to do all these things, because they're the
38 right thing to do for a person. But just where the
39 responsibility lies gets a little bit grey when you think
40 about primary care and a public hospital setting.
41
42 We're also doing some work with our PHNs, with our
43 primary health network, our state group, and we've
44 developed a joint statement, again under Dr Lyons's
45 leadership, and got some agreement around some performance
46 measures for particular groups of patients that we can both
47 hold ourselves to account. Again it's an attempt to align

1 our efforts around people with chronic disease, like
2 chronic heart failure, for example: what would be the
3 measures that primary health would want to see and what
4 would be the things we would want to see? Hopefully,
5 collectively, we're all moving in the same direction for
6 that particular patient group in a particular location. So
7 we're just embarking on that work at the moment.
8
9 THE COMMISSIONER: But for the general practitioner
10 specialists to be the integrators that Dr Chant said, that
11 would require a reform to the MBS, wouldn't it, as to how
12 there's funding for a general practitioner to go from fee
13 for service and treating someone for a particular illness,
14 as distinct from treating them for the condition they've
15 got that might require not just a different model from the
16 GP but integrated, multidisciplinary care as well? Is
17 that generally --
18
19 DR LYONS: That's correct. That is generally correct. In
20 fact, there are moves in that direction as a result of the
21 some of the strengthening Medicare work. Voluntary patient
22 registration to a practice is an example --
23
24 THE COMMISSIONER: Yes, that's what I had in mind.
25
26 DR LYONS: -- creating the relationship where a patient is
27 seen to be --
28
29 THE COMMISSIONER: It doesn't matter where I look, either
30 the camera is in the way or the microphone, so I'll just
31 keep moving.
32
33 DR LYONS: The other component of that is ultimately that
34 there will be funding to support the change in practice
35 from the GP to be much more involved in the ongoing care
36 that won't be linked, necessarily, to MBS. So those are
37 the directions the Commonwealth has signalled through the
38 changes. That needs to be built on and expanded.
39
40 THE COMMISSIONER: So this is - is it "VP" - voluntary
41 patient enrolment?
42
43 DR LYONS: Voluntary patient registration, enrolment, yes.
44
45 THE COMMISSIONER: Which, as I understand, the AMA is on
46 board with, provided it doesn't move to capitation, but is
47 actually just strengthening the bond of a particular

1 patient to a general practice, and then moving towards
2 perhaps a better model of care for chronic disease.
3
4 DR LYONS: The next steps are going to be critically
5 important because the enrolment alone is not going to give
6 it --
7
8 THE COMMISSIONER: No.
9
10 DR LYONS: So it has to be what comes next and how that
11 supports the changes we need to see.
12
13 But I would go beyond. I mean, I think we as a system
14 need to value generalism and general practices especially
15 much more than we currently have. We've valued our
16 specialties and our sub-specialties, quite rightly, because
17 they are very important to the sort of health system that
18 we have and enjoy outcomes from, but generalism now, given
19 the change in demographic of our community - ageing,
20 frailty, multiple conditions, chronic conditions, the need
21 for ongoing care - we must support generalism.
22
23 At the moment, we refer upstream to specialties, like
24 that's a good thing for patients, and it is, but what we
25 need to do is reorient the secondary care services back to
26 primary care, so that they're actually supporting the
27 general practitioner to deliver the care without need for
28 referral, as much as possible, to maintain that holistic
29 care and to have that ongoing relationship, rather than the
30 fragmented, episodic arrangements that we have at the
31 moment that rely on lots of information being transferred
32 that isn't automatically transferred, and potential gaps in
33 care.
34
35 DR CHANT: And it may go beyond primary care. It may be
36 also the way that specialist services can take phone calls
37 from GPs or can review results and things.
38
39 THE COMMISSIONER: Yes, we heard about that the day in a
40 workshop.
41
42 DR CHANT: Because we know also just even travelling to
43 a specialist can be a barrier in terms of the time. Just
44 thinking of it from the patient's perspective, where do
45 they want to seek care, what's the best setting, what do we
46 need to do if we're going to have primary care as the
47 integrating practitioner, what else does that mean for the

1 changes around it, both our system, but also the
2 specialist, the private specialist systems in terms of
3 support for that general practice?
4
5 THE COMMISSIONER: An example of the topic you just
6 raised, it would seem crazy - I have mild psoriasis, so if
7 I go to my GP and my GP has recommended whatever,
8 Diprosone, but it's not working very well and there is
9 a different ointment or cream I could get. Under the
10 current system, you need a referral to the specialist
11 dermatologist, you have to go there, and they say, "Yes,
12 your GP was right. Instead of potion A, you can have
13 potion B"; whereas if the GP could have just called the
14 specialist and said, "Beasley's been on potion A. Should
15 we try potion B", the specialist says, "Yes", I don't have
16 to go to the specialist.
17
18 DR CHANT: And they may also have telemedicine so he can
19 actually visualise it, so it could be a very quick episode
20 or it could be review the scan or review the test. So it's
21 not all the time that it requires a full assessment by the
22 specialist. It's a question of how do we put and value the
23 specialist knowledge of the general practitioner as the
24 integrator, and then what also can our services
25 consistently do, so that if the general practitioner is
26 working to their full scope, where will we be as a backstop
27 if things go outside that boundary where they're feeling
28 they need that referral and can we predictably support
29 them?
30
31 THE COMMISSIONER: I should clarify, I don't intend to
32 expose all my ailments.
33
34 MR GLOVER: Commissioner, it is 10 past 3. Might I
35 suggest a short break, so our witnesses can have a short
36 break and also our reporters.
37
38 THE COMMISSIONER: Would you like a short break?
39
40 MS WILLCOX: It is up to you. We're fine.
41
42 THE COMMISSIONER: You want one?
43
44 MR GLOVER: I do.
45
46 THE COMMISSIONER: We will have a break until 20 past.
47

1 MR GLOVER: Thank you.
2
3 **SHORT ADJOURNMENT**
4
5 THE COMMISSIONER: Yes, Mr Glover.
6
7 MR GLOVER: Thank you, Commissioner.
8
9 If we can go back to the report, please, and we'll go
10 to paragraph 69. Reference is made there to hospitals
11 operating at different levels, and we've had some evidence
12 about those levels this morning, but also referred to is
13 a "multipurpose service". What is a "multipurpose
14 service"?
15
16 MS WILLCOX: Thank you. Yes, a multipurpose service,
17 they're principally in our rural and regional communities
18 and provide care, sub-acute care, and in the main, aged
19 care in our rural and regional communities. They are
20 staffed by local health district staff, GPs frequently come
21 in and provide primary care, and they tend to be elderly,
22 long-stay patients.
23
24 MR GLOVER: How are those funded in the Commonwealth-state
25 sharing arrangement? Dr Lyons, everyone is looking at you.
26
27 DR LYONS: By agreement, the multipurpose services have
28 a contribution agreement for the healthcare side of things,
29 but given that they also have responsibility to provide
30 residential aged care, there's an agreement from the
31 Commonwealth to fund the aged care beds as well through the
32 aged care funding stream.
33
34 It's actually a very good solution for the rural
35 communities because it allows the concentration of the
36 health and aged care services. There will be an emergency
37 department, which is providing after-hours medical care.
38 You might have a couple of acute beds. You will have
39 access to some community health services on site. You
40 might have access to a dental chair in the MPS, so that
41 visiting oral health services can be provided. So it's
42 a very good solution to maintain a presence around the
43 health and aged care services for that community.
44
45 MR GLOVER: And although they are providing aged and
46 primary care, are they managed by the LHDs in which they
47 sit for all of their services?

1
2 DR LYONS: They are, they are.
3
4 MR GLOVER: Can we go to paragraph 72.
5
6 THE COMMISSIONER: Sorry, can I just ask, are multipurpose
7 services facilities widespread in New South Wales?
8
9 DR LYONS: I think New South Wales has the largest
10 concentration of multipurpose services in the country.
11 Most of our small community rural hospitals have been
12 converted to multipurpose services over the years.
13
14 MS WILLCOX: I don't know the exact figure off the top of
15 my head. I thought it was 30 to 40, but we could confirm
16 that.
17
18 MR GLOVER: Over at paragraphs 70 and 71 leading into 72,
19 there's discussion about the network arrangements, which we
20 have spoken about already. Then in 72, as part of those
21 networked arrangements, it is said in the last sentence:
22
23 *Some elements of care may be provided with*
24 *network support, including through virtual*
25 *care arrangements.*
26
27 Can you just describe what is being referred to there?
28
29 MS WILLCOX: Yes. So the networked arrangements would
30 assist clinicians in determining what might be an
31 appropriate treatment response to a patient in their care
32 and whether they needed to be transferred to a high-level
33 setting. A critical care patient or a small child would be
34 an example of that.
35
36 Increasingly, we have service models that enable
37 a clinician at one particular location to be hooked up with
38 a camera, video and sound to a clinician at another
39 location to make an assessment - paediatrics, our neonatal
40 service is a really good example of that, where the
41 neonatal intensive care service people are able to have
42 that discussion, observe a child, get an account of its
43 condition and jointly make a decision with the clinician
44 locally as to whether that little one needs to be
45 transferred to a higher acuity setting. So that would be
46 the type of example.
47

1 MR GLOVER: Is another example the arrangement between,
2 I think you said, Broken Hill and RPA this morning; is that
3 another example?
4
5 MS WILLCOX: Yes, it is. The Broken Hill community is
6 obviously a very long way away, Adelaide is the nearest
7 large and tertiary facility. There are some natural
8 connections between Western NSW and RPA, it's really an
9 extension of that. It's about obviously giving that
10 immediate support to a clinician and giving guidance around
11 a patient, but it also goes to building capability in an
12 educative role as well for those clinicians.
13
14 MR GLOVER: Just referring to the fact that for Broken
15 Hill, the closest major city is Adelaide, are there some
16 arrangements between New South Wales and other states for
17 those types of communities?
18
19 MS WILLCOX: There would be a number of patients from
20 Broken Hill that would travel to Adelaide for planned care,
21 in the main. We have cross-border arrangements with
22 Albury, and the ACT. They have formal cross-jurisdictional
23 arrangements, where activity and flow of residents moving
24 between the two is accounted for, again through the IHACPA
25 model as well, and a reconciliation done at the end of each
26 year to clarify that activity and monitor the flows and
27 a payment schedule arranged.
28
29 MR GLOVER: Is the purpose of those arrangements to ensure
30 that residents in those communities can access the care
31 that they need in a seamless way?
32
33 MS WILLCOX: Yes, that is exactly the reason. Again, the
34 matter of the dotted line around the boundary is not
35 relevant to a person. They want to go and access care
36 which is the closest or the place that is most appropriate,
37 and our job is to facilitate.
38
39 MR GLOVER: Can we go to paragraph 75, please. There it
40 is stated that:
41
42 *Community health services aim to ensure*
43 *adequate short or long term clinical care*
44 *and direct efforts towards addressing the*
45 *social and environmental determinants of*
46 *health.*
47

1 What are the social and environmental determinants of
2 health?
3
4 MS WILLCOX: I will ask Dr Chant to make some comment on
5 this as well, but just some initial remarks. If we look at
6 mental health patients, for instance, mental health
7 consumers, there will often be a complexity of social and
8 environmental impacts - housing, family support, dietary
9 issues impacted by the medications they may be on for their
10 chronic mental health issues. When you come into a mental
11 health community service for care, our aim is to look at
12 all of you and to provide nutrition and dietary support, as
13 well as managing your mental health issues and managing
14 your medications, ensuring your housing support is
15 adequate.
16
17 When community mental health staff go into people's
18 homes, they can scan the environment and see if someone is
19 coping and functioning in their place. These bring a total
20 picture of what a person's situation is like and it may
21 lead, for instance, to a community health nurse making
22 contact through the service to our housing partners or to
23 the Department of Communities and Justice, wherever we'd
24 need to go to ensure that we get the wrap-around around
25 that individual that they require. It might just be sort
26 of a sub-case study of the nature of what that language is
27 they'll need to explain.
28
29 DR CHANT: I'm going to draw from the AIHW's discussion
30 of social determinants because I think that's quite useful.
31 There is clear evidence that supports the close
32 relationship between people's health and wellbeing and the
33 living and working conditions which form part of their
34 social environment. Factors such as socioeconomic
35 position, their education, conditions of employment, power
36 and social support, social connection, known collectively
37 as the social determinants of health, act together to
38 either strengthen or undermine the health of individuals.
39
40 We can see that we can turn that into a positive, that
41 if you have social connection, you're not socially
42 isolated, then that's going to improve your outcomes. Even
43 if you experience the same disease, perhaps, as someone who
44 is potentially suffering social isolation, the challenges
45 for you getting the same outcomes will be different and the
46 care we'll need to provide will have to attend to that
47 social isolation.

1
2 All the data demonstrates that the social determinants
3 play out. Australia has quite an equitable health system,
4 but we know there are still, across all our data sources,
5 gaps between the most advantaged in our population and the
6 most disadvantaged, and that derives from those social
7 determinants of health.
8
9 MR GLOVER: Aside from social isolation, how in other ways
10 do they play out?
11
12 DR CHANT: Perhaps if we talk about socioeconomic
13 circumstances. I think in the submission we draw attention
14 to the differences between the most advantaged in our
15 population and the most disadvantaged.
16
17 Just perhaps thinking about yourself, if you're having
18 to make a decision about expending or accessing health
19 services, you might delay that if you've got a job where
20 you might be in insecure employment and if you take a day
21 off work you might be seen negatively. You might be able
22 to get a day off work but then you might be on a very, very
23 low income or you might have other demands on your
24 disposable income and you don't have access to
25 a bulk-billing GP, that's a barrier. You might say "I'll
26 get better. I'll delay."
27
28 You may particularly not attend to preventative
29 treatment to go to those prevention health checks because
30 you might see that as discretionary. Even when you get to
31 the specialist, you might access a bulk-billing general
32 practitioner. But then if that bulk-billing general
33 practitioner sends you to a private specialist, the
34 majority of private specialists, are associated with out of
35 pocket expenses, they're not covered fully by Medicare.
36 You may express that view to your GP but you may feel
37 uncomfortable saying to your GP that you can't afford to go
38 to the specialist, and so the GP may not know you've gone
39 there. So that's an example.
40
41 The GP could provide you to outpatients, but again,
42 our outpatient services perhaps have waits associated with
43 them and prioritisation; they may not be as convenient as
44 a local specialist.
45
46 Then when you even get to your treatment, then there's
47 a question of will you take the time off work, can you

1 afford any out of pocket expenses, can you get transport to
2 those services that you need?
3
4 I've just given a sort of characterisation of
5 someone's flow through the system, but you can see how that
6 would be a different perspective. If you're very
7 advantaged, you have secure employment, you have high
8 disposable income, no other factors in play, your
9 navigation of that pathway will be a lot more streamlined
10 and not impacted by so many decision points that are
11 impacting on your ability to access care.
12
13 DR LYONS: I will give you a very simple illustrative
14 example. It was a patient with long-term chronic
15 respiratory condition, frequent readmissions to hospital.
16 When the community health team went out to where that
17 person was living, they found that they were living in a
18 caravan with a leak that was wetting the carpets and
19 creating a mouldy environment. So when the person was
20 being sent home - that was where they were going to - their
21 chronic respiratory condition was being exacerbated and
22 leading to readmission.
23
24 These are the sorts of things that are really
25 important to get to the nub of because they have a big
26 impact on an individual's outcome and that's why community
27 health and those sorts of visits are important.
28
29 MR GLOVER: And what about cultural or language diversity;
30 is that another factor?
31
32 DR CHANT: Yes. Cultural and linguistic diversity
33 presents challenges, and we should actually say it's the
34 responsibility of our services to meet these challenges.
35 When we use terms like "health literacy", that can almost
36 be saying there is a problem for individuals. It is really
37 a problem for our services in making sure that we community
38 in a way that is accessible and understood.
39
40 Clearly there are going to be issues of language
41 barriers if English is not your first language. Do you
42 have access to a doctor that speaks your language? There
43 may be barriers. We have translator services, there are
44 funded translator services, but again they might be timely
45 or awkward, you might feel uncomfortable asking.
46
47 There's also potential interplay between culturally

1 and linguistically diverse communities, and perhaps newly
2 arrived migrants may not have secure employment or housing.
3 Again, it's not culturally and linguistically diverse
4 people alone, people come with many different challenges,
5 but you can see how language can be a barrier to accessing
6 care if you cannot read or write, and even read our forms.
7 Do we put things in multiple languages? Do we do it in
8 very simple language?
9
10 I think through COVID we've really learnt about how to
11 work in partnership with CALD communities to make sure that
12 the resources we've developed are more tailored to their
13 needs, which may be videos, doctors from culturally and
14 linguistically diverse communities talking in language as
15 trusted providers of information.
16
17 I think the responsibility on us is to do better, but
18 that gives an example of how we actually have to work a
19 little harder and really do that co-design with communities
20 to make sure our resources help people navigate, where
21 English is not the first language.
22
23 MR GLOVER: Some of the responses that you've just
24 described, and particularly in terms of how services are
25 delivered, are within the remit of NSW Health, but do other
26 responses to the social determinants of health require
27 a cross-government response?
28
29 DR CHANT: Absolutely.
30
31 MS WILLCOX: Thank you for your question, because I was
32 going to raise The First 2000 Days Framework, because,
33 I guess it is one of the things from a policy perspective
34 that really brings the social environmental determinants
35 matter really to the top. There is an incredible amount of
36 evidence around the adverse childhood events and the
37 prenatal and antenatal period of a little one's life and
38 what there can be as a predictor in terms of their future
39 health, education and their socioeconomic wellbeing.
40
41 So the First 2000 Days is something that has been
42 primarily generated out of health, but we partner with the
43 Department of Education in particular around early
44 childhood checks of little ones at around 4 years old.
45 It's around a universal screening to try to identify where
46 a little one may have some speech or motor issues or
47 concentration issues and about an earlier intervention,

1 which may be as simple as play therapy, it doesn't
2 necessarily mean some significant intervention, but it's
3 again part of antenatal care, optimising that pregnancy for
4 a woman in terms of their diet, not smoking, alcohol, a
5 safe stress-free environment to the extent it can be - we
6 know stress in an unborn child has an impact on their
7 long-term prospects - looking after that woman through the
8 entire pregnancy, the delivery, and then the postnatal care
9 of her and her little one is something that we are very -
10 this piece of policy work is really driving a whole lot of
11 work across the system.
12
13 Now, much of what is being done, for instance, in
14 maternity services, fits neatly into First 2000 Days. The
15 system has always been well geared in terms of caring for
16 women pre, during and post, but I think The First 2000 Days
17 really gives a strong evidence base for these additional
18 interventions and services and how we think about an unborn
19 child right through to them being five years of age and how
20 we can really change the course of their life if we get
21 this right. So there has been great cross-government
22 support and investment on this.
23
24 DR CHANT: I suppose more broadly, the World Health
25 Organization has recognised that for countries to address
26 health outcomes at this broad-based policy construct across
27 government is so critical, be that building transport
28 infrastructure to make sure that people have access to
29 health care, but also employment opportunities, access to
30 the high-quality education is critical to long-term
31 outcomes, housing affordability.
32
33 All of these factors require not health alone; it's
34 very much a whole of government setting, but they are very
35 important if we are actually to reduce inequity of outcomes
36 at a population level or enjoy the benefits of the health
37 gains that new technology and preventative health can
38 afford us.
39
40 MR GLOVER: And how can NSW Health influence those matters
41 in other areas like transport and planning?
42
43 DR CHANT: I'll give you some examples. So probably at
44 a macro level, health has advocated, over history, for
45 particular changes in the planning Act to recognise the
46 importance of health outcomes as a planning outcome itself,
47 health and wellbeing, as a desirable outcome of any

1 planning; work with treasury to value the aspects like
2 physical activity and mental wellbeing around accessible
3 and built environments or in terms of assessments of
4 transport corridors, valuing the ability for incidental
5 exercise. As a population health practitioner, I very much
6 like people catching trains and buses or riding to work or
7 walking because it actually gives them incidental exercise.
8 So factoring in some of those benefits to health from those
9 transport corridors or making things more walkable or
10 rideable, we've been working with treasury about some tools
11 that give us better value in future gains in that regard.
12
13 Our local health districts work - there has been some
14 great innovative work, working in partnership with some of
15 the builders of apartment blocks about how you build an
16 apartment block that really promotes physical activity and
17 social cohesion and then trying to look at how that can be
18 used as a bit of a template.
19
20 Active playgrounds - there's a lot of science to go
21 into how do you make a playground that promotes kids to be
22 active and appealing. We've actually worked with the
23 University of New South Wales on a whole planning toolkit
24 which goes through things like how do you make spaces
25 active and safe and used, and that's around safety and
26 security and making sure that you've got good lighting,
27 design principles.
28
29 There's a lot of work that health does in partnership
30 with other government agencies to really get that
31 recognition of the importance of how spaces can really
32 promote social cohesion, social gathering, but also
33 physical activity, and all of those things are so important
34 to overall health of the community.
35
36 MR GLOVER: How effective is that collaboration in
37 actually getting the outcomes that would see improvements
38 in these areas?
39
40 DR CHANT: Look, I think it's complex, it's always
41 challenging. But I think that health has taken up a number
42 of opportunities. Clearly this is an area that we need to
43 work at, at a state level, but also our local health
44 districts have great partnerships with local council as
45 well, and creating those play-spaced strategies. I think
46 you will hear from a number of our local health districts
47 around partnerships that they've developed with communities

1 and local council about how they've really changed the
2 nature of some of the environments to really promote health
3 and wellbeing.
4
5 THE COMMISSIONER: The First 2000 Days program - that
6 started in 2020; is that right? It's a five-year program.
7
8 MS WILLCOX: Yes.
9
10 THE COMMISSIONER: Is that entirely funded by New South
11 Wales?
12
13 MS WILLCOX: Yes, by New South Wales Government, including
14 education and health.
15
16 THE COMMISSIONER: So there's no Commonwealth fund into
17 that program?
18
19 MS WILLCOX: No.
20
21 THE COMMISSIONER: There is a free health and development
22 check at four years for kids at preschools, is it?
23
24 MS WILLCOX: That's right, Commissioner. We're in the
25 process of rolling that out across the state. It's
26 currently in six local health districts, Illawarra, South
27 Eastern, South Western, Mid North Coast and Northern NSW..
28
29 THE COMMISSIONER: And there is an evaluation process
30 going on at the moment, is there, as well
31
32 MS WILLCOX: There is, and part of the funding commitment
33 around that is actually obviously to have very strong
34 monitoring and evaluation to show that the work that we're
35 actually doing is actually bringing about what is intended
36 to do. I mean, much of it will be on a longer time frame,
37 but we're identifying kids who need some additional support
38 and we're able to divert them into those appropriate
39 services, and as I said, some might be very low key and
40 other children may need some more specialist speech therapy
41 support, for instance.
42
43 THE COMMISSIONER: What prompted me to ask that was there
44 is a submission that is probably on the website, I imagine,
45 from Minderoo, which I've associated more with early
46 education, but they're linked, obviously, health and --
47

1 DR CHANT: Yes. I suppose just that there is strong
2 evidence that access to early childhood education,
3 preschool access, is very strong. So even when we are
4 looking at working with our families, we would see that as
5 almost a co-enabler to good outcomes, where securing
6 supported family play groups or early childhood education
7 or child care is a really good component to strengthening
8 the nature of the intervention to support the family, to
9 support the outcomes.
10
11 THE COMMISSIONER: This is ground zero for prevention,
12 right?
13
14 DR CHANT: This is the area where you get the quickest
15 return on investment because of the importance, yes.
16
17 THE COMMISSIONER: Minderoo does congratulate the New
18 South Wales Government for this program, although I think
19 their submission wants the checks even younger. But the
20 child digital health record - is that the old blue book
21 that we used to get?
22
23 MS WILLCOX: That's correct.
24
25 THE COMMISSIONER: So it is being digitised?
26
27 MS WILLCOX: Just so that it is easier for access.
28 Instead of carrying the book around in the bag, you have an
29 app on your telephone and you can keep up to date with your
30 records and, yes, it is just a more convenient way for
31 a mother, in the main, to access it.
32
33 THE COMMISSIONER: Is that a New South Wales program or
34 a Commonwealth program?
35
36 MS WILLCOX: It's New South Wales.
37
38 THE COMMISSIONER: That's New South Wales too?
39
40 MS WILLCOX: Yes.
41
42 THE COMMISSIONER: Thanks.
43
44 MS WILLCOX: Just on The First 2000 Days, if I might add,
45 in terms of some of the background evidence work that was
46 done as the framework and policy was developed, for every
47 dollar invested, they indicate it's somewhere around a $13

1 return. If we do early intervention, the forecasts say
2 that over $15 billion a year could be saved in sort of more
3 high intensity interventions that a young one might want.
4 Certainly, as Dr Chant indicated, those early predictors of
5 adverse child events can actually predict if a person is
6 going to have heart disease perhaps in their 50s, so
7 it's --
8
9 THE COMMISSIONER: Even though you are evaluating it, all
10 of the evidence about this is well known and well
11 established and highly reliable.
12
13 DR WILLCOX: It would be about validating.
14
15 DR LYONS: Very strong.
16
17 DR CHANT: I suppose it's also important to recognise that
18 general practice also has a key role in early childhood
19 development. Just as an example, we have high rates of
20 coverage of childhood vaccinations, up around 94 per cent,
21 and the vast majority of that is done by general practice
22 for our under 5s. It means that children are actually
23 going to our general practitioners many times, and so
24 again, the role of general practice with their nurses and
25 other things in this space is also important to complement
26 the work that our services do in that more sustained home
27 visiting and support for families. Again, it highlights
28 the complementariness of the services, and I suppose it is
29 how we design the services to be complementary and maximise
30 the focus of each of the services.
31
32 THE COMMISSIONER: Yes.
33
34 MR GLOVER: Dr Lyons, did you have anything to add to that
35 general topic?
36
37 DR LYONS: Nothing more, thanks, no.
38
39 MR GLOVER: Can we go to paragraph 76, please. There,
40 it's said that:
41
42 *Services are focused on specific population*
43 *groups and/or a combination of health*
44 *issues.*
45
46 What is meant by that phrase?
47

1 MS WILLCOX: The phrase intends to outline in our
2 community health centres, of which a local district may
3 have a number of community health centres, there will be
4 a different collection of services potentially at any one
5 of those services. One might provide dental and child and
6 family, others might do some aged care, some public health
7 services, so they will be developed and designed in order
8 to meet the needs of their population, based on that
9 service planning that we discussed earlier.
10
11 For some specific population groups, if we talk to
12 refugee health, there is, for instance, a large Tibetan
13 community up in the Northern Beaches at Dee Why, the
14 community health service up there has a very strong refugee
15 service there to attend to that community and to encourage
16 the community to connect with the system. So in our
17 culturally and linguistically diverse communities, you will
18 find pockets of activity and community health services
19 across the state to serve the needs of their specific
20 populations.
21
22 MR GLOVER: Is that one of the benefits of devolved
23 planning within the districts?
24
25 MS WILLCOX: Yes, definitely. I think clearly having that
26 macro level to understand population movements and how it's
27 playing out across the state is obviously valuable, but
28 ultimately, it's our local health districts who will be
29 connecting most closely with those communities, and
30 appropriately so, and in partnership with those
31 communities, designing the types of services their
32 communities may need because there will be variation
33 amongst different population groups of what some of the
34 more predominant health needs may be.
35
36 THE COMMISSIONER: It's linked to the discussion that you
37 had about social determinants and health?
38
39 MS WILLCOX: Yes.
40
41 THE COMMISSIONER: And the example Dr Chant gave about TB?
42
43 MS WILLCOX: That's exactly right, yes. There may be some
44 more sort of trauma-informed care for some communities,
45 particularly our refugee communities, so there are
46 particular skills that our staff require. On trauma
47 informed, as an example, we have a trauma-informed policy

1 and a framework that helps to guide and support staff
2 dealing with communities that have experienced trauma, and
3 that may not just be refugees, it can be all manner of
4 individuals - domestic violence, child abuse --
5
6 THE COMMISSIONER: Natural disasters.
7
8 MS WILLCOX: Natural disasters, yes. More and more,
9 unfortunately, all of our clinicians need to be well versed
10 in this.
11
12 MR GLOVER: Dr Chant, do you have something to add?
13
14 DR CHANT: I know you are interested in how our districts
15 work across boundaries --
16
17 MR GLOVER: Yes.
18
19 DR CHANT: -- and I just wanted to assure you that there
20 are examples we can also provide about how we recognise
21 that culturally and linguistically diverse communities
22 don't adhere to the boundaries, but there has been some
23 great work across South Western Sydney and Western Sydney
24 local health districts with the Pasifika community, working
25 on diabetes and other health promotions. So we can give
26 you some examples that highlight how our local health
27 districts collaborate where they have communities of
28 interest with those shared networks.
29
30 MR GLOVER: I take it that collaboration is important,
31 firstly to ensure that the appropriate services are being
32 delivered to the community that needs them; correct?
33
34 DR CHANT: That's right, but also by having that
35 engagement, when new and emerging issues arise, we know how
36 to engage and what is the appropriate mechanism and what is
37 acceptable to the community, and that really speeds up our
38 response. If we've got new and emerging threats or new
39 issues we want to bring to the community, we already have
40 established trusted partners and we've got trust with that
41 community. I think we need to do that. That's one of the
42 strengths of our devolved structure.
43
44 MS WILLCOX: And they teach us to be culturally informed
45 because communities have different features around how they
46 interact and what's important and culturally relevant to
47 them, and they teach us and help us so that we make sure

1 those services are informed, and that means they'll come to
2 us and trust us.
3
4 MR GLOVER: That collaboration across districts where the
5 community may be spread presumably also leads to
6 efficiencies in the delivery of that care to that
7 community?
8
9 DR CHANT: That's right, and the engagement. So rather
10 than developing resources or products or care pathways
11 twice, they can be developed collaboratively. So, yes, our
12 districts themselves will recognise where there are shared
13 interests across our boundaries and work together.
14
15 MR GLOVER: If we go to paragraph 78, there reference is
16 made to strategies employed by NSW Health that foster
17 communication and connectivity across primary hospital and
18 community health care providers. We've spoken earlier
19 today about some of the challenges that the fragmentation
20 of the healthcare system provides. What are the strategies
21 being referred to in that paragraph.
22
23 MS WILLCOX: Thank you. There are a number, and some we
24 have touched on, as you said.
25
26 One important part of connectivity is information.
27 Having integrated patient records across sectors would be
28 highly useful in terms of that patient experience and safer
29 care as people move between different parts of the health
30 system.
31
32 In NSW Health we have developed the Lumos system and
33 had significant traction with the Commonwealth on this and
34 working with them to see if the Lumos model can be expanded
35 across the country.
36
37 Whilst it is not real-time on a particular person, it
38 gathers information to understand the patterns of movement
39 of people and their care journeys to help us better design
40 services.
41
42 We are, as you know, implementing the single digital
43 patient record over the next few years. Having one medical
44 record platform across the state will give us much stronger
45 integration of patient information. People will be able to
46 move across local health district lines, knowing that their
47 information will follow them, it won't require a phone call

1 or a faxing of information or a scanning of documents, so
2 that is both safer for patient care and more efficient and
3 probably a better experience for our patients as well.
4
5 Interfacing single digital patient record with primary
6 care systems is the next level. I think about two or three
7 information systems are used principally in primary care,
8 and we would look to see how we might manage and interface
9 there. There is My Health Record at the moment, but it is
10 a static uploading of a document. It is not a real-time,
11 integrated --
12
13 THE COMMISSIONER: That interface with GPs you just
14 discussed, that presumably is going to be looked at after
15 the single digital patient record is rolled out, or at the
16 same time?
17
18 MS WILLCOX: We will attempt to have a look at it as we
19 roll out, because if we can do that as we --
20
21 THE COMMISSIONER: Does that include when it gets rolled
22 out in Hunter New England as the first LHD?
23
24 MS WILLCOX: Yes.
25
26 THE COMMISSIONER: It might just also help if one of you
27 put on the record what the difference is between what Lumos
28 offers and what the single digital patient record will
29 offer. I don't care who.
30
31 DR LYONS: I can do that.
32
33 MS WILLCOX: Nigel is part of the architects of Lumos, so
34 I'll get him to do that.
35
36 DR LYONS: Lumos is actually an after-the-event capture of
37 data from the systems that looks at the patterns of service
38 delivery and care across the GP practice and the conditions
39 that the patient had in the GP practice, and then links
40 with our ED datasets, our inpatient datasets, our ambulance
41 service, births, deaths; it looks at mortality linkages.
42 It shows what happens to patients that are seen frequently
43 in general practice and the patterns that follow from that;
44 patients who very rarely go and the patterns that follow
45 from that.
46
47 It is done every six months and provides a report back

1 to the general practitioners around their patient group and
2 can give them really useful information around do their
3 patients attend EDs regularly, how does that compare with
4 another general practice like theirs in another place. It
5 just gives that information around service delivery
6 patterns and benchmarking around their outcomes for their
7 patient cohort. So it is useful information around whole
8 of system, but being fed back to the GP primary care
9 providers.
10
11 MS WILLCOX: Commissioner, the single digital patient
12 record that goes to the medical record that belongs to an
13 individual, currently we have, how many systems? Four?
14
15 DR CHANT: Eight domains, so --
16
17 THE COMMISSIONER: I thought it was six.
18
19 DR CHANT: Six or eight.
20
21 MS WILLCOX: Something of that order. Suffice to say,
22 multiple domains, so information can't pass between each of
23 them. If a person accesses care in one local health
24 district and then goes on holidays down to Batemans Bay,
25 has a fall, becomes unconscious and lands in Batemans Bay
26 Hospital, their medical record will not follow them or the
27 clinician down there won't be able to access it, so you can
28 see the sort of clinical risk potentially that that
29 creates.
30
31 This will give us one platform, one system. A person
32 moves around, everyone can access it. As I mentioned, it
33 will obviously be much better for the patient. That
34 constant restating, if they are in a position to do so, of
35 their situation and getting multiple questions, they'll be
36 relieved of some of that. It will give some access to
37 real-time measures.
38
39 It will be stronger in that the operability will allow
40 us to, I think, access data more easily from across the
41 system for both clinical service planning but also
42 research. You can imagine the inputs that could be derived
43 from one platform of gathering medical information from
44 across the system, obviously de-identified.
45
46 So this will be a rolling program over the next four
47 to five years. And as you're obviously aware, Hunter New

1 England is going first. It really is a clinical
2 transformation, not an IT system rollout, and we're just
3 settling on our statewide governance, which obviously can
4 include a large number of our clinical teams, to assist
5 with that and for us to support them as we roll it out.
6
7 Epic is the vendor that has been selected and most of
8 the modules have been constructed so we won't be having
9 a whole lot of boutique systems, but there will be a work
10 flow and change management and some bespoke things that our
11 system will require, but in the main the modules come in
12 the one system that is known as Epic.
13
14 MR GLOVER: I'm going to move to a different topic now,
15 Commissioner. Is that a convenient time?
16
17 THE COMMISSIONER: It is. Thank you all for your time
18 today, and we will adjourn until 10am tomorrow.
19
20 MR GLOVER: Thank you.
21
22 **AT 3.59PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
23 **TO WEDNESDAY, 29 NOVEMBER 2023 AT 10AM**
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