**Special Commission of Inquiry**

**into Healthcare Funding**

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

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

**Wednesday, 29 November 2023 at 10.00am**

**(Day 003)**

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

**Also present:**

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

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner, yesterday before the start of the evidence I handed up a tender list by way of bulk tender. Just to ensure it is reflected in the record, I dealt with the tender of the joint report, which is A1, but I also, as part of that bulk tender, tender documents which have been notionally marked as exhibits A2 to A52 in that list.

**EXHIBIT #A2-A52 BULK TENDER OF DOCUMENTS MARKED A2 TO A52 AS IDENTIFIED IN TENDER LIST**

**<NIGEL LYONS, on former oath: [10.02am]**

**<KERRY CHANT, on former affirmation: [10.02am]**

**<DEBORAH WILLCOX, on former affirmation: [10.02am]**

MR GLOVER: Can we have the joint report [MOH.9999.0001.0001] put up on the screen, please, and we will go to paragraph 80.

Ms Willcox, we're still in your section of the report so I will start directing these questions to you, but, like yesterday, if any of Dr Chant or Dr Lyons wish to add at any time, please feel free to do so.

In this section of the report, the concept of preventative health is dealt with, and we touched on this a little bit yesterday, but what I would like to do to start today is explore what that concept is, what it involves and how it is currently being managed within the system. What is within the ambit of preventative health?

MS WILLCOX: Good morning and thank you. I will pass over to Dr Chant shortly. I'll just make some initial comments.

So preventative health, as the submission highlights, is a joint responsibility across both governments and primary care, of course.

In NSW Health, our community health centres would be one of the key locations where we have programs around weight management, diet, exercise, avoidance of smoking, alcohol and the like - those preventative measures that we know from a very strong evidence base to keep people well

and avoid the development of chronic disease or hospitalisation for other reasons.

We have a number of programs across the state. There's a myriad of initiatives. We focus very much too on the ageing and frailty, attending to issues that may lead people to fall, so falls programs are a very common preventative program across the state. Exercise routines such as Tai Chi, for instance, are very popular in our older communities in terms of keeping people strong and balanced and well and avoiding injury from fall or frailty.

The ability to improve our interaction with patients in more opportunistic ways across the system - so, for instance, if a patient is coming in for surgery, they would routinely go to a preadmission clinic. There would be chest x-ray, perhaps, and bloods taken, but there might be discussions around weight, smoking, mobility - anything that can be done to contribute to a better outcome for that surgery, for instance.

I think one of the things Dr Chant would probably want to add to the discussion today is just how we increase that opportunistic - I don't mean that in a pejorative sense, but in a positive sense - how wherever we interface with patients and consumers we can be contributing to some of the preventative health opportunities that we can support them with, and that they can actually do self-managed preventative care is a very positive option. Not everybody needs a program or a clinician to support them.

MR GLOVER: Just before I go to Dr Chant for that purpose, you mentioned, as it is set out in the submission and in the report, that it is a joint responsibility across governments. How is that joint responsibility being delivered at the moment?

MS WILLCOX: There is a National Preventative Health Strategy, a 10-year strategy that the Commonwealth produced along with the states, which guides some of the population/nationwide preventative health measures that are important to the wellbeing of the community.

I think I would probably now throw to Dr Chant to talk in detail. It is really in her bailiwick, thank you.

DR CHANT: Thanks you very much for the question. Perhaps

just if we take it step by step through the process and we look at some of the primary determinants of the healthy population. They're going back to of the social determinants of health. So the places where people live and work can really influence health. For instance, if we have reduced travel times, we have more time for leisure, physical activity, able to have time to prepare meals.

If we have walkable parks that are safe, well lit, we reduce social isolation, promote physical activity. So the environments in which we live can shape, can be a positive factor that can support people to adopt those healthy behaviours and lifestyles.

Government also has a key role in regulation, so setting things like tobacco regulation. We've heard recently Minister Butler that has announced the Commonwealth reforms in e-cigarettes. So regulation is also a whole of government initiative and those things can enable a health-promoting environment in which we live.

In terms of primary care - this goes to the joint responsibility across governments - primary care is an important setting for prevention. Things like the regular health checks, skin checks, cancer screening, all of those things are important, as well as regular blood pressure checks, management of high cholesterol.

These are preventable risk factors that can be modified by, in some cases, advice around healthy diet, maintaining healthy weight, physical activity, as well as, in some cases, it may require medication or more formal treatment. So that's again a pivotal role of general practice.

We then perhaps can categorise a set of conditions whereby they're more likely to be secondary prevention, so people already have disease, but we know that even smoking reduction in someone that already has lung disease can slow progression, or heart disease, quitting smoking can actually improve outcomes quite radically. So this would be, for instance, things that primary care would do, but that also may occur in our system where people are touching our system, be it for cancer diagnosis, heart diagnosis, lung diagnosis, those conversations around smoking cessation and supporting people to quit smoking.

We also have, for instance, very good evidence that physical activity, if you're on cancer treatment, actually can improve your outcome. So again, incorporating some of these lifestyle modification programs within our care pathway is actually strongly evidence based and --

MR GLOVER: I'm sorry to cut you off, just from that answer, do I understand it that primary care is a significant deliverer, if I could put it that way, of preventative health?

DR CHANT: Yes. Primary care is the first port of call who would do the majority of the clinical preventative care, as I have described that more whole of government prevention sort of setting, but in terms of clinical engagement around primary/secondary prevention, clearly primary health care is very heavy lifter in that space

MR GLOVER: Although when people come into hospital, there are other opportunities to deliver preventative health measures to improve their overall health and outcomes.

DR CHANT: That's correct, and for some of our services also we provide access to those that may not be connected to primary care. We talked earlier yesterday about some of the barriers to accessing primary care, be they rural/regional and distribution of general practice, all the way through to the fact that the client may not have financial means, transport.

So our services provide an opportunity for engagement in that broader health promotion, with the aim ideally to connect them back to a primary care setting, but in the meantime, it presents opportunities for us to look at tobacco cessation, we may look at other screening, and addressing immediate - whilst we're addressing other health concerns of the individual, it's an opportunity for us to do other preventative care, including things like immunisation as well.

MR GLOVER: How well is primary care delivering those preventative health services?

DR CHANT: I think primary care is doing a lot of the heavy lifting. I would just like to say, if we look at our vaccination coverage for our under 5s, which I described yesterday, we have around 95 per cent immunisation coverage

when we get to that five-year mark. The vast majority in New South Wales context is done by general practice.

So general practice is obviously doing a lot of the heavy lifting in this respect. You may hear from them about whether the funding adequately supports the focus on prevention, whether the funding supports the full scope of other multidisciplinary practitioners in their practice taking their full scope - for instance, things like nurses being able to claim potentially Medicare benefits for the immunisation independently would be an example where that scope might be considered safe and appropriate. So there might be other roles that could be done in a broader multidisciplinary team. I think you'll hear some of those comments if you engage with the primary care practitioners.

THE COMMISSIONER: The MBS items and the fee for service that have been direct or created to provide pathways for preventative health like the GP management plans and things of that nature - are you aware of published evaluations about those, about what the outcomes have been from those changes to the MBS over the last 20-odd years?

DR CHANT: I think we could provide some evidence perhaps around some of the health-screening items more in the Aboriginal health - the introduction of the 715 health screening, and some of the evaluations.

DR LYONS: To answer your question, Commissioner, I'm not aware of any evaluation around those particular changes to the MBS that you referred to, and that's something we could investigate further.

THE COMMISSIONER: You read many reviews, including from the Productivity Commission, which will analyse or provide opinions regarding ABF and fee for service and say neither really promotes preventative health measures. Then I think, or imagine, to address that, items have gone on the MBS - you know, like the management plans I mentioned. I either haven't found or haven't had brought to my attention how effective these things are. Bearing in mind, I think, the reports also say that for any preventative health measure, getting the evidence is difficult, partly because it is such long term.

DR LYONS: That is an ongoing challenge. I think if you look at these things in totality, episodic care, such as

the opportunities that we have to intervene when people are with our services are not the best place - they are an important opportunity to promote healthy lifestyles and activities that will improve outcomes for people and changes, but a lot of those changes require individuals to have behavioural change over a longer term. That needs to be through a reinforcement and support for those changes in an ongoing relationship, which is where primary care is best placed to deliver that.

I think we need to look at these things in the context of the health promotion activities that we can do for a community at population health level, which carry very much a primary prevention, and then there's the secondary prevention in which we all have a very big part to play. Secondary prevention is very much where we believe our services should focus their activities certainly in the acute settings at least.

THE COMMISSIONER: Thanks.

MR GLOVER: Picking up on one of the Commissioner's questions, I take it that some preventative health activities take a long time to see the benefit in the system; would that be right?

DR CHANT: Some do but some don't.

MR GLOVER: Are there some examples of more immediate results?

DR CHANT: Yes. For instance, we know that the role of primary care, particularly in STI screening, is probably a very classic example, where diagnosing sexually transmitted infections and effectively treating those, where there is an effective treatment. That is a classic example.

Vaccination, where we know that if you vaccinated for the flu season, you're going to reduce your admissions to hospital for those that have been identified as requiring the vaccination. So there's a clear link.

Tobacco cessation, as I said, although it provides a longer term, we know that even stopping tobacco smoking prior to surgery will improve your postoperative recovery. So for many things, it can be quite short term.

But what is important is we also have very strong evidence that changing those behaviours will change long-term outcomes. So we don't actually need to do the long-term outcomes; we know in itself that if weave helped someone quit smoking, that we don't then need to measure, because we can draw on other studies that show that that's beneficial for them to be off smoking.

MR GLOVER: Those are measures that not only improve the health of the individual but do they also reduce demand over time on the public hospital system?

DR CHANT: Yes, they do, because we know that many of those risk factors cause a multiplicity of chronic diseases, and what we would be aiming to do is to support people to live healthier lives, chronic disease free lives.

MR GLOVER: To the extent that preventative care is delivered in the public hospital system, how is that funded? Is that wholly funded by the state or is there a Commonwealth contribution to it?

DR CHANT: It would be picked up under the activity based funding system and then there are particular payment programs.

DR LYONS: There are programs that are funded centrally. Those are funded through a block, often, through specific programs that are directed towards health promotion activities and prevention activities.

THE COMMISSIONER: Are these short-term programs or time-limited programs?

DR LYONS: No, they are actually ongoing, and things like the work we do on screening programs and --

MS WILLCOX: "Munch & move".

DR LYONS: "Munch & Move".

DR CHANT: They are probably different in state based funding. There's a number of shared screening programs that we would have a role in, so bowel cancer, BreastScreen. The part we pay in the funding varies. For instance, in the mammography, I understand - we will have

to check - it's a shared funding arrangement with the Commonwealth, in terms of that. But we may fund some additional work on targeting those that are hard to reach or where participation in the program is identified to be less than usual, and in that's specific programs.

DR LYONS: There are those specific programs. But then the other components would be included in the care activities that are occurring that would be funded through activity. There is not a specific component of that that I am aware of that relates to prevention; it is considered to be in the totality of that care and funded through those activity arrangements.

DR CHANT: In relation to some of the state funding programs, there is funding, as Ms Willcox said, for some programs in the childhood space. We work in partnership with education, but we do a lot of work in early childhood settings. A program called Munch & Move which again is trying to educate and support healthier eating and physical activity that's appropriate in that setting.

We also work in partnership with schools. We do work with curriculum in schools to support education incorporate health in all its dimensions and, most recently, we've been doing some work to embed, for instance, e-cigarettes, in age-appropriate guidance on e-cigarettes within the health curriculum in schools.

So they're just examples of state funded programs that really address this work. We've also done some work around healthy canteens in schools and supported education in that. Again, a lot of those have been programs that have been supported by whole of government approach. There has been a recognition around the focus on young children and recognition that some of the trajectory for the risk factors of being above a healthy weight and not physically active are set very early. So again, it supports the work in this early intervention space particularly for families.

THE COMMISSIONER: Can I just ask a question I should know the answer to but I don't, so I have to ask the question. In the Productivity Commission's "Shifting the Dial" review back in August 2017, when it was dealing with the issue of the topic of changes to hospital funding, in relation to activity based funding, it said this:

> *If there are better ways of changing activity-based funding to give [local health networks] or [primary health networks] the incentives to improve health status, and avoid hospitalisations, hospital durations and other health care costs, then implement [them].*

It said:

> *One way of formalising a new approach would be to establish a Prevention and Chronic Condition Prevention and Management Fund ... in each local health district with both the Australian Government and ... state governments [contributing].*

Did that happen?

DR LYONS: Not to my knowledge.

THE COMMISSIONER: Can I also ask this, just while we're on this topic. Again, I don't know the answer to this but I probably should. I'm sure you would be aware, there was a Queensland review a few years back, it must have been right in the middle of the pandemic, "Unleashing the potential: an open and equitable health system". Are you aware of that review?

DR LYONS: Not the detail of it, Commissioner

THE COMMISSIONER: It was published in August 2020, so it was right in the middle of the pandemic. But one of the recommendations was to amend what would be the equivalent of our Health Services Act to add prevention and population health as activities and responsibilities for the LHDs, our equivalent of LHDs. I know it's not in the Act but is that incorporated in the service agreements?

DR LYONS: It has always been - I won't talk to the details, but --

THE COMMISSIONER: It might depend on how you read the functions under the Act as to whether it's incorporated already.

DR LYONS: Yes. Certainly it's a component of the

responsibilities of the local health districts and always has been, under all of the arrangements, that we have a responsibility to the community to keep them healthy and well as well as to treat illness and diseases, so --

THE COMMISSIONER: You say that's broad enough to include prevention?

DR LYONS: Absolutely.

THE COMMISSIONER: And that's the way it has been interpreted?

DR LYONS: Absolutely. And, yes, there population health teams, public health teams, health promotion teams that exist within the local health districts that have that focus.

THE COMMISSIONER: That might be a case - well, I won't say it. Maybe it was a case of Queensland catching up with New South Wales already. Who knows.

MR GLOVER: If we just go ahead to paragraph 174 in the report, please. There in the first line of 174:

> *Preventive services and early interventions should be strong pillars of Australia's healthcare system ...*

Are they currently?

DR CHANT: I think I would answer that question by saying Australia does really well. Our infant mortality rates are low, our life expectancy is one of the top - in the top three of the world. So we do well. Can we do more and with the rebalancing towards chronic disease, does that put additional challenges where we need to refocus on prevention, I would argue yes.

THE COMMISSIONER: Living longer is just one issue. The real issue, especially for the cost of the health system, is living long but if you're living longer with chronic disease, then that's expensive.

DR CHANT: That's correct.

THE COMMISSIONER: And not great for people, either.

DR CHANT: And not great, yes, that's right. So I think what we would really want to look at is making sure that people had lived very healthy lives into age, but healthy, active lives that were mentally challenging and socially inclusive.

So whilst I comment on length of life, I suppose I can give you a whole range of metrics that we actually do well in - disability adjusted life years lost, all of those metrics. I think we need to position Australia as well - we have adopted a lot of prevention screening programs, we have rolled out a lot of vaccines, we have had a lot of access to those things.

Do we need to do more? I would say yes. Do we need to align - I suppose we need to think about the challenges that are laid out by the way the burden of disease has changed and we need to pivot and evolve our funding systems and our systems to deal with the challenges facing us. But it's not only a health issue. I hope you've heard from the testimony we've given that, really, this is a whole of government issue and it cuts across multiple levels of government.

DR LYONS: Just to use a single example which I think is illustrative. If we had people that were all a healthy weight, we would hugely reduce the burden of both osteoarthritis and musculoskeletal conditions, and that leads to joint replacement surgeries, which have a huge impact; and also diabetes, which has huge implications for the costs of delivering health care and implications for people in terms of living healthy lives. Just that one change alone - and it would have other flow-on effects to other conditions as well.

DR CHANT: Cancer, cardiovascular disease.

DR LYONS: Cancer and a lot of other things. But that is one example that that is not just a health issue, that's a whole of society issue.

THE COMMISSIONER: Can I just ask two things that flow from that. One, I fully accept that best preventative health measures, plans, programs, aren't defined necessarily by how much money is spent on them, it's how well they are designed and then implemented, because it's

so complex. But we've heard various figures or percentages about how much either Australia or New South Wales spends on preventative health as a percentage of total health expenditure. So I've seen 2 per cent, I've seen larger than 2 per cent. The Productivity Commission, I'm sure I have seen, Australia-wide, 1.5 per cent, with other equivalent relatively First World nations higher. Is there a definitive figure as to how much either New South Wales or Australia spends on preventative health as a percentage of the health spend?

DR CHANT: There are definitions that are meant to capture it, but it's actually very difficult to do so, and there has to be caution applied in any comparisons. I'll give you an example.

In New South Wales, we have reasonably high levels of water fluoridation which prevents dental caries, which prevents other issues. That is funded and supported, local councils do that, and there is a subsidy provided by government to councils for the renewal of the plants and we support local councils to implement that. That would be different in other states and territories. I have talked about some of the --

THE COMMISSIONER: That's an example of preventative health, though, where the population or the people don't have to do anything because it's in the water.

DR LYONS: Yes.

DR CHANT: But there are costs. There are cost associated with renewal of the infrastructure and supporting the councils with that, so that's a choice with that. I suppose my point was the boundaries of how you capture it and define it are very challenging and various estimates are there.

Another example, for instance, is there's good evidence around brief interventions for tobacco and, as I said, how do we capture everything, every time our doctors, interns, residents are doing that? But there's really good evidence and it only needs to be a one-minute line to reinforce the importance and then the GP following up.

THE COMMISSIONER: Tobacco is an example where someone

does have to do something - you have to stop smoking. But to go, I think, to both of your points, Dr Lyons and Dr Chant, about whole of government, there has been a whole of government approach to tobacco because of the changes to advertising. In the course of my life, it used to be Paul Hogan on TV. Now there is no TV, there is no sports sponsorships, plain paper packaging. I'll just forget to raise it if I don't continue, but what we're told is, in terms of prevention, how important obesity is, because it leads to so many --

DR CHANT: Issues, yes.

THE COMMISSIONER: -- different health conditions. I was reading the other day that in the last - it might only be since 1992, maybe, Britain has had 20 or more obesity plans. But that's where whole of government is important because it's one thing for NSW Health to develop a plan, but if people are inundated with advertising for processed foods and sugary drinks, it's very difficult for health to get much traction in a prevention plan. Is that a reasonable observation?

MS WILLCOX: Yes. I think it goes to a number of the things that Dr Chant talked about yesterday and touched on this morning around - urban planning is a very important area. I know that Dr Chant will talk to this but the NSW Food Authority and labelling of foods and enabling people to make the right choices when they go into a supermarket is not necessarily that easy, the way labelling is done and I know there is work with the Food Authority.

DR CHANT: And health ministers. So I think tackling people being above healthy weight is a major issue for us, and also getting people physically active as well. So we want to also focus on the multiple risk factors. As I've defined, there's a lot of enablers for that which sit outside government.

But health has a key role in advocacy or presenting the evidence or working with its partners, and there has actually been a lot of work on obesity, particularly childhood obesity, in New South Wales. We've rolled out height and weight measures and linkage to care. We've got programs that I've articulated.

We've got a program in maternity services called "Get

Healthy in Pregnancy". So women are supported through with specialist practitioner support to maintain healthy weight and diet and exercise through pregnancy. That has been well adopted through a health coaching model. So there are a range of initiatives, but you're correct in saying that to tackle these very complex issues, it does require whole of government and a discussion with the community around how do we work together. This is really going to have to be a partnership between all levels of government, industry and people --

THE COMMISSIONER: And it's also a preventative health measure, without needing to go into the details, I think, where there's opposition because of commercial interests, or retail --

DR CHANT: There are particular views around that, but I hope that you've taken it from our perspective that we believe that individuals and communities need to be supported with enabling environment and recognise that there are barriers for people to take up the behaviour. So it's not around making it an issue for the individual; it's really seeing it as a community and a place-based and whole of government response.

MR GLOVER: Just in paragraph 175:

> *Low proportional investment in preventive health, the wider determinants of health and increasing burden of chronic disease has led to increased spending on treatments to manage conditions that could be prevented ...*

et cetera. By that, do we understand that historically, the focus on those things hasn't been as you would want it, as of now?

DR LYONS: Our system has been responding to the demand it sees in treating patients who are unwell. That has been the focus of hospitals and the local health district service over many years, and that increasing demand we're seeing means that to respond to it increasingly we're putting resources into those emergency departments, hospitalisations, surgeries that people need, to make sure we can treat people.

So we've tended to focus on invest engine that side, proportionally, at a proportionally greater level, because of the need and demand, and I think what we're signalling is there needs to be a shift over time to get more proportional spending into the prevention space. But that's not just a state issue. That's for everybody involved in designing and delivering health services in this country.

MR GLOVER: Are there challenges in making that shift whilst also catering to the current demands on the public health system?

DR LYONS: Absolutely. That's the challenge we're highlighting and the need for a refocusing. I mean, we shouldn't be taking away from those really important services we provide around treating people with disease. We do it very well. We need to keep that focus, but we need to proportionally spend more on the prevention side.

MS WILLCOX: It's probably why - it is not "probably", it is why you've seen and heard from, I'm sure, many people, including us, about the work around integrated care, caring for chronic and complex patients and how we try and keep people out of hospital and support them in the home. We have made a significant shift.

Integrated care activities such as Dr Lyons referred to, with people that might require a knee replacement, with osteoarthritis, can now go to a clinic and with an exercise regime and often weight support, can avoid actually having knee surgery and we can take people off the wait list for surgery.

So the system has been innovative in terms of identifying different pathways to provide care and to try to mitigate the risk of somebody ending up in hospital with a chronic and complex condition that could be managed in the home or in a community-based setting. So it has been the driver for much of this work.

MR GLOVER: This integration that you speak of is not just within the public hospital network but across primary care settings as well, is it?

DR CHANT: That's correct. It's very important that, regardless of the two levels of government that are

funders, that we actually run a seamless system for the patients, that the patient actually can move between it and that our services adjust for the services where they're best delivered. As we spoke about yesterday, primary health practitioners being the integrator and the fundamental providers of primary prevention, but we provide evidence-based care that really is supportive and introduces and incorporates prevention that supports the work of the primary health care practitioner.

DR LYONS: We have signalled this direction through a number of changes we have made, and one of them was mentioned yesterday - the agreement we've reached with the primary health networks across the state.

Historically, we've run parallel systems almost and where patients get referred between them, and what we're saying is we need to turn that around to have a one system mindset, that we're the one health system, no matter where people are in it, they are supported with information, with a range of activities that will enable them to receive optimal care in any of those settings, but it's joined up. That has been the challenge up until now and we need to refocus what we do, but we need other parts of the system to change as well.

DR CHANT: I'd just like to comment, so that's the sort of general approach, but there are then some services that we run in the health system that see very vulnerable groups of patients, where it's actually taken quite a lot of time to build trust for them to come and access our services. That creates an incredible opportunity for us to have that broader discussion. So they may be coming in to us with drug and alcohol or mental health issues, but that gives us an opportunity, as we're addressing the drug and alcohol concerns, to actually screen them for other things, offer them vaccination, potentially address their broader health issues, all the time looking at transference to a primary care practitioner. But for a period of time, due to that fact that they may have faced stigma and discrimination, they may have felt very uncomfortable attending the primary care. It will need a bit more intensive work for us to support them where we might be providing services which are more in the primary care domain for a discrete group of individuals as we transition them and then link them in to primary care.

THE COMMISSIONER: When you talk about primary care clinicians being the integrators, I have to be careful about saying this, but that does require a funding model to facilitate them playing that role, doesn't it?

DR CHANT: Of course, but it's also to respect that important - the fact that GPs are specialist, and they are the generalist.

THE COMMISSIONER: That may be some blended funding model, it might be changes to the MBS to help incentivise more integrated care. I'm hesitant to - the reason for my hesitation is you read these reviews and it will say, "ABF, or the fee for service model for general practitioners doesn't incentivise preventative health, doesn't incentivise keeping people out of hospital", and that, it seems to me, has to be purely an economist's opinion, because I feel as though my general practitioner does want to prevent me getting more unwell and does want to prevent me going to hospital, simply because they're a caring, good doctor.

DR CHANT: Professional, yes.

THE COMMISSIONER: But accepting that we do learn stuff from economists, for the GPs to play a broader role in preventative health, it does require the funding model to assist that at least.

MS WILLCOX: I think too, and again Dr Lyons was part of this committee but he probably should speak to it, the work the Commonwealth have done through the Strengthening Medicare Taskforce, it's incremental, like all these changes that are required, but I think the additional funding for general practice to employ allied health professionals and nurses in the practice, certainly that's been very difficult for small GPs, single general practitioners, to do, and those other health professionals can provide some of this preventative care. It won't always require a general practitioner to do it. So I think that's a very positive step in terms of getting that multidisciplinary team.

I suppose the other contributor to enabling some connectivity around preventative care and supporting general practice is around data and sharing of information, and we touched briefly on Lumos yesterday, but information

is also a powerful thing, not just funding, in terms of how to support primary care.

DR LYONS: I think that's right. I think valuing those different approaches - I think there is a concern that within general practice, MBS needs to be maintained as it is because of concerns around relative remuneration as opposed to other specialties. I think that's a valid concern. We need to continue to value the role of the generalist and as we move into more chronic disease management, health promotion to health prevention activities, value the time it takes to do that well.

I think how that is done and the basis on which it's funded is a really important consideration, as we make these shifts. So it is important to think about how we do that differently but understanding and being conscious of the concerns of the individuals who are currently providing those services for us.

MR GLOVER: One of the challenges we touched on yesterday was access to general practitioners and one of the issues that we have heard about is not only from affordability, as I think you raised yesterday, Dr Chant, but in certain areas just being able to see one. How do those challenges intersect with the need to create this integrated model of care across both the primary care and public hospital system?

DR CHANT: There's not one simple solution. I think it --

MR GLOVER: We hear that a lot.

DR CHANT: I think part of it goes to some of the discussion that has just been had by my colleagues around broadening the multidisciplinary teams supporting the general practitioner.

We've also seen general practices get larger and that means the workforce has been able to be more sustainable. Bringing in different practitioners, all the way through from allied health practitioners to pharmacists, as part of the treating team gives a bit more team stability. I think there's always going to be difficulties in our rural/remote areas, and that's where we've got to use telemedicine or other novel hubbed ways, so GP services may well have to be hubbed out of larger centres.

We've learnt a lot about how we can deliver care in different ways, but some of the key components would be increasing the scope and fully utilising the scope of other health practitioners. We've also been doing some work with pharmacists in some areas, looking at their scope. Often there's a pharmacy in some of the smaller towns, and again how we can network --

THE COMMISSIONER: There is a trial on now, which might be expanded, and Queensland's got the --

DR CHANT: Yes, that's right. There is a trial of UTI that we're rolling out, and oral contraceptive pill, and we're going to be doing skin conditions. That's under a clinical trial framework, we'll get some good intelligence. But when I'm out and about, many of the community really do often access some advice from pharmacists as a first port of call. So I think we're also working with them, notwithstanding the trial, on support for some of those other evidence-based prompts around patients that might be coming in with a pregnancy test. Are they advising them about the need for folate, folic acid and iodine supplementation at that time, or people might be raising the fact that they're wanting a family, perhaps linking them again to some of the preconception health advice, so basically supporting them in that more holistic role.

THE COMMISSIONER: Just on the pharmacy trial that's current here and the slightly more expanded one in Queensland, which I think is UTI, contraceptive pill and mild skin conditions, is there much resistance to that from any parts of the health network? If I could go to the pharmacist to get a prescription medicine for psoriasis, is there push-back to that?

DR CHANT: I think it's important that we choose conditions that align with the scope of practice of the pharmacist. Some of the concern - I would like to say I would --

THE COMMISSIONER: "Skin condition" wouldn't be a nasty looking mole.

DR CHANT: So, for instance, my team, is responsible for rolling out and working in partnership, we've procured the

assistance of the University of Newcastle in a consortium arrangement to roll that out. We're very pleased that we have had engagement from the RACGP and the AMA on the trial, but I think what's important is to look at those conditions that are, we think, within the scope, that we have very clear protocols and we have very clear communication between the pharmacist and the GP. One of the things we don't want to do is further fragment care.

So in implementing it, we're very cautious of having a broad range of stakeholders support the clinical protocol, agree when the touchpoints are for referral to the general practitioner, require that there's communication between the pharmacist and the GP as part of agreement to the trial conditions, and then I'm hoping --

THE COMMISSIONER: Because we don't want people to keep going back for antibiotics to deal with a UTI, which would be risky.

DR CHANT: Which would be problematic. We don't want people that perhaps have underlying medical conditions, like diabetes or other conditions, not to get picked up through that process. So I think it is around looking at those things that general pharmacists would reasonably have, but there's also an important role of pharmacists themselves in providing advice.

Many people with a skin rash would go into a pharmacist and say what can they do. They can already prescribe - they can already dispense some over the counter medications. So this is looking at where the scope can safely be extended, and we've had very good support as we've worked it through step by step, thinking about those issues, but making sure we manage clinical risks, but we also make sure there is good strong integration.

THE COMMISSIONER: Sure.

MR GLOVER: Dr Lyons, you mentioned in an earlier answer the role of the primary health networks in this integration model. How effective has that been?

DR LYONS: I think we've established good relationships at the state level with all of the PHNs and we have regular interaction with them, and I think as a state, we've been very committed to ensuring we've got solid relationships

with the PHNs at our level, at the state level, as well as, very importantly, a strong relationship at the local level with the local health districts.

There are always examples of places that are doing really well and they've got the activities that are very impressive and might be a little ahead of game, and others that may be not as advanced, and you'll see that variation across the PHNs. But as a general rule we are very committed to ensuring that those relationships are the foundation on the connections and integration.

The important component from our point of view is reach to general practice, though. I think the thing that we are challenged by is that not all GPs relate to the primary health networks, and so we need to work at two levels in the state.

We are working very closely with the PHNs and committed to it, but if you use the example of Lumos, we've actually had to go to the general practices as well to get agreement to link up their data systems. So I think that's the challenge we face, but we're committed to ensuring that we create those connections so that we use the existing mechanisms to drive hard on that collaborative work and highly integrated service delivery at the local level.

MR GLOVER: One of the points you made yesterday was that there had been an observed increase in people presenting to hospital that otherwise might be managed in the primary care setting; correct?

DR LYONS: That's correct.

MR GLOVER: Has the ministry done any work to identify why that has occurred over time?

DR LYONS: Well, it's quite obvious to us in certain places, because there are no GPs in some of the communities that we're providing services in, where there used to be, and so when people don't have a GP resident in their local community anymore, they are using our services for primary care. So there are examples of where there are no GPs, where there used to be or where there are fewer GPs, where there used to be.

There is an issue clearly occurring, and we've heard

it reported, about the fact that medical graduates are not choosing to go into that specialty as frequently or at the levels that they need to to replace the people who are leaving as they retire.

We've also got maldistribution, so we've got issues around distribution of those practitioners across the state and there are less in the rural and regional communities. We know that, there's evidence of that, and we see the patterns of service delivery as a result.

In relation to our metropolitan services, we've seen increases in activity in our emergency departments, but it's not in the lower level acuity categories, necessarily, it's in the higher acuity categories, and people would --

MR GLOVER: Just before you go, there are people who are presenting sicker, if I can put it that way?

DR LYONS: Sicker, yes. Sorry, I should have clarified that.

MR GLOVER: No, that's okay.

DR LYONS: Yes, we triage category 1 to 5 and the lower acuity categories are 4 and 5. Often people say you could have primary care substitute for some of that. Not all the people agree with that for those, not all of those conditions could be treated in primary care, but many could be.

But what we're seeing is an increase proportionally in the number of people presenting in the triage categories, particularly 2 and 3, and those are people who have underlying conditions which are having acute exacerbations and needing more complex care and treatment.

MR GLOVER: Are they examples of conditions like those referred to in paragraph 175 that if managed in the primary care setting, may have avoided the presentation?

DR LYONS: That's correct. So people who are living with congestive heart, chronic heart failure, chronic respiratory conditions, ongoing pain. Mental health is another big issue that's driving attendance at our services, people with mental health conditions.

These conditions are certainly increasing in their prevalence in the community and are leading to increased demand on our services. Our contention would be that if we can strengthen up and support primary care - which is why we've invested in a number of programs to start to focus our energies in those areas, even though, historically, they've not been our responsibility, but we have identified the need to start to invest in those to look at innovative ways to start to support improved primary care and get that integration.

MR GLOVER: What's an example of such a program?

DR LYONS: We talked yesterday about the collaborative commissioning work, and you might want to expand on that?

MS WILLCOX: Thank you, Dr Lyons. The collaborative commissioning model is one - I'll give a particular example, which is assisted by the fact that the boundaries for the primary health network are the same as the local health district. The majority are, but not all are, so it's certainly helpful when they do align.

MR GLOVER: That wasn't always the case, was it?

MS WILLCOX: I think there is just one LHD.

DR LYONS: Pretty much in New South Wales, they're very close. I think Central Coast and Hunter New England have one primary care that goes across the two local health districts, but most of the others align pretty closely.

MS WILLCOX: Which certainly helps in terms of building relationship and communication. The collaborative commissioning work that was undertaken in Northern Sydney and with the Northern Sydney Primary Health Network was looking at frailty and looking at patients who were having frequent presentations to the emergency department, understanding what their background conditions were, leading to and connecting with general practice to try and optimise the care of those people in general practice so they would avoid relapsing and arriving in the emergency department.

If you looked at a triangle or pyramid of those people, unfortunately, those individuals that had the most frequent presentations to the emergency department tended

to be people that didn't have a general practitioner, which would not be a surprising outcome, and a very small group - and I say this cautiously because the lion's share, the large number, of GPs, and they're well served in primary care - but a very small percentage of general practitioners that weren't actively engaged in the work that we had - we struggled to make contact with and to build rapport with so that we could work with them to try to mitigate the risk of their patients coming in to the emergency department.

But that was funding thorough the PHN with the local health district, quite a long lead time to do this work, understanding the cohorts of patients, getting the right data and then making those very individual engagements with primary care and general practice to see what we could do to avoid their patients coming into our emergency departments.

THE COMMISSIONER: Just to give it a label, is this part of the framework for integrated care of NSW Health, or am I thinking of something else?

MS WILLCOX: Collaborative commissioning is a form of integrated care. Yes, I'm not quite sure - does it sit specifically under the integrated care banner?

DR LYONS: So the framework for integrated care is a framework that drives the notion and activities around integration. Collaborative commissioning is a particular program that is investing in those integration activities, if that explains it, Commissioner.

MS WILLCOX: So, yes, the integrated care principles are used in collaborative commissioning to ensure people can move between the two and have joined-up care and avoid attendance to emergency departments.

There are other ones in Western Sydney, ones in cardiology.

THE COMMISSIONER: That was what I had in mind. I remembered vaguely, I think, Western Sydney, the specialists in the hospital having a relationship with the GPs outside, but, of course, it wasn't picked up by activity based funding so it had to be funded elsewhere. Is that what you were --

MS WILLCOX: Yes. And again, funding through the PHN.

THE COMMISSIONER: It was to manage people with chronic diseases, I think.

DR LYONS: Correct.

MS WILLCOX: There are a number of then now across the state. South Eastern Sydney has one in chronic obstructive pulmonary disease. The Western Sydney one is around atrial fibrilation, a particularly abnormal heart rhythm.

DR LYONS: There are ones with diabetes in a number of the districts as well. The integrated care framework drives the basis on which those activities would be undertaken, and collaborative commissioning is an example of a program where it's invested in driving those around particular projects.

MR GLOVER: Dr Lyons, we spoke about increased presentations to emergency departments, but has there been increased demand on public health services generally through what might be described as a lack of either primary care or aged care services in a particular region?

DR LYONS: Certainly it plays out. We believe the intersection between the other services that are provided impacts on our system, and there are examples of where that has had impact. We could talk about aged care, for instance. And I think it is really good that the Royal Commission has highlighted the importance of additional support for residential aged care facilities and having staff with health qualifications on duty 24/7. We highlighted that as an issue from our side.

It was leading to residents who had a deterioration in their condition having an ambulance called and transferred to the emergency department. Many of our services would have in place outreach teams that would provide medical support into aged care facilities, but we are seeing increased attendances from aged care facilities into EDs, and those strategies are being put in place to address that, because that's not best care for those residents. That's not a great place for their care, in a busy emergency department, particularly if it's a simple condition which could be treated in their home.

There are some examples of those, but there are also examples at the other end where people who are admitted and have illnesses that do need acute treatment being ready for discharge and having nowhere to go in terms of a residential aged care facility bed that can take them. We've seen increasing numbers of people in our acute care settings who are ready for discharge but are unable to be discharged because there's nowhere for them to go.

MR GLOVER: What effect does that have on that facility?

DR LYONS: It's a huge issue because the flow of patients through our hospitals is dependent on beds being freed up, and every bed that's blocked stops the ability to admit somebody from an emergency department into an inpatient bed. If that occurs for any length of time - I think we've had examples of 250, 300 patients across the state and then another couple of hundred patients who are NDIS clients who are ready for discharge and not able to be cared for in the community. So between the two groups, up to 500 people at a time in our hospitals who are not able to be discharged, which has a huge impact on the hospital system's ability to respond to people who need to be admitted.

MS WILLCOX: If I could just add to that, I think at 15 November there were just over 400 elderly people who were assessed and ready for placement. We use the analogy that that's more than Prince of Wales Hospital in its entirety who would be caring for these individuals.

I think the important thing also to add to this is that, yes, certainly Dr Lyons is right, there's a flow issue we have in emergency departments in planned surgery. But the impact on these elderly people while they await placement is significant. Frailty occurs very quickly. Being immobile for a couple of days in a chair, not having the sort of recreational activities and the socialisation that an aged care facility can provide really does set back these elderly people.

So there are the two elements to that. I do want to acknowledge, we're working very hard with the Commonwealth around this and with the aged care sector. There is definitely market failure in the sector and, as Dr Lyons said, we absolutely support the increased capability of the residential aged care workforce and all of the other things that the Royal Commission provided.

But the reality is that there is a lot of difficulty in recruiting staff in aged care facilities across the state. We've seen a significant number of closures in various areas. Illawarra has been profoundly affected, but also South Western Sydney, and spatterings around other parts of the state. Also, because of their inability in the main to recruit suitably qualified staff - and I am again careful with my language - it is very difficult for some of the aged care facilities then to accept admission of elderly people who have very complex behaviours, dementia and behavioural disorders, which need a very specialised intensive care. So if you can't recruit registered nurses or occupational therapists or whatever professional that you require to safely care for these people, the option is to not accept admission.

MR GLOVER: Going back to the start of your answer where you described the effect on the patient who might be ready for discharge, do I understand that to mean that not only is hospital not the best place for them, it might actually be ultimately harmful for them to stay there longer?

MS WILLCOX: Indeed. The risk of infection, all the risks that come with - whilst we have physiotherapist and the nursing staff who would walk and mobilise elderly people in their care, an acute setting is not an environment that is focused on these less acute activities about keeping mobilised, keeping engaged, social interaction, all of the things that add to physical and mental wellbeing for an elderly person.

MR GLOVER: Does that also apply to the category of patient described in paragraph 175 who would have been better managed in the community avoiding the presentation and then they ultimately present at a higher acuity level?

DR LYONS: Absolutely, absolutely.

MS WILLCOX: If you are a person who has some chronic respiratory disorders, often they're on steroid medication which can make them more at risk of infection, so staying in a hospital setting, where there's a lot of patient flow and churn of patients and staff - there are many risk factors. Our hospitals are safe in the main but you're much better if you are able to be cared for in home, or a community setting is a much safer place to be.

DR CHANT: Can I add in the less acute areas it also plays out. For instance in our sexual health clinics, we would see that the majority of patients would get their sexual health screening, testing and support within a primary care practitioner setting, but if our services are inundated, that doesn't allow us to do our work, which is probably in the more complex patients that require that more multidisciplinary team to care for them. So again, it's this tension about access to primary care, which is a critical importance, but it plays out at all levels in our system.

MR GLOVER: I want to come to question 5 of the report, which deals with the burden of disease, which ties in to some of the issues we have been talking about, about preventative care. In that section - I think this is your section, Dr Chant --

DR CHANT: Yes, it is.

MR GLOVER: -- Ms Willcox can take a break - you set out how it has changed, but just in general terms, has the change that you describe in this section of the report been coming for some time?

DR CHANT: Clearly demographic change or the change in the age structure of the population takes time. We've also reflected on the increasing ethnic diversity of our populations. These were predictable, but clearly it's taken time for this to impact.

MR GLOVER: By that, you mean it may have been predicted that, as we live longer, people would get older, but how that would affect the system is being seen in more recent times?

DR CHANT: I think you'll find that there are many economic analyses at the Commonwealth level around the impact of the ageing population and the challenge and the demographic shifts and what it means for our working population.

DR LYONS: I think there is no doubt that in the early status, the projections of the health care utilisation of people once they get into their late 70s, 80s, and 90s now, was significantly underestimated because we projected

through based on past experience of people in their 60s. In fact, the experience has been that they use health services multiple times at a higher level than people who are in their 60s. The planning initially was done on projections that were looking at those rates of admission and healthcare utilisation. In fact, our experience has been that the healthcare utilisation is at a much higher level.

MR GLOVER: The other element to that, is it, is that not only are people living longer, but they're living with a different category of disease to that which might have been the case 20 or 30 years ago?

DR CHANT: That's correct. The switch is very much to chronic disease and also a key feature is also mental health issues which have certainly been amplified.

MR GLOVER: When we discuss chronic disease in these contexts, what does that actually mean?

DR CHANT: "Chronic disease" is a grab-bag term for something that's not acute and recoverable, where you recover totally. So chronic diseases - the big groups of chronic diseases we talk about are largely cardiovascular, so that would be affecting heart sort of conditions, blood flow; respiratory; and then neurological.

I think you've seen with the ageing in the population a key risk factor for dementia is ageing, so we would predictably support that dementia is going to be a growing issue for us and that raises a lot of challenges both for the individual but also for the carers and the care system that we need to have.

DR LYONS: The other big one is mental health. Mental health is the other one that has grown quite significantly, so people living with mental health conditions in a chronic way.

MS WILLCOX: Also cancer is becoming a chronic disease. Many people are living, for instance, with prostate cancer for decades, but there are impacts of that in the treatments and in the effects.

DR CHANT: We should say that for some of them it's a positive disease because with the newer therapies,

they've been able to hold and stabilise and give people years of further quality life. For some of it's a positive story; for others it's probably more of a call to action and reflects why our health system needs to change and shift in response to these changes.

MR GLOVER: So this is a category of condition that is not immediately life threatening but will affect a large cohort of the population over a number of years in their later lives?

DR CHANT: That's correct. I suppose, just looking back to the previous prevention conversation, we know that risk factors such as tobacco, alcohol, lack of physical activity and being above a healthy weight all predispose to multiple chronic diseases including cancer.

MR GLOVER: What challenges does that present to the public health system going forward?

DR CHANT: I think we have reflected on the focus on prevention. I think we would all, along this table, aspire to the fact that we would want a healthy ageing population. We would want a population that is free of disability, as it ages. We all have to die of something, but we would like there to be a very short interval between when we had a very long disease-free interval and probably a very peaceful death.

DR LYONS: The other challenge it creates is in terms of service delivery. I think we were very organised around the specific diseases and systems, so our specialties are all focused on those, and in the past we've been very successful in dealing with and keeping people alive from those conditions. If you just use the example of cardiovascular disease and deaths from acute myocardial infarction, ischaemic heart disease, the change has been dramatic. The improvement is amazing. People don't die, as they used to, from those conditions, so people are staying alive longer.

Because they've got multiple conditions which go across a number of different systems, organ systems, and our specialties are organised around those organ systems, it means that we need to have a range of different teams involved. You've got your stroke teams, you've got your heart teams, you've got your gastrointestinal teams. So

the challenge for us in service delivery is how people with those chronic conditions access the right care and who coordinates it all. That's the shift that has occurred which is challenging for us.

MR GLOVER: That is multidisciplinary care, in a nutshell?

DR CHANT: That's right, and the integration piece and who is the integrator.

MS WILLCOX: I would add for our patients that are within our hospitals, just building on Dr Lyons's comment, it's more often than not that a patient has multiple conditions that require attention. They may be in for one particular thing, but the totality of their needs also has to be managed while they are in hospital. And the sub-specialisation means a lot of consultations from various parts of the medical, nursing and allied health professionals to attend to their hospitalisation, which makes it a more costly and complex exercise and takes us back to the discussion around the pricing and the costing and how important it is to capture all these interactions to ensure that we really truly reflect the nature of the care we are providing.

MR GLOVER: We will come back to that, but at a service delivery level, has there been a need to pivot the way services are designed and how they are delivered to meet this change in demographic?

DR LYONS: I think it's work in progress. It's clearly something that we would say where there needs to be an even greater shift over time for the whole system. I think the whole system is geared up around that historical approach of episodic care, around a specific condition, and as the demography has changed and people are living with those chronic conditions, as they are frail and elderly now and have difficulty in accessing services, the whole service system needs to shift in its approach.

But examples of where we've done work like shifting the focus is some of the work that has been done around health care hubs, which is where we are focused on delivering a range of services in one place and integrating that with other providers. So where primary care might be working alongside our community health teams, allied health, there might be diagnostic services available as

well. We need to see more investment in those types of holistic care in the community setting that enable as much care to be provided for somebody who has a range of different conditions and needs to be accessing a range of different providers and services, who can have their diagnosis made without being referred to an emergency department, who can have arrangements for ongoing care with a specialist arranged outside of a hospital setting. That's the shift we need to see and we need to see more investment in those sorts of health service delivery arrangements.

DR CHANT: I would also be interested to hear Nigel's perspective on this, but our geriatricians are probably the integrators in the hospital system, and the question for us is, what's the proportion of investment in that integrator versus the specialty stream? I think there are some interesting aspects there.

DR LYONS: There is no doubt, there has been increasing investment in aged care and geriatrics in our acute settings. There has been a need for that. They are the people who look at the whole person in an aged care sense.

The sub-specialties are really important as well, but we need to have within our service system people who have the care of the whole patient, particularly the frail/elderly. So that focus on aged care, acute geriatrics, but having that shared into a community setting and the integration with GPs and primary care, is probably the key piece that we need to see more of.

And valuing the role of the general practitioner and the primary care team, that it needs to be a team, as we've talked about, a multidisciplinary team, and having them closely working alongside our services is where we need to go.

MR GLOVER: Is the role of the primary care physician in that scenario important, because I imagine it might be quite difficult for a patient with a chronic condition to navigate themselves through a variety of specialties and treatments over the course of their illness?

DR LYONS: That's absolutely correct. Some of our primary care doctors struggle with navigating our system as well. Part of what needs to change is we need to make it easier

to navigate our complex system. We need to redesign it. So we've had a focus around specialties and building our system around those service areas, which has been highly successful and is really valued, and we need to maintain it, but we need to now reorient our secondary care and specialist care to say: what do we need to do to support primary care? What is the focus the need? Rather than having patients referred up to specialists all the time, do we need to have our specialists have a focus on supporting the primary care team to manage that patient in a primary care setting more effectively? How do we organise the system to do that? How do we support the information being shared? How do we support the appropriate remuneration of the practitioners, because our system is geared around a referral to a specialist and the specialist being remunerated for that?

If there's a need for a conversation to support the care of that person in the primary care setting, how can the specialist be remunerated for that appropriately to reflect that work? I think these are the things that we need to see a shift in to make sure we can see that change occur, and it needs to happen, because it's the only way we're going to meet the demands and meet the care needs of these patients into the future.

MR GLOVER: Building on from that last portion of your answer, is it anticipated that, as the population continues to age and people live longer, there will be greater demand for services from those with these chronic conditions?

DR CHANT: Yes.

DR LYONS: On our current trajectory, yes, which is why we need to start to shift the focus to say what can we treat more effectively earlier which doesn't then require an admission to hospital? What can we prevent happening in the first place through the prevention measures we've talked about? So that's the shift. At the moment we're geared around responding to the diseases and the acute conditions exacerbating through our hospitals. We've got to shift that focus.

DR CHANT: The risk is also that if we as a society across government don't address some of those risk factors such as an increasing population above a healthy weight, people being physically inactive, the age of the chronic disease

profile will manifest at a younger age. So that's a double whammy - we'll have the ageing, but we'll also have chronic diseases manifest at a younger age. So we need to work on both ends, adjust our services but also support a strong focus on prevention.

DR LYONS: There have been some statistics shared about the fact that life expectancy of people being born now, because of some of these changes, is actually less than the previous generations, so we really need to avoid that shift occurring.

MR GLOVER: Addressing chronic conditions early would have benefits beyond just the individual health of the patient - that is, wider societal benefits as well?

DR LYONS: Absolutely.

MS WILLCOX: Yes.

DR CHANT: Absolutely, often there are economic benefits if people can remain active in the workplace. So a lot of the economic analysis of tackling some of the risk factors accrues in - economists attribute that to workplace inability to maintain employment.

MR GLOVER: Is one of the pieces of work directed to meeting this challenge the future health structure?

MS WILLCOX: Yes, definitely. The whole purpose of embarking on the future health strategy was to start to prepare ourselves or continue to work preparing ourselves for the next decade. As I think Dr Lyons talked about yesterday, literally thousands of staff were involved in the process. Sometimes these strategies and glossies perhaps seemingly lack appeal, but we had enormous contribution from our staff right across the system, and there was great alignment around the things that people felt were the most important - patient experience, sustainability, keeping people safe and well, safe care. You know, it was very clear what everybody felt were the priorities.

What we've aimed to do now is to frame our activities to align with that. It would be rare that an idea for a model of care or some innovation didn't fit into one of those categories, but we're very much trying to create a

strong discipline that as we approach anything, we make sure that they're contributing to all these strategic outcome areas of future health so we can all push, as they say, in the same direction.

MR GLOVER: We might bring it up on the screen, [SCI.0001.0010.0001].

Commissioner, you'll find this in the hard copy bundle at volume 2, tab A14.

There is the glossy cover --

DR LYONS: Yes, very familiar.

MR GLOVER: -- in New South Wales blue. If we go to page 9, please. Thank you.

In that blue box at the very top, there's a projection of the growth anticipated in spending over the next just shy of 40 years. The response that's needed to address the demographic change, does that also need to be made to ensure the sustainability and viability of the public health system generally?

DR LYONS: Yes.

MS WILLCOX: Yes.

DR LYONS: It's not just in terms of dollar spend; it's about the workforce. Our people are so critical to us being able to deliver services, and the projections of what this would mean in relation to the workforce required would not be able to be met because we don't have that level of workforce available. Really important.

MR GLOVER: Just going down the first paragraph and the three dot points, this is a high-level summary of the NSW Health budget, currently, 85 per cent concentrated in hospitals. Prevention and promotion currently account for 10 per cent. What's within prevention and promotion in that paragraph?

DR CHANT: That would cover some of the screening programs. It would cover our population health services in local health districts; it would cover the ministry's population health programs; it would cover probably

a component of our sexual health clinics that provide a lot of prevention work; components of our drug and alcohol.

That estimate would have been derived using one of the definitions, I haven't got it in front of me but, as I said, those percentages can be contested depending on the definitions you use, because, as we described, prevention can be a component of every healthcare delivery, all the way through the programmatic areas that I have described.

MR GLOVER: There is not a universal agreement on what "prevention" means; is that right?

MS WILLCOX: Yes.

MR GLOVER: What about promotion? We spoke a lot about prevention earlier today. What does "promotion" mean?

DR CHANT: We would say that promotion is one form of prevention. So it's under the umbrella of that. What I suppose that is calling out more is that primary prevention or working with partners to promote the work we do in schools and child care, the work we do with working with local government, work we do working across government. That would be our promotion activities. We also do a lot of campaigns. That term broadly could be including some of our campaigns and our social marketing to support people to adopt healthy behaviours.

MR GLOVER: Encouraging more exercise, Crunch&Sip programs in primary schools?

DR CHANT: Sure.

MS WILLCOX: The local health districts have health promotion units that are there to deliver on statewide campaigns or more bespoke activities that meet the needs of their community that they're responsible for. So things around falls would probably be in all areas, so would exercise and the "Munch & Move" and the "Crunch&Sip", things that you've mentioned.

But there might be more particular things around men's health or women's health. In our Aboriginal services that are provided through our Aboriginal health unit teams, men's health, you know, is a very important area and the health promotion team would work with their Aboriginal

health colleagues to create days when men could come in a safe culturally sensitive environment to talk about how they are. So it takes on many forms, but there would be some fundamentals across the state that we know are contributors to wellbeing, such as diet and falls and weight management and exercise.

MR GLOVER: Dr Lyons, earlier you made reference to a need to adjust or calibrate where the spend is being directed. One way is to increase the size of the funding envelope, but if we just assume for the moment that the envelope is what it is, do I understand that passage of evidence to mean there needs to be, in your view, an adjustment - less of the 85 on traditional hospital models of care, more into the prevention space?

DR LYONS: Yes. I think, though, the challenge for us is while the demand is there and the community expectations for treatment - and we can't deny people treatment when they need it - so while those pressures exist, it's difficult to make that shift. So it needs to be maintaining the important role they play and the services they provide, that investment; incrementally more going into the other components than has been in the past. So it is about proportional investment in those in the future but while maintaining those other important services that we're responsible for.

MS WILLCOX: If I could just add, for as long as probably Dr Lyons and Dr Chant and I have been in the health system, there has always been a view that, at some point in the near future, the health system will consume almost the entire budget. But what has occurred is the health system continues to innovate, refine, look at different ways of providing care, trying to make the shift around principles such as integrated care, working with primary care. We keep evolving in order to mitigate that demand and manage the impact on that 85 per cent.

DR LYONS: I think it would be fair to say that - and my colleagues might challenge me a bit on this, but it will be interesting to see - the activity based funding has driven a focus on activity, and it has driven a focus on activity in settings where the revenue to be gained by that treatment is to be maximised. So it's tended to focus our service deliverers on in-hospital care. Reflecting on that over the time that I've been in the system, when we didn't

have activity based funding, often the investment would be made in settings outside of a hospital. But at the moment there's a drive through the funding arrangements for people to see the need to continue to deliver activity in settings that generate the highest level of revenue for them and reflect resource utilisation.

I think we have got to make that shift in terms of continuing to have activity based funding to have transparency around what we spend and the cost of that and being able to benchmark it, but also think about how we start to incentivise the shift in those activities into other settings. How we do that is going to be very important to getting that change that we need to see.

MR GLOVER: In a passage in the report - I don't need to take you to it, you will no doubt recall it- one of the benefits of activity based funding is it drives what is described as "technical efficiency", that perhaps I think you describe as one of the shortcomings, that it's at the expense of allocative efficiency; is that right?

DR LYONS: That's exactly what I --

MR GLOVER: The very issue that you are speaking of?

DR LYONS: That's correct.

MR GLOVER: I want to explore the term "allocative efficiency" a little bit more. What does that mean in practice?

DR LYONS: It's about getting the right mix of investment across all of the different areas to ensure that we're getting optimal outcomes for our patients and addressing the health needs of the community in a sustainable way. So that's about the investment across the various programs we've talked about in different areas, so in service delivery across primary care, secondary care, tertiary and quaternary care, those examples we use. Primary care is what we do at the closest level of the community, right up to the most highly specialised services in our large teaching hospitals, the quaternary services.

It's about getting the right mix of investment across all of those to ensure that we are optimising the resources we receive, getting best outcomes and keeping people as

healthy and well as we possibly can. The tendency has been to invest in that higher end. We need to refocus on the lower end, not that it is less important, it's actually more important now because of the demography of our population.

MR GLOVER: In your view does the current focus of the NHRA - is it too narrow on what can be described as in a traditional hospital activity?

DR LYONS: Yes, but I think we also need to be conscious that the NHRA is only one component of all the funding we receive. We've talked about the New South Wales health system, we've got to acknowledge all of the other components of the health system that we're not responsible for. It's our contention that the intersection between what happens in the MBS funding environment, the PBS, the pharmaceutical benefits funding scheme environment, investment in private health care, they all need to be looked at in totality so that we get the right mix and we've got all of those working in alignment to see that shift occur. So what happened in one part of the system, if we try to address that from our end but not having those other components also shifting, we won't see the change we need to see, because they're working against each other, potentially.

So there's a need for us collectively to agree what do we want the health system to look like, and then how do the various components that the Commonwealth is responsible for, the states are responsible for, private health insurance funds that individuals pay for out of pocket - all of that is aligned to that direction and reinforcing and supporting that change.

MR GLOVER: Is that assessment particularly important in circumstances where the needs of the population in terms of their health care is changing?

DR LYONS: Absolutely. While we should be very proud of the health system we have in this country and in this state, clearly, its success is leading to some of the challenges we're now seeing because we're keeping people alive longer and they are living with these conditions and so we need to re orient and shift but maintain the very important services that we have, and are very successful in doing what they do.

DR CHANT: I suppose just another sort of lens on that is just the health benefits haven't accrued equally across our population. So therefore, if our remit is to improve the health of the population overall and reduce inequity, we have to do some more boutique or tailored programs or additional supports which are not reflected in the current ABF sort of funding arrangements. So more bundled care for some populations, to ensure that they're receiving the same outcomes from intervention.

DR LYONS: I think that's a really important point. Universal access to care has been around, treating everybody the same in our system, pretty much, in terms of the programs and services we offer. While that has raised the health status of the community generally, there are some groups who have been left behind in the process. So we need to refocus and redouble our efforts around those groups.

We've talked about targeted universalism, I think we've used that term. We have a standardised approach for the community but there are some groups we need to be more specific in what we do because of their particular needs, and I think that's where we need to go.

MR GLOVER: That is an important piece of the puzzle. What types of communities or groups do you have in mind when you are raising that?

DR CHANT: I suppose it is important to say that, for instance, health promotion itself can increase inequity, because if you are just giving messaging, messaging will be adopted by those who, if the message is given in English, can understand English, who are listening to the channels that you are pushing it out on.

If you then unpack that, you then need to look at perhaps the different groups. So I think our data has clearly highlighted the difference between the most advantaged and the less advantaged. I think for us, the outcomes can be differential across some CALD communities; clearly our homeless population; some of our communities that - our Aboriginal communities have poorer health status. So for all of those communities, we need to look at what are the additional steps to the model of care or the clinical pathway that we have to put around them to

actually give them equal outcome. So it is not about treating them preferentially, it's just around the fact that we know that we have to do these other things to get the same outcome.

MR GLOVER: To combat the inequities.

DR CHANT: To combat the inequities and the fact that they are living in a context where they have other barriers.

MS WILLCOX: If I could just add to what Dr Lyons said, I think we are but one part of the system, and to his point, the NHRA is but one part of the funding model, which is very much focused on hospitals, and we know that the system is much, much more.

We have many partners in the non-government sector, many partners in private sector, and this concept we touched on yesterday around regional planning is one construct by which to see all of this, and that if you have a region or a geographical area with all of these partners, how you could leverage off one another, if the funding structures - and I realise it's not easy, but how we could allow more movement between all partners in care delivery in a particular area for a population, and then their ability to focus on those people that are more vulnerable is strengthened.

MR GLOVER: Is that a convenient time, Commissioner?

THE COMMISSIONER: Yes. We'll come back at 10 to 12.

**SHORT ADJOURNMENT**.

MR GLOVER: Thank you, Commissioner. Just before the break, Ms Willcox, you made some reference to NGOs and they are part of the system.

MS WILLCOX: Yes.

MR GLOVER: If we can go to the joint report at paragraph 101, please.

There, some of the services that are provided by NGOs are described. Firstly, how are those services integrated within the public hospital system?

MS WILLCOX: Thank you. Our non-government organisations, as outlined in (a) to (h), form a very important role in the health system.

We talked briefly yesterday around the planning, I guess the hierarchy of planning: so from a statewide strategic planning perspective there will be a number of our non-government organisations that would be factored in. One example might be family planning or Karitane and Tresillian that provide support for parenting and mums and families; at a local health district level - and sorry I should say from the state level - certainly from drug and alcohol and some of the areas that fall into Dr Chant's areas as well.

At a local district level, there will be particular needs of particular NGOs that may have a greater footprint or do work in the communities that are more predominant, and so you'll find there's local partnerships, but in the main, our NGOs are funded through ministerially administered grants. There is a Grants Administration Guide for the public sector or government agencies that guides the process of procuring these services and the contractual relationship and the reporting and monitoring and the like.

Some of our NGO partners will have their relationships managed at a local health district level. For instance, just drawing on Karitane again, South Western Sydney Local Health District manages that contract and Sydney Local Health District manages the contract for Tresillian. So there is a little bit of flexibility in that, but in the main, ministerially administered through a statewide Grants Administration Guide for probity and appropriate procurement and evaluation and monitoring, to enable us to monitor the delivery of the services that those NGOs are providing.

Sorry, I'm just jumping around a little bit, my apologies. But in a local health district too, those relationships would be part of performance meetings and discussions, so they would be meeting with the large NGO providers to talk about the services and are they meeting the need and just that general relationship.

MR GLOVER: Is this another way that integrated model of care can be developed through using NGOs?

MS WILLCOX: Yes, it's an acknowledgment that clearly the public health system cannot do all things and that we have partners existing within the system who are performing very important work that contributes to the health and wellbeing of the community. Many have very bespoke services - you know, our LGBTIQ+ Health, the AIDS Council of New South Wales, ACON, an incredibly large and important longstanding organisation that cares for that community and integrates with our services to make sure we're delivering for those communities as well.

MR GLOVER: I think as, Dr Chant touched on yesterday, do they also play a role in reducing inequities, excess?

MS WILLCOX: Refugee health would be an obvious one.

Did you want to comment on some of the drug and alcohol ones, Dr Chant?

DR CHANT: Yes, certainly. I think that the partnership with some of the NGOs also goes to a partnership in strategy. For instance, Ms Willcox has talked about the key role of ACON and some of our other NGOs, that we would have them as active partners in developing the strategy and responding to the evidence of emerging risks or things that we may need to change in the response.

MR GLOVER: In (h), two in particular are mentioned. ACCHOs, what are they?

MS WILLCOX: They're Aboriginal community controlled health organisations. The Aboriginal medical service is about one structure around the Aboriginal medical health service model, and the ACCHOs is the collective term for those community controlled health organisations providing services to Aboriginal communities.

MR GLOVER: What sorts of services are they providing to Indigenous communities?

MS WILLCOX: Do you want to talk to that, Dr Chant?

DR CHANT: Aboriginal medical services, if I just start with that group, provide pivotal primary health services, but what they also do is recognise that to achieve those outcomes they need to provide more holistic care. For

instance, they will also partner with our local health districts in terms of having specialist input. They will also partner with other government agencies, so they might have legal and employment services coming in. They're really around treating the person as a whole, so they basically provide those important primary care functions, prevention functions. They will run programs that support risk factor reduction in their populations, chronic disease programs, they also run - often in partnership with us - some dental programs as well.

There are other Aboriginal controlled health organisations that might specialise in mental health services or drug and alcohol, and again it's around making sure that we have a diversity of high quality providers that can meet the needs of the population so that we address some of those equity issues.

MR GLOVER: Do they play a role in ensuring that those populations get care in what's described in some of the literature in a culturally safe way?

DR CHANT: That's correct. They're very important in doing that and we also partner with them locally. We try to maintain very close relationships between our Aboriginal medical health services and our local health districts and have them as an active voice in that partnership because we recognise their important role in providing and servicing Aboriginal people.

MR GLOVER: And do they receive funding in the same way?

DR CHANT: They receive Commonwealth grant funning. They receive Medicare, so they're eligible for Medicare. There's also a number of other programs that they might apply for funding - for instance, in relation to child protection or other activities that they might have funding sources.

We also provide grant funding to the AMSs and then separately we may ask the AMSs to deliver additional services on our behalf and they would be funded additionally to that sort of base-level funding that the state provides to them.

MS WILLCOX: They also have a very strong relationship with the Aboriginal health units in the local health

districts. As part of the partnership arrangement that Dr Chant referred to in a number of the AMSs, specialist medical staff and dental staff from local health districts would run clinics out of our AMSs as well for specialist services such as cardiology or diabetes.

MR GLOVER: In some evidence given before the break, Dr Chant, you were talking about the need to tailor some of these integrated responses to particular communities. When looking at Aboriginal or Torres Strait Islander communities, are those organisations part of that approach that you were describing earlier?

DR CHANT: That's correct. But within our local health districts we also have strong Aboriginal leaders heading up Aboriginal health streams. I think the key principle is co-designing with community and making sure there is strong community involvement into how we design our clinical pathways, how we integrate and work collaboratively.

MR GLOVER: If we go ahead in the report to paragraph 134, please.

This is related to some of the evidence given before the break about the anticipated increase in proportion of the population with disease and drivers of demand on system.

I think Dr Lyons, you reflected on this. The statistics in this paragraph, do they suggest that the system needs to pivot now, or continue to pivot, if I can put it that way, otherwise it's going to be overwhelmed?

DR LYONS: I wouldn't use the word "overwhelmed" because our system has always, despite all of the challenges it has faced, been able to respond. But it is certainly going to be challenged to a greater extent than it currently is and with a focus on that hospital care, which is what we need to change, because that's not a sustainable arrangement in terms of delivering these services, and that's not best outcome for our community either. We want to see people living a life outside of being admitted to hospital and as well as possible with the conditions that they are living with.

It's certainly, I think, a statistic which highlights the importance of continuing to support this change and the

criticality of doing so, otherwise we will see the sorts of statistics that are highlighted there with three-quarters of a million people, more people - that's a lot of people - living with multiple chronic conditions and that would be a huge challenge for us to meet.

MR GLOVER: We touched on, and we'll return to it later today, how the funding models might need to be reviewed, but are there other barriers in the system to carrying through that change either structurally or within the workforce?

DR LYONS: Workforce is a big issue and I think we've highlighted the importance of workforce availability. I think the important thing to highlight here is also the intersection between the care workforces. Aged care, disability care, health care, often have health professionals who can work in any of those sectors. So as one of those expands, it can put pressure on any of the others, and I think we're seeing that play out at the moment, with the investments that are being made in aged care. It's difficult to attract the nursing staff that are required in some of our aged care facilities to the extent that they need to be there, and if they are attracted, it might leave other areas short. So I think we've got to look at these things in totality. That's the first point.

The second point, I think in terms of barriers, the workforce is not the only barrier. We have highlighted the importance of information systems that allow information to be shared in real time. Those are going to be critical investments for the future across all of the different care delivery modes, and all of the professionals involved.

We talked this morning about the importance of primary care collectively. If we're talking about multidisciplinary primary care, it's all of the allied health groups as well as general practitioners who are involved in delivering that. A lot of those health professions are working in practices in the community, which might be separated physically, so it's important that information is able to be shared in real time to all of the places it needs to be to support the care of those patients in those settings. Otherwise, we'll have further fragmentation and likely to have reduced quality of care.

MR GLOVER: Is there a need for the whole system to pull

in one direction when making this shift?

DR LYONS: We would say yes, because unless that information - so, you know, the policy, the funding, the information system, all those enablers of the shift need to all be working in concert to achieve that change, and if they are, we'll see the benefits delivered. If we don't see them all working in concert, we'll be here having another review with the situation much the same as it is.

I think the reasons why things don't happen is because all of the things that need to be in place to support that happening aren't all achieved at the same time.

DR CHANT: Just to add to Dr Lyons' comments around data, I think it's around making outcomes visible and transparent to all the practitioners. For instance, if the patient is admitted to hospital and there isn't information back in that way to the hospital, they won't know that the person actually re-presented to the GP or, for instance, the patient may not have initiated the therapy that was required and if the person goes back to hospital, that may not be visible to the GP.

The system has to continue to learn about how we manage chronic complex patients and best support them, and ultimately we want those outcomes, but at the moment those outcomes are less visible to all the participants in it, so it doesn't drive that continual learning and reflection.

DR LYONS: I think that's a really important point around the data and the information used to help manage those components of the system, and to be clear about the accountabilities of the various parts of the system in the totality of healthcare delivery, because unless we can ensure that each part of the system is doing what it needs to do effectively, we won't see the overall outcomes achieved, and the measurement of activity, the measurement of performance, defining the accountabilities around what we see each component of the system doing well and monitoring that, is critical to see the change delivered.

DR CHANT: This will be a particularly important strategy also in addressing inequity because those that have good health literacy can navigate the system, can navigate all of these components, will actually be able to do that role more fully themselves.

The GP or the other practitioners will need to be more conscious if someone doesn't really understand why they need to get that test at that particular time, why it's really critical that they stop that other medication and change this medication. Again, this ability to see outcomes across all of the players and share data more will be important to drive good quality clinical practice, but it actually potentially will also reduce that inequity.

MR GLOVER: And would it also drive efficiencies in delivery of care?

DR LYONS: Absolutely it would. So it would stop duplication. That's the first thing. If the information is shared adequately, it will reduce the cost of that duplicated care. It will stop some of the gaps in care that are currently occurring because information is not shared adequately and people aren't aware what's going on. But it will also give us the opportunity to assess what we talked about yesterday around the value of the care and address issues around low value care ultimately as well.

I think those connections, making sure we've got that data available, feeding that back to clinicians, but also being able to have that systematic review of how care is being delivered are really critical.

MS WILLCOX: I was just going to add to what Dr Lyons said. It also saves our clinicians time. They want to be attending to patients and applying their skills to the best of their abilities. If we can provide the systems, whether that's technology, processes, data, information, to enable that, to free up their time, that's an incredibly important thing that we can do.

I think COVID showed the capability, and the word "agile" was used far too frequently, but again if one has a common purpose, it showed how agile and capable the system is at shifting. I see some of the things that we're contending with around some of these statistics that are in our submission, again, it's about focus and about giving the clinical teams the support and the infrastructure and the data they need to make the most important changes.

MR GLOVER: If we can go ahead to paragraph 152, please.

Just picking up your last point, Dr Lyons, we did touch on this yesterday, but in terms of the pivot to meeting the current and future needs of the population, where it says in that paragraph that there needs to be a far greater process in prioritisation and disinvestment from low value care, and further work to reduce futile care, what initiatives are being implemented in that space?

DR LYONS: Certainly our work around the introduction of the value based care concepts, which are outlined there, which is around the routine collection of information to support care - so the experiences, the outcomes that people are wanting to see from the treatment they're receiving; the experience of the provider in delivering that; the cost of doing that; and, the efficiency and the effectiveness of the outcomes - those are the steps that we need to take to continue to be able to monitor and drive these improvements.

It is very much around what matters to the patient and taking the time to understand that. Because through understanding what matters to the patient, we can actually ensure that the care that's provided will meet their needs, rather than assuming what we think the outcome should be. What has tended to happen in the system, I think, when the system is under pressure and there is so much demand on service, our clinicians tend to do the same things without exploring that detail with the patients, carers or families, because it's sometimes a difficult conversation to have or it takes time to gather the people together to have that conversation. So ensuring we've created the supports for that to occur and continuing to monitor that is going to be a key change.

MR GLOVER: As increased demand flows through the system, why is it important to reduce low value care and futile care to ensure the sustainability of the system going forward?

DR LYONS: Because, in effect, care that is provided in those circumstances is not good use of the resources that are available; it could be redirected to respond to those other needs. But it's got to be driven around the desires of the patient. It's got to be directed around what the patient sees as important to them. It can't be the system deciding that; it has to be driven by the patient themselves.

MR GLOVER: How does that work in practice where it may be clinically viewed that this is not the appropriate model of care for this patient? How do you balance that with the desires or wishes of the patient that you've just described?

DR LYONS: I think it is about having the conversation to enable there to be an assessment about what the patient needs. I mean, I think, yes, we have an assumption that we're here to save lives and to treat everything before us. In fact, sometimes a person might be at the point in their life where they don't want active treatment for a condition, and before assuming that that's what they want, we should have the conversation.

As our clinicians will tell us, the time for having that conversation is not when somebody's in an intensive care unit, intubated and ventilated. It's too late to have that conversation with a family at that point. It's something that needs to occur earlier and we need to be able to have it in an ongoing way, because we need to be also conscious that circumstances change and people's views change about what care they would like to receive. So it needs to be that constant reference but it's so critical that we do that because sometimes patients don't want us to intervene.

The example would be one of the fantastic programs that was established around chronic renal disease and dialysis and having pathways that are alternate to being actively dialysed.

Those models have been introduced over the last five years or so and have involved our palliative care physicians working with our renal physician, and giving people an option about not going on to active dialysis treatment but maybe being treated in a supportive way around their symptoms, but doing that in a way that enables our clinicians to feel safe in giving that option and having patients feel like they are not being abandoned by the system if they choose not to be actively treated.

That's a direction we need to go, because that's being well received by our patients and our clinicians feel very supported with that change also. It's an example of where thinking about how we do things differently and ensuring

that we're responding to patient needs, but having the system designed around that, is so important.

DR CHANT: I think the key element of that is the strong evaluation of that program and being able to present data to patients around the experience and the evidence to support choice, the patient choice, across the two arms. I suppose that's probably something that we would like more discussion around - the patient's goals of care, have those as frequent discussions and around end of life.

It's probably something our system is naturally focused on, you know, saving lives, but the quality of a person's life at their end of life and the quality of death is really also an incredibly important component. Some clinicians would say that's, for them, so important; they've seen the benefit of those discussions. It's a complex area but it's probably an area we need more focus on, just ensuring those discussions are embedded as a patient moves through our system.

MR GLOVER: Is that part of the patient-centred approach that we discussed yesterday?

DR CHANT: That's correct. That's correct.

MR GLOVER: If we can go back to the Future Health Report, [SCI.0001.0010.0001] on page 9 there, thank you.

Under the three dot points that I took you to earlier, there's the observation that that distribution reflects the historic hospital-focused approach, which we spoke about, and it has been an appropriate model for decades, but in the paragraph below, it's recognised that there's a need to shift and the shift is planned. What barriers does the current funding model, if any, create for that shift that's contemplated in this report?

DR LYONS: We've talked about the --

THE COMMISSIONER: Which funding model?

MR GLOVER: That's a good question. I'll start again.

Does the NHRA provide enough flexibility within its framework to enable this shift to occur whilst maintaining the integrity of the current system?

DR LYONS: Our contention would be no, because of the issues we've outlined, I think through evidence yesterday, around how difficult it is to get changes in the general list and the funding of those different approaches to delivering care, particularly outside of hospital settings. So that's an issue within the NHRA.

There's also the issue around the driving of activity into hospitals, as we said, because of the incentive to get revenue streams. I think how we address those within the context of the activity based funding model is also an issue.

But then there's the intersection with the other financing systems because, as we said, the whole of the system is not just what happens in the NHRA; it's also what happens through the MBS schedule and access to Medicare funding; it's what happens in the Pharmaceutical Benefits Scheme and those sources of funding; it's decisions that are made around what happens with private health insurance, what it covers and what services are covered and delivered through private health insurance; it's also what patients are prepared to pay for out of pocket.

So all of those factors come to bear on how we support this shift and the intersection between those funding models and sources of funding and how they relate to each other. Unless we make changes that support that direction in all of those different components of funding, we won't see the shift in service delivery because the incentives will be in the wrong place and we won't see the change we want to see without that clear direction through the funding models and the intersection of those funding models.

MS WILLCOX: Could I just add to that, one of the things that we need to do to contend with the chronic disease and change in demand is to come up with different models of care and innovation to accommodate the change. Dr Lyons has referred to the structural and financial components of that.

One of the issues is around how things are costed, and that IHACPA, that we talked about yesterday, is very much about an in-hospital activity, and to broaden the scope of that to allow more hospital avoidance and things that would

help people with chronic disease into that, things that are in-scope, would be helpful.

Yesterday again Dr Lyons, I think, mentioned about a number of innovative models that the system in New South Wales had developed and our ability to get those funded through the Commonwealth, albeit a collaborative, collegiate process, took an inordinately long time because the actual structures made that a cumbersome process.

MR GLOVER: Is that a cumbersome process because what the NHRA structure looks at is what is described in the Future Health Report as a "traditional hospital focus", whereas what you're trying to deliver is something more innovative to meet the current demands of the community?

MS WILLCOX: That's correct.

DR LYONS: That's correct, yes

DR CHANT: Also clearly it doesn't pick up the additional cost that may be overrepresented in some areas around the provision of these other attendant services to get the same outcome, what we would call colloquially "the wrap-around services".

It also doesn't actually reflect totally what evidence-based prevention care would be fit for purpose in those settings, acknowledging that our hospitals are not there to replace general practice, but there are some clear evidence-based prevention activities that our hospitals could systematically implement, which would be in the best interests of the patient, that are not reflected adequately.

MR GLOVER: And which otherwise might be provided in the primary health care system?

DR CHANT: That's right but again we know, for instance, that there's evidence that in tobacco cessation, even just systematically having a very brief intervention by the specialist, and then supported and followed up by the primary practitioner, that intervention by the specialist will actually have traction.

MR GLOVER: Back to the joint report, please [MOH.9999.0001.0001] at paragraph 157. One of the

potential responses to the issue we've just spoken about is an increased focus on outcome based funding going forward; is that right?

DR LYONS: Absolutely, I mean, I think --

MS WILLCOX: I think so, yes.

DR LYONS: -- it's where we need to go, because at the moment it's difficult for our clinical teams, when they don't have those feedback loops around the outcomes. That's why we're building the system around collecting those outcomes more systematically. It's not just those hard outcomes like mortality and morbidity; it's about those outcomes that are important to a patient being delivered, and fed back to the care teams to ensure that what they're doing is actually patient centred, that is delivering to the patient's need and is not wasteful in terms of delivering things that they don't want.

MR GLOVER: What would an outcome based funding model look like?

DR LYONS: It would need to reflect that the outcomes are being delivered for the funding to be - so it could be that there's an incentive created to ensure that if the outcome is delivered, the revenue provided for that treatment is perhaps at an incentivised rate, if the outcome is achieved; if it's not achieved, it might be at a discounted rate. There are some examples of where this has been tried in different systems around the world.

The evidence is mixed about how you pay for quality and outcomes in terms of the evidence that I have seen. In part, I think because it's really important that we define what those outcomes are very clearly, that we're able to assign accountability to the care team or the practitioner delivering it, and ensuring that when those outcomes are delivered, all of the other systems that need to be in place to support it, as well as the financing - it can't just be around a funding lever; it has to be around those enablers being linked up as well to ensure that those outcomes are able to be delivered.

DR CHANT: I think it's important to say we're probably using the term "intermediate outcomes" and basing it on where evidence-based care that we know through longer

studies is linked to particular outcomes.

As an example, there may be certain patients that are discharged from hospital with follow-up advice to undergo other diagnostic testing. We know if they don't undergo that diagnostic testing or commence medication that was prescribed or continue medication that was prescribed - again this goes to the fact that it has to be clear where the accountability lies, but it may be that we need to fund and acknowledge that there's a greater cost in connecting to the primary care practitioner. It may be that we put in an intermediate follow-up process.

For instance, in some districts they have done follow-up from admission. The Aboriginal health workers or practitioners might follow up those who have been discharged from emergency departments, just to make sure they're connected to care, they've got follow-up, they've got their blood results back. So it may cost us more to do that connection, but we know that if we don't do that connection, then that person is likely to re-present. So it's funding that connection component.

MR GLOVER: So do I take it from that answer you're not just speaking of if the outcome is good, you get more, if it's bad, you'll get disincentivised, but also there's actually a funding model that recognises and funds that sort of connectivity?

DR CHANT: Connection to primary care, be it data, infrastructure to support outcomes or data to link. But it's recognising that ultimately, to get the outcomes for that patient, to prevent them readmitting, connecting them in to an ongoing care model is going to be critical, and therefore we have to work to look at what would be that funding for that connection - because it requires more effort on both parts than at the moment.

DR LYONS: When I was talking about incentivising, the important thing is to recognise that to do that well and get the best outcome might mean more effort is involved or more work has to be done. If those components aren't delivered, then we shouldn't pay for them, if they don't exist. It's about linking the outcomes to the components of care that are required to achieve that outcome. That's the reference around incentivising and disincentivising.

MR GLOVER: And incentivising the work to create those linkages that Dr Chant referred to, is that part of the way it may, as set out in paragraph 157, improve access particularly for vulnerable cohorts?

DR CHANT: Yes.

MS WILLCOX: I was just going to add that our service level agreements, some of these measures are process measures but they are increasingly focused on outcomes, in terms of keeping people safe and well and quality care and the like, when you look at things around we have targets around childhood obesity, smoking in pregnancy, discharge against medical advice, immunisation, all of these. So, yes, they are KPIs for the purpose of the service agreement but they're designed around producing better health outcomes in a population sense, in a local health district, as opposed to just talking about individual outcomes that we're referring to.

THE COMMISSIONER: Is there any difference between - I've seen various forms of payments or funding models described as outcome based funding models or value based funding models. Are they one and the same thing?

DR CHANT: "Outcomes" is used - caution needs to be applied in looking at when the term "outcomes", is used. I've seen it used in many things that we wouldn't perhaps see as outcomes, so there needs to be that forensic look at it. Your other comment I think related to --

THE COMMISSIONER: Value based. So just for example - I mean, I have seen both of those, but in the addendum for the long term health reform principles, it says - this is C1(b):

> *[The priority of] delivering safe, high-quality care in the right place at the right time through*
> *...*
> *(ii) paying for value and outcomes.*

Are they different concepts, "value" and "outcomes", in terms of the funding model?

DR CHANT: I think "value" goes to sustainability and evidence but I think they're interrelated.

DR LYONS: They're interrelated, I think. They're slightly different but interrelated. Paying for value is in terms of assessment of the resource consumed for --

THE COMMISSIONER: For the outcome.

DR LYONS: Yes, for the outcome, and the outcome is what are you seeking to achieve from the treatment.

MR GLOVER: Paragraph 163, please.

That picks up an issue I raised with you not long ago, Dr Lyons, about the ability of the system to adapt - that is, the ABF system - to new models of care. I think we touched on the notion that new models can blur the boundaries, hence creating the difficulty. Are there some examples of new models that have encountered this difficulty - that is, getting recognised by IHACPA for ABF funding?

DR LYONS: I'm just trying to think about a specific example. I know we've put submissions up for a range of different things around care being delivered in different settings. It's primarily around settings outside of what have been traditional hospital settings, because anything that's construed as being outside of the scope of those hospital services is considered to be a change in the scope that the Commonwealth should be responsible for.

It's been primarily in those sorts of models where we've tried to drive care to be delivered not in the hospital setting but outside of it. I'll have to come back to you with a specific example, but certainly the general issue is that the list is constraining and is fixed, and it's very difficult to get agreement that there should be a service funded under the NHR arrangements outside of that specific list.

MR GLOVER: Is there engagement between the other states and territories around these issues?

DR LYONS: There is, and the states and territories have put up some issues, like we have in the past, for funding, and had some that have been successful but a lot that have been unsuccessful, for the very reasons that I have outlined.

We would argue that there needs to be greater flexibility. But it needs to be done in a safe way, because I can understand why the Commonwealth would be concerned about investing in services, unless there's a demonstrated benefit in terms of the evaluation and the evidence around that being an appropriate shift and leading to the things that we have talked about, more efficient delivery of care, better outcome for the patient. Those concepts needs to be a critical component of the assessment of those services up front.

MR GLOVER: If there's lack of flexibility in the ABF model, is that a reason why other sources of funding from the Commonwealth may be sought as being appropriate to deal with new models of care, for example?

DR LYONS: That's correct. So we are constantly putting forward concepts around how we might progress activities that drive us in the direction we want to go to in the future health strategy to get that better integration. Those examples have been through the types of work we've done with integrated care and collaborative commissioning, as examples, but also the work we've done with aged care services to provide support for residents in aged care facilities.

MR GLOVER: Can we go ahead to paragraph 170.

The "Single Front Door" there is raised. What is that initiative and how does it fit in with the integration of care that we've spoken about?

MS WILLCOX: The single front door is a model to enable individuals in the community to make contact through what is a national organisation called Healthdirect that is funded by the Commonwealth and the states. By contacting the single front door, a clinician will be on the end of the line who will, using algorithms and other protocols, give guidance to a person on the phone who is raising concerns about their health and their symptoms.

The real transformation around this is about what sorts of services a person can be directed to. Traditionally, it would have been an emergency department, if it sounded serious, call an ambulance, which is absolutely the right thing to do if something is. But

through the single front door, the plan is to connect people to their GP if appropriate, to a deputising GP service if they don't actually have a general practitioner themselves, or one not available, and then through to other new and emergent services called "urgent care services" and "urgent care centres", which are a Commonwealth initiative.

We also have, through the single front door, a virtual kids line as well. So it's about giving a range of service options based on clinical algorithms and protocol to an individual to avoid going to an emergency department if they don't need to, but giving a suite of options that would be appropriate for their needs at any given time.

DR LYONS: It's off the back of a couple of things. The first is that we understand from work we've done with our communities that when people want to access care for something they're concerned about, particularly in an after-hours situation, they're often not aware of anywhere else to go other than to an emergency department. That's the first thing.

During COVID, we actually established and enhanced these services for people who had positive COVID results to access care without having to turn up to a clinical service and doing it through the use of telehealth. So on the back of those experiences, we're now saying we actually could expand access to care through these means, as long as we're able to triage and assess people appropriately, but also have a range of different places to refer them, depending on the assessment of their condition.

So we need to reorient our service delivery model. If this is going to be the access point, there's got to be a place for someone to receive the care they need after that assessment. So it needs a total redesign of the way we do things. Urgent care centres will be a part of it; access to primary care and having agreement with GPs, for instance, that they might have some vacant slots available the next day for patients who are assessed through this process to be seen if they need to be. It's going to need a lot of work to actually get the system set up to enable this to occur in a way that gives confidence to the community that when they access through this portal or this process, they will access the care they need safely and confidently every time. But it is a direction we think we need to go, because otherwise, people will just continue to

turn up to emergency departments. Notwithstanding the investment in urgent care services and centres and all those things that are very good, that won't necessarily meet all of the needs, and it's about how we redirect some of our efforts into these strategies that enable better access but better organisation of the service delivery models.

MR GLOVER: Is part of that program designed to, as Dr Chant mentioned earlier, connect people with primary care where they may not have had it in the first place?

DR CHANT: I think the driver for that is that there are strong links to primary care in the pathway, so it will be emphasising the importance of having the primary care provider, and our messaging always is, "Talk to your primary care provider first".

This is probably more when the primary care provider isn't available that people would call it, but again, it's an important service and there is a lot of care and attention that has been going on in the design of this service, again, to make it acceptable and have high utility for our culturally and linguistically diverse communities. So that attention is going from the design of it, again, because we don't want to find that technology actually further --

MR GLOVER: Creates another barrier.

DR CHANT: -- creates another inequity, so that is a real consciousness of how we provide that, what training we need to provide, access to interpreters, and how we support access to appropriate services.

MS WILLCOX: It is about getting people to the right place at the right time. Obviously our focus is in mitigating the increasing demand in the emergency departments, but our intent is to make sure people, as I say, get access to the right location.

But importantly, just to share a statistic, of 61,000 people who contacted the centre, 48 per cent of them had said they intended to go to an emergency department but made this call instead and got some different advice. So, you know, that was avoidance of 29,000 attendances to our emergency department. So it gives you some sense of the

potential scale of this, but also how important it is for individuals to get the right advice.

MR GLOVER: Getting care which they need, which may well be outside the hospital environment.

MS WILLCOX: Yes.

DR LYONS: Yes.

MR GLOVER: If we go ahead to paragraph 186, in that paragraph it describes workarounds in the aged care setting. Are there other examples of workarounds that have had to have been implemented by NSW Health.

MS WILLCOX: There has been a number of models that our local health districts have undertaken in order to prevent unnecessary admission of elderly people into our emergency departments. You will have probably heard the term "flying squads" or "in-reach teams" - usually our geriatric services, nursing staff in particular, who will be deployed to go to an aged care facility and attend to a patient; it might be a catheter change or a wound dressing or something simple, a simple process like that. A number of the LHDs have a direct link in with the ambulance service so they can see when an ambulance is being deployed to an aged care facility and can intercept that call and have a discussion with the paramedic on site and with the staff on site at the aged care facility and make a decision there and then whether that care can be provided by the paramedic or whether the geriatric in-reach team then come and visit the aged care facility to provide care, or, if necessary, the person can be transferred to an emergency department.

So there is a variety in terms of how the models are applied, but in the main, it's about either an in-reach service or a diversion service or a virtual and hybrid model where a decision is made whether a person stays or is transferred to hospital.

MR GLOVER: Are there any examples outside of the aged care setting of workarounds that have been developed to address issues of increased demand on the system?

DR CHANT: I think in all of the areas whereby there is a subtlety of flow of patients to our system that are affected by general practice access. So I've given you the

example earlier on around our sexual health services, so some of the additional services we've put in place are things like telemedicine; for our drug and alcohol services, we've put in telemedicine support, and purchased centrally to deal with some of the workforce constraints.

Some of those patients may well have been able to be managed in primary care but, again, that's a workaround to support rural and regional. So a number of our initiatives have multiple purposes, but they are responding to the fact that there is this unmet need.

DR LYONS: There are examples of after-hours medical services that have been established in partnership in various districts through relationships with the general practitioners as well as the local health district, to provide access to after-hours care where that is not available, where there have been models like in Western Sydney looking at the access to specialists and backing up the care to ensure that patients don't end up in the emergency department if that can be avoided.

So there are examples of these where the system has developed arrangements to try to prevent ED attendances.

Urgent care services are another example of where they have been established and are now being built on and enhanced as an alternate to an emergency department attendance. They are all services that have been built to try to avoid or change the need for a person to turn up at an ED because that's the only avenue they've got for accessing care.

MR GLOVER: "Urgent care services" have been mentioned a few times. What is an urgent care service? Why is it an alternative to an ED?

DR LYONS: Urgent care services are about creating a level of service that is available in situations where maybe access to primary care is not as easily accessible - so evenings, weekends - and where there is a service that includes primary care physicians, clinicians, ideally, who can be involved in assessing patients who may not have the clinical needs of an emergency department but can be cared for appropriately in that environment, and it gives another option available to people who feel they've got an urgent clinical condition that can't wait until they could access

care through other means, but then can actually access a service that doesn't mean turning up to the emergency department as the only option.

MR GLOVER: And to the extent that includes primary care, how is that funded?

DR LYONS: Those services are being established - the Commonwealth has agreed to a number of them that are being implemented in New South Wales. I can't remember the number exactly from the Commonwealth, but I think there are about 10 of those for New South Wales; and New South Wales's state government has committed to a further number as well to enhance the total number of those services that are being established over the next 12 months or so, to ensure that those services are available as an alternate.

MR GLOVER: So there is a combined funding arrangement between the Commonwealth and the state to fund those services?

DR LYONS: That's correct.

MR GLOVER: If we go ahead to paragraph 205, please:

> *Integrated funding models to support care in the community need to be fast-tracked with a more blended funding model moving away from a reliance on ABF in dominating decisions on budget allocations at the state level.*

What do you mean by, firstly, "integrated funding models", and then, secondly, "blended funding models"?

DR LYONS: So "integrated" means that the sources are from different sources than they currently are, so starting to look at those funding systems that exist, that we've talked about before, the ones that the state's responsible for, the ones that the Commonwealth is responsible for, and starting to look at how they are integrated to enable that shift in care into the community setting.

It's our contention that we can't continue to move services into the community setting without support from the Commonwealth, because just as they are concerned around the general list and the NHRA, we are starting to stray

into territory that is historically provided by the Commonwealth, and the state can't continue to expand what it does without a contribution from the Commonwealth to support that shift.

MR GLOVER: Is that because, to the extent it does so now, it's not receiving a Commonwealth contribution?

DR LYONS: That's correct, and because if we go in and solve those problems in the primary care space and find solutions for them with state funding, without a commitment from the Commonwealth, it's taking away from all of the other things we need to do and the pressures that we're under and the things that we've talked about, the reasons why we've got to continue to fund hospitals at a certain level. We can't continue to expand into other places without the support to do so. So that's the integrated funding models.

The "blending" is away from activity being the only basis on which only services are funded, starting to think about bundling payments or looking to have a contribution from different sources but not necessarily tied around an episode or an activity, starting to be more programmatic in thinking so that we're not driving this activity and episodic approach, we're actually thinking about more continuity and time-based to enable the appropriate care to be delivered. That's the sort of thinking.

MR GLOVER: Are these conceptual ideas or are there examples in practice in other jurisdictions?

DR LYONS: There will be examples. You know, block funding and some activity based is an example, we have those in our system already; we do that. It is building on those types of models but it is where the block comes from and where the activity funding comes from and how that's administered and delivered in a way that gets the best service delivery model.

I think we have some examples that we can build on there, but there is much more that needs to be done in that space, but we have to have agreement that it is an appropriate direction to go and that we're not actually compromised by those shifts in terms of the current funding we receive.

That would be the sort of direction we want to go. It's building on knowledge we already have, and there will be examples in other jurisdictions when this occurs as well.

MS WILLCOX: Some of the collaborative commissioning that we have seen in New South Wales is about one program of work going between a group of general practice and the state system, but they tend to be individual programs as opposed to having the change of structure that is required to enable that to become the norm, as opposed to a boutique piece of work that is done because of relationships or individual general practice and the relationship with a local health district. It's about making it the norm.

DR LYONS: Systematising it.

DR CHANT: And perhaps even just changing the narrative away from recognising that there will be components of a service that are ABF but then block funding for evidence-based services to address particular models of care to live with that equity lens or equivalent outcomes. So I think it is really around more explicitly calling out that and maybe funding those initiatives that support that either integration with primary care or additional models of care that need to support that equity outcome.

MR GLOVER: There is a word of caution in the last sentence of paragraph 205 about the need to consider underlying equity and the responsibility to maintain the safe operation of the public health system. That seems obvious, but why is that an important focus that must not be lost sight of in this debate about funding models?

MS WILLCOX: It is the sharing of risk and how that is managed so that we can continue to do what we do and adapt and change with what is required. But, yes, we would have to make sure that anything that we moved towards didn't negatively impact on vulnerable communities or impact on the issues of equity that Dr Chant has talked about and enable us to continue to care for people safely. It is just a management of risk and a sharing of risk and a clarity of roles and responsibilities that you have to keep your eye on as you do any change management exercise or change a structure or model.

MR GLOVER: Can we go ahead to paragraph 207. "The lack

of social licence to implement alternative models of service delivery" - what do you mean by that?

MS WILLCOX: I can start. I think the term that we're using there is to reflect what might be community expectation and expectations of our clinical teams as well that over a long period of time, the traditional models of delivering care and what patients expect - it might be going to a general practitioner, expecting an antibiotic when they have a cold, from the simplest interaction to some of the more complex - and I think we talked yesterday a little around capital planning for our hospitals and the size and scale and the huge investment we make in those, and how do we start to have discussions with community around what might be some alternative models, and how do they want their care to be delivered in their community.

So I think social licence is about expectations and our ability, as people working in the health system, with clinicians in our teams, to have this community engagement and to start to explore other models and what patients and communities see as appropriate.

MR GLOVER: Does that flow from the fact that people are used to be being treated in a hospital setting, although current evidence may suggest they are in fact better treated outside of that setting? Is that the type of issue you are raising?

MS WILLCOX: That would be one element. I think, as we have said, it is a tremendous system and people have huge confidence and care about their hospitals, and that has been built up over many, many, many decades and that's a great thing. We want to have conversations with them about how else and where else they might receive care, but not see it as a plan B, but plan A might be to stay at home and apply some remote monitoring and have a team visit you once a week or connect you virtually. It is about exploring these options with the community so that they feel safe, and that confidence they have in our hospital system is equally translated into an alternative way of providing care to them.

MR GLOVER: Does that mean the conversation around this is "It's not a substitution of what you had, but this is perhaps a better model"?

MS WILLCOX: Yes, we have to be able to articulate the benefits for them and develop that trust and confidence that this is not just because the hospital is busy, you know, "You are making me go elsewhere", or "You are making me stay at home". The conversation has to be one, "That's terrific. I would be very happy to go home because I know someone is going to ring me every day or a nurse is going to attend or I've got an application on my phone that helps me monitor and self-manage my situation."

MR GLOVER: This picks up on a point made by the Commissioner yesterday of the importance of taking the community along on that journey; correct?

MS WILLCOX: Yes.

MR GLOVER: And the workforce?

MS WILLCOX: Definitely.

MR GLOVER: Are there any barriers to those conversations either commencing or being progressed at the moment?

MS WILLCOX: We have our Health System Advisory Council that we talked about yesterday, and we also mentioned that we are establishing a similar statewide group for our consumers, I mean at a very peak level. That's not a conversation with our workforce and the community of itself, but it can start there, to start as to how we frame these discussions.

I think probably some of our colleagues in our regional and rural areas, whilst they have some particularly difficult issues to confront, they are actually closer to community, there are local health advisory committees in our local health districts in the regions that allow very strong interface with community leaders, local government and the like, to engage in what they want in the health service. I think I mentioned yesterday there is a small group of regional communities that are actually doing some active service planning. So it is about finding the right mechanism to connect, and not all communities are the same.

MR GLOVER: Did you want to add something, Dr Chant?

DR CHANT: No.

MR GLOVER: Dr Lyons?

DR LYONS: I would say this: it certainly was highlighted through the recent rural and regional health inquiry and the fact that we need to do better in this. The expectations, quite rightly, from any of our communities who feel safe about having a hospital in their environment, but the expectations around what that hospital will do, are still in times that are well and truly past. I mean, the ability for a hospital to have a doctor who is available 24/7, in solo practice - that's not safe and it's not sustainable.

Equally, having somebody who can deliver a baby, who can do an operation, can give an anaesthetic, those days are long gone where those services can be sustained by having one or two or three people. The requirements for safe care and appropriate care and the expectations that people would have from the services we deliver can't always be delivered in sites that they used to be delivered, and that's just by nature of the fact that the technology, the evidence, the skills required to do those things safely, have altered and the expectations about who can do that well have also altered.

There are requirements about how many deliveries you need to do to maintain skills, how many anaesthetics you continue to do, in what circumstances, to maintain skills. All of those things have changed over the last 10, 20 years, and perhaps our communities are not aware of those shifts and we do need to do a lot better in explaining the reasons why things need to be different than the way they used to be.

MR GLOVER: And does NSW Health more generally require some more support from other government agencies to make those conversations easier with the community?

DR LYONS: I think we need to do better in communicating that. I mean, we heard a lot of feedback from local government about unhappiness with our services. Those connections are important to maintain, those relationships are important to build. We need to do better in that regard, that's clear. We need to have the feedback that our local politicians hear from their communities. We need to alter that, because sometimes the advocacy occurs around

keeping services available that are not sustainable, and an understanding and appreciation of why that needs to be different is something we need to work hard at delivering for the whole community.

MR GLOVER: Is that an education of the community or the politicians or both?

DR LYONS: I think the politicians are a reflection of the community, so it is fundamentally about how we get those messages through in a way that people feel safe that these changes are appropriate and that are being delivered in a way that they feel comfortable with.

THE COMMISSIONER: Can we just go back to paragraph 205.

MR GLOVER: Yes.

THE COMMISSIONER: It was too quick for me. Can I just ask, when we're saying "with a more blended funding model" - look, there are other people we can explore this with as well, but I'm just writing down what I understand to be the models, firstly. There's fee for service, which we understand; there's activity based funding; there's capitation, which can be just based on population, but it can be risk adjusted for particular demographics or dealing with a population with particular disease; and then there is salary. By "blended funding model", first of all, are you talking about integrating these models to provide best value and best outcomes? Is that, at the highest level, what is being suggested there?

DR LYONS: That's correct, Commissioner. I think the sources of the funding and the way it is administered and delivered - we would like to see much more integration around that. The components you have mentioned about the various options --

THE COMMISSIONER: Are there any other options other than those?

DR CHANT: Maybe if I give just an example with Ms Willcox around maternity care, and the reason we chose that is because of the incredible importance of that first 2000 days. But, for instance, the maternity care would currently be provided as an episode of admission, but we would know that increasingly there is a lot of prevention

opportunities, like preconception, there is a lot of prevention opportunities within pregnancy, in vaccinations, screening, supporting tobacco cessation in pregnancy, modifying other risk factors, and the question is: does the current activity based funding model reflect the intensity that that requires?

Then we know there will be some sub-populations within our population of pregnant women who will benefit from things like sustained home visiting or specific programs such as substance use in pregnancy. So we actually have a blended funding model where we say, "The actual baseline admission to hospital, maternity care pathway, costs X. But actually, for a proportion of the population, you need to factor in sustained home visiting" - and it may be 20 per cent of your cohort depending upon your demographics of your population - "and also these prevention services need to be beefed up in pregnancy, this is a profile of your pregnant women, this is what you would need and this is an additional, perhaps, workforce, additional model that we would need to support that intensity." So there would be a component of funding. It still could be sort of a modified ABF funding, but it would accept that these other things are important add-ons to achieve the outcome we want for the mother and the family overall.

We might also say that, for instance, smoking cessation - our model of care might actually have to be the family, not the woman. So the pregnant woman might - but actually, to have a holistic intervention we might need to deal with a number of other complex issues in that family. But actually, the intervention might be more with the family, and that's not something that is aligned with an ABF where the clinical service might see that it is the mother that is the patient; actually, we might need that broader intervention for the family, again to get those outcomes.

Because in early childhood we do have incredibly good longitudinal data, and what we would be aiming for is for the children to be well and have school readiness, we want them to be retained in education, and so we have worked across with linked datasets to look at that long term trajectory. That's why we need these investments in these things that perhaps strictly wouldn't be funded through an ABF model.

MS WILLCOX: Yes. Nothing further.

MR GLOVER: Commissioner, I don't have much to go, and with the benefit of lunch I may even be able to truncate it further. Can I suggest a slightly earlier adjournment and I will be a bit more efficient after the break.

THE COMMISSIONER: All right. We will come back at 2 o'clock. We will adjourn until then.

**LUNCHEON ADJOURNMENT**

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner.

Dr Lyons, just before lunch you were giving an example of services that may no longer be able to be delivered in a regional area due to changes in technology or the way those services are delivered. Do you remember that passage of evidence?

DR LYONS: I do.

MR GLOVER: You gave the example of a baby being delivered in a facility that may have two or three clinicians. The changes that you spoke about, are they accreditation changes?

DR LYONS: Yes, they're requirements for maintenance of professional skills that are set by the colleges. For GP obstetricians I think there's a joint program between the College of Obstetricians and Gynaecologists and the College of General Practitioners who come to agreement about the ongoing requirements for maintenance of skills for people who are practising as GP obstetricians.

MR GLOVER: If you're able to tell us, what does that process involve in terms of reviewing and setting those parameters?

DR LYONS: I'm not sure of the detail of the processes other than I can say that both of the colleges come together and make a decision about what appropriate practice looks like in the current context to maintain safety and in the context of the skills that need to be maintained for safe practice, and then would promulgate the

position that they have, which then, by and large, the public health system would follow.

MR GLOVER: If you're not aware, please say so, but does that take into account community expectations around those issues?

DR LYONS: I don't think that would be the major driver. I think the major driver would be looking at international evidence around best outcomes for a mother and baby and how safe high quality care could be maintained within the profession rather than what the community expectations might be.

MS WILLCOX: If I could add just from a service perspective, local health districts too will monitor, if we're talking maternity, the number of deliveries, particularly some of our smaller district hospitals as well, and the college is obviously relevant to the obstetrician and gynaecologist, but equally it's about the skill mix of the team that is involved in the maternity services, not just the single practitioner. So the skill base is diffused amongst other groups not just the obstetricians.

MR GLOVER: When you're referring to that skill mix, can you just expand on what you're actually --

MS WILLCOX: The midwives and the allied health professionals who would be working with an obstetrician for the antenatal and the delivery and the postnatal care of a woman and baby. There is an interdisciplinary team there, and the volume issue applies equally. An obstetrician, in theory, may say, "I do X number of deliveries in the private sector, that means in hospital Y it's not relevant to me because I do enough according to college requirements", but the "enough" has to be about the entire service, not just the individual practitioner.

MR GLOVER: That is because it may be clinically safe in accordance with those guidelines for that practitioner to deliver the baby, but then there's a whole series, a range of other care that needs to be delivered as well.

MS WILLCOX: Correct.

MR GLOVER: I didn't quite hear that last passage of your

answer, but do the volume and regularity of that care being delivered apply to those other professionals in that space as well?

MS WILLCOX: We don't specifically count the procedures against every clinician, it's more the service is delivering X number of babies or providing that particular procedure, so as the service it's the volume that is relevant to, not to the individual practitioners in our hospitals.

MR GLOVER: If the colleges set those standards that Dr Lyons was referring to earlier, do they automatically bind those practitioners or is there another layer of oversight from the ministry level as to how they're implemented?

DR LYONS: Usually, as I said, the districts would take the college recommendations and apply those in relation to the clinical privileges that an appointed clinician might have. Usually there's a direct relationship between what the colleges might stipulate and that flows through into how the services are delivered.

MR GLOVER: Thank you. Building on another passage of your earlier evidence, Dr Lyons, the Strengthening Medicare Taskforce - you were involved in that?

DR LYONS: Yes, I was, yes.

MR GLOVER: What was that process directed to --

DR LYONS: That was --

MR GLOVER: -- other than strengthening Medicare?

DR LYONS: It was established by Minister Butler and the incoming Labor government when they were elected federally to look at how supports could be provided to improve primarily general practice in the context of Medicare. It was really around what needs to be done to strengthen the Medicare support for general practice and primary care.

MR GLOVER: A report was delivered at the end of last year?

DR LYONS: That's correct.

MR GLOVER: Can we have on the screen [SCI.0001.0053.0001].

Commissioner, this isn't presently in the tender bundle. I have a hard copy here, if you wish. Otherwise we'll mop it up tomorrow in tomorrow's tender.

If we go to page 9, there are a number of recommendations throughout the report, but on page 9, there are some dealing with the connectivity and sharing of data, which was one of the matters you raised earlier, Dr Lyons. Do you see in particular point 2:

*Better connect health data across all parts of the health system ...*

DR LYONS: Yes, I do.

MR GLOVER: Do you have that?

DR LYONS: Yes.

MR GLOVER: And that's a recommendation that has been made in other reviews and inquiries over the years; is that right?

DR LYONS: Yes, that's correct.

MR GLOVER: Part of the work that has been done within NSW Health to achieve that is the single digital patient record?

DR LYONS: That's correct. So, by having one single digital patient record for the whole state, my understanding is, there are probably two, or maybe three maximum, software packages that GPs use mostly, it will allow us to develop interfaces. I think ultimately the aim is to develop interfaces with those two software packages that are used by the GPs to enable the exchange of information electronically which is currently not able to be done systematically.

MR GLOVER: It will go some way but perhaps not all of the way to meeting that second recommendation; is that right?

DR LYONS: It will go substantially to meeting that

recommendation, if we can ensure that integration occurs in a way that the information is presented meaningfully at both ends.

MR GLOVER: This issue, if I can put it that way, having been raised over a number of years, have there been any barriers to it being implemented?

DR LYONS: I think in part the barriers have been on the state side as well as the Commonwealth side, because the state's hospital medical records systems have not always - so we've had six or seven different instances of our patient record system. That means you would have to create seven or eight interfaces with the GP software just in New South Wales for that to be effective, and the consistency in how that information would be conveyed may not be there - so by having one system.

But I understand in other states, each hospital might have a different system, so the challenge of actually creating enough links between the various systems that exist to enable that to occur seamlessly nationally is a major barrier.

I think the emphasis was put into My Health Record and trying to create a repository of information that would be useful across the system, I think in its current form My Health Record hasn't delivered, because it is more a repository of PDF style - where information is uploaded, and often it isn't uploaded by everybody who is involved in the person's care, what's available is just PDFs and it's not searchable in a way that is easy to access for clinicians. They go searching for things and can't find them. So it's not helping them in the patient care. But my understanding is that the Digital Health Agency, which is a national agency that is supporting electronic information in healthcare settings, is looking at establishing a new approach to My Health Record where it will be modernised and be more fit for purpose.

Ultimately we see the benefit of actually dot point 2 being the major benefit because it will enable real-time clinical information to be shared that will help patient care at the point of care for clinicians.

MR GLOVER: And is it a costly exercise to set up these linkages?

DR LYONS: It is. The single digital patient record in New South Wales - that is a hundreds of millions of dollars investment for the state.

MR GLOVER: Is it the availability of funding being a barrier to implementing the data sharing?

DR LYONS: I think in part funding, but also the good thing about New South Wales is there has been consistency in IT systems statewide for some time. We have a common payroll system, we have common financials, we have a common procurement process through the systems that exist across the districts and HealthShare.

Moving towards a single digital patient record is a direction which has been supported by a number of those changes in New South Wales over the years. I think it's an example of the benefits of that centralisation we've been talking about versus the sort of governance. We've got the centralisation agreement around the information systems but devolved in terms of how they're used at the local level.

MR GLOVER: The single digital patient record project, is that being funded entirely by New South Wales?

DR LYONS: It has. Ms Willcox may want to comment, because I think you're chairing the steering group for it, aren't you?

MS WILLCOX: Yes. It's entirely funded by the state.

THE COMMISSIONER: Have you gone off this? Are you finished?

MR GLOVER: I will be in a moment.

THE COMMISSIONER: Sorry, are you going back to it?

MR GLOVER: No.

THE COMMISSIONER: This report was obviously drafted to be at the highest level of generality, was it?

DR LYONS: I can't comment on that, Commissioner, I didn't draft it, but it's a summary of the discussions --

THE COMMISSIONER: Read what I just said in bold. So I assume the recommendations are all to be fleshed out later, are they?

DR LYONS: The detail about how this will be implemented and the time frame over which it will be done, yes, are a subject for the Commonwealth.

THE COMMISSIONER: For example, in relation to primary care, "Recommendation":

> *Support general practice in management of complex chronic disease through blended funding models integrated with fee-for-service, with funding for longer consultations and incentives that better promote quality bundles of care for people who need it most.*

I imagine the detail of that --

DR LYONS: Are you going to ask me to explain that, Commissioner?

THE COMMISSIONER: I reckon it's pretty self-explanatory. All of these are just, as I said, incredibly general with the detail to come later; is that right?

DR LYONS: I think the detail is to be further agreed in terms of the timing and the support for that in terms of changes to investments that need to be made.

THE COMMISSIONER: I mean, recommendation: "Strengthen funding to support more affordable care" - that sounds fantastic. What does it mean?

DR LYONS: I think some of those changes have occurred. There have been changes to the incentive payments for bulk billing for certain groups. I think those things have been progressed.

Do you want to make any comments, Ms Willcox?

MS WILLCOX: I just wanted to add, Commissioner, in terms of the Commonwealth's progression of this work, they've set up some subgroups now - I am participating on one currently - that relate to dedicated bodies of work --

THE COMMISSIONER: There were only six meetings of this task force, though.

MS WILLCOX: Yes, that Dr Lyons was --

THE COMMISSIONER: So two pages per meeting to get to the 12-page report. Okay.

So you are tendering that?

MR GLOVER: Yes. I propose to do it as part of tomorrow's tender, if that's convenient.

THE COMMISSIONER: That's fine.

MR GLOVER: If we can go back to the joint report at paragraph 211, this paragraph lists a number of, as described there, "governance and funding barriers". We've touched on many of them. There are just a couple that I'd like to go to. Subparagraph (d):

*Insufficient investment in multidisciplinary care, and lack of focus on generalists, allied health and nurse practitioners and enhancing scope of practice.*

At which level of the system is that directed, or which levels, perhaps?

MS WILLCOX: I think we were focused on primary care in this context. I would have to read the preceding paragraphs, but I think our reference was as part of primary care, but I suspect relevant to our own services as well.

DR LYONS: It is. It's relevant to our own services as well as others'.

MR GLOVER: And "insufficient investment in multidisciplinary care within the NSW Health services" - what do you have in mind?

DR LYONS: I think we have examples of fantastic multidisciplinary care but there are also examples of where we can do better, particularly, I think, in the out of

hospital community space about how the care teams are organised, and there's clarity around optimising who does what to ensure that the services are appropriately accessed for patients who are receiving care in those settings.

It's also, I think, highlighting the importance of the development of roles like nurse practitioner roles. We have a number of nurse practitioner roles in the system, but there is an opportunity to think about more nurse practitioners in the settings that we operate from too, with skills that would support the delivery of health services.

MR GLOVER: Why would that be of benefit?

DR LYONS: Particularly in areas where we don't currently have doctors, for instance, who are able to do things because of issues around workforce distribution and availability and supply, so we've often got nurse practitioners in emergency department settings across the state. We've got examples of nurse practitioners with advanced skills in neonatal intensive care, that provide services for neonatal babies. We've got examples of where nurse practitioners are providing a primary care type model for communities.

There is an opportunity to expand the number of those and provide more nurse practitioners for those settings, and we certainly heard through the rural and regional health inquiry, that there was an opportunity to have more of those clinicians available in those settings and that would provide better service delivery.

MR GLOVER: Are there governance barriers to that occurring?

DR LYONS: Not so much governance barriers in our context. I think it's more around the fact that we probably haven't given enough focus to the investment in the training and skills development of those categories of staff and providing career opportunities to enable people to see the potential of going into those roles. Certainly that's become much more of a focus, we've talked about it in the last 12 months or so. We've had strong programs that maybe haven't been as advanced over the last few years, and there have been some other distractions that we're aware of, but we are reactivating those now.

MS WILLCOX: The models of care, too, have evolved where we've identified that, potentially, an allied health practitioner or a nurse practitioner may actually be the more appropriate health professional to provide that service and it doesn't necessarily have to be a medical practitioner. So some of the insufficient attention to this in part could be described as things have changed and moved along and we've seen new models of care where we can have a different emphasis.

MR GLOVER: Are there funding barriers to this development?

DR CHANT: I suppose I could, perhaps before answering that question, give you some other examples.

MR GLOVER: Yes, please.

DR CHANT: Clearly, we're also looking at the role of Aboriginal health workers, which are important, and Aboriginal health practitioners, and making sure again we've got clear role delineation, utilising those practitioners to their full scope.

We're currently looking at whether we can provide additional training so Aboriginal health practitioners can be involved in immunisation activities. There's a strategy to reach and achieve even higher coverage in Aboriginal communities.

Some of the examples that there are sometimes funding barriers but also probably an example where the Commonwealth has taken action to address this is we've recognised, and we particularly recognised through COVID, the important role that pharmacies did as complementary to the work of our primary care practitioners, our GPs in rolling out vaccines. We've known that they did perform that function for influenza, but throughout the year we've really increased the scope and scale of vaccines that are available to the pharmacists under the National Immunisation Program, which are funded vaccines from the Commonwealth.

But from the beginning of next year, 1 January, the Commonwealth has actually introduced a remuneration payment to pharmacy for the provision of the NIP vaccines. Again,

that removes a particular barrier which would be a financial barrier, and so building up immunisation services through pharmacies will complement the important role primary health care continues to play in immunisation services. But that's an example where there's a funding mechanism that has now been introduced to support that extended scope, whereas otherwise there would have been a co-contribution barrier from the patient.

MR GLOVER: And enhancing the scope - reference has been made throughout the evidence to other trials and investigations in that area?

DR CHANT: That's correct.

MR GLOVER: Subparagraph (e):

> *Inability to regulate where or how medical health specialists consultative care is provided, resulting in activity being driven to the public ... system.*

What did you mean by that?

DR LYONS: I can start off. This is an example of where we've got a maldistribution of specialists across the state. If you move outside of the metropolitan settings, the number of specialists in many communities is limited, which leads to difficulties in access, either because of geographical distances to travel, or because those specialists are so busy that the waiting times to access them are very long, or because there are significant out of pocket costs to actually see the specialist that mean that patients can't afford to access that specialist, or we've heard anecdotally that even in some situations, specialist referrals might need to be screened before they're accepted, before they'll accept a referral from a general practitioner, or where there might be a view that --

THE COMMISSIONER: Sorry, what does "screened" mean?

DR LYONS: So that rather than accept a referral, the GP will be asked to forward a referral letter to the receptionist of the specialist practice, and the specialist will review whether or not that's an appropriate patient to be seen, before the referral is accepted.

We've also heard that, in some situations, there's a question of whether or not the patient is privately insured, and if there's no private health insurance, then the patient is not able to be seen at that specialist practice either.

All of those factors, whether or not they exist - and I'm not saying they exist everywhere but they are factors that we have heard - are impacting on the ability of members of the public to access specialist care, so often that means those patients will end up in the public system on our waiting lists for our patient care or in our emergency departments.

MR GLOVER: Is the inability to regulate that's being referred to in subparagraph (e) pointing to an inability of NSW Health to influence those types of circumstances?

DR LYONS: We have no control over any of those circumstances. We are completely powerless on that and just respond to the situation.

MR GLOVER: Aside from driving demand into the public health system, are there any other impacts on the delivery of care by those circumstances?

DR CHANT: I think it's really important that when we look at disparities in access, conditions that are particularly elective - what might be seen as more elective in nature - can be amplified because access to those procedures occurs through largely a specialist system, so this just contributes to some of the inequities of access.

MR GLOVER: Finally, to paragraph 212. Dr Lyons, you, I think, referred perhaps yesterday to the development of health hubs that are referred to in this paragraph. What do you have in mind by a health hub?

DR LYONS: I think I outlined some of the concepts, which are collocation of services that the state provides with services that might be provided by other providers.

MR GLOVER: Are there examples in existence now?

DR LYONS: We have some examples. They're not widespread, and what we would like to see is building on those that currently exist, evaluating their effectiveness and making

them more systematised in terms of the delivery of those types of models. Part of it is the capital that's available to do that. We need to probably think about the types of facilities that we actually have available for people to work from and whether or not we can support more of those being delivered.

MR GLOVER: These are different to MPSs?

DR LYONS: Yes. They wouldn't have inpatient care, for instance, they would be focused on delivering care in community settings and allowing the multidisciplinary team, whether that's our teams or the teams that exist in primary care groups, diagnostics services, whether that's pathology or imaging, some specialists, allied health and medical specialists to be available in the one setting to enable that holistic care around the patient and ensuring that the patient wasn't asked to go from one place to another, to another, to another, to another to ensure that they could - you would have pharmacy services on the site as well, so you would be able to provide a one-stop shop.

What we hear from many patients is an advantage coming to an emergency department is that it is a one-stop shop. You get all those things together and if you need medications, they'll be provided to you in the acute circumstances as well. So replicating that type of model to enable people to access holistic care and be treated effectively in the one space is the sort of model we're talking about.

MR GLOVER: In terms of funding, would that be wholly funded by the state or would there be a Commonwealth contribution?

DR LYONS: Ideally there'd be a contribution from the Commonwealth as well, particularly for the services that are existing on the Commonwealth side.

MR GLOVER: Is there a barrier to, if the state was delivering general practitioner type services, receiving funding under the MBS?

DR LYONS: If we are salarying the doctors, there is section 19(2), I think, of the agreement, which says that people can't access an MBS benefit unless there's an application made and there are certain criteria that need

to be met for that to be agreed to. So salaried doctors would be an, issue. But if they're doctors who are working within the MBS arrangements they can access those payments.

MR GLOVER: There are some examples, aren't there, of those exemptions having been granted?

DR LYONS: There are. We have examples of things like the single employer model in the Murrumbidgee where that's to support general practice training and ensuring that ultimately GPs are retained within rural communities.

MR GLOVER: Just briefly describe that model.

DR LYONS: It's a model where rather than - so for most of the specialty training in our system, specialists are trained within the public health system, apart from general practice. So nearly all of the other specialties are trained within our services.

General practice is unique in that people train in general practice settings, which are outside of our responsibility. So historically we've had no responsibility after the first couple of years of graduation, and then people will choose to do general practice training.

Part of that is that they relinquish the employment arrangements they have with the system, the state, and go into an arrangement where they negotiate contracts of employment with the various supervisors in those practices.

What we heard from trainees, and the reason it drove the single employer model, was that that was a barrier for people who were just graduating and embarking on a career, that they lose the certainty of entitlements of an employment arrangement and have to go into a contracted arrangement, which is not ideal.

Having the single employer model enabled the candidates who wanted to go into that training to feel more confident about going into that training, because they knew they were in an employment arrangement that went for the length of time they would be in training, and enabled the services to support them as they went through that training and with a view that, at the end of that training, the practitioners would want to stay in those environments and

continue to work with those skills.

MR GLOVER: In addition to the training benefits, there are also the benefits in having services on the ground to be delivered to the community?

DR LYONS: Absolutely.

MR GLOVER: Is that model being expanded?

DR LYONS: Yes, through the success of that model, which emanated in the Murrumbidgee, the Commonwealth have supported that expansion, and we are looking at expanding that right across the state into the rural and regional settings across the state.

MR GLOVER: Is that another example of being able to develop this hub model of care?

DR LYONS: It's an example of innovation and developing new ways of doing things that require flexibility. Ultimately, it could lead to the development of these hubs, but it doesn't necessarily, of itself, lead to those outcomes.

MR GLOVER: Thank you. That's all I have, Commissioner.

THE COMMISSIONER: All right. Thanks. Did you want to ask anything, Mr Cheney?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you all very much for your time over the last two days. It is greatly appreciated. Thanks.

We adjourn until 10 o'clock tomorrow?

MR GLOVER: 10 o'clock tomorrow.

THE COMMISSIONER: All right. We will adjourn until then.

**AT 2.27PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 30 NOVEMBER 2023 AT 10AM**

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