

**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)

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

1 THE COMMISSIONER: Yes, Mr Glover.

2

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

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

13

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

15

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

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

19

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

23

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

28

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

35

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

38

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

42

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

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

3
4 We have a number of programs across the state.
5 There's a myriad of initiatives. We focus very much too on
6 the ageing and frailty, attending to issues that may lead
7 people to fall, so falls programs are a very common
8 preventative program across the state. Exercise routines
9 such as Tai Chi, for instance, are very popular in our
10 older communities in terms of keeping people strong and
11 balanced and well and avoiding injury from fall or frailty.

12
13 The ability to improve our interaction with patients
14 in more opportunistic ways across the system - so, for
15 instance, if a patient is coming in for surgery, they would
16 routinely go to a preadmission clinic. There would be
17 chest x-ray, perhaps, and bloods taken, but there might be
18 discussions around weight, smoking, mobility - anything
19 that can be done to contribute to a better outcome for that
20 surgery, for instance.

21
22 I think one of the things Dr Chant would probably want
23 to add to the discussion today is just how we increase that
24 opportunistic - I don't mean that in a pejorative sense,
25 but in a positive sense - how wherever we interface with
26 patients and consumers we can be contributing to some of
27 the preventative health opportunities that we can support
28 them with, and that they can actually do self-managed
29 preventative care is a very positive option. Not everybody
30 needs a program or a clinician to support them.

31
32 MR GLOVER: Just before I go to Dr Chant for that purpose,
33 you mentioned, as it is set out in the submission and in
34 the report, that it is a joint responsibility across
35 governments. How is that joint responsibility being
36 delivered at the moment?

37
38 MS WILLCOX: There is a National Preventative Health
39 Strategy, a 10-year strategy that the Commonwealth produced
40 along with the states, which guides some of the
41 population/nationwide preventative health measures that are
42 important to the wellbeing of the community.

43
44 I think I would probably now throw to Dr Chant to talk
45 in detail. It is really in her bailiwick, thank you.

46
47 DR CHANT: Thanks you very much for the question. Perhaps

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

8
9 If we have walkable parks that are safe, well lit, we
10 reduce social isolation, promote physical activity. So the
11 environments in which we live can shape, can be a positive
12 factor that can support people to adopt those healthy
13 behaviours and lifestyles.

14
15 Government also has a key role in regulation, so
16 setting things like tobacco regulation. We've heard
17 recently Minister Butler that has announced the
18 Commonwealth reforms in e-cigarettes. So regulation is
19 also a whole of government initiative and those things can
20 enable a health-promoting environment in which we live.

21
22 In terms of primary care - this goes to the joint
23 responsibility across governments - primary care is an
24 important setting for prevention. Things like the regular
25 health checks, skin checks, cancer screening, all of those
26 things are important, as well as regular blood pressure
27 checks, management of high cholesterol.

28
29 These are preventable risk factors that can be
30 modified by, in some cases, advice around healthy diet,
31 maintaining healthy weight, physical activity, as well as,
32 in some cases, it may require medication or more formal
33 treatment. So that's again a pivotal role of general
34 practice.

35
36 We then perhaps can categorise a set of conditions
37 whereby they're more likely to be secondary prevention, so
38 people already have disease, but we know that even smoking
39 reduction in someone that already has lung disease can slow
40 progression, or heart disease, quitting smoking can
41 actually improve outcomes quite radically. So this would
42 be, for instance, things that primary care would do, but
43 that also may occur in our system where people are touching
44 our system, be it for cancer diagnosis, heart diagnosis,
45 lung diagnosis, those conversations around smoking
46 cessation and supporting people to quit smoking.

47

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

6
7 MR GLOVER: I'm sorry to cut you off, just from that
8 answer, do I understand it that primary care is
9 a significant deliverer, if I could put it that way, of
10 preventative health?

11
12 DR CHANT: Yes. Primary care is the first port of call
13 who would do the majority of the clinical preventative
14 care, as I have described that more whole of government
15 prevention sort of setting, but in terms of clinical
16 engagement around primary/secondary prevention, clearly
17 primary health care is very heavy lifter in that space

18
19 MR GLOVER: Although when people come into hospital, there
20 are other opportunities to deliver preventative health
21 measures to improve their overall health and outcomes.

22
23 DR CHANT: That's correct, and for some of our services
24 also we provide access to those that may not be connected
25 to primary care. We talked earlier yesterday about some of
26 the barriers to accessing primary care, be they
27 rural/regional and distribution of general practice, all
28 the way through to the fact that the client may not have
29 financial means, transport.

30
31 So our services provide an opportunity for engagement
32 in that broader health promotion, with the aim ideally to
33 connect them back to a primary care setting, but in the
34 meantime, it presents opportunities for us to look at
35 tobacco cessation, we may look at other screening, and
36 addressing immediate - whilst we're addressing other health
37 concerns of the individual, it's an opportunity for us to
38 do other preventative care, including things like
39 immunisation as well.

40
41 MR GLOVER: How well is primary care delivering those
42 preventative health services?

43
44 DR CHANT: I think primary care is doing a lot of the
45 heavy lifting. I would just like to say, if we look at our
46 vaccination coverage for our under 5s, which I described
47 yesterday, we have around 95 per cent immunisation coverage

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

3
4 So general practice is obviously doing a lot of the
5 heavy lifting in this respect. You may hear from them
6 about whether the funding adequately supports the focus on
7 prevention, whether the funding supports the full scope of
8 other multidisciplinary practitioners in their practice
9 taking their full scope - for instance, things like nurses
10 being able to claim potentially Medicare benefits for the
11 immunisation independently would be an example where that
12 scope might be considered safe and appropriate. So there
13 might be other roles that could be done in a broader
14 multidisciplinary team. I think you'll hear some of those
15 comments if you engage with the primary care practitioners.

16
17 THE COMMISSIONER: The MBS items and the fee for service
18 that have been direct or created to provide pathways for
19 preventative health like the GP management plans and things
20 of that nature - are you aware of published evaluations
21 about those, about what the outcomes have been from those
22 changes to the MBS over the last 20-odd years?

23
24 DR CHANT: I think we could provide some evidence perhaps
25 around some of the health-screening items more in the
26 Aboriginal health - the introduction of the 715 health
27 screening, and some of the evaluations.

28
29 DR LYONS: To answer your question, Commissioner, I'm not
30 aware of any evaluation around those particular changes to
31 the MBS that you referred to, and that's something we could
32 investigate further.

33
34 THE COMMISSIONER: You read many reviews, including from
35 the Productivity Commission, which will analyse or provide
36 opinions regarding ABF and fee for service and say neither
37 really promotes preventative health measures. Then
38 I think, or imagine, to address that, items have gone on
39 the MBS - you know, like the management plans I mentioned.
40 I either haven't found or haven't had brought to my
41 attention how effective these things are. Bearing in mind,
42 I think, the reports also say that for any preventative
43 health measure, getting the evidence is difficult, partly
44 because it is such long term.

45
46 DR LYONS: That is an ongoing challenge. I think if you
47 look at these things in totality, episodic care, such as

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

10
11 I think we need to look at these things in the context
12 of the health promotion activities that we can do for a
13 community at population health level, which carry very much
14 a primary prevention, and then there's the secondary
15 prevention in which we all have a very big part to play.
16 Secondary prevention is very much where we believe our
17 services should focus their activities certainly in the
18 acute settings at least.

19
20 THE COMMISSIONER: Thanks.

21
22 MR GLOVER: Picking up on one of the Commissioner's
23 questions, I take it that some preventative health
24 activities take a long time to see the benefit in the
25 system; would that be right?

26
27 DR CHANT: Some do but some don't.

28
29 MR GLOVER: Are there some examples of more immediate
30 results?

31
32 DR CHANT: Yes. For instance, we know that the role of
33 primary care, particularly in STI screening, is probably
34 a very classic example, where diagnosing sexually
35 transmitted infections and effectively treating those,
36 where there is an effective treatment. That is a classic
37 example.

38
39 Vaccination, where we know that if you vaccinated for
40 the flu season, you're going to reduce your admissions to
41 hospital for those that have been identified as requiring
42 the vaccination. So there's a clear link.

43
44 Tobacco cessation, as I said, although it provides
45 a longer term, we know that even stopping tobacco smoking
46 prior to surgery will improve your postoperative recovery.
47 So for many things, it can be quite short term.

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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 we've 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

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

6
7 DR LYONS: There are those specific programs. But then
8 the other components would be included in the care
9 activities that are occurring that would be funded through
10 activity. There is not a specific component of that that
11 I am aware of that relates to prevention; it is considered
12 to be in the totality of that care and funded through those
13 activity arrangements.

14
15 DR CHANT: In relation to some of the state funding
16 programs, there is funding, as Ms Willcox said, for some
17 programs in the childhood space. We work in partnership
18 with education, but we do a lot of work in early childhood
19 settings. A program called Munch & Move which again is
20 trying to educate and support healthier eating and physical
21 activity that's appropriate in that setting.

22
23 We also work in partnership with schools. We do work
24 with curriculum in schools to support education incorporate
25 health in all its dimensions and, most recently, we've been
26 doing some work to embed, for instance, e-cigarettes, in
27 age-appropriate guidance on e-cigarettes within the health
28 curriculum in schools.

29
30 So they're just examples of state funded programs that
31 really address this work. We've also done some work around
32 healthy canteens in schools and supported education in
33 that. Again, a lot of those have been programs that have
34 been supported by whole of government approach. There has
35 been a recognition around the focus on young children and
36 recognition that some of the trajectory for the risk
37 factors of being above a healthy weight and not physically
38 active are set very early. So again, it supports the work
39 in this early intervention space particularly for families.

40
41 THE COMMISSIONER: Can I just ask a question I should know
42 the answer to but I don't, so I have to ask the question.
43 In the Productivity Commission's "Shifting the Dial" review
44 back in August 2017, when it was dealing with the issue of
45 the topic of changes to hospital funding, in relation to
46 activity based funding, it said this:

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

8
9 It said:

10
11 *One way of formalising a new approach*
12 *would be to establish a Prevention and*
13 *Chronic Condition Prevention and Management*
14 *Fund ... in each local health district with*
15 *both the Australian Government and ...*
16 *state governments [contributing].*

17
18 Did that happen?

19
20 DR LYONS: Not to my knowledge.

21
22 THE COMMISSIONER: Can I also ask this, just while we're
23 on this topic. Again, I don't know the answer to this but
24 I probably should. I'm sure you would be aware, there was
25 a Queensland review a few years back, it must have been
26 right in the middle of the pandemic, "Unleashing the
27 potential: an open and equitable health system". Are you
28 aware of that review?

29
30 DR LYONS: Not the detail of it, Commissioner

31
32 THE COMMISSIONER: It was published in August 2020, so it
33 was right in the middle of the pandemic. But one of the
34 recommendations was to amend what would be the equivalent
35 of our Health Services Act to add prevention and population
36 health as activities and responsibilities for the LHDs, our
37 equivalent of LHDs. I know it's not in the Act but is that
38 incorporated in the service agreements?

39
40 DR LYONS: It has always been - I won't talk to the
41 details, but --

42
43 THE COMMISSIONER: It might depend on how you read the
44 functions under the Act as to whether it's incorporated
45 already.

46
47 DR LYONS: Yes. Certainly it's a component of the

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

5

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

8

9 DR LYONS: Absolutely.

10

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

13

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

18

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

22

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

25

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

29

30 Are they currently?

31

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

39

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

44

45 DR CHANT: That's correct.

46

47 THE COMMISSIONER: And not great for people, either.

1
2 DR CHANT: And not great, yes, that's right. So I think
3 what we would really want to look at is making sure that
4 people had lived very healthy lives into age, but healthy,
5 active lives that were mentally challenging and socially
6 inclusive.

7
8 So whilst I comment on length of life, I suppose I can
9 give you a whole range of metrics that we actually do well
10 in - disability adjusted life years lost, all of those
11 metrics. I think we need to position Australia as well -
12 we have adopted a lot of prevention screening programs, we
13 have rolled out a lot of vaccines, we have had a lot of
14 access to those things.

15
16 Do we need to do more? I would say yes. Do we need
17 to align - I suppose we need to think about the challenges
18 that are laid out by the way the burden of disease has
19 changed and we need to pivot and evolve our funding systems
20 and our systems to deal with the challenges facing us. But
21 it's not only a health issue. I hope you've heard from the
22 testimony we've given that, really, this is a whole of
23 government issue and it cuts across multiple levels of
24 government.

25
26 DR LYONS: Just to use a single example which I think is
27 illustrative. If we had people that were all a healthy
28 weight, we would hugely reduce the burden of both
29 osteoarthritis and musculoskeletal conditions, and that
30 leads to joint replacement surgeries, which have a huge
31 impact; and also diabetes, which has huge implications for
32 the costs of delivering health care and implications for
33 people in terms of living healthy lives. Just that one
34 change alone - and it would have other flow-on effects to
35 other conditions as well.

36
37 DR CHANT: Cancer, cardiovascular disease.

38
39 DR LYONS: Cancer and a lot of other things. But that is
40 one example that that is not just a health issue, that's
41 a whole of society issue.

42
43 THE COMMISSIONER: Can I just ask two things that flow
44 from that. One, I fully accept that best preventative
45 health measures, plans, programs, aren't defined
46 necessarily by how much money is spent on them, it's how
47 well they are designed and then implemented, because it's

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

11
12 DR CHANT: There are definitions that are meant to capture
13 it, but it's actually very difficult to do so, and there
14 has to be caution applied in any comparisons. I'll give
15 you an example.

16
17 In New South Wales, we have reasonably high levels of
18 water fluoridation which prevents dental caries, which
19 prevents other issues. That is funded and supported, local
20 councils do that, and there is a subsidy provided by
21 government to councils for the renewal of the plants and we
22 support local councils to implement that. That would be
23 different in other states and territories. I have talked
24 about some of the --

25
26 THE COMMISSIONER: That's an example of preventative
27 health, though, where the population or the people don't
28 have to do anything because it's in the water.

29
30 DR LYONS: Yes.

31
32 DR CHANT: But there are costs. There are cost associated
33 with renewal of the infrastructure and supporting the
34 councils with that, so that's a choice with that.
35 I suppose my point was the boundaries of how you capture it
36 and define it are very challenging and various estimates
37 are there.

38
39 Another example, for instance, is there's good
40 evidence around brief interventions for tobacco and, as
41 I said, how do we capture everything, every time our
42 doctors, interns, residents are doing that? But there's
43 really good evidence and it only needs to be a one-minute
44 line to reinforce the importance and then the GP following
45 up.

46
47 THE COMMISSIONER: Tobacco is an example where someone

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

11
12 DR CHANT: Issues, yes.

13
14 THE COMMISSIONER: -- different health conditions. I was
15 reading the other day that in the last - it might only be
16 since 1992, maybe, Britain has had 20 or more obesity
17 plans. But that's where whole of government is important
18 because it's one thing for NSW Health to develop a plan,
19 but if people are inundated with advertising for processed
20 foods and sugary drinks, it's very difficult for health to
21 get much traction in a prevention plan. Is that
22 a reasonable observation?

23
24 MS WILLCOX: Yes. I think it goes to a number of the
25 things that Dr Chant talked about yesterday and touched on
26 this morning around - urban planning is a very important
27 area. I know that Dr Chant will talk to this but the NSW
28 Food Authority and labelling of foods and enabling people
29 to make the right choices when they go into a supermarket
30 is not necessarily that easy, the way labelling is done and
31 I know there is work with the Food Authority.

32
33 DR CHANT: And health ministers. So I think tackling
34 people being above healthy weight is a major issue for us,
35 and also getting people physically active as well. So we
36 want to also focus on the multiple risk factors. As I've
37 defined, there's a lot of enablers for that which sit
38 outside government.

39
40 But health has a key role in advocacy or presenting
41 the evidence or working with its partners, and there has
42 actually been a lot of work on obesity, particularly
43 childhood obesity, in New South Wales. We've rolled out
44 height and weight measures and linkage to care. We've got
45 programs that I've articulated.

46
47 We've got a program in maternity services called "Get

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

11
12 THE COMMISSIONER: And it's also a preventative health
13 measure, without needing to go into the details, I think,
14 where there's opposition because of commercial interests,
15 or retail --

16
17 DR CHANT: There are particular views around that, but
18 I hope that you've taken it from our perspective that we
19 believe that individuals and communities need to be
20 supported with enabling environment and recognise that
21 there are barriers for people to take up the behaviour. So
22 it's not around making it an issue for the individual; it's
23 really seeing it as a community and a place-based and whole
24 of government response.

25
26 MR GLOVER: Just in paragraph 175:

27
28 *Low proportional investment in preventive*
29 *health, the wider determinants of health*
30 *and increasing burden of chronic disease*
31 *has led to increased spending on*
32 *treatments to manage conditions that could*
33 *be prevented ...*

34
35 et cetera. By that, do we understand that historically,
36 the focus on those things hasn't been as you would want it,
37 as of now?

38
39 DR LYONS: Our system has been responding to the demand it
40 sees in treating patients who are unwell. That has been
41 the focus of hospitals and the local health district
42 service over many years, and that increasing demand we're
43 seeing means that to respond to it increasingly we're
44 putting resources into those emergency departments,
45 hospitalisations, surgeries that people need, to make sure
46 we can treat people.

47

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

9
10 MR GLOVER: Are there challenges in making that shift
11 whilst also catering to the current demands on the public
12 health system?

13
14 DR LYONS: Absolutely. That's the challenge we're
15 highlighting and the need for a refocusing. I mean, we
16 shouldn't be taking away from those really important
17 services we provide around treating people with disease.
18 We do it very well. We need to keep that focus, but we
19 need to proportionally spend more on the prevention side.

20
21 MS WILLCOX: It's probably why - it is not "probably", it
22 is why you've seen and heard from, I'm sure, many people,
23 including us, about the work around integrated care, caring
24 for chronic and complex patients and how we try and keep
25 people out of hospital and support them in the home. We
26 have made a significant shift.

27
28 Integrated care activities such as Dr Lyons referred
29 to, with people that might require a knee replacement, with
30 osteoarthritis, can now go to a clinic and with an exercise
31 regime and often weight support, can avoid actually having
32 knee surgery and we can take people off the wait list for
33 surgery.

34
35 So the system has been innovative in terms of
36 identifying different pathways to provide care and to try
37 to mitigate the risk of somebody ending up in hospital with
38 a chronic and complex condition that could be managed in
39 the home or in a community-based setting. So it has been
40 the driver for much of this work.

41
42 MR GLOVER: This integration that you speak of is not just
43 within the public hospital network but across primary care
44 settings as well, is it?

45
46 DR CHANT: That's correct. It's very important that,
47 regardless of the two levels of government that are

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

10
11 DR LYONS: We have signalled this direction through
12 a number of changes we have made, and one of them was
13 mentioned yesterday - the agreement we've reached with the
14 primary health networks across the state.

15
16 Historically, we've run parallel systems almost and
17 where patients get referred between them, and what we're
18 saying is we need to turn that around to have a one system
19 mindset, that we're the one health system, no matter where
20 people are in it, they are supported with information, with
21 a range of activities that will enable them to receive
22 optimal care in any of those settings, but it's joined up.
23 That has been the challenge up until now and we need to
24 refocus what we do, but we need other parts of the system
25 to change as well.

26
27 DR CHANT: I'd just like to comment, so that's the sort of
28 general approach, but there are then some services that we
29 run in the health system that see very vulnerable groups of
30 patients, where it's actually taken quite a lot of time to
31 build trust for them to come and access our services. That
32 creates an incredible opportunity for us to have that
33 broader discussion. So they may be coming in to us with
34 drug and alcohol or mental health issues, but that gives us
35 an opportunity, as we're addressing the drug and alcohol
36 concerns, to actually screen them for other things, offer
37 them vaccination, potentially address their broader health
38 issues, all the time looking at transference to a primary
39 care practitioner. But for a period of time, due to that
40 fact that they may have faced stigma and discrimination,
41 they may have felt very uncomfortable attending the primary
42 care. It will need a bit more intensive work for us to
43 support them where we might be providing services which are
44 more in the primary care domain for a discrete group of
45 individuals as we transition them and then link them in to
46 primary care.

47

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

5

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

9

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

22

23 DR CHANT: Professional, yes.

24

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

29

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

43

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

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

3

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

13

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

20

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

29

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

31

32 MR GLOVER: We hear that a lot.

33

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

38

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

1
2 We've learnt a lot about how we can deliver care in
3 different ways, but some of the key components would be
4 increasing the scope and fully utilising the scope of other
5 health practitioners. We've also been doing some work with
6 pharmacists in some areas, looking at their scope. Often
7 there's a pharmacy in some of the smaller towns, and again
8 how we can network --

9
10 THE COMMISSIONER: There is a trial on now, which might be
11 expanded, and Queensland's got the --

12
13 DR CHANT: Yes, that's right. There is a trial of UTI
14 that we're rolling out, and oral contraceptive pill, and
15 we're going to be doing skin conditions. That's under
16 a clinical trial framework, we'll get some good
17 intelligence. But when I'm out and about, many of the
18 community really do often access some advice from
19 pharmacists as a first port of call. So I think we're also
20 working with them, notwithstanding the trial, on support
21 for some of those other evidence-based prompts around
22 patients that might be coming in with a pregnancy test.
23 Are they advising them about the need for folate, folic
24 acid and iodine supplementation at that time, or people
25 might be raising the fact that they're wanting a family,
26 perhaps linking them again to some of the preconception
27 health advice, so basically supporting them in that more
28 holistic role.

29
30 THE COMMISSIONER: Just on the pharmacy trial that's
31 current here and the slightly more expanded one in
32 Queensland, which I think is UTI, contraceptive pill and
33 mild skin conditions, is there much resistance to that from
34 any parts of the health network? If I could go to the
35 pharmacist to get a prescription medicine for psoriasis, is
36 there push-back to that?

37
38 DR CHANT: I think it's important that we choose
39 conditions that align with the scope of practice of the
40 pharmacist. Some of the concern - I would like to
41 say I would --

42
43 THE COMMISSIONER: "Skin condition" wouldn't be a nasty
44 looking mole.

45
46 DR CHANT: So, for instance, my team, is responsible for
47 rolling out and working in partnership, we've procured the

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

9
10 So in implementing it, we're very cautious of having
11 a broad range of stakeholders support the clinical
12 protocol, agree when the touchpoints are for referral to
13 the general practitioner, require that there's
14 communication between the pharmacist and the GP as part of
15 agreement to the trial conditions, and then I'm hoping --

16
17 THE COMMISSIONER: Because we don't want people to keep
18 going back for antibiotics to deal with a UTI, which would
19 be risky.

20
21 DR CHANT: Which would be problematic. We don't want
22 people that perhaps have underlying medical conditions,
23 like diabetes or other conditions, not to get picked up
24 through that process. So I think it is around looking at
25 those things that general pharmacists would reasonably
26 have, but there's also an important role of pharmacists
27 themselves in providing advice.

28
29 Many people with a skin rash would go into
30 a pharmacist and say what can they do. They can already
31 prescribe - they can already dispense some over the counter
32 medications. So this is looking at where the scope can
33 safely be extended, and we've had very good support as
34 we've worked it through step by step, thinking about those
35 issues, but making sure we manage clinical risks, but we
36 also make sure there is good strong integration.

37
38 THE COMMISSIONER: Sure.

39
40 MR GLOVER: Dr Lyons, you mentioned in an earlier answer
41 the role of the primary health networks in this integration
42 model. How effective has that been?

43
44 DR LYONS: I think we've established good relationships at
45 the state level with all of the PHNs and we have regular
46 interaction with them, and I think as a state, we've been
47 very committed to ensuring we've got solid relationships

1 with the PHNs at our level, at the state level, as well as,
2 very importantly, a strong relationship at the local level
3 with the local health districts.
4

5 There are always examples of places that are doing
6 really well and they've got the activities that are very
7 impressive and might be a little ahead of game, and others
8 that may be not as advanced, and you'll see that variation
9 across the PHNs. But as a general rule we are very
10 committed to ensuring that those relationships are the
11 foundation on the connections and integration.
12

13 The important component from our point of view is
14 reach to general practice, though. I think the thing that
15 we are challenged by is that not all GPs relate to the
16 primary health networks, and so we need to work at two
17 levels in the state.
18

19 We are working very closely with the PHNs and
20 committed to it, but if you use the example of Lumos, we've
21 actually had to go to the general practices as well to get
22 agreement to link up their data systems. So I think that's
23 the challenge we face, but we're committed to ensuring that
24 we create those connections so that we use the existing
25 mechanisms to drive hard on that collaborative work and
26 highly integrated service delivery at the local level.
27

28 MR GLOVER: One of the points you made yesterday was that
29 there had been an observed increase in people presenting to
30 hospital that otherwise might be managed in the primary
31 care setting; correct?
32

33 DR LYONS: That's correct.
34

35 MR GLOVER: Has the ministry done any work to identify why
36 that has occurred over time?
37

38 DR LYONS: Well, it's quite obvious to us in certain
39 places, because there are no GPs in some of the communities
40 that we're providing services in, where there used to be,
41 and so when people don't have a GP resident in their local
42 community anymore, they are using our services for primary
43 care. So there are examples of where there are no GPs,
44 where there used to be or where there are fewer GPs, where
45 there used to be.
46

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

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

5

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

11

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

16

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

19

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

22

23 MR GLOVER: No, that's okay.

24

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

31

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

37

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

41

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

47

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

11
12 MR GLOVER: What's an example of such a program?

13
14 DR LYONS: We talked yesterday about the collaborative
15 commissioning work, and you might want to expand on that?

16
17 MS WILLCOX: Thank you, Dr Lyons. The collaborative
18 commissioning model is one - I'll give a particular
19 example, which is assisted by the fact that the boundaries
20 for the primary health network are the same as the local
21 health district. The majority are, but not all are, so
22 it's certainly helpful when they do align.

23
24 MR GLOVER: That wasn't always the case, was it?

25
26 MS WILLCOX: I think there is just one LHD.

27
28 DR LYONS: Pretty much in New South Wales, they're very
29 close. I think Central Coast and Hunter New England have
30 one primary care that goes across the two local health
31 districts, but most of the others align pretty closely.

32
33 MS WILLCOX: Which certainly helps in terms of building
34 relationship and communication. The collaborative
35 commissioning work that was undertaken in Northern Sydney
36 and with the Northern Sydney Primary Health Network was
37 looking at frailty and looking at patients who were having
38 frequent presentations to the emergency department,
39 understanding what their background conditions were,
40 leading to and connecting with general practice to try and
41 optimise the care of those people in general practice so
42 they would avoid relapsing and arriving in the emergency
43 department.

44
45 If you looked at a triangle or pyramid of those
46 people, unfortunately, those individuals that had the most
47 frequent presentations to the emergency department tended

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

10
11 But that was funding thorough the PHN with the local
12 health district, quite a long lead time to do this work,
13 understanding the cohorts of patients, getting the right
14 data and then making those very individual engagements with
15 primary care and general practice to see what we could do
16 to avoid their patients coming into our emergency
17 departments.

18
19 THE COMMISSIONER: Just to give it a label, is this part
20 of the framework for integrated care of NSW Health, or am
21 I thinking of something else?

22
23 MS WILLCOX: Collaborative commissioning is a form of
24 integrated care. Yes, I'm not quite sure - does it sit
25 specifically under the integrated care banner?

26
27 DR LYONS: So the framework for integrated care is
28 a framework that drives the notion and activities around
29 integration. Collaborative commissioning is a particular
30 program that is investing in those integration activities,
31 if that explains it, Commissioner.

32
33 MS WILLCOX: So, yes, the integrated care principles are
34 used in collaborative commissioning to ensure people can
35 move between the two and have joined-up care and avoid
36 attendance to emergency departments.

37
38 There are other ones in Western Sydney, ones in
39 cardiology.

40
41 THE COMMISSIONER: That was what I had in mind.
42 I remembered vaguely, I think, Western Sydney, the
43 specialists in the hospital having a relationship with the
44 GPs outside, but, of course, it wasn't picked up by
45 activity based funding so it had to be funded elsewhere.
46 Is that what you were --
47

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

2

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

5

6 DR LYONS: Correct.

7

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

12

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

19

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

25

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

35

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

47

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

9
10 MR GLOVER: What effect does that have on that facility?

11
12 DR LYONS: It's a huge issue because the flow of patients
13 through our hospitals is dependent on beds being freed up,
14 and every bed that's blocked stops the ability to admit
15 somebody from an emergency department into an inpatient
16 bed. If that occurs for any length of time - I think we've
17 had examples of 250, 300 patients across the state and then
18 another couple of hundred patients who are NDIS clients who
19 are ready for discharge and not able to be cared for in the
20 community. So between the two groups, up to 500 people at
21 a time in our hospitals who are not able to be discharged,
22 which has a huge impact on the hospital system's ability to
23 respond to people who need to be admitted.

24
25 MS WILLCOX: If I could just add to that, I think at
26 15 November there were just over 400 elderly people who
27 were assessed and ready for placement. We use the analogy
28 that that's more than Prince of Wales Hospital in its
29 entirety who would be caring for these individuals.

30
31 I think the important thing also to add to this is
32 that, yes, certainly Dr Lyons is right, there's a flow
33 issue we have in emergency departments in planned surgery.
34 But the impact on these elderly people while they await
35 placement is significant. Frailty occurs very quickly.
36 Being immobile for a couple of days in a chair, not having
37 the sort of recreational activities and the socialisation
38 that an aged care facility can provide really does set back
39 these elderly people.

40
41 So there are the two elements to that. I do want to
42 acknowledge, we're working very hard with the Commonwealth
43 around this and with the aged care sector. There is
44 definitely market failure in the sector and, as Dr Lyons
45 said, we absolutely support the increased capability of the
46 residential aged care workforce and all of the other things
47 that the Royal Commission provided.

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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.

1
2 DR CHANT: Can I add in the less acute areas it also plays
3 out. For instance in our sexual health clinics, we would
4 see that the majority of patients would get their sexual
5 health screening, testing and support within a primary care
6 practitioner setting, but if our services are inundated,
7 that doesn't allow us to do our work, which is probably in
8 the more complex patients that require that more
9 multidisciplinary team to care for them. So again, it's
10 this tension about access to primary care, which is
11 a critical importance, but it plays out at all levels in
12 our system.

13
14 MR GLOVER: I want to come to question 5 of the report,
15 which deals with the burden of disease, which ties in to
16 some of the issues we have been talking about, about
17 preventative care. In that section - I think this is your
18 section, Dr Chant --

19
20 DR CHANT: Yes, it is.

21
22 MR GLOVER: -- Ms Willcox can take a break - you set out
23 how it has changed, but just in general terms, has the
24 change that you describe in this section of the report been
25 coming for some time?

26
27 DR CHANT: Clearly demographic change or the change in the
28 age structure of the population takes time. We've also
29 reflected on the increasing ethnic diversity of our
30 populations. These were predictable, but clearly it's
31 taken time for this to impact.

32
33 MR GLOVER: By that, you mean it may have been predicted
34 that, as we live longer, people would get older, but how
35 that would affect the system is being seen in more recent
36 times?

37
38 DR CHANT: I think you'll find that there are many
39 economic analyses at the Commonwealth level around the
40 impact of the ageing population and the challenge and the
41 demographic shifts and what it means for our working
42 population.

43
44 DR LYONS: I think there is no doubt that in the early
45 status, the projections of the health care utilisation of
46 people once they get into their late 70s, 80s, and 90s now,
47 was significantly underestimated because we projected

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

9

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

14

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

18

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

21

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

28

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

35

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

40

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

45

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

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

6
7 MR GLOVER: So this is a category of condition that is not
8 immediately life threatening but will affect a large cohort
9 of the population over a number of years in their later
10 lives?

11
12 DR CHANT: That's correct. I suppose, just looking back
13 to the previous prevention conversation, we know that risk
14 factors such as tobacco, alcohol, lack of physical activity
15 and being above a healthy weight all predispose to multiple
16 chronic diseases including cancer.

17
18 MR GLOVER: What challenges does that present to the
19 public health system going forward?

20
21 DR CHANT: I think we have reflected on the focus on
22 prevention. I think we would all, along this table, aspire
23 to the fact that we would want a healthy ageing population.
24 We would want a population that is free of disability, as
25 it ages. We all have to die of something, but we would
26 like there to be a very short interval between when we had
27 a very long disease-free interval and probably a very
28 peaceful death.

29
30 DR LYONS: The other challenge it creates is in terms of
31 service delivery. I think we were very organised around
32 the specific diseases and systems, so our specialties are
33 all focused on those, and in the past we've been very
34 successful in dealing with and keeping people alive from
35 those conditions. If you just use the example of
36 cardiovascular disease and deaths from acute myocardial
37 infarction, ischaemic heart disease, the change has been
38 dramatic. The improvement is amazing. People don't die,
39 as they used to, from those conditions, so people are
40 staying alive longer.

41
42 Because they've got multiple conditions which go
43 across a number of different systems, organ systems, and
44 our specialties are organised around those organ systems,
45 it means that we need to have a range of different teams
46 involved. You've got your stroke teams, you've got your
47 heart teams, you've got your gastrointestinal teams. So

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

5

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

7

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

10

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

25

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

30

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

40

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

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

12
13 DR CHANT: I would also be interested to hear Nigel's
14 perspective on this, but our geriatricians are probably the
15 integrators in the hospital system, and the question for us
16 is, what's the proportion of investment in that integrator
17 versus the specialty stream? I think there are some
18 interesting aspects there.

19
20 DR LYONS: There is no doubt, there has been increasing
21 investment in aged care and geriatrics in our acute
22 settings. There has been a need for that. They are the
23 people who look at the whole person in an aged care sense.

24
25 The sub-specialties are really important as well, but
26 we need to have within our service system people who have
27 the care of the whole patient, particularly the
28 frail/elderly. So that focus on aged care, acute
29 geriatrics, but having that shared into a community setting
30 and the integration with GPs and primary care, is probably
31 the key piece that we need to see more of.

32
33 And valuing the role of the general practitioner and
34 the primary care team, that it needs to be a team, as we've
35 talked about, a multidisciplinary team, and having them
36 closely working alongside our services is where we need to
37 go.

38
39 MR GLOVER: Is the role of the primary care physician in
40 that scenario important, because I imagine it might be
41 quite difficult for a patient with a chronic condition to
42 navigate themselves through a variety of specialties and
43 treatments over the course of their illness?

44
45 DR LYONS: That's absolutely correct. Some of our primary
46 care doctors struggle with navigating our system as well.
47 Part of what needs to change is we need to make it easier

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

17
18 If there's a need for a conversation to support the
19 care of that person in the primary care setting, how can
20 the specialist be remunerated for that appropriately to
21 reflect that work? I think these are the things that we
22 need to see a shift in to make sure we can see that change
23 occur, and it needs to happen, because it's the only way
24 we're going to meet the demands and meet the care needs of
25 these patients into the future.

26
27 MR GLOVER: Building on from that last portion of your
28 answer, is it anticipated that, as the population continues
29 to age and people live longer, there will be greater demand
30 for services from those with these chronic conditions?

31
32 DR CHANT: Yes.

33
34 DR LYONS: On our current trajectory, yes, which is why we
35 need to start to shift the focus to say what can we treat
36 more effectively earlier which doesn't then require an
37 admission to hospital? What can we prevent happening in
38 the first place through the prevention measures we've
39 talked about? So that's the shift. At the moment we're
40 geared around responding to the diseases and the acute
41 conditions exacerbating through our hospitals. We've got
42 to shift that focus.

43
44 DR CHANT: The risk is also that if we as a society across
45 government don't address some of those risk factors such as
46 an increasing population above a healthy weight, people
47 being physically inactive, the age of the chronic disease

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

6

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

12

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

16

17 DR LYONS: Absolutely.

18

19 MS WILLCOX: Yes.

20

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

26

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

29

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

43

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

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

5

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

8

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

11

12 There is the glossy cover --

13

14 DR LYONS: Yes, very familiar.

15

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

18

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

25

26 DR LYONS: Yes.

27

28 MS WILLCOX: Yes.

29

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

36

37 MR GLOVER: Just going down the first paragraph and the
38 three dot points, this is a high-level summary of the
39 NSW Health budget, currently, 85 per cent concentrated in
40 hospitals. Prevention and promotion currently account for
41 10 per cent. What's within prevention and promotion in
42 that paragraph?

43

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

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

3
4 That estimate would have been derived using one of the
5 definitions, I haven't got it in front of me but, as
6 I said, those percentages can be contested depending on the
7 definitions you use, because, as we described, prevention
8 can be a component of every healthcare delivery, all the
9 way through the programmatic areas that I have described.

10
11 MR GLOVER: There is not a universal agreement on what
12 "prevention" means; is that right?

13
14 MS WILLCOX: Yes.

15
16 MR GLOVER: What about promotion? We spoke a lot about
17 prevention earlier today. What does "promotion" mean?

18
19 DR CHANT: We would say that promotion is one form of
20 prevention. So it's under the umbrella of that. What
21 I suppose that is calling out more is that primary
22 prevention or working with partners to promote the work we
23 do in schools and child care, the work we do with working
24 with local government, work we do working across
25 government. That would be our promotion activities. We
26 also do a lot of campaigns. That term broadly could be
27 including some of our campaigns and our social marketing to
28 support people to adopt healthy behaviours.

29
30 MR GLOVER: Encouraging more exercise, Crunch&Sip programs
31 in primary schools?

32
33 DR CHANT: Sure.

34
35 MS WILLCOX: The local health districts have health
36 promotion units that are there to deliver on statewide
37 campaigns or more bespoke activities that meet the needs of
38 their community that they're responsible for. So things
39 around falls would probably be in all areas, so would
40 exercise and the "Munch & Move" and the "Crunch&Sip",
41 things that you've mentioned.

42
43 But there might be more particular things around men's
44 health or women's health. In our Aboriginal services that
45 are provided through our Aboriginal health unit teams,
46 men's health, you know, is a very important area and the
47 health promotion team would work with their Aboriginal

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

7
8 MR GLOVER: Dr Lyons, earlier you made reference to a need
9 to adjust or calibrate where the spend is being directed.
10 One way is to increase the size of the funding envelope,
11 but if we just assume for the moment that the envelope is
12 what it is, do I understand that passage of evidence to
13 mean there needs to be, in your view, an adjustment - less
14 of the 85 on traditional hospital models of care, more into
15 the prevention space?

16
17 DR LYONS: Yes. I think, though, the challenge for us is
18 while the demand is there and the community expectations
19 for treatment - and we can't deny people treatment when
20 they need it - so while those pressures exist, it's
21 difficult to make that shift. So it needs to be
22 maintaining the important role they play and the services
23 they provide, that investment; incrementally more going
24 into the other components than has been in the past. So it
25 is about proportional investment in those in the future but
26 while maintaining those other important services that we're
27 responsible for.

28
29 MS WILLCOX: If I could just add, for as long as probably
30 Dr Lyons and Dr Chant and I have been in the health system,
31 there has always been a view that, at some point in the
32 near future, the health system will consume almost the
33 entire budget. But what has occurred is the health system
34 continues to innovate, refine, look at different ways of
35 providing care, trying to make the shift around principles
36 such as integrated care, working with primary care. We
37 keep evolving in order to mitigate that demand and manage
38 the impact on that 85 per cent.

39
40 DR LYONS: I think it would be fair to say that - and my
41 colleagues might challenge me a bit on this, but it will be
42 interesting to see - the activity based funding has driven
43 a focus on activity, and it has driven a focus on activity
44 in settings where the revenue to be gained by that
45 treatment is to be maximised. So it's tended to focus our
46 service deliverers on in-hospital care. Reflecting on that
47 over the time that I've been in the system, when we didn't

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

7

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

15

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

22

23 DR LYONS: That's exactly what I --

24

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

26

27 DR LYONS: That's correct.

28

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

32

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

44

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

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

6

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

10

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

27

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

35

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

39

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

1
2 DR CHANT: I suppose just another sort of lens on that is
3 just the health benefits haven't accrued equally across our
4 population. So therefore, if our remit is to improve the
5 health of the population overall and reduce inequity, we
6 have to do some more boutique or tailored programs or
7 additional supports which are not reflected in the current
8 ABF sort of funding arrangements. So more bundled care for
9 some populations, to ensure that they're receiving the same
10 outcomes from intervention.

11
12 DR LYONS: I think that's a really important point.
13 Universal access to care has been around, treating
14 everybody the same in our system, pretty much, in terms of
15 the programs and services we offer. While that has raised
16 the health status of the community generally, there are
17 some groups who have been left behind in the process. So
18 we need to refocus and redouble our efforts around those
19 groups.

20
21 We've talked about targeted universalism, I think
22 we've used that term. We have a standardised approach for
23 the community but there are some groups we need to be more
24 specific in what we do because of their particular needs,
25 and I think that's where we need to go.

26
27 MR GLOVER: That is an important piece of the puzzle.
28 What types of communities or groups do you have in mind
29 when you are raising that?

30
31 DR CHANT: I suppose it is important to say that, for
32 instance, health promotion itself can increase inequity,
33 because if you are just giving messaging, messaging will be
34 adopted by those who, if the message is given in English,
35 can understand English, who are listening to the channels
36 that you are pushing it out on.

37
38 If you then unpack that, you then need to look at
39 perhaps the different groups. So I think our data has
40 clearly highlighted the difference between the most
41 advantaged and the less advantaged. I think for us, the
42 outcomes can be differential across some CALD communities;
43 clearly our homeless population; some of our communities
44 that - our Aboriginal communities have poorer health
45 status. So for all of those communities, we need to look
46 at what are the additional steps to the model of care or
47 the clinical pathway that we have to put around them to

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

5
6 MR GLOVER: To combat the inequities.

7
8 DR CHANT: To combat the inequities and the fact that they
9 are living in a context where they have other barriers.

10
11 MS WILLCOX: If I could just add to what Dr Lyons said,
12 I think we are but one part of the system, and to his
13 point, the NHRA is but one part of the funding model, which
14 is very much focused on hospitals, and we know that the
15 system is much, much more.

16
17 We have many partners in the non-government sector,
18 many partners in private sector, and this concept we
19 touched on yesterday around regional planning is one
20 construct by which to see all of this, and that if you have
21 a region or a geographical area with all of these partners,
22 how you could leverage off one another, if the funding
23 structures - and I realise it's not easy, but how we could
24 allow more movement between all partners in care delivery
25 in a particular area for a population, and then their
26 ability to focus on those people that are more vulnerable
27 is strengthened.

28
29 MR GLOVER: Is that a convenient time, Commissioner?

30
31 THE COMMISSIONER: Yes. We'll come back at 10 to 12.

32
33 **SHORT ADJOURNMENT.**

34
35 MR GLOVER: Thank you, Commissioner. Just before the
36 break, Ms Willcox, you made some reference to NGOs and they
37 are part of the system.

38
39 MS WILLCOX: Yes.

40
41 MR GLOVER: If we can go to the joint report at
42 paragraph 101, please.

43
44 There, some of the services that are provided by NGOs
45 are described. Firstly, how are those services integrated
46 within the public hospital system?

47

1 MS WILLCOX: Thank you. Our non-government organisations,
2 as outlined in (a) to (h), form a very important role in
3 the health system.
4

5 We talked briefly yesterday around the planning,
6 I guess the hierarchy of planning: so from a statewide
7 strategic planning perspective there will be a number of
8 our non-government organisations that would be factored in.
9 One example might be family planning or Karitane and
10 Tresillian that provide support for parenting and mums and
11 families; at a local health district level - and sorry
12 I should say from the state level - certainly from drug and
13 alcohol and some of the areas that fall into Dr Chant's
14 areas as well.
15

16 At a local district level, there will be particular
17 needs of particular NGOs that may have a greater footprint
18 or do work in the communities that are more predominant,
19 and so you'll find there's local partnerships, but in the
20 main, our NGOs are funded through ministerially
21 administered grants. There is a Grants Administration
22 Guide for the public sector or government agencies that
23 guides the process of procuring these services and the
24 contractual relationship and the reporting and monitoring
25 and the like.
26

27 Some of our NGO partners will have their relationships
28 managed at a local health district level. For instance,
29 just drawing on Karitane again, South Western Sydney Local
30 Health District manages that contract and Sydney Local
31 Health District manages the contract for Tresillian. So
32 there is a little bit of flexibility in that, but in the
33 main, ministerially administered through a statewide Grants
34 Administration Guide for probity and appropriate
35 procurement and evaluation and monitoring, to enable us to
36 monitor the delivery of the services that those NGOs are
37 providing.
38

39 Sorry, I'm just jumping around a little bit, my
40 apologies. But in a local health district too, those
41 relationships would be part of performance meetings and
42 discussions, so they would be meeting with the large NGO
43 providers to talk about the services and are they meeting
44 the need and just that general relationship.
45

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

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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

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

11
12 There are other Aboriginal controlled health
13 organisations that might specialise in mental health
14 services or drug and alcohol, and again it's around making
15 sure that we have a diversity of high quality providers
16 that can meet the needs of the population so that we
17 address some of those equity issues.

18
19 MR GLOVER: Do they play a role in ensuring that those
20 populations get care in what's described in some of the
21 literature in a culturally safe way?

22
23 DR CHANT: That's correct. They're very important in
24 doing that and we also partner with them locally. We try
25 to maintain very close relationships between our Aboriginal
26 medical health services and our local health districts and
27 have them as an active voice in that partnership because we
28 recognise their important role in providing and servicing
29 Aboriginal people.

30
31 MR GLOVER: And do they receive funding in the same way?

32
33 DR CHANT: They receive Commonwealth grant funning. They
34 receive Medicare, so they're eligible for Medicare.
35 There's also a number of other programs that they might
36 apply for funding - for instance, in relation to child
37 protection or other activities that they might have funding
38 sources.

39
40 We also provide grant funding to the AMSs and then
41 separately we may ask the AMSs to deliver additional
42 services on our behalf and they would be funded
43 additionally to that sort of base-level funding that the
44 state provides to them.

45
46 MS WILLCOX: They also have a very strong relationship
47 with the Aboriginal health units in the local health

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

6
7 MR GLOVER: In some evidence given before the break,
8 Dr Chant, you were talking about the need to tailor some of
9 these integrated responses to particular communities. When
10 looking at Aboriginal or Torres Strait Islander
11 communities, are those organisations part of that approach
12 that you were describing earlier?

13
14 DR CHANT: That's correct. But within our local health
15 districts we also have strong Aboriginal leaders heading up
16 Aboriginal health streams. I think the key principle is
17 co-designing with community and making sure there is strong
18 community involvement into how we design our clinical
19 pathways, how we integrate and work collaboratively.

20
21 MR GLOVER: If we go ahead in the report to paragraph 134,
22 please.

23
24 This is related to some of the evidence given before
25 the break about the anticipated increase in proportion of
26 the population with disease and drivers of demand on
27 system.

28
29 I think Dr Lyons, you reflected on this. The
30 statistics in this paragraph, do they suggest that the
31 system needs to pivot now, or continue to pivot, if I can
32 put it that way, otherwise it's going to be overwhelmed?

33
34 DR LYONS: I wouldn't use the word "overwhelmed" because
35 our system has always, despite all of the challenges it has
36 faced, been able to respond. But it is certainly going to
37 be challenged to a greater extent than it currently is and
38 with a focus on that hospital care, which is what we need
39 to change, because that's not a sustainable arrangement in
40 terms of delivering these services, and that's not best
41 outcome for our community either. We want to see people
42 living a life outside of being admitted to hospital and as
43 well as possible with the conditions that they are living
44 with.

45
46 It's certainly, I think, a statistic which highlights
47 the importance of continuing to support this change and the

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

6
7 MR GLOVER: We touched on, and we'll return to it later
8 today, how the funding models might need to be reviewed,
9 but are there other barriers in the system to carrying
10 through that change either structurally or within the
11 workforce?

12
13 DR LYONS: Workforce is a big issue and I think we've
14 highlighted the importance of workforce availability.
15 I think the important thing to highlight here is also the
16 intersection between the care workforces. Aged care,
17 disability care, health care, often have health
18 professionals who can work in any of those sectors. So as
19 one of those expands, it can put pressure on any of the
20 others, and I think we're seeing that play out at the
21 moment, with the investments that are being made in aged
22 care. It's difficult to attract the nursing staff that are
23 required in some of our aged care facilities to the extent
24 that they need to be there, and if they are attracted, it
25 might leave other areas short. So I think we've got to
26 look at these things in totality. That's the first point.

27
28 The second point, I think in terms of barriers, the
29 workforce is not the only barrier. We have highlighted the
30 importance of information systems that allow information to
31 be shared in real time. Those are going to be critical
32 investments for the future across all of the different care
33 delivery modes, and all of the professionals involved.

34
35 We talked this morning about the importance of primary
36 care collectively. If we're talking about
37 multidisciplinary primary care, it's all of the allied
38 health groups as well as general practitioners who are
39 involved in delivering that. A lot of those health
40 professions are working in practices in the community,
41 which might be separated physically, so it's important that
42 information is able to be shared in real time to all of the
43 places it needs to be to support the care of those patients
44 in those settings. Otherwise, we'll have further
45 fragmentation and likely to have reduced quality of care.

46
47 MR GLOVER: Is there a need for the whole system to pull

1 in one direction when making this shift?

2

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

10

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

14

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

24

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

30

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

42

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

1
2 The GP or the other practitioners will need to be more
3 conscious if someone doesn't really understand why they
4 need to get that test at that particular time, why it's
5 really critical that they stop that other medication and
6 change this medication. Again, this ability to see
7 outcomes across all of the players and share data more will
8 be important to drive good quality clinical practice, but
9 it actually potentially will also reduce that inequity.

10
11 MR GLOVER: And would it also drive efficiencies in
12 delivery of care?
13

14 DR LYONS: Absolutely it would. So it would stop
15 duplication. That's the first thing. If the information
16 is shared adequately, it will reduce the cost of that
17 duplicated care. It will stop some of the gaps in care
18 that are currently occurring because information is not
19 shared adequately and people aren't aware what's going on.
20 But it will also give us the opportunity to assess what we
21 talked about yesterday around the value of the care and
22 address issues around low value care ultimately as well.
23

24 I think those connections, making sure we've got that
25 data available, feeding that back to clinicians, but also
26 being able to have that systematic review of how care is
27 being delivered are really critical.
28

29 MS WILLCOX: I was just going to add to what Dr Lyons
30 said. It also saves our clinicians time. They want to be
31 attending to patients and applying their skills to the best
32 of their abilities. If we can provide the systems, whether
33 that's technology, processes, data, information, to enable
34 that, to free up their time, that's an incredibly important
35 thing that we can do.
36

37 I think COVID showed the capability, and the word
38 "agile" was used far too frequently, but again if one has
39 a common purpose, it showed how agile and capable the
40 system is at shifting. I see some of the things that we're
41 contending with around some of these statistics that are in
42 our submission, again, it's about focus and about giving
43 the clinical teams the support and the infrastructure and
44 the data they need to make the most important changes.
45

46 MR GLOVER: If we can go ahead to paragraph 152, please.
47

1 Just picking up your last point, Dr Lyons, we did
2 touch on this yesterday, but in terms of the pivot to
3 meeting the current and future needs of the population,
4 where it says in that paragraph that there needs to be
5 a far greater process in prioritisation and disinvestment
6 from low value care, and further work to reduce futile
7 care, what initiatives are being implemented in that space?
8

9 DR LYONS: Certainly our work around the introduction of
10 the value based care concepts, which are outlined there,
11 which is around the routine collection of information to
12 support care - so the experiences, the outcomes that people
13 are wanting to see from the treatment they're receiving;
14 the experience of the provider in delivering that; the cost
15 of doing that; and, the efficiency and the effectiveness of
16 the outcomes - those are the steps that we need to take to
17 continue to be able to monitor and drive these
18 improvements.
19

20 It is very much around what matters to the patient and
21 taking the time to understand that. Because through
22 understanding what matters to the patient, we can actually
23 ensure that the care that's provided will meet their needs,
24 rather than assuming what we think the outcome should be.
25 What has tended to happen in the system, I think, when the
26 system is under pressure and there is so much demand on
27 service, our clinicians tend to do the same things without
28 exploring that detail with the patients, carers or
29 families, because it's sometimes a difficult conversation
30 to have or it takes time to gather the people together to
31 have that conversation. So ensuring we've created the
32 supports for that to occur and continuing to monitor that
33 is going to be a key change.
34

35 MR GLOVER: As increased demand flows through the system,
36 why is it important to reduce low value care and futile
37 care to ensure the sustainability of the system going
38 forward?
39

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

1
2 MR GLOVER: How does that work in practice where it may be
3 clinically viewed that this is not the appropriate model of
4 care for this patient? How do you balance that with the
5 desires or wishes of the patient that you've just
6 described?

7
8 DR LYONS: I think it is about having the conversation to
9 enable there to be an assessment about what the patient
10 needs. I mean, I think, yes, we have an assumption that
11 we're here to save lives and to treat everything before us.
12 In fact, sometimes a person might be at the point in their
13 life where they don't want active treatment for
14 a condition, and before assuming that that's what they
15 want, we should have the conversation.

16
17 As our clinicians will tell us, the time for having
18 that conversation is not when somebody's in an intensive
19 care unit, intubated and ventilated. It's too late to have
20 that conversation with a family at that point. It's
21 something that needs to occur earlier and we need to be
22 able to have it in an ongoing way, because we need to be
23 also conscious that circumstances change and people's views
24 change about what care they would like to receive. So it
25 needs to be that constant reference but it's so critical
26 that we do that because sometimes patients don't want us to
27 intervene.

28
29 The example would be one of the fantastic programs
30 that was established around chronic renal disease and
31 dialysis and having pathways that are alternate to being
32 actively dialysed.

33
34 Those models have been introduced over the last five
35 years or so and have involved our palliative care
36 physicians working with our renal physician, and giving
37 people an option about not going on to active dialysis
38 treatment but maybe being treated in a supportive way
39 around their symptoms, but doing that in a way that enables
40 our clinicians to feel safe in giving that option and
41 having patients feel like they are not being abandoned by
42 the system if they choose not to be actively treated.

43
44 That's a direction we need to go, because that's being
45 well received by our patients and our clinicians feel very
46 supported with that change also. It's an example of where
47 thinking about how we do things differently and ensuring

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

3

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

11

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

21

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

24

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

26

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

29

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

38

39 DR LYONS: We've talked about the --

40

41 THE COMMISSIONER: Which funding model?

42

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

44

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

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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

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

3

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

10

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

16

17 MS WILLCOX: That's correct.

18

19 DR LYONS: That's correct, yes

20

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

26

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

35

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

38

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

45

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

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

4
5 DR LYONS: Absolutely, I mean, I think --

6
7 MS WILLCOX: I think so, yes.

8
9 DR LYONS: -- it's where we need to go, because at the
10 moment it's difficult for our clinical teams, when they
11 don't have those feedback loops around the outcomes.
12 That's why we're building the system around collecting
13 those outcomes more systematically. It's not just those
14 hard outcomes like mortality and morbidity; it's about
15 those outcomes that are important to a patient being
16 delivered, and fed back to the care teams to ensure that
17 what they're doing is actually patient centred, that is
18 delivering to the patient's need and is not wasteful in
19 terms of delivering things that they don't want.

20
21 MR GLOVER: What would an outcome based funding model look
22 like?

23
24 DR LYONS: It would need to reflect that the outcomes are
25 being delivered for the funding to be - so it could be that
26 there's an incentive created to ensure that if the outcome
27 is delivered, the revenue provided for that treatment is
28 perhaps at an incentivised rate, if the outcome is
29 achieved; if it's not achieved, it might be at a discounted
30 rate. There are some examples of where this has been tried
31 in different systems around the world.

32
33 The evidence is mixed about how you pay for quality
34 and outcomes in terms of the evidence that I have seen. In
35 part, I think because it's really important that we define
36 what those outcomes are very clearly, that we're able to
37 assign accountability to the care team or the practitioner
38 delivering it, and ensuring that when those outcomes are
39 delivered, all of the other systems that need to be in
40 place to support it, as well as the financing - it can't
41 just be around a funding lever; it has to be around those
42 enablers being linked up as well to ensure that those
43 outcomes are able to be delivered.

44
45 DR CHANT: I think it's important to say we're probably
46 using the term "intermediate outcomes" and basing it on
47 where evidence-based care that we know through longer

1 studies is linked to particular outcomes.

2

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

13

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

23

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

29

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

38

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

47

1 MR GLOVER: And incentivising the work to create those
2 linkages that Dr Chant referred to, is that part of the way
3 it may, as set out in paragraph 157, improve access
4 particularly for vulnerable cohorts?
5

6 DR CHANT: Yes.
7

8 MS WILLCOX: I was just going to add that our service
9 level agreements, some of these measures are process
10 measures but they are increasingly focused on outcomes, in
11 terms of keeping people safe and well and quality care and
12 the like, when you look at things around we have targets
13 around childhood obesity, smoking in pregnancy, discharge
14 against medical advice, immunisation, all of these. So,
15 yes, they are KPIs for the purpose of the service agreement
16 but they're designed around producing better health
17 outcomes in a population sense, in a local health district,
18 as opposed to just talking about individual outcomes that
19 we're referring to.
20

21 THE COMMISSIONER: Is there any difference between - I've
22 seen various forms of payments or funding models described
23 as outcome based funding models or value based funding
24 models. Are they one and the same thing?
25

26 DR CHANT: "Outcomes" is used - caution needs to be
27 applied in looking at when the term "outcomes", is used.
28 I've seen it used in many things that we wouldn't perhaps
29 see as outcomes, so there needs to be that forensic look at
30 it. Your other comment I think related to --
31

32 THE COMMISSIONER: Value based. So just for example -
33 I mean, I have seen both of those, but in the addendum for
34 the long term health reform principles, it says - this is
35 C1(b):
36

37 *[The priority of] delivering safe,*
38 *high-quality care in the right place at the*
39 *right time through*

40 *...*
41 *(ii) paying for value and outcomes.*
42

43 Are they different concepts, "value" and "outcomes", in
44 terms of the funding model?
45

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

1
2 DR LYONS: They're interrelated, I think. They're
3 slightly different but interrelated. Paying for value is
4 in terms of assessment of the resource consumed for --

5
6 THE COMMISSIONER: For the outcome.

7
8 DR LYONS: Yes, for the outcome, and the outcome is what
9 are you seeking to achieve from the treatment.

10
11 MR GLOVER: Paragraph 163, please.

12
13 That picks up an issue I raised with you not long ago,
14 Dr Lyons, about the ability of the system to adapt - that
15 is, the ABF system - to new models of care. I think we
16 touched on the notion that new models can blur the
17 boundaries, hence creating the difficulty. Are there some
18 examples of new models that have encountered this
19 difficulty - that is, getting recognised by IHACPA for ABF
20 funding?

21
22 DR LYONS: I'm just trying to think about a specific
23 example. I know we've put submissions up for a range of
24 different things around care being delivered in different
25 settings. It's primarily around settings outside of what
26 have been traditional hospital settings, because anything
27 that's construed as being outside of the scope of those
28 hospital services is considered to be a change in the scope
29 that the Commonwealth should be responsible for.

30
31 It's been primarily in those sorts of models where
32 we've tried to drive care to be delivered not in the
33 hospital setting but outside of it. I'll have to come back
34 to you with a specific example, but certainly the general
35 issue is that the list is constraining and is fixed, and
36 it's very difficult to get agreement that there should be
37 a service funded under the NHR arrangements outside of that
38 specific list.

39
40 MR GLOVER: Is there engagement between the other states
41 and territories around these issues?

42
43 DR LYONS: There is, and the states and territories have
44 put up some issues, like we have in the past, for funding,
45 and had some that have been successful but a lot that have
46 been unsuccessful, for the very reasons that I have
47 outlined.

1
2 We would argue that there needs to be greater
3 flexibility. But it needs to be done in a safe way,
4 because I can understand why the Commonwealth would be
5 concerned about investing in services, unless there's
6 a demonstrated benefit in terms of the evaluation and the
7 evidence around that being an appropriate shift and leading
8 to the things that we have talked about, more efficient
9 delivery of care, better outcome for the patient. Those
10 concepts needs to be a critical component of the assessment
11 of those services up front.

12
13 MR GLOVER: If there's lack of flexibility in the ABF
14 model, is that a reason why other sources of funding from
15 the Commonwealth may be sought as being appropriate to deal
16 with new models of care, for example?

17
18 DR LYONS: That's correct. So we are constantly putting
19 forward concepts around how we might progress activities
20 that drive us in the direction we want to go to in the
21 future health strategy to get that better integration.
22 Those examples have been through the types of work we've
23 done with integrated care and collaborative commissioning,
24 as examples, but also the work we've done with aged care
25 services to provide support for residents in aged care
26 facilities.

27
28 MR GLOVER: Can we go ahead to paragraph 170.

29
30 The "Single Front Door" there is raised. What is that
31 initiative and how does it fit in with the integration of
32 care that we've spoken about?

33
34 MS WILLCOX: The single front door is a model to enable
35 individuals in the community to make contact through what
36 is a national organisation called Healthdirect that is
37 funded by the Commonwealth and the states. By contacting
38 the single front door, a clinician will be on the end of
39 the line who will, using algorithms and other protocols,
40 give guidance to a person on the phone who is raising
41 concerns about their health and their symptoms.

42
43 The real transformation around this is about what
44 sorts of services a person can be directed to.
45 Traditionally, it would have been an emergency department,
46 if it sounded serious, call an ambulance, which is
47 absolutely the right thing to do if something is. But

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

7
8 We also have, through the single front door, a virtual
9 kids line as well. So it's about giving a range of service
10 options based on clinical algorithms and protocol to an
11 individual to avoid going to an emergency department if
12 they don't need to, but giving a suite of options that
13 would be appropriate for their needs at any given time.

14
15 DR LYONS: It's off the back of a couple of things. The
16 first is that we understand from work we've done with our
17 communities that when people want to access care for
18 something they're concerned about, particularly in an
19 after-hours situation, they're often not aware of anywhere
20 else to go other than to an emergency department. That's
21 the first thing.

22
23 During COVID, we actually established and enhanced
24 these services for people who had positive COVID results to
25 access care without having to turn up to a clinical service
26 and doing it through the use of telehealth. So on the back
27 of those experiences, we're now saying we actually could
28 expand access to care through these means, as long as we're
29 able to triage and assess people appropriately, but also
30 have a range of different places to refer them, depending
31 on the assessment of their condition.

32
33 So we need to reorient our service delivery model.
34 If this is going to be the access point, there's got to be
35 a place for someone to receive the care they need after
36 that assessment. So it needs a total redesign of the way
37 we do things. Urgent care centres will be a part of it;
38 access to primary care and having agreement with GPs, for
39 instance, that they might have some vacant slots available
40 the next day for patients who are assessed through this
41 process to be seen if they need to be. It's going to need
42 a lot of work to actually get the system set up to enable
43 this to occur in a way that gives confidence to the
44 community that when they access through this portal or this
45 process, they will access the care they need safely and
46 confidently every time. But it is a direction we think we
47 need to go, because otherwise, people will just continue to

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

8

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

12

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

18

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

28

29 MR GLOVER: Creates another barrier.

30

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

35

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

41

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

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

3

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

6

7 MS WILLCOX: Yes.

8

9 DR LYONS: Yes.

10

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

15

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

34

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

40

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

44

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

1 example earlier on around our sexual health services, so
2 some of the additional services we've put in place are
3 things like telemedicine; for our drug and alcohol
4 services, we've put in telemedicine support, and purchased
5 centrally to deal with some of the workforce constraints.
6

7 Some of those patients may well have been able to be
8 managed in primary care but, again, that's a workaround to
9 support rural and regional. So a number of our initiatives
10 have multiple purposes, but they are responding to the fact
11 that there is this unmet need.
12

13 DR LYONS: There are examples of after-hours medical
14 services that have been established in partnership in
15 various districts through relationships with the general
16 practitioners as well as the local health district, to
17 provide access to after-hours care where that is not
18 available, where there have been models like in Western
19 Sydney looking at the access to specialists and backing up
20 the care to ensure that patients don't end up in the
21 emergency department if that can be avoided.
22

23 So there are examples of these where the system has
24 developed arrangements to try to prevent ED attendances.
25

26 Urgent care services are another example of where they
27 have been established and are now being built on and
28 enhanced as an alternate to an emergency department
29 attendance. They are all services that have been built to
30 try to avoid or change the need for a person to turn up at
31 an ED because that's the only avenue they've got for
32 accessing care.
33

34 MR GLOVER: "Urgent care services" have been mentioned
35 a few times. What is an urgent care service? Why is it an
36 alternative to an ED?
37

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

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

4
5 MR GLOVER: And to the extent that includes primary care,
6 how is that funded?

7
8 DR LYONS: Those services are being established - the
9 Commonwealth has agreed to a number of them that are being
10 implemented in New South Wales. I can't remember the
11 number exactly from the Commonwealth, but I think there are
12 about 10 of those for New South Wales; and New South
13 Wales's state government has committed to a further number
14 as well to enhance the total number of those services that
15 are being established over the next 12 months or so, to
16 ensure that those services are available as an alternate.

17
18 MR GLOVER: So there is a combined funding arrangement
19 between the Commonwealth and the state to fund those
20 services?

21
22 DR LYONS: That's correct.

23
24 MR GLOVER: If we go ahead to paragraph 205, please:

25
26 *Integrated funding models to support care*
27 *in the community need to be fast-tracked*
28 *with a more blended funding model moving*
29 *away from a reliance on ABF in dominating*
30 *decisions on budget allocations at the*
31 *state level.*

32
33 What do you mean by, firstly, "integrated funding models",
34 and then, secondly, "blended funding models"?

35
36 DR LYONS: So "integrated" means that the sources are from
37 different sources than they currently are, so starting to
38 look at those funding systems that exist, that we've talked
39 about before, the ones that the state's responsible for,
40 the ones that the Commonwealth is responsible for, and
41 starting to look at how they are integrated to enable that
42 shift in care into the community setting.

43
44 It's our contention that we can't continue to move
45 services into the community setting without support from
46 the Commonwealth, because just as they are concerned around
47 the general list and the NHRA, we are starting to stray

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

5

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

8

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

19

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

29

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

32

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

40

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

47

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

5
6 MS WILLCOX: Some of the collaborative commissioning that
7 we have seen in New South Wales is about one program of
8 work going between a group of general practice and the
9 state system, but they tend to be individual programs as
10 opposed to having the change of structure that is required
11 to enable that to become the norm, as opposed to a boutique
12 piece of work that is done because of relationships or
13 individual general practice and the relationship with
14 a local health district. It's about making it the norm.

15
16 DR LYONS: Systematising it.

17
18 DR CHANT: And perhaps even just changing the narrative
19 away from recognising that there will be components of a
20 service that are ABF but then block funding for
21 evidence-based services to address particular models of
22 care to live with that equity lens or equivalent outcomes.
23 So I think it is really around more explicitly calling out
24 that and maybe funding those initiatives that support that
25 either integration with primary care or additional models
26 of care that need to support that equity outcome.

27
28 MR GLOVER: There is a word of caution in the last
29 sentence of paragraph 205 about the need to consider
30 underlying equity and the responsibility to maintain the
31 safe operation of the public health system. That seems
32 obvious, but why is that an important focus that must not
33 be lost sight of in this debate about funding models?

34
35 MS WILLCOX: It is the sharing of risk and how that is
36 managed so that we can continue to do what we do and adapt
37 and change with what is required. But, yes, we would have
38 to make sure that anything that we moved towards didn't
39 negatively impact on vulnerable communities or impact on
40 the issues of equity that Dr Chant has talked about and
41 enable us to continue to care for people safely. It is
42 just a management of risk and a sharing of risk and
43 a clarity of roles and responsibilities that you have to
44 keep your eye on as you do any change management exercise
45 or change a structure or model.

46
47 MR GLOVER: Can we go ahead to paragraph 207. "The lack

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

3

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

17

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

23

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

29

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

43

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

47

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

10

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

14

15 MS WILLCOX: Yes.

16

17 MR GLOVER: And the workforce?

18

19 MS WILLCOX: Definitely.

20

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

23

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

31

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

44

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

46

47 DR CHANT: No.

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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

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

5

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

8

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

14

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

16

17 MR GLOVER: Yes.

18

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

32

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

38

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

41

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

1 opportunities, like preconception, there is a lot of
2 prevention opportunities within pregnancy, in vaccinations,
3 screening, supporting tobacco cessation in pregnancy,
4 modifying other risk factors, and the question is: does
5 the current activity based funding model reflect the
6 intensity that that requires?
7

8 Then we know there will be some sub-populations within
9 our population of pregnant women who will benefit from
10 things like sustained home visiting or specific programs
11 such as substance use in pregnancy. So we actually have
12 a blended funding model where we say, "The actual baseline
13 admission to hospital, maternity care pathway, costs X.
14 But actually, for a proportion of the population, you need
15 to factor in sustained home visiting" - and it may be
16 20 per cent of your cohort depending upon your demographics
17 of your population - "and also these prevention services
18 need to be beefed up in pregnancy, this is a profile of
19 your pregnant women, this is what you would need and this
20 is an additional, perhaps, workforce, additional model that
21 we would need to support that intensity." So there would
22 be a component of funding. It still could be sort of
23 a modified ABF funding, but it would accept that these
24 other things are important add-ons to achieve the outcome
25 we want for the mother and the family overall.
26

27 We might also say that, for instance, smoking
28 cessation - our model of care might actually have to be the
29 family, not the woman. So the pregnant woman might - but
30 actually, to have a holistic intervention we might need to
31 deal with a number of other complex issues in that family.
32 But actually, the intervention might be more with the
33 family, and that's not something that is aligned with an
34 ABF where the clinical service might see that it is the
35 mother that is the patient; actually, we might need that
36 broader intervention for the family, again to get those
37 outcomes.
38

39 Because in early childhood we do have incredibly good
40 longitudinal data, and what we would be aiming for is for
41 the children to be well and have school readiness, we want
42 them to be retained in education, and so we have worked
43 across with linked datasets to look at that long term
44 trajectory. That's why we need these investments in these
45 things that perhaps strictly wouldn't be funded through an
46 ABF model.
47

1 MS WILLCOX: Yes. Nothing further.

2

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

7

8 THE COMMISSIONER: All right. We will come back at
9 2 o'clock. We will adjourn until then.

10

11 **LUNCHEON ADJOURNMENT**

12

13 THE COMMISSIONER: Yes, Mr Glover.

14

15 MR GLOVER: Thank you, Commissioner.

16

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

22

23 DR LYONS: I do.

24

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

29

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

37

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

41

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

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

3

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

7

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

14

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

25

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

28

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

39

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

44

45 MS WILLCOX: Correct.

46

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

1 answer, but do the volume and regularity of that care being
2 delivered apply to those other professionals in that space
3 as well?
4

5 MS WILLCOX: We don't specifically count the procedures
6 against every clinician, it's more the service is
7 delivering X number of babies or providing that particular
8 procedure, so as the service it's the volume that is
9 relevant to, not to the individual practitioners in our
10 hospitals.
11

12 MR GLOVER: If the colleges set those standards that
13 Dr Lyons was referring to earlier, do they automatically
14 bind those practitioners or is there another layer of
15 oversight from the ministry level as to how they're
16 implemented?
17

18 DR LYONS: Usually, as I said, the districts would take
19 the college recommendations and apply those in relation to
20 the clinical privileges that an appointed clinician might
21 have. Usually there's a direct relationship between what
22 the colleges might stipulate and that flows through into
23 how the services are delivered.
24

25 MR GLOVER: Thank you. Building on another passage of
26 your earlier evidence, Dr Lyons, the Strengthening Medicare
27 Taskforce - you were involved in that?
28

29 DR LYONS: Yes, I was, yes.
30

31 MR GLOVER: What was that process directed to --
32

33 DR LYONS: That was --
34

35 MR GLOVER: -- other than strengthening Medicare?
36

37 DR LYONS: It was established by Minister Butler and the
38 incoming Labor government when they were elected federally
39 to look at how supports could be provided to improve
40 primarily general practice in the context of Medicare. It
41 was really around what needs to be done to strengthen the
42 Medicare support for general practice and primary care.
43

44 MR GLOVER: A report was delivered at the end of last
45 year?
46

47 DR LYONS: That's correct.

1
2 MR GLOVER: Can we have on the screen
3 [SCI.0001.0053.0001].
4

5 Commissioner, this isn't presently in the tender
6 bundle. I have a hard copy here, if you wish. Otherwise
7 we'll mop it up tomorrow in tomorrow's tender.
8

9 If we go to page 9, there are a number of
10 recommendations throughout the report, but on page 9, there
11 are some dealing with the connectivity and sharing of data,
12 which was one of the matters you raised earlier, Dr Lyons.
13 Do you see in particular point 2:
14

15 *Better connect health data across all parts*
16 *of the health system ...*
17

18 DR LYONS: Yes, I do.
19

20 MR GLOVER: Do you have that?
21

22 DR LYONS: Yes.
23

24 MR GLOVER: And that's a recommendation that has been made
25 in other reviews and inquiries over the years; is that
26 right?
27

28 DR LYONS: Yes, that's correct.
29

30 MR GLOVER: Part of the work that has been done within
31 NSW Health to achieve that is the single digital patient
32 record?
33

34 DR LYONS: That's correct. So, by having one single
35 digital patient record for the whole state, my
36 understanding is, there are probably two, or maybe three
37 maximum, software packages that GPs use mostly, it will
38 allow us to develop interfaces. I think ultimately the aim
39 is to develop interfaces with those two software packages
40 that are used by the GPs to enable the exchange of
41 information electronically which is currently not able to
42 be done systematically.
43

44 MR GLOVER: It will go some way but perhaps not all of the
45 way to meeting that second recommendation; is that right?
46

47 DR LYONS: It will go substantially to meeting that

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

4

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

8

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

18

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

24

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

40

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

45

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

1
2 DR LYONS: It is. The single digital patient record in
3 New South Wales - that is a hundreds of millions of dollars
4 investment for the state.

5
6 MR GLOVER: Is it the availability of funding being
7 a barrier to implementing the data sharing?

8
9 DR LYONS: I think in part funding, but also the good
10 thing about New South Wales is there has been consistency
11 in IT systems statewide for some time. We have a common
12 payroll system, we have common financials, we have a common
13 procurement process through the systems that exist across
14 the districts and HealthShare.

15
16 Moving towards a single digital patient record is
17 a direction which has been supported by a number of those
18 changes in New South Wales over the years. I think it's an
19 example of the benefits of that centralisation we've been
20 talking about versus the sort of governance. We've got the
21 centralisation agreement around the information systems but
22 devolved in terms of how they're used at the local level.

23
24 MR GLOVER: The single digital patient record project, is
25 that being funded entirely by New South Wales?

26
27 DR LYONS: It has. Ms Willcox may want to comment,
28 because I think you're chairing the steering group for it,
29 aren't you?

30
31 MS WILLCOX: Yes. It's entirely funded by the state.

32
33 THE COMMISSIONER: Have you gone off this? Are you
34 finished?

35
36 MR GLOVER: I will be in a moment.

37
38 THE COMMISSIONER: Sorry, are you going back to it?

39
40 MR GLOVER: No.

41
42 THE COMMISSIONER: This report was obviously drafted to
43 be at the highest level of generality, was it?

44
45 DR LYONS: I can't comment on that, Commissioner, I didn't
46 draft it, but it's a summary of the discussions --

47

1 THE COMMISSIONER: Read what I just said in bold. So
2 I assume the recommendations are all to be fleshed out
3 later, are they?
4

5 DR LYONS: The detail about how this will be implemented
6 and the time frame over which it will be done, yes, are a
7 subject for the Commonwealth.
8

9 THE COMMISSIONER: For example, in relation to primary
10 care, "Recommendation":
11

12 *Support general practice in management of*
13 *complex chronic disease through blended*
14 *funding models integrated with*
15 *fee-for-service, with funding for longer*
16 *consultations and incentives that better*
17 *promote quality bundles of care for people*
18 *who need it most.*
19

20 I imagine the detail of that --
21

22 DR LYONS: Are you going to ask me to explain that,
23 Commissioner?
24

25 THE COMMISSIONER: I reckon it's pretty self-explanatory.
26 All of these are just, as I said, incredibly general with
27 the detail to come later; is that right?
28

29 DR LYONS: I think the detail is to be further agreed in
30 terms of the timing and the support for that in terms of
31 changes to investments that need to be made.
32

33 THE COMMISSIONER: I mean, recommendation: "Strengthen
34 funding to support more affordable care" - that sounds
35 fantastic. What does it mean?
36

37 DR LYONS: I think some of those changes have occurred.
38 There have been changes to the incentive payments for bulk
39 billing for certain groups. I think those things have been
40 progressed.
41

42 Do you want to make any comments, Ms Willcox?
43

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

1
2 THE COMMISSIONER: There were only six meetings of this
3 task force, though.

4
5 MS WILLCOX: Yes, that Dr Lyons was --

6
7 THE COMMISSIONER: So two pages per meeting to get to the
8 12-page report. Okay.

9
10 So you are tendering that?

11
12 MR GLOVER: Yes. I propose to do it as part of tomorrow's
13 tender, if that's convenient.

14
15 THE COMMISSIONER: That's fine.

16
17 MR GLOVER: If we can go back to the joint report at
18 paragraph 211, this paragraph lists a number of, as
19 described there, "governance and funding barriers". We've
20 touched on many of them. There are just a couple that I'd
21 like to go to. Subparagraph (d):

22
23 *Insufficient investment in*
24 *multidisciplinary care, and lack of focus*
25 *on generalists, allied health and nurse*
26 *practitioners and enhancing scope of*
27 *practice.*

28
29 At which level of the system is that directed, or which
30 levels, perhaps?

31
32 MS WILLCOX: I think we were focused on primary care in
33 this context. I would have to read the preceding
34 paragraphs, but I think our reference was as part of
35 primary care, but I suspect relevant to our own services as
36 well.

37
38 DR LYONS: It is. It's relevant to our own services as
39 well as others'.

40
41 MR GLOVER: And "insufficient investment in
42 multidisciplinary care within the NSW Health services" -
43 what do you have in mind?

44
45 DR LYONS: I think we have examples of fantastic
46 multidisciplinary care but there are also examples of where
47 we can do better, particularly, I think, in the out of

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

5
6 It's also, I think, highlighting the importance of the
7 development of roles like nurse practitioner roles. We
8 have a number of nurse practitioner roles in the system,
9 but there is an opportunity to think about more nurse
10 practitioners in the settings that we operate from too,
11 with skills that would support the delivery of health
12 services.

13
14 MR GLOVER: Why would that be of benefit?

15
16 DR LYONS: Particularly in areas where we don't currently
17 have doctors, for instance, who are able to do things
18 because of issues around workforce distribution and
19 availability and supply, so we've often got nurse
20 practitioners in emergency department settings across the
21 state. We've got examples of nurse practitioners with
22 advanced skills in neonatal intensive care, that provide
23 services for neonatal babies. We've got examples of where
24 nurse practitioners are providing a primary care type model
25 for communities.

26
27 There is an opportunity to expand the number of those
28 and provide more nurse practitioners for those settings,
29 and we certainly heard through the rural and regional
30 health inquiry, that there was an opportunity to have more
31 of those clinicians available in those settings and that
32 would provide better service delivery.

33
34 MR GLOVER: Are there governance barriers to that
35 occurring?

36
37 DR LYONS: Not so much governance barriers in our context.
38 I think it's more around the fact that we probably haven't
39 given enough focus to the investment in the training and
40 skills development of those categories of staff and
41 providing career opportunities to enable people to see the
42 potential of going into those roles. Certainly that's
43 become much more of a focus, we've talked about it in the
44 last 12 months or so. We've had strong programs that maybe
45 haven't been as advanced over the last few years, and there
46 have been some other distractions that we're aware of, but
47 we are reactivating those now.

1
2 MS WILLCOX: The models of care, too, have evolved where
3 we've identified that, potentially, an allied health
4 practitioner or a nurse practitioner may actually be the
5 more appropriate health professional to provide that
6 service and it doesn't necessarily have to be a medical
7 practitioner. So some of the insufficient attention to
8 this in part could be described as things have changed and
9 moved along and we've seen new models of care where we can
10 have a different emphasis.

11
12 MR GLOVER: Are there funding barriers to this
13 development?

14
15 DR CHANT: I suppose I could, perhaps before answering
16 that question, give you some other examples.

17
18 MR GLOVER: Yes, please.

19
20 DR CHANT: Clearly, we're also looking at the role of
21 Aboriginal health workers, which are important, and
22 Aboriginal health practitioners, and making sure again
23 we've got clear role delineation, utilising those
24 practitioners to their full scope.

25
26 We're currently looking at whether we can provide
27 additional training so Aboriginal health practitioners can
28 be involved in immunisation activities. There's a strategy
29 to reach and achieve even higher coverage in Aboriginal
30 communities.

31
32 Some of the examples that there are sometimes funding
33 barriers but also probably an example where the
34 Commonwealth has taken action to address this is we've
35 recognised, and we particularly recognised through COVID,
36 the important role that pharmacies did as complementary to
37 the work of our primary care practitioners, our GPs in
38 rolling out vaccines. We've known that they did perform
39 that function for influenza, but throughout the year we've
40 really increased the scope and scale of vaccines that are
41 available to the pharmacists under the National
42 Immunisation Program, which are funded vaccines from the
43 Commonwealth.

44
45 But from the beginning of next year, 1 January, the
46 Commonwealth has actually introduced a remuneration payment
47 to pharmacy for the provision of the NIP vaccines. Again,

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

9

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

13

14 DR CHANT: That's correct.

15

16 MR GLOVER: Subparagraph (e):

17

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

22

23 What did you mean by that?

24

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

39

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

41

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

47

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

6
7 All of those factors, whether or not they exist - and
8 I'm not saying they exist everywhere but they are factors
9 that we have heard - are impacting on the ability of
10 members of the public to access specialist care, so often
11 that means those patients will end up in the public system
12 on our waiting lists for our patient care or in our
13 emergency departments.

14
15 MR GLOVER: Is the inability to regulate that's being
16 referred to in subparagraph (e) pointing to an inability of
17 NSW Health to influence those types of circumstances?

18
19 DR LYONS: We have no control over any of those
20 circumstances. We are completely powerless on that and
21 just respond to the situation.

22
23 MR GLOVER: Aside from driving demand into the public
24 health system, are there any other impacts on the delivery
25 of care by those circumstances?

26
27 DR CHANT: I think it's really important that when we look
28 at disparities in access, conditions that are particularly
29 elective - what might be seen as more elective in nature -
30 can be amplified because access to those procedures occurs
31 through largely a specialist system, so this just
32 contributes to some of the inequities of access.

33
34 MR GLOVER: Finally, to paragraph 212. Dr Lyons, you,
35 I think, referred perhaps yesterday to the development of
36 health hubs that are referred to in this paragraph. What
37 do you have in mind by a health hub?

38
39 DR LYONS: I think I outlined some of the concepts, which
40 are collocation of services that the state provides with
41 services that might be provided by other providers.

42
43 MR GLOVER: Are there examples in existence now?

44
45 DR LYONS: We have some examples. They're not widespread,
46 and what we would like to see is building on those that
47 currently exist, evaluating their effectiveness and making

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

7

8 MR GLOVER: These are different to MPSs?

9

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

22

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

31

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

35

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

39

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

43

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

1 to be met for that to be agreed to. So salaried doctors
2 would be an, issue. But if they're doctors who are working
3 within the MBS arrangements they can access those payments.
4

5 MR GLOVER: There are some examples, aren't there, of
6 those exemptions having been granted?
7

8 DR LYONS: There are. We have examples of things like the
9 single employer model in the Murrumbidgee where that's to
10 support general practice training and ensuring that
11 ultimately GPs are retained within rural communities.
12

13 MR GLOVER: Just briefly describe that model.
14

15 DR LYONS: It's a model where rather than - so for most of
16 the specialty training in our system, specialists are
17 trained within the public health system, apart from general
18 practice. So nearly all of the other specialties are
19 trained within our services.
20

21 General practice is unique in that people train in
22 general practice settings, which are outside of our
23 responsibility. So historically we've had no
24 responsibility after the first couple of years of
25 graduation, and then people will choose to do general
26 practice training.
27

28 Part of that is that they relinquish the employment
29 arrangements they have with the system, the state, and go
30 into an arrangement where they negotiate contracts of
31 employment with the various supervisors in those practices.
32

33 What we heard from trainees, and the reason it drove
34 the single employer model, was that that was a barrier for
35 people who were just graduating and embarking on a career,
36 that they lose the certainty of entitlements of an
37 employment arrangement and have to go into a contracted
38 arrangement, which is not ideal.
39

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

1 continue to work with those skills.

2

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

6

7 DR LYONS: Absolutely.

8

9 MR GLOVER: Is that model being expanded?

10

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

16

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

19

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

25

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

27

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

30

31 MR CHENEY: No, Commissioner.

32

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

36

37 We adjourn until 10 o'clock tomorrow?

38

39 MR GLOVER: 10 o'clock tomorrow.

40

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

42

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

45

46

47

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