

**Special Commission of Inquiry  
into Healthcare Funding**

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

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

**Friday, 23 February 2024 at 10.00am**

**(Day 009)**

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

**Also present:**

**Mr Lachlan Gyles SC with Ms Joanna Davidson for NSW Health**

1 THE COMMISSIONER: Good morning.

2

3 MR MUSTON: Good morning. We're continuing with  
4 Ms Rechbauer.

5

6 <CARMEN RECHBAUER, on former affirmation: [10am]

7

8 <EXAMINATION BY MR MUSTON CONTINUING:

9

10 MR MUSTON: Q. I am told, Ms Rechbauer, that you may  
11 want to clarify one of the answers that you gave yesterday?

12 A. Yes. Yesterday, at the end of the session, when you  
13 were asking me about the statewide price and the local  
14 health district - and a local health district being able to  
15 go below the statewide price, and doesn't that make it  
16 lower for the state, I was reflecting on that yesterday  
17 afternoon after I left.

18

19 The reason that we have statewide contracts is to get  
20 the best price for the state, which I talked about  
21 yesterday. Now, that takes time to work with the supplier  
22 community in terms of understanding the disciplines around  
23 that. So whilst mathematically, you're right, if there's  
24 a statewide price and a local health district can get  
25 a lower price, overall, you would, on the surface of it,  
26 think that that would be lower for the state.

27

28 The reality is that once that behaviour creeps in, as  
29 we go to subsequent contracts, the statewide price can go  
30 higher because suppliers then know that they can go to  
31 individual local health districts with lower prices. So  
32 it's actually - in terms of equity across the system over  
33 time, it becomes inequitable again.

34

35 THE COMMISSIONER: Q. How do we know that?

36 A. From experience. So prior to there being the number  
37 of statewide contracts in place, suppliers would offer the  
38 same product to different local health districts and even  
39 to hospitals within local health districts - some would be  
40 paying a much higher price than others because of their  
41 ability or lack of ability to be able to negotiate a price,  
42 and so that's what the statewide price is about, is to stop  
43 that type of behaviour.

44

45 MR MUSTON: Q. Can I ask you a few things about that.  
46 First, so I understand it correctly, you say there's  
47 benefit in centralised negotiation of the contracts,

1 because the state, as a collective, has a better capacity  
2 to bargain with a supplier than would perhaps a smaller  
3 LHD?

4 A. Yeah. That's correct, because it's volume based.

5  
6 Q. So to the extent that you're talking about inequity  
7 between LHDs or potential inequity between LHDs there, it  
8 may be that one of them, say a large metro LHD, if they  
9 were going it alone, would have a better capacity to  
10 bargain than a smaller, more remote LHD?

11 A. Yes.

12  
13 Q. So that's the negotiation aspect of it. The second  
14 aspect of it that we're talking about is the price, is  
15 consideration given to different pricing structures across  
16 the different LHDs ever?

17 A. There's - there are always exceptions to - it depends  
18 on what the product is. So - how can I best describe it?  
19 In the standing offer of agreement that we have with the  
20 suppliers, if they are to go to a local health district  
21 with a lower price for a particular product, they're  
22 contractually obliged to advise HealthShare so that we can  
23 understand what that - how that will impact the system.

24  
25 So there are circumstances where that would be  
26 supported, but on a general basis, it's the statewide price  
27 to make sure that there's equity across the system, that  
28 everybody's getting the same price and there isn't that -  
29 and to reduce the possibility for suppliers to be able to  
30 charge more to one hospital and less to another.

31  
32 Q. Can I ask you some questions about the items that are  
33 on the inventory, so the Onelink warehouse items?

34 A. Yes.

35  
36 Q. Those items are being delivered by suppliers to the  
37 Onelink warehouse only, not to different LHDs?

38 A. That's right, yes.

39  
40 Q. So in that case, it's a single, volume-based purchase?  
41 A. That's right.

42  
43 Q. And you are seeking to - once you have chosen the  
44 product that you think is the best product, you are seeking  
45 to extract the best price by your market volume?

46 A. Yes.

47

1 Q. Those items then need to be delivered to LHDs?  
2 A. That's right.  
3  
4 Q. The price that each LHD pays for the item is the same?  
5 A. Yes.  
6  
7 Q. Do the LHDs have to pay a delivery cost from the  
8 warehouse?  
9 A. It's free into store, that price.  
10  
11 Q. What does that mean, free into store?  
12 A. That means that the price that they pay from the  
13 warehouse is the price that they have. However, there is  
14 a transport price applied to rural local health districts.  
15  
16 Q. So just unpacking that, if a metropolitan local health  
17 district located very close to the Onelink warehouse was  
18 buying a box of swabs, they would pay the price of the  
19 swabs and what, if anything, for the delivery of those  
20 swabs?  
21 A. Yeah, they'd --  
22  
23 Q. What, if anything?  
24 A. Yes.  
25  
26 Q. Would they pay an amount on top of --  
27 A. They wouldn't. It's free into store.  
28  
29 Q. So it's free - for a metropolitan LHD the LHD is not  
30 charged any money --  
31 A. Yes.  
32  
33 Q. -- for an item to be delivered from the Onelink  
34 warehouse --  
35 A. That's right, yeah.  
36  
37 Q. -- to a hospital within the metro area?  
38 A. Yeah.  
39  
40 Q. A rural or regional LHD that wants to acquire that  
41 same box of swabs would have to pay what?  
42 A. It's free into store.  
43  
44 Q. So there's no charge --  
45 A. Actually, the rural local health districts do pay  
46 a transport charge under the current warehousing  
47 arrangement, and so that - yeah, that's correct. But they

- 1 get the same price for the product as the other local  
2 health districts.
- 3
- 4 Q. So they would pay the same price for the box of swabs?  
5 A. Yes.
- 6
- 7 Q. But in addition to that, they would pay actual freight  
8 costs incurred?  
9 A. Yeah, yeah,
- 10
- 11 Q. To deliver those swabs from the Onelink warehouse  
12 to --  
13 A. Yeah, depending on - depending on the product, yes.
- 14
- 15 Q. When you say "depending on the product", how is it  
16 differentiated?  
17 A. Look, that level of detail I'd need to come back to  
18 you on. But there is - the rural local health districts do  
19 feel somewhat disadvantaged because of that transport cost,  
20 and that's recognised. And that is something that we are  
21 currently working on for the new contract.
- 22
- 23 Q. If it be assumed that the rural LHDs are paying more  
24 to have the items delivered from the Onelink warehouse to  
25 their hospitals, they're paying more, in a practical sense,  
26 for the products, aren't they?  
27 A. Yes. But they're still better off because of the  
28 statewide price. So even when you take into account the  
29 transport costs, because they would have had that anyway,  
30 because of where they're located.
- 31
- 32 Q. You say that. Can I ask, has any economic modelling  
33 been done in relation to that?  
34 A. There is modelling done by our --
- 35
- 36 Q. Who does that?  
37 A. That is done within HealthShare by the category - by  
38 the category teams.
- 39
- 40 Q. What form does that modelling take?  
41 A. Well, yeah, I - I'd need to get that level of detail  
42 for you.
- 43
- 44 Q. Do you know whether there is information available as  
45 to precise levels of usage of different items at different  
46 hospitals?  
47 A. We know how much is used by each item, and the thing

1 that you need to keep in mind is that rural local health  
2 districts are buying much smaller volumes of products than  
3 the metros, so the benefit that they're getting is that the  
4 price that they are paying for the particular good is based  
5 on the volume of the state, which they would not be able to  
6 do on their own, and they would still be charged  
7 a transport cost.

8

9 Q. Who in your team does this modelling?

10 A. It's done by the category teams. So there is  
11 a number - the products that are done are - so there's  
12 approximately half a dozen category managers and teams, and  
13 they are the ones responsible for looking at the total  
14 contract and the service that accompanies that.

15

16 Q. We might have to take that up with them. It's the  
17 case that you don't know the details of the modelling that  
18 they do --

19 A. Look, I'd need to --

20

21 Q. -- or what the inputs or outputs of that exercise are?

22 A. I'd need to refer to the experts in procurement on  
23 that.

24

25 Q. Can I ask you, then - do you still have a copy of your  
26 statement in front of you?

27 A. I do.

28

29 Q. Can I ask you to go to paragraph 19 of that statement,  
30 which, for the operator, is [MOH.9999.0009.0001] on  
31 page .0006?

32 A. Did you say paragraph 19?

33

34 Q. Paragraph 19.

35 A. Yeah.

36

37 Q. I take it that in paragraph 19, that reflects what you  
38 and HealthShare aspire to achieve? You're not suggesting  
39 that those goals are necessarily achieved in every  
40 instance, are you?

41 A. No. We - as I said yesterday, we're an organisation  
42 that is maturing and we work on a continuous improvement,  
43 and obviously things change in the marketplace, things  
44 change in health, and we need to be responsive to that. So  
45 I wouldn't say that in every instance we're perfect.

46

47 THE COMMISSIONER: No, I just read the first sentence as

1 at least partly aspirational.

2

3 MR MUSTON: Q. Can I ask you then to go down - do you  
4 see three lines from the bottom, where you say "These  
5 services help to achieve good patient outcomes"?

6 A. Yes.

7

8 Q. Can I just ask what you mean by "good patient  
9 outcomes", where you use that term in that paragraph?

10 A. So obviously the goal of everybody who works in  
11 NSW Health is to ensure that patients receive the best  
12 quality care, and our role in that is to ensure that the  
13 services that we provide work towards that goal, so whether  
14 that be ensuring that, you know, the linen is right, you  
15 know, is clean; that food is served --

16

17 Q. Can I ask you to focus on the procurement activities.

18 A. Mmm.

19

20 Q. Insofar as HealthShare is involved in procurement, to  
21 what extent do you say that it is striving to achieve good  
22 patient outcomes, or in what way? What sort of outcomes?

23 A. That we have the right product at the right price.

24

25 Q. Just pause there. When you say "the right product",  
26 what is the outcome that you are referring to when you're  
27 talking about a patient outcome?

28 A. So through our processes, our tendering and contract  
29 processes, that we have engaged with clinicians  
30 appropriately to identify the --

31

32 Q. I think we might be at cross-purposes.

33 A. Okay.

34

35 Q. I'm not wanting to ask about the process. You talk  
36 about striving to achieve a good patient outcome.

37 A. Mmm-hmm.

38

39 Q. All I want to know is, from the perspective of  
40 HealthShare, what is a good patient outcome?

41 A. That the patient leaves hospital better than when they  
42 came in, so whether that be a knee replacement or whether  
43 that be a bandage, that that has gone towards their -  
44 a healthy outcome.

45

46 Q. And in terms of that good patient outcome, when you  
47 use that term, are you looking at anything beyond that, in

1 terms of a patient leaving a hospital better than when they  
2 came in, say, for example, longer-term outcomes for that  
3 patient?  
4 A. That would be part of the goal. We're there to  
5 support clinicians in delivering that. Am I understanding  
6 your question correctly?  
7  
8 Q. Yes. Could I ask the witness to be shown  
9 exhibit B.016, which is [SCI.0003.0001.0023].  
10  
11 THE COMMISSIONER: It might be 16 is the med tech - sorry,  
12 B.016? That's where you are going to? Right.  
13  
14 MR MUSTON: It is.  
15  
16 Q. I can give you a hard copy. There's also a copy that  
17 you can see on that screen behind you?  
18 A. Oh, that would be better.  
19  
20 Q. I just want to invite you to read - do you see there  
21 a paragraph headed "2.1, "Current NSW Approach problems"?  
22 A. Yes.  
23  
24 Q. Can you invite you to read that paragraph down to  
25 2.1.1.3 to yourself. Once you have considered it, I just  
26 want to give you an opportunity to respond to that.  
27 A. Yes, I've read it.  
28  
29 Q. So just understand where that comes from, that's  
30 a view being expressed by Paul Dale of the Medical  
31 Technology Association of Australia?  
32 A. Yes.  
33  
34 Q. Do you agree with what he's saying there in  
35 paragraph 2.1?  
36 A. No. No, I don't.  
37  
38 Q. In relation to 2.1.1.1, his suggestion that an  
39 inappropriate weight is placed on the price of solutions  
40 instead of using a holistic approach which capturing  
41 additional value such as improved patient outcomes and  
42 indirect costs to the health system --  
43 A. Yes.  
44  
45 Q. -- how do you respond to that?  
46 A. I think that's an incorrect statement.  
47



1 Q. In what way?

2 A. I think patient safety and quality is our overarching  
3 goal, so to say that price is - inappropriate weight is  
4 placed on price, I would disagree with that. In terms of -  
5 yeah, I disagree.

6  
7 Q. So how is it that you say in its procurement  
8 activities - I'm not talking about linen and shared  
9 services at the moment, I'm just talking about the  
10 procurement activities --

11 A. Yeah, yeah.

12  
13 Q. How is it that you say HealthShare is using a holistic  
14 approach which captures additional values such as improved  
15 patient outcomes and indirect costs to the health system?  
16 How is it doing that?

17 A. Because when we go - when we go out to market, we -  
18 it's the process that we use as we go out to market and we  
19 need to take into consideration what products are on the  
20 market since the last contract, take into account the  
21 patient safety aspect, take into account any kind of  
22 service provision that might accompany a particular  
23 product - I could give you an example, if an example would  
24 be helpful.

25  
26 Q. It would be useful, yes.

27 A. So hips and knees - we went out in 2018 and were  
28 able - so prior to 2018, that was procured locally.  
29 Bringing that together into a statewide contract, we were  
30 actually able to reduce the number of suppliers and have  
31 a more standardised approach to the products that we were  
32 purchasing.

33  
34 That contract came up for renewal in 2022 and at that  
35 time, when we went out to tender, we also asked the market  
36 what else they might be able to offer, and so a robotic  
37 process was identified, which was trialled in Southern New  
38 South Wales. So that was something that was - suppliers  
39 were actually able to say, "Look, not only do we have these  
40 knees and hips, but we've also - what is associated with  
41 that is assistive technology in placing them into people."  
42 And so that --

43  
44 THE COMMISSIONER: I think the knees and hips contract is  
45 referred to in Mr Dale's statement at 4.3.

46  
47 THE WITNESS: So that would be a good example of where,

1 you know - I think is a very good example of where price is  
2 not the overarching consideration.

3  
4 MR MUSTON: Q. When you are considering tenders,  
5 I gather what you're telling us is that good patient  
6 outcomes, as you understand that term, is something which  
7 is factored in to your consideration of which of the  
8 tendering parties should be offered the contract?

9 A. Yes.

10  
11 Q. How do you assess the patient outcomes which are being  
12 potentially associated with the different tendering  
13 parties' offerings?

14 A. So that would be feedback that we receive from  
15 contract managers and clinical product managers in the  
16 local health districts. So we have - when we have monthly  
17 meetings with them, it is about not only the performance of  
18 the contract but, you know, all aspects of that, which  
19 would include the - you know, what is provided.

20  
21 Q. Can I ask, with all due respect to contract managers  
22 and clinical product managers - they're individuals within  
23 the procurement stream?

24 A. Mmm-hmm.

25  
26 Q. Is that right?

27 A. Yes.

28  
29 Q. To what extent are they, do you think, well qualified  
30 to express a view about the likely patient outcomes  
31 associated with using a particular product?

32 A. Well, they receive the feedback from clinicians.  
33 That's their role. So clinical product managers are  
34 clinicians themselves and have - that's their role in the  
35 local health districts, to liaise with the clinicians and  
36 get that feedback. When we ask for representatives on the  
37 technical evaluation committees, they are clinicians who  
38 are using those products, so there's also part of the  
39 evaluation process before going out.

40  
41 Q. So first way that you try and assess the likely  
42 patient outcomes of using a particular product is to get  
43 feedback from the category managers within your  
44 organisation who, in turn, are informed by category  
45 managers within the LHDs, who in turn, it's hoped, are  
46 informed by clinicians on the ground?

47 A. That's right.

- 1  
2 Q. That's, you would accept, potentially an imperfect  
3 process insofar as it depends upon information being passed  
4 from one to the other to the other, which is reliable?  
5 A. But we also --  
6  
7 Q. No, just pause with that one. Do you accept that that  
8 is an inherently unreliable way of assessing the potential  
9 patient outcomes because it depends upon a chain of people  
10 passing on information?  
11 A. No, I don't - I don't think it's unreliable.  
12  
13 Q. Do you accept that that requires a chain of people,  
14 starting with clinicians, ending perhaps several layers  
15 through the procurement pathway at HealthShare, to pass on  
16 information about their experience of price?  
17 A. No. I believe our processes are very thorough and  
18 that clinicians have good opportunity to be able to provide  
19 feedback, and I have confidence not only in HealthShare but  
20 also in the teams within the local health districts, that  
21 that information is received accurately.  
22  
23 Q. But when you say that you have confidence, that's  
24 because you assume it happens; is that right?  
25 A. Because I know it happens.  
26  
27 Q. How do you know that it happens?  
28 A. Because we meet regularly with the local health  
29 districts and receive feedback.  
30  
31 Q. Who from within the local health districts are you  
32 receiving the feedback from and having the meetings with, I  
33 should say?  
34 A. So we meet monthly with the contract managers about  
35 the contract, and we meet monthly with the clinical product  
36 managers, who give us feedback on the actual products.  
37  
38 Q. Is HealthShare meeting regularly with clinicians on  
39 the ground in the LHDs - yes or no?  
40 A. I would say - well, yes, we are, yeah.  
41  
42 Q. Who at HealthShare is doing that?  
43 A. The category managers.  
44  
45 Q. And what's the nature of these meetings? Are they  
46 a formal arrangement or informal arrangement?  
47 A. Through the clinical product managers. So that's

1 where the - that's where the feedback comes.

2

3 Q. I think maybe I wasn't clear enough in my question.

4 Are people from HealthShare meeting directly with  
5 clinicians in the various LHDs regularly - yes or no?

6 A. The answer to that question would be yes.

7

8 Q. So the meetings that HealthShare is having with  
9 clinicians regularly, what's the structure? Is there  
10 a regular structure whereby those meetings occur?

11 A. Well, I think the - the best way to answer that  
12 question is that clinicians are there to look after  
13 patients, so they have a support system around them to be  
14 able to communicate to HealthShare if there are problems  
15 with particular products.

16

17 Now, we - if there was a particular problem with  
18 a product, then we would then meet directly with clinical  
19 product managers and clinicians to discuss that particular  
20 product. But if you are asking do we meet with them on  
21 a monthly or quarterly basis formally about products, then  
22 the answer to that question would be no, but we definitely  
23 have relationships with numerous clinicians across the  
24 state. So there are avenues for that feedback to come  
25 directly to HealthShare.

26

27 Q. But those avenues would depend upon, to use the  
28 example you gave a moment ago, clinicians on the ground  
29 telling the relevant procurement people within their LHDs  
30 that they perceive there to be problems with a product; is  
31 that right?

32 A. They also have access to HealthShare.

33

34 Q. So they could also contact HealthShare --

35 A. They can yes.

36

37 Q. -- if they perceive there to be a problem with  
38 a product?

39 A. And they do, and they do.

40

41 Q. Would I be right to say that that's an ad hoc process?

42 A. It's an as needed process.

43

44 Q. I think you told us a moment ago about, as part of  
45 this tender evaluation - did you say there was  
46 a technical --

47 A. Evaluation committee.

- 1  
2 Q. -- evaluation committee. Who is on that committee?  
3 A. So when we go - prior to going out to tender, we write  
4 to all the local health districts and ask them to nominate  
5 representatives to sit on our technical evaluation  
6 committees.  
7  
8 Q. So is there a representative from every LHD on  
9 a technical evaluation committee?  
10 A. In some cases, yes. In some cases, no. It depends on  
11 whether clinicians are available to sit on those  
12 committees. Sometimes local health districts might be  
13 quite happy to be represented by another local health  
14 district. But they certainly are all invited.  
15  
16 Q. Do any of the other pillars have representatives on  
17 the technical evaluation committees?  
18 A. At times, yes. So the Clinical Excellence Commission  
19 may be part of an evaluation committee or we use them as  
20 a reference point for the clinical evaluation committee.  
21  
22 Q. What about the ACI? Does the ACI sit?  
23 A. ACI from time to time may be as well.  
24  
25 Q. When you say "from time to time", what --  
26 A. As required. It depends on the contract.  
27  
28 Q. When you say that, what's the trigger for it being  
29 required that the ACI participates in one of these  
30 committees?  
31 A. So ACI is obviously the Agency for Clinical  
32 Innovation, so if it's - if there is a particular product  
33 that we require the expertise of the ACI, then we would  
34 either reference them or invite them on to the evaluation  
35 committee.  
36  
37 Q. How does HealthShare decide whether it requires the  
38 assistance of the ACI in any particular instance?  
39 A. It would come through the technical evaluation  
40 committee members.  
41  
42 Q. So let me understand that process. The technical  
43 evaluation committee is formed and meets?  
44 A. Yes.  
45  
46 Q. And pausing there, that is the - the technical  
47 evaluation committee is representatives who happen to be

- 1 available from LHDs?  
2 A. Yes.  
3  
4 Q. And I think I might have not asked you who else is on  
5 that committee. So you have the LHD representatives and  
6 who else?  
7 A. They can then draw - they can then --  
8  
9 Q. Just listen to my question.  
10 A. Sorry, yeah.  
11  
12 Q. The committee involves people who have come from the  
13 LHDs?  
14 A. Yes.  
15  
16 Q. After the invitation has been issued?  
17 A. Mmm-hmm.  
18  
19 Q. Is there anyone else who are standing or normal run of  
20 the mill members of these committees - someone from  
21 HealthShare, for example?  
22 A. Well, HealthShare is on the committee in terms of  
23 running the process.  
24  
25 Q. Anyone else who would routinely be these committees?  
26 A. It would depend on the particular product. So, as  
27 I said, there are various categories, so it's very much up  
28 to - so if you - if the question is in relation to the  
29 Agency for Clinical Innovation or the Clinical Excellence  
30 Commission, usually, the tender evaluation committee would  
31 refer to those - so they may not be members but they could  
32 actually provide advice into the technical evaluation  
33 committee.  
34  
35 Q. So have I got this right, the technical evaluation  
36 committee process, run by HealthShare --  
37 A. Mmm-hmm.  
38  
39 Q. -- sends out invitations to LHDs for representatives  
40 to join the committee?  
41 A. Yeah.  
42  
43 Q. LHDs will, sometimes yes, sometimes no, send along  
44 representatives who are clinicians?  
45 A. Mostly yes, yeah, yeah.  
46  
47 Q. Subject to availability?

- 1 A. Yes.  
2
- 3 Q. That group then meets and decides whether it thinks it  
4 might be useful to obtain input from either the CEC or the  
5 ACI?  
6 A. Yes.  
7
- 8 Q. If so, advice is sought from one or both of those  
9 organisations?  
10 A. Yes.  
11
- 12 Q. But if the technical evaluation committee does not  
13 consider it to be something which is needed, then they  
14 won't call for the advice of the CEC or the ACI.  
15 A. That would be - that would be right, yeah.  
16
- 17 Q. There is no standing arrangement whereby either of  
18 those organisations have representatives that sit on  
19 technical evaluation committees?  
20 A. Not - no, not all the time.  
21
- 22 Q. In relation to the clinicians who are sent by the  
23 LHDs, would it be right to assume that the particular  
24 experience and qualification of the representative depends  
25 very much on what it is that is being purchased?  
26 A. Yes, definitely.  
27
- 28 Q. So for wound care items, for example, it might be  
29 nursing staff who are sent to --  
30 A. Yes.  
31
- 32 Q. -- provide clinical input?  
33 A. Yes.  
34
- 35 Q. An orthopaedic prosthetic device, it might be an  
36 orthopaedic surgeon?  
37 A. Yes.  
38
- 39 Q. Would that be right?  
40 A. Yeah, yes.  
41
- 42 Q. Do you know, in relation to the evaluations carried  
43 out by these committees, how they go about assessing or  
44 measuring the patient outcomes that are associated with  
45 particular items - that is, the competing items? Perhaps  
46 let me give you an example.  
47 A. Mmm.

1  
2 Q. Just so you can talk me through it by reference to an  
3 example. You've got two different sutures. One of them  
4 has some antibiotic product and the other one doesn't.  
5 There's obviously a price differential. The technical  
6 evaluation committee is called to make an assessment about  
7 which one is going to be the better one to be purchasing.  
8 Do you know how they go about evaluating the patient  
9 outcomes that might be attributable to using, say, one over  
10 the other?

11 A. Look, I'd have to - I'd have to take advice from my  
12 teams. That level of detail is - I wouldn't be able to  
13 accurately answer that.

14  
15 Q. But insofar as you're aware, there's no formal  
16 structure, is there, where particular outcomes are  
17 identified and put forward to you, for example, at  
18 HealthShare, so that ultimately you can form a view about  
19 which of the two products is going to produce the better  
20 patient outcomes?

21 A. That's the discussion that's held in the technical  
22 evaluation committee.

23  
24 Q. So am I right, the technical evaluation committee,  
25 internally, decides which product --

26 A. Yes.

27  
28 Q. -- will produce the best patient outcomes?

29 A. Yes. And then they make a recommendation as to which  
30 suppliers and which products.

31  
32 Q. Do you know whether the particular patient outcome  
33 that they have relied upon as an important determining  
34 factor is something which is identified outside of that  
35 committee - that is, is someone told, outside of the  
36 committee, who is involved in signing the contract, "This  
37 is why we've gone with this product"?

38 A. So part of the role of the technical evaluation  
39 committee is actually to, as a starting point, review how  
40 the previous contract and suppliers on that contract have  
41 performed and that helps inform them for the next contract.  
42 So there would be --

43  
44 Q. I think my question was, though, to the extent that  
45 the technical - I think I said technical advisory - is it  
46 technical evaluation committee?

47 A. That's all right. I know what you mean, technical



1 evaluation.

2

3 Q. To the extent that the technical evaluation committee  
4 identifies, for example, a particular patient outcome,  
5 which it thinks justifies going with a particular product  
6 say, longer life span of a prosthesis or less  
7 complications --

8 A. Yeah.

9

10 Q. -- to the extent that they identify a feature like  
11 that as the patient outcome which should be given weight in  
12 the tender process --

13 A. Yes.

14

15 Q. -- do you know whether they identify that patient  
16 outcome to whoever it is up the chain who ultimately makes  
17 the decision about whether or not to enter into the  
18 contract?

19 A. That is the role of the category managers both at the  
20 local health district and HealthShare to monitor.

21

22 Q. Pausing there, it's the role, but does the committee  
23 actually communicate that to anyone? Namely, "This is why  
24 we have recommended this product - because of this patient  
25 outcome"?

26 A. They receive - so as part - being members of that  
27 committee, they receive the feedback of that product over  
28 the life of the contract. So that's taken into account in  
29 their considerations.

30

31 Q. So when it comes to the balancing act of deciding  
32 whether or not to enter into a particular contract, do you  
33 know how the patient outcome is assessed in the mix of  
34 factors that ultimately make up deciding --

35 A. That's probably --

36

37 Q. -- whether or not to sign a contract?

38 A. That's probably a level of detail that I'd have to  
39 refer to our technical teams. You're getting quite  
40 technical now.

41

42 Q. So let me just ask you at a process level.

43 A. Sure.

44

45 Q. I don't want to ask you about a particular technical  
46 item - and it may well be that you don't know the answer,  
47 so don't feel pressed to give us one if you don't know it.

- 1 A. That's fine. No, I won't.  
2
- 3 Q. Is there some formal process whereby particular  
4 patient outcomes are given any sort of formal weighting as  
5 part of a tender evaluation process relative to other  
6 considerations like price, contract performance, et cetera?  
7 A. Again, I'd need to refer to the technical teams, but  
8 it would definitely be - it would have - yeah, it would be  
9 part of the considerations, I would expect.  
10
- 11 Q. I think you said you would expect, but you don't - but  
12 the position is you don't know whether they take into  
13 account any particular patient outcomes in their assessment  
14 of a tender; is that right?  
15 A. I'd need to refer to our - to the experts in our  
16 procurement team. I think that, you know, it depends on -  
17 would depend very much on the product that we're looking to  
18 purchase.  
19
- 20 Q. Who makes the ultimate decision about whether or not  
21 to sign the contract?  
22 A. So the technical evaluation committee makes the  
23 recommendation. That then gets briefed, comes through to  
24 me. I sign off on the process.  
25
- 26 Q. Pausing there, the brief that comes to you, what  
27 information does that brief contain? Does it take  
28 a standard form or --  
29 A. The brief - yeah, the brief basically outlines what  
30 the contract is, what the process that has been followed,  
31 what the recommendation has been. I look to make sure that  
32 the process has been followed. I sign off on that. That  
33 goes to the chief procurement officer of NSW Health and  
34 then he signs off on the recommendation, and if the chief  
35 procurement officer has any queries, then it may come back  
36 to the tender evaluation committee and then go back up.  
37
- 38 Q. So I understand you check the process --  
39 A. Yes.  
40
- 41 Q. -- you check the recommendation? Does the brief  
42 that comes to you contain any sort of discussion or  
43 analysis of the relative pros and cons of the various  
44 tendering parties?  
45 A. It wouldn't go - it doesn't go into that level of  
46 detail.  
47

- 1 Q. So to the extent that the tender evaluation committee  
2 has identified particular patient outcomes as being  
3 a factor which may justify purchasing a particular item --  
4 A. Yes.  
5
- 6 Q. -- that's not information which finds its way into the  
7 brief that goes to you?  
8 A. No. What comes to me is the recommendation of the  
9 suppliers.  
10
- 11 Q. And in terms of what goes from you to the chief  
12 procurement officer, do you know whether it's the same  
13 information?  
14 A. The chief procurement officer receives the same  
15 information.  
16
- 17 Q. Thank you. I think we've talked about patient  
18 outcomes. Are service levels being offered by particular  
19 tendering parties something else which might be taken into  
20 account as part of the mix in deciding whether or not to  
21 enter into a contract?  
22 A. I'm not quite sure what you're asking me there. In  
23 terms of service levels, what --  
24
- 25 Q. So, for example, the extent to which a contracting  
26 party is able to provide products reliably and promptly and  
27 accurately - is that a factor which is taken into account  
28 as part of an assessment of a tender?  
29 A. That becomes part - that becomes part of their  
30 commitment when they sign the contract.  
31
- 32 Q. At what stage in the process is that considered?  
33 A. That would go into the standing offer of agreement, or  
34 the head agreement, as we refer to, with the suppliers  
35 where all of that is - all those expectations are outlined.  
36
- 37 Q. Is an assessment made at any point in the process,  
38 prior to that, as to whether or not a particular contractor  
39 is likely to be able to meet those performance standards?  
40 A. That - and that forms part of the - that forms part of  
41 the considerations of the technical evaluation committee.  
42 So when the suppliers put their tenders in, they have had  
43 to answer all of those questions that they are, you know,  
44 able to provide the products, you know, on time, right  
45 price, those types of things. So that forms part of their  
46 tender, and then when it comes to the contract, those  
47 requirements are then embedded in the contract and they're

- 1 contractually obliged to follow that.  
2
- 3 Q. So the tender process requires the potential supplier  
4 to say they will do something?  
5 A. That's right.  
6
- 7 Q. In terms of performance levels?  
8 A. Correct.  
9
- 10 Q. I think HealthShare's own KPI about picking that we  
11 talked about yesterday - I assume that individual  
12 suppliers --  
13 A. Yes.  
14
- 15 Q. -- have a similar requirement imposed upon them?  
16 A. Yes.  
17
- 18 Q. They say in their response to tender, "Yes, we can  
19 comply with that requirement that we get the deliveries  
20 right and on time", by a particular percentage of the time,  
21 98 per cent, say?  
22 A. Yeah, whatever, yeah.  
23
- 24 Q. Is any assessment made at any stage before the  
25 contract is signed as to whether or not --  
26 A. They can do that?  
27
- 28 Q. -- it's felt that they can actually achieve what they  
29 have told you they can achieve?  
30 A. There would be - there would be - past performance  
31 would be. We'd, I would imagine, take that - well, not  
32 "imagine", we'd take that into account.  
33
- 34 Q. So, just pausing there, if they take past performance  
35 into account, there are two contractors tendering for the  
36 job, one has a poor past performance record and one has  
37 a good past performance record, but the one with the poor  
38 past performance record is offering a lower price, may that  
39 be a factor which warrants paying a little bit more for the  
40 product to ensure the better performance?  
41 A. Price isn't the only consideration, so if - there  
42 needs to be - we wouldn't just go for the lower price and  
43 accept lower performance; we would want the best price and  
44 good performance.  
45
- 46 Q. So if an assessment is made that a particular low  
47 price - lower-priced contractor may not be able to perform,

1 that is a basis upon which you might pay a slightly higher  
2 price for the same product; is that essentially what you're  
3 saying?

4 A. Mmm-hmm, yeah.

5

6 Q. In terms of that assessment of past performance, in  
7 what way is the performance of contractors who have been  
8 providing a service to HealthShare prior to that tender  
9 process assessed?

10 A. So part of the contract management process,  
11 HealthShare meets quarterly with suppliers. There are  
12 forums where the suppliers, HealthShare and the local  
13 health districts can provide feedback to one another.  
14 There's also the procurement teams within the local health  
15 districts who meet regularly with suppliers and engage  
16 regularly with suppliers. So when we meet with contract  
17 managers and clinical product managers on a monthly basis,  
18 that feedback about suppliers is given. So there is  
19 a continual monitoring of the performance of suppliers  
20 throughout the contract period.

21

22 Q. We might come back to that. Can I ask the witness to  
23 be given exhibit B.023.129 again, that's the  
24 [MOH.9999.0010.0001]. We might even be able to get it up  
25 on the screen, and that's the easiest way, but if you need  
26 a hard copy, do let me know.

27 A. That's all right. I can read this screen here. It's  
28 just that one I have a bit of trouble with.

29

30 Q. That's the statement of service again. Could I ask  
31 that we go to page .0018. Do you see the heading there  
32 "Future Health actions and performance deliverables". Can  
33 I just ask, in terms of where the various items that sit  
34 within this aspect of the document sit relative to the more  
35 granular KPIs in the pages immediately before --

36 A. Yes.

37

38 Q. -- what is the obligation that's imposed upon by  
39 HealthShare by these statements? Are these aspirational  
40 statements or are they hard requirements - that is to say,  
41 the achievement statements and actions that are set out in  
42 the table that follows.

43 A. So they're - I would say that they're aspirational  
44 statements.

45

46 Q. Perhaps I didn't put the question very well. What are  
47 the consequences for failing to meet those aspirations,

1 from HealthShare's perspective?  
2 A. In terms of our contract management of suppliers; is  
3 that what you --  
4  
5 Q. In terms of your arrangements - your arrangement with  
6 the secretary under the statement of service?  
7 A. Yes. So our --  
8  
9 Q. If one of these achievement statements is not met,  
10 what are the consequences?  
11 A. With the secretary or with suppliers?  
12  
13 Q. With the secretary?  
14 A. Well, we're accountable to the secretary to ensure  
15 that we manage our relationships with suppliers and local  
16 health districts, forms part of our agreement with the  
17 secretary.  
18  
19 Q. But to the extent that a particular item referred to  
20 in this "Future Health actions" is not achieved, what are  
21 the consequences, if any?  
22 A. So value and act upon feedback - will I use that an  
23 example or do you want to pick one out? There's quite  
24 a few there.  
25  
26 Q. Why don't we turn over to page 0020, page 19 in the  
27 hard copy, we see, "The health system is managed  
28 sustainably", for example; do you see that?  
29 A. Yes.  
30  
31 Q. The first item there:  
32  
33 *Scale successful solutions: Successful*  
34 *VBHC initiatives are scaled and applied at*  
35 *a local and state level.*  
36  
37 THE COMMISSIONER: Is VBHC value based health care.  
38  
39 MR MUSTON: I was about to ask that.  
40  
41 THE COMMISSIONER: That was my guess.  
42  
43 THE WITNESS: You are right, you are spot on.  
44  
45 MR MUSTON: Mine too, but we'd better make sure your guess  
46 and mine are the same as the witness's guess.  
47

1 THE WITNESS: You will know these acronyms better than us,  
2 soon. So that's:

3  
4 *Complete a refresh of all Procurement*  
5 *category strategies with input from across*  
6 *the system including identification of*  
7 *opportunities to drive better value and*  
8 *eliminate inefficiencies.*

9  
10 So we need to - as part of our yearly performance  
11 reporting, we have to demonstrate that we're able - that we  
12 are able to do that.

13  
14 MR MUSTON: Q. And so to the extent that there's actions  
15 listed there, what you need to demonstrate is that you've  
16 gone somewhat down the path towards taking those actions by  
17 the date specified?

18 A. Yeah, and be able to prove that we're doing that, you  
19 know, show - it's not just a matter of saying, "Oh, yes,  
20 we're meeting that particular aspiration", but also to be  
21 able to demonstrate how we've done that. And then, in some  
22 cases, we may not have done it - been able to do it to, you  
23 know, the level that we aspire to, but we need to be able  
24 to demonstrate what we have done and what we plan to do.  
25 So it's part of that continually improving our service  
26 delivery.

27  
28 Q. Going back to that term VBHC - the value based health  
29 care - what do you understand that to mean in a practical  
30 sense?

31 A. I think fundamentally, value based health care is very  
32 much about ensuring that we, as a system, consider as many  
33 things as possible when procuring products or services for  
34 the system.

35  
36 Q. When you say "as many things as possible" obviously  
37 there's a universe - that covers a universe of things,  
38 but --

39 A. I mean, it does, yes, but you think - there's millions  
40 of products that are circling out in the system, so what -  
41 you know, for a bandaid, would be very different than a hip  
42 or a knee, for instance. So it really depends on the  
43 product.

44  
45 Q. But when you're making that assessment in relation to  
46 any particular product, what do you understand the concept  
47 of value based health care to require, as an outcome?

1 A. Well, that it's safe for the - the product is safe for  
2 the patient; that it's a quality product; that it's fit for  
3 purpose; that it is - obviously price is part of that mix;  
4 it may even be, you know, we've got to take into account  
5 modern slavery; we've got to take into account small/medium  
6 enterprise; we need to take into account local suppliers -  
7 so all of that comes into the mix for consideration when we  
8 are looking to procure products.

9

10 Q. But to the extent that you're looking to procure  
11 products in a way which delivers value based health care as  
12 an outcome, what is value based health care as an outcome,  
13 as you understand it?

14 A. As I understand it, it's not just about the price.  
15 It's taking into consideration all other aspects that go  
16 into being able to provide safe products for patients.

17

18 Q. Now, in relation to the three items which are  
19 6.1.1.1.17 through to .21, how is it that the actions which  
20 are identified in the third column there have a capacity to  
21 deliver value based health care or enhance the delivery of  
22 value based health care as an outcome, as you understand  
23 it?

24 A. Can you just ask that question again? I'm not quite  
25 sure what you're getting at.

26

27 Q. Let's look at the first one. Number 17 -- 17.

28 A. Yeah.

29

30 Q.

31 *Scale successful solutions: Successful*  
32 *[value based health care] initiatives are*  
33 *scaled and applied at a local and state*  
34 *level".*

35

36 Then do you see next to that there is a column that is  
37 headed "Actions"?

38 A. Yes.

39

40 Q. I won't read it out to you, but can you explain how  
41 those actions are likely to have as their consequence the  
42 successful value based health care initiatives being scaled  
43 and applied at a local and state level? Perhaps we could  
44 roll it back a step. What do those actions actually mean?  
45 What do they involve someone doing?

46 A. So when we're talking - well, take that .17:

47



1           *Optimise back of house services at key*  
2           *sites, leveraging the principles and*  
3           *learnings from the Task Allocation System*  
4           *pilot, and develop roadmap for broader*  
5           *rollout.*  
6

7           What that's referring to is being able to ensure that the  
8           cleaning services that we provide are optimised to ensure  
9           that, you know, wards, theatres, are cleaned appropriately  
10          that contribute to a good outcome for patients.

11  
12          Q.    So those actions relate to the way in which the  
13          cleaning services --

14          A.    Well, it's an example. So the "Scale successful  
15          solutions" comes from the, you know, future health  
16          framework, and then in that "Actions", we're providing  
17          examples of how we contribute to that aspiration.

18  
19          Q.    So the next one, .20?

20          A.    Yes.

21  
22          Q.

23                 *Complete a refresh of all Procurement*  
24                 *category strategies with input from across*  
25                 *the system including identification of*  
26                 *opportunities to drive better value and*  
27                 *eliminate inefficiencies.*

28  
29          A.    Yeah, that's part of our statewide contracts.

30  
31          Q.    Is that part of this tender evaluation committee  
32          process that we've been talking about?

33          A.    Yeah, well, it's the whole - it's the tender process,  
34          the contract management process, the delivery of goods.  
35          It's the whole chain and how that supports - that then  
36          supports good outcomes for patients. So it's not - we're  
37          not just going on price.

38  
39          THE COMMISSIONER:    Q.    So it's no more complex than value  
40          based health care is - cost is an aspect, but you also  
41          consider things like, in terms of what you're doing or what  
42          you're buying, health outcomes --

43          A.    Mmm, correct.

44  
45          Q.    -- experience of the clinicians and staff, experience  
46          of the patients, those sorts of things as well?

47          A.    Yes, exactly. So if we, you know - if you'd like an

1 example, food, for instance, we have to take into account  
2 all the nutritional needs. So we can't just give Vegemite  
3 on toast, for instance - that would be, you know --

4  
5 Q. Cost effective but not really great?

6 A. -- cost effective but not nutritionally sound. The  
7 same with patient transport, you know. You can't just put  
8 somebody --

9  
10 Q. There are plenty of people, I think, WHO like Vegemite  
11 on toast.

12 A. Yes, I had it for breakfast, which is why it came to  
13 mind.

14  
15 Q. It was actually an awful example but I know what you  
16 mean.

17 A. You know what I mean, yeah.

18  
19 MR MUSTON: Q. Building on that, what you, I think, have  
20 told us, both in terms of the delivery of the shared  
21 services and your assessment of tenders is a range of  
22 factors in addition to price --

23 A. Yes, yeah.

24  
25 Q. -- which need to be taken into account?

26 A. Yes.

27  
28 Q. And I think you have told us, and again correct me if  
29 I am summarising it incorrectly, that when you're engaging  
30 in procurement activities, two of those factors that you  
31 take into account when deciding whether or not to pursue  
32 a particular product over and above price are patient  
33 outcomes, which can be derived from the use of that  
34 product --

35 A. Yes.

36  
37 Q. -- and the performance of the contractor under the  
38 contract, the likely performance of the contractor under  
39 the contract?

40 A. Yes.

41  
42 Q. And they're important from the point of view of  
43 patient outcomes because value based health care requires  
44 you to deliver the best patient outcomes that you can?

45 A. Yeah.

46  
47 Q. And in terms of the performance of the contractor,

1 they're important because there are - again, correct me if  
2 I'm wrong - potentially significant costs to be incurred in  
3 chasing up bad contractors --  
4 A. Yes.  
5  
6 Q. -- to the extent that they don't deliver items on time  
7 and accurately?  
8 A. Yep, and that - it has a potential impact to patients.  
9  
10 Q. It has a potential impact on the delivery of service  
11 to start with?  
12 A. Yes.  
13  
14 Q. The time and cost associated with chasing  
15 a recalcitrant supplier --  
16 A. Yes.  
17  
18 Q. -- means that the cost that you're actually,  
19 system-wide paying for the particular item is higher than  
20 that which is shown on the sticker, as it were?  
21 A. That's right.  
22  
23 Q. And the difference between the sticker price and what  
24 you're actually paying is that time which is eaten up --  
25 A. Yes.  
26  
27 Q. -- in dealing with the contractor?  
28 A. Yes.  
29  
30 Q. And so would you agree that it's very important to  
31 know whether you're securing the benefits beyond the  
32 price - like patient outcomes and performance - for there  
33 to be a continual monitoring and assessment of performance?  
34 A. Yeah, yes.  
35  
36 Q. Both of the product, in terms of patient outcomes?  
37 A. Yes.  
38  
39 Q. And of the performance of the actual contractor in  
40 terms of those performance benefits that you have factored  
41 in to your decision to accept a particular --  
42 A. Yes, yeah.  
43  
44 Q. -- contractor? Let me break them up. In terms of  
45 patient outcomes how do you assess or monitor patient  
46 outcomes which are generated by the use of a particular  
47 product?

1 A. That feedback would come via the local health  
2 districts via their - their engagement with clinicians.

3

4 Q. So in relation to that, to the extent that patient  
5 outcomes are being measured or assessed, they are patient  
6 outcomes which are visible to those clinicians who are  
7 seeing patients within the acute setting?

8 A. Yes.

9

10 Q. To the extent that there might be issues associated  
11 with patient outcomes which are only revealed within the  
12 private - within the primary health setting, so after  
13 they've been released from hospital and they are seeing,  
14 say, their GP --

15 A. Mmm.

16

17 Q. -- that's something which those in the acute setting  
18 don't have any awareness of?

19 A. I think that would be a question more for the local  
20 health districts.

21

22 Q. In terms of the performance from a "patient outcomes"  
23 point of view, is there any process whereby clinicians at  
24 the local health district are asked to monitor particular  
25 outcomes which might have been important in the  
26 decision-making --

27 A. Again, I think that's a - that is a question for local  
28 health districts. Because the clinicians are part of the  
29 local health district, and how the local health districts  
30 gather that information, I think that's where that question  
31 needs to be directed.

32

33 Q. But is there any process whereby the local health  
34 districts are told to ask their clinicians to gather  
35 particular information about products with a view to  
36 assessing whether the patient - expected patient outcomes  
37 which are featured in the tender process have actually been  
38 secured? Yes or no?

39 A. Look, I don't know the answer to that question.

40

41 Q. Now, in terms of contract management, could I invite  
42 you to go to paragraph 49 of your statement, just to make  
43 sure that we're all talking about the same thing. You see  
44 in paragraph 49 you refer to HealthShare having an ongoing  
45 role in contract management? What is that role, as you see  
46 it?

47 A. So that - so once the contract is in place and the

1 standing offer of agreement has been signed, then  
2 HealthShare has an ongoing role in liaising with the - so  
3 this is talking about level 2 and level 3, so statewide  
4 contracts, so HealthShare has the role of ensuring that the  
5 contracts are - that the suppliers are providing products  
6 and services in line with the contract. They receive that  
7 feedback from contract managers at the various local health  
8 districts.

9  
10 So our role in terms of - we would monitor  
11 performance. So when we have the meetings, the contract  
12 managers would provide feedback on how the contracts are  
13 going. If there is - if a local health district has  
14 difficulty with a particular supplier, the procurement  
15 teams within the local health district would, in the first  
16 place, work with that supplier.

17  
18 If it becomes more problematic, then that would be  
19 referred to HealthShare and then HealthShare would see  
20 whether it is just that local health district or whether it  
21 is more broad than that, so is it a statewide problem, in  
22 which case we would need to engage with the supplier for  
23 them to pick up their game.

24  
25 Sometimes it might be just a - you know, they're  
26 having a supply chain glitch. In other cases, it might be  
27 more serious than that, and so there are various measures  
28 that we can take. And so that is what goes - that is what  
29 this paragraph is talking about, that that is the  
30 management process that HealthShare undertakes on behalf of  
31 NSW Health.

32  
33 Q. So there would be a difference - the position might be  
34 slightly different in relation to suppliers who are  
35 delivering directly to the Onelink warehouse, in the sense  
36 that HealthShare, presumably, has visibility of what's  
37 being delivered to the Onelink warehouse and when?

38 A. Yeah, yeah.

39  
40 Q. So HealthShare places orders with the Onelink  
41 warehouse?

42 A. Yeah, yeah.

43  
44 Q. And HealthShare is able to assess whether or not, in  
45 relation to those items, the contractor is performing?

46 A. Yeah, yeah.

47

- 1 Q. In relation to those contracts where things are being  
2 delivered direct to the Onelink warehouse, what is the  
3 process that HealthShare undertakes to monitor performance  
4 by the contractors?
- 5 A. So it's the same as if those suppliers were delivering  
6 direct to a local health district or, you know, to  
7 a hospital. It's the same process of understanding, you  
8 know, how the goods are coming into the warehouse, are they  
9 meeting their obligations, and if they're not, it's the  
10 same - it's the same process as to whether it's direct to  
11 the hospital.  
12
- 13 Q. Maybe I have misunderstood the process. The Onelink  
14 warehouse, is it HealthShare that maintains a stockpile of  
15 goods or is it really just a pass-through, orders placed by  
16 LHDs go to the warehouse, and then go to --
- 17 A. So we have a supplier - we have an arrangement with  
18 the supplier to provide us with, I don't know --  
19
- 20 Q. Swabs?
- 21 A. Swabs. Those swabs are delivered in bulk to the  
22 warehouse.  
23
- 24 Q. Just pausing at that step in the process, who decides  
25 when and how much needs to be delivered to the warehouse?  
26 Is it HealthShare or is it driven by orders placed  
27 downstream?
- 28 A. No, HealthShare, based on the daily information that  
29 it receives in terms of what comes into the warehouse and  
30 what goes out.  
31
- 32 Q. So on that issue, HealthShare maintains --
- 33 A. The stock levels.  
34
- 35 Q. -- visibility of a stockpile?
- 36 A. Yeah.  
37
- 38 Q. And when that stockpile falls below a particular  
39 threshold, someone from HealthShare will contact the swab  
40 supplier and ask that it be replenished?
- 41 A. Yes. Yes.  
42
- 43 Q. So in that case, HealthShare knows when it has placed  
44 an order?
- 45 A. Yes.  
46
- 47 Q. It knows when that order has been delivered?

- 1 A. Received, yeah.  
2
- 3 Q. And it is able to make an assessment of whether or not  
4 the contractor has performed in respect of its obligations  
5 in relation to that delivery?  
6 A. Yes. That's right.  
7
- 8 Q. So that's one scenario. Different scenario I think is  
9 the one you were telling us about a moment ago where  
10 a statewide or whole of health contract contemplates goods  
11 being delivered from a supplier direct to an LHD?  
12 A. Yes.  
13
- 14 Q. In that case, order is placed through the iProcurement  
15 system?  
16 A. Yes, by the LHD to the supplier.  
17
- 18 Q. By the LHD. That sends an order, through that system,  
19 to the supplier?  
20 A. Yeah.  
21
- 22 Q. The supplier then deals directly with the LHD in terms  
23 of the delivery of the goods?  
24 A. Yes.  
25
- 26 Q. HealthShare, other than through this process that you  
27 spoke of a moment ago, has no direct visibility of  
28 performance by that contractor of its obligations in  
29 relation to that supplier; is that right?  
30 A. No.  
31
- 32 Q. So HealthShare relies on the LHDs to escalate problems  
33 in the way that you've just been through with us?  
34 A. Yes. And that's why each LHD has its own procurement  
35 team. That's the federated model.  
36
- 37 Q. So I think if we go over to paragraph 52, this is  
38 still dealing with the level 2 and 3 procurement contracts,  
39 is it?  
40 A. Yes.  
41
- 42 Q. So in terms of your administration with the terms and  
43 conditions, you're ensuring that the supplier maintains its  
44 insurances and licences?  
45 A. Yeah.  
46
- 47 Q. You don't expect LHDs to --

- 1 A. That's --
- 2
- 3 Q. -- continually make an assessment of that?
- 4 A. No, that's our role. That's - we take that on.
- 5
- 6 Q. And then in relation to b, seeking legal advice before
- 7 agreeing to material variations, can you just explain what
- 8 that aspect of the contract administration involves?
- 9 A. Mmm-hmm. So sometimes we will enter into a contract
- 10 with a supplier on a particular item. Now, that supplier
- 11 may - this is just one example, but the supplier may
- 12 receive, completely out of their control, a very big price
- 13 increase, for instance.
- 14
- 15 So in that case, they would come to HealthShare and
- 16 say, "Look, this is what's happened. We have a contracted
- 17 price here, but because of things out of our control, we
- 18 need to increase the price by X per cent." So sometimes,
- 19 we may need to get legal advice if we don't agree with
- 20 that, for instance. So we might - it may be
- 21 a straightforward case of, "Yes, we are aware of that
- 22 impost, we've experienced that ourselves", or we might
- 23 determine that the supplier is not bona fide in terms of
- 24 what it - you know, of what they're putting forward, and
- 25 therefore we might need some legal advice as to how we
- 26 manage that situation.
- 27
- 28 Q. So the process there, am I right, contemplates
- 29 situations where a supplier wants to vary the terms of the
- 30 agreement?
- 31 A. Yes.
- 32
- 33 Q. For some external reason?
- 34 A. Yes.
- 35
- 36 Q. Maybe legitimate, maybe illegitimate?
- 37 A. Exactly.
- 38
- 39 Q. What you're telling us is, at that point you are
- 40 making an assessment of whether or not you think it is
- 41 a legitimate or illegitimate reason?
- 42 A. Yes.
- 43
- 44 Q. And seeking legal advice in relation to the variation?
- 45 A. Correct.
- 46
- 47 Q. At that stage, can I ask, does the technical



1 evaluation committee get reconvened with a view to  
2 considering whether whatever change is proposed --  
3 A. No. No, that then becomes purely a contractual issue  
4 that HealthShare deals with, that we may need to refer to  
5 local health districts; we may need to refer to the  
6 ministry in terms of the chief procurement officer; and  
7 obviously legal.

8  
9 Q. So to the extent that the technical evaluation  
10 committee might have balanced up price against a whole lot  
11 of other considerations like patient outcomes,  
12 performance --

13 A. Yeah.

14  
15 Q. -- and the like, and made an assessment that, in the  
16 balance, pursuing that contract was the right - was  
17 something they were minded to recommend --

18 A. Yeah.

19  
20 Q. -- no attempt is made to work out whether that  
21 recommendation would change if whatever factor it is, say,  
22 price, that you're looking at changing through the  
23 variation, were on the table at the time?

24 A. Well, it may be that we might need to, you know,  
25 change products or change suppliers, in which case we would  
26 go back to clinical product managers in the local health  
27 districts and seek advice.

28  
29 Q. But in working out whether or not you need to change  
30 products or suppliers at the time that a variation - the  
31 example you gave a price increase you've brought forward -  
32 the technical evaluation committee, as I understand it, is  
33 not reconvened unless the decision is made not to vary the  
34 contract and, in fact, to get a new contract instead?

35 A. That's right.

36  
37 Q. So in making that first decision, should we vary the  
38 contract or should we not, there's no recourse to the  
39 technical evaluation committee --

40 A. No.

41  
42 Q. -- to see whether the change that's being proposed  
43 would have altered their recommendation in any way?

44 A. No.

45  
46 Q. Putting it simply, if the price increased by \$3 per  
47 item, no-one takes the step of asking the technical

1 evaluation committee whether, in making their  
2 recommendation, a \$3 increase in the price would have made  
3 a difference?

4 A. No.

5

6 Q. In paragraph 55, just a little bit further down on the  
7 same page, you talk about contract monitoring being  
8 undertaken to ensure performance and compliance for  
9 "emerging, legacy and strategic suppliers", and the keeping  
10 of a report of noncompliance or performance issues. Do you  
11 see that?

12 A. Yes.

13

14 Q. So in relation to the Onelink warehouse items, what is  
15 that process and what are the records that are kept of  
16 noncompliance?

17 A. So it's the information that we receive daily from the  
18 warehouse in terms of what products have been received,  
19 what hasn't been received, and where there might be - and  
20 if there are any performance, ongoing performance issues.  
21 So there's always things that go wrong, you know, one-offs,  
22 but it's more about where there's a, you know, systemic  
23 problem with a supplier, where we would record that as part  
24 of our engagement with that supplier.

25

26 Q. So in relation to the Onelink warehouse items, someone  
27 from HealthShare maintains, what, a running spreadsheet of  
28 performance?

29 A. Yeah. Yes, so we --

30

31 Q. And assesses that against KPIs?

32 A. Yes. We know at any one time how a supplier is  
33 performing against the contract that we've engaged them  
34 for.

35

36 Q. In relation to the Onelink warehouse items?

37 A. Yes.

38

39 Q. I want now to ask you about the items that are not  
40 going through the Onelink warehouse?

41 A. Yeah.

42

43 Q. Where they are being delivered directly to the LHD.  
44 In those cases, someone within the LHD will place an order  
45 through the system?

46 A. Mmm-hmm.

47

1 Q. Say a nurse unit manager?  
2 A. Mmm-hmm.  
3  
4 Q. Items will arrive in a loading dock at the hospital?  
5 A. Yes.  
6  
7 Q. Make their way up to that nursing unit manager's ward  
8 or storeroom?  
9 A. Storeroom.  
10  
11 Q. And someone, perhaps a store person involved in the  
12 procurement side of things, will unpack the order. They  
13 might find that something has not arrived or has been  
14 placed on back order.  
15 A. Yes.  
16  
17 Q. I assume you're familiar with the concept of back  
18 order?  
19 A. I am. I'm impressed at your knowledge.  
20  
21 Q. It's growing. It's growing. So that store person,  
22 I think if I've understood the way you described the system  
23 a moment ago, would liaise with the supplier about that?  
24 A. That's right.  
25  
26 Q. And, hopefully, that store person would resolve the  
27 issue?  
28 A. Yeah, in most cases that would be the case.  
29  
30 Q. And if the issue is resolved it wouldn't get escalated  
31 to a procurement manager within the LHD probably?  
32 A. It wouldn't?  
33  
34 Q. Would not?  
35 A. Probably not, no.  
36  
37 Q. And would not be escalated to someone within  
38 HealthShare?  
39 A. No, no. The supply chain is imperfect so, you know,  
40 there's a reasonable tolerance level applied, but it's more  
41 when things - when there is continual problems with the  
42 supplier that things will escalate.  
43  
44 Q. But as to when that store person or nurse unit manager  
45 escalates something, that will depend on a range of very  
46 personal factors to that individual, won't it, for example,  
47 how irritated they are by the problem?

1 A. Yes, yeah.  
2  
3 Q. Whether they think it's a big problem?  
4 A. Yeah.  
5  
6 Q. How busy they are?  
7 A. Correct.  
8  
9 Q. So to the extent that they don't think it's a big  
10 problem --  
11 A. Yeah.  
12  
13 Q. -- or are very busy and just don't want to have to  
14 deal with it because they think they will just solve it  
15 themselves --  
16 A. Yeah.  
17  
18 Q. -- the problem and knowledge of the problem lives and  
19 dies with them?  
20 A. Yes.  
21  
22 Q. So to the extent that they become sufficiently  
23 troubled by an issue - say, it's impacting on the  
24 scheduling of procedures or it's resulting in a huge amount  
25 of time at LHD level for people to try and either make  
26 phone calls liaising with the supplier --  
27 A. Mmm-hmm.  
28  
29 Q. -- or spend time trying to rejig arrangements to  
30 enable procedures to continue, they might escalate that to  
31 their LHD-based procurement team?  
32 A. Yes.  
33  
34 Q. Somewhere in the chain within the LHD-based  
35 procurement team?  
36 A. Yes.  
37  
38 Q. You would expect, wouldn't you, that if they were able  
39 to resolve that problem, then it may not come to the  
40 attention of HealthShare?  
41 A. It may not, yes. That's true.  
42  
43 Q. And again, that will depend on a range of very human  
44 factors - relationship that the procurement person has with  
45 the relevant category manager at HealthShare?  
46 A. Yeah.  
47

1 Q. The extent to which they have time to --  
2 A. Yeah.  
3  
4 Q. -- tell someone about the problem that they feel they  
5 have solved?  
6 A. That is their role, as procurement - you know, the  
7 procurement team is to ensure that - the procurement team  
8 at the local health district is to ensure that suppliers  
9 are, you know, delivering their products and services  
10 according to the contracts that they have been engaged. So  
11 if there is - if it's just a one-off situation, you know -  
12 often suppliers will ring before the local health district  
13 even becomes aware of it. However, it's more when there  
14 are systemic problems with that particular supplier.  
15  
16 Q. There's a huge number of people across the LHDs  
17 system-wide --  
18 A. Yeah.  
19  
20 Q. -- who are involved in procurement, probably  
21 thousands?  
22 A. Yes, definitely.  
23  
24 Q. And working out whether or not there's a systemic  
25 problem might require some assessment to be made of the  
26 small problems being experienced by each of those people  
27 system-wide?  
28 A. Yes, yes, yeah.  
29  
30 Q. And if I've understood the process correctly, the only  
31 way in which a system-wide assessment is being made of  
32 performance issues by HealthShare is through a collection  
33 of reports and discussions where things have become so  
34 problematic that they've made their way up through the  
35 chain?  
36 A. Yes, and that's - yeah, that's right, because that's  
37 how our federated model works. Each - you know, everybody  
38 has their role to play in the good management of, you know,  
39 contracts and suppliers.  
40  
41 Q. But under that model, no-one can really be certain,  
42 can they, of the adequacy of performance by any particular  
43 contractor, outside of the Onelink warehouse arrangement?  
44 Let me be a bit more specific by reference to an example.  
45 The picking errors that we've talked about - picking errors  
46 are an irritation at an LHD level?  
47 A. Yes.

- 1  
2 Q. They cost money --  
3 A. Yes.  
4  
5 Q. -- because someone needs to use a little bit of their  
6 FTE to fix the problem?  
7 A. Yes.  
8  
9 Q. They can potentially cause service problems, which in  
10 turn require FTE to be deployed towards solving those  
11 problems?  
12 A. Yes, that's right.  
13  
14 Q. So to the extent that picking errors are happening  
15 across the system, no-one is actually measuring, in respect  
16 of these deliveries, whether or not a particular KPI - say  
17 98 per cent - is being satisfied or not, are they?  
18 A. In terms of the Onelink warehouse, that is part of our  
19 KPIs. But if you are talking about at the local health  
20 district, at the hospital level, that would depend very  
21 much on the local health district procurement team and how  
22 they require that to be reported.  
23  
24 Q. But whilst one local health district might have a good  
25 experience of a contractor, another local health district  
26 might have a bad experience?  
27 A. That's possible.  
28  
29 Q. And, in fact, every local health district might have  
30 an average experience, but not be bothered really to  
31 escalate the problem up the chain because it's not quite  
32 that bad?  
33 A. That's where the monthly meetings with the contract  
34 managers of the local health districts - because that's  
35 where they, where those discussions will occur. So a local  
36 health district may say, "Look, we're finding this supplier  
37 is being completely unreliable"; another local health  
38 district might say "Well, we" --  
39  
40 Q. But, pausing there, that local health district  
41 conversation between the procurement category managers and  
42 HealthShare is only going to reveal these problems if the  
43 nurse unit manager or the store person has told them that  
44 a problem exists?  
45 A. Yes, and that's part of the role of their job, yes.  
46  
47 Q. Is there any process whereby, in performing that role,

1 they are asked to gather information about performance in  
2 any systemic way?

3 A. That would be the role of the procurement team. So if  
4 they've got - if a number of nurse unit managers, for  
5 instance, are reporting the same problem, then the local  
6 procurement team would be able to say, "Well, there's  
7 a problem there", and that needs to be raised with  
8 HealthShare. So it's part of that monitoring of how the  
9 contract is being executed.

10  
11 Q. But you accept, if a number of nurse unit managers are  
12 experiencing that problem and not reporting it to their  
13 procurement team because it's not that big an issue for  
14 them and they are busy, then that's the end of it, in terms  
15 of the gathering of that information?

16 A. That's unlikely.

17  
18 Q. I will come back to the question I asked a moment ago:  
19 is there any process or requirement imposed by HealthShare  
20 upon the LHDs whereby the LHDs are to systemically collect  
21 performance data in respect of these statewide or whole of  
22 health contracts? When I say, "performance data", I mean  
23 actual figures, not just anecdotal experience?

24 A. Yes, I know what - yes, I know exactly what you are  
25 asking, and that's probably a detail that I would need to -  
26 I'd need to come back to you on. We do gather --

27

28 Q. So you don't know whether there is --

29 A. We do gather information. In terms of your specific  
30 question about is there an expectation of local health  
31 districts to do that and feed that to HealthShare, I'd need  
32 to - I'd need to come back to you on, because I am aware  
33 that we have monthly meetings, I'm aware that we provide  
34 information to the local health districts as to how  
35 contracts are performed, but in terms of what the local  
36 health districts bring to those meetings, I would need to  
37 come back to you on.

38

39 Q. But insofar as you are aware, there is no policy, for  
40 example, that requires LHDs to collect the information you  
41 would need to work out whether the picking error KPI, under  
42 any given whole of health contract, is being met or not  
43 met?

44 A. I - as I said, I'd have to come back to you with that.

45

46 Q. You would accept without that information, it is not  
47 really possible to make any assessment of the costs

1 actually being incurred in connection with acquiring the  
2 product, when one adds to the cost, cost incurred in  
3 acquiring the product, time spent chasing suppliers, for  
4 example?

5 A. That's a pretty hard cost to quantify, try and work  
6 that out but, yes, there would be a cost in that, which is  
7 part of the reason why we're moving towards more automation  
8 and making it easier, you know, for those errors not to  
9 occur.

10  
11 Q. So it is a difficult cost to quantify, but if the  
12 contractor is complying with its obligations and delivering  
13 what it is supposed to, there is no cost, above --

14 A. Yes.

15  
16 Q. -- no additional cost above and beyond the cost of  
17 ordering the item --

18 A. Agree.

19

20 Q. -- and paying for the item?

21 A. Agree.

22

23 Q. And so that cost leakage associated with chasing --

24 A. Yes.

25

26 Q. -- suppliers for non-performance --

27 A. Yes, it's time. It's time.

28

29 Q. -- is not being experienced. Where it is being  
30 experienced, it is not being measured?

31 A. Yes.

32

33 Q. Is that right?

34 A. Yes.

35

36 THE COMMISSIONER: We might give everyone a break now,  
37 Mr Muston, if that's okay. We will adjourn to 11.50.

38

39 **SHORT ADJOURNMENT.**

40

41 THE COMMISSIONER: Yes, please continue.

42

43 MR MUSTON: Q. I want to move now to procurement  
44 activities which are referred to HealthShare, so that is,  
45 LHD-based procurement exercises referred to HealthShare,  
46 which I think you tell us about in paragraph 61 of your  
47 statement.



- 1 A. Yeah.
- 2
- 3 Q. So I understand where they fit in the landscape,  
4 that's procurement activities that relate to purchases of  
5 over \$250,000?
- 6 A. Yes.
- 7
- 8 Q. So that is, over that \$250,000 threshold, an LHD is  
9 required, as I understand your statement --
- 10 A. Yeah, yes.
- 11
- 12 Q. -- to refer all of the tendering to HealthShare to  
13 carry out.
- 14 A. Yes.
- 15
- 16 Q. Is it the case that in some instances, LHDs will refer  
17 to HealthShare tendering below that threshold so that  
18 HealthShare can provide assistance in relation to that  
19 tendering?
- 20 A. That's right, yeah.
- 21
- 22 Q. You then go on and tell us in the following paragraphs  
23 about the steps taken by HealthShare in relation to that  
24 procurement process. I don't need to take you through  
25 that.
- 26 A. Yes.
- 27
- 28 Q. But can I ask you to go to paragraphs 65 and 66?
- 29 A. Yeah.
- 30
- 31 Q. Just remind yourself of those two steps in the  
32 process.
- 33 A. Mmm-hmm.
- 34
- 35 Q. That's approach to market and managing, in essence,  
36 the tender assessment process?
- 37 A. Mmm-hmm.
- 38
- 39 Q. Can I ask, in relation to either of those steps, is  
40 any consideration given by HealthShare to the benefits of  
41 standardisation of the items being procured across all of  
42 the LHDs?
- 43 A. Well, that's part of what we do in the statewide  
44 contracts and the tendering process, yes.
- 45
- 46 Q. But just here, we're not talking about statewide  
47 contracts, we're talking about a contract that has been -

1 or a need that has been identified within an LHD?  
2 A. Mmm.  
3  
4 Q. The LHD is going out to tender for a particular item?  
5 A. Oh, you're talking for under 250,000 now?  
6  
7 Q. No, so over \$250,000 --  
8 A. Yes.  
9  
10 Q. LHD has identified a need for an item worth more than  
11 \$250,000?  
12 A. Oh, yes, I'm with you now, yes. HealthShare's  
13 managing that process for them, yes.  
14  
15 Q. HealthShare is managing the process?  
16 A. Yeah.  
17  
18 Q. The process goes through its preliminaries that you've  
19 told us about in paragraphs 62 to 64?  
20 A. Yeah.  
21  
22 Q. Then I just want to take you particularly to those two  
23 steps that you've identified in paragraphs 65 and 66?  
24 A. Yeah, yeah.  
25  
26 Q. I'm just asking you whether, at either of those  
27 stages, is any consideration given to the benefits or  
28 potential benefits that could be secured by standardisation  
29 of the item in question across LHDs?  
30 A. Okay. So if I understand the question correctly,  
31 we're working with one LHD?  
32  
33 Q. Yes.  
34 A. On a particular contract, and what you'd like to know  
35 is, when we look at that contract, do we look at  
36 standardising that across to other LHDs? Do we look for  
37 opportunities?  
38  
39 Q. No. So I think you've told us in paragraph 43 - and  
40 you don't need to go to it - that sometimes, when  
41 HealthShare is presented with a \$250,000 plus contract to  
42 tender, it considers whether or not that might provide an  
43 opportunity to generate a new statewide or whole of health  
44 contract for that item?  
45 A. Mmm-hmm, yes. That's right, yeah.  
46  
47 Q. So that's one way we can go.

1 A. Yeah.

2

3 Q. What I'm wondering is whether, when you're presented  
4 with the \$250,000 plus purchase required by a particular  
5 LHD, and HealthShare is managing that tender process for  
6 the LHD, does HealthShare take a step back and ask itself  
7 in relation to the product that's being procured, "What are  
8 other LHDs doing in terms of this product" --

9 A. Yes.

10

11 Q. -- is there an ability to standardise the product  
12 across LHDs through this process?

13 A. Yes, we do.

14

15 Q. How do you do that?

16 A. So we have what's called the local health district  
17 tendering team, so there's a team that specifically works  
18 with local health districts. So those teams would have  
19 oversight of what a number of local health districts are  
20 doing. If I could give you an example --

21

22 Q. Yes.

23 A. -- so renal services was something that was picked up  
24 by our local tendering team, in terms of they could see  
25 that a number of local health districts were actually going  
26 to the same suppliers, and so a recommendation was made to  
27 take that to a statewide level and standardise.

28

29 Q. So we've been given some evidence of a particular  
30 issue that arises in relation to arterial lines?

31 A. Okay.

32

33 Q. When patients are transferred from one LHD to another,  
34 from one - sometimes even from one facility to another?

35 A. Oh, yes, yeah.

36

37 Q. -- there's an incompatibility between the arterial  
38 lines which are used at one LHD and the arterial lines  
39 which are used at another?

40 A. Mmm.

41

42 Q. Are you aware of that issue?

43 A. I'm not aware of that particular issue, but yes, that  
44 would be an opportunity.

45

46 Q. And I assume that what that means, and I'm not -  
47 I must say, I'm not familiar with an arterial line or even

1 what it looks like, but I assume one end of it goes into  
2 the patient?

3 A. You and me both.

4

5 Q. The other end gets plugged into a machine somewhere?

6 A. If you say so.

7

8 Q. As I gather from the evidence that we've received, the  
9 bit that plugs in to the machine doesn't plug into the  
10 machines at one LHD but it does plug into the machines at  
11 another one?

12 A. And that would be a good example of an opportunity to  
13 standardise, and the benefits that that could have for  
14 people moving around the system. Not only patients but  
15 staff.

16

17 Q. Potential benefits for patients, in that they don't  
18 have to have an arterial line taken out and put back in?

19 A. Mmm-hmm, yeah.

20

21 Q. Potential economic benefits in that you don't have to  
22 throw away that arterial line that you've taken out because  
23 the plug is the wrong shape?

24 A. Yeah.

25

26 Q. And potential benefits for practitioners because they  
27 don't have to go through the process of replacing it and  
28 using, no doubt, their --

29 A. Yeah.

30

31 Q. -- limited time to do it? In terms of that sort of  
32 issue, what is the process that HealthShare goes through in  
33 respect of tenders that are referred to HealthShare in an  
34 attempt to make sure that it's not compounding a problem  
35 like that?

36 A. So that would form part of our discussions with local  
37 health districts, or we might - and we might make  
38 a recommendation to the chief procurement officer.

39

40 Q. Just pausing there, the discussions with local health  
41 districts, is there a process whereby, when a \$250,000-plus  
42 tender is referred to HealthShare, there is consultation  
43 with all other LHDs about the item?

44 A. Yes. So what HealthShare would do would be to consult  
45 with other local health districts to get an understanding  
46 of what they're doing and --

47

1 Q. Who within HealthShare does that?

2 A. That would be the category managers. So, you know,  
3 let's say the medical consumable category team. And they  
4 would make a recommendation that this is the product that,  
5 you know, might be suitable for standardisation, and then  
6 there needs to be very, very detailed consultation with  
7 clinicians across the state.

8

9 Q. So let's assume we're in this process, the  
10 \$250,000-plus contract for a new piece of monitoring  
11 equipment at, say, RPA Hospital has been referred to  
12 HealthShare. There has been some discussion with other  
13 LHDs which has revealed this issue, namely, the potential  
14 need to standardise the product across the board. The very  
15 lengthy and detailed process that you've just referred to,  
16 how does that happen and within what time frame?

17 A. So there are a number of forums that are managed  
18 either by the Ministry of Health, ACI, CEC - so they  
19 would - HealthShare would refer that particular product.  
20 Let's say - well, it happened with the - can I give you an  
21 example?

22

23 Q. Please do.

24 A. Pharmaceuticals is a good example. So there was an  
25 identification - it was identified that pharmaceuticals  
26 could be rationalised. The Clinical Excellence Commission  
27 stepped in and developed the state formulary in  
28 consultation with the clinicians across the state. So  
29 they, like us, would go to each of the local health  
30 districts, ask for representatives, and then discussions  
31 would take place.

32

33 Q. Pausing there, though, the formulary and  
34 pharmaceuticals are a consumable and not a capital item?

35 A. Mmm.

36

37 Q. I'm just at the moment focusing on - perhaps I haven't  
38 been clear about that - capital items, where there's an  
39 expensive acquisition of a capital item, like a piece of  
40 monitoring equipment or a --

41 A. Yeah. It would be a similar process. It would -  
42 HealthShare would then - so, look, there are so many  
43 different advisory groups, committees, task forces,  
44 depending on what that device is, there would be a group of  
45 clinicians who provide advice on that on a statewide level.  
46 That would be referred to one of those groups to see if  
47 there is an opportunity to standardise that particular

1 product.

2

3 Q. So the reference that you gave then to so many  
4 different committees and groups and task forces, is there  
5 a process whereby the views or voices of those wide array  
6 of groups actually get collated somewhere and provided to  
7 HealthShare?

8 A. Well, when I say there's a lot of groups, you know,  
9 obviously there's many specialties in health, so clinicians  
10 are, you know, grouped together for particular products and  
11 activities that they do, so it wouldn't be just about  
12 procurement; it would be a whole range of things to do with  
13 their particular discipline.

14

15 Q. Yes.

16 A. But that would be, say, a place that HealthShare would  
17 go to to say, "Look, we have, you know, identified that  
18 this is possibly a piece of equipment that we could  
19 standardise across the state. What would that look like?"

20

21 Q. But is there any formal process whereby tenders  
22 referred to HealthShare have to be distributed to all of  
23 these groups and have the feedback of these groups  
24 provided?

25 A. I'd say that it would be more on a case-by-case basis.

26

27 Q. Can I move on to paragraph 67 of your statement. You  
28 tell us there that after the contract is awarded - so we're  
29 talking about the more than \$250,000 contract that  
30 HealthShare has managed the tendering process in relation  
31 to --

32 A. Yeah.

33

34 Q. -- HealthShare then administers the contract through  
35 the processing of purchase orders raised by the LHD, SHN or  
36 agency. Can I just ask, what is the role that HealthShare  
37 has in the ongoing contract management of those contracts?

38 A. For contracts - so these are contracts that are over  
39 250,000 that HealthShare has supported the local health  
40 district in terms of developing that contract, and then the  
41 local health district is responsible for managing that  
42 contract. The role that HealthShare would play in that  
43 would be that if the local health districts need some, you  
44 know, advice or support, the local health district would  
45 contact HealthShare. Otherwise, that local health district  
46 would manage that contract, by their procurement teams.

47

- 1 Q. Again, so there's no doubt, HealthShare does not,  
2 itself, make any attempt to monitor the performance of  
3 those - under those contracts?
- 4 A. That's not - in those situations, the role of the  
5 local - it's the role of the local health districts to  
6 manage their contracts, not - HealthShare's role is not to  
7 monitor.  
8
- 9 Q. So again, just so we're sure, whoever might have the  
10 role, the fact is that HealthShare does not monitor  
11 performance of those contracts after they've been entered  
12 into?
- 13 A. No, no - oh --  
14
- 15 Q. Unless assistance is called for by an LHD in relation  
16 to some issue that arises?
- 17 A. Yes. So - just to be very clear, if contracts are  
18 valued over \$150,000, they must be loaded into the PROCURE  
19 system, which then has, you know, information about those  
20 contracts. So there is visibility of what is on contract  
21 over \$150,000.  
22
- 23 Q. But in terms of --
- 24 A. But that --  
25
- 26 Q. -- whether or not that contract is being performed by  
27 the supplier, that's --
- 28 A. But that doesn't have supplier performance in it.  
29 PROCURE doesn't hold information about supply performance.  
30
- 31 Q. Can I come to the shared services, so food and linen  
32 and payroll and those services?
- 33 A. Yes.  
34
- 35 Q. Moving away from the procurement for a minute --
- 36 A. Thank God.  
37
- 38 Q. -- and into the shared services. In respect of those  
39 services, is there any benchmarking done to work out  
40 whether the shared service that's being delivered by  
41 HealthShare is delivering better or equivalent value to an  
42 LHD to what it could secure if it was supplied by the  
43 market?
- 44 A. Yes. There is.  
45
- 46 Q. How is that done?
- 47 A. So it's done - it's done in a few different ways. So

1 we market - we market test. Would you like an example.

2

3 Q. Yes, that would be useful.

4 A. I'll give you two examples. First example is the  
5 linen services. So HealthShare manages the linen services  
6 for the whole of the state. We went through a market  
7 testing process where we actually tested the market in  
8 various regions around New South Wales to test the market  
9 and the result of that was that NSW Health was best  
10 serviced by HealthShare, so that --

11

12 Q. So when you went through that market testing, was that  
13 going to the regions and determining what a local linen  
14 provider might be able to provide a local hospital --

15 A. Yes.

16

17 Q. -- in terms of price?

18 A. Understanding for the local health district what they  
19 could provide. It wasn't just for particular hospitals but  
20 for the local health district. So that process resulted in  
21 the linen services remaining with HealthShare.

22

23 Q. Just before you move on, in relation to linen, has any  
24 market testing been done of prices that might be secured by  
25 entering into a statewide contract for linen services with  
26 a private linen entity?

27 A. No, we haven't gone - we haven't done a statewide  
28 approach. What we - we decided - it was decided that  
29 NSW Health wouldn't benefit from having a private provider  
30 providing linen on a statewide basis.

31

32 Q. Why was that?

33 A. Because those - that has been - in other states, that  
34 has not resulted in a very good outcome. And so we  
35 recognise that there is a place for the private sector to  
36 support HealthShare, and so we, at that time, tested the  
37 market on a regional basis to see whether there were some  
38 opportunities, and at that time - at that time, it was  
39 decided to remain in-house.

40

41 The other example is warehousing. So we --

42

43 Q. Just before we move on from the linen, when you say  
44 "at that time", when was this testing done?

45 A. So that would have been probably nine years ago now.

46

47 Q. Is it done with any regularity, that sort of testing?



1 A. So at the moment it's more - we do market testing more  
2 as a point in time depending on the business. I think - so  
3 obviously COVID interrupted our natural flow for a few  
4 years, but I think there's definitely an opportunity for us  
5 to do more regular market testing, but, in addition to  
6 that, we do work with a lot of private providers in our  
7 various business lines, including linen.

8

9 Q. So in terms of food, I think you told us yesterday  
10 that food is not being supplied to Western and perhaps Far  
11 Western LHDs as a shared service?

12 A. No, that's right.

13

14 Q. That's because it was not economical for HealthShare  
15 to do that?

16 A. No, there's no economies of scale. There's no benefit  
17 for those local health districts.

18

19 Q. No benefits to whom? To the local health district or  
20 to HealthShare?

21 A. No, to the local health districts. They wouldn't - we  
22 don't provide - we provide - they can order off the  
23 contracts that we establish, the food contracts. They  
24 might come to us for advice on food safety, for instance.  
25 They may even come to us for advice on - you know, to  
26 benchmark with what we're doing in other local health  
27 districts. But they are responsible for delivering those  
28 services themselves.

29

30 Q. So is that an exception that has been made to the  
31 direction in respect of shared services, food-shared  
32 services, in relation to those LHDs?

33 A. Yes.

34

35 Q. Who sought that variation from the direction -  
36 HealthShare or the LHD?

37 A. That was I think, well, it would have been - when  
38 HealthShare did its due diligence, so when the food  
39 services transitioned, went through the transition process  
40 from the local health districts to HealthShare, we did  
41 a due diligence on each of the local health districts, and  
42 HealthShare's recommendation was that those - HealthShare  
43 and the local health district agreed that there wasn't much  
44 value to be gained by HealthShare providing those services,  
45 but that they could piggyback off our food contract.

46

47 Q. Can I ask you to go to paragraph 28 of your statement,

- 1           which is on page 9.  
2           A.    Yes.  
3  
4           Q.    You tell us there about the --  
5           A.    Sorry, paragraph 28?  
6  
7           Q.    Paragraph 28.  It should be broken up into three  
8           subparagraphs, a, b and c?  
9           A.    Sorry, I went to page 28.  Okay, yes.  Three  
10          intra-health funding models.  
11  
12          Q.    So these are the three means by which, if I've  
13          understood it correctly, HealthShare is reimbursed by LHDs  
14          for the services that are being provided?  
15          A.    Yes.  
16  
17          Q.    Now, in relation to b, just starting with that one,  
18          volume based service model - I think that's relatively  
19          self-explanatory?  
20          A.    Yes.  
21  
22          Q.    Correct me if I've misunderstood it.  If an LHD, say,  
23          purchases 10 boxes of swabs, they are charged the price for  
24          10 boxes of swabs?  
25          A.    Mmm, yeah.  
26  
27          Q.    Likewise, linen and food --  
28          A.    Yeah.  
29  
30          Q.    -- is it correct to say that they are a volume based  
31          service, so if a particular LHD orders 1,000 pillowcases  
32          a month, they pay a per pillowcase price?  
33          A.    Yes.  
34  
35          Q.    How is the price of the shared services items  
36          calculated?  So, for example, whatever the per pillowcase  
37          price is, how does HealthShare arrive at that price?  
38          A.    Oh, that's quite a detailed accounting question.  
39          There's quite a lot --  
40  
41          Q.    What are the factors that go into it?  
42          A.    Well, there's modelling involved in that.  Look,  
43          that's a level of detail I think you'd need to - I'd need  
44          to refer to one of our finance team.  
45  
46          Q.    Does that modelling or the basis upon which those  
47          charges are calculated get shared with the LHDs?

1 A. Yeah, the LHDs receive a pricing booklet every  
2 financial year, with an outline of the services and how  
3 that works.

4

5 Q. So just in relation to that, the pricing booklet tells  
6 them what it costs per, say, pillowcase?

7 A. Mmm-hmm.

8

9 Q. But does it actually tell them anything about how that  
10 cost has been arrived at by HealthShare?

11 A. Possibly not.

12

13 Q. Now --

14 A. Not that it couldn't be. It's just --

15

16 Q. Do you think it would be of benefit to the system if  
17 it was revealed to LHDs - the basis upon which these prices  
18 for volume based services, that they're required to  
19 purchase through HealthShare, are actually quantified?

20 A. So we have regular meetings with the local health  
21 district.

22

23 Q. Sorry, the question I asked was; do you think it would  
24 be of benefit to the system if the manner in which the  
25 prices for volume based services that LHDs are directed to  
26 acquire from HealthShare are quantified?

27 A. Yeah.

28

29 Q. In relation to the fixed price service model - so  
30 that's 28a - are you able to tell us how those prices are  
31 quantified?

32 A. So it would probably be easier if I explain that via  
33 an example. Would that be okay?

34

35 Q. I think an example that I'm curious - it might be  
36 a good one, I won't identify the number because  
37 I understand there's a confidentiality claim made in  
38 relation to that, which we will deal with at some point,  
39 but, for example, the price per employee for what are  
40 described as core workforce services. Do you know how that  
41 price is arrived at?

42 A. Sorry, what is that?

43

44 Q. The core workforce services, which is described as  
45 operational HR advice, transactional HR services,  
46 industrial advice, recruitment support, performance  
47 development, workforce reporting, work health and safety,

1 safety packaging for customers with staff who are eligible  
2 for salary packaging. As a lump sum item, there's a single  
3 figure per head which is charged to the LHD for each of its  
4 employees?

5 A. Well, those services that you're just talking about  
6 there, we don't provide those services to the local health  
7 districts. Those services are provided to pillar agencies.  
8 That's what that would refer to.

9

10 Q. So that's --

11 A. So that would be like ACI, CEC, Bureau of Health  
12 Information. We provide workforce or people and culture  
13 services, and so there would be a figure arrived at, and  
14 then we would say, "All right, per employee, it will be X  
15 amount of dollars." So if they have 100 employees, it's  
16 that cost times 100 employees.

17

18 Q. So how is that cost, that you multiply by 100,  
19 determined? What --

20 A. By the number of staff that we have, in that - so the  
21 pillar would say, "We would like to have this scope of  
22 services", and then we would work out how many - so the  
23 pillar would say, "All right, we have 1 00 employees. We  
24 need this scope of services." And then we would work out  
25 how many staff we would need to support that, the level of  
26 what the pillar would want, and then that is an aggregated  
27 figure that's then, say - say 100 employees, whatever, say  
28 we've got 20 employees to look after 100, wouldn't be that  
29 many, probably 5, 6, divided by the cost of those employees  
30 and then that becomes the charge to the pillar.

31

32 Q. Let me come up with perhaps a more widespread example.  
33 A visiting medical officer payment?

34 A. A what?

35

36 Q. A visiting medical officer payment?

37 A. Yes.

38

39 Q. As I understand the HealthShare statewide pricing  
40 guide, there's a fixed price per VMO payment that's  
41 charged?

42 A. Mmm-hmm.

43

44 Q. Would it be fair for me to assume that each LHD makes  
45 a number of VMO payments --

46 A. That would be right, yes.

47

1 Q. -- in any given period?

2 A. And we would have a team of people who process those  
3 payments.

4  
5 Q. And how does HealthShare go about deciding what the  
6 price per payment charged to LHDs will be?

7 A. So it's usually - a lot of the services that we --

8  
9 Q. In that case?

10 A. Well, in that case, that would be labour to administer  
11 those payments, and so --

12  
13 Q. But in what respect? Is some assessment made of how  
14 long it takes someone to process a payment, or is it --

15 A. Yeah. So there would be - there are KPI - there would  
16 be KPIs applied to that particular team as to, you know,  
17 the number of VMO payments they pay, and then that would be  
18 built up into a pricing schedule.

19  
20 So let's say there are, as a very crude example,  
21 10 people looking after VMO payments across the state, then  
22 their salaries would then be divided out and that - and  
23 charged to the local health districts. That's crude.

24  
25 Q. Is that sort of information shared with the LHDs, in  
26 terms of --

27 A. Not to that - no, not to that --

28  
29 Q. -- the way in which the prices --

30 A. Not to that level.

31  
32 Q. Just let me finish the question.

33 A. Sorry.

34  
35 Q. Is that sort of information shared with the LHDs in  
36 terms of the way in which the prices are calculated?

37 A. Not to that level of detail, no.

38  
39 Q. What's the rationale for charging LHDs for these  
40 fixed-price items? What's the - you might not know, but  
41 what's the rationale for HealthShare charging an LHD for  
42 dealing with processing VMO payments, for example?

43 A. So the shared service model - so, if I can just go  
44 back to prior to the - so those transactional services  
45 you're talking about are offered out from our shared  
46 service, what we call our shared service centre. So prior  
47 to --

- 1  
2 Q. Just pausing there, when you say "offered out", the  
3 LHDs are directed to use them?  
4 A. Well, yes. So provided to the local health districts.  
5 Now, prior to those services being done centrally by  
6 HealthShare, there were processing teams in each of the  
7 local health districts. So by aggregating that into the  
8 shared service centre, fewer number of people were required  
9 to provide those services to the local health districts.  
10 So the benefit to the system is that it's cheaper to bring  
11 that together in a centralised model. The next --  
12  
13 Q. But, just asking you to pause there, there's no reason  
14 why that benefit would be lost if the system centrally  
15 funded that service in a way that didn't then send a bill  
16 to each individual LHD for it?  
17 A. That would be a lot of transactions occurring, where -  
18 and the other benefit from --  
19  
20 Q. Well --  
21 A. Can I just --  
22  
23 Q. You said, "that would be a lot of transactions". I'm  
24 just asking, there's no reason why the service could not be  
25 provided centrally in the way in which it is, without  
26 individual LHDs being sent a bill for that service?  
27 A. So the --  
28  
29 Q. Couldn't it?  
30 A. So the opportunities that exist in that shared service  
31 environment, so that was what I was trying to explain, was  
32 that they are now - they are centralised. There is now an  
33 opportunity to automate a lot of those processes, which  
34 then would deliver benefits to the local health districts  
35 in terms of reduced costs.  
36  
37 Q. But coming back to my question, there's no reason why  
38 those benefits couldn't have been secured in a way that did  
39 not involve the LHDs being sent a bill from HealthShare for  
40 the provision of those centralised shared services? And  
41 I'm not talking about food and linen; I'm talking about  
42 things like managing a payment system?  
43 A. I'm not sure what you're getting at.  
44  
45 Q. So HealthShare could be funded to manage the payment  
46 system, system-wide, as it does?  
47 A. Yes.

1  
2 Q. That funding doesn't need to come individually from  
3 LHDs; it could come from the ministry?  
4 A. Theoretically.  
5  
6 Q. So HealthShare could be given an amount of money that  
7 it has to work with in order to deliver that service?  
8 A. So --  
9  
10 Q. Just yes or no? Could be?  
11 A. It's not a yes or no answer, I'm afraid.  
12  
13 Q. Well, HealthShare could be given money from the  
14 ministry to manage those centralised services across the  
15 system, couldn't it? It's possible?  
16 A. That - if that were the case, then those services  
17 would need to be standardised for that to work in that  
18 case.  
19  
20 Q. Well, why?  
21 A. Pardon?  
22  
23 Q. Why?  
24 A. For it to be - for it to be efficient.  
25  
26 Q. Let's take payroll services, for example.  
27 A. Yes.  
28  
29 Q. Is there any reason why HealthShare could not be  
30 funded by the ministry to deliver payroll services across  
31 the system?  
32 A. It could.  
33  
34 Q. And in terms of benefits that might be - financial  
35 benefits that might be secured by, say, standardisation, as  
36 I think you've referred to a moment ago --  
37 A. Yeah.  
38  
39 Q. -- those sorts of efficiencies would be incentivised  
40 if it was HealthShare having to produce from within its own  
41 budgetary envelope an outcome in terms of the delivery of  
42 those services, wouldn't it?  
43 A. Yeah, but you're --  
44  
45 THE COMMISSIONER: Q. I think what Mr Muston is putting  
46 to you, Ms Rechbauer, is not - he's certainly not gone  
47 there yet, he's not suggesting what he's putting as

1 a possibility is necessarily the best system?

2 A. No.

3

4 Q. He's just putting it to you that it's possible it  
5 could be done a different way?

6 A. Look, it is possible, but it would ignore the  
7 federated system in which we work. Because each local  
8 health district is - has a role to play in staff being  
9 paid. So the reason that HealthShare - the reason that  
10 HealthShare charges the local health districts for its  
11 services is that we're charging them for a component of the  
12 transactional process. I'm not explaining that very well,  
13 am I? I'm sorry.

14

15 MR MUSTON: Q. So when any individual working within  
16 a system receives that pay, that's a centralised process at  
17 the moment?

18 A. The transactional side, yes, that's right.

19

20 Q. And so to the extent that there's an entry made,  
21 perhaps at an LHD level, that says, "Midwife Jones has  
22 worked the following shifts", HealthShare then goes away  
23 and takes that information, processes it and produces  
24 a payment into the bank account of Midwife Jones?

25 A. Yeah, mmm.

26

27 Q. There's no reason, is there, why each LHD has to pay  
28 a fee to HealthShare for delivering that service?

29 A. You would lose the benefit of seeking efficiencies  
30 across the state if you were to lump it all together.

31

32 Q. What efficiencies would be lost in relation to payroll  
33 management?

34 A. So there would be - so, look, there are a number of  
35 steps in the payroll process that result in a person  
36 getting paid. So whilst HealthShare pays - whilst  
37 HealthShare pays staff at the end of the day, there are  
38 slight variations between each of the local health  
39 districts about what they do and what HealthShare does.  
40 And so that's where the charging comes into it because  
41 it's a - we've delivered this service at this price. And  
42 so it provides the opportunity for the system to further  
43 standardise, because we can see what local - you know, what  
44 works in various local health districts and what could be  
45 scaled. It's been an evolutionary process.

46

47 Q. All I'm really asking is whether the efficiencies to



1 be driven through that standardisation could be achieved if  
2 HealthShare was centrally funded to deliver that service?

3 A. That's a model.

4  
5 Q. And HealthShare itself would be incentivised in those  
6 circumstances to deliver the most efficient and  
7 standardised system that it could?

8 A. The services that we deliver to the local health  
9 districts require the local health districts to work with  
10 HealthShare to achieve those efficiencies, so it's not  
11 a one - it's not a one-way efficiency. There's two sides  
12 to it. One that - in the services we provide, there are  
13 requirements for the local health districts to do certain  
14 things and for HealthShare to do certain things.

15  
16 THE COMMISSIONER: Q. Do you mean that by having to pay,  
17 the LHDs are incentivised to be more efficient themselves?

18 A. Exactly. Exactly. Yes. Otherwise it just becomes,  
19 you know, you end up going to the lowest common denominator  
20 and that was the reason for shared services.

21  
22 MR MUSTON: Q. On that issue, I understand all LHDs are  
23 required to use a single system called "HealthRoster"; is  
24 that right?

25 A. Yes, yeah.

26  
27 Q. That's a standardised system?

28 A. Yes.

29  
30 Q. And so the charges that are being levied to the LHDs  
31 for those payroll services don't drive any particular  
32 further standardisation within the LHDs, do they?

33 A. But there may be inefficiencies in the local health  
34 districts as to how those processes are entered into the  
35 system, which creates extra work for HealthShare once it  
36 gets to the shared service centre, and then they get - they  
37 are charged accordingly.

38  
39 Q. But the charges are on a per head of staff basis,  
40 levied on a per head of staff basis, aren't they, the  
41 payroll charges?

42 A. But there are - if we are required to - if a local  
43 health district wants us to do more than another local  
44 health district, then they need to pay for that.

45  
46 Q. But that may be because they've got more staff?

47 A. No, no, it is not a matter of staff; it's a matter of

- 1 scope of what they're requiring HealthShare to do.  
2
- 3 Q. So there's no reason, is there, why the basic service  
4 couldn't be funded through a budget given to HealthShare?  
5 A. Potentially. That would be another model.  
6
- 7 Q. And then any additional service that might be required  
8 could be charged on a volume basis or a pass-through basis  
9 of the type you refer to in paragraph 28b and c?  
10 A. That's possible as well.  
11
- 12 Q. And that would strongly incentivise LHDs sticking in a  
13 standard way with the basic model?  
14 A. And that's where HealthShare wants to move to with the  
15 local health districts. That's our next tranche of  
16 standardisation. You might recall --  
17
- 18 Q. My understanding of the payroll system and the  
19 payments relating to it might be wrong but at the moment,  
20 LHDs are not paying nothing for the standard system, are  
21 they?  
22 A. No, they're paying for the services that we provide.  
23
- 24 Q. So they pay an amount for the standard system to  
25 HealthShare?  
26 A. Mmm.  
27
- 28 Q. And then to the extent they want more services or more  
29 variations to it, they pay more?  
30 A. Mmm.  
31
- 32 Q. Could I ask you to go to paragraph 112 of your  
33 statement, it is on page .0030 in the top right-hand  
34 corner.  
35 A. 112?  
36
- 37 Q. 112. It is at page 30, and it is at the bottom of the  
38 page.  
39 A. Oh, yeah, "Cross agency collaboration"?  
40
- 41 Q. The one immediately beneath it, the "In  
42 business-as-usual activities"?  
43 A. Oh, 113? Maybe I've got --  
44
- 45 Q. It is 112 in mine?  
46 A. Okay, I've got it, "In business-as-usual activities",  
47 yeah.

1  
2 Q. Just to make sure we're using the same document the  
3 paragraph commencing "In business-as-usual activities" --  
4 A. I've got that.  
5  
6 Q. -- is that paragraph 112 in your document?  
7 A. No. I've got 113, but that's okay.  
8  
9 Q. Could we have a look at the document that you've got?  
10  
11 THE COMMISSIONER: My 112 starts "In business-as-usual" as  
12 it is up on the screen.  
13  
14 MR MUSTON: That's comforting to me, but could I ask you  
15 to --  
16  
17 THE COMMISSIONER: You might have an earlier draft of your  
18 statement.  
19  
20 THE WITNESS: Yeah, I may have printed out an earlier  
21 version.  
22  
23 MR MUSTON: Perhaps the witness could be given - just to  
24 make sure we're not at cross-purposes about anything.  
25  
26 THE COMMISSIONER: Q. That hasn't happened - when you  
27 have been directed to paragraphs before, it's all been  
28 correct?  
29 A. It's all been okay. So, yeah, I'm not quite sure  
30 what's happened there. But I've got here, "In  
31 business-as-usual activities".  
32  
33 MR MUSTON: Q. Perhaps if you look at the one on the  
34 screen would be the easiest thing.  
35 A. All right.  
36  
37 Q. -- to save the court officer the trouble of getting  
38 another copy. You see that paragraph there now. Can I ask  
39 you, is that a feature of HealthShare's current procurement  
40 arrangements, what you've described there - that is, a lack  
41 of visibility about what's on hand at any particular moment  
42 in any particular hospital?  
43 A. At the moment, and that's what the DeliverEASE program  
44 is about.  
45  
46 Q. So at the moment, HealthShare does not have visibility  
47 of what's on hand in relation - in any particular hospital

- 1 at any particular moment?  
2 A. Not in all hospitals, no. In some, we do, because of  
3 DeliverEASE.  
4  
5 Q. So as part of HealthShare's procurement operations, is  
6 it anticipated that after DeliverEASE is introduced, it  
7 will be potentially moving stock from one hospital or one  
8 LHD in order to fill orders?  
9 A. That would be a possibility. That is something that  
10 we would be able to do, and that came out --  
11  
12 Q. It is a possibility, but is it something which is  
13 currently being planned?  
14 A. Well, what's - what we want to achieve out of  
15 DeliverEASE is that we have the visibility of stock across  
16 the system so if required, it could be - it is possible.  
17  
18 Q. So, for example, we've heard some evidence in the  
19 Commission about stock in some small facilities only being  
20 available in largish quantities?  
21 A. Right.  
22  
23 Q. And that stock is used in small quantities in those  
24 facilities --  
25 A. Right.  
26  
27 Q. -- such that a box of 50 might need to be purchased.  
28 In the period of time before it goes off, you might only be  
29 able to realistically use two of them.  
30 A. Right.  
31  
32 Q. And so 48 of them end up getting tossed.  
33 A. Okay.  
34  
35 Q. Is there any consideration being given as part of this  
36 DeliverEASE system - by HealthShare, I should say - to  
37 introducing some sort of process whereby stock and its  
38 potential expiry is being monitored and being shifted  
39 around in the system to avoid that wastage?  
40 A. Well, that - that would be a benefit that DeliverEASE  
41 would - could offer. It could --  
42  
43 Q. So, breaking that up, it definitely sounds like it  
44 would be a benefit --  
45 A. Yes.  
46  
47 Q. -- that is, if wastage was being reduced?

1 A. Mmm-hmm.

2

3 Q. I understand that it's something that  
4 DeliverEASE could offer. What I am wanting to know is, is  
5 that something which HealthShare is currently working  
6 towards delivering through the DeliverEASE process?

7 A. So the stock is still managed by the local health  
8 districts, so it would be a local health district decision  
9 to be able to move stock around, but the DeliverEASE would  
10 provide the information for the local health district to  
11 make that decision if they wanted to.

12

13 Q. I think that means the answer to my question is no;  
14 HealthShare is not currently looking at implementing  
15 a system whereby it monitors stock around the state and  
16 seeks to fulfil orders using stock that's already out there  
17 in the system in order to reduce wastage through stock  
18 going out of date?

19 A. I would say that would be an aspiration.

20

21 Q. Is HealthShare aware of that being a problem around  
22 the state - items which are going out of date because  
23 they're only able to be purchased in larger quantities than  
24 is needed?

25 A. Yes, we --

26

27 Q. How is that being brought to HealthShare's attention?

28 A. Well, again, that's down through the procurement - the  
29 local health district procurement community.

30

31 Q. Other than through the aspirations for the DeliverEASE  
32 system, is HealthShare - has it taken any active steps to  
33 do anything about that problem after it was brought to its  
34 attention?

35 A. So it depends on - it would depend on the particular -  
36 that would be something that we would need to discuss with  
37 the suppliers. If that feedback is about the Onelink  
38 warehouse and the products that come out of the Onelink  
39 warehouse, then that would be certainly something that  
40 HealthShare would be seeking to - would be looking to  
41 address.

42

43 Q. When you say HealthShare "would be looking to  
44 address", do you know whether - of any instances where  
45 HealthShare has addressed that issue?

46 A. I would say that - look, I think those types of issues  
47 arise from time to time and as they do, then HealthShare

1 works with the local health districts and suppliers to  
2 rectify those situations.

3  
4 THE COMMISSIONER: Q. Sorry, does that mean you're aware  
5 of that happening or you think that's what would happen?

6 A. No, I'm aware that that happens. There are - you  
7 know, just within - like anything, there are always  
8 improvements that need to be made.

9  
10 So an example would be that we're currently going out  
11 to contract for our warehousing services and based on the  
12 experience that we've had over the past few years, we're  
13 looking at some different models to address some of the  
14 challenges that local health districts have had with the  
15 current contract. But - and we also deal with things on an  
16 ad hoc basis.

17  
18 MR MUSTON: Could the witness be shown exhibit B.023.15,  
19 which is [MOH.0001.0013.0001].

20  
21 THE WITNESS: Which paragraph?

22  
23 MR MUSTON: Q. We might use the one that's up on the  
24 screen. That might be the easiest way, if that's  
25 convenient to you?

26 A. I see, yes, this one, yes the audit office report.

27  
28 Q. The auditor-general's report?

29 A. Yes.

30  
31 Q. For the benefit of the record, that's the  
32 auditor-general's report, performance audit of HealthShare  
33 dated 31 October 2019. Could I ask that we roll down to  
34 page 3 in the hard copy. I'm sorry, my numbers are not  
35 lined up with the ones in the top right-hand corner. Do  
36 you see there a heading:

37  
38 *HealthShare's contract management practices*  
39 *are limited by inadequate performance*  
40 *monitoring?*

41  
42 A. Yes.

43  
44 Q. And the first paragraph there that refers to - well,  
45 I invite you to read just to yourself everything under that  
46 heading.

47 A. Yes.

1  
2 Q. Can we jump forward to page 19 in the bottom  
3 right-hand corner. Again do you see at the very foot of  
4 that page:

5  
6 *HealthShare's contract management practices*  
7 *are limited by inadequate and inconsistent*  
8 *performance monitoring.*

9  
10 A. Yes.

11  
12 Q. Then there's a reference again to the same issue  
13 raised?

14 A. Yeah.

15  
16 Q. Namely, HealthShare is indicating that it didn't have  
17 the capacity to closely manage individual contract  
18 performance?

19 A. Yeah.

20  
21 Q. And even if it did, it does not have the information  
22 to do so?

23 A. Yeah.

24  
25 Q. Do you see there there is a reference to HealthShare  
26 working on solutions to deliver that information?

27 A. Yeah.

28  
29 Q. What are those solutions and to what extent have they  
30 been delivered since the report was issued in 2019?

31 A. All right. So you'd like to know what we have done in  
32 terms of - so the headline is "Contract management  
33 practices are limited by inadequate and inconsistent  
34 performance monitoring" - what have we done about that?

35  
36 Q. Yes.

37 A. Okay.

38  
39 Q. It says there HealthShare is - I assume "it" in that  
40 second sentence is HealthShare"?

41 A. Yes.

42  
43 Q. Where it says, "It is working on solutions to deliver  
44 that information"?

45 A. Yes.

46  
47 Q. So what has been done to deliver that information?

1 A. Okay. So in terms of - so in - at the time that this  
2 report was done, contracts weren't being loaded  
3 consistently into the PROcure system, so HealthShare has  
4 done a lot of work in conjunction with the local health  
5 districts to --

6  
7 Q. Pausing there, HealthShare knew what the terms of the  
8 contracts were, obviously enough; is that right - in the  
9 case of whole of local health and statewide contracts?

10 A. I'm not understanding your question there.

11  
12 Q. So you indicated that one of the things that's been  
13 done is - that was not happening at that time was that  
14 contracts were not loaded up into the system?

15 A. There were some contracts loaded up into the system  
16 but not as many as should be, which is what the audit  
17 office report picked up.

18  
19 Q. But when it was indicated there that HealthShare did  
20 not have the capacity to closely manage individual contract  
21 performance, an absence of knowledge around the contracts  
22 wasn't a problem for HealthShare at that time, because  
23 HealthShare knew what the contracts were; is that right?

24 A. Mmm-hmm. Mmm-hmm.

25

26 Q. So what were the capacity issues that were causing  
27 HealthShare to be unable to manage contract performance at  
28 that time?

29 A. So the challenge at that particular time was  
30 a resourcing challenge. And then --

31

32 Q. So resourcing challenge in what respect? Resourcing  
33 challenge within HealthShare?

34 A. Across the system. So that was --

35

36 Q. What resources, further resources, were required?

37 A. So we - so from a HealthShare perspective - so the  
38 audit office report focused on contract management and  
39 what - and HealthShare, at the time, was challenged with  
40 the number of contracts that they were required to oversee.  
41 So part of - what resulted from the audit office report was  
42 really a - really was one of the factors that led to the  
43 overarching procurement reform program, and so what's  
44 happened since the audit and now is that roles and  
45 responsibilities for overseeing contract management have  
46 been much clearer; HealthShare has proactively ensured that  
47 contracts over \$150,000 are loaded into PROcure, and in



1 terms of the performance monitoring of the contract  
2 management, there have been regular meetings, regular  
3 meetings with suppliers, and with local health districts,  
4 in terms of that overall contract management performance.

5  
6 Q. So coming back to some evidence you gave us earlier  
7 about the store person or nurse unit manager who  
8 experiences non-performance at a possibly small level on  
9 a given day --

10 A. Yeah.

11  
12 Q. -- doesn't tell anyone else about it?  
13 A. Yeah.

14  
15 Q. Maybe that happens regularly but they don't tell  
16 anyone about it because it doesn't inconvenience them  
17 enough --

18 A. Yeah, yeah.

19  
20 Q. -- a real problem gets escalated to someone within  
21 procurement within the LHD?

22 A. Yeah, yeah,

23  
24 Q. As part of the dialogue, that person within the LHD  
25 might raise that with --

26 A. That's right.

27  
28 Q. -- a category manager at HealthShare, but again,  
29 depends on whether they think they can deal with it  
30 themselves: that arrangement was no different in October  
31 of 2019, was it? That was the way it worked back then?

32 A. You're right. What you're describing is a very manual  
33 process, which has been tightened up, I guess, in terms of,  
34 you know, how that performance cascades through the system,  
35 and the next step to that is actually automating that.  
36 That's where that whole DeliverEASE and SmartChain come  
37 into play, that we're not totally reliant on, as you  
38 describe, people reporting things. So --

39  
40 Q. When you said a moment ago that the system's been  
41 tightened up --

42 A. Yeah.

43  
44 Q. -- in what way has it been tightened up?

45 A. So where it says here "inconsistent performance  
46 monitoring", right what the audit report picked up there is  
47 that our engagement with suppliers at the time -

1 HealthShare was focusing on more of the high-value  
2 suppliers or the high-risk categories of products, rather  
3 than putting a system in place whereby we had a consistent  
4 engagement with contractors around their performance. So  
5 that's what I mean by it's been tightened up.  
6

7 THE COMMISSIONER: Q. There's a couple of examples given  
8 on the next page that might assist you about the patient  
9 transport services contract and the contracts for clinical  
10 IV administration?

11 A. Yeah.

12  
13 Q. When you say that things have been "tightened", is it  
14 in relation to what were identified as the deficiencies  
15 here?

16 A. Yes. So, for instance, take the patient transport  
17 services, we've got a number of private providers who we  
18 meet with regularly. We benchmark their services against  
19 our services. We work out how they can support us most  
20 efficiently. You know, what should HealthShare concentrate  
21 on when it comes to patient transport and what should we  
22 give to our private providers. So there's far more  
23 discipline and rigour in our processes today than there was  
24 back in 2019. And the next step from that is obviously,  
25 you know, where can automation assist us.  
26

27 MR MUSTON: Q. So while we're on that page, page 20,  
28 I think, if we scroll down, do you see the heading  
29 "HealthShare does not always collect or validate  
30 performance data"?

31 A. Yes.

32  
33 Q. Do you see the criticism that's made there in that  
34 first paragraph of the then practices of HealthShare?

35 A. Yes.

36  
37 Q. Do you see the second paragraph:

38  
39 *In the HealthShare initiated contracts that*  
40 *were reviewed, HealthShare contract*  
41 *managers did not always collect or validate*  
42 *performance data, significantly increasing*  
43 *the risk that poor supplier performance was*  
44 *not identified or managed.*

45  
46 A. Yes.  
47

1 Q. So has that situation changed?

2 A. Yes.

3

4 Q. How is the performance data being collected and  
5 validated in respect of, say medical consumables?

6 A. So that's where our category teams have been so - the  
7 category teams have been, I guess, more specialised as  
8 they've got more, you know - we've got six, I think we're  
9 about to go - about to create another category team. So  
10 there's greater specialisation of people in those teams.

11

12 We have systems in place where we record, when we've  
13 met with suppliers, what the issues have been, what their  
14 performance has been like, what actions have been taken,  
15 who we've consulted.

16

17 Q. Pausing you there, your ability to talk to them, or  
18 your category managers' ability to talk to them about what  
19 their performance is like is informed by the ad hoc or  
20 episodic reporting of problems from LHDs that we've talked  
21 about?

22 A. And from the - from what data we do have. So, you  
23 know, there is some data that we receive, and certainly as  
24 we move down the DeliverEASE and SmartChain process, that  
25 data will become - you know, that - the information that is  
26 derived from that data will further strengthen where we are  
27 today.

28

29 Q. There is a number of recommendations made by the  
30 auditor-general in the report. Is there any internal  
31 HealthShare reporting or documentation of the actions taken  
32 in response to those recommendations?

33 A. We had to report to the - we had to respond to that  
34 audit office report, yes.

35

36 THE COMMISSIONER: I think it's an appendix. There is  
37 a response, 29 October 2019, from the then health  
38 secretary.

39

40 MR MUSTON: I think, though, if we go to page 5 of the  
41 auditor-general's report, there are some recommendations  
42 which go beyond the date of the report.

43

44 THE COMMISSIONER: Yes, sure.

45

46 MR MUSTON: I think we can probably take that up  
47 elsewhere. I don't have any other questions for this

1 witness, Commissioner.

2

3 THE COMMISSIONER: Mr Gyles?

4

5 MR GYLES: Just one matter, if I might, Commissioner.

6

7 <EXAMINATION BY MR GYLES:

8

9 MR GYLES: Q. Ms Rechbauer, is it correct to say that  
10 one of the consequences of the auditor-general's report was  
11 the implementation of a new operating model?

12 A. Yes.

13

14 Q. And where there are difficulties identified in terms  
15 of data information - that is, a lack of data information -  
16 once the operating model comes into effect through the  
17 component parts, such as DeliverEASE, SmartChain and  
18 enabling traceability, there will be a greater access to  
19 data information --

20 A. Most definitely.

21

22 Q. -- than there was at the time the auditor-general's  
23 report was brought out?

24 A. Without a doubt.

25

26 Q. To the extent that there are resourcing issues  
27 identified in the auditor-general's report, because of the  
28 automation and greater level of information that's  
29 available, there will be less need for resources - that is,  
30 human resources - as compared to the benefits to be  
31 obtained from the new technology?

32 A. Yes. The resources will also be redirected. So  
33 there's, you know, lots of manual processes still  
34 occurring, so as automation increases, then resources will  
35 be used to analyse the data and provide information to the  
36 system to improve. That's the goal.

37

38 Q. And in terms of managing individual contracts, is it  
39 fair to say that the category manager plays, obviously,  
40 a pretty prominent role in that?

41 A. Plays a very big role, yes.

42

43 Q. And I think you have said you are adding a new  
44 category in?

45 A. That's right.

46

47 Q. So there is an additional headcount there?

1 A. Yes.  
2  
3 Q. And resourcing to that area?  
4 A. Yes.  
5  
6 Q. And they all, going forward, will have access to  
7 a greater level of information?  
8 A. Yes, that's right.  
9  
10 Q. So, in a way, once that all comes in, ideally, that  
11 will have a material impact on the sorts of issues that  
12 were being raised by the auditor-general?  
13 A. Yes, that's right. So the audit report focused very  
14 much on contract management. Our response to the audit  
15 report is actually to look at our whole procurement and  
16 supply chain ecosystem across NSW Health to support  
17 improved reporting as per the recommendations of the audit  
18 report.  
19  
20 MR GYLES: Thank you, Ms Rechbauer. Thank you,  
21 Commissioner.  
22  
23 THE COMMISSIONER: Nothing came out of that?  
24  
25 MR MUSTON: I don't have any further questions.  
26  
27 THE COMMISSIONER: Thank you very much for your time. It  
28 is greatly appreciated.  
29  
30 THE WITNESS: My pleasure, thank you.  
31  
32 THE COMMISSIONER: You are excused.  
33  
34 THE WITNESS: Thank you.  
35  
36 <THE WITNESS WITHDREW  
37  
38 THE COMMISSIONER: All right. We will adjourn until 2.  
39  
40 LUNCHEON ADJOURNMENT  
41  
42 <ZORAN BOLEVICH, affirmed: [2.04pm]  
43  
44 <EXAMINATION BY MR MUSTON:  
45  
46 MR MUSTON: Q. Could you state your full name for the  
47 record, please?

1 A. My name is Zoran Bolevich.  
2  
3 Q. Dr Bolevich, what's your current role?  
4 A. I am the chief executive of eHealth NSW and also the  
5 chief information officer for NSW Health.  
6  
7 Q. You have prepared a statement to assist us in relation  
8 to this Inquiry?  
9 A. Yes.  
10  
11 MR MUSTON: I think that statement is exhibit B.006, which  
12 is [MOH.0001.0433.0001] for the benefit of the operator.  
13  
14 Q. Do you have a copy of that statement with you?  
15 A. I have it in front of me, thank you.  
16  
17 Q. Your statement helpfully sets out a lot about your  
18 organisation and the work you do. I won't take you through  
19 that again. At the moment, I'd like to focus on the shared  
20 services which are provided by eHealth?  
21 A. Mmm-hmm.  
22  
23 Q. Can I take you immediately to paragraph 51 of your  
24 statement.  
25 A. Paragraph 51?  
26  
27 Q. Fifty-one, 5-1.  
28 A. Yes.  
29  
30 Q. You tell us in that paragraph that LHD and SHNs are  
31 directed to obtain certain services from eHealth - that's  
32 the shared services that we're talking about.  
33 A. Yes. So shared services are part of the NSW Health  
34 structure and under the documents outlined here in the  
35 statement are designated to provide certain types of  
36 services across the health system to all the various  
37 entities of NSW Health.  
38  
39 Q. I will just ask you to pause there. If you go over to  
40 the next page, page 26 -- -  
41 A. Yes.  
42  
43 Q. Do you see amongst the shared services covered by the  
44 direction is, in iii at the very top, the information and  
45 communication technology services --  
46 A. Correct.  
47

1 Q. -- which are being provided by eHealth?

2 A. Yes.

3

4 Q. "Information and communication technology services"  
5 sounds like a pretty broad description. What are the  
6 actual services that are being provided by eHealth?

7 Perhaps starting in general terms?

8 A. I will try. eHealth NSW provides the entire span of  
9 ICT and digital services, from planning and investment  
10 management, things like developing business cases and  
11 maintaining architectures and standards for ICT in  
12 NSW Health.

13

14 We also project manage and coordinate implementation  
15 of new systems and digital capabilities across NSW Health,  
16 so we have a very significant project management part of  
17 our services. And then, once those systems are in place,  
18 are in use in our various organisations, we also provide  
19 support for users of those systems, of those digital  
20 platforms, right across NSW Health. It's the entire span  
21 of the ICT value chain, as we call it.

22

23 Q. I think in paragraph 53, at the foot of page 26 there,  
24 you set out, going across to page 27, the categories of  
25 services being provided. Does that cover the field in  
26 terms of the services?

27 A. It does, and just again, a very high-level overview.  
28 It goes from things like ICT infrastructure, things like,  
29 for instance, wide area network that connects our 225  
30 hospitals and 300-plus community health centres, to hosting  
31 systems and platforms, either in the data centre or in the  
32 cloud; and then supporting and maintaining and enhancing  
33 various types of business systems, corporate systems like  
34 workforce, finance, payroll, procurement; and then,  
35 probably most importantly, clinical systems like electronic  
36 medical record systems.

37

38 Q. So in terms of the IT or information and communication  
39 technology services that LHDs might acquire, are there any  
40 services which are acquired by LHDs outside of those  
41 provided by eHealth - that is to say, are LHDs purchasing  
42 information and communication services from other  
43 suppliers?

44 A. Yes. Yes, they do.

45

46 Q. Do you have any examples of that - not all of them,  
47 obviously?

1 A. For example, the local devices, you know, for  
2 instance, laptops, desktops, workstations on wheels, you  
3 know, mobile devices used by clinicians, those sorts of  
4 things, are procured locally, and sometimes support  
5 mechanisms for them can also be supplemented by services  
6 from the private market.

7  
8 Q. From the perspective of the individual who runs  
9 eHealth, do you see that as a good thing or a bad thing?

10 A. I see it as a good thing.

11  
12 Q. Why is that?

13 A. Because it does enable us to, I guess, provide for  
14 local needs and local specific requirements and contexts of  
15 our local health districts and various other agencies but  
16 we still do it in the context of statewide standards and  
17 architectures. So it is not an isolated activity, as it  
18 were, but actually happens in the broader context.

19  
20 Having said that, the environment is changing and I'm  
21 sure we'll come to that as we move on through the  
22 discussion.

23  
24 Q. Can I ask you to go back to paragraph 15 on page 3 of  
25 your statement.

26 A. Fifteen?

27  
28 Q. Fifteen, 1-5.

29 A. Yes.

30  
31 Q. In that paragraph you tell us that the shared services  
32 operate on a cost recovery model?

33 A. Yes.

34  
35 Q. Just so I'm sure we're all talking about the same  
36 thing, the various services that you detailed in  
37 paragraph 53 --

38 A. Yes.

39  
40 Q. -- to the extent they're provided to the LHDs, are  
41 provided on the basis that the LHDs are charged by eHealth  
42 for them?

43 A. Except for rollout of new systems which tend to be  
44 capitally funded so that's - when I talked about sort of  
45 big project management machine that we have, we do that in  
46 partnership with our LHDs because a lot of implementation  
47 activity happens locally, but that tends to be funded



1 through capital expenditure.

2  
3 The user charges will typically apply to those sorts  
4 of services that relate to capabilities, technologies,  
5 et cetera, that are already in place, what we call  
6 "business as usual" type technologies and services. They  
7 are the ones that sort of are used on a day-to-day basis  
8 across the health system that are primarily subject to user  
9 charges.

10  
11 Q. So is the distinction, if eHealth rolls out a new  
12 system across LHDs - for example, the single digital  
13 patient record that we'll come to --

14 A. Correct, yes.

15  
16 Q. -- there's a component of that rollout which is funded  
17 by eHealth on the basis that it's not being recovered from  
18 the LHDs?

19 A. Well, it's funded by the government, by treasury, by  
20 ministry, through a process of capital expenditure approval  
21 and those sorts of processes, but yes, in principle,  
22 projects are funded as specific time limited endeavours, if  
23 you want.

24  
25 Q. But the important point is, in relation to the  
26 rollout --

27 A. Yes.

28  
29 Q. -- of those projects, individual LHDs are not being  
30 sent a bill by eHealth --

31 A. No.

32  
33 Q. -- for rollout costs?

34 A. No, no.

35  
36 Q. But in relation to the business as usual, as you  
37 described --

38 A. Can I say, though, they often contribute over and  
39 above to what, you know, project budgets necessarily have  
40 factored in to it, because we do engage with our - you  
41 know, in particular, clinicians and other users across the  
42 system a lot, and their input into those processes is  
43 important.

44  
45 Q. So your point there is, whilst LHDs are not being sent  
46 a bill by eHealth for that rollout --

47 A. Correct.

1  
2 Q. -- people within the LHD are individually working --  
3 A. Yeah.  
4  
5 Q. -- on the rollout project and their time is money?  
6 A. Absolutely. Yeah. Sometimes, supplemented - it's  
7 a bit complicated - by project funds, but often not in  
8 totality.  
9  
10 Q. So the supplementation might be, for example,  
11 supplementation for additional staff?  
12 A. Correct.  
13  
14 Q. Within an LHD to assist with a rollout?  
15 A. Correct, correct.  
16  
17 Q. In relation to the "business as usual" type  
18 activities, though, eHealth is sending a bill to LHDs for  
19 the provision of those services?  
20 A. We are, and I can probably use that word now because  
21 we call it "Bill of IT", we've recently, over the last  
22 couple of years, changed the way that we administer our  
23 user charges.  
24  
25 Q. Pausing there, how were they once administered --  
26 A. It was relatively simplistic cost allocation model.  
27 So you take kind of the total cost of eHealth chargeable  
28 services, and then there were some relatively simple  
29 allocation metrics - number of FTEs, number of clinical  
30 FTEs, those sorts of things.  
31  
32 Q. And then that resulted in, what, a single number being  
33 given to LHDs?  
34 A. Pretty much, largely sort of fixed cost driven type  
35 arrangement. I mean, there was still some science behind  
36 it but certainly not as detailed and, I would say, advanced  
37 as what we now have.  
38  
39 Q. So in terms of what you now have, can I ask, first,  
40 how do you go about quantifying the various charges that  
41 eHealth levies for the provision of its services?  
42 A. Yeah. So there are two components to our charging  
43 model now. It's becoming truly what we call a consumption  
44 based model, and the idea is that there are two components  
45 to volume, if you want the - how services are utilised in  
46 LHDs and other agencies. Mind you, it's not just LHDs, we  
47 support all other agencies of health. And then there is

1 a price component.

2

3 So the price component is really determined by the  
4 cost that eHealth incurs, either through charges by various  
5 sorts of vendors and third parties, and/or by cost of our  
6 own staff and - et cetera. So for each service, there is a  
7 price determined and then --

8

9 Q. How is that price determined --

10 A. That is determined --

11

12 Q. So it's a combination of the cost of any licences and  
13 the like to eHealth?

14 A. Correct. It's pretty granular.

15

16 Q. Plus what?

17 A. It's pretty granular and each service is analysed for  
18 various sorts of cost drivers, et cetera, et cetera.

19

20 Q. So can I ask this in relation to that?

21 A. Yes.

22

23 Q. The granular assessment or granular calculation of the  
24 charge --

25 A. Yes.

26

27 Q. -- is that granularity shared with the LHDs?

28 A. Increasingly so. Phase 1 of our Bill of IT process  
29 has been really to establish that clear determination:  
30 here's the price, here's the service catalogue of 250-odd  
31 services that we provide. For each service, here's the  
32 price, and here is the key metric - FTE, number of users,  
33 number of accounts, whatever the technology demands.

34

35 Then there is an assessment of the utilisation, the  
36 volume, if you want, of those services that LHD is forecast  
37 or estimated to use, and obviously multiplication of those  
38 two factors provides us a service charge for the year for  
39 each LHD or each agency. Volume times price.

40

41 Q. Is that calculated in advance or is it calculated  
42 afterwards?

43 A. It is calculated in advance based on historical  
44 figures, and then it is provided to LHDs now on a monthly  
45 basis. We've created - we use some pretty advanced  
46 technology that's been specifically developed for IT  
47 billing that helps us produce those dashboards, and LHD

1 colleagues - typically a combination of directors of  
2 finance and CIOs - have access to those dashboards. They  
3 receive an update every month. They can log on and that's  
4 where they can see all that granular detail or, by service  
5 line, which services the LHD has been consuming and how  
6 much of those services. And then, once a quarter, our team  
7 has a discussion with LHDs about, I guess, understanding  
8 the bill, discussing elements of it, and probably most  
9 importantly, as we mature, we are now at a point where  
10 we're working together in partnership to see how we can  
11 actually find opportunities for efficiencies and cost  
12 savings in there.

13  
14 Q. On that issue of efficiencies, it would be possible,  
15 as an alternative model, for eHealth to be funded by the  
16 ministry to deliver all of the shared services, as opposed  
17 to the funding being given to the LHDs and then recovered  
18 by eHealth - just, first of all, structurally, that would  
19 be a possibility?

20 A. Conceptually, yes. Now, I would probably be stepping  
21 outside my realm of expertise here and I would suggest you  
22 canvass some of these ideas with our activity based funding  
23 and finance experts in the ministry but the benefit of what  
24 we're doing --

25  
26 Q. Just pause, I'll ask you the next question, which is:  
27 do you see a benefit which is secured by the current cost  
28 recovery model which would not be secured through that  
29 central funding model?

30 A. Yes, insofar that it enables local health districts  
31 and other agencies to, first of all, have visibility of how  
32 they're utilising IT services, which gives them an  
33 opportunity to apply themselves to various sorts of areas  
34 for improvement, saving, et cetera, et cetera. So it's  
35 a good discipline, to start with.

36  
37 Secondly, it is my understanding, although I'm not an  
38 expert, that this also enables LHDs and ministry as the  
39 system manager to have a really good grasp of what are the  
40 elements of, for instance, ICT and digital that feed in to  
41 the provision of clinical care.

42  
43 That, again - I'm not an expert - is an important  
44 component in what I understand to be the activity based  
45 funding model. So conceptually what you're suggesting,  
46 I think could work, but there are some technical nuances to  
47 it that I think would have to be explored from the

1 perspective of broader funding models for health.

2

3 Q. Can I ask this: are you aware that some CIOs within  
4 the LHDs believe that their own teams have the capacity to  
5 perform some of the services which are being performed  
6 currently by eHealth?

7 A. Yes, and we discuss that regularly.

8

9 Q. What's the forum in which those discussions take  
10 place?

11 A. We have a forum which we call CIO executive leadership  
12 group, or CIOELG for shorter - we like our acronyms. We  
13 meet about every six weeks on average. It's usually  
14 a full-day meeting, with packed agendas, where we discuss  
15 all manner of things from, you know, new technology  
16 standards that we need to be developing statewide to  
17 various sorts of programs that are going on, to these sorts  
18 of issues around where is perhaps the lack of clarity  
19 around service provision; what are some elements that could  
20 be done locally that - or in a more consolidated way? So  
21 that's one of the forums where some of these issues can get  
22 raised.

23

24 Q. So if a CIO from one of the LHDs comes to you and  
25 says, "eHealth is charging me for this service that my own  
26 in-house technology team can perform adequately", how is  
27 that dealt with by you?

28 A. We would want to understand the concern or the concept  
29 better and see where those overlaps might exist. Obviously  
30 we are trying to avoid those situations wherever possible.  
31 What is, I think --

32

33 Q. Why is that?

34 A. Well, what's really important to understand here is we  
35 do try and work as a network, as a health system, if you  
36 want, as one organisation, and I guess at the end of the  
37 day, it is the end user of those IT and digital  
38 capabilities that we place at the centre. So we see it as  
39 our shared responsibility between the eHealth team and  
40 local IT teams to provide the best possible experience to  
41 the users on the ground.

42

43 So the question is how do we best leverage what is  
44 available locally and what's available in eHealth, without  
45 duplicating?

46

47 Q. Are those the issues that you are referring to in

1 paragraph 63 of your statement, which is at the bottom of  
2 page 28?

3 A. Yes.

4

5 Q. Particularly that last sentence - they are the  
6 problems that you see are being abated by centralisation?

7 A. Yes. Yeah, that's correct. It's one of the, I guess,  
8 advantages of standardising and consolidating certain ICT  
9 capabilities.

10

11 Q. In terms of those overlaps and inefficiencies, do you  
12 know how they were measured or whether they were measured  
13 or tested in any empirical way?

14 A. Well, what we have done - I'm not sure whether that  
15 will meet your definition of "empirical", but there have  
16 been a number of initiatives over the years, I can think of  
17 one or two off the top of my mind, where we worked with the  
18 local team to do sort of journey mapping, if you want, and  
19 kind of worked backwards from the need of the local user,  
20 let's say, a frontline clinician, and then kind of worked  
21 backwards from that and start mapping, okay, what are the  
22 elements of that service provision that are done locally;  
23 what's working; what's not working; how does that then flow  
24 into eHealth; what are we doing about it; are there some  
25 opportunities to streamline those journeys and those  
26 workflows? That kind of work has occurred.

27

28 And there has been also some external validation,  
29 various sorts of reviews and things like that, where we had  
30 input and suggestions provided, "Look, this is kind of  
31 industry good practice. Consider this." So in that sense,  
32 we have had some empirical evidence.

33

34 Q. Can I ask you to go down to paragraph 68?

35 A. Yes.

36

37 Q. You say you're unaware of instances where individual  
38 entities have been able to secure better pricing on an  
39 equivalent item?

40 A. Mmm.

41

42 Q. To the extent that - well, first question: have you  
43 had discussions with LHDs where they have indicated that  
44 they could do anything more cost-effectively than eHealth  
45 is currently doing it for them?

46 A. Well, I think the point we were trying to make here  
47 was specifically in relation to procurement outcomes, and

1 really, what we're trying to point out here is that we have  
2 developed over the years, I think, a pretty effective ICT  
3 procurement mechanism whereby, in collaboration with LHDs  
4 we are able to be really clear on what are the needs and  
5 requirements for LHDs and for the wider health system and  
6 then through competitive procurement processes achieve  
7 really good economies of scale and really competitive price  
8 points.

9  
10 So that's what we are trying to articulate here, that  
11 certainly we feel that the effectiveness of this - of that  
12 procurement process to date has been good, strong, and  
13 I certainly am not aware of an example where on  
14 a like-for-like basis, market is giving a better deal to an  
15 individual entity as opposed to us as a system. That's  
16 what we were trying to point out there.

17  
18 Q. Can I ask you to go back to paragraph 29 where you  
19 tell us about a range of statewide ICT and digital projects  
20 and reforms that have been completed?

21 A. Yes.

22  
23 Q. These are the projects that are amongst those managed  
24 by eHealth?

25 A. Correct.

26  
27 Q. Did that management involve any planning or assessment  
28 of the costs associated with the reform and its rollouts in  
29 the LHDs?

30 A. Yes, yes.

31  
32 Q. How is that assessed?

33 A. Well, normally, that process starts even at the  
34 business case phase, so when we're developing business  
35 cases for some of these, especially larger investments,  
36 larger programs, there's an assessment of what we expect  
37 would be costs associated with acquiring technology,  
38 through procurement, what are then the costs of designing,  
39 configuring, you know, adopting it for the needs of  
40 New South Wales, and then ultimately what are the costs  
41 involved with implementation, change management, training.  
42 These are very complex systems that are being introduced.

43  
44 So to the extent that we are able to, we model those  
45 types of costs at the business case phase and then, as we  
46 go through the process, it becomes increasingly clear,  
47 first for the procurement process, whether we've got those

- 1 assumptions right and then, as we start planning  
2 implementations, we also go back and recheck those  
3 assumptions.  
4
- 5 Q. So in terms of the modelling that you do, I think  
6 you've already told us that an assessment is made of the  
7 likely resources involved in the rollout?  
8 A. Yes.  
9
- 10 Q. So people to deliver the training?  
11 A. Correct.  
12
- 13 Q. People to upload the system on to people's machines  
14 and the like?  
15 A. Correct, yes.  
16
- 17 Q. And so you, as part of your business case, make an  
18 attempt to quantify that?  
19 A. Correct, correct.  
20
- 21 Q. That's communicated to the ministry?  
22 A. Yes, correct.  
23
- 24 Q. And I think - I gather from what you told us a moment  
25 ago, that sometimes results in supplementation at the  
26 district level?  
27 A. Yes.  
28
- 29 Q. And no doubt informs --  
30 A. Yes.  
31
- 32 Q. -- eHealth's budget for the particular period?  
33 A. The process for, in particular, larger projects for  
34 having those business cases approved, et cetera, is quite  
35 involved, and goes beyond health itself. There is a whole  
36 of government framework which health is bound by, which is  
37 administered by our colleagues in the department of  
38 customer service, there's a whole investment assurance  
39 framework, there are gateways to go through. It's a pretty  
40 complex business.  
41
- 42 Q. Can I bring you back to the modelling?  
43 A. Yes.  
44
- 45 Q. Is equivalent modelling done of the likely human -  
46 ongoing human resources needed in LHDs to operate --  
47 A. It is, some of that modelling is done.



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Q. Is that communicated to the ministry for the purpose of informing the ministry about --

A. It is, yes.

Q. -- what it might be costing LHDs to operate these systems?

A. Yes, it is.

Q. How is that communicated?

A. Well, obviously the business cases have the sort of capital component and then the ongoing recurrent expenditure component where we are trying to capture some of those elements that you're describing.

Q. Can I ask you a specific question? Does eHealth have any role to play in relation to duress alarms at hospitals and facilities?

A. Not in any direct sort of a way, but we have been part of discussions with LHDs and with our colleagues in health infrastructure, who have a role to play in that space, when new capital builds - you know, new hospitals have been built. We have been having discussions especially in recent months and years about opportunities potentially in the future to have greater standardisation of those technologies, and the reason why we think that the time is good to be considering that is - I don't know whether you'll ask me about it later on or not but I'll mention it now - we have been doing some really good work with LHD colleagues around standardising local hospital networks.

Q. That's the wi-fi?

A. That's the health grade enterprise, "HGEN" project, which we have described in here, which is trying to modernise and standardise local networking in hospitals. This is very important for things like duress alarms.

So as we move through the HGEN process and start seeing greater standardisation and modernisation of all those wi-fi and other local networking equipment and services, that opens up opportunities for us to look, okay, what are other services that are sitting on top of those networks - duress alarms, building management systems, telephony and so on. So that's why we are starting those considerations and looking at what we might be able to do in the future.

1 Q. Could I take you to paragraph 85 of your statement,  
2 which is on page 32.

3 A. Yes.  
4

5 Q. Can I invite you to just read that and perhaps just  
6 explain to us in practical terms what the disadvantage that  
7 you are identifying there is, by reference maybe to an  
8 example, that might make it easier for us to understand?

9 A. Well, there have been situations where, you know,  
10 we've made certain commitments as a system to, for example,  
11 move some of the local infrastructure into the government  
12 data centre, you know, and we make certain investments and  
13 commitments of resources and time and technology into those  
14 processes.  
15

16 But it tends to take, then, a long time to align  
17 everybody's local priorities, and there's almost a feeling  
18 sometimes of a bit of an optionality of some of these  
19 things. So we make an assumption that everybody's  
20 committed to the journey, but it takes then a long time to  
21 actually get everybody to participate, which is one of  
22 those situations we've come across.  
23

24 Sometimes, it also relates to the adoption of certain  
25 clinical systems, and so there are certain local  
26 circumstances that sometimes prevent LHDs to participate,  
27 or participate in a timely fashion in these sorts of  
28 initiatives and statewide initiatives. It's not  
29 surprising, I guess, in a large complex system, but it is  
30 something that we continue to work on to make sure that  
31 when these commitments are made, that we're actually all in  
32 lockstep and moving forward.  
33

34 Q. Moving forward to paragraph 88 on the next page, it  
35 identifies another disadvantage some of the complexity  
36 around the current procurement and service delivery  
37 arrangements?

38 A. Yes. Mmm.  
39

40 Q. Are you commenting there on the actual policies  
41 themselves, when you refer to "complexity" or the actual  
42 practical steps required to implement them or both?

43 A. Well, there are two elements to that comment. One,  
44 again, just acknowledging it is a complex system with lots  
45 of stakeholders and we try and make sure that we involve  
46 people in these processes and that we get the best possible  
47 understanding of requirements, specifications, et cetera,

1 et cetera, and that can take time.

2  
3 But then there is another element to it, which we are  
4 commenting on here, which is that the procurement  
5 frameworks themselves are quite complex and at times  
6 burdensome and seem to have an ever-growing list of  
7 requirements, you know, cybersecurity is a really good  
8 example. It's really become big in our world, right, and  
9 we are seeing, for instance, more cybersecurity - more onus  
10 on cybersecurity, for instance, in procurement processes.

11  
12 Then there are some other detailed elements, the  
13 various procurement frameworks which are not always making  
14 our process easy.

15  
16 Q. So has eHealth taken any steps or done anything in an  
17 attempt to deal with the complexity of all of these various  
18 pieces?

19 A. We are very engaged with colleagues in the sort of  
20 whole of government space, because a lot of these  
21 procurement frameworks for ICT are actually all of  
22 government frameworks, and NSW Health is required to apply  
23 them and use them.

24  
25 Q. Can I ask you to pause there. To assist eHealth's  
26 staff in applying and using those policies, do they have to  
27 sit and read through all of them and understand them or  
28 are there some steps --

29 A. Absolutely.

30  
31 Q. Every single one of them?

32 A. Yes.

33  
34 Q. So has eHealth taken any step to assist them in  
35 understanding all of those policies and how they work  
36 together?

37 A. Oh, in terms of local procurement stuff?

38  
39 Q. Local.

40 A. Yes, so obviously for those procurements that are  
41 procurements for statewide capabilities or for one of these  
42 projects that I was talking about, eHealth will be taking  
43 the lead role in procurement anyway.

44  
45 For those procurements where we are now acting, if you  
46 want, as an ICT category manager, under the new procurement  
47 policy, in other words, where LHDs are coming to us for

1 procurements over \$150,000, yes. So what we are trying to  
2 do there is to kind of provide, if you want, an advisory  
3 service approach to those procurements and assist LHD  
4 colleagues with navigating that pretty complex set of  
5 requirements.  
6

7 Q. Have you prepared any resources to assist in that -  
8 providing that service? Have you got a --

9 A. We rely on our own procurement team inside - in health  
10 for that.  
11

12 Q. You refer at the end of that paragraph to  
13 a potentially lengthy, costly and time consuming process  
14 that lacks agility and responsiveness. Do you have an  
15 example of an instance where a lack of agility and  
16 responsiveness has potentially been a problem, that you can  
17 call to mind?

18 A. Sorry, which paragraph was that?  
19

20 Q. Paragraph 88, you see the last sentence there. I'm  
21 particularly interested in your comment that the processes  
22 lack agility and responsiveness.

23 A. Yeah.  
24

25 Q. What I'm wondering is whether you can call to mind any  
26 particular example where you think that has actually been  
27 a problem in a practical sense rather than just an  
28 irritation?

29 A. Yes, I would have to think of a good example. I guess  
30 maybe by way of the opposite, what we have seen, for  
31 instance, during the COVID years, as we refer to them in  
32 health, we've seen an incredible acceleration and ability  
33 for us to move in a very agile and responsive fashion,  
34 because we had that sort of singular focus on responding to  
35 the pandemic, and there was also a little bit more -  
36 I won't say that processes - the procuring processes were  
37 less stringent, but there was - there was a real appetite  
38 to streamline and cut through some of the bureaucracy and  
39 get to the outcome faster. That is not the normal modus  
40 operandi because there are so many of these requirements  
41 that we have to step through. So that's what we're  
42 commenting on here.  
43

44 Both eHealth and our LHD colleagues would always, of  
45 course, want us to get to the outcome faster, and to be  
46 able to respond to their requirements. Sometimes, because  
47 of the complexity of these processes and the many

1 requirements we have to examine and be compliant with, it  
2 does take a long time. So that might be the - I can give  
3 you one example of a very prolonged process but we probably  
4 don't have too many regrets about it and that, in fact, is  
5 the single digital patient record. It was a very  
6 extensive, comprehensive, long procurement process, but  
7 it's not the one that I would criticise for it.

8  
9 The reason why I say that is because we actually  
10 decided to make that process very, very inclusive. As part  
11 of that process we had at one stage about 350 staff  
12 participating, and most of them clinicians, participating  
13 in the evaluation process, and there was more than one  
14 product to evaluate. And as you can imagine, constructing  
15 an exercise like that is not trivial.

16  
17 But we felt that we had to do it because that's how  
18 you arrive at a really, really good outcome. So sometimes  
19 it is actually appropriate to take time to do your  
20 procurement process properly.

21  
22 But there might be some pieces of technology or  
23 processes that are perhaps not as complex and are less  
24 risky and we could cut through that much more quickly, yet  
25 there is a template to follow and we have to stick with it.

26  
27 Q. So just sticking with the single digital patient  
28 record for the moment, that's a project that you've  
29 described in paragraph 31a of your statement.

30 A. Yes.

31  
32 Q. Just again, I'll summarise my understanding of it,  
33 again in a very high-level way. Tell me if I'm roughly on  
34 the right track. So the idea is, at the moment, there are,  
35 across different LHDs, a range of different electronic  
36 medical record systems in operation?

37 A. Correct.

38  
39 Q. Which have in their origin, as their origin,  
40 procurement exercises performed by different perhaps local  
41 area health services at some point in history; correct?

42 A. Yes, and even some statewide exercises which were,  
43 I guess, of their time.

44  
45 Q. A consequence of those exercises, whatever they might  
46 have been, is a system where different LHDs and different  
47 hospitals could collect patient information electronically?

- 1 A. Correct.  
2
- 3 Q. They are not able to talk to one another  
4 electronically, in the sense that a patient's records are  
5 stored at one hospital; if the patient presents at another  
6 hospital in a different LHD, those records might not be  
7 readily accessible?  
8 A. Broadly speaking, yes.  
9
- 10 Q. The idea of the reform is to introduce a network-wide  
11 single digital patient record --  
12 A. Correct.  
13
- 14 Q. -- which is accessible anywhere within the system  
15 where a patient might present?  
16 A. Correct, correct.  
17
- 18 Q. And there's a range of different components to that  
19 system which no doubt will operate in different parts of  
20 the system's operations, whether it be imaging records  
21 which need to be accessible across the system?  
22 A. Yes, yes, correct.  
23
- 24 Q. Or the readouts from bedside point of care machines  
25 that get picked up by the system?  
26 A. Correct. Correct, yes.  
27
- 28 Q. So the idea is that all of these different pieces of  
29 patient information, which might be collected  
30 electronically within a hospital setting, are then recorded  
31 to the single digital patient record?  
32 A. Correct.  
33
- 34 Q. And able to be viewed anywhere in the system where  
35 that patient might require treatment?  
36 A. Correct, correct. Plus, it is a very powerful  
37 internal communication and what we call work flow, clinical  
38 work flow management tool, because electronic medical  
39 records enable clinicians to order tests, receive results,  
40 make observations, record progress notes, capture patient  
41 history and a lot more. So you could really call it the  
42 work horse of a clinical institution.  
43
- 44 Q. So in terms of the work flow, am I right in my  
45 understanding that the system will, once completed, have  
46 the capacity to prompt a clinician in relation to  
47 a particular course of - a potential course of treatment,

- 1 depending on, for example, the recordings of a patient that  
2 have been made in the system?
- 3 A. Yes. And even our incumbent EMRs have some of those  
4 capabilities. Obviously we expect that with the new  
5 platform we would go a step or two further, but yes, that's  
6 typically what you can do with electronic medical records.  
7
- 8 Q. So would an example of that, say, be the sepsis  
9 pathway?
- 10 A. Sepsis pathway is one.  
11
- 12 Q. Just pausing in relation to that one, if a patient  
13 presents and has particular observations made which, under  
14 the sepsis pathway, should alert a practitioner to the  
15 possibility that the person has sepsis, there will be some  
16 sort of a prompt on the system to say, "These two  
17 observations have been made. Have you considered whether  
18 or not this patient should be on the sepsis pathway"?
- 19 A. Correct.  
20
- 21 Q. Something like that?
- 22 A. Correct. Yes, in principle. If I may, maybe another  
23 example, NSW Health has a very well-established method  
24 called "Between the Flags", which was developed by our  
25 Clinical Excellence Commission here in New South Wales and  
26 has been used for many years successfully on paper, but we  
27 now have a digital version in the EMRs and that is very  
28 helpful because it helps our clinicians to detect early  
29 potentially deteriorating patients, so if they're outside  
30 of the parameters, outside of the flags, so to say, they  
31 can then intervene and prevent the patient from  
32 deteriorating.  
33
- 34 Q. So that, once the system is completed, ideally  
35 provides a single source of information within the acute  
36 care setting?
- 37 A. Correct.  
38
- 39 Q. Current arrangements, putting to one side the  
40 different systems in different LHDs - current arrangements  
41 have patient information split across a number of different  
42 platforms?
- 43 A. (Witness nods).  
44
- 45 Q. The acute care setting, so the EMR or, in future, the  
46 single digital patient record?
- 47 A. Yes.

- 1  
2 Q. Within a primary care setting, there'll be patient  
3 records kept by the patient's GP?  
4 A. Correct.  
5  
6 Q. Possibly within an aged care facility or some other  
7 NDIS type facility, for example, there might be patient  
8 records kept?  
9 A. (Witness nods).  
10  
11 Q. Those are records that, at the moment, are not able to  
12 be viewed as a single point source of information in  
13 relation to the patient, are they?  
14 A. There are some ways or methods in which summarised  
15 patient information can be viewed across different levels  
16 of care that you are describing, principally the federal My  
17 Health Record plays that role.  
18  
19 Q. So the federal My Health Record, and maybe if I can  
20 jump to the next point you were going to make, to the  
21 extent that a patient is discharged from a hospital, if the  
22 system works, there should be a discharge summary which  
23 goes to --  
24 A. Correct.  
25  
26 Q. -- the GP?  
27 A. Correct.  
28  
29 Q. The quality of the information, of course, there,  
30 depends upon what has been written into the discharge  
31 summary?  
32 A. Correct.  
33  
34 Q. Whether or not it gets to the right person or to  
35 a person who is providing treatment in the future depends  
36 upon the person identifying who the GP is at the time of  
37 their admission and then in future visiting the same GP?  
38 A. Correct, correct.  
39  
40 Q. It would be beneficial, wouldn't it, from a health  
41 point of view, for there to be a single point source of  
42 information in relation to a patient's medical records -  
43 that is, a single point of information which shows the  
44 treatment delivered and the observations made of the  
45 patient both in an acute setting and, say, in a primary  
46 care setting?  
47 A. That certainly is the Holy Grail of digital health and



1 something that nationally, and even internationally, we're  
2 all striving towards. It often gets, then, bundled into  
3 this concept of interoperability in digital health, or lack  
4 of it, which is in other words ability of all of these  
5 different disparate systems to seamlessly share patient  
6 information.

7  
8 A lot of work is currently going in to developing  
9 standards that will hopefully enable a more streamlined  
10 sharing of information between different systems, so even  
11 if we don't get to the Nirvana that you are describing, at  
12 least then we can ensure that those individual systems -  
13 primary care, hospital care, aged care - have an ability to  
14 seamlessly and safely and securely share certain defined  
15 core datasets in the interests of the patient.

16  
17 Q. So whether it reaches the Nirvana stage or just  
18 a slightly greater sharing of information, any level of  
19 information sharing or the accessibility of a single point  
20 of common information about a patient will enhance --

21 A. Undoubtedly.

22  
23 Q. -- continuity of care?

24 A. Undoubtedly.

25  
26 Q. And it will reduce wastage through duplication?

27 A. Undoubtedly.

28  
29 Q. And it will enable a better assessment of outcomes  
30 when considering the value of the health care delivered?

31 A. Yes, yes.

32  
33 Q. Does the single digital patient record project, as  
34 it's currently conceptualised, contemplate any bridging of  
35 these information gaps, in particular between the acute  
36 care setting and the primary care setting?

37 A. Yes, yes, it does.

38  
39 Q. In what way does it conceptualise that?

40 A. Well, first of all, the platform that we've chosen and  
41 that we will be configuring and implementing here in  
42 New South Wales has quite robust and pretty advanced  
43 integration capabilities, which will enable us to do the  
44 interoperability better, let's put it that way.

45  
46 It also has a number of other interesting features,  
47 like there is a portal for providers - for instance, GPs -

1 to be able to come in to the system and see a view of the  
2 patient. There is a portal for patients themselves - there  
3 is a very competent patient app, which comes with the  
4 system as well. So those are some of the ways in which we  
5 think SDPR will advance the cause.  
6

7 Q. Just pausing there, that assists in the transition of  
8 patient information from the acute care setting to the  
9 primary care setting?

10 A. Correct.

11  
12 Q. Either because, if these components become  
13 operational --

14 A. Correct.

15  
16 Q. -- a GP can get into the system and see information --

17 A. That's it.

18  
19 Q. -- or, alternatively, the patient can get into the  
20 system and see information which they can share with their  
21 GP?

22 A. Correct, yes.

23  
24 Q. It doesn't currently contemplate the other side of it,  
25 which is the sharing of information between the GP and the  
26 hospital?

27 A. It does - obviously that would require us to develop  
28 those interoperability mechanisms with primary health care  
29 software tools and work with industry who support, develop  
30 those types of systems.

31

32 Q. In relation to that, can I ask you --

33 A. And this is where the adoption of standards  
34 I mentioned earlier is a very important enabler.

35

36 Q. In relation to that, can I ask you, are there a number  
37 of major suppliers of medical record technology in the  
38 primary health care setting?

39 A. Yes.

40

41 Q. That is to say, are there multiple suppliers across  
42 the system or is there a small handful who would supply  
43 everyone?

44 A. There is a multiplicity of suppliers but it's fair to  
45 say that there's probably three or four companies that have  
46 the largest market share. So we know who those market  
47 leaders are, as it were.

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Q. As part of the single digital patient record project, is any work being done to try to get at least those market leaders in a position where information is capable of being shared between the primary health care setting and the acute care setting - that is, in that direction?

A. Not directly as yet, would be my answer, but we have commenced conversations with colleagues in the primary health care sector, just recently had a really important conversation with primary health networks here in New South Wales to see how we can collaborate with them and have them involved in this very program.

Q. Can I ask you to go to paragraph 105 of your statement, which is on page 35.

A. Yes.

Q. I think you set out there some of these discussions. What I really want to ask you about is the very last two lines. Do you see?

A. Yes.

Q. You perceive there to be a need to review and modernise legislation and policy frameworks to enable that information sharing to occur?

A. Yes, that's correct.

Q. What is the modernisation of legislation and policy framework that you have in mind?

A. All Australian jurisdictions have ever so slightly different health information, privacy legislation and regulation, and here in New South Wales, of course, we have our own version of that.

What we are referring to here specifically is a set of, I guess, policies and potentially legislative instruments that would facilitate that sharing of information between primary health care and hospitals. So at the moment, my understanding is that, for instance, GPs accessing our hospital electronic medical record is something that requires a number of steps and special dispensations and things like that for special circumstances. Whereas in other jurisdictions, for instance, in Queensland, they have changed their regulatory framework so as to enable GPs to have a much easier access, for instance, to the hospital digital records.

1           So that's an example of what we're talking about. And  
2 we believe that, obviously, with the advent of single  
3 digital patient record, now is a perfect time for us to  
4 actually pause and have a look at what we've got and how  
5 those frameworks that are now 15, 20 years old, how do they  
6 actually perform in today's environment which is becoming  
7 increasingly digital.

8  
9           Q.    Can I move to another topic. We've been told by  
10 a number of people that artificial intelligence is going to  
11 revolutionise health care, amongst other things. It's not  
12 explicitly mentioned in your - or the opportunities that  
13 you identify at the end of the statement, but do you  
14 perceive there to be any opportunities presented by  
15 artificial intelligence?

16           A.    Very much so, and to try and grasp those  
17 opportunities, NSW Health has just recently established an  
18 AI task force, which I have the pleasure of co-chairing  
19 together with my very good colleague Jean-Frederic  
20 Levesque, who is the chief executive of ACI. We had our  
21 inaugural meeting just recently, the Minister for Health  
22 very kindly came to open it for us.

23  
24           The idea there is for us as a system, again, across  
25 LHDs, ministry, pillars, to work together to figure out  
26 what are some of the enablers for a safe, purposeful,  
27 effective, equitable adoption of these technologies into  
28 our health system. Not to create red tape and bureaucracy  
29 around it but actually to create a sensible and useful  
30 framework which will enable our clinical teams, research  
31 teams, et cetera, et cetera, to innovate in a safe and  
32 hopefully scalable way, you know, some of those local  
33 innovations. If we are successful in what we are trying to  
34 do, hopefully we can identify early those ones that are the  
35 most promising and high-value innovations, and then we can  
36 scale them across the system.

37  
38           So those are some of the ideas that we will be  
39 exploring and we want to develop some framework for safe  
40 adoption of AI in health as well.

41  
42           Q.    The last thing I want to ask you some questions about  
43 is eHealth's involvement in the procurement reforms --

44           A.    Of course.

45  
46           Q.    -- that are under way. You tell us a little bit about  
47 them, I think, in paragraph 23b of your statement.

1 A. Yes.

2

3 Q. At b and c in particular are two that I would like to  
4 just ask you some questions about.

5 A. Yes.

6

7 Q. Now, in terms of the second of those systems, the  
8 SmartChain, are you familiar with the system which is used  
9 in at least two of the metropolitan LHDs called "h-trak"?

10 A. I am familiar with it, yes. Not in detail, but I know  
11 what you are referring to.

12

13 Q. At a very general level, does its functionality  
14 overlap with what you understand to be some of the  
15 functionality of the SmartChain traceability system?

16 A. To some extent. One, I would say - one component of  
17 it does, yes, or one component of SmartChain overlaps with  
18 h-trak, yes.

19

20 Q. There may be a very good reason for not doing so, but  
21 do you know whether consideration was given to scaling up  
22 the h-trak as opposed to replacing it with the SmartChain?

23 A. My understanding is that h-trak has been introduced in  
24 a number of LHDs in a sort of locally specific way. So  
25 what we have at the moment is a number of different  
26 implementations of h-trak, with, so I understand, not much  
27 commonality or standardisation between them. So therefore,  
28 I guess, conceptually, if one were to contemplate scaling  
29 that, you would have to go through a process of  
30 standardising and, you know, changing the way those local  
31 implementations are currently working.

32

33 That doesn't seem like a particularly rational  
34 proposition when we actually already own an enterprise  
35 product which is our Oracle ERP, which has these  
36 capabilities out of the box, ready to go. So I guess we  
37 are using capability and technology that we already have in  
38 the health system to try and tackle the problem and deliver  
39 the outcome that hospitals need.

40

41 MR MUSTON: I have no further questions for this witness -  
42 oh, hang on, I might. No, I've got no further questions  
43 for this witness.

44

45 THE COMMISSIONER: Mr Gyles?

46

47 MR GYLES: I do not have any questions, thank you,

1 Commissioner. Thank you.  
2  
3 THE COMMISSIONER: Thank you very much for your time,  
4 sir, it's greatly appreciated. You are free to go.  
5  
6 THE WITNESS: Thank you, Commissioner.  
7  
8 <THE WITNESS WITHDREW  
9  
10 MR MUSTON: The next witness is Michael Gendy.  
11  
12 THE COMMISSIONER: We might have a short break, then, and  
13 come back.  
14  
15 MR MUSTON: I will let you know that Mr Gendy is next and  
16 when we are back arrangements can be made to have him in  
17 the chair.  
18  
19 THE COMMISSIONER: We will have a break until 10 past 3.  
20  
21 MR MUSTON: Okay.  
22  
23 **SHORT ADJOURNMENT**  
24  
25 THE COMMISSIONER: Yes, Mr Muston.  
26  
27 MR MUSTON: I call Michael Gendy.  
28  
29 <MICHAEL GENDY, sworn: [3.10pm]  
30  
31 <EXAMINATION BY MR MUSTON:  
32  
33 MR MUSTON: Q. Could you state your full name for the  
34 record, please?  
35 A. Michael Gendy.  
36  
37 Q. And you are the chief procurement officer for  
38 NSW Health?  
39 A. That's correct.  
40  
41 Q. You've held that role since January 2018?  
42 A. Correct.  
43  
44 Q. You've prepared a statement to assist the Commission  
45 dated 31 January 2024?  
46 A. Yes.  
47

- 1 Q. It is exhibit B.005 [MOH.0001.0434.0001]. Do you have  
2 a copy of that statement with you?  
3 A. I do.  
4
- 5 Q. Could I ask you to go directly to paragraph 4 of that  
6 statement.  
7 A. Yes.  
8
- 9 Q. You tell us there that one of your responsibilities is  
10 to oversee what you've described as the NSW Health  
11 procurement policy and procedures, along with related  
12 systems, structures and frameworks, for procurement  
13 activities?  
14 A. Yes.  
15
- 16 Q. That's the policies, frameworks and legislation that  
17 you have sought to summarise in paragraphs 32 to 57 of your  
18 statement; is that right?  
19 A. Yes, correct.  
20
- 21 Q. I think you return to them, in terms of their  
22 application, in paragraphs 70 to 79.  
23 A. Yes.  
24
- 25 Q. Would it be fair to say that those policies are very  
26 complex?  
27 A. They are.  
28
- 29 Q. And it would be difficult for someone on the ground,  
30 in an LHD, wanting to acquire something, to understand how  
31 they all fit together?  
32 A. It's fair to say that, yes.  
33
- 34 Q. There are thousands of people within the system who  
35 have responsibilities at various levels for procurement  
36 within NSW Health?  
37 A. Yes.  
38
- 39 Q. Do you consider that it's realistic for it to be  
40 expected that those individuals who are tasked with  
41 procurement responsibilities will have a sufficiently  
42 mature understanding of all of those policies to enable  
43 them to perform their procurement functions in accordance  
44 with them?  
45 A. The expectation is that the procurement leads or the  
46 procurement officers at the district should be fairly  
47 familiar with the NSW Health procurement policy and

1 procedures, and they are essentially the touch point and  
2 contact for any local staff or nurse unit manager, perhaps,  
3 who doesn't really need to be at that level of  
4 understanding of the policy.

5  
6 Q. Are you aware that a number of LHDs have produced  
7 their own local policies and frameworks in an attempt to  
8 synthesise the requirements of the various policies you've  
9 identified so as to enable staff on the ground to  
10 understand and apply them?

11 A. I'm aware that there are local procedures within every  
12 district, and they vary by district, and they are in line  
13 with the district's financial delegations so as to ensure  
14 accountability and responsibility, obviously for taxpayer  
15 money.

16  
17 Q. So the delegations deal with the financial point at  
18 which a decision needs to be passed up the chain?

19 A. Yes.

20  
21 Q. But in terms of what that decision is and whether or  
22 not the making of that decision complies with the various  
23 policies, frameworks and pieces of legislation you've  
24 identified, are you aware that the LHDs - some LHDs have  
25 produced, as it were, "health procurement policies and  
26 framework for dummies" manual?

27 A. Yes, so to be clear, there is only one NSW Health  
28 procurement policy. What the districts, again, would have  
29 produced is a manual at a local level or a flow chart, so  
30 to speak, to enable the staff who are not meant to really  
31 be involved in procurement at that extent to really  
32 understand, as you highlighted, you know, a manual for the  
33 individual at a ward, so that they understand how to  
34 actually go about procuring a good or service within the  
35 district.

36  
37 Q. Do you see any benefit in potentially simplifying or  
38 streamlining all of those policies in a way that makes them  
39 a little bit more digestible to a procurement person on the  
40 ground?

41 A. We certainly have - we certainly have strived and we  
42 continue to strive to simplify it as much as possible. The  
43 challenge is always trying to incorporate a lot of the  
44 statewide government policies and directions within our  
45 framework to ensure that we are compliant, as a cluster or  
46 a portfolio, with all those directions and frameworks that  
47 are set by central government. So whilst we try and



1           endeavour to simplify that, it is still very difficult to  
2           get it down to a simple couple of pages. We have certainly  
3           attempted that, and what we then - what we try and do is to  
4           have a simple way of allowing individuals to jump on  
5           a procurement portal, and through that procurement portal  
6           they are able to at least get an understanding of: right,  
7           what do I want to buy today, this is how I go about it, and  
8           these are the different touch points throughout the system.

9  
10          Q.    So is it right to say that in relation to a lot of the  
11          requirements of this complex array of policies, they are  
12          factored in to the portal in a way that means one doesn't  
13          need to understand them because the portal works in a way  
14          that, by necessity, applies them as one passes through the  
15          pathway of that portal?

16          A.    Correct, to a degree. Ultimately, complex  
17          procurements which would not occur at a ward level would  
18          require deeper understanding of the policy, and this is  
19          where the procurement staff or the procurement contact  
20          leads at a district level would be very familiar with that.

21  
22          Q.    So is it right that at least at a ward level and  
23          a day-to-day procurement level, the reforms that you tell  
24          us a lot about in your statement have sought to cut through  
25          some of the complexity that sits around these policies?

26          A.    That is definitely the aim, yes.

27  
28          Q.    And the areas in which you've had trouble simplifying  
29          the policies in a way that produces, I think, what you  
30          described as a two-pager, is more in that area of  
31          high-level, high-value procurement that would ordinarily be  
32          carried out by someone within a procurement team, either at  
33          the LHD level or possibly at HealthShare?

34          A.    Correct.

35  
36          Q.    We've been told as part of the evidence we've been  
37          given this week about a range of different channels through  
38          which procurement, at a ward level or at an operational  
39          level, can occur.

40          A.    Yes.

41  
42          Q.    There's the PCard you've heard about?

43          A.    Yes.

44  
45          Q.    There's the S1 form?

46          A.    Yes.

47

1 Q. There's the iProcurement portal?

2 A. Yes.

3

4 Q. There's the DeliverEASE system, which, as we  
5 understand it, interacts automatically with the  
6 iProcurement portal?

7 A. Yes.

8

9 Q. Are there any other means by which someone in an  
10 operational role within a hospital might need to procure  
11 something, or any other ways in which they would go about  
12 procuring something?

13 A. Not that I'm aware of, but if I can expand a bit on  
14 those points.

15

16 Q. Yes, please.

17 A. So there really is one centralised platform, an  
18 enterprise platform, being Oracle. That's really the  
19 foundation, if you think about it, the foundation of where  
20 purchase orders and requisitions are raised against.

21

22 DeliverEASE is a solution that is actually enabling  
23 a level of efficiency across the supply chain and inventory  
24 management. And I think you mentioned the S1 form. My  
25 understanding is that that's a manual form where you're  
26 seeking to procure items that are out of trust funds.  
27 Again, we don't - because it is not necessarily related to  
28 taxpayer funds, but they do come to me for exemptions,  
29 where I can see them, but that's a very sort of - I see  
30 very minimal of those. In fact, I've only seen one come  
31 through in my six years.

32

33 So the challenge is trying to make sure that  
34 everything integrates with a single platform that we have,  
35 being Oracle.

36

37 Q. I think the other one, I'm reminded, is a SARA,  
38 S-A-R-A, request, which seems to be, if you can't work out  
39 which of those other platforms to use, you put it into SARA  
40 and hope something comes back?

41 A. SARA is - whilst it's a platform used for requesting  
42 to procure an item, it's not necessarily a - it's not  
43 necessarily a platform that actually makes payments or - it  
44 is really all the payments and requisitions are coming  
45 through the Oracle platform, and iProcurement, which you  
46 referred to Mr Muston, is essentially the ordering platform  
47 itself, so to speak, that has the catalogue for all the

1 items that are part of this large extensive catalogue we  
2 have for health.

3  
4 Q. So how does an individual working within the system,  
5 who needs to acquire something, actually know which of the  
6 various processes they should be using?

7 A. Depending on where they work and what department they  
8 work. So if we take an example of a nurse unit manager who  
9 is responsible for, you know, their - basically a ward and  
10 they are responsible for that area within the hospital,  
11 they would, as part of their induction, I would imagine,  
12 be, you know, made familiar with what the ordering platform  
13 is, how do I go about raising a requisition, what are the  
14 different challenges, and it's fair to say there is a level  
15 of knowledge that is transferred there.

16  
17 The other method is, we are developing some modules  
18 within the procurement academy that we launched about  
19 18 months ago, and some of those modules are really  
20 tailoring procurement for non-procurement folk. So again,  
21 whilst our modules are really targeting procurement  
22 capability and capability uplift at a district level for  
23 those procurement staff, but it's also important to ensure  
24 that, as you mentioned, someone who doesn't really - who's  
25 not a procurement expert, how do they go about procuring  
26 items within their position.

27  
28 Q. So the procurement academy, this is some online  
29 educational material that's being prepared to assist in  
30 letting people who are non-procurement folk know which  
31 platform they should be using to buy what?

32 A. Yeah, it's not online material; it's actually a  
33 face-to-face delivery or it can be virtual depending on the  
34 location. Obviously, we're looking always to save costs  
35 and be efficient.

36  
37 But these are modules that have been - procurement  
38 modules and training that have been specifically developed  
39 and tailored for health, so they're developed within my own  
40 branch, in conjunction with the Chartered Institute of  
41 Procurement & Supply Chain, so we wanted to make sure that  
42 we're leveraging industry best practice as part of that  
43 when it comes to negotiating and contract management, so  
44 these are modules that have been designed and tailored for  
45 NSW Health procurement staff.

46  
47 Q. Could I ask you to turn to paragraph 64 on page 21 of

1 your statement.

2 A. Yes.

3

4 Q. You tell us there about the four work streams that are  
5 part of the procurement reforms. Would it be right to say  
6 that the first one you tell us about there in subparagraph  
7 a is part of this process of synthesising or simplifying  
8 the policies that we've been talking about?

9 A. That's correct.

10

11 Q. Turning over to b, the medicines formulary, I think we  
12 understand how that works, in terms of it being a list of  
13 particular medications which have been identified as  
14 appropriate for use within New South Wales public  
15 hospitals, in an attempt to reduce down what was once  
16 a large and varying list of medications used across the  
17 system.

18 A. (Witness nods).

19

20 Q. But you use the phrase:

21

22 *... develop a holistic framework governing*  
23 *the procurement and usage of*  
24 *pharmaceuticals to support optimum clinical*  
25 *governance and better value health care*  
26 *leading to improved patient outcomes.*

27

28 A. Yes.

29

30 Q. Is that just a longer-winded version of what I just  
31 said?

32

33 A. Yes. But I'll add - what I'll add there is, the  
34 medicines formulary started off, and as everything that we  
35 do in health has to be about patient outcomes, and it's  
36 obviously had the clinical - the objective to have a better  
37 clinical outcome for the patients and make sure that  
38 there's consistency in prescribing, making sure that  
39 obviously we don't have a multitude of variability around  
40 different items and medications - and again, I'm not  
41 a clinician, not an expert, but if you look at where we  
42 were and where we are now, moving from over 6,700  
43 medications or medicines on the list down to about just  
44 over 2000 or so, and we're still covering the range of  
45 prescribing and ability to provide those medications as  
46 required, it just shows you that there was probably a lot  
47 of benefit in going down that path to standardise that.

1           The second piece to that would be, now that we have  
2 a list, a consistent list, so to speak, in simple terms, of  
3 what these medications are that we're going to be  
4 prescribing and we have and are in the system, and our  
5 requirements, how can we now leverage that knowledge and  
6 now overlay that with our procurement strategy to enable  
7 a greater level of commercial efficiency across that? So  
8 it's a two-pronged approach.

9  
10          Q.    The next one you tell us about is the DeliverEASE?

11          A.    Yes.

12  
13          Q.    Which I think you've told us a little bit about  
14 already. That's a platform or a mechanism by which the  
15 ordering process through the iProcurement system is  
16 automated?

17          A.    Yes.

18  
19          Q.    We've been told by people who are using it that it  
20 involves scanning of items using a barcode and scanner or  
21 an iPad?

22          A.    Yes. So there is a barcode on the shelf, for every  
23 row of items or section of items, and when the  
24 procurements - sorry, when the staff member within the  
25 hospital or the ward notices that the items have gone down  
26 below their minimum levels, they can then scan that code  
27 through the STARR app and input how much more they require.  
28 So it saves them having to manually go back to their desk  
29 and actually type in and raise a requisition for every  
30 single item on that shelf.

31  
32          Q.    So the ordering process is simplified because they see  
33 they need an item?

34          A.    Yes.

35  
36          Q.    They scan the item using the STARR app? They put in  
37 the number of the item that they want to buy and then the  
38 procurement automatically happens thereafter?

39          A.    Absolutely, and DeliverEASE has a hard and - I guess  
40 a hard or a physical component to it and a software  
41 component. So the physical component is getting the  
42 storeroom right in the first place, so actually making sure  
43 that there's a level of organisation without - within the  
44 storeroom, to enable anyone who walks in, irrespective of  
45 which facility they work in, to locate whatever item they  
46 need.

1 Q. So it's a standardisation in a physical sense of  
2 storerooms?

3 A. Yes.

4

5 Q. Across the system?

6 A. Yes.

7

8 Q. So if a nurse needs to go and get a particular sized  
9 bandage, he or she would know that they - whichever  
10 hospital they happened to be in or whichever ward, if they  
11 go into the storeroom, it's going to be in roughly the same  
12 location?

13 A. Correct. So that's the physical piece and that's very  
14 important, before you go down the path of any software or  
15 automation, that you have to get the physical nature of  
16 that storeroom organised.

17

18 The second piece is the software, which is the smarts  
19 behind the ordering - the inventory management. This is  
20 where how could you actually automate that ordering  
21 process, and where we are right now is really the first  
22 phase, which is - and sorry if I'm adding a little bit  
23 further to your question.

24

25 Q. No, no.

26 A. So the first phase involves, okay, we've got the  
27 physicality sorted out. The second piece is how can we  
28 automate that? Automation occurs in two ways. The first  
29 one is ensuring that you have the right stock levels on the  
30 shelf, and this is where the min/max comes in, minimum and  
31 maximum levels.

32

33 Q. Pausing there, who decides in respect of any  
34 particular item what the min and max should be for that  
35 item in any given ward?

36 A. So this is - the project team works directly with the  
37 LHDs to ensure, at a ward level, what should you really be  
38 having on that shelf and -- -

39

40 Q. Can I ask you to pause there?

41 A. Yes.

42

43 Q. So a ward that might have a very high turnover, maybe  
44 a busy metropolitan emergency department, might need  
45 a large number of bandaids on stock because they might go  
46 through a large number of them.

47 A. Yes.

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Q. The equivalent department in a small regional centre might need much smaller quantities, because if they had a large quantity, they would end up holding on to them until they went off?

A. Absolutely.

Q. So there is tailoring, is there, of the min/max levels in each of those settings?

A. Correct. There's customisation around those min/max levels, depending on the ward. Not every ward is going to - as you said, not every ward is the same.

Q. Before we move on from that, is there - in terms of part of that process, has that generated any consideration of the volumes in which items are supplied? Perhaps to give a practical example, we've been told that a particular item which is available in a box of 50 is delivered to a small regional outpatients or LHD emergency department, where they're lucky to use two of that box before they go off. But as they understand the system, you need to buy the box, because that's all you can do, and so they repeatedly buy a box, use two, throw 48 away, buy a new box, ad infinitum. Is that something which is being looked at through this process?

A. Absolutely. The aim of DeliverEASE is to eliminate waste, and waste is something that obviously we shouldn't have anywhere, and part of the exploration phase of DeliverEASE was we identified a lot of stock that was on the shelf that was actually expired because of, one, individuals not being able to locate it in the first place; but the other was historically, as an orderer or a nurse unit manager, or whoever is placing the order, "I feel comfortable always having six boxes of something, even though I may not necessarily go through the six boxes in three months, but that's just how I - you know, I've always done it that way and that's how we're doing it."

But the reality is DeliverEASE will eliminate that waste by really targeting what that ward, an individual customised ward, requires to enable it to continue until the next ordering cycle, without having expiration date issues based on that. So the Onelink warehouse can break down products. There is no reason why a ward or an individual feels that they have to procure an item that will take them 12 months to go through. That shouldn't be the case.

1  
2 Q. In the example that we've been given - and I can't,  
3 I must say, remember what the item was, but that probably  
4 wouldn't matter, although you might know them all - there's  
5 a possibility, is there, that the person who's ordering the  
6 box of 50, perhaps just is not on top of the functionality  
7 of the system which would enable them to order two, if  
8 that's all they feel they need.  
9 A. Correct. I would imagine that in this particular  
10 example, DeliverEASE has not been rolled out to that  
11 facility, and possibly there's a lack of knowledge back to  
12 Onelink, and this is where I guess, from a contact  
13 perspective, the procurement lead for that district would  
14 be aware to say, "Actually, if I'm aware of this, I will  
15 contact Onelink and say, 'Can you please ensure that next  
16 time we place an order for this, we don't get a box of 50,  
17 we only get a box of 2?'"  
18  
19 Q. But your point is with the DeliverEASE system, once  
20 it's in and operational, the item gets scanned, "How many  
21 do you need?" You press "2".  
22 A. Yes.  
23  
24 Q. And that's all that's going to arrive?  
25 A. Correct, correct.  
26  
27 Q. I think I diverted you. So the first step in  
28 DeliverEASE was setting up the storerooms?  
29 A. Yes.  
30  
31 Q. The second step was setting up the STARR app platform  
32 that enables a scanning of the items to assist in the  
33 ordering?  
34 A. Yes.  
35  
36 Q. And there's this process of customisation of the  
37 min/max in each particular storeroom to make sure it suits  
38 the needs?  
39 A. Yes.  
40  
41 Q. We've heard a lot over the last week about nurses,  
42 store staff and procurement, operational staff, counting  
43 items in storerooms. Is it anticipated that the  
44 DeliverEASE reform will reduce the need for that manual  
45 counting?  
46 A. Yes.  
47



1 Q. How is it going to do that?

2 A. In two stages. So the first stage will be - at the  
3 moment we're gathering the data to build up a picture and a  
4 history for every ward. The first stage of evolution for  
5 the deliveries is what is called a "proposed order", an  
6 order proposal, where the - after a period of time of data  
7 gathering the system and the algorithm will be able to say,  
8 "Right, based on historical usage, and the next time you're  
9 going to get delivery, you will need X amount of items",  
10 because it's already got that history of reordering within  
11 over, let's say, let's call it, a 12-month period. So it  
12 has developed a pattern, so to speak, to understand, that  
13 well, every time - and within that period of time, you  
14 know, within the month of November/ December, you ordered X  
15 amount, and you go through that amount every day, you will  
16 need this and --

17

18 Q. Just pausing there, that information is being gathered  
19 based on current ordering practices?

20 A. Yes.

21

22 Q. So as the procurement store officer goes into that  
23 storeroom, counts what's there, enters into DeliverEASE,  
24 how many more they need to get to the max, that data is  
25 being harvested to produce a predictive system that says  
26 "It's December, you normally use 100 of these  
27 during December, it's been a while since you ordered them,  
28 and so we anticipate if things are going to plan, that you  
29 should be placing another order"?

30 A. Correct.

31

32 Q. To work out whether or not that predictive system is -  
33 or the prediction is right, someone will still at the  
34 moment need to go in and count to see what's in the  
35 storeroom to make sure that there hasn't been a surge, or  
36 that there hasn't been a slow month or --

37 A. Correct. And the reasons for the cycle counts that -  
38 you would have heard that term over the course of the week.  
39 The reasons behind these cycle counts is because that's the  
40 only way to understand what stock is on the shelf.

41

42 As clinicians/nurses, are taking stock from that room,  
43 the only way for the system to be dynamic and transparent  
44 enough is every time you would take out a bandage, you  
45 would have to scan. Now, they're not - that's not really  
46 practical in our environment, and the environment/setting  
47 that they are in, and hence why there's an algorithm that

1 sits in the background that would require a data feed over  
2 a period of time to build the intel to say, "I think this  
3 is what you need, and if you agree, press 'Okay', and  
4 that's all you have to do."  
5

6 Q. So one efficiency there is you don't need to punch in  
7 the number that you need; you can just say that looks  
8 right?

9 A. Yes.

10  
11 Q. The second efficiency is, would I be right, it might  
12 reduce the frequency of physical counting if people within  
13 the wards become comfortable that this predictive ordering  
14 is pretty right, but there needs to be probably a stocktake  
15 done at a wider interval than is currently happening?

16 A. Correct. You still will need to have those stocktakes  
17 to make sure that the system has the right data.  
18

19 Q. You mentioned the scanning in, scanning out. Is that  
20 a future - is that something that you have in mind as  
21 a future development to the DeliverEASE process?

22 A. No, because again, the practicality behind scanning  
23 every single item that goes - that's being consumed, and  
24 then reliance on those individuals to actually scan them,  
25 so the scanner is still a manual, physical item that you  
26 have to apply. So if individuals don't scan items that  
27 they're taking out of the room, then there's no point in  
28 having a scanner there. So we realise, we're practical  
29 enough to understand that that's not really a practical  
30 solution, hence why we've got that intel and smarts in the  
31 background.  
32

33 Q. To the extent that that is a practical solution - so,  
34 for example, you are undoubtedly familiar with the h-trak  
35 system?

36 A. I am.  
37

38 Q. And what we've been told is that where that h-trak is  
39 being used in theatres, for example, there is a physical  
40 scanning of every single item that is used in every  
41 procedure from the swabs down to the - up to the prosthetic  
42 device?

43 A. Yes.  
44

45 Q. In that instance, is the DeliverEASE system able to  
46 accommodate a push/pull model based on the scans?

47 A. The items in theatres are quite high value, and

1 obviously apart from the smaller swabs and bandages that  
2 you may have mentioned, but the reality is that h-trak is  
3 also there as a transparency and costing solution. So it  
4 does offer, in its off the shelf configuration, a costing  
5 of a procedure - so how much does a knee replacement or hip  
6 replacement, or whatever the procedure may be, what was the  
7 cost of that? So it enables the district to sort of  
8 understand holistically where that - where they are, and  
9 potentially understand from a funding perspective, well,  
10 this is where our efficiency lies at that level.

11  
12 It does also, obviously, track implantables, so  
13 prostheses and other items that are used in the procedure.  
14 But the volume that is involved in that scanning is not as  
15 high as it would be in a typical ward storeroom, so there  
16 is quite a - those items in the ward stock room are very  
17 fast-moving items, and again, at the pace that staff would  
18 be working on, it would be an interruption in that work  
19 flow, particularly, say, in an ED environment.

20  
21 Q. So the question, though, is accepting that that may be  
22 right --

23 A. Yes.

24  
25 Q. -- where it is being done, in theatres - we're coming,  
26 I think, to the next of the reforms, the SmartChain  
27 reform --

28 A. Yes.

29  
30 Q. -- that will involve scanning of the type which is  
31 currently used in the h-trak system of consumables and -  
32 anything that's used in the operation; is that right?

33 A. So the SmartChain solution, or SmartChain, is - again  
34 it's a solution, but it is a project name, it's a solution  
35 name; it's not a different system per se. SmartChain is  
36 not a replacement for h-trak. h-trak is a patented  
37 software that is owned by a vendor and it's a stand-alone  
38 system. It's not integrated within our enterprise system.

39  
40 The solution that is tabled as SmartChain, what that  
41 is going to do is to essentially look at what are all the  
42 features and solutions that we need at a theatre level, at  
43 a ward level, holistically across the entire supply chain,  
44 and essentially connect all that together.

45  
46 So to answer your question around scanning in and out  
47 within theatres, that will continue, that can continue, so

1 the software will allow that to happen.

2

3 Q. That is, the software that underlies the SmartChain  
4 solution will continue to allow that scanning to happen?

5 A. Correct. Correct. So we --

6

7 Q. So my question in relation to that is: to the extent  
8 that the scanning will be a feature of at least some part  
9 of future operations under the reforms --

10 A. Yes.

11

12 Q. -- is it contemplated that that scanning process could  
13 be used to do away with or greatly reduce the need for  
14 physical counting in storerooms, at least where that  
15 scanning is happening, for example, in theatres?

16 A. It's possible, but it's not part of the solution at  
17 the moment.

18

19 Q. Okay. Could I ask you to go to paragraph 94 of your  
20 statement.

21 A. Yes.

22

23 Q. You identify there some of the key challenges in  
24 delivering the procurement reform program, including  
25 resourcing?

26 A. Yes.

27

28 Q. In terms of facing those challenges, have you looked  
29 at the way that procurement and supply chain systems are  
30 run in other settings, so, for example, the private  
31 hospital settings?

32 A. I haven't personally looked at private hospital  
33 settings, but certainly through my experience, over two  
34 decades-worth of experience and knowing, at a supply chain  
35 level and a procurement level, the holistic end-to-end  
36 supply chain models that are out there, that is informing  
37 a lot of the input into this, but also liaising with other  
38 colleagues in the industry, the supply chain industry, to  
39 understand, at the end of the day, the supply chain is  
40 pretty consistent across whatever setting you have.

41 Obviously it's varying in complexity based on whether it's  
42 a hospital or whether you are in the hospital industry, so  
43 there are risks that have to be managed in those various  
44 settings, but ultimately, what we are aiming to do here is  
45 to eliminate a lot of the manual input and inefficiencies  
46 that may exist simply because historically we've never  
47 really had one holistic, end-to-end supply chain ecosystem

1 and --

2

3 Q. Have you, or has anyone within health to your  
4 knowledge, looked at the procurement systems and logistics  
5 systems which are operated within private hospital networks  
6 to see whether they could be adapted for use in the public  
7 hospital setting?

8 A. I'm not aware of that.

9

10 Q. Has anyone, insofar as you are aware of, looked at  
11 equivalent supply chain and logistics type operations in  
12 perhaps different but vaguely analogous settings like aged  
13 care facilities and the like?

14 A. I'm not personally aware of that.

15

16 Q. And as part of the process of considering how to - or  
17 whether and how to roll out the reforms, is consideration  
18 being given to any - to contracting them out to a third  
19 party, for example, an Amazon or someone like that?

20 A. Sorry, just to clarify your question, are you saying  
21 to actually contract or put out the entire supply chain  
22 process to a third party?

23

24 Q. Yes.

25 A. We have looked at - and when I say "we", as in my  
26 colleagues in HealthShare and eHealth, who are obviously  
27 driving a lot of that project implementation, visited  
28 Amazon warehouse to sort of see at an enterprise level and  
29 a system level what that looks like, and some of the  
30 smarts, and obviously there's a level of sophistication  
31 around order picking and packing and obviously with, you  
32 know, an organisation like Amazon.

33

34 So there has been some leveraging of that knowledge to  
35 try and understand what is industry doing out there that  
36 we, one, can leverage, but also understanding that there's  
37 an inherent risk by simply putting out our entire supply  
38 chain to an organisation and really kind of saying, "Here  
39 you go. You can manage this for us." Obviously it's very  
40 different if an order is missed for - you know, if you  
41 don't get an Amazon order today and you get it the next  
42 day, it's not an issue, but for us if items are running low  
43 for a certain reason, it's important that there's a greater  
44 level of involvement and ownership of that supply chain  
45 ecosystem.

46

47 Q. Could I ask you to turn back to paragraph 93, so

1 that's just the page before that one.

2 A. Sure.

3  
4 Q. You tell us a little bit about what you perceive to be  
5 some of the benefits of the procurement reform. I'm just  
6 wondering, particularly in relation to a, 93a, how is it  
7 that you perceived the reform program is going to produce  
8 that as an outcome? Perhaps I should take it in two steps.  
9 What do you regard value based care to be, where you use  
10 that term in 93a(i)?

11 A. Value based health care for me is all about patient  
12 outcomes and the primary focus of that is the outcomes that  
13 we can achieve for our patients. Everything that we do is  
14 all for our patients.

15  
16 Whilst the word "value" is there, I think we need to -  
17 we need to make sure that we don't associate "value" plural  
18 with price. It's - value encompasses, you know, the  
19 efforts of staff but also the value that the patient has in  
20 the end after their surgery as well, which is related to  
21 their outcome. So that's, for me, what value based health  
22 care is. It's really all about patient outcomes and how we  
23 can approve that outcome for the patient.

24  
25 Q. So how is it that the reform procedure, as you  
26 envisage it, is going to assist in delivering better  
27 patient outcomes?

28 A. From a procurement perspective, the - all the systems  
29 that we're working on and these improvements across Oracle,  
30 and, you know, to be specific, the SmartChain solution is  
31 an example, what that will enable us to do is to ensure  
32 that we are maximising the commercial value of what we're  
33 procuring, which can then translate into, obviously,  
34 operating within the same envelope, cost envelope, so to  
35 speak, but actually getting more items and getting greater  
36 commercial value for those items.

37  
38 How that is going to be achieved is by saying, well,  
39 ensuring that every district is procuring the items at the  
40 correct price and ensuring equity and availability for  
41 those items across the entire system. You know, some of  
42 the things that we've discovered through the reform program  
43 for SmartChain and also master catalogue, which you may  
44 have heard of across the week - some facilities, some  
45 districts, are paying a different price for the same item  
46 that another district is paying for --

47

1 Q. So, cutting to the chase, is the point that you're  
2 making there that by generating economic efficiencies in  
3 procurement, that will free up money?

4 A. Yes.

5

6 Q. Which can be used to deliver - assist in delivering  
7 clinical services?

8 A. Yes.

9

10 Q. And thereby drive better patient outcomes?

11 A. And also the level of efficiency that will be  
12 associated with also freeing up staff. So ensuring that  
13 staff are able to focus on patients rather than having to  
14 focus on placing orders.

15

16 Q. Can I ask you to jump back to paragraph 87, which is  
17 on the previous page, page 30.

18 A. Yes.

19

20 Q. In relation to that one, can I just ask you to read  
21 that to yourself --

22 A. Sure.

23

24 Q. -- so you familiarise yourself with what we are  
25 talking about?

26 A. Yes. Yes.

27

28 Q. Where you refer to "volume discounts: That's fairly  
29 understandable. Talking about "equitable procurement  
30 across geographic areas", can I just ask you what you have  
31 in mind when you refer to that?

32 A. Given the scale of the system that we have in  
33 NSW Health, we're obviously spread across the entire state,  
34 and it is fair to say that it can be challenging  
35 logistically for those districts that are in rural and  
36 regional settings, what we're trying to ensure is for those  
37 districts to not be disadvantaged and have equity across  
38 that item portfolio. In other words, whatever a district  
39 in metro is able to order and procure, whether it be, you  
40 know, a particular good or a knee or a hip, or whatever it  
41 may be, that a district in rural and regional is also able  
42 to procure that and not be disadvantaged simply because  
43 they are, you know, 400 kilometres away from the city.

44

45 Q. When you say equally "able to procure", do you mean at  
46 the same price?

47 A. At the same price but also at the same availability.

1 In other words, you're not going to have to wait, you know,  
2 two weeks for a product that is readily available in metro.  
3 They're some of the things we're wanting to make sure, that  
4 every setting is the same.

5

6 Q. So dealing with consumables, medical consumables  
7 first, there's the Onelink warehouse we've heard about?

8 A. Yes.

9

10 Q. Items get delivered to the Onelink warehouse?

11 A. Yes.

12

13 Q. And are then distributed to LHDs?

14 A. Yes.

15

16 Q. Are we right in our understanding that there is  
17 a transport cost associated with delivery from the Onelink  
18 warehouse to LHDs? LHDs that are more remote from the  
19 warehouse pay more for the transportation?

20 A. There is a - my understanding is there is an add-on  
21 charge, simply because of the logistics costs with having  
22 to go out to that area. However, the base price of that  
23 product is the same.

24

25 Q. That's because the base price of the product is  
26 product as delivered to the Onelink warehouse?

27 A. So the product that comes out. So if we take  
28 a product that is costing \$5, so a metro LHD would pay \$5  
29 for that product because there's no delivery charge, it's  
30 obviously built into that model. A district in rural and  
31 regional may pay \$5.30, for example, because there is an  
32 added-on cost to be able to get there. However, the \$5  
33 price that's charged is the same across; it's just that  
34 additional cost for the recovery of that logistics.

35

36 Q. But in terms of the costs associated with getting that  
37 item to the more remote LHD, that's not a cost that's being  
38 absorbed system-wide?

39 A. No.

40

41 Q. It's being borne solely by the more remote LHD?

42 A. Correct.

43

44 Q. So the concept of equitable procurement, at least in  
45 that respect, is not working, at least in a perfect way?

46 A. No, but then you would have the issue of one  
47 subsidising the other. But the volume, I guess, if we - if



1 you look at it from a different perspective, the volume  
2 associated with some of the rural and regional settings is  
3 far less. So that additional supply chain cost may be -  
4 you know, when you actually compare it to the cost of the  
5 item itself, can be very, very small.

6  
7 Q. So that's in terms of the transportation costs?

8 A. Yes.

9  
10 Q. We have heard some evidence given by procurement  
11 people within the LHDs about this concept that metro LHDs  
12 might be able to acquire an item for a lower price than  
13 that which is on the statewide contract.

14 A. (Witness nods).

15  
16 Q. And it's been, I think, suggested that the reason that  
17 that is not allowed to happen is because the single price  
18 means LHDs, whether they be remote or metro, should be able  
19 to procure the product for the same price, and that's the  
20 way in which equity, in the way I think it's described in  
21 paragraph 87, is delivered?

22 A. Can I clarify with your question, do you mean an  
23 item - you did say that it's not on the statewide contract,  
24 but is it an item that is actually even used in NSW Health  
25 at all?

26  
27 Q. So, for example, this is a piece of imaging equipment,  
28 I think is the example that's been given.

29 A. Right. Okay. Probably imaging is not - I wouldn't  
30 say - I wouldn't use that example only because imaging is  
31 very transparent, so if you are transporting a piece of  
32 equipment, both metro and regional will have a delivery  
33 charge. If we take another consumable that's not through  
34 the ward, so it's an item that the suppliers deliver  
35 directly to the facility, those items are actually at the  
36 same cost. So suppliers don't actually charge an extra  
37 delivery charge, so there's equity when you compare those  
38 directly delivered items.

39  
40 Some of those examples that are being raised are  
41 probably relating to items whereby some suppliers, who have  
42 missed out on actually picking up a part of a contract, are  
43 then saying, "Well, I've missed out on the process. Let me  
44 try and go into the district through another avenue." So  
45 there's probably a level of undermining the actual  
46 procurement process itself by simply saying, "Let me try  
47 and go down that path", or, in some instances whereby we

1 have volume based - market share pricing, and that market  
2 share pricing relies on a certain volume or pooling of  
3 volume to a particular supplier, another supplier who may  
4 only have a certain market share would want to say, "Hey,  
5 I want to increase my market share. How about if I just  
6 simply, you know, give you a better deal", which again  
7 would then try to undermine - well, you've got another  
8 supplier who does all the right things, and who is offering  
9 a great price. Why is someone else trying to undermine it?  
10 My question to that would be if they can offer that, why  
11 didn't they offer it as part of the tender submission?  
12

13 Q. Can I ask this about the process.

14 A. Sure.

15

16 Q. Is it the case that items sometimes could be acquired  
17 more cost effectively in the metro areas than in the rural  
18 and regional areas - not under the state contract. Were  
19 the metro and LHD to go it alone, they might be able to  
20 secure a better price for an item than, say, a smaller  
21 rural or regional LHD?

22 A. I don't believe rural or regional would hinder the  
23 ability of the metro LHDs in totality to be able to get  
24 a good price.

25

26 Q. So when you say that, are you saying that the price  
27 that is achieved for the metro LHDs --

28 A. Yes.

29

30 Q. -- is the best price available; it is not a compromise  
31 in any way to reflect the fact that that price needs to be  
32 delivered not only to the metros but also to the rural and  
33 regional LHDs?

34 A. I think we would have to look at the particular  
35 scenario and example. I don't think there is a one size  
36 fits all or a template solution to enable me - I can't  
37 answer that question fully without actually knowing  
38 a particular live example that would occur and the  
39 circumstances.

40

41 If I can add on that note, we have - again, you know,  
42 we do hear these things as well, and to address that,  
43 again, we're very open and transparent, and it's very  
44 important for me, and I've made this very clear to all the  
45 directors of finance across all the districts, no district  
46 should be worse off by being on a statewide contract. And  
47 what I mean by that is if there is evidence that you can

1 show me that by you coming on a statewide contract you've  
2 actually gotten to a worse position, both I and the CFO,  
3 the chief financial officer, will look at that and analyse  
4 the situation, this particular situation, and say, "Right,  
5 well, if, hypothetically, there is a total system benefit  
6 of \$1 million for this particular whole of health contract,  
7 and the district may be able to get an additional \$50,000  
8 in there, then we will look at how we can adjust that so  
9 that the district doesn't feel like, 'Well, I'm actually  
10 worse off now, I'm trying to do the right thing but I'm in  
11 a worse-off position'". But as a system, holistically, we  
12 are in a better position by having a whole of health  
13 contract.

14  
15 Q. In relation to that, can I just explore with you the  
16 sophistication of the modelling that goes into working out  
17 whether, at the time of entering into the whole of health  
18 contract, it does actually reflect the best value for the  
19 system?

20 A. Sure.

21  
22 Q. So let's say a piece of capital equipment, bedside  
23 point of care machine, maybe?

24 A. Yes.

25  
26 Q. To what extent, in working out whether or not  
27 a particular contractual arrangement is a good one, is an  
28 assessment made of the statewide fleet of point of care  
29 machines, the location and the - say the - which of them  
30 are toward end of life and where they might be?

31 A. Sure. So in this particular example, the first thing  
32 is obviously the - whether that machine is fit for purpose.  
33 So does it - the first criteria, and generally the first  
34 criteria for us is the non-price weighting of the  
35 assessment, and this would be fully reviewed by the tender  
36 evaluation committee.

37  
38 So their focus is to say, "Right what we're procuring,  
39 is it fit for purpose? Is it innovative, in other words,  
40 does it actually offer the best in class, best in market?  
41 Is it going to really cover all our requirements from  
42 clinical service delivery?"

43  
44 Q. So step one, you look at whether the piece of  
45 equipment you're buying is the most desirable piece of  
46 equipment in terms of its attributes?

47 A. Yes. Forget price for now.

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Q. Step two is price?

A. Correct. So the second step is, "Right, here are all the items", so after they've actually put a weighting based on their evaluation and expertise on those - on the evaluation criteria. And, by the way, the evaluation criteria is set before we even go to market, so it's part of the procurement plan. When you are going to market, you have to set up a weighting and evaluation criteria that's preset, so there's no - from a probity perspective.

And price is not looked at when you're doing that first section. The price generally in some cases is only 30 per cent because it's very important, again, relating it back to patient outcomes, it's not about price, it's actually about getting the right outcome and the right outcome would be through procuring fit for purpose equipment.

The price is then looked at, so the commercial offering by that vendor or provider is looked at, and it may not be that one supplier covers everything. Generally, it's never one supplier covering an entire system, because in most cases, it's a risk as well, you are putting all your eggs in one basket. But also, there is a level of clinical choice, so we're not restricting and saying, "You must only have one supplier, and this is the only thing you must procure." There is a level of clinical choice out there, and because --

Q. Just asking you to pause there, in relation to that clinical choice, is consideration given at your level to the benefits of standardisation across the system?

A. Yes.

Q. How does that factor in to the evaluation of a tender?

A. So you have to strike the right balance, and when I say by describing the right balance, is if, at the moment, we're moving from 10 vendors of one item, which essentially is there because we've allowed, you know, everybody to really choose whatever they want, versus a tender evaluation committee that is made up of clinicians and experts and subject matter experts saying, "Actually, we can really go from 10 down to 4", as an example.

Q. For example.

A. Yes, as an example. Then clinically, if there is no

1 need to - and, you know, deemed by the SMEs, the subject  
2 matter experts - if there is no need to go beyond the four  
3 and, you know, we can actually achieve the same clinical  
4 outcome and then have greater level of value by pooling and  
5 more greater level of volume through the system, then why  
6 do we need to do that?

7  
8 So in my consideration of contract award I do look at  
9 the evaluation report and the recommended evaluation  
10 report, particularly for whole of health contracts, where  
11 I can sort of see the variability in some of the pricing,  
12 the variability of the evaluation committee - and also the  
13 evaluation committee also has to sign off on that to say  
14 "Yes, we agree with the recommendation".

15  
16 Q. So the evaluation report sets out the way in which the  
17 particular item has been assessed relative to a number of  
18 criteria?

19 A. Yes.

20  
21 Q. Including patient outcomes?

22 A. Yes.

23  
24 Q. And perhaps performance of the contractor?

25 A. Correct. There are a number of, I guess, "must haves"  
26 within the contract. So the supplier has to conform to  
27 some minimum requirements, like any other engagement,  
28 because we do have, you know, liability insurance,  
29 et cetera, et cetera, et cetera, so there are a number of  
30 "must haves" that they have to conform to, and if they do  
31 want to deviate from that, then obviously we won't  
32 completely rule them out but we have to obviously have that  
33 conversation. Then the assessment of the clinical aspects  
34 of that product is then conducted by the tender evaluation  
35 committee.

36  
37 MR MUSTON: I note the time, Commissioner. I've probably  
38 only got about 10 minutes to go, if you are continue to sit  
39 on.

40  
41 THE COMMISSIONER: I'm content for you to continue.

42  
43 MR MUSTON: Q. I think you told us a moment ago that  
44 price is only around 30 per cent and so 70 per cent is made  
45 up of this other array of considerations --

46 A. Yes.

47

1 Q. -- as to what's perceived to be the value of the  
2 particular product?

3 A. Yes. Approximately - it can be 30, 35, depending on  
4 the item.

5

6 Q. Could I ask this: do you know the extent to which  
7 that sort of 65 to 70 per cent worth of the considerations  
8 are monitored, as to whether or not they are achieved,  
9 after the contract has been entered into? Perhaps if I put  
10 it a different way: if patient outcomes is a 20 per cent  
11 or a 40 per cent consideration --

12 A. Yes.

13

14 Q. -- do you know whether there is any ongoing monitoring  
15 or assessment of whether the patient outcomes which have  
16 been hoped for in choosing to get that product have  
17 actually been achieved?

18 A. There is certainly feedback of data through our  
19 colleagues in ACI and also the system reform branch and  
20 essentially the value based health care team and  
21 commissioning for better value team, they would monitor  
22 some of those patient outcomes flowing through.

23

24 Q. To what extent is that a formalised process, in the  
25 sense that if a particular wound care item is chosen  
26 because the clinical evaluation or tender evaluation  
27 committee come to the view that, "Well, that one, we think,  
28 is going to produce better outcomes", to what extent, in  
29 relation to a run-of-the-mill item like that, would you  
30 expect to see any monitoring or reporting back of whether  
31 or not these outcomes have been achieved?

32 A. I think probably that question is more - would be  
33 better directed to ACI around how that monitoring works,  
34 because I certainly don't have that level of interaction.

35

36 Q. In terms of other considerations like general  
37 performance under the contract, to what extent, if at all,  
38 are you aware of any monitoring of contractual performance,  
39 in terms of things like, say, delivery standards and the  
40 like?

41 A. Yes. So what I'm advised of and aware of is that for  
42 whole of health contracts, HealthShare, being the category  
43 managers per se, they have a responsibility to monitor the  
44 performance of those suppliers and have regular supply  
45 meetings to go through some of those metrics that the  
46 supplier said, "I'm going to comply with this" - have they  
47 actually complied with those metrics or not? Then also it

1 is an opportunity to provide feedback that would have  
2 filtered up or made its way up from the districts. So  
3 districts have a channel whereby they can contact the  
4 HealthShare respective category manager and provide that  
5 feedback to them.  
6

7 Q. Without going through it in detail, the sense we've  
8 got from some of the evidence given is that noncompliance  
9 with - let me take it back a step, that failures in terms  
10 of delivery and the like make their way up to HealthShare  
11 in a reasonably ad hoc way, and only when it becomes  
12 a serious problem.

13 A. Yes.  
14

15 Q. In those circumstances, would it be right that, at  
16 least insofar as you are aware, there is no overall  
17 system-wide monitoring in a forensic way --

18 A. Yes.  
19

20 Q. -- of the extent to which those sort of KPIs are being  
21 complied with by --

22 A. Not at present, no.  
23

24 Q. And you would agree, wouldn't you, that noncompliance  
25 with delivery requirements and the like produces knock-on  
26 costs in LHDs in terms of time spent dealing with suppliers  
27 to remedy the problem?

28 A. Possibly.  
29

30 Q. And the potential need to reorder or rearrange  
31 operations within an LHD to deal with that noncompliance at  
32 a practical level?

33 A. Possibly. I guess it's important also, if I may add,  
34 supply chain is not a perfect science, in that in any  
35 supply chain setting there will always be situations where  
36 sometimes, you know, the delivery in full on time may not  
37 occur. But it is how you actually manage that. That's the  
38 key thing for me. I think by having an end-to-end  
39 ecosystem that we're looking to build by saying, right,  
40 well, from the time the stock arrives at the dock and it's  
41 been receipted to how it actually then goes into the stock  
42 room, and making sure that items are recorded within the  
43 system, would then enable us to have a bit more visibility  
44 and transparency so that we can have a greater level of  
45 data about performance.  
46

47 Q. So you anticipate that the reforms, once they become

1 more mature, will enable a greater level of data gathering  
2 in terms of performance?

3 A. Yes.

4

5 Q. Is there any document that has been prepared which  
6 sets out in a detailed way the pathway and ultimate  
7 destination of these reforms?

8 A. So there are business cases, so SmartChain, if we take  
9 SmartChain, so SmartChain has a business case that sets out  
10 the current phases for the SmartChain initiative or the  
11 SmartChain project, I should say, and it obviously sets out  
12 the benefits associated with the solution and the different  
13 phases that are within SmartChain. So, you know,  
14 traceability being one of them, which you touched on  
15 previously as relating to h-trak. So there is that  
16 document that outlines what the solutions are. But it's  
17 also fair to say - and we've proven with this procurement  
18 reform - that once you establish a foundational enterprise  
19 platform and say, "You know what, we can actually tap into  
20 this platform further than what we've got and continue to  
21 evolve" - so with supply chain, it's always an evolution,  
22 so we can continue to evolve and add on other features  
23 where possible, but for us, we've prioritised these streams  
24 at present because we feel they are critical and important  
25 for us, but it's fair to say that it's an evolution, we  
26 will continue to evolve.

27

28 Q. In terms of the roles and responsibilities, who do you  
29 understand to be ultimately responsible for the contract  
30 management of the statewide and whole of health contracts?  
31 Is it HealthShare?

32 A. Yes.

33

34 Q. So to the extent that monitoring of performance  
35 metrics needs to be done, it's something which needs to be  
36 done or needs to be driven by HealthShare?

37 A. Yes.

38

39 Q. So even if the only way at the moment of doing that is  
40 by inviting procurement teams within the LHDs to gather the  
41 requisite information and pass it on, that's something  
42 which HealthShare should be doing?

43 A. Yes. So we have - I mean, to that point, we've  
44 recognised the importance of contract management, and  
45 certainly invested - and the ministry - the ministry has  
46 funded 76 FTEs, 43 across the districts, across the LHDs,  
47 as a one-off investment for two years, and then 33 across



1 HealthShare, eHealth and pathology, to really address that,  
2 to just ensure that there is that contract management  
3 investment within the system. It's a crucial part of the  
4 procurement lifecycle.

5  
6 Q. In terms of other contracts, not the statewide and  
7 whole of health contracts but, say, the contracts in excess  
8 of \$250,000 where the tendering is delivered by  
9 HealthShare, who do you see as being ultimately responsible  
10 for the contract management of those contracts?

11 A. If it is a local agreement, so if it is a local  
12 contract only for that district, it is the district that  
13 will be managing that contract.

14  
15 Q. Could I ask you to go back to paragraph 48 --

16 A. Yes.

17  
18 Q. -- on page 14 of your statement.

19 A. Yes.

20  
21 Q. First, it is a long paragraph. Can I ask you to go  
22 over two pages to page 16. You see subparagraph h at the  
23 top there, where you identify some of the actions taken as  
24 including embedding value based health care into the  
25 system-wide procurement activity?

26 A. Yes.

27  
28 Q. Again, you have told us a little bit about value based  
29 health care as you understand it, but do you want to add  
30 anything to what you have already told us about how you see  
31 value based health care as having been embedded into the  
32 system-wide procurement activities?

33 A. No, nothing further.

34  
35 Q. Would it be right to say that the way in which value,  
36 as represented as a patient outcome, is assessed, is wholly  
37 through this tender evaluation committee process?

38 A. Yes.

39  
40 Q. Can I ask you to turn back to page 15, where you refer  
41 in subparagraph f at the very bottom of that page to what  
42 you have perceived to be the benefits of or a benefit in  
43 implementing a NSW Health community of practice?

44 A. Yes.

45  
46 Q. Who do you anticipate might be incorporated into that  
47 community?

1 A. So a perfect live example is the pharmaceutical  
2 procurement governance committee which I chair, and that is  
3 made up of all - or a number of directors of pharmacy  
4 across the system, and in this situation, what we're saying  
5 is, right, we're obviously discussing the formulary and how  
6 it's being implemented across the system, but at the same  
7 time, it's then focusing on phase 2, which is, right, how  
8 are we then maximising the benefit of that formulary  
9 through the procurement contracting piece, so  
10 implementation of a statewide contract for a certain  
11 tranche of pharmaceuticals, how are we tracking on that?  
12 So this is a community of practice where we've got  
13 directors of pharmacy from across the system who are  
14 actually providing that feedback to us around directly any  
15 challenges, how can we help them, what level of support  
16 they need from HealthShare, given HealthShare is really  
17 driving that contract management piece and have supported  
18 and provided a level - a good level of support into  
19 implementing those contracts.  
20

21 Q. Do you see a role for suppliers on that or within that  
22 community of practice? For example, the community of  
23 practice that you have just spoken of, do you see  
24 potentially a role for pharmaceutical manufacturers to come  
25 and be part of that community to say, "This is what you  
26 guys think is the way to go. We, with our various product  
27 offerings, think there is a different way, perhaps a better  
28 way, that you could go, which would produce better  
29 outcomes"?

30 A. Possibly. We are, on that note, actually embarking on  
31 having supplier forum days, and this is - you know, one of  
32 the supplier forum days which we have booked in the agenda  
33 at the moment is to actually bring in our top two suppliers  
34 to talk about a number of opportunities and the direction  
35 for health, so that it is important that we have a two-way  
36 relationship with our suppliers so that they also know  
37 where we are heading, the same way we know about them.  
38

39 But, yes, it's possible to have a specific supplier  
40 forum that addresses this. We have to obviously be careful  
41 around confidentiality and how we - what issues are  
42 discussed as part of that forum.  
43

44 Q. And the same presumably would apply to medical  
45 technology suppliers?

46 A. Yes, correct.  
47

1 Q. Am I right in my understanding at the moment, to the  
2 extent that there might be some advance or development in  
3 medical technology which could be to the benefit of  
4 patients in New South Wales, the primary way that it enters  
5 the thinking is a representative of some company that  
6 manufactures this device or technology might seek to  
7 persuade a clinician somewhere within the system - or more  
8 than one clinician - that it is a great development and  
9 something that should be used?

10 A. That is one path that exists but the other path is  
11 also when a head agreement is set up, or a standing offer  
12 agreement is set up - and let's take the example, it is set  
13 up for five years - within that five-year period there are  
14 opportunities to refresh that panel and refresh the, in  
15 this case, medical piece of equipment, say if we take  
16 a CT scanner or an MRI machine. There is that opportunity  
17 through the refresh of that standing offer agreement to  
18 enable us to understand what has occurred over, say, the  
19 last two years, and enable additional technology to be  
20 added to the SOA through the supplier panel.

21  
22 Q. But just in relation to that refresh process, how does  
23 the fresh water flow into the tank? Where does it come  
24 from, this new information about developments?

25 A. It comes from suppliers to HealthShare.

26  
27 Q. So these are suppliers who are already on contract?

28 A. Or they may not be on contract and we add - we can add  
29 them to the contract by going out to market. So it's an  
30 open - we're not restricting it by any way and we're  
31 saying, right, there may be other pieces of technology out  
32 there that have been finalised and completed over the last  
33 12 or 24 months - technology is evolving and it is  
34 important for us as a system to ensure that we can have  
35 that adaptability within our head agreements.

36  
37 MR MUSTON: I have no further questions for this witness,  
38 Commissioner.

39  
40 MR GYLES: I just have one question, Commissioner.

41  
42 **<EXAMINATION BY MR GYLES:**

43  
44 MR GYLES: Q. Mr Gendy, the statewide contracts are  
45 obviously an integral part of what you are trying to  
46 achieve, and that facilitates standardisation of products  
47 for the reasons you have already told us, that benefits can

1 be obtained from that?

2 A. Yes.

3

4 Q. So just again so we can understand, the statewide  
5 contracts in the formation stages, HealthShare has a role  
6 in that, but ACI and the clinicians - do they have a role  
7 in that process and, if so, how does that work? How does  
8 that come about?

9 A. In terms of the introduction of new pieces of  
10 technology or --

11

12 Q. Well, no, no, just in statewide contracts generally,  
13 the role of ACI and/or clinicians in those decision-making  
14 and the formation of those contracts?

15 A. They are directly involved in the assessment of the  
16 non-price criteria, which essentially assesses the fit for  
17 purpose, whether that product is going to be, I guess,  
18 meeting our requirements for safety and clinical service  
19 delivery as well.

20

21 Q. And that's, in effect, part of a value based as  
22 compared to --

23 A. Correct.

24

25 Q. Sorry, a value based method of procurement?

26 A. Correct. And it's important also that as part of that  
27 consideration from a commercial perspective, that the total  
28 cost of ownership is taken into account.

29

30 So there is no point in taking on a piece of equipment  
31 that has a very small up-front cost but does cost us quite  
32 a lot every year to maintain because of a certain level of  
33 consumables - again, I'm not the expert, but that could be  
34 a scenario. So it's important that we take that holistic  
35 approach when we are doing that evaluation.

36

37 MR GYLES: Thank you. Thank you, Commissioner.

38

39 MR MUSTON: Might the witness be excused?

40

41 THE COMMISSIONER: Thank you very much for your time. It  
42 is greatly appreciated.

43

44 THE WITNESS: Thank you, Commissioner.

45

46 THE COMMISSIONER: You are free to go.

47

1 <THE WITNESS WITHDREW

2

3 MR MUSTON: Thank you, and can we extend our gratitude to  
4 the court reporters who have sat 20 minutes longer than  
5 normal.

6

7 THE COMMISSIONER: Yes, thank you.

8

9 We will adjourn until 10 on Monday.

10

11 **AT 4.25PM THE COMMISSION WAS ADJOURNED TO MONDAY,**  
12 **26 FEBRUARY 2024 AT 10AM**

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**\$150,000** [4] - 939:18, 939:21, 956:47, 976:1

**\$250,000** [8] - 933:5, 933:8, 934:7, 934:11, 934:41, 935:4, 938:29, 1013:8

**\$5.30** [1] - 1004:31

**\$50,000** [1] - 1007:7

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**'Can** [1] - 996:15

**'Okay'** [1] - 998:3

**'Well'** [1] - 1007:9

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**00** [1] - 944:23

**0006** [1] - 898:31

**0018** [1] - 913:31

**0020** [1] - 914:26

**0030** [1] - 950:33

**009** [1] - 893:24

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**10AM** [1] - 1017:12

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**14** [1] - 1013:18

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**17** [3] - 916:27, 916:46

**18** [1] - 991:19

**19** [6] - 898:29, 898:32, 898:34, 898:37, 914:26, 955:2

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**2"** [1] - 996:21

**2.04pm** [1] - 961:42

**2.1** [2] - 900:21, 900:35

**2.1.1.1** [1] - 900:38

**2.1.1.3** [1] - 900:25

**20** [6] - 917:19, 944:28, 958:27, 984:5, 1010:10, 1017:4

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**2019** [5] - 954:33, 955:30, 957:31, 958:24, 959:37

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**23** [1] - 893:22

**23b** [1] - 984:47

**24** [1] - 1015:33

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**250,000-plus** [2] - 936:41, 937:10

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**27** [1] - 963:24

**28** [5] - 941:47, 942:5, 942:7, 942:9, 970:2

**28a** [1] - 943:30

**28b** [1] - 950:9

**29** [2] - 959:37, 971:18

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**3** [7] - 921:3, 923:38, 925:46, 926:2, 954:34, 964:24, 986:19

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**30** [5] - 950:37,

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**32** [2] - 974:2, 987:17

**33** [1] - 1012:47

**35** [2] - 983:15, 1010:3

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**4** [2] - 987:5, 1008:44

**4.25PM** [1] - 1017:11

**4.3** [1] - 901:45

**40** [1] - 1010:11

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**43** [2] - 934:39, 1012:46

**48** [3] - 952:32, 995:23, 1013:15

**49** [2] - 920:42, 920:44

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**5** [5] - 944:29, 959:40, 1004:28, 1004:32

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**50** [4] - 952:27, 995:18, 996:6, 996:16

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**52** [1] - 923:37

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