Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Dubbo RSL,
Cnr Brisbane Street & Wingewarra Street,
Dubbo, New South Wales

Thursday, 16 May 2024 at 10am

(Day 028)

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

Also present:

Mr Richard Cheney with Mr Hernan Pintos-Lopez for NSW Health

1 THE COMMISSIONER: We will begin this morning.
2
3 MR MUSTON: I call Mark Spittal.
4
5 <**MARK PHILLIP SPITTAL, sworn**: **[10am]**
6
7 <**EXAMINATION BY MR MUSTON**:
8
9 MR MUSTON: Q. Could you state your full name for the
10 record, please?
11 A. Mark Phillip Spittal.
12
13 Q. You are the chief executive of the Western New South
14 Wales LHD?
15 A. That's correct.
16
17 Q. It's a role you have held since January 2022?
18 A. Correct.
19
20 Q. I think, prior to that, you acted in the role for
21 a period of six months?
22 A. On and off; that's correct.
23
24 Q. Before that, you were - or perhaps coincidental with
25 that period - the executive director of operations within
26 the LHD?
27 A. Since the middle of 2018 that was my role.
28
29 Q. Which rounds out, or these are the most recent
30 examples of over 30 years' worth of experience that you
31 have had working in public health in New South Wales and
32 New Zealand?
33 A. Correct.
34
35 Q. You have prepared two statements to assist the
36 Commissioner in relation to his work. The first is
37 a statement dated 6 February 2024, which is exhibit B.8 -
38 there is no need to bring that up on to the screen, it was
39 tendered during the procurement hearing - and more recently
40 a statement dated 30 April 2024, [MOH.9999.1202.0001].
41 Have you had an opportunity to read and consider that
42 statement?
43 A. I have, yes.
44
45 Q. I understand there is a correction that you may wish
46 to make to an aspect of it. I also understand that, in
47 order to assist you in doing that, a document may be able

1 to be brought up on to the screen next to you.
2 A. Correct, yes.
3
4 Q. So we can assume that any imperfections in the
5 reproduction of the graph caused by using a mobile phone to
6 take a photograph of it will be corrected in due course.
7 Does that - am I right in understanding that paragraph 20
8 and the graph which appears immediately beneath it in that
9 statement, you would wish to replace with the paragraph 20
10 and the graph which appears on the screen at the moment?
11 A. That's correct, and in a technical data review, we
12 recognised an error in the way things were expressed. So
13 this is a technical correction that doesn't alter the
14 meaning of the previous paragraph but makes it more
15 technically true.
16
17 Q. Other than that correction, are you satisfied that the
18 content of your statement is true and correct to the best
19 of your knowledge?
20 A. That's correct.
21
22 MR MUSTON: In due course, Commissioner, that will be
23 tendered as part of the bulk tender.
24
25 THE COMMISSIONER: Yes.
26
27 MR MUSTON: Q. Can I ask, before we get into the
28 substance of your evidence, one other small matter.
29 Yesterday we heard some evidence from Professor Arnold,
30 where he discussed the roles of various groups within the
31 LHD insofar as service planning is concerned, and I think
32 the evidence he gave was to the effect that it was service
33 delivery that was involved in some of those planning
34 operations. Accepting as correct the evidence that he
35 gave, that it was not him or his group who were responsible
36 for those activities, is it in fact the case that service
37 delivery is responsible for that planning or is it another
38 group within the LHD that does that?
39 A. There are multiple levels in planning in any large
40 organisation like a local health district. The primary
41 responsibility for planning is headed up by our strategic
42 reform planning and partnerships team, and you heard from
43 Maryanne Hawthorn, the executive director of that group,
44 yesterday. The service delivery unit and the staff within
45 the service delivery unit have input into that planning
46 process, particularly clinical service planning or service
47 planning across the district, and I can absolutely

1 understand how Professor Arnold, as a relative newcomer to
2 the district, who in the last year has been busy both
3 sorting out research and standing up voluntary assisted
4 dying services in our district - he will see that planning
5 coming to the executive group, which he is a member of, and
6 as we review it on the way to the board, but in discussion
7 with his medical colleagues, I can absolutely understand
8 how he would have formed the impression it was primarily
9 delivered out of the service delivery group because, of
10 course, that's the group where the doctors are employed and
11 that's the group from which they have interactions with the
12 work of Maryanne's team.
13
14 Q. But the primary responsibility for that planning rests
15 with Maryanne and her team?
16 A. That's correct.
17
18 Q. No doubt with input from service delivery?
19 A. Absolutely.
20
21 Q. And a range of other groups and individuals within the
22 LHD?
23 A. Yes.
24
25 Q. We'll come back to service planning in a while. But
26 I might take things a little bit in reverse. I want to ask
27 you this question: if you were given an opportunity to
28 start afresh and design what you regard to be the optimal -
29 an optimal and equitable system for the delivery of health
30 services to the people within your LHD, what would it look
31 like?
32 A. No doubt we will traverse this in my statement during
33 the course of the morning but, unsurprisingly, given my
34 background and a lot of my early career until very recently
35 has been in the context of the New Zealand health system,
36 I have a slightly different perspective and a different
37 history than had I grown up within the Australian health
38 system. Fundamental to that, and a point of difference, is
39 how you deal with the issue of planning at a population
40 level, so services for populations.
41
42 In my evidence I suggest that there is a need for
43 legislative reform at state level, and perhaps
44 Commonwealth, although that's not the jurisdiction of this
45 Inquiry, to make it fundamentally clearer who, which parts
46 of the system and which individuals, whether they be
47 ministers, secretaries, chief executives, have the

1 fundamental responsibility for improving the health
2 outcomes of the populations that they serve.
3
4 New South Wales legislation is over 30 years old and
5 it's very perfunctory and transactional in its nature, in
6 my view, and non-aspirational, to be frank.
7
8 In modern legislation written in a different way that
9 started with a very single question, "Who is accountable
10 for improving the health outcomes for the population, for
11 the people of New South Wales that we serve" - that would
12 go a long way. So that would be the first thing that
13 I would do.
14
15 The second thing - and this is not a perfect system,
16 there are no perfect systems - I would then do what
17 Maryanne suggested in her evidence yesterday, which is to
18 have a far clearer understanding between governments,
19 organisations like ours, others involved in the delivery of
20 health services and the community at large about what we
21 would expect in terms of the kind of services that might be
22 available, for example, in a community of 18 houses like
23 Weilmoringle in the north of our district, hundreds of
24 kilometres from anywhere else - in their language, not
25 remote; in mine, well and truly into the outback of
26 New South Wales - versus a community like Orange, a large
27 community in rural New South Wales, or Dubbo, capable of
28 supporting a much larger population, much larger services,
29 able to provide far more advanced services than might be on
30 the ground.
31
32 That definition should include all kinds of services,
33 whether they be access to community mental health, drug and
34 alcohol services, primary care, secondary or hospital care,
35 aged care, to have some rough prescription of roughly,
36 given the constraints of our ability as taxpayers to afford
37 to fund a system, but what should we expect for
38 a community? So in other words, what's the - I hate to use
39 this term but what's the civil contract, the psychological
40 contract between taxpayers and the government about what
41 might be received in a particular community or residents of
42 a community.
43
44 I don't mean that in an overly prescribed way, because
45 of course, what works and how the health system should work
46 should be heavily interconnected and place based, to
47 a degree, but every place has to be connected to another

1 place. So, in other words, it's just as important for me
2 to understand how a community member in Weilmoringle might
3 have access to cardiac surgery in RPA in Sydney, and that
4 network and how that works and how that flows is just as
5 important, as to understand how they might have access to
6 a community drug and alcohol worker. So you can't plan any
7 part of the system in isolation but neither can you be
8 overprescriptive because that would be an impossible task.
9
10 Health is what we would describe as a complex adaptive
11 system, like the human body, and you can intervene in all
12 sorts of ways in the health system, and I think as Matthew
13 Daley gave evidence earlier, health does not respond well
14 to revolution. There are plenty of examples. My own
15 country, dare I say without being too political, has tried
16 to revolutionise its health system in very recent years and
17 is paying the price and will for a number of years to come
18 for trying to be too ambitious.
19
20 But it responds well to evolution, and it responds,
21 and should respond, well to a much better and clearer set
22 of constructs around at a high level how the systems should
23 connect together, what a community should expect. Believe
24 me, I've been doing this work for a long period of time and
25 there is no community that would vote to have something
26 that they perceive to be inferior as the community down the
27 road. They will all want services that may not be safe to
28 provide in their community. They won't understand, they
29 will have very low health system literacy, let alone health
30 literacy - and those are two very different things, it's an
31 incredibly complex health system. But to have some basic
32 and high level of understanding of "These things will be
33 provided in this part of the district, these things will be
34 provided in that part of the district", not our only
35 services but other services, would go a very long way.
36
37 Having got that kind of political or public
38 understanding, you would then go on to look at how are we
39 going to fund, and you would also look at what's there
40 already to identify the gaps. I won't labour that.
41 I think Maryanne's evidence yesterday covered that well.
42 I'm used to a health system that is capitated - that is,
43 that a local health district, in New Zealand's case, the
44 district health boards had a very similar function when
45 I worked there - they received capitation funding. So that
46 is every head of population had a certain amount of funding
47 that came with them, and New Zealand runs a formula, it is

1 a very complex formula, that not only accounts for head
2 count but it counts for a range of things such as social
3 deprivation and differences in health outcomes in
4 communities, differences in disease burden, differences in
5 the disproportionate burden of inability to access and
6 participate in society in the same way as some groups
7 experience relative to others, and particularly in
8 Australia, that is absolutely clear for First Nations
9 people.
10
11 But having derived, for example, what is the fair
12 share of the pie that a population of a particular size -
13 and you can't do it at the level of a small town, you have
14 to do it at the level of a large population, because
15 otherwise you can't manage the risks - then you can then
16 say, "Okay, what is the most efficient way to allocate that
17 pie to get the best health outcomes for the people across
18 that part of New South Wales?" You would, alongside that,
19 undertake a very detailed analysis of what services are
20 available. That would inform you about what are the gaps,
21 what are the bits where we're providing services that in
22 fact have very high cost and very low utilisation? How
23 might we evolve some of those services so that that money
24 was better spent to get a better outcome from the community
25 and, believe me, that is not an easy journey to take, but
26 it's an absolutely essential one given that so much of our
27 health services and how they are delivered - by their very
28 nature, these are dinosaurs, these are very large oil
29 tankers, very hard to turn when they have got up a head of
30 steam.
31
32 What is it that, in the future, we might evolve and
33 gravitate towards, given that we know our population is
34 changing. We know that their needs in 20 years' time will
35 be different than they are today. I look at my own
36 district. The infrastructure across my district is vastly
37 differently proportioned than where it is provided and what
38 is provided because it reflects health services of 50 years
39 ago, not the health services of today or, indeed, the
40 requirements of communities in 20, 30 years' time.
41
42 So, to me, a well planned and organised health system
43 is always forward-looking. So it has a mind on the present
44 about what is going well, how do we adjust the present, but
45 it has a strategic orientation about how do we evolve the
46 systems and the needs of our communities, the needs of
47 patients and their families so that they are well served

1 into the future.
2
3 None of that is an easy conversation. It is made
4 fundamentally more difficult in Australia because of the
5 federal and state divide and how our health services are
6 funded, and I would go so far as to say - and I will own
7 this statement and I will probably be damned forever by
8 it - the reality is that MBS funded systems preference the
9 wealthy, and I passionately believe in democracy. One of
10 the greatest threats to democracy is the growing divide
11 between those who have an ability to access services of
12 government to accumulate wealth in Australian society
13 versus those who are being marginalised by that process.
14
15 That sounds controversial, but in fact, many of our
16 systems drive them that way. I think you will see - and
17 we've provided evidence, we've talked a little bit about it
18 on the screen, to correcting evidence - where in fact that
19 is exactly the outcome that is being driven, so in the
20 context of regional and rural New South Wales, in our
21 statement of evidence, in mine, I have proposed a different
22 way of doing things, not to say that we have the solution
23 but to say that in rural and regional New South Wales, and
24 especially in remote rural and regional New South Wales, in
25 districts like mine, there is a palpable need to do things
26 differently in order to get better outcomes for our
27 community, which is not to be dismissive of the
28 extraordinary outcomes that are already being achieved, not
29 to throw the baby out with the bath water but to recognise
30 that going forward we need to do things differently.
31
32 My personal view is that we need to find mechanisms
33 that bring together in a pooled kind of mechanism the
34 funding between Commonwealth and state that enables for
35 local service planning, local determination of the most
36 efficient way to distribute funding, to achieve the
37 outcomes from that funding in the best interests of the
38 local population.
39
40 The New Zealand system that I referred to, of course -
41 because many services, health services to people in our
42 district are not provided by our district, we are hugely
43 grateful for a range of highly specialised services
44 provided by our colleague LHDs in the metropolitan basin.
45 We couldn't survive, our patients would not get the level
46 of care they get without those services.
47

1 In the New Zealand system, as a chief executive of a
2 district health board or a local health district, I would
3 receive the funding for my population, but I would be
4 responsible for paying for those services that my
5 population received irrespective of where they received
6 them from a public hospital anywhere in New Zealand, and
7 there was a wash-up process around that.
8
9 Equally in a capitated model - so there are those in
10 New South Wales who would say, "Didn't we have some form of
11 population funding a decade or so ago, and didn't that lead
12 to inefficient services" - and I wasn't here then, so
13 I can't comment, but no doubt all systems have a tendency
14 of entropy and need a bit of a wake-up call from time to
15 time - but my experience is that you can have systems that
16 combine very effectively both population and capitation
17 funding, both primary and secondary care, other services,
18 tertiary care, as well as activity-based funding, which is
19 a very, very good mechanism, particularly in larger
20 entities and organisations such as larger hospitals, to
21 drive efficiency in the system, and there is lots of very
22 good evidence of Australian society benefiting very, very
23 well from the introduction of ABF funding.
24
25 But on its own, it's not a panacea. It's not
26 a solution. It's just one tool in a wide range of tool
27 kits, and the thing that brings them together in a sensible
28 way with other things, such as block funding or various
29 other ways to fund services is, firstly, the idea that
30 there is a transparent population based capitated
31 distribution of the public purse, which deals with the
32 issue of transparency and fairness from the point of view
33 of the citizen, and then there is intensive, joined-up,
34 good local planning, which is not only about what services
35 should we have in the town of Bourke, but it's actually
36 about the entire system.
37
38 So how should the people of Bourke best receive their
39 services balancing quality, workforce issues, how the
40 entire health system works? And I have to say, with the
41 exception of the absence of the transparency about funding
42 on a population basis, about the issues - and I have said
43 in my submission and stand by this statement, that I think
44 we've got a long way to learn how to deal with the issues
45 of equity and how we fund services.
46
47 With those exceptions primarily, the New South Wales

1 health system is an - achieves extraordinary things. I can
2 say with almost 40 years of work in health, two different
3 countries, many different settings, it is by far the most
4 collegial system that I've worked in.
5
6 The passion of people to try to make it work well,
7 whether they be clinicians at the coalface, whether they be
8 the secretary, whether they be senior people in the
9 ministry, people in my LHD, is extraordinary, and
10 I absolutely - while I call for reform, in no sense am
11 I being dismissive of what is there. But there are
12 tensions in the system and there are ways that are very,
13 very clear in rural and regional New South Wales that we
14 can and absolutely need to do things differently, because
15 if we don't, the gap in health outcomes for rural and
16 regional people and people in remote communities will only
17 get larger.
18
19 Health services will only get more fragile - and we've
20 heard a lot of evidence from GPs about just how fragile
21 that part of the health system is, which is nothing to do
22 with NSW Health in one sense, and everything in another,
23 particularly in small towns. So I'm sorry, a very
24 longwinded answer, but you asked an open question, so
25 I gave you an honest perspective.
26
27 Q. Tempting as it is to sit down after that, I will ask
28 another one. We might develop a couple of the consents
29 that you have touched on in a little bit of detail.
30 Perhaps if we start with funding and the funding model that
31 you think would be better suited to the delivery of health
32 care within rural and regional areas and perhaps more
33 widely. The first point, though, is you tell us in
34 paragraph 76 of your statement that your LHD is in a
35 position of some deficit at the moment relative to the
36 budget that has been allocated to it by NSW Health, and in
37 paragraph 77 you identify some of the reasons for that,
38 principal amongst them seemingly being the reliance, or
39 heavy reliance, on premium labour in the form of locums and
40 agency nursing staff.
41 A. (Witness nods).
42
43 Q. Would it be fair to say that, at least as you view it,
44 the particular slice of the budgetary pie that is allocated
45 to your LHD relative to others is more a creature of
46 history than reflective of any clear assessment of the
47 precise needs in terms of system delivery, and the means by

1 which and the cost that might be incurred in delivering on
2 those needs?
3 A. I think all chief executives would probably say that.
4 I think that's certainly true in our district.
5
6 Q. At some point in the past, someone has presumably made
7 some assessment of what is needed by the LHD, either
8 because that's what has been spent in some given year in
9 the past, or - you have to answer out loud.
10 A. So my sense - and others more technically involved
11 might correct this at some point - is when ABF funding was
12 largely introduced into New South Wales, that essentially,
13 we built - we've built from that point, about whatever was
14 being spent, wherever it was being spent prior to that
15 introduction, and there's been gradual evolution since
16 then, but fundamentally within the New South Wales health
17 system, it does not seem to me that the issue of equity
18 of - in a population sense, and I don't mean equality,
19 I mean equity - that as a consideration of the social
20 determinants, the factors that drive differences in health
21 outcomes, the differences in disease burden and a weighted
22 model to allocate funding according to population - that's
23 not a feature of the New South Wales health system in
24 general. It is at the margins, in terms of some new
25 programs.
26
27 There is very clear evidence of that. And it is very
28 clear that this is an area of evolution within the ministry
29 itself, senior people of NSW Health. There is a lot of
30 debate going on.
31
32 The difficulty, of course - and this has to be
33 acknowledged and I think again, as Matthew Daley gave in
34 his evidence - there is a sense in which funding the base,
35 by which we mean the services that already exist - you
36 don't want to destroy what is working well while you move
37 to something else. However, if the base has always been
38 preferentially advantaging some parts of the state versus
39 others, that's a really difficult problem to resolve over
40 time.
41
42 In my evidence, I mentioned somewhere, it is analogous
43 to when ABF funding was introduced which showed that
44 different parts of the state, different hospitals had
45 vastly different levels of efficiency in how they were
46 using their funding. So there was a long period of
47 transitional grants, if you like, technically the incorrect

1 word, but transitional funding which identified the
2 inefficiency differences between health services at that
3 time and gave them a pathway, over a decade or more, in
4 order to get closer to where average efficiency for those
5 kinds of services might be.
6
7 I suspect - in fact, I strongly encourage the New
8 South Wales health system, and my own LHD for that matter,
9 because this is equally an issue internally as for the
10 system as a whole - it can reflect deeply on the issues of
11 equity in terms of health outcomes, the distribution of
12 resources, and then to firstly design really good models to
13 determine that. Secondly, to plot a pathway towards a much
14 more equitable health system in terms of health outcomes
15 and the needs of the population which will not occur
16 overnight, has to be a process over a number of years in
17 order to ensure that what is working well already does not
18 get fragmented and is unable to deliver high-quality
19 services to the populations it serves.
20
21 Q. Without wanting to cast any doubt at all on your
22 ability and the ability of those who work with you to
23 generate efficiencies where they can be found, or deal with
24 the premium labour situation to the extent that that is
25 possible, do we take it from the answer that you have just
26 given that it's your view that it's not really possible to
27 deliver health care to the residents of your LHD which is,
28 to use your term, "optimal and equitable", within the
29 current budgetary envelope that has been allocated to your
30 LHD?
31 A. Perhaps if I can comment on two aspects of that.
32 Firstly, the budget that is not allocated to the LHD. So
33 many of the things that my LHD is doing is grappling with
34 a failure of other parts of the health system. It's no
35 longer - people don't like to use the word "failure", they
36 like to use the words "thin markets". The reality is in
37 some places there are no markets at all.
38
39 So we're addressing those issues, so services that you
40 would not expect to be the responsibility of NSW Health or
41 the state government as well as --
42
43 Q. This, I gather, is a reference to primary care and
44 potentially specialist outpatient clinics?
45 A. So those are two of a number of examples. We could
46 expand to talk about aged care. There are a number of
47 services where that dynamic is true.

1
2 Within the funding received from NSW Health, well,
3 I can only reflect in this way: our LHD, until this
4 current year - and we can talk specifically about why
5 because I think it's insightful - we were one of a very
6 small number of local health districts in New South Wales
7 that met its budget, had consistently done so for half
8 a decade or more. Prior to that, it had had some real
9 financial problems.
10
11 Another example, which I think is still true today,
12 would be the Far West LHD.
13
14 The health outcomes of the population served by both
15 our health district and the Far West LHD and a number of
16 other rural and regional LHDs are some of the worst in the
17 state. So we've been financially good performers but poor
18 performers in terms of health outcomes, and I think that
19 the distinction of those two things answers your question.
20
21 Q. I will explore with you how it was that the LHD came
22 to deliver services within its budget in a moment, but
23 before coming to that, do we take it from the answer that
24 you have just given and the health outcomes that you allude
25 to within the LHD, that whilst it may have ticked the box
26 in terms of the budgetary KPI, it was, nevertheless,
27 failing to deliver an optimal and equitable health service
28 to the population that it served?
29 A. So the evidence of our district is that over that
30 period of time health outcomes did improve. So it was not
31 all disastrous. There are many areas, and there are many
32 indicators and we have some of those in the evidence, where
33 it did improve over that time. There are also indicators
34 where it got worse and in certain communities and for
35 certain parts of our society out here in the central west,
36 there's clear evidence that that was the case.
37
38 Q. So perhaps if it gets - in terms of that issue or the
39 question about whether or not the health services being
40 delivered were optimal and equitable, is it the case that
41 the answer is different depending on which particular
42 pocket or which particular sub-community within your LHD
43 you might be looking at?
44 A. Absolutely, and the answer will be different not only
45 on the basis of what services we provide and NSW Health
46 funds within its jurisdictional mandate, but what services
47 the Commonwealth provides and other providers provide or

1 the Commonwealth funds.
2
3 Q. Probably by using the terms "optimal and equitable",
4 I might have unintentionally confused matters. Maybe the
5 question would have been better put: for some communities
6 or some groups within your LHD, the health service being
7 delivered within budget over that period of time was no
8 doubt optimal, or at least sufficiently good for their
9 health to have been improving throughout that period?
10 I note you are nodding. You need to give your answer out
11 loud --
12 A. Yes.
13
14 Q. -- for the benefit of the transcript.
15 A. Yes.
16
17 Q. But for others, where health outcomes were declining
18 across that period, clearly the health service that was
19 being delivered was far from optimal?
20 A. If the measure is to improve health outcomes, and, as
21 I said before, the current legislative framework in
22 Australia, both at federal and state level, is completely
23 unclear as to who has both a responsibility, let alone the
24 primacy of responsibility, for improving health outcomes
25 for Australian residents.
26
27 Q. But a system that produces optimal outcomes for some
28 but less optimal outcomes for others, depending on social
29 factors and where you happen to live, is, by definition, an
30 inequitable system, isn't it?
31 A. Sorry, is --
32
33 Q. Is, by definition, inequitable?
34 A. Yes. Yes, it is.
35
36 Q. Can I just ask, something you touched on a moment ago
37 and you deal with in paragraphs 28 to 32 of your statement,
38 suggests that your view - and I don't for one moment
39 suggest you are alone in this view - is that when one looks
40 at the need to produce health outcomes - let's park for the
41 moment who is responsible for it and accept that someone
42 within the system should take primary responsibility for
43 delivering health outcomes for the people of its
44 population - the dividing up of that responsibility across
45 different portfolios within government potentially
46 compromises the ability to deliver on that objective, does
47 it not?

1 A. Potentially it does, but it's not a necessary outcome
2 of that division. So there are some enormous advantages in
3 dividing portfolios across government. One might not
4 expect ministers of government to be divine in their
5 abilities, to be the master of everything, to know
6 everything, to be all powerful and omniscient over
7 everything is not what we expect either of bureaucrats like
8 me or ministers. So we have to be pragmatic on how the
9 system is designed in various portfolios within government
10 to give focus to the services is an incredibly important
11 architecture of government.
12
13 Having said that, there also need to be very strong
14 incentives and mechanisms that those various portfolios
15 come together around issues of common interest and,
16 generally, that will be most effective when they come
17 together at the location. So it's one thing to come
18 together in a senior officials' group in Sydney, and those
19 things certainly occur and they are very productive. It's
20 quite another to come - for all of those agencies to come
21 together at the level of a community or a sub-region or
22 district, a part of a district.
23
24 There are good examples of when that does occur and
25 there are some fantastic examples in our district of some
26 really great outcomes that have occurred. I would suggest
27 that they are the exception rather than the norm, and part
28 of the evolution, both for health and for all other social
29 and other government agencies, is learning how to
30 collaborate and to work together within our jurisdictions
31 in ways that make a meaningful difference for our
32 communities.
33
34 Q. As you point out, issues like housing, education,
35 community justice and a range of others that you list in
36 those paragraphs, if they are all working together in a way
37 that is harmonious and producing the best outcomes that
38 each of those little siloed areas is capable of producing,
39 then the overall health outcomes are going to be vastly
40 better enhanced than would be the case if you had
41 a perfectly funded and operated health system, but the rest
42 were all still out there doing their own thing in a less
43 coordinated way?
44 A. I think that's absolutely true. I think Maryanne
45 Hawthorn gave evidence yesterday, statistically - and it is
46 internationally observed in a number of studies - just how
47 important addressing a range of factors that affect risks,

1 risk factors for people in the community, social
2 determinants of health, is. In many respects, it will
3 sometimes be more important in some communities than the
4 interventions of the health system itself.
5
6 Q. You point out that where it has worked in your LHD and
7 there has been a good collaboration between various
8 branches of government, it has produced good outcomes. Can
9 I ask, is that essentially because, at least in a practical
10 sense, the parties with each of their various portfolios
11 and the levers that they can pull, have sat down in a
12 practical sense and pooled their resources to look at how
13 those resources, having regard to the levers that each can
14 pull, can be best spent to deliver the optimal outcome for
15 a community?
16 A. Very frequently, it's not actually a question of
17 pooling resources. More frequently, it is a question of
18 building relationships, facilitating collaboration between
19 the agencies. Let's not forget we're talking about staff
20 who are overwhelmed with the day-to-day demands of their
21 jobs. I will give an example that in our district a number
22 of years ago worked extremely well. It worked well because
23 there was a concentrated effort on building relationships
24 and facilitation.
25
26 Q. The example that you gave, is that the example of the
27 patients who were repeat visitors to emergency departments
28 who then received the benefit of the wrap-around care?
29 A. It wasn't one that I was thinking of, but that is
30 another example. The one that I was thinking of was the
31 Coonamble Together Project. When the Commission visited
32 Coonamble I think you received some evidence about that.
33 That was a great project where a number of agencies, our
34 own, Family and Community, DCJ, FACS, various others, came
35 together - police, education. I think in those days it was
36 FACS funded a person, a facilitator on the ground, who had
37 some discretionary funds. The simple act of funding
38 a facilitator for that community, who was a very, very
39 effective facilitator, to bring together all the agencies
40 on a regular basis out of that, became a project called the
41 Coonamble Together Project.
42
43 What was actually happening is that on a weekly basis,
44 it may have been fortnightly, the local police sergeant,
45 the local principals of the local schools, the local health
46 service manager, local representatives of FACS and so on,
47 were getting - and the local government, various other

1 agencies in that town, the Aboriginal affairs and so on -
2 were coming together around the table, talking about common
3 issues and, in some cases, even to facilitate and spin off
4 joint case management of the issues that some families or
5 individuals were facing.
6
7 When one of those people didn't turn up - for example,
8 the local police sergeant may have missed a meeting - well,
9 the facilitator was empowered, and believe me the police
10 sergeant turned up to the next meeting - or our health
11 service manager got busy doing something else, and all
12 agencies had empowered the facilitator to take a more than
13 just fatherhood and apple pie approach, but actually had
14 some ability to be quite assertive about the outcomes that
15 they were receiving.
16
17 The outcome of that was a family might have had an
18 issue that, for example, related to housing. That issue
19 might have been expressed by them approaching the local
20 emergency department with some kind of health related
21 condition. So that was the door of the government system
22 that they pushed open. But we had an interagency working,
23 practical working on the ground, that meant that we would
24 then make sure that we took responsibility for connecting
25 that individual with Housing New South Wales or what other
26 part of the system. It wasn't a paper-based referral that
27 sat in someone's intray for a couple of months until they
28 had the time to get around to it; it was actually picking
29 up the phone, helping, navigating the individual through
30 the parts of the system. They may have been in trouble
31 with the police. But, actually, their issue might have
32 actually been something related to health.
33
34 There are great examples of that across our district
35 in aged care, where often an older citizen who is facing
36 cognitive decline starts to express that in extremely
37 antisocial behaviours in the community. It comes to the
38 attention of the police or to neighbours who want the
39 police to do a welfare check, and in Dubbo is a good
40 example, there is an aged care crime prevention officer -
41 I think we all hate the title but that's their function -
42 who will then interact with our aged care services in the
43 community and make sure that there is a combined approach
44 between police and health about how we actually get proper
45 and appropriate services to the individual, rather than
46 just put them through the court system and incarcerate them
47 for behaviours which might have an organic cause, which

1 health can address. And so on. So there are many examples
2 of this at multiple levels in the system.
3
4 But there are very few examples of where, at the level
5 of a local community, it is well resourced, it is well
6 facilitated, and it keeps going.
7
8 Q. I think you have indicated that those instances of
9 great collaboration that have produced and are producing
10 good results, at least in terms of health outcomes from the
11 perspective that you view it, are the exception rather than
12 the norm?
13 A. At a community level they are an exception. There are
14 other examples in our district led by different agencies or
15 organisations, but they are not the norm. It's an area
16 where we're learning and growing.
17
18 Another example you referred to, the Planned Care for
19 Better Health program and our emergency department
20 diversion, we recognise, so that program looks at people
21 who have turned up to an emergency department 10 or more
22 times. There are some algorithms that assess their risk
23 for hospitalisation. We have a whole team that does an
24 intensive amount of work with them, not based in the
25 hospital, based in the community. We've discovered that
26 many of those individuals have no connection with primary
27 care at all. Many of them will be suffering significant
28 social disadvantage - homelessness, couch surfing.
29 Homelessness in the sense of people sleeping on a park
30 bench or in a tent in the main street is relatively not
31 that obvious in Australia, certainly compared to other
32 countries, but homelessness in terms of couch surfing,
33 20 people to a household that is really designed for four,
34 is absolutely endemic in some of our communities. We
35 discovered that through COVID.
36
37 That service wraps people around, it will connect them
38 if there issue is housing. If there is issue is - they may
39 often have an encounter with the criminal justice system.
40 If their issue is navigating access to primary care and how
41 we get long-term connections with primary care, if their
42 issue is fronting at the ED but really their needs would be
43 better served by a community mental health team engagement
44 or a community alcohol and drug service, they help those
45 individuals navigate to the other part of either our system
46 or other part of government system. It is very intensive,
47 very, very expensive to deliver. It's hard work, because

1 the reality is that the system, by its nature, and
2 unavoidably, is immensely complex from the perspective of a
3 consumer. I find it complex and I know more than most
4 other members of our community about how to work the
5 system, just simply by the privilege of the work experience
6 I've had over many, many years. So the need for us to join
7 together and navigate, facilitate services across
8 government is profound.
9
10 Q. You have given an example of Coonamble Together which,
11 in the context of a small town like Coonamble can be
12 achieved through a community facilitator role. In a large
13 community like Dubbo, for example, do you have a view about
14 ways in which that greater connectivity between different
15 agencies might work?
16 A. So the principle is the same. In a community like
17 Dubbo, there are large parts of the community for whom they
18 don't need that assistance, so it is very targeted. We
19 target it around individual circumstances, individual parts
20 or family or individuals in our community. But the
21 principles are the same, of facilitation between the
22 agencies, which is a very different level of facilitation
23 than, for example - and through regional New South Wales
24 there is really good facilitation between senior leaders,
25 myself, the police inspector, and so on, other parts of
26 government which we come together in a formal regional
27 leadership forum from time to time, facilitated by regional
28 New South Wales.
29
30 That's effective at the level of policy, it is
31 effective at the level of more generic projects, for
32 example, how are we going to respond to the energy zones
33 being developed in parts of our region together and the
34 impact that might have on services. But there is a very
35 different level of collaboration that occurs much closer to
36 the coalface, and what it requires is recognition - there
37 is no NWAU for bringing together agencies and communities
38 to get our collective services to work together. There is
39 no block funding to do that. And while it is an issue in
40 all communities, I would suggest it is a far more
41 pronounced issue in regional, rural and remote communities
42 than in most parts of metropolitan New South Wales.
43
44 Q. Your reference to the fact that there is no NWAU or
45 block funding for providing that connectivity carries with
46 it an implication that it is the health ministry's
47 responsibility to be the facilitator. They may be the

1 best, but do you have a view about that, whether health is
2 well placed to be the facilitator of that whole of
3 government coordination, or is it your view that maybe
4 there is another body that's better placed to do that?
5 A. Unsurprisingly, my answer would be that I personally
6 believe that health is well placed, if it was funded by
7 government to do that, simply because, by the nature of the
8 services that we provide, we often interact with exactly
9 the most vulnerable members of our community who we're
10 talking about targeting.
11
12 Having said that - and, for example, you could
13 theoretically say that some other part of government should
14 plan the distribution of health services across our
15 district, which I would be strongly opposed to. Having
16 worked in the system, it's taken me 40 years to really
17 understand it. I think the Commission's ability to
18 understand the nuance of how things come together in the
19 system has been remarkable in a short period of time, but
20 with absolutely no disrespect to the Commission, I can tell
21 you that there are gaps in understanding and knowledge
22 because you haven't worked in the system, and that's -
23 there is nothing pejorative in what I'm saying, I'm just
24 simply saying it takes a long period of time. But what I'm
25 not saying is that health should do it alone.
26
27 Q. So whilst your view might be that the person who is
28 funded to actually manage that facilitation may be well
29 positioned within health, funding needs to be provided to
30 each of the various branches of government who are required
31 to collaborate to enable that collaboration to occur, in
32 the sense of making sure that there are sufficient people
33 delivering the workload that's already weighing heavily
34 upon them, for each who needs to, to set aside some time to
35 have that meeting once a fortnight with their colleagues
36 and make sure everything's ticking along in a coordinated
37 way?
38 A. I think it would be arrogant for me to make an
39 assumption on behalf of other parts of government. What
40 I can do is talk knowledgeably about the needs of our local
41 health district. I would suggest that dedicated funding to
42 support that process, to do it extremely well in our more
43 vulnerable communities, would be an appropriate part of the
44 health funding infrastructure, but I emphasise, from
45 a whole of government outcome perspective, not merely from
46 a health perspective. That's what we're trying to
47 facilitate across these communities.

1
2 Q. I will come back to KPIs shortly, but the current KPIs
3 don't contemplate any assessment being made of, say, the
4 extent to which facilitation of the type you have spoken of
5 is being attempted or achieved, do they? When I say KPIs,
6 I'm referring to those contained in your service level
7 agreement.
8 A. KPIs by themselves are very often a measure of
9 process. There are lots of process KPIs. There are some
10 in the service agreement which are measures of prevention
11 of disease - for example, reduction of smoking rates in
12 pregnant women. There aren't KPIs that are really about
13 how we take our leadership role with our communities to
14 improve health outcomes, and some would argue that they
15 shouldn't be there, because as I said right at the start,
16 the legislation is entirely unclear as to whether that's
17 the responsibility of NSW Health or not.
18
19 Q. Is there not ultimately a risk that process-driven
20 KPIs might lead to a focus on process which distracts
21 attention from the ultimate objective of delivering good
22 health outcomes for a community, or improved health
23 outcomes for a community?
24 A. All health systems have multiple objectives and
25 sometimes they have conflicting objectives. Process KPIs
26 are really important in order to meet community
27 expectations of certain kinds. For example, surgical
28 waiting lists - something that community members having
29 access to surgery require, it is incredibly important to
30 them, so that's a really important process KPI. Community
31 members' access to timely care in emergency department -
32 really important KPIs that are very meaningful to the
33 community. So those things are really important.
34
35 What's missing, however, are the KPIs that drive
36 towards an ultimate outcome of improving health outcomes
37 for communities. I would argue that they are rightly not
38 in service agreements at this point in time. They can only
39 be achieved if, in fact, the fundamentals of how you
40 structure the health system is to have a population based
41 mechanism for funding, at which point it might well be
42 entirely reasonable to compare my activity as chief
43 executive in my local health district with the activity or
44 outcomes achieved by another chief executive in a local
45 health district, because if our funding is equitable at a
46 population basis weighted for the determinants of health,
47 the inequalities of health outcomes, you are actually

1 starting from a level playing field in terms of if you are
2 going to measure health outcomes as core KPIs.
3
4 Q. In terms of health outcomes as core KPIs, can I ask
5 this practical question: is it your view that there are
6 KPIs which would measure health outcomes which are actually
7 capable of being objectively set?
8 A. Yes. Absolutely. Yes.
9
10 Q. Just in your view, what are the sorts of KPIs that
11 might - were we dealing with a capitated system in the way
12 that you have discussed, that might be set to actually
13 assess the extent to which the funding, appropriately
14 weighted funding that you might receive to deliver health
15 outcomes for your community, is actually doing what it's
16 intended to do?
17 A. Mortality, morbidity rates, disease burden, there are
18 a whole range of them. You know, far more erudite people
19 than me can answer this question. There are textbooks by
20 the millions that have been written on this and there are
21 some countries that have experimented with this not only
22 for health but in other parts of government through social
23 investment models. But there are - the essence, without
24 getting into the detail and wasting time, it is entirely
25 possible to envisage not only direct KPIs but also proxy
26 KPIs.
27
28 At the moment one that we use within our own district,
29 it is not part of our service agreement but it is part of
30 our sense of community responsibility and passion to do
31 things better that our LHD has would be around rates of
32 morbidity, mortality, and with that also, increasingly
33 looking at some - albeit process measures - access to
34 services that we know make a difference across our various
35 LGAs.
36
37 Q. Just coming back very briefly to the wrap-around whole
38 of government approach, to the extent that costs incurred
39 in health - for example, the provision of adequate primary
40 care in a community that does not otherwise have it -
41 reflect an experience within the health budget, are you
42 aware of any assessment being made of the economic benefits
43 that would be derived on a statewide level by paying
44 whatever it costs, might cost, to deliver that primary care
45 adequately within the community?
46 A. So there have been some attempts, very focused
47 attempts, more at a disease-specific focus attempt,

1 collaborative commissioning is one of those, but they are
2 very small-scale, and more to do with the specifics of
3 a particular disease than the generality of all of the, by
4 nature, general health services primary care provides.
5
6 In our district we have not done an economic modelling
7 of the benefit of that in terms of outcomes for the
8 community, yet. What we are early in the process - and
9 Maryanne gave some evidence of the health needs analysis
10 that we were doing and so and providing to the PHN - some
11 of the work that we are now doing is looking at the rates
12 of access to primary care and specialist medical care
13 through MBS billing rates on a population basis across all
14 of our LGAs.
15
16 Unsurprisingly, there is a correlation with the health
17 outcomes in some of those LGAs. It's very much at the
18 infancy in our district and requires a lot more
19 sophistication, but we've recognised that's exactly where,
20 in order to plan and deliver the services that our
21 community needs, we need to go. Traditionally, planning in
22 our system, quite rightly, has been focused on the services
23 that we provide. It is often very focused on the need to
24 rebuild an infrastructure over time - for example,
25 a hospital - to meet the needs of its community. But where
26 we are working, and we've invested heavily in our strategic
27 reform, planning and partnerships team to take us on this
28 journey, is to look at differential rates of access and
29 then, beyond that, to try and draw a connection with the
30 health outcomes for a community.
31
32 If I may, in my statement - as you can tell, I can
33 talk, so please make sure the time is used in the way that
34 you would like - but if I can draw your attention to
35 paragraph 17, and above paragraph 17 in my statement
36 a graph which shows general practice attendances between
37 2013 and 2023 across all of the local LGAs in our district.
38 What that shows is that in every single one of the local
39 government areas in Western NSW LHD, we have a lower rate
40 of general practice attendances, particularly for children
41 aged zero to 15 years, than is the average for New South
42 Wales.
43
44 So the next step is to take that information and at an
45 LGA level start a deep dive: so what are the health
46 outcomes that we're seeing for young children? There has
47 been a lot of work looking at health outcomes for young

1 children in our district, which is extremely important. We
2 invest heavily - the New South Wales Government invests
3 heavily in First 2000 Days services, because we all
4 recognise that what happens in the first five years of
5 a child's life will have a fundamental difference on how
6 healthy, well they are in their 30s, 40s, 50s, 60s, 70s.
7 It will have a fundamental difference in how productively
8 they can participate in society, gain good jobs, good
9 income, participate constructively in communities. We
10 participate heavily in looking at that.
11
12 Q. You may not be able to answer this, but we did receive
13 some evidence in an earlier block of hearings to the effect
14 that The First 2000 Days was identified as a premier's
15 priority, as a result of which all branches of government
16 were able to attract additional funding at budget time, if
17 they could identify The First 2000 Days outcomes as being
18 something that would be achieved through the delivery of
19 that funding. Is it your view that the First 2000 Days
20 work that is being done by your LHD would have been done
21 had it not been for the availability of that funding source
22 through the budgetary process, or would have been done to
23 the extent that it is?
24 A. It would have been impossible to do to the extent that
25 it is in any local health district or other part of
26 government. What you are essentially asking is that - does
27 government have a leadership role, whatever form or shape
28 or colour of government, in terms of the services and the
29 way that government supports its population. Well, by
30 definition, that's the definition of democracy.
31
32 Q. Coming to a slightly more practical, nuts and bolts
33 point, though, in terms of producing good health outcomes,
34 do you have a view about what might be a good priority or
35 what might be a good objective to identify as a source
36 whole of government for funding through this budgetary
37 process that would actually result in better health
38 outcomes for people within your LHD and perhaps others?
39 A. So there are many, and if I've learned anything about
40 health, it's complex and multifactorial, and if anybody
41 says there is a simple answer or a single-system answer,
42 they are generally somebody you shouldn't pay too much
43 attention to.
44
45 However, First 2000 Days, which is a priority for the
46 government, was a priority for previous governments, is
47 still being funded, is clearly, in anybody's language,

1 a priority for investment. The health outcomes and
2 services for First Nations people, I would suggest, is and
3 should be a priority.
4
5 Then there are a range of other priorities. So one of
6 the particular issues in our district that, for our
7 district, absolutely has to be a priority but may not
8 necessarily need to be a priority for other parts of the
9 New South Wales health system in quite the same way, would
10 be services to older citizens, so services for those who
11 are aged 70 years or older or First Nations people, perhaps
12 50 years and older.
13
14 How all of that comes together - again, it is a split
15 responsibility between the Commonwealth and the state - we
16 provide the acute health services for those parts of our
17 community, we also provide a whole range of assessment
18 services on behalf of the Commonwealth, and increasingly we
19 subcontract community based providers to provide home based
20 support services for older people, but in our district, the
21 rapid ageing of our population, which is disproportionately
22 greater than the rest of New South Wales, that will be an
23 absolutely critical issue, so that people can age well in
24 our communities to the best of their abilities.
25
26 Any health economist would tell you, given a choice
27 between focusing on children and focusing on older people -
28 and, please, I say this with absolute respect for our older
29 citizens - but the return on investment across somebody's
30 lifetime if you focus on them when they are two years of
31 age will, by definition, be far greater than if you are
32 focusing on their needs in the last one or two years of
33 life.
34
35 Having said that, the care of the elderly in our
36 community would be an absolute priority for our LHD, and
37 absolutely is.
38
39 To give you an example of what that might mean and how
40 the system needs to come together in a far better way, any
41 day of the week - I will use Dubbo hospital because I'm in
42 Dubbo today, it's only one example of many. There is
43 a gentleman who has been in Dubbo hospital for over 110
44 days, with no acute health need to be in Dubbo hospital.
45 It is an unsafe place for that gentleman to be,
46 particularly going into winter. He will be exposed to
47 diseases and illnesses in that hospital merely by the fact

1 he is in there and unable to get out of the hospital, that
2 he would not be exposed to if he was living in the
3 community, because, by definition, people who aren't well
4 go to hospitals. That's our business.
5
6 We can't get him out of the hospital. He is perfectly
7 ready for discharge into residential aged care. In Dubbo,
8 there are many providers - and I will just use this example
9 but I know there is one provider, and as well as this
10 gentleman, on any given day of the week, there will be 12
11 or 13 or more people in Dubbo hospital who do not need to
12 be there for their clinical treatment but are there because
13 they are unable to access a place in residential aged care.
14
15 There is at least one provider - this is only one of
16 many of residential aged care in Dubbo - who today has nine
17 free bed places, but they are a private provider, they have
18 no obligation to accept a discharge from the hospital, they
19 are an independent business, and like all sensible
20 independent businesses, given the range of different kinds
21 of funding from the funding you'd receive for somebody with
22 very low care needs to the funding that you would receive
23 for somebody with very high care needs, there's actually
24 a middle band that if you are a residential aged care
25 provider, commercially, you are sensible only to take
26 people in that middle band.
27
28 If their care needs are too low, well, actually, they
29 should be in the community, and in fact you will consume
30 a lot of resource for them relative to the income that you
31 will get. If their care needs are too high, you will
32 consume and need to put a lot of staffing around them that
33 you won't necessarily want to do, and specialised staffing
34 that you may not have. So as a private residential aged
35 care provider, you will always aim to take people who are
36 going to return for you the optimal return or profit on the
37 fact of having them in your community.
38
39 The people who I'm talking about in Dubbo don't nicely
40 fit into that band, so where do they go? There is nowhere
41 for them to go.
42
43 Another example - I'm sorry, but these are the real
44 world things that we really need to focus on in aged care,
45 and there parts of the system where focusing on aged care
46 isn't important, but in rural and regional LHDs it
47 absolutely is. Because of the MPSs that we provide,

1 roughly half of the bed base across our entire districts,
2 our hospital footprint or MPS footprint is residential aged
3 care beds. So it's incredibly important for us.
4
5 Another example. Tuesday evening - I watched
6 a testimony during the day from the hearing. Around about
7 quarter to five I received an email from the general
8 manager of the Parkes Shire Council who had just been
9 informed by the provider of a residential aged care
10 facility in Parkes, a 48-bed facility, so not small, that
11 they were closing. Nothing to do with me. Nothing to do
12 with my LHD. However, I'm the person on the spot that they
13 know - I'm not an anonymous person in the Commonwealth
14 department of aged care that they don't know. So they
15 contact me, "What are we going to do about this? How are
16 we going to respond to this?" In a small town like Parkes,
17 a town of 10,000 people, taking out 48 residential aged
18 care beds on the verge of winter will be enormous, and
19 I can already tell you - and I used the example of the rest
20 home that I referred to in Dubbo that had the nine free
21 beds. So already, that provider, quite rightly, because
22 they have to re-place their residents who are currently in
23 Parkes, an hour and a half away, is in direct consultation
24 with that provider to fill those nine beds. At one level,
25 that's a great thing. But at another level, from the point
26 of view of the acute healthcare system, that removes yet
27 another opportunity for either Parkes hospital or Dubbo
28 hospital to discharge older residents that they are going
29 to need to, and who need to be into residential aged care,
30 on the eve of going into winter. And removing those levels
31 of capacity is going to be very difficult.
32
33 Now, the reason I've taken some time to paint that
34 picture is because the reality is there is no joined-up
35 planning between the Commonwealth and state about the
36 delivery of services for older people, whether it be in
37 primary care, whether it be in residential aged care,
38 whether it be in community based care, they don't come
39 together. They don't join. The two large systems of
40 government that fund work from entirely different bases.
41 We're about to see all of the community aged care services,
42 whether it's assessment or the delivery of things like
43 community home support across New South Wales, be put
44 through an entirely contestable process by the federal
45 government.
46
47 Well, you will see in a few days - and, believe me,

1 I'm a passionate believer in using contestability to drive
2 efficiency of services, but in "thin markets",
3 quote/unquote, or non-existent markets or fragile markets,
4 those kind of processes actually just drive market
5 dysfunction. They drive an inability to plan.
6
7 So I'm coming back to your question, you asked me what
8 parts of society would I focus on? Those are the three for
9 us in our district, and there are many others. One is
10 services to young children, First 2000 Days of life. One
11 is services to First Nations people. And the third one is
12 services to the older people who, many of whom, and
13 increasingly in our district an increasing proportion of
14 our population - I think those over 70 will increase by
15 41 per cent or something between now and the early 2030s in
16 our district - to have focus on services to older people
17 are absolutely critical.
18
19 Q. I think we heard that particular group described as
20 a populational speed bump yesterday. Do you, in terms of
21 future planning, have a sense of the extent to which the
22 need to provide for that particular burden of elderly
23 residents within your broader district is a transitional
24 issue in the sense that at the moment, there is a larger
25 and possibly increasing proportion of the population which
26 is elderly, but that that percentage, as time rolls on,
27 will decrease relative to the overall population?
28 A. So demographic projections suggest that going into the
29 2040s. But it's proportionally very, very different across
30 the footprint of our district. So we have towns - if I can
31 describe it this way, we have some towns, I won't name
32 them, they will get very upset if I do, some shires in our
33 district, where the population is expected to more than
34 half between now and the early 2040s, and mostly that's
35 reflecting the older population who are just now coming
36 into the 10, 15, 20 years where they will need intensive
37 service support and increasingly intensive service support
38 and, of course, they and their families want them to remain
39 in those communities, it's where they have lived, it is
40 where their networks of support are, and that will be
41 pretty intensive in those towns and increasingly so for the
42 next 15 to 20 years. And then, as their life takes its
43 natural course, the need and the demand will reduce.
44
45 But at the same time, and equally opposite to that -
46 I think our district is a perfect example of this - there
47 are other towns, Parkes would be a case, I've spoken about

1 them, certainly all of the larger regional towns, and the
2 further south you go in our district the more true this
3 is - the population is actually rapidly increasing, and
4 I think somebody yesterday spoke about Dubbo, which, you
5 know, just over 40,000 people now within the early 2030s is
6 expected to be somewhere about 65,000 people, and there are
7 residential developments that would support those kind of
8 numbers, they are not just plucked out of the air.
9
10 But what is happening is there is internal migration
11 in our district from far more remote towns, and some of
12 that is driven by the lack of access to services,
13 particularly NDIS services, in small towns that enable
14 people to stay in their own homes. I literally know of
15 anecdotes of community members who have had to uproot their
16 families and themselves and move to larger communities
17 within our district, even though they lived their for
18 decades, because they couldn't get home based services that
19 they needed to support, despite having very well funded
20 packages that they could have purchased services if they
21 were available.
22
23 Q. That's a consequence of workforce challenges or
24 workforce distribution; would that be right?
25 A. It is partly a consequence of workforce changes.
26 I would also suggest it is a heavy consequence of if you
27 have a thin and fragile market and you constantly
28 disaggregate it through repetitive rounds of contestable
29 "Let's go out and contract for this and give somebody
30 a 12-month contract for this" - providers struggle to build
31 capacity, and capacity over the long term. So it is not
32 only about lack of workforce, it is, I would suggest, also
33 a reflection of a fundamental miscalibration between some
34 public policy approaches in more regional and rural and
35 remote communities, compared to what would actually make
36 services sustainable in those communities.
37
38 In saying that, and the point that I really wanted to
39 make, because it will get us back to the core and the focus
40 of the Inquiry, which is of course health care financing in
41 New South Wales - we've talked a lot about Commonwealth
42 services over the week, we've talked a lot about primary
43 care, which is not the responsibility of the New South
44 Wales Government - within our district, our population
45 across the LHD is static, and in fact, the growth funding
46 for population that I received last year as the local
47 health district was negative, it was around about a million

1 dollars less. And that trend will continue for some time,
2 and at one level you can say that's appropriate. At
3 another level, because it is not equity adjusted, I would
4 argue strongly it is not appropriate, given the needs of
5 our community.
6
7 However, what that means is, I've got parts of our
8 community that have an increasing need for services because
9 of the increasing or increased health needs of the people
10 who live in those communities - let's say older people - so
11 that's going to be more expensive for me to deliver and
12 support over a long period of time. And then I have other
13 communities, and let's take Dubbo - I could equally take
14 Orange or Bathurst as an example - where in fact the needs
15 of the population to provide increasingly complex hospital
16 services, specialist services, larger emergency
17 departments, because the population is flowing into those
18 communities, is also extreme.
19
20 So, in other words, I'm describing, in some ways,
21 a sausage that is being squeezed at both ends.
22
23 THE COMMISSIONER: Q. Can I just ask you why you are
24 saying, or what you mean by, primary care is not the
25 responsibility of the New South Wales Government?
26 A. Just to divert slowly, and I will answer your
27 question, Commissioner, of course - I have used the term
28 "primary care" inclusive of a whole range of aspects of
29 primary care, and that definition, what I said, is
30 incorrect. There are clearly aspects of primary care that
31 are the responsibility both of the local health district
32 and the New South Wales Government.
33
34 Q. New South Wales Government, of course, doesn't do the
35 MBS.
36 A. That's right. So that's what I was getting to. So
37 general practice and the MBS. In fact, in the graph - and
38 there are a number of graphs in my evidential statement,
39 but the one that's on the screen, and I will just point
40 out, that's about GP attendances, what that graph is
41 showing you is MBS funded attendances. So it's telling you
42 two things. Not only is, for most of the LGAs in my
43 district, access to MBS funded GP services actually being
44 taken up by consumers, by members of the public, less than
45 the New South Wales average, but what the data source shows
46 you, it's not only general practices in my district. These
47 general practices, so these general practice encounters

1 between residents of Western New South Wales and a general
2 practitioner, could have occurred anywhere in Australia,
3 anywhere in New South Wales. So it's a true recognition,
4 if you like, of the differential access to MBS funded GP
5 services, and I show in my later evidence similar evidence
6 related to specialist MBS funded services, and more
7 correctly in my statement, Commissioner - and I do stand
8 corrected - the provision of MBS or Commonwealth funded
9 services, not all of which are MBS funded, there are some
10 programmatic funding through the Commonwealth, is clearly
11 not the - through the national health reform agreement is
12 clearly not the responsibility of the state government.
13
14 MR MUSTON: Q. That's because there is a compact between
15 the Commonwealth and the state, pursuant to which the
16 Commonwealth has agreed to provide a funding source, via
17 the MBS, to meet the primary care needs of the community?
18 A. Well, it's not only a funding source. The
19 Commonwealth has also stood up its own intervention
20 mechanism in Australia, we call them primary health
21 networks, in order to facilitate the growth of general
22 practice and to identify service gaps and to meet those
23 service gaps through interventions, and that's the
24 Commonwealth's primary agency on the ground in relation to
25 general practice.
26
27 THE COMMISSIONER: Even your question about "The
28 Commonwealth has agreed to provide a funding source via the
29 MBS to meet the primary care needs of the community" - even
30 that, it's not the entirety of primary care. Yes.
31
32 MR MUSTON: The compact provides that the Commonwealth
33 will deliver to the holder of a provider number
34 a particular amount of money - views about the adequacy of
35 which we have heard a lot - to the extent that that holder
36 of the provider number delivers a service which has an item
37 number.
38
39 Q. Your point about the primary health networks being
40 involved in identifying service gaps - it's not the role of
41 the primary health networks, as you said, to deliver
42 service, though, where those gaps are found?
43 A. No, but it is the role of the primary health network
44 to advocate and to commission services on behalf of the
45 Commonwealth to meet those gaps to the extent that the
46 Commonwealth funds them to do so.
47

1 THE COMMISSIONER: Q. For example, an example of primary
2 care being facilitated and funded that doesn't involve the
3 Commonwealth or the state is Bogan shire, where the local
4 government has stepped in to provide a means of their
5 community having primary care where, if they hadn't have
6 done anything, there might be none.
7 A. Sir, Bogan shire is a good example. However, they do
8 receive MBS billing for that practice, of course, the
9 Commonwealth has a role.
10
11 Q. Of course. If there is no GPs, there is no MBS.
12 A. That's right. But I would also reflect on the
13 testimony of the Bogan shire. I think they are running -
14 and this is a small shire, I don't know what their budget
15 is - I think their evidence was that they were forecast to
16 make about a half million dollar loss on their practice.
17
18 Q. That was what they told us, yes.
19 A. And they also proffered a view that it wasn't the
20 responsibility of local government to fund what most
21 taxpayers would assume they were paying taxes to the
22 Commonwealth Government to do rather than rates, ie, they
23 are being taxed twice. I would personally find that
24 argument very, very difficult to refute - in fact I agree
25 with it.
26
27 Q. It's not the first time that's been discussed.
28 A. However, what I would say is what an extraordinary
29 thing on behalf of their community that the Bogan shire
30 stepped in to that gap. One has to respect that. I think
31 what we're saying here is that they ought not to have had
32 to step into that gap, particularly not in a funding
33 sense - perhaps in a facilitatory sense, but not in a
34 funding sense to the extent that they are.
35
36 THE COMMISSIONER: Sure.
37
38 MR MUSTON: Q. I will come back to Bogan shire. Can
39 I ask you to turn to paragraph 108 of your statement, just
40 to round out --
41 A. I'm sorry?
42
43 Q. Paragraph 108 of your statement.
44
45 THE COMMISSIONER: Just keep going. We will take a break
46 at 11.30.
47

1 MR MUSTON: Yes. I'm content to take a break whenever it
2 is needed. We started at 10, I think, so I assumed 11.30.
3
4 THE COMMISSIONER: Deal with this point and then we'll
5 take the break.
6
7 MR MUSTON: Q. You see in paragraph 108 there you point
8 to successive governments in New South Wales, across all
9 political persuasions, having arguably made comparatively
10 less use of legislative regulatory intervention to improve
11 health outcomes than many other jurisdictions
12 internationally. The first question around that: do you
13 have particular jurisdictions in mind where you think
14 legislative intervention has been made effectively?
15 A. Well, New South Wales and Australia has used
16 legislation to effect in certain situations, and I think
17 Maryanne talked about some of those yesterday. My point is
18 that, in fact, they could go a lot further, and there are
19 many jurisdictions around the world where there is evidence
20 of that. My familiarity is New Zealand, so a far from
21 perfect society, let me say, and I don't like drawing
22 comparisons between the two, but because that's my
23 experience.
24
25 Q. I'm content for you to give us an example based on
26 your New Zealand experience if that is one that you can
27 call readily to mind.
28 A. Sure. So in New Zealand, it would be illegal to
29 advertise gambling on television. In this community -
30 again, because we're in Dubbo, I will just use an example -
31 a million dollars a week departs the Dubbo community
32 through pokie machines in this community. Why is that
33 important? Why does that relate to health? Well, we know
34 that the link between economic impoverishment in households
35 and family violence is a clear correlation between those
36 two things. We know that when families get economically
37 stressed, that often, unfortunately, family violence
38 erupts.
39
40 We know - and I have given evidence in my statement -
41 that the link between family violence and harm to children,
42 or to women particularly, and their long-term health and
43 social outcomes is demonstrably lower because of being
44 exposed - not always, not at the level of the individual,
45 necessarily people can overcome extreme disadvantage and do
46 extraordinary things - but, on average, the evidence from
47 various studies of harm and maltreatment is that there will

1 be significant long-term disadvantage for people because of
2 economic impoverishment. So that's an example of
3 a different use of legislation between one jurisdiction and
4 another.
5
6 Q. In relation to that one, do we take from that that
7 there are obvious health-based legislative interventions
8 like plain packaging with tobacco, for example, and I think
9 some evidence was given of that yesterday.
10 A. Yes.
11
12 Q. But, equally, when one looks to, say, the social
13 determinants of health, there are other levers, legislative
14 levers, which could, and in your view should, be pulled in
15 order to turn around health outcomes by influencing those
16 social factors?
17 A. Yes. And I will give you another example, again to be
18 controversial and, obviously, I don't want to stray too far
19 into the realm of politics, but the evidence suggests that
20 the return on investment from using sensible legislation in
21 a sensible way around some of these things - return on
22 investment is something like 53 to 1. It outweighs any
23 other form of health intervention by an extraordinary
24 amount.
25
26 So other interventions that might be useful, for
27 example, the level of sugar in certain processed foods.
28 I think it's true, but I will say this is anecdote because
29 I'm on the stand, so anecdotally, I understand that the
30 level of sugar in a bottle of Coke in Australia is
31 significantly greater than the level of sugar of a bottle
32 of Coke that you would buy in the United Kingdom. Why?
33 Because the legislative framework is different.
34
35 Why is that important? Well, in the Western New South
36 Wales PHN district, so our district and Far West, that PHN
37 reports statistically as having the highest levels of
38 obesity per capita of any primary health network district
39 anywhere in Australia. We know about the links between
40 obesity and long-term negative health outcomes. You've got
41 to say, intervention that gets to the source - because
42 a lot of what happens in health and a lot of what happens
43 in our responses to health is the treatment of symptoms.
44 What we think the health system should be designed to do,
45 as best as it can within all of the compromises that we
46 have to do in a democratic system, is try to address the
47 root causes of long-term health outcomes as much as we also

1 address the immediate symptoms of some kind of dysfunction
2 in the system.
3
4 Another example - and I will just use this because it
5 did strike me when I came from a different country - when
6 I was responsible for public health services in another
7 country, a lot of their work was in fact - I would have
8 public health physicians who would turn up, for example, in
9 development applications for fast food outlets, and we
10 would present to local government - and you wouldn't do it
11 in Australia, the legislative framework is different - we
12 would present countervailing arguments as to why the
13 density of fast foods - and unhealthy fast foods I'm
14 meaning in saying this - might be regarded differently by
15 the local government in terms of awarding development
16 applications than otherwise, or we would turn up to
17 a liquor licensing process and again provide strong
18 evidence about the social harm if liquor licensing was
19 disproportionately allocated to one suburb within
20 a community versus another.
21
22 And why are these things important? Well, there is
23 ample evidence that the proportion per head of population
24 of fast food outlets or liquor outlets is
25 disproportionately concentrated in suburbs where the
26 socioeconomic base is lower.
27
28 Q. When you say you would turn up, is it turn up because
29 the institution responsible for health thought it was
30 a good idea to do, or because legislatively it was
31 a mandatory consideration, namely, the health impacts of
32 whatever decision was being made about, say, the fast food
33 or liquor outlet?
34 A. No, because as in Australia, public health physicians
35 and public health professionals recognise actually it is
36 a very sensible thing to do. So they were professionally
37 driven to turn up. The difference was that the legislation
38 required a broader set of factors to be considered in the
39 process of awarding licences or applications for these
40 things to occur than is the case in various parts of
41 legislation in Australia. So those are two examples.
42
43 A third one, a very similar vein - and why is this
44 example important? I'm about to give you an example of
45 fluoridation of local water supplies. It is extremely
46 important because we know there is a direct correlation
47 between poor oral health and long-term heart disease,

1 cardiac issues. It is a proven correlation and it is also
2 a very well proven correlation between the fluoridation of
3 public water supplies and oral health over the long term of
4 somebody's life.
5
6 So in another country, where they were empowered by
7 law, to the extent that national legislation eventually got
8 changed to require councils to do things differently than
9 they had before, we would often turn up at public hearings,
10 and public hearings being highly legal hearings such as
11 this today, to advocate strongly about why a local council
12 should be required to fluoridate its water supply in a way
13 that it currently doesn't.
14
15 In Western New South Wales today, less than half of
16 the publicly-supplied water supplies across our footprint
17 are fluoridated, including Dubbo, as at today, does not
18 have a fluoridated water supply. To give due deference to
19 the Dubbo regional council when that deficit was pointed
20 out to them a couple of years ago - they are investing
21 heavily in order to supply and correct that deficit, so
22 I take my hat off to them. But they are examples of
23 legislative frameworks that exist in other jurisdictions,
24 which are perhaps less well evolved in the New South Wales
25 or the Australian context than they might be.
26
27 I note a period of caution, because I know what my
28 detractors will say. I'm not arguing at all for the nanny
29 state. But I am arguing that the frameworks of legislation
30 should allow for a balanced consideration to the benefit to
31 the community overall between the interests of private
32 individuals wanting to promote businesses or conduct their
33 public affairs in ways that are more beneficial to the
34 individual or the public agency than they are to community
35 as a whole - that there needs to be balanced conversation
36 and debate about that in a legislative way.
37
38 MR MUSTON: I note the time, Commissioner. I'm going to
39 move on to another topic.
40
41 THE COMMISSIONER: Yes. We will take a 20-minute break.
42 So we'll adjourn until five to 12.
43
44 **SHORT ADJOURNMENT**
45
46 THE COMMISSIONER: Are we ready to resume?
47

1 MR MUSTON: Yes.
2
3 THE COMMISSIONER: Please do.
4
5 MR MUSTON: Q. I will just ask you one quick point of
6 clarification around some evidence you gave before the
7 morning tea adjournment. You gave some evidence about the
8 48-bed aged care facility in Parkes which is closing?
9 A. Mmm-hmm.
10
11 Q. I think you said in relation to that, that whilst you
12 are the person on the spot who is called, "It's nothing to
13 do with me, nothing to do with my LHD". I gather from that
14 answer, you are essentially alluding to the fact that the
15 funding stream for aged care is a Commonwealth
16 responsibility, not something which forms part of your
17 budgetary allocation as the Western NSW LHD?
18 A. It would be - what I'm meaning is both that the
19 funding isn't the responsibility or the responsibility of
20 NSW Health, neither is the provision of private residential
21 aged care. That is the responsibility of a private
22 enterprise. I think, essentially, the point that I was
23 making is that fragility in that system will almost always,
24 by default, fall to the chief executive of the local health
25 district. They will get pulled in by all of the
26 stakeholders to try and solve the consequences of the
27 failure of a private business or the business decisions
28 of - in this case, the business decisions to change where
29 and how they invest in aged care relative to Parkes.
30
31 So we will be pulled in to try and help solve the
32 issue because we are the people on the ground and our
33 communities, our local shires will contact us, involve us
34 in trying to provide parts of the solution, although
35 specifically it has nothing to do with us.
36
37 But we'll also get drawn in to providing the
38 downstream solutions to all of the downstream consequences.
39 In the example I gave of Parkes, I know, as a result of
40 Tuesday evening, that the pressure on Parkes hospital and,
41 indeed, the pressure on Dubbo hospital to be able to
42 discharge patients back into residential aged care in the
43 middle of winter, which they will need to do in the coming
44 months, will be fundamentally more difficult because of
45 that closure than it was going to be on Monday evening.
46
47 It will take some time for that closure to occur, but

1 the point I'm making is that local health districts and New
2 South Wales health system essentially plays the provider of
3 last resort responsibility. The Commonwealth doesn't
4 necessarily fund the New South Wales health system to be
5 a provider of last resort. And there are many examples,
6 whether it is in aged care - I just used that because it
7 was an example in aged care - or primary care or general
8 practice, where, in the interests of the community, in the
9 interests of improving health outcomes, chief executives of
10 local health districts and, indeed, officials in the
11 Ministry of Health, will stray far beyond the traditional
12 bounds that one might have expected of a chief executive,
13 let's say, 10, 15 years ago within the New South Wales
14 health system with problems to solve, simply because - and
15 by "chief executive", I mean our teams, I don't mean solely
16 rests with me - but the system, the New South Wales health
17 system will respond simply because there is nobody else who
18 is going to.
19
20 THE COMMISSIONER: Q. We can all guess, but were you
21 given in indication as to the reasons why that 48 -bed
22 facility was closing?
23 A. Again, at the level of anecdote, so it is third hand,
24 I understand that the facility requires substantial
25 infrastructure investment by the provider. I think the
26 local shire had been pointing that out to them for half
27 a decade or more. The provider has decided to rationalise
28 their services and to sell off one of their facilities in
29 an adjacent town in the central west, for which they have
30 a buyer, but for this facility, given its infrastructural
31 problems, they have no buyer, so they will close it.
32
33 THE COMMISSIONER: Thank you.
34
35 MR MUSTON: Q. Can I ask you some questions about
36 primary care, which we've already discussed the divided
37 funding responsibilities and where, in your view, primary
38 care sits in relation to that divide, but you point in
39 paragraph 124 of your statement to a decline in the
40 availability of primary care as a fundamental challenge
41 faced by your LHD.
42 A. Correct.
43
44 Q. I think you tell us, and I think it is most unlikely
45 to be controversial, in paragraphs 18 and 19, of the
46 importance of good accessible primary - and stable primary
47 care for long-term health outcomes of a population?

1 A. It is the absolute bedrock of any western health
2 system.
3
4 Q. In relation to the planning that you are undertaking
5 as part of your LHD, you tell us in paragraph 129 that you
6 are aware of the 41 towns within the LHD that are at
7 significant risk of not having a GP within the next 10
8 years. Just pausing there, that was a 2019 study. Is that
9 10 years from 2019?
10 A. It would have been at that time, and that was
11 a forecast, that study was done by the primary health
12 network.
13
14 Q. So we're halfway there.
15 A. Mmm-hmm.
16
17 Q. What do you see as being the solution to the delivery
18 of primary care in those 41 towns, assuming that allowing
19 it to fail and not having accessible primary health care
20 within those communities is not a viable solution.
21 A. Well, if I start at the stratosphere, clearly the way
22 that funding is organised between the Commonwealth/state,
23 it drives you to the conclusion that, in fact, it is
24 a viable solution, at least in the perspective of those who
25 fund MBS, because that's what it drives. Nevertheless --
26
27 Q. By that, I gather you mean if you are funding the MBS
28 scheme and the MBS scheme is dependent upon an effective
29 market to deliver health care funded by that funding
30 stream, if there is no market and you have no funding
31 obligation, then that's not necessarily a negative outcome
32 from a funding point of view?
33 A. From a budgetary point of view, but from a social
34 responsibility point of view quite different.
35
36 Q. From the point of view of the community in those towns
37 radically different, I would suggest?
38 A. That's right. And I don't mean in any sense to be
39 pejorative about the motivations of people in the system.
40 It's not generally how it works. But that is the
41 unavoidable technical conclusion of what's going on.
42
43 So what do I see the solution, which is really what
44 your question is? And the reason I went there was right at
45 the beginning I suggested a fundamentally different way of
46 organising funding, recognising social determinants, social
47 deprivation, rurality, all of those kind of things that

1 I had experienced elsewhere and under that model the local
2 health district equivalent was responsible for funding
3 primary care as well, so all of the funding was pooled.
4 They had obligations around the percentage split of their
5 funding that had to support primary care so that it wasn't
6 all sucked up into the large hospitals, which are money
7 rapacious at the best of times.
8
9 They also had obligations in terms of achieving health
10 outcomes, which the current structures of the systems in
11 Australia don't have.
12
13 So having sorted that - and I've suggested that part
14 of the solution in rural and remote areas, and may
15 I preface it this way, what I'm proposing in my evidence is
16 a solution to the issues faced by remote, rural and
17 regional New South Wales. They may not be appropriate
18 solutions for a metropolitan area, and that's one of the
19 differences between local health districts --
20
21 Q. Before we move on, would it be right to say that even
22 within remote, rural and regional New South Wales, the
23 particular solution that might be best suited to
24 a particular town or community will depend very much on the
25 circumstances of that community --
26 A. Yes.
27
28 Q. -- its needs --
29 A. Absolutely.
30
31 Q. -- the viability of the existing market, et cetera?
32 A. Yes. And I think, as you heard yesterday, any large
33 organisation like a local health district should be very,
34 very averse to moving into situations where they disrupt
35 the viability of private enterprise in delivering
36 healthcare services through general practice. So you have
37 to be very mindful about that. There are some tests we
38 could apply to when an intervention is good or not.
39
40 Q. Is a critical starting point, though, to the extent
41 that there is any existing market in a town, close and
42 careful consultation and collaboration with that existing
43 market to find a solution which does not undermine the
44 viability of it, yet meets the needs of the community
45 insofar as they are not being met by that market-based
46 solution?
47 A. Absolutely it is, and we refer - this term is poorly

1 used, you hear it often thrown away - place-based planning,
2 but that's exactly what we're meaning, engagement with all
3 of the stakeholders on the ground. In our district, we
4 haven't seen any examples of high quality place-based
5 planning to date. Our LHD has in its '24/'25 annual plan
6 a particular shire in our district where we want to move on
7 that journey. We've discussed that at a board level with
8 the PHN board around one of the places that we may try an
9 experiment to do things in a more joined-up way, but not
10 only between us and the sectors that we represent but
11 between the practitioners on the ground, community members,
12 stakeholders on the ground, NGOs, GPs and so on, and we've
13 chosen a particular shire, which I won't name because that
14 would be premature, we've yet to finalise that agreement
15 with the PHN, but a shire that has moderate levels of
16 difficulty, ie, is not really a basket case. So, in fact,
17 we've got somewhere that might be a test bed that has both
18 strong general practice in some towns but not others.
19
20 Q. So without needing to get too far into the details, is
21 this one of those towns that does not have a nice thick
22 market of general practice that's meeting the needs
23 adequately of its community --
24 A. It is a shire that has some towns that have really
25 viable general practice and some that do not. So it's
26 a mixture of towns of small and moderate size, and the
27 towns that do not previously would have had - and did
28 have - viable general practice.
29
30 Q. Being delivered through a long-serving and perhaps
31 long suffering GP VMO who also delivered care into --
32 A. In some cases in some of those towns it was a GP not
33 a GP VMO and in others it was a GP VMO, yes.
34
35 Q. I interrupted you.
36 A. The distinction between those two things, the GP who
37 works solely in office-based general practice and one who
38 is a rural generalist who might also provide services to
39 a community hospital or an MPS. Sorry, could you just
40 bring me back to your question?
41
42 Q. The ultimate question was: what's the solution to the
43 failure of general practice within those 41 towns, but
44 I think you were telling us about the project that you are
45 undertaking with the shire of the place based planning?
46 A. About to undertake in the '24/'25 year. So that's
47 part of the solution, joined-up planning in a really

1 authentic, well-engaged way, and you've seen members of my
2 team, some of them, have got enormous capability in that
3 area, and I'm confident will do a good job. But it's not
4 us doing it alone; it is us doing it in collaboration and
5 partnership with others across the system, whether it is
6 NGOs, whether it is community members, whether it is
7 shires, whether it is the PHN.
8
9 Another example of a model which you will be well
10 aware of is the Four Ts where, in fact, we did have general
11 practice failure. Might I say, there is a bit of a myth in
12 Australia that local health districts - or local health
13 networks if we're in other states - don't step in to
14 providing general practice services. In fact, there are
15 many examples, I can think of some in Victoria, obviously
16 the Four Ts is an example, some in Queensland - in fact,
17 I'm about to visit a very longstanding one in Longreach
18 where that has been a way, in a rural and remote community,
19 to provide both hospital-based MPS-type services as well as
20 general practice for some time, an accepted model that
21 works for those communities.
22
23 The Four Ts was our version of that. It was a pilot
24 across four of our towns that, as you have heard I think in
25 previous evidence, were going to lose their general
26 practitioners.
27
28 What was different about that pilot was instead of
29 dealing with a single town and a single general practice,
30 we joined up four proximate towns to try and build
31 a general practice, which was the amalgamation of four, and
32 technically in a commercial sense, we've got four
33 independent general practices across those towns, but we
34 have an overarching licensing body, of which I'm
35 a principal, so I'm a general practice owner in my job,
36 along with other members of my organisation, and we are
37 providing general practice services through a section 19(2)
38 exemption in those communities.
39
40 That's an example of a model that has worked and
41 arisen out of place-based planning in those communities of
42 a very specific type, so we're just looking at general
43 practice services, not the totality of all services in that
44 community, that has worked very well. There is a caution.
45
46 Q. You give us the caution and then I will ask my next
47 question.

1 A. So the caution is it relies on section 19(2), and we
2 have got five communities, we've got section 19(2) in
3 place, we've got about another seven, we're in the final
4 stages with the PHN about trying to have section 19(2)
5 availability in those towns and another seven on the list
6 after that. So we're trying to progress --
7
8 Q. The question that I was going to ask relates to that,
9 so at the risk of interrupting you, the section 19(2)
10 exemption in the Four Ts model enables a salaried GP
11 operating within the public health system to gain access to
12 MBS money to the extent that they are delivering primary
13 care in those towns.
14 A. Yes.
15
16 Q. To the extent that we've heard evidence or engaged
17 with parties in relation to the potential role of LHDs in
18 primary care, we're often told "That will involve a big
19 fight with the Commonwealth." Are you aware of any
20 situations in which an LHD has developed a model like your
21 Four Ts model, or their own bespoke version of it,
22 implemented it, asked the Commonwealth for a 19(2)
23 exemption and been knocked back?
24 A. Well, the reality is an LHD would be unwise to
25 implement a model without a section 19(2) exemption because
26 they would carry the entire cost of general practice. And
27 it's not quite that simple.
28
29 So in order to get a 19(2) exemption, you also, of
30 course, have to consult with all of the private enterprises
31 in that community and gain their agreement as well as the
32 agreement of the PHN, even before you put a proposition to
33 the Commonwealth, and that's part of the checks and
34 balances. That's an appropriate mechanism, but you can, on
35 occasion, run up against a conflict of interest, for
36 example, with an existing practitioner who might be close
37 to retirement, very keen to sell their practice for the
38 maximum market value that they can obtain for it. Well,
39 there is direct conflict, perhaps, between that motivation
40 and the motivation to support a section 19(2) exemption.
41
42 What I would suggest, however - and the section 19(2)
43 exemption is one mechanism, and then after having got local
44 agreement you've then got to work with the Commonwealth,
45 and I'm pretty sure, but again I will say this is anecdote,
46 that there are some pauses in section 19(2) exemptions
47 while Commonwealth policy is being reviewed, but others at

1 the ministry could give you more accurate advice on that -
2 but it is only one model. So a far more elegant model - so
3 section 19(2) is a highly bureaucratic - MBS is a highly
4 bureaucratic mechanism to fund services and, as we've heard
5 from evidence of a number of our GPs, in fact, the MBS
6 rates don't cover their costs.
7
8 So the issue of co-payment and bulk billing and all of
9 that kind of stuff comes into it, and I would suggest that
10 a far more elegant mechanism between the Commonwealth and
11 the state would be, for example, let's pick a community,
12 let's look at its population and its access to general
13 practice. Let's compare that community on a per-population
14 basis with what the average MBS spend for general practice
15 services might be in one of the eastern suburbs of Sydney,
16 so metropolitan Sydney. Let's use that as the benchmark,
17 and let's say that amount of money, per head of population,
18 should go into a single pot to provide the general practice
19 component of all of the services going into that community.
20
21 Let's then work out mechanisms that enable us to have
22 good outcomes for the community, measure the health
23 outcomes, measure the productivity, measure the funding is
24 actually being used for the purpose that it is intended.
25 But let's just strip out all of the bureaucracy, all of the
26 layers of itemised billing that actually add nothing to the
27 value of the care that the patient has received.
28
29 Q. Coming back, though, to your notional eastern suburbs
30 per capita pot of money, I gather from what you have told
31 us elsewhere in your statement that for a system to be
32 working equitably, that pot of money would need to be
33 adjusted, to the extent necessary, to take into account
34 what might potentially be radically different social and
35 health - the radically different social and health
36 demographic of the population in the small town of your
37 choosing on the one hand and the small suburb in the
38 eastern suburbs on the other?
39 A. Yes, but it's also not quite that simple. So let's
40 talk about where the starting point is, not even taking
41 into account any of the socioeconomic factors. We know in
42 our district, when we look at MBS billing compared to the
43 average for metropolitan Sydney, for example, there is
44 a $16 million gap every year between the rate of billing
45 per head of population in our district compared to the rate
46 of MBS billing per head of population in metropolitan
47 Sydney.

1
2 If we took the average for Australia, it's
3 a $12 million gap. So even without --
4
5 Q. Can I ask you --
6 A. What I'm really saying, sorry, is that even without
7 considering the differential health outcomes and social
8 deprivation and all of those kinds of things, even just on
9 a per head of population basis, there is a fundamental
10 differential that needs to be corrected, and the MBS,
11 because it is driven on a private enterprise model, is
12 completely incapable of addressing that.
13
14 Q. Without wanting to undermine what might nevertheless
15 be a strong trend, that MBS data that you refer to, is that
16 based on the location or residence of the person who is
17 accessing the care, or is it based on the location at which
18 the care is provided?
19 A. No. So in all of the MBS related graphs - I'm sure
20 this is true, in all of the information that I have
21 provided in my statement, technical detail, it is all based
22 on the resident - on the person. The care could be
23 delivered, whether it is by a general practitioner,
24 a specialist, anywhere in Australia, so it is a true
25 measure, and those graphs are true measures, if you like,
26 of a wealth differential, and an access differential for
27 MBS funded services, between residents of our communities
28 compared to residents in communities on average in
29 Australia and also on average in metropolitan Australia.
30
31 THE COMMISSIONER: Q. Sorry, I'm not quite following
32 something you have said, and it's probably me, but when you
33 said "when we look at MBS billing compared to the average
34 for metropolitan Sydney, there is a $16 million gap every
35 year between the rate of billing per head of population in
36 our district" - is it per head of population?
37 A. Sorry.
38
39 Q. Per thousand?
40 A. Not per head of population, but population. Some of
41 the graphs we show are per estimated residential
42 population, so - but that figure, I'm sorry, is for the
43 totality of our population.
44
45 Q. Is another way - and tell me if this is wrong or not
46 your view - would another way of looking at it be for these
47 rural communities or regions where primary health care is

1 failing, for everyone with an interest to get together and
2 work out what are the primary care health needs for that
3 community - and by "primary care", I mean GPs, allied
4 health, the works; if there wasn't a failure of primary
5 care, what would the Commonwealth have to pay, and approach
6 it that way? Because if there wasn't a failure of primary
7 care, the Commonwealth would be paying, it would be paying
8 the MBS. Is that another way of looking at it?
9 A. Commissioner, that's a far more elegant way of saying
10 what I was attempting to say.
11
12 Q. Not necessarily, but that's generally - you are
13 nodding your head, so we will leave it at that.
14 A. Yeah.
15
16 MR MUSTON: Q. In terms of your $16 figure, now to make
17 sure that I'm not more confused than I was at the outset,
18 I gather what you are saying is if you take your average
19 metropolitan person and identify the amount of MBS money
20 which is spent on that person in a calendar year, and then
21 you take that number and multiply it by the number of
22 people in your population, what you will find is the result
23 of that produces a figure $16 million higher than the
24 actual MBS spend delivered to that population?
25 A. Yes.
26
27 Q. That is your population?
28 A. Yes, that is what I'm saying, and I'm sorry,
29 I confused in my evidence by saying "per person". What
30 I was meaning is at a population level.
31
32 Q. Yes. I assumed it wasn't $16 million per head of
33 population. That would be a big funding deficit.
34
35 THE COMMISSIONER: That one we couldn't solve.
36
37 MR MUSTON: Q. Could I just quickly ask you, by way of
38 clarification, in paragraph 132 of your statement, you tell
39 us about - and following - the knock-on effect of the
40 failure of primary care or increasing reduction in access
41 to primary care is having an impact on emergency
42 presentations within your LHD. You refer to some linear
43 trend analysis. Could you just explain in layman's terms
44 what that linear trend analysis is and what it shows?
45 A. So we have some extraordinarily clever mathematicians
46 within our health intelligence unit who have taken the
47 information about ED attendances and extrapolated it over

1 a five-year period. Because in that five-year period we
2 had the impact of the pandemic, they needed to
3 statistically adjust to make sure that the aberrations of,
4 you know, ED attendance rates around the pandemic were
5 adjusted for, and they have done that moving forward.
6 Essentially, what that shows is over that five-year period
7 there has been an 11 per cent increase in attendance at ED.
8
9 Another statistic in my statement that paints a very
10 similar picture, and if I just take triage 4 and 5
11 categories, so these are the least urgent - it doesn't mean
12 to say they are the least complex, it just means to say
13 that when they turn up in ED they can wait the longest in
14 clinical terms to be seen - in every local government area
15 within Western New South Wales, we have a higher percentage
16 of triage 4 and 5 presentations to our emergency
17 departments than the New South Wales average, which I think
18 most commentators in the system would suggest the evidence
19 strongly correlates that with difficulties in accessing
20 affordable primary care in a timely manner.
21
22 Q. You tell us a little bit later on in your statement
23 that in Trangie and Tullamore there's been a reduction in
24 ED presentation, or the trend has turned. It's tempting to
25 infer that that - the fact that Trangie and Tullamore are
26 two of the Four Ts is no coincidence. Do you have any
27 analysis that actually enables you to more firmly conclude
28 that the rolling out of the Four Ts model has in fact
29 resulted in that reduction in ED presentations in those two
30 towns?
31 A. So there is a strong association between the LHD
32 stepping in to provide general practice that was otherwise
33 failing and a reduction in attendances at the emergency
34 department. A different model in a different community,
35 where we fund a general practice company to provide
36 general - GP VMO services into our MPSs across all of our
37 northern - most northern six towns.
38
39 Q. Is that the arrangement with Ochre that you tell us
40 about?
41 A. Yes, that's right. That is one of the things that we
42 did entering into that contract as we recognised - we did
43 a whole lot of data analysis, when are people turning up to
44 the EDs. An example that stands out in my mind is Bourke,
45 where we had a spike in presentations on a Friday evening
46 after 5 o'clock and then through the weekend. So we
47 deliberately contracted them in a way that it required them

1 to provide a presence on a Saturday morning, because when
2 we looked at the data and spoke to the local community,
3 many of the things that people were presenting after
4 5 o'clock on a Friday with were very basic things, like
5 "I don't have a script", or "At least I have a script, but
6 I haven't got medications to get me through the weekend and
7 I need some", or "I've got a health condition that I don't
8 want my kids to go through all the weekend because I'm a
9 little bit concerned about it".
10
11 So we contracted them in a way that meant that their
12 general practices or their services to us extended into the
13 weekend and, again, that showed a dramatic - it showed that
14 actually you can fundamentally change the presentation
15 behaviour of people in the community to emergency
16 departments according to how you structure and fund the
17 health systems that they are trying to access.
18
19 Q. In terms of structural changes to emergency
20 departments and emergency department presentations, in
21 recent days we've heard quite a lot about urgent care
22 centres and urgent care clinics. Do you have any of those
23 facilities in your LHD?
24 A. There is one that has been funded by the state
25 government, not the federal government, through the primary
26 health network in Orange, which is just - I think it opened
27 in about March of this year. So it will be still in its
28 gearing-up phase.
29
30 Q. Do you have a view about the extent to which services
31 like that are usefully addressing - well, do you have
32 a view about how services like that fit within the broader
33 health system in terms of whether they are a good addition
34 or whether they are perhaps masking a bigger problem?
35 A. I spoke before that health has a tendency to address
36 symptoms rather than root causes and I think that's
37 relevant to this conversation. I will also refer back to
38 some experience in New Zealand, because it's a model that
39 actually I believe the Australian Government looked
40 internationally before coming to that point.
41
42 There is no question that comprehensive long-term
43 therapeutic relationships in general practice with a member
44 of the community to avoid the exacerbation of illness, to
45 the extent that it is possible to do so, is the best
46 intervention of all. That's the first bedrock of the
47 health system.

1
2 Second point over that, of course, somebody needs
3 access to services, and the only place they can get it is
4 an ED, but actually their need is a general practice ED.
5 Well, we need to find different solutions to that without
6 clogging up our EDs and the urgent care centres have a role
7 to play in that, but I will give you some caveats.
8
9 So we see already - Brisbane would be an example. We
10 see already the emergence for the first time in Australia
11 of a FACEM-based private emergency department. So what
12 we're really saying is, we're seeing the emergence of
13 the privatisation of one of the very few specialties that
14 had no private options that's absolutely essential to the
15 running of emergency departments, and I'm not sure that
16 that is in the long-term interests of Australia, or in fact
17 any health system. No disrespect to the FACEMs. So it's
18 a good model --
19
20 Q. When you say not in the long term interests of
21 Australians, are there two aspects to that - first, the
22 service being provided through those facilities is not
23 stable and continuous --
24 A. No, no, not at all. The service provided through
25 those facilities is fundamentally able to be accessed by
26 wealthier members of society, not all members of society,
27 because it has a huge out-of-pocket component.
28 I understand they are fabulous services.
29
30 Q. As to the second potential problem, do you see it as
31 impacting or exacerbating workforce challenges that
32 already --
33 A. Absolutely. That's essentially the concern that
34 I would have. You are suddenly creating a market that can
35 only be inflationary in the context of supply and demand
36 for emergency department doctors. And that's a different
37 problem - sorry, it is a different solution on the back of
38 urgent care, which was really intended to address the
39 problem of lower acuity, more general practice patients.
40
41 So it has a place, and I am not at all arguing it
42 doesn't have a place. But it has to be carefully managed
43 and has to be done in a way that, as best as it possibly
44 can, transfers patients back into long-term care.
45
46 If I can compare an example, a difference of how it
47 works - and there are some other difficulties with the

1 model, particularly when it is corporate general practices,
2 so corporate general practices are the one category of
3 general practice in New South Wales that is less likely to
4 contribute health information data to Lumos, which is
5 a technical system whereby health planners are trying to
6 join up general practice information about who is accessing
7 what services to determine community need, and
8 hospital based or LHD information, it is a fantastic
9 initiative, but corporatised general practice has a much
10 greater reluctance and, in reality, a much lower uptake of
11 contributing data, so that's a problem.
12
13 Q. Why might that be? Are there any disincentives to
14 a corporate-based general practice outfit to provide that
15 information, or is it just another piece of work that needs
16 to be done that's not being paid for through an item
17 number?
18 A. I would suggest that information is power, and in an
19 information age, if you are able to control access to the
20 information that you have, you are able to have a leverage
21 in the marketplace that you wouldn't otherwise have, and
22 that's no different in health than it is in companies
23 making biscuits.
24
25 What I was going to say, and as a comparison, just how
26 the model works here and, again, I apologise, let me be
27 very, very clear, the New South Wales health system, the
28 Australian health system, is a fabulous system, it produces
29 hugely beneficial outcomes and the Productivity Commission
30 recently reported on that. Any government at any level
31 would be very proud with the outcomes discussed in that
32 report, by and large.
33
34 However, a difference between my experience in
35 New Zealand, if I went to the equivalent of an urgent care
36 centre in New Zealand as a consumer - and I did that,
37 I broke bones in my foot on one occasion - I knew, because
38 I knew the system, that they had perfect capability to deal
39 with that issue in a way that would be entirely
40 satisfactory to me, without clogging up the emergency
41 department. I knew they would refer me to the orthopaedic
42 department for follow-up care, all of those kind of things,
43 so I would have a fantastic experience. So I went there.
44 It cost me a little bit, didn't particularly matter because
45 it was also funded.
46
47 But what I also knew was happening behind the scenes,

1 and that's a bad example because it was a trauma case, but
2 let's say I had gone there because I had a chronic health
3 condition that was being exacerbated. I was also at the
4 time enrolled in a general practice that was being paid
5 a capitation fee for me, for My Health Care across the
6 course of the year. So that general practice that I was
7 enrolled in would have received a negative adjustment to
8 its capitation funding in order to pay the urgent care
9 centre a portion of the fact that I had turned up out of
10 hours in unplanned care. So, in other words, the general
11 practice itself was highly incentivised financially to make
12 sure that I didn't go to the urgent care centre unless
13 I really needed to.
14
15 Now, in my example of a traumatic injury, it was
16 entirely appropriate that I went there. But if I had gone
17 there because my respiratory condition had got out of whack
18 or because I needed a script filled that I hadn't - my
19 general practice hadn't been able to deal with because
20 I couldn't get an appointment in a timely enough manner to
21 have that happen, the general practice itself was
22 disincentivised for me turning up to the urgent care
23 centre.
24
25 So, in other words, the system worked as a whole, not
26 just as a component partial intervention to a particular
27 problem, in this case overcrowding in EDs.
28
29 Q. Could I ask you to go to paragraph 135 of your
30 statement where you refer to the MBS data that we've been
31 talking about. Perhaps just turn over to the top of
32 page 26. Do you see at the beginning of the last sentence,
33 you refer to the evidence suggesting a reduced availability
34 of affordable and timely access to Commonwealth funded
35 primary care is failing to meet the needs of communities in
36 remote, rural and regional New South Wales. I just want to
37 ask you this question in relation to that. When you refer
38 to the evidence pointing to that, just out of an abundance
39 of certainty, what is the evidence that you are referring
40 to there?
41 A. Well, it's multilevel. So in my statement I include
42 some statistical analysis of MBS billing, and we've talked
43 about that.
44
45 Q. Yes, so the evidence points to the disparity between
46 the MBS billing.
47 A. Yes.

1
2 Q. As to the impact that that's having on health
3 outcomes, could you identify the evidentiary sources that
4 you would refer to which you say draw that correlation?
5 A. Again our health needs analysis, and you have heard
6 a lot about that, and I think that may have been tendered
7 into evidence, and if not, there are snippets of it right
8 throughout my evidential statement which point to that.
9 Also, the evidence from communities and general
10 practitioners - and you have heard quite a lot of that.
11
12 In fact, for good reason in our context, but perhaps
13 surprisingly in other contexts within NSW Health, the
14 Commission itself has focused heavily on the issues of
15 primary care rather than the New South Wales health system
16 itself per se, while you have been in our district, and you
17 have heard a lot of evidence from general practitioners.
18 I know, in consultation with community members, both in the
19 stand and outside of that, you have heard a lot of
20 anecdotal evidence.
21
22 We certainly hear evidence in surveying consumers
23 around their issues of access to primary care, and
24 somewhere in my statement I also refer to our planned
25 care - sorry, the study that we've done around, I think
26 it's in particular Dubbo, who is presenting to Dubbo's ED,
27 and what we have discovered is that a primary motivation
28 and driver for that uptick in presentations, there were two
29 factors that stood out, or three, actually. One was the
30 completely disproportionate percentage of First Nations who
31 were driving the increase, it's almost 50 per cent in that
32 particular emergency department.
33
34 Secondly, the disproportionate lack of connection
35 between primary care and the people who were turning up and
36 driving that percentage increase, and the third - and
37 I think this is really instructive - when those people were
38 turning up. They weren't turning up late at night in
39 extremis, they were turning up between the office hours,
40 the normal office hours that you would expect general
41 practice to be operating, and all - so those are just kind
42 of factors that you could argue are they causative? They
43 are highly associative, if not causative, between the
44 issues and the accessing affordable primary care. If you
45 go into some of our smaller communities, then, and
46 particularly those that no longer have general practice,
47 and whether it is through our vRGS service or through the

1 GP VMOs that we are putting into our emergency departments,
2 then they have no other service, and the service they get
3 from us is episodic care. It's not holistic, long-term,
4 well-rounded primary care, both in terms of a general
5 practitioner but also allied health professionals, all of
6 the other kind of things that go into that generic
7 description of primary care that we would have.
8
9 Q. When you say the care that they receive from you,
10 that's the care that they would receive from you in the
11 emergency setting?
12 A. That's right, yes.
13
14 Q. Where you have stepped in to, say, the Four Ts model,
15 the care that patients within that model are receiving, is
16 that more holistic care?
17 A. Absolutely. It's standard general practice, and as
18 you have indicated before, there is a dramatic association
19 with us doing that and a reduction in the rate of people
20 turning up to the emergency departments in those sites.
21
22 Q. Whilst you point to the correlation between the
23 emerging crisis in relation to accessibility to primary
24 care and the increase in emergency department
25 presentations, I don't understand you to be suggesting that
26 a desire to shift or reduce ED presentation numbers should
27 be the driver for addressing this primary health crisis?
28 A. In some settings it would be an appropriate driver,
29 but it's only addressing a symptom. So in generality, the
30 driver should be to improve the access of Australians to
31 the health services that they pay taxes for, which is
32 fundamentally and primarily and initially in primary care.
33
34 Q. Because addressing - it would be right that merely
35 acting to address an increased - acting in a manner which
36 seeks to decrease emergency department presentations would
37 be reactionary and not really dealing with the underlying
38 core problem?
39 A. That's right, yes. Still beneficial but reactionary.
40
41 Q. Is there an extent to which the urgent care centres,
42 to the extent that one of their stated objectives is to
43 reduce pressure on emergency departments, falls potentially
44 into that category of not necessarily grappling with the
45 core underlying problem in some settings?
46 A. It's grappling with an absolutely essential problem,
47 which is the overburdening of emergency departments and in

1 that sense is a very valuable and worthwhile intervention,
2 but it is not addressing the fundamental problem, which is
3 the failure in the timely and affordable access to primary
4 care.
5
6 Q. I think we've spoken quite a bit about the Four Ts.
7 Could I ask you to tell us a little bit more about the
8 HealthOne model, which its is something that is being
9 rolled out in Canowindra?
10 A. Yes, and in fact we have a number of mature HealthOne
11 models across our district. A HealthOne model differs
12 slightly from the Four Ts. The Four Ts is an example of an
13 LHD-owned general practice. The HealthOne model is
14 essentially a facility-based model whereby we construct
15 a facility or use an existing facility with the deliberate
16 intention of bringing together general practice, that is,
17 private general practice and the community based services
18 delivered by our local health district, be they allied
19 health staff in the community, community-based nurses,
20 family health care nurses and so on.
21
22 We have a number of examples of that throughout our
23 district. A very mature example would be in Molong, and
24 I understand that Dr Robin Williams, who is also the chair
25 of the PHN, will give evidence tomorrow. That's an example
26 in his town of that practice working. That example is not
27 collocated with the MPS in the town. It's not that far
28 away, but it is a model where we've deliberately tried to
29 bring together state funded community services and
30 Commonwealth funded general practice and community services
31 into one location to get the synergies of both.
32
33 We have similar versions of that model in a number of
34 other towns, not all of them, and it is certainly a model
35 that our planning suggests has great merit. Particularly
36 where there is viable general practice, why on earth would
37 our organisation want to step in and provide something that
38 others could provide when we've got lots of other needs we
39 can't meet in our community. But a good example right now
40 is in Canowindra, where traditionally we had downtown in
41 Canowindra a building which housed our community services
42 staff, we had a community hospital up the hill in
43 Canowindra, and we had general practice, in fact two
44 general practices in the town in Canowindra.
45
46 So through a process of health planning with that
47 community, we are now in the process of demolishing an

1 unused facility on the community hospital site in order to
2 build a HealthOne and, when that is built, then the general
3 practitioner, or at least one of them in the town, one
4 practice in the town, will move on to the site, along with
5 all of our community services. But it's also collocated
6 with the community hospital.
7
8 Part of our long-term vision with the shire - and
9 I say this with some aspiration but not certainty at this
10 point in time - around that community hospital and the New
11 South Wales Government owns, by reason of history,
12 a substantial land holding in fields, a farm around the
13 local community hospital, which is an accident of history,
14 but actually you could imagine - and this is not something
15 NSW Health would do, but you could absolutely imagine in a
16 future iteration of services into that community, well
17 planned and designed, we might encourage a private
18 entrepreneur to come into that town to establish
19 a retirement village, that graduated kind of retirement
20 village between own your own apartment, moving through
21 ultimately to residential aged care, that would sit
22 absolutely beautifully on a campus with a HealthOne around
23 it, pharmacy, all of those kinds of things, general
24 practice, community-based allied health and district
25 nursing services.
26
27 Now, that's not - we can't go that far at this point
28 in time, but we've gone as far as funding the development
29 through the New South Wales Government of a HealthOne,
30 which was currently being built. But if you cast your mind
31 and gave it a sort of five, 10-, 15-year vision, you could
32 see how health services for older people and younger people
33 in the community of Canowindra could be far more
34 integrated, with far greater effect, without the need for
35 the state to deliver them all, but with good place-based
36 planning for that community and consultation with the local
37 shire and the local practitioners and potentially even
38 entrepreneurs who don't exist in that community today, how
39 you could end up with a health precinct or a campus that
40 was substantially superior than what is there today.
41
42 Q. Even to the extent that that work is being done to
43 date, though, you have used the term "place-based planning"
44 again. There is obviously more to it than just building
45 buildings close to one another with a view to putting all
46 of the health services on a similar footprint. There
47 presumably is some close collaboration and consultation

1 with the existing general practice?
2 A. Yes. Of course, absolutely, and in fact, place-based
3 planning I would suggest is not about building buildings.
4 That may be one of many outcomes. And I think that, as
5 I said earlier in my statement - in my evidence, sorry, the
6 tendency of the New South Wales health system has been to
7 plan for the services that we provide, and particularly to
8 plan for the infrastructure required for those services, be
9 it our hospitals or whatever else. Our aspiration, and
10 I believe the correct aspiration of the New South Wales
11 health system, or the Commonwealth Government health
12 systems, would be to plan for the needs, the health needs
13 of a community as the core thing that it does through
14 place-based planning, and the infrastructure requirements
15 or the service provider requirements to meet that need are
16 secondary to the core purpose of planning. As I said right
17 at the beginning, current legislation does not drive the
18 system towards that goal when, in my view, clearly it
19 should.
20
21 Q. Could I ask you to turn to paragraph 164 of your
22 statement, where you tell us about some collaborative
23 partnerships with larger NGO organisations using single
24 employer models and the like. Could you just explain,
25 perhaps by reference to some examples, what you are talking
26 about there?
27 A. So a good example would be some work that is happening
28 in our allied health space, and I think you touched on this
29 with Marathon Health's testimony earlier in the week. So
30 we have traditionally operated in silos. Through some very
31 good leadership work both by the NGOs and our executive
32 director of allied health, there has been a coming together
33 at chief executive level and senior executive level across
34 not only our organisation and one NGO - Marathon, and they
35 are a large NGO, so that made sense - but a number of
36 others, like the RFDS, LiveBetter and so on, to look at
37 actually how might we do this.
38
39 A good example in our district would be we've had many
40 areas where we've had vacancies in small towns, so it might
41 be 0.2 of a physio, in a hypothetical example. There might
42 be three or four NGOs going into that town to provide
43 different services under different grants, Commonwealth or
44 state funded, through different mechanisms, all of whom
45 equally have a 0.2 vacancy for a physio, and none of us can
46 recruit a 0.2 physio because it's not enough to make an
47 income from.

1
2 So we are exploring, in fact, how we might have
3 a single employer model. So one of the agencies - and in
4 different towns it could be a different agency, sometimes
5 it could be us, sometimes it could be the NGO - how we
6 actually work out how we pool our respective needs and that
7 contribution towards salaries to do that.
8
9 Now, obviously that's not simple. The awards and
10 remuneration rates and all the conditions of employment
11 need to be harmonised to do that to a certain extent, and
12 so we're in the early days of exploring that.
13
14 Alongside that - and we currently have in front of the
15 New South Wales Government at an agency level and have also
16 briefed ministerial officers and in some cases ministers on
17 it - a project on the back of the VET review that's under
18 way in New South Wales, a review of vocational training
19 through the TAFEs. We see a real opportunity for an
20 employer-led collaborative model to train both care workers
21 and health workers to get certification through the TAFE
22 system in a way that enables people in that training
23 pathway to staircase their time that they might spend, for
24 example, in my organisation or at Marathon Health or RFDS
25 or LiveBetter, in a kind of structured apprenticeship, for
26 want of a better word, along with some academic input and
27 training from the TAFE system or the Charles Stuart
28 University, where and as it is relevant, so that their time
29 spent in different organisations can count towards their
30 qualification, but their qualification is also being
31 re-engineered so that the practice experience on the
32 ground, supervised by others in our organisation, counts
33 towards their learning rather than them having to, for
34 example, leave Cobar, where they live, for extend periods
35 of time to go to TAFE to sit in a class environment in
36 Dubbo, three hours away, three or four hours away, leaving
37 their kids behind and for extended periods of time.
38
39 So it is a different employer - and we're calling it
40 a Regional Workforce Activation Hub proposal. We've had
41 very positive reception from both the officials in the
42 Minister of Education and TAFE's office and in the Minister
43 of Health's office. We believe - we currently have
44 briefing up through TAFE New South Wales and executives in
45 that organisation have very favourably responded to the
46 proposal. We've done the same through NSW Health, both the
47 workforce branch and the regional health division, and they

1 are currently evaluating, but again, very positive and
2 supportive.
3
4 That's an example of a way that you come together -
5 and ultimately in that, the trainees will be under a single
6 employer model so that they can move freely between the
7 organisations in a planned and staircased pathway of
8 training, and we've got to work through. Our proposition
9 is to establish a pilot so we can actually do all the hard
10 work about working out how that model might work in Western
11 New South Wales, fully minded that if we can work out the
12 details between the NGOs, the TAFE and us that actually
13 make a single employer model work for that category of
14 worker, then that's entirely transportable to anywhere else
15 in New South Wales and would be of huge interest to other
16 regional local health districts.
17
18 Q. It may be something you haven't yet identified, in
19 which case tell us, but on that single employer model, if
20 you have got five people in a town or close cluster of
21 towns, each of whom has a 0.2 of a physio that they want to
22 fill, and they collectively have found someone who would
23 happily take that 1 FTE worth of physio work and spread it
24 across all of them - are there any legislative or
25 structural impediments that you are aware of at the moment
26 that could be cleared in order to make that happen, or need
27 to be cleared in order to make that happen?
28 A. Well, clearly harmonisation of terms of employment
29 would be one.
30
31 Q. That's award reform in the sense that --
32 A. Yes.
33
34 Q. -- whether you be employed by the Ministry of Health
35 or Marathon Health or some other private enterprise that
36 might be delivering physiotherapy care in a community, an
37 impediment is the disconnect between the employment
38 conditions that apply to each of them?
39 A. Yes, and it would make it simpler - not essential but
40 simpler - for example, what you will find in our district,
41 and certainly with a large and better equipped organisation
42 like Marathon Health, they will tend to follow the state
43 award lead. They need to do so if they wish to attract
44 staff. Not all smaller NGOs are able to do that, and in
45 some cases, particularly where NDIS is concerned, the state
46 funded services have no possibility of competing with the
47 rates of remuneration that somebody working for NDIS in a

1 small town would be able to earn under NDIS packages.
2
3 Q. Are these some of the challenges that you have
4 identified or you allude to in paragraph 158 of your
5 statement?
6 A. Paragraph 158 related specifically to visiting medical
7 officers, staff specialists and the Rural Doctors'
8 Settlement Package, but the same issue applies. There are
9 many examples, and you heard one I think from Dr Harfield
10 earlier in the week, where we are piloting the use of the
11 staff specialist award in order to employ GP VMOs in
12 Mudgee. If I can explain that in practical terms, to use
13 that award to employ GP VMOs is substantially more
14 expensive than using the Rural Doctors' Settlement Package,
15 which was kind of a fee for service arrangement with GPs,
16 but it's cheaper than employing locum GP VMOs - an order of
17 many dollars different and cheaper, so it makes sense for
18 the state to do it. But in doing it, what it is also
19 doing, and to be clear, is hard-baking into the cost of
20 delivering services in that procedural hospital an uplift
21 in the cost of doing that that is greater than the
22 historical cost of doing that, which would have been
23 delivered because a GP got rung and pulled out of their
24 general practice to come up to the hospital.
25
26 So it is a necessary evolution, but the awards that
27 I'm referring to, across all of the medical specialty
28 awards, have not been subject to award reform for over
29 a decade. So the conditions that were relevant a decade
30 ago - and in fact, that is true in many awards in New South
31 Wales - are still the conditions, they will have been
32 inflated through various government determinations since
33 then, but the opportunity to have a meaningful dialogue
34 between industrial organisations and the New South Wales
35 health system that not only looked at rates of remuneration
36 but looked at how might this all work effectively to the
37 benefit of the community and the practitioners without one
38 capturing all the benefits at the expense of the other but
39 also lead to some productivity reform, so sensible
40 improvements in how things are done so that the cost of
41 services overall might reduce, simply hasn't suggested and
42 I would suggest, as I do in my evidence, that there are
43 innumerable examples that those awards are no longer fit
44 for purpose.
45
46 What is happening instead - and our district's
47 financial performance is the classic example of this, where

1 we've gone from balancing the books to a substantial
2 forecast deficit, $48 million at the end of this financial
3 year - and I say that with great grief, because I as chief
4 executive, and I know many of my staff and our board, have
5 an absolute commitment to use and be wise stewards of the
6 resources that we receive, and it grieves us not to be able
7 to balance the books, but we also have other objectives
8 that we want to achieve, and delivering safe healthcare
9 services to our communities is one of those - 60 per cent
10 of that change in our financial circumstance is driven
11 entirely by changes in the cost of employing medical staff
12 as locums or under various other arrangements such as
13 I have described, and in some cases, a necessary investment
14 in gaps in medical workforce; 30 per cent of it is being
15 driven by the cost of needing to employ agency nurses at
16 rates which are phenomenally higher than they have ever
17 been in New South Wales.
18
19 Q. When you refer to the 60 and 30 per cent, do we
20 understand you to mean not that 60 per cent is the total
21 income being paid to those doctors, it is the differential
22 between --
23 A. No, no. When we look at what has changed the
24 financial performance of our local health district, that's
25 what I'm describing.
26
27 Q. So 60 per cent is the uplift in cost associated with
28 delivering medical care through locums rather than --
29 A. Through medical staff of various types, of which
30 primarily locums would be the primary driver; and
31 30 per cent is through the cost of employing nursing staff,
32 particularly through agencies in order to close that gap.
33
34 Q. And again, the 30 per cent is the premium that you are
35 paying for the agency staff - not the total cost associated
36 with agency staff that are taking places not otherwise
37 being --
38 A. No, these are differentials. So in other words, we
39 stood back and said, "What on earth is going on? Where do
40 we need to focus our attention to get some discipline back
41 into expenditure?", and we pulled it apart, then at a macro
42 level, those are the kinds of trends.
43
44 Now, there are a whole lot of other things underneath
45 that. Some of our services aren't as efficient as they
46 were, post the pandemic, that we need to focus on, and some
47 areas we need to recalibrate levels of staffing and so on,

1 but in a general sense, the fundamental drivers of the
2 difference in financial performance come from those two
3 places.
4
5 Why is that hugely important to us? Well, obviously
6 value for money. But what I'm also describing is
7 a transfer of wealth from taxpayers to a very, very small
8 portion of Australian society - ie, those who have the
9 education and skill to capture that wealth through the
10 income demands that they are making on the health system.
11 That is not, I would suggest, a good and equitable use of
12 public funds. So we desperately need to get into some
13 solutions of that problem. We in our district - there are
14 many, some which are local, some which are not able to be
15 distributed locally. For example, it is impossible for all
16 local health districts - I will just use agency nursing, or
17 I could use locums, as an example. It is impossible for
18 us, as a purchaser of those services, to form together
19 under Australian or state commercial competition law - and
20 there is good case law around this - in order to discipline
21 that market, ie, to hold out, "No, we're not going to pay
22 locum rates of this type as a system." It's impossible for
23 New South Wales to stand out - it is less of an issue,
24 well, it is an issue for me, but more of an issue for some
25 of my colleagues in border towns - to attempt to discipline
26 the locum medical market, for example, in Queensland and
27 Victoria, South Australia, Northern Territory and Western
28 Australia, let alone our own.
29
30 There have to be - and as you will be well aware,
31 better aware than I - there are constitutional issues that
32 have to be navigated, in order to navigate that, but those
33 things don't help.
34
35 Where it is potentially possible, and a good example -
36 and there is work at a whole of Commonwealth and state
37 government level to try and look at some of those issues -
38 what you find, and certainly has been the case in our
39 district, we've had to create some alternative solutions,
40 and Virtual Rural Generalist Service is one of those
41 solutions, without which our district would not be
42 functioning and our deficit would be substantially greater,
43 which is why, in my view some parts of various professions
44 are critical at times of services, like vRGS, because it
45 has the ability to use virtual technologies to discipline
46 the market, to provide a practitioner into a town which we
47 would have otherwise had to physically do - and I, like

1 everybody else, would agree that the physical presence of
2 a medical practitioner is a hugely beneficial thing, we
3 don't want to undermine that, but it is absolutely true
4 that the use of virtual means, in order to not be captured,
5 in tiny town markets, by those who wish to maximise their
6 income through excessive locum fees - it's a helpful
7 intervention.
8
9 Another example of an intervention that we used in our
10 district - we held our breath going into Christmas - we had
11 been forced to pay extremely high agency nursing costs, and
12 to give you some sense of that, there are today positions
13 advertised in Townsville, or at least very recently, at an
14 agency nursing rate, that if you annualised the salary, was
15 over $430,000 a year that that individual would earn, if
16 they were in town on the agency rate that was going to be
17 paid to them on a daily basis, and they would get
18 accommodation and travel supplied, driven in a highly
19 specialised area by the absolute need of that community;
20 it's not in our state. That is a real example. And I can
21 absolutely understand why the organisation in that district
22 was driven there, because if they did not do that, all hell
23 would break loose around the inability to provide services
24 that the community needed.
25
26 But it shows you how unsustainable some of that was,
27 and the trajectory it was going in Australia. So just
28 prior to Christmas - sorry, longwinded answer but it is the
29 real world that we deal with - I made a determination,
30 along with my executive, talking to staff, that we were no
31 longer going to pay those rates, and they generally had
32 been paid in some of the more remote parts of our district
33 to provide nursing staff into our MPSs. We held our
34 breath. Because the reality was, we were going into
35 Christmas and it might well have been the case that we were
36 unable to provide any service at all, which of course - so
37 it was a bit of brinkmanship.
38
39 We discovered over time - and we had to do some horse
40 trading in certain places in order to maintain service for
41 a short period of time, but today we no longer pay those
42 rates anywhere in our district, and we're still paying
43 premium rates, we're not paying hyper premium rates because
44 we had to, if you like, play chicken with the market, with
45 the providers of agency nurses.
46
47 To a certain extent, all LHDs have done that, both for

1 medical staff and for agency nurses, but you cannot do that
2 in its complete sufficiency moving forward. And it is not
3 that agency nurses or locum staff don't have a role to
4 play. They have an absolutely beneficial role to play into
5 the system. They are vital. The system can't deal with
6 the fact that somebody gives two weeks' notice when you are
7 a nurse and they're gone, but it might take you three,
8 four, five months to recruit a nurse to replace them in
9 that town. You've got to have agency nurses as a viable
10 part of the system, and it works incredibly well.
11
12 But what has happened since the pandemic and the
13 floods and the various other things that have just
14 decimated workforce, and that's starting to correct itself,
15 is we've been forced - as you would expect, people saw an
16 opportunity, they saw an ability to leverage. They're
17 sensible, intelligent individuals in one sense and they
18 maximised the opportunity, but the maximising has got to
19 the point where it is to the complete detriment of health
20 services in Australia. So the New South Wales Ministry of
21 Health is currently running a statewide panel tender for
22 nursing agencies, which we don't know the outcome, but we
23 know that by trading as a state, in the sense of making it
24 clear that you won't get any work with any LHD in the state
25 unless you are providing a bid to that tender in a range
26 that ultimately NSW Ministry of Health is going to find an
27 acceptable rate under acceptable conditions through a panel
28 tender process, then actually, the using commercial means
29 to offer agencies the potential for wider market share in
30 return for lower episodic - individual rates in supplying
31 agency nurses, and then for those agency nurses to be
32 providing a more secure and potential to work at various
33 places across the state - there are nurses who just love
34 being, if you like, the missionary nurse, they love flying
35 in to a remote community for a couple of months and then
36 being evacuated, for want of a better term, or extracted to
37 another part of Australia.
38
39 It's - you know, there are nurses who, completely
40 understandably, like to gain life experience and
41 understanding of what remote, rural and regional Australia,
42 not only New South Wales, is like by doing that. It's a
43 fabulous way to expose nurses who might ultimately end up
44 working in a metropolitan hospital, but then they will know
45 when somebody comes from Enngonia or Weilmoringle - they
46 will know what it is like and how different it is and what
47 the community that those nurses - those patients might then

1 return to is like, and they will know not to assume the
2 range of services in Enngonia is anything like the range of
3 services that might be available to a patient in Northern
4 Beaches.
5
6 So there is this real benefit the system can get from
7 agency nurses, provided that the price of locums and agency
8 nurses is correct. And in our evidence and our experience,
9 there is a desperate need at both a Commonwealth level and
10 across multiple states and through the Commonwealth and
11 state mechanisms to bring discipline into the locum medical
12 market in particular, and at a state level to bring
13 discipline into the agency nursing market - not to remove
14 those commercial opportunities entirely, but to ensure that
15 the people who ultimately fund their wages are getting
16 value for money.
17
18 MR MUSTON: I note the time, Commissioner. I've got a
19 little while to go.
20
21 THE COMMISSIONER: We will adjourn until 2pm.
22
23 **LUNCHEON ADJOURNMENT**
24
25 THE COMMISSIONER: All right, are we set to resume,
26 Mr Muston?
27
28 MR MUSTON: Yes.
29
30 THE COMMISSIONER: Thank you. Please go ahead.
31
32 MR MUSTON: Q. I would just like to ask you quickly
33 about specialist outpatient clinics. You tell us in
34 paragraphs 21 and 22 of your statement about some internal
35 analysis that has been done that reveals significant gaps
36 in terms of the availability of outpatient medical
37 services. I assume, much like other forms of primary
38 health, to the extent that that might be regarded as an
39 extension of primary health, that the consequences of not
40 having a good and accessible specialist care available
41 where it is genuinely needed has negative impacts on
42 long-term health outcomes for members of the population who
43 are experiencing that shortage?
44 A. Absolutely, it does.
45
46 Q. There are two challenges I perceive from your
47 statement that are combining to result in these gaps. The

1 first is a funding shortage in the sense that if you don't
2 have funding for a sufficient number of FTE to man or woman
3 the clinics, you can't run them. That's one challenge.
4 Would that be right?
5 A. That's one challenge.
6
7 Q. And a second challenge, and perhaps one that exists
8 whether or not you have got adequate funding, is workforce
9 maldistribution challenges, which means if you are in a
10 position to fund a clinic, your ability to stand it up is
11 dependent upon your ability to find a suitably qualified
12 specialist who will work and deliver that clinic in the
13 area where it is needed?
14 A. That's the second - agreed, that's a second challenge.
15 There are other challenges.
16
17 Q. What are the others?
18 A. As per paragraph 20 of my statement, of course,
19 specialist outpatients are both funded as part of private
20 entrepreneurship through MBS billings and gap payments by
21 individuals, and as I corrected in my evidence right at the
22 start of today, there is a substantial differential between
23 the average number of specialist attendances across our
24 district compared to the average for New South Wales, and
25 equally - so that's one aspect. So the private market
26 itself is --
27
28 Q. Is that, in a way, its own form of maldistribution
29 between private and public delivery of specialist care,
30 albeit perhaps not a geographic one of the type that we've
31 heard a lot about?
32 A. Well, it can be both geographic, but it is
33 a maldistribution, because of course, MBS funded specialist
34 outpatient care is also generally reliant on co payment.
35 So if you have an inequality of wealth between different
36 members of the community, their ability to access those
37 services will be very, very different.
38
39 Q. Would it be right to assume that that disparity is
40 exacerbated in a community, a rural or remote community,
41 where the availability of specialist appointments is
42 already significantly stretched, such that those that are
43 available and can comfortably be absorbed by those willing
44 to pay a large gap leave nothing left for those who are not
45 able to pay that gap?
46 A. That's a reasonable assumption.
47

1 Q. Sorry, I think I interrupted you. You were telling us
2 about there is the disparity between private and public --
3 A. So that's one aspect. And then there are also
4 publicly funded specialist outpatient clinics, which of
5 course local health districts will fund and provide. Of
6 course, to be able to do so, you need to be able to attract
7 a specialist workforce, and a specialist workforce will
8 find it far more attractive to go to places where they can
9 have a viable private practice with significant co payments
10 met by members of the community in their private practice,
11 as well as a bit of public practice on the side.
12
13 There's also - I would suggest that outpatient or
14 specialist outpatient services, there are some substantial
15 policy gaps across New South Wales. For example, on what
16 basis should somebody have access to a publicly funded and
17 free specialist attendance versus a private one? As chief
18 executive of a local health district, if I stand up
19 a publicly funded specialist service with no gap payment,
20 essentially, I'm being asked to stand in the role of judge
21 and adjudicator of who is worthy for that service, unless
22 I make it available for everybody, which is generally what
23 happens. It's on a referral and demand basis.
24
25 But that's an inefficient use of the public fund, to
26 make public clinics available to those who could afford to
27 go privately and have the insurance to do so, but may want
28 to avoid the co payment, even though they are wealthy
29 enough to pay it.
30
31 But if we get into the territory as a chief executive
32 of saying "Person A can have access to a public clinic but
33 person B can't", I would suggest that that is an
34 inappropriate use of a chief executive's powers, unless
35 there was a framework which was mandated by the parliament
36 to determine the conditions under which one member of the
37 community might have access to a preferentially freer or
38 less expensive form of outpatient specialist attendance
39 versus another, and I - the point I'm really making is that
40 that's a policy gap in the system. I don't believe that
41 should be left to the discretion of individual chief
42 executives. I don't think that's the role of the public
43 service. I think it's the role of the parliament to
44 determine effectively where a welfare intervention should
45 occur. None of that exists within the New South Wales
46 system. It's not necessarily a fault of NSW Health, it's
47 just a glaring gap, because the history and genesis of

1 specialist outpatient clinics has largely been derived from
2 private practice through MBS billing.
3
4 Q. There might be some easy differentiators like holders
5 of health cards, those who are on pensions of various sorts
6 or recipients of welfare, but would you see that
7 necessarily as - let me put it another way. If that were
8 a differentiator in your community, would you see there to
9 be a risk that there would still be a substantial group
10 that fall somewhere between capable of paying for private
11 outpatient services on the one hand, or holding a health
12 card or being a welfare recipient of some sort on the
13 other, who would still be missing out on those services,
14 and need them?
15 A. So that could be possible. What I'm really
16 suggesting - and today we don't have the time to get into
17 the detail - is that there's a policy formulation to ensure
18 that the community's expectation of fairness is met through
19 whatever the intervention is.
20
21 Q. We have seen in your LHD some excellent examples of
22 metropolitan based specialists who are delivering care
23 through your facilities.
24 A. Mmm-hmm.
25
26 Q. Through networked arrangements which don't, on their
27 face at least, appear to have a clear systemic or
28 structural basis but, rather, seem to have arisen out of
29 well-intentioned metropolitan based specialists liaising
30 and collaborating with people from within your region to
31 produce an outcome which delivers excellent services to the
32 people of your region.
33 A. (Witness nods).
34
35 Q. Do you have a view about whether there might be
36 a structure or more formal arrangement which could be put
37 into place to try and deal with some workforce issues by
38 requiring or making available to people in your LHD
39 specialist care delivered by specialists who might, for
40 a range of reasons, choose to live in a metropolitan area?
41 A. Well-designed, there could be some advantages of that.
42 What you are essentially asking to do - is specialists in
43 the metropolitan area to do, by and large, is to forgo
44 a substantial portion of their income they would get
45 through gap fees in order to provide services in rural
46 locations where the possibility of significant gap fees
47 doesn't exist. But the opposite is also true, the

1 specialists are not here because of that market dynamic.
2
3 So well-designed. However, there is a caveat, in that
4 I think most rural LHDs and certainly ours and most
5 specialists in rural areas would not be particularly
6 welcoming of a style of delivery of care that effectively
7 undermined the ability to grow local services, and from
8 time to time, that can be exactly the outcome of FIFO-based
9 services, that you don't grow a local service because
10 you've got a great FIFO service. And an example, and no
11 disrespect to any of the specialists who are doing fabulous
12 work for us in this regard, would be our Dubbo orthopaedic
13 service, which is largely provided by orthopaedic surgeons
14 out of Northern Sydney. Great service. Fantastic people.
15 They fly in, they fly out. They've been doing it for years
16 and years and years and years. But the consequence is,
17 there is no homegrown orthopaedic service in Dubbo.
18
19 Q. So were one to be looking to design a more systemic
20 networking approach that at least provided potential access
21 or availability of specialists from metropolitan hospitals
22 to deliver care in rural and regional areas, an important
23 component of that would be to ensure that part of that
24 planning involved facilitating training opportunities for
25 specialist registrars in rural and regional LHDs with
26 a view to ideally growing one of your own and relieving the
27 Sydney or metropolitan LHD of the need to continue
28 delivering those services?
29 A. That would be true, and I must stress that there are
30 many examples in our local health district where
31 specialists do come out from metropolitan LHDs,
32 hyper-sub-specialists come out. The question is around the
33 formality of that, the planned nature of that as opposed to
34 the individual has an interest in doing that, and in doing
35 it in a way that's well structured, and of course - with
36 trainees and so on, and of course when you get to that
37 point, you also have to address the issue of funding. So
38 there are - I would - it would not be difficult for me to
39 imagine that there were specialists who would be prepared
40 to come to rural and remote, larger centres, so we're
41 talking Dubbos and Oranges and Bathurst potentially, or
42 some of our other procedural sites - they might well be
43 willing to come out here, but the LHD is unable to
44 redistribute its funding across all of the services that it
45 has to provide in order to free up the cash to support that
46 expansion of service.
47

1 Q. Is that part of the problem that contributes to what
2 you have told us at paragraph 84 of your statement, if you
3 could turn to that? You identify some challenges.
4 A. So one of the challenges is the complete hyper
5 fragmentation of many parts of the health system. There
6 are many, many organisations that will bring in FIFO
7 medical specialist services or other types of services into
8 a town. Keeping track of that is impossible. Even from
9 a local town - I remember, I went to the Warren shire not
10 many years ago, community meeting with the shire and so on,
11 and one of their big issues was "We're getting really
12 frustrated because we hear after a specialist has been in
13 town that they have been in town and, had we known, we
14 could have done this". And the whole point that they were
15 making was that, even at a community level, they didn't
16 know.
17
18 And there are multiple agencies who may bring in those
19 specialists. I remarked in testimony, I think - early in
20 the week someone described the Commonwealth funding the
21 Rural Doctors Network, who was funding RFDS to bring in
22 specialist services into various parts, and that's
23 a fabulous system. Our community benefits hugely from
24 that, but I have just described multiple players who are
25 doing hand-offs to each other in order to deliver the
26 outcome on the ground and that does seem to me a rather
27 fragmented approach. No disrespect to the partners, and
28 I value hugely our relationship with the Rural Doctors
29 Network and the work that they do and the way that that
30 occurs, but alongside that, you will have an AMS that may
31 be doing the same thing. You may well have a specialist
32 who has a relationship with a general practice doing the
33 same thing. You may well have a whole lot of private
34 specialists who are just doing it off their own bat and you
35 may have us doing something, and it changes all the time.
36
37 So trying to give our community - us, who work in the
38 system, let alone our communities - a sense of a planned
39 approach to the provision of outpatient medical specialist
40 or specialist services is almost impossible and, again,
41 I think it comes back to the way the system has been
42 developed over many, many decades, has essentially emerged
43 out of private practice, and private practice is a hugely
44 important part of the Australian health system, I am not
45 being pejorative in any sense about that, but there is
46 certainly a role for both NSW Health, local health
47 districts, all of the other players, through the kind of

1 planning processes we talked about earlier today, to have
2 a more planned approach to the provision of those services.
3
4 Q. Let's come to the planning process. You have told us
5 that your LHD has long recognised the limitations of
6 a facility-centric view to planning an operation. Could
7 you just explain in a little bit more detail what you had
8 in mind when you referred to that facility-centric view and
9 what it is that your LHD does which is a little bit
10 different? That's paragraph 46, if that helps.
11 A. Thank you. A lot of the planning mechanisms that are
12 used within NSW Health - I made the statement earlier this
13 morning - they are really driven by the needs of capital
14 processes to prioritise limited capital funds - which
15 hospital needs to be renovated, rebuilt and so on - and
16 there is nothing wrong with that. Those processes are
17 fundamentally better today than they were, in my opinion,
18 even in the five, six years I've been in western
19 New South Wales. A lot of reform has gone on in making
20 them better systems of prioritisation and allocation.
21
22 However, they are all based around the facility.
23 A good example would be we have done a lot of work in
24 health clinical service planning for the three towns of
25 Wellington, Narromine and Dubbo. Narromine and Wellington
26 are sort of 35, 40 minutes away from Dubbo. It makes
27 absolute sense that we would operate those three facilities
28 as a network. They could have sub-specialisation, for
29 example, rehabilitation in one of them and perhaps care for
30 older people, by which I mean - I don't mean residential
31 aged care, I mean clinical medical care for older people -
32 in another, for example.
33
34 So we did all of that planning process around
35 a network of hospitals, based on the needs of the services.
36 We've had to redo it all, because providing a networked
37 approach across multiple communities and multiple hospitals
38 didn't fit the modelling and the assessment processes that
39 are used around these things. So we've literally spent
40 a year, having done what I think was some pretty innovative
41 work to bring things together, to segment them apart again
42 to fit the process.
43
44 Another example might be, and I think we've made it
45 pretty clear, it would be easier for me to justify
46 a planning process around an MPS in a small community,
47 putting resources into doing that, because I know that

1 there will be a capital funding process at some point,
2 hopefully round 6 of an MPS program, jointly funded by the
3 Commonwealth and state. So I can justify getting ready for
4 that, putting staff into a planning process.
5
6 But what if the real planning need or the needs of
7 that community had nothing to do with a facility? What if
8 it had to do with the distribution of kind of resources
9 and, in fact, infrastructure was not the need of that
10 community, so it was in the provision of services in the
11 community in a different way, let's say through extended
12 general practice or extended roles of nurses or allied
13 health or, indeed, even as we heard from our fabulous
14 mental health team yesterday, I think, the involvement of
15 peer workers in a community, et cetera. None of that fits
16 easily into the traditional planning processes, which are
17 quite rightly heavily based around this is the
18 facility-based service that you have traditionally
19 provided. We're going to have to upgrade those facilities
20 at some point of time, or the community need has changed in
21 a facility sense, so let's plan on that basis.
22 I understand why NSW Health does that.
23
24 It's a very different basis of planning than you would
25 plan if you started with the question of what are the
26 health outcomes we want for this community and, secondary
27 to that, asked what are the ways to deliver that, some of
28 which might be through facilities.
29
30 Q. Is that further complicated by the reality - and
31 correct me if it's not a reality - as I heard you say
32 earlier that much of what exists out there in terms of
33 infrastructure for the delivery of health care across your
34 LHD, and no doubt many others, is the product of history
35 and not some careful planning process?
36 A. Well, I wasn't here 50 years ago, and so I don't know
37 what the planning processes were back then, but the point I
38 was making is the community has shifted vastly. Much of
39 the infrastructure across New South Wales, particularly in
40 small towns, will reflect the needs of generations gone by.
41 You know, we used to need TB hospitals, we used to need
42 quarantine hospitals of one kind or another that we no
43 longer need or use today.
44
45 Having said that - and I want to make this very, very
46 clear - my view, and I think it's also - well, it is the
47 LHD's view, there is far too much rigidity in the system to

1 enable sensible reinvestment or evolution of the ways in
2 which we're investing to improve the health outcomes for
3 our community.
4
5 What I'm not saying when I say that, because my
6 community has some of the worst health outcomes in
7 New South Wales, some of my communities, some of the
8 poorest communities in New South Wales, and one of my great
9 fears, and I have lived through this in a different
10 country, where countries go into recession, we saw it in
11 the UK, we certainly saw it in New Zealand - when a country
12 goes into an extended recession economically, all of the
13 things that the political processes have been avoiding get
14 dealt to very, very quickly, because they are no longer
15 affordable.
16
17 So the idea that you might no longer have a community
18 hospital in this community because it is no longer needed,
19 but you might have an investment in community-based
20 services in that community that's really viable - general
21 practice, viable general practice and all the rest -
22 doesn't come to the table when you are closing things
23 because the country is in recession, and one of the great
24 difficulties in Australia is, of course, we've had several
25 decades of no recession at all, and long may it continue,
26 but what it means is that the reliance on adjusting and
27 ceasing inefficient and uneconomic investments and ways of
28 delivering services is not easy to progress, because of
29 course the political will, or indeed even sometimes the
30 will of the bureaucracy, people like me, to take on wicked
31 problems that you know are going to be highly resisted and
32 very difficult to work through in communities in a way that
33 keeps them on board - we've got plenty of other problems in
34 our day jobs to address instead.
35
36 So one of my fears is we will get forced there in
37 circumstances where, in fact, resources depart from the
38 very communities that need more resource, not less, on the
39 back of forced change because of economic recession.
40
41 Q. That's to say, that during a time of austerity, you
42 might have the closure of an inefficient hospital, for
43 example, through necessity, but what you don't have at that
44 time is the luxury of the reinvestment of the moneys which
45 are needed to actually meet the genuine health needs of
46 that particular community in the way that they could better
47 be met?

1 A. Yes, and a very good and practical example of what I'm
2 describing in our district, fabulous people, great staff,
3 great communities, but I have seven emergency departments
4 fully staffed 24/7, nursing and sometimes other staff, who
5 see fewer than 1,000 patients a year. The consequence of
6 that is I have emergency departments seeing 45,000 people
7 a year, 25, whatever the numbers are, who I struggle to
8 staff, or another consequence might be, because I've got
9 a staff member who has to be there, so it's a stand-by
10 cost, they - we want them there, we hugely value them, they
11 have to be there, but the utility for the patients coming
12 through the door or the community is really low, because
13 they see a small number of patients per shift compared to
14 any other part of the health system.
15
16 And if I was to hypothetically say "Actually, I would
17 rather take all that money and invest it in a really great
18 community-based intervention that reduced as far as
19 possible the need for an ED in this town", for example, it
20 really heavily invested in community drug and alcohol
21 services, or whatever the issue was in using the same cash,
22 it would be virtually impossible to do that without
23 a substantial rigidity and substantial political push to
24 and fro right throughout the system.
25
26 I'm not suggesting that - there is a real community
27 need and interest that's very legitimate for both the
28 parliament, political parties, bureaucrats to recognise.
29 We're stewards and servants on behalf of our communities,
30 but it does worry me that the flipside of that important
31 public duty is also an ability to ignore very real and
32 genuine ways to realign the system, until it is too late,
33 and that's what I worry about within the New South Wales
34 health system, not so much because of NSW Health but
35 because the complexity of what I'm talking about, planning
36 with communities, going on a journey of investment in the
37 things that produce the best outcomes for that community,
38 is not easy, it is not simple.
39
40 I could pick one small town in our district, and I've
41 got many small towns in my district, and I could guarantee
42 you that would be a full-time preoccupation for me as chief
43 executive probably for 18 months to get from whoa to go,
44 and that's the nature of doing it well. Now, none of that
45 transition, none of that process of transition is
46 necessarily catered for particularly well in an ABF model.
47 If I can use the example of the Four Ts, which I have

1 spoken about before, it is a good example of where we have
2 done something, although we have four poorly utilised
3 EDs generally - that's unfair, two of the four are probably
4 poorly utilised now because the model has been very, very
5 successful. But all of the process, all of the manpower,
6 the brain power, the whatever, to deal with that was funded
7 by the LHD. In fact, somebody gave evidence the other day,
8 I think it was the Lachlan Shire Councillor, of believing
9 the Commonwealth had given a grant to them. That was not
10 the case. That was all funded by the LHD. The
11 Commonwealth gave a grant for an evaluation of that model
12 post the event, which is great and we welcome that, but it
13 was all bankrolled by the LHD in the days when we actually
14 had a bit of head room to bankroll stuff which is not
15 today, and the reality is the LHD, because we're not
16 experienced in running general practice, we made
17 substantial losses for a couple of years on the back of
18 that while we were learning how to run complex general
19 practices and bill in the right way, and I'm talking close
20 to a million dollars a year on that transition across those
21 four towns.
22
23 There's no other entity in the health system that
24 could possibly have underwritten that change, but there was
25 no underwriting of the LHD in making that change.
26
27 Q. In relation to that --
28
29 THE COMMISSIONER: Sorry to interrupt, can we just go back
30 a step.
31
32 Q. The seven EDs that you mentioned that see fewer than
33 1,000 patients, I assume, one, you have got the data on
34 this, but I will just ask you: I assume it is not a
35 thousand people in triage category 1. What are they
36 typically going into these EDs for?
37 A. As I think I indicated earlier, Commissioner, every
38 LGA, or every facility, rather, in Western New South Wales
39 has a much higher presentation of category 4 and 5 patients
40 than New South Wales as an average.
41
42 Our district maintains a comprehensive database of
43 activity, a whole range of issues, distances to other sites
44 and all those kind of things, where we're looking
45 intensively at the services that we provide and what might
46 be better, but I hasten to rapidly add, having made that
47 statement, so we do have a lot of information and data that

1 we've deliberately pulled together, because it is a real
2 issue for us, we do not have a plan, there is no
3 deliverable plan, we have some ideas. We are not so
4 arrogant as to assume that we would have the right answer
5 for a community. It is a place-based planning process with
6 the community that determines that answer. But we
7 certainly have, and I am led to believe by colleagues in
8 the ministry that Western New South Wales probably has the
9 most mature and advanced database that would support
10 place-based planning around the services that we provide,
11 not only EDs but other kinds of services, of any LHD in
12 New South Wales.
13
14 MR MUSTON: Q. Let me ask a quick question about the
15 Four Ts. You indicated that there was, I think,
16 a $1 million per annum shortfall during a process where
17 you, as a traditionally non-operator of a GP practice were
18 learning how to deal with the billing and the efficiencies
19 of an enterprise like that. Is that continuing, or is that
20 something which, through that process of learning, has
21 abated?
22 A. Definitely abated and still being worked on. So we
23 did both evaluations but also economic evaluations and then
24 got an independent third party who really understands
25 primary care to look at how we were billing and what we
26 were doing and our practice manager is actively working
27 through with our staff, general practitioners and making
28 sure that we maximise the billing opportunities through our
29 primary care services.
30
31 Our sense is at the end of that we will still have
32 a slight deficit per annum, but compared to the alternative
33 of having to supply locum GP VMOs into those towns to run
34 effectively episodic crisis services rather than general
35 practice, it's still a cheaper option. So it's an
36 underwriting that we're prepared to live with it. It's of
37 the order of $100,000 or so, maybe 200,000 a year, across
38 those sites, but nothing of the order that our learning
39 curve in delivering general practice exposed us to.
40
41 Q. Acknowledging that without any sort of formal
42 modelling it's probably not much more than an educated
43 guess, but the deficit, such as it might be, which is
44 referable to operating the Four Ts program, would be
45 eclipsed, would it not, by whole of government savings
46 derived through the health benefits delivered to the
47 population that are receiving adequate primary care in

1 circumstances where they would not otherwise be receiving
2 it?
3 A. Oh, unquestionably.
4
5 Q. Could I just take you to the place-based planning and
6 the service planning. I take it that when we're dealing
7 with place-based planning, what you are telling us is the
8 best way to approach the planning of a health service is to
9 start at the bottom, smaller communities, smaller areas,
10 and move your way up to look globally at the way in which
11 they all interact - would that be right - as opposed to
12 what might traditionally have been done, which was either
13 provide a global solution for everyone, that's a top-down,
14 or to use your term, the facility-centric view, which is
15 let's identify a hospital, we've gone into planning
16 processes around that, without thinking more widely -
17 somewhere in the middle is a more appropriate approach.
18 Would that be right?
19 A. That's right. You don't want to plan at too small
20 a level because you will never get agreement around
21 realignment of the investment or all those kind of things,
22 and everyone will want a cardiac unit in a town of
23 100 people, given the opportunity.
24
25 Q. The starting point is identifying your health needs,
26 certainly not on a street-by-street basis, maybe not even
27 on a town-by-town basis, but within blocks of the community
28 where you think you have identified a reasonably
29 homogeneous group of health needs which could be met by the
30 provision of - the local provision of services which should
31 be delivered locally?
32 A. We will tend to do that at an LGA level. Sometimes
33 that's not granular enough. So, for example, if we were
34 looking at Weilmoringle, we would want to do that at a far
35 more granular level than an LGA. But generally an LGA is
36 about the right size of constituency to try and plan
37 across.
38
39 Q. So having mapped out your health needs in a way in
40 which those needs are distributed across the region, next
41 step in the process is to map out what might be considered
42 the optimal and equitable health system that will deliver
43 on those needs to that community, accepting that precisely
44 what that might look like could be contested?
45 A. That's right, and they could be concurrent, because
46 one is a question of philosophy and the other is a question
47 of scientific evidence.

1
2 Q. So is that a process that you currently undertake in a
3 place-based way, or in an LHD-wide way?
4 A. I think as you heard from both Maryanne and myself
5 previously, there isn't a clear definition of what is the
6 appropriate kinds of services for any particular sized
7 population in its context, and I would suggest that would
8 beneficially be done, at the very least, at an LHD level,
9 but I would actually suggest it's, to be honest, more of
10 a state level of issue, because of course the questions
11 we're grappling with are fundamentally political ones, they
12 are ones of the nature of the implied contract between
13 voters and the government.
14
15 Q. There comes a point, doesn't there, where in order to
16 give, say, an LHD or a health service flexibility in
17 delivering the needs which are actually there, something
18 that hovers a little bit lower than that political level in
19 terms of deciding what is an optimal health service for the
20 delivery of those health needs is --
21 A. In the example that I gave, and this is prospective,
22 so it has not yet happened, where we want to undertake what
23 we understand to be really thorough place-based planning,
24 that will be supported by a health needs assessment, it
25 will be supported by an interactive series of dialogues
26 about what, for these communities in this particular part
27 of our district, is an appropriate distribution of not -
28 not distribution, but what kind of services should be
29 available for the people in the particular towns in these
30 communities, which could be anything from no service to
31 some service, or service that comes in on an ambulatory
32 basis through to something that's permanently there, then
33 overlaying that - so what's there now, which may be not
34 only our services but services provided by other providers,
35 as best we're able to determine that, given the multiple
36 funding sources that go on --
37
38 Q. Coming back to an example that we've discussed
39 already, primary care, to the extent that you regarded
40 primary care as a not negotiable for a health system that
41 adequately meets the health - optimally meets the health
42 needs of a population, if it's not there at all and you see
43 that as a gap, which is part of your planning process, you
44 think at least in terms of putting on paper that optimal
45 health service, "How are we going to fill that gap". If
46 there is something there in the form of a market, and it's
47 a viable market, then presumably you take the view not

1 unreasonably, "Well, there is a gap we don't need to fill"?
2 A. Not only not unreasonably, I think the role of the
3 government is not necessarily to try and do all things
4 which private enterprise can do satisfactorily.
5
6 Q. Certainly not things that private enterprise are
7 already doing perfectly adequately?
8 A. That's right. Absolutely.
9
10 Q. And I think you mentioned a moment ago, obviously
11 enough, you can't provide every service in every location,
12 otherwise everyone would want a cardiac unit and everyone
13 would want all manner of other things, which on no rational
14 view are needed. So at some point, whether it be at
15 a political level or at an LHD level, someone has to make
16 a hard decision about what is going to be or needs to be
17 provided as part of the optimal health service for
18 a population?
19 A. That's right, and taking into account clinical safety,
20 what should sensibly be provided, because we know we can
21 safely do it versus what we sensibly should not provide
22 because we know we safely cannot.
23
24 Q. So you have identified the needs of the population,
25 you have identified, starting with place-based assessments
26 but considering each of those separate places as a system
27 or a network that feed into one another, what the actual
28 optimal health system might look like for the delivery of
29 equitable health care to the populations across the LHD,
30 and then I think the next step, you say, is you identify
31 from all of the sources, both what you are delivering
32 yourself, what other entities, including the private
33 market, might be delivering, and then you look at the gaps?
34 A. Yes. The absolutely essential component that we
35 haven't talked about is then you not only have to think
36 about the local place base that you are planning, but you
37 have to think about how it connects with the rest of the
38 health system. So, for example, if I was planning services
39 in Bourke, I would need to understand how we meet the needs
40 of health - of the community of Bourke in the context of
41 where the regional hospitals are and what they provide, in
42 the context of the transport infrastructure, both emergency
43 and non-emergency between those communities. And then
44 I would have to understand that in the context of the
45 relationships between, in this case, the hospital in Dubbo,
46 and the rest of the NSW Health, tertiary and quaternary
47 system, delivered out of metropolitan Sydney, and how all

1 of that connects together. Because it is the overall way
2 that you're going to meet the health needs of the community
3 in Bourke that you are trying to solve and some of those,
4 sensibly, would never be met outside of metropolitan
5 Sydney. So it is the escalation, and that's the beauty of
6 NSW Health, I have to say, having worked in many other
7 systems - the ability to work as a cohesive whole and plan
8 together.
9
10 We have, in our case, in our district, not all
11 services but the vast majority of tertiary services are
12 provided out of Royal Prince Alfred or Sydney Local Health
13 District, and we have a very close and interactive
14 relationship, both in a day-to-day sense, how we transfer
15 patients to and fro and between specialists picking up the
16 phone, talking to each other about the care needs of an
17 individual, but also in terms of how that network flows
18 between the two LHDs in terms of the planning and design of
19 services, and you will see a very good example of that when
20 you go to Far West, with the virtual support into their
21 critical care services there.
22
23 Q. In terms of - I won't use the term disinvestment - the
24 evolution of existing facilities into facilities that might
25 better meet the needs of a population in a system-wide way,
26 how do you deal with that? You talk about a lot of
27 rigidity, but do you have a view about how best to push
28 through that rigidity and produce results which are to the
29 benefit of the health system but also to the population in
30 these small communities?
31 A. You can only do that with open and transparent
32 dialogue. But, also there has to be system transparency,
33 which is why, to me, it is so important that we look at how
34 the Commonwealth and the state health funding systems come
35 together, particularly for small rural and remote towns.
36 So that you can actually get to the point of saying,
37 "Actually, the funding available to you in this community
38 is equitable compared to the funding available to a similar
39 sized part of Northern Beaches", for example. So that the
40 community understands that, in fact, they are not being
41 short done by, adjusting not only for head of population
42 but the equity in their health status and whatever, and
43 from that sense of transparency across the whole system,
44 you can then start to have very transparent conversations
45 around, actually, you know, the value of an emergency
46 department that sees triage five patients largely, a
47 thousand a year, compared to all of that money going into

1 something else, in terms of the health outcomes for our
2 community, let's have a conversation about does that work.
3 We've only talked about EDs, but there are many other
4 examples that I could talk about in terms of the way that
5 historically services have been delivered and I think,
6 I don't want to leave the impression it is only about EDs;
7 it is actually about everything provided in that service,
8 in that community.
9
10 Q. I think you have told us in paragraph 148 that the MPS
11 model has not continued to evolve with changing
12 demographics and health care delivery trends. What did you
13 have in mind when you --
14 A. So the MPS model was an absolutely fantastic model for
15 rural communities. It was a solution to a set of problems
16 back - I think it was around the '90s some time when it
17 started to evolve, and particularly around the
18 sustainability of more acute services in those towns.
19
20 The contemporary situation, as such, is that the real
21 crisis that requires solution is primary care in those
22 towns. So I'm a very strong advocate that, in fact, the
23 consideration of how we grow and develop MPSs in towns that
24 don't have viable sustainable primary care should
25 absolutely evolve and mature to be a model that is about
26 aligning aged care, primary care, community services and
27 that kind of - because that's the core of what a service -
28 the services that a community need in place.
29
30 Now, there may also be considerations of the ED and
31 all of those kinds of bits, but it is a fundamentally
32 different - the core of what you are trying to do is
33 provide aged care and primary care that's really robust,
34 and primary care, I'm meaning far more than general
35 practice. Some of that may not be in any institution, it
36 might be in people's homes in the community, or whatever.
37 That's the core that the MPS model should be, in my
38 opinion, evolving towards in future rounds of MPS funding,
39 and in some towns, the MPS may end up not having an ED or
40 sub-acute beds at all, because it is the better solution,
41 whereas in another town, in fact, they may be entirely
42 important things because, in fact, the presentation rates
43 and the needs for that may be entirely important.
44
45 Of course, for every service that you take out, then
46 you have to work through, so what's the alternative, what's
47 the risk that the community's prepared to wear, how do we

1 address those kind of issues. But, again, I just come back
2 to, and I in no sense - do any of my staff or any of my
3 communities should be hearing me to be dismissive of the
4 hugely important work that they do, but the reality is the
5 value to the community of a well-staffed bed in an MPS
6 facility that has nobody in it is zero.
7
8 Q. Important in that process, though, is, I think you
9 said earlier, a strong process of dialogue with the
10 community that is most directly affected by the decisions
11 that we're talking about. We often hear the distinction
12 between doing things for people or to people, on the one
13 hand, and doing things with people on the other. It's the
14 latter that's most effective, is it not, in terms of
15 bringing a community along on the journey towards shifting
16 that slow-moving oil tanker that is their branch of the
17 local health service?
18 A. Unquestionably. We are servants of the community,
19 we're public servants. It is a public health system. We
20 need to work with our communities and bring them with us.
21
22 Q. Similarly, in a system that's always going to be
23 dynamic, having planned, it's important to carefully
24 monitor the extent to which whatever services have been
25 planned and are in the process of being delivered are
26 actually meeting the needs or achieving the objectives that
27 are intended?
28 A. Absolutely.
29
30 Q. Continuous and careful consultation with the community
31 that is being served by that system, again, is an important
32 part of that process?
33 A. Yes.
34
35 Q. How, in your view, is that best done, that
36 consultation process within, say, a small community that's
37 had - gone through an evolution, they have at least, by and
38 large, come along on the journey, how do you consult with
39 them and continue --
40 A. In the hypothetical example that we've talked about
41 this morning.
42
43 Q. In the hypothetical example that you are soon going to
44 be looking at --
45 A. That's right.
46
47 Q. -- as part of your place-based planning.

1 A. So on the assumption that we've moved beyond a "Let's
2 just let lack of workforce make all of the tough decisions
3 that a lot of other people are paid to make" and we get
4 into a better world, then I think Maryanne spoke to you
5 about something we're trialling here in the district and
6 progressively expanding, it's very intensive work in terms
7 of meaningful community engagement, we've started
8 a regional planning committee or regional committee
9 process, we have one around Dubbo and we have one around
10 a number of the northern towns in our district and we want
11 to expand into another area. It is hugely intensive work.
12 I would argue - I've been unable to adequately resource it
13 in the LHD yet, we will find a way to do that as we expand
14 forward.
15
16 The difference between that and the old hospital
17 board - they were fantastic, but the local health committee
18 type of structure tended, over time, to become
19 non-representative of its community. We would have the
20 local pharmacist, it would have people of the type who
21 naturally gravitate to being community leaders who may be
22 very, very different in every aspect of who they are
23 compared to the community at average. So we've tried very
24 hard to work with a range of bodies to make sure we've got
25 very representative people. In fact, on both of those
26 committees I've described, the northern one, I think,
27 57 per cent of the participants in that community are First
28 Nations people and in Dubbo I think it's about 50 per cent.
29
30 Trying to get into having genuine members of the
31 community - sorry, that's a terrible phrase, to have people
32 of the community who reflect the diversity of the community
33 rather than just a part of it. And that's an ideal
34 framework, both to support planning, as we move forward,
35 but also to support monitoring and evaluation, and as we've
36 heard over the course of the week here, sometimes the views
37 of how well things are going in communities - that the
38 community have, differ fundamentally from how well the
39 views that organisations might have at a distance, people
40 like me.
41
42 So we have to be open to be on the ground, to hear in
43 a respectful and an open way about the reality of what's
44 going on and to provide those committees with information
45 around actually how are the outcomes from the community
46 being achieved over time; what is happening to the health
47 of the local community; listening to their concerns. And

1 a really good example of that has come out of the Dubbo
2 regional committee, committee members in Narromine were
3 very, very concerned about vaping, particularly by
4 adolescents in their community, and it spanned a whole
5 community project, education got on board, the schools got
6 on board, we got on board. That was the one thing that
7 they really wanted to see an intervention in health in
8 Narromine - there were many other things, but that was the
9 really big top of mind thing. And it spawned an actual,
10 very visible series of interventions into that community
11 that will be ongoing around vaping.
12
13 Now, we simply don't have the resource to do that
14 everywhere, but we did have the resource to focus on
15 something that had arisen from the community and it will
16 now feed into the outcomes ongoing for the people involved
17 in that community, and you can imagine, as you get into
18 a more mature and stable state of realigned services, you
19 have rebalanced between primary and hospital services where
20 investment was running, assuming that you've got the state
21 and Commonwealth to agree to take a pooled funding approach
22 and all of these kind of very achievable but very difficult
23 to achieve things, then you can have a conversation about
24 "This is what the health of our people looks like. This is
25 what the service gap is this year compared to last year, or
26 last five years. This is where the needs of the community
27 are shifting because the demographics of the community are
28 shifting, and this is where we should be investing".
29
30 Q. It is particularly important in your region to engage
31 in a genuine collaborative way with First Nations
32 communities?
33 A. Absolutely.
34
35 Q. Their particular circumstances, particularly where, as
36 I think you have mentioned earlier, if you have large First
37 Nations communities living in remote areas, the way in
38 which you might approach the engagement and planning of
39 services for what might be regarded as a small population
40 in a remote area could actually be quite different, having
41 regard to the objectives that you are seeking to achieve
42 through that engagement and delivery of health care?
43 A. It will be fundamentally different.
44
45 Q. Did you have an opportunity to hear the evidence given
46 by the Murdi Paaki assembly?
47 A. Yes, I did.

1
2 Q. Without wanting to go into any of the specifics of it,
3 one was left with the sense that at least the chairs of the
4 community working groups or working parties who appeared
5 did not have a sense that they were being well engaged in
6 relation to service planning and the adequacy of the
7 delivery of service within their areas. Is that something
8 that you were alive to before that evidence?
9 A. Perhaps I can step back.
10
11 Q. Please do.
12 A. One of the reasons that the Murdi Paaki Regional
13 Assembly and the local decision-making community chairs
14 presented evidence to the Commission was because the LHD
15 suggested that, in fact, the Commission should reach out to
16 them. Because in our LHD, we believe that giving a voice
17 to our Aboriginal communities is fundamentally important.
18 We were in a position of power in this process to open the
19 door. We didn't know what they would say.
20
21 But, in opening the door, nothing that I'm about to
22 say - I absolutely do not wish to reject the testimony that
23 was heard, because, as you will know from any other court
24 process, you can have two witnesses to an event who have
25 entirely different views of what actually occurred as
26 a matter of fact, and my responsibility as chief executive,
27 and I think the health system's responsibility, is not only
28 to open the door so that people can have a voice, but when
29 they speak, to listen, rather than refute.
30
31 So in that context, I think they gave hugely valuable
32 evidence for us as a committee. It was extremely
33 distressing, some of their stuff. I found it distressing
34 at times, and I know a number of our Aboriginal staff found
35 it distressing for differing reasons.
36
37 However, having said all of that, there is also
38 a reality that some of those present are on our regional
39 planning committee in the north, we're evaluating that, and
40 I think Maryanne spoke about that yesterday, and in fact,
41 we know - I know from early conversation about the
42 evaluation - that it is actually being very positively
43 received by both Aboriginal and non-Aboriginal people
44 involved in that process. We agree, and I absolutely
45 agree - and it had already been raised with us by the
46 regional assembly - that we could improve that engagement
47 by involving the chairs of the community working parties

1 moving forward, and so we're - and we had already begun and
2 we're in dialogue over how we might bring the community
3 working party chairs into that process. That will occur
4 and I actually think from the evidence that we heard
5 yesterday, or whatever day it was, it made me even more
6 convinced of the absolute importance to make sure that
7 First Nations people have a voice in our planning
8 processes.
9
10 Alongside that, of course, we have for many years had
11 accords that we have entered into with our regional
12 assemblies, both Murdi Paaki, Three Rivers assembly, they
13 are accords that happen at a higher multi-agency level of
14 government, but they have schedules in them and one of them
15 relates to health and, through that process, Aboriginal
16 health and wellness directorate, executive director, will
17 enter into negotiations about what should be in a schedule,
18 issues of importance related to health, and out of that
19 comes action plans that we try and progress together,
20 moving forward.
21
22 We would all say that we've got to do a lot more work
23 to actually achieve the aspirations and outcomes. Our
24 organisation has a Reconciliation Action Plan, it is the
25 second one, I think, or one of very few parts of NSW Health
26 that is now on to its second, next tier up Reconciliation
27 Action Plan that we're absolutely committed to, to
28 delivering better outcomes, and part of that is about
29 listening, giving agency, giving voice to our First Nations
30 people, whether they be staff, whether they be consumers,
31 whether they be communities, and working out how we're
32 going to deal with what are sometimes very uncomfortable
33 learnings for when different cultures that have vastly
34 different histories and vastly different experiences of
35 modern Australia, let alone historical Australia, try and
36 come together to work out how we move forward together.
37
38 Q. Could I move to another issue very briefly. Could you
39 go to paragraph 41 of your statement where you deal with or
40 reach some conclusions in relation to mental health issues.
41 I just want to ask you if you could expand upon the last
42 sentence there where you say there is a suggestion that
43 people are being exposed to harm because of deeply
44 ingrained silos that exist between mental health services
45 and other types of clinical care within the health system
46 generally. What did you have in mind when you were --
47 A. Well, the evidence that we give in our statement and

1 indeed in the diagram following on - on the page following
2 is that for people who have a mental health condition,
3 their personal health outcomes - that is, their non - you
4 know, their physical conditions - I think at the top of
5 that graph we show life expectancy on average. It would be
6 fundamentally different for people with a mental health
7 condition than people who do not have a diagnosed mental
8 health condition. There are a whole range of factors that
9 might lead to that. It could be their medication and so
10 on. It might also be, in fact, the stereotypes that come
11 with people when they interact with other parts of the
12 health system about the quality of care that they receive.
13
14 This is very new evidence within NSW Health. I take
15 my hat off to the Ministry of Health, the mental health
16 branch, who have been doing a really deep dive project on
17 behalf of mental health consumers to look at what their
18 experiences are in terms of health outcomes in other parts
19 of the health system, and what the evidence shows is that
20 they are far more likely - consumers, on average, with
21 a mental health condition, are far more likely to be
22 admitted to a hospital for a condition that could have been
23 prevented; far more likely to turn up to an ED with
24 a condition that could have been prevented; far less likely
25 to be undertaking some kinds of sensible screening
26 activities or disease prevention activities than other
27 members of the community. And the net result is, in our
28 district, something like 13 years difference in life
29 expectancy for those with a mental health condition than
30 those who don't.
31
32 We have similar analyses, which are much better known
33 around, for example, First Nations people. But this is new
34 work, and what it has meant for us is we have picked that
35 up locally, we have started to target some interventions
36 between our mental health team, our Planned Care for Better
37 Health team, because there is a huge correlation, as you
38 heard from Helen and Warren the other day, between people
39 with a risk of hospitalisation and mental health conditions
40 and a whole range of other social determinants - the
41 ability to, if you like, take control of society rather
42 than be on the ebb and flow of just opportunity in society,
43 including housing and everything else. And to wrap around
44 services for those people, which may have nothing to do
45 with health - housing would be a great example - but to
46 help them navigate the system, because one of the things
47 about health is it is such a complex system, I - the best

1 thing that anybody who works in health can do is be
2 a patient in a hospital. If every nurse, if every doctor,
3 if every allied health person, if every manager, if every
4 bureaucrat or whatever label we want to put on anyone would
5 find themselves in an emergency department in dire need, or
6 their family in dire need, and then navigate through the
7 health system with them, they will come out the other end
8 with a fundamentally different view of the kind of care and
9 the way that they should provide care and an understanding
10 of how that care is provided than prior to that experience,
11 because they'll have lived experience of it and they'll see
12 it warts and all in a way that you don't see it when you
13 are just a practitioner in a part of the system.
14
15 The same is true for mental health people, which is
16 there is this hugely important research, hugely important
17 that we pick it up and do something with it, and what it
18 really points to is, in fact, if we think about the mental
19 health services traditionally, the argument - I will make
20 a pantomime of it, but for purpose, the argument would have
21 been "They don't have a mental health - that's not a mental
22 health problem, that's a physical problem, go and see the
23 general medicine team".
24
25 Well, the general medicine team would say "That's not
26 a physical problem, that's a mental health problem, go and
27 see the mental health team". The consumer is stuck in the
28 middle. And, at scale, the kinds of indications that we're
29 seeing here, are in part that kind of siloing going on
30 before, but equally in part, and you heard a bit of this in
31 a way from Martin in his testimony - these people, well,
32 many of them won't have a general practice attachment. If
33 they do, it's highly likely that they won't be seeing the
34 same general practitioner when they turn up. It's far more
35 likely they can't afford to turn up, and it's far more
36 likely that, for whatever reason, they feel marginalised
37 from the primary care system so they don't have
38 a connection anyway.
39
40 And many of the things that we're talking about here
41 are the impact of chronic diseases for those people that
42 are far better addressed somewhere else in the health
43 system. And traditionally mental health services would not
44 have looked at that. I think you heard some wonderful
45 evidence from Helen and Warren the other day, and in my
46 statement, and I'm not sure about anybody else's, but
47 certainly in mine, I allude to some of the interventions of

1 the Planned Care for Better Health team that we have
2 underway in mental health services, working with them,
3 precisely to wrap services around people in a way that
4 overcome some of those really intense silos that exist
5 between specialties in the New South Wales health system,
6 or any western - that's not a New South Wales health
7 system - that is the way that hyper specialisation which
8 deals with body parts not with human beings drives you,
9 unavoidably.
10
11 All western health systems recognise the need to try
12 and reintegrate, without losing the advantages of hyper
13 specialisation, because that's how you get better treatment
14 for individual diseases, but if you lose the human being in
15 the middle of that process, you end up treating body parts
16 and nobody comes as a body part. In fact, the body part
17 doesn't need to be treated because, most appropriately,
18 a body part is in the morgue.
19
20 Q. The wraparound service that you have referred to
21 obviously comes at a cost to deliver. Is that a cost which
22 is recognised by existing funding models?
23 A. There are some funding models that support that kind
24 of activity and some of it will be activity funded, some of
25 it won't and we're just navigating that. There is a whole
26 series of changes going on around how mental health
27 services are funded, potentially at this point in time, for
28 their component. Mostly, this is programmatic funded, so
29 it's funded on a "We'll do this for the next year or the
30 next two or three years", so many of our staff who work in
31 this kind of work are actually on temporary contracts.
32
33 Q. Does that present particular challenges for the LHD,
34 the programmatic and time limited nature of some of these
35 funding sources?
36 A. Yes, because in order to be fiscally responsible, we
37 will only enter contracts with staff for the duration that
38 we can avoid being exposed to, for example, redundancy
39 costs if the program ends and is not replaced. I would
40 suggest - and we're doing some internal work - that
41 actually we've been a little more tight in that respect,
42 and provided we enter into employment contracts with people
43 that allows an upfront agreement that if the program ends
44 they will be willing to be redirected into some other kind
45 of work within their capability within the LHD - and of
46 course not everybody will agree to that, but if we were to
47 have that kind of agreement in a mutually legally binding

1 and agreeable way, then that would overcome some of these
2 difficulties. We're just starting to look at that in some
3 of our services moving forward.
4
5 Q. What's the origin of the time limited program funding?
6 Is it state funding, Commonwealth funding or --
7 A. It could be either. So, for example, our aged care
8 assessment services in the district are Commonwealth
9 funded. Literally - literally, it was about two weeks ago
10 that we received advice from the Commonwealth that
11 contracts that were ending on 30 June could be ended to
12 30 December, because the Commonwealth has agreed to extend
13 the funding for another six months.
14
15 You know, these are specialised staff, and I have to
16 say that I take my hat off to registered nurses, others,
17 who have got a choice of career, that you would be prepared
18 to take the entirety of the risk of the longevity of your
19 employment on short-term funding arrangements.
20
21 Q. So in terms of the challenges presented to the LHD,
22 there is a challenge associated with the time limited
23 nature of the project funding, that is, a year or two
24 years, which in and of itself creates workforce
25 complexities?
26 A. So that can be part of it. I think what the real
27 issue I'm trying to point to is I think we need more
28 sophisticated mechanisms to address that risk rather than
29 expect that risk to be entirely carried by the employee.
30
31 Q. But to the extent that the risk is being carried by
32 the employee, do I hear you to say that that risk is being
33 in the administration of the schemes or in a practical
34 sense exacerbated by the fact that not only are the
35 programs or projects time limited in their funding, but
36 decisions around whether or not to extend it or roll it
37 over for another term are being made so late in the piece
38 that it does literally leave employees in a position where
39 they are wondering whether they are going to have a job in
40 a fortnight or a month's time?
41 A. Yes, and unavoidably so, because many of those
42 programs will be reliant on government processes that
43 establish budgets very close or after the end of the
44 financial year. So to give you an example, and I think in
45 the evidence there's example of the funding, the starting
46 budget for the LHD, which - somewhere in the evidence
47 bundle that was requested and provided. But that starting

1 budget that's outlined there in the service agreement was
2 actually $22 million less than the closing budget of the
3 prior year, because of the programmatic funding, which was
4 then waiting for a subsequent budget process or indeed
5 program decisions, and that happens every year, and it will
6 happen again this year. Sometimes you've got a sense
7 forward for a few years.
8
9 NSW Health is doing the best it can to give chief
10 executives a three-year horizon where they can, but in many
11 cases, they can't, around some programmatic funding.
12
13 To a degree, that is entirely appropriate. Some of
14 this is pilots, let's try this, let's do that. Some of it
15 is very much determined by the discretion of governments,
16 which may of course change in their emphasis of where
17 they - on a policy basis between one government and
18 another.
19
20 Q. I asked you a question a moment ago whether decisions
21 around whether or not the funding of a project would be
22 extended were being made so late in the piece that it
23 literally receives employees in a position where they are
24 wondering whether they are going to have a job in a
25 fortnight's or a month's time, and your answer was "Yes,
26 and unavoidably so". Can I ask for this clarification in
27 relation to the answer. When you say it's unavoidably so,
28 I presume you are saying, from the perspective of the LHD,
29 there is nothing that you have the power to do which would
30 avoid that situation?
31 A. I'm actually saying from the perspective of
32 NSW Health. So NSW Health is unable to spend money for
33 which it has yet to be appropriated.
34
35 Q. But in terms of decisions around project funding, if
36 they were made earlier by those who have the power to make
37 those decisions, be they Commonwealth or state based, not
38 the LHD, that would avoid the situation that these
39 employees are being put in, would it not?
40 A. So that's one possible mechanism, perhaps unfair to
41 a degree, because we all expect government process to
42 readjust priorities and budget at both Commonwealth and
43 state level. What I also alluded to is perhaps there are
44 some more sophisticated mechanisms than we have
45 historically used, both at a NSW Health level and at an LHD
46 level, which might better share the risk, should employees
47 in those roles be prepared to enter into employment

1 arrangements which gave perhaps them less discretion about,
2 if the program ends, within the scope and capability and
3 professional qualifications they have, about work that they
4 might be redeployed to do than is currently the case.
5
6 Q. If I take you to infrastructure planning and delivery,
7 we've canvassed the issue of a site-based or facility-based
8 planning and the potential challenges that that introduces
9 when it comes to your ability to roll out a more holistic
10 health system that meets the variety of health needs of
11 a population. I just want to get down to some specific
12 questions about Dubbo Base Hospital. Like many that we
13 have seen, it is an amalgam of old and new buildings joined
14 together by an arterial network of corridors. The new
15 sections are a phenomenal facility, at least through the
16 eyes of a layperson --
17 A. Mmm-hmm.
18
19 Q. -- who visited it. The old parts of the hospital are,
20 in some cases, in serious need of renovation. Is there
21 anything about the way in which planning and the delivery
22 of infrastructure projects operate within NSW Health which
23 creates particular challenges for you in relation to the
24 way in which the redevelopment of a hospital like that
25 happens - that is, particularly having regard to the
26 significant disparity between the new and the old bits?
27 A. I would hope that today - and I don't know this for
28 certain but it is a hope, and I think it's probably more
29 reflective of today's reality - that what happened at Dubbo
30 was not occurring elsewhere, which is essentially that
31 Dubbo was funded in tranches without any guarantee of the
32 next tranche. I think they've completed stage 4 of
33 a multi-year program over about 12, 15 years in Dubbo.
34
35 We need to do at least another stage. It's not
36 a small investment. Our estimation in today's dollars,
37 we're probably talking well north of 300 million to
38 complete the job.
39
40 Generally today, and there are many examples of that
41 both in our district and others, the entirety of a job
42 would be committed to at the commencement. So that's some
43 learnings of history.
44
45 Moving forward - and of course the commencement of
46 that process is clinical services planning, and we have, as
47 we've indicated before, done the clinical services planning

1 for Dubbo, Narromine and Wellington, precisely so that we -
2 and we do have on our strategic asset management plan, our
3 asset management plan and CIP process, capital investment
4 proposals through NSW Health, we do have Dubbo there. That
5 is, of course, not a guarantee that that will be funded.
6 Ultimately, those are decisions for Dubbo to complete the
7 job. But, by and large, across most large hospital
8 redevelopments these days, you would attempt to do the
9 entirety of the job.
10
11 The difficulty with that is of course the elephant in
12 the room for everybody at all levels of society who are
13 trying to build anything at the moment. I will use
14 Bathurst hospital as an example. We did a similar process
15 to get a redevelopment at Bathurst, an extension of the
16 hospital to meet community demand. Great process with the
17 community. We were successful in getting substantial money
18 from the New South Wales Government in the budget process,
19 200 million or thereabouts, and at the time we thought that
20 was an enormous amount of money that had great head room
21 for it.
22
23 The reality is that the estimated inflation in
24 construction costs, that job's 3 million dollars a month,
25 every month for the last six months. So all of our head
26 room that we thought we might be able to achieve - and
27 I just use that as a particular example that we're working
28 through how we're going to address this issue, but it would
29 apply across any major construction project anywhere in
30 Australia, whether it's a road, whether it is a rail
31 network, whether it is a hospital, whether it is a school -
32 the hyper inflation in the construction industry at this
33 point in time is a significant concern, and I think even
34 the Productivity Commission and Treasury has, at both state
35 and Commonwealth levels, recognised the significant impost,
36 the amount of investment in public infrastructure is
37 occurring, and of course the problem that we've all got is
38 we all want the infrastructure, we all need it, but in the
39 post pandemic era there is enormous inflation occurring
40 that we have to navigate and make the best value for money
41 out of.
42
43 And I take my hat off to those in health
44 infrastructure, those in NSW Health finance department,
45 those in Treasury, those in our own LHD who are grappling
46 with that very, very real and very human issue. Because,
47 of course, all of us want the best outcomes for the

1 communities that we serve.
2
3 Q. You have canvassed a lot of challenges. Are there any
4 that we've missed, significant ones, that you think ought
5 be brought to the attention of the Commission and made the
6 subject of its consideration?
7 A. You can tell I'm aspirational that the Commission
8 might achieve some really substantial improvements across
9 the system, which is not to denigrate what is there, and
10 I just come back to it, the system is an extraordinarily
11 good system, but there are some fundamental weaknesses and,
12 as time goes on, they will get more profound, particularly
13 around the way the Commonwealth and state work together.
14
15 It would not be surprising as a rural chief executive
16 and not surprising I spoke about the deficit, that this LHD
17 was now encountering, what I didn't mention, I gave the
18 figures on the occupational issues driving that or the -
19 what I didn't mention is that, in our district, 75 per cent
20 of that deficit arises from our rural facilities, either
21 MPSs, community hospitals, procedural hospitals, and
22 similar - obviously, the drivers I'm talking about are
23 particularly connected in saying that.
24
25 But I do think that one of the real issues in
26 NSW Health that does need to be looked at far more closely
27 is the funding of small community and MPS hospitals, so the
28 rural funding model. There is a model. There is a model
29 that typically works quite well but, in the interests of
30 time, I might give you two analogies to try and perhaps
31 give you insights. One is perhaps of a painting of
32 Escher's staircase on the wall of an art gallery, the Dutch
33 painter. Two people can look at that. One can say "That's
34 a fantastic staircase. Look at the perspective. Look at
35 the way it works. That's a beautiful picture", and they
36 would be correct.
37
38 Another person could look at the same painting and say
39 "That's not a staircase at all". And they would be
40 perfectly honest and perfectly correct. And the difference
41 between two, one is looking at form, so the artistic form
42 of the drawing of Escher's staircase, which, by the way,
43 doesn't go anywhere, you cannot walk up Escher's staircase
44 in the way that it is drawn; and one will be looking at the
45 function and saying "Actually, does this achieve the actual
46 outcome that you want?" One will say "Yes, that's
47 a fantastic staircase". Another will say "No, it's not",

1 and they will both be completely honest and completely true
2 in their assessments.
3
4 If I can put it in a different way, given the multi
5 layers starting from the Commonwealth down, you might have
6 two different people with two different cars. One can say
7 "This is a fantastic Ford. It is a great Ford car. Look
8 at it. It's all connected. I turn the motor. It goes.
9 Fantastic. I can get from A to B and in the journey from A
10 to B, I can tell whether or not I've had a lead foot on the
11 accelerator and have been inefficient in getting there", or
12 "I can tell that actually I've driven really well and I've
13 consumed no more than I needed to get from A to B", and
14 someone else can tell "Yeah, you got from A to B, but in
15 that car you went through C", and whatever, so there is
16 that kind of model or sense of a car. And they can look at
17 that and say "That's a fantastically working car".
18
19 Another person can come along with a car that's in kit
20 set form, so all the parts of a car, but they are not
21 joined together. They can say "I've got a car", and both
22 people will be absolutely true, but they are talking about
23 something fundamentally different.
24
25 So there are people in this system who rightly will
26 look and say "We've got a car that works", and others in
27 the system will look at the same thing and say "We don't
28 have a car that works". What they are really saying,
29 I will give you an example, in the kit set version, you
30 might have a process that takes out the starter motor and
31 turns the starter motor over and the starter motor works,
32 at which point you conclude you've got a car. That's
33 great. This piece works, it's fantastic. You might even
34 connect it to the engine block and turn the engine block
35 over and say "Great, we've got a car, it works". And they
36 will be true in saying that.
37
38 I will make the point that I'm making in a far more
39 precise way shortly but I'm trying to draw a story because
40 you will get conflicting advice on this.
41
42 As a rural chief executive, I'm a pragmatist. I'm
43 only interested in a car that I can jump in, turn the
44 ignition, drive from A to B and know that I'm not going to
45 be lost somewhere in the middle of the road because the
46 parts of the car are not connected. That's my definition
47 of a rural funding model for small hospitals. I know in a

1 practical and functional sense that it works.
2
3 Others will have a definition of a rural funding model
4 for small hospitals, which is about a starter motor. So
5 let's break that down.
6
7 How do rural hospitals get funded, because it is very
8 complex. So at a state level you can get - sorry,
9 Commonwealth to state, NRH level, national health reform
10 level, there are two different kind of mechanisms that you
11 can get funded. One of course is through the national
12 efficient price, NWAU price, it gets broken down into
13 a state efficient price and so on, and that funds ABF
14 activity. The other is through a national efficient cost
15 model, which is of course designed for small hospitals and
16 so on, and there is a variant of that which is designed for
17 MPSs.
18
19 So that model works. And it comes into the state
20 government at the level of the state government and, then,
21 within NSW Health, there is a model, the district network
22 return model whereby we will submit evidence as to the cost
23 of providing services in small community rural hospitals,
24 and that will have its own model, it will have different
25 weights and different levels of fixed versus variable cost
26 in it than the Commonwealth model has. Then underneath -
27 so those two processes already are there, independently of
28 each other.
29
30 Then, underneath, you will have an annual budget
31 expressed in your service agreement, and of course that
32 process may or may not be connected to the district network
33 return process within NSW Health.
34
35 So I've just described to you only three of multiple
36 parts of a kit set, which in their splendid isolation of
37 one another actually look like they work really well and
38 they do work really well and there are plenty of people who
39 put enormous effort with great integrity to try to make
40 them work really well. But I'm interested in a transparent
41 connection between knowing that when I jump in a car, that
42 all of the component parts have been connected and the
43 petrol flows in the way it should. Why is that hugely
44 important? Well, firstly, transparency. We spoke about
45 the importance of transparency when it comes to long-term
46 structural reform about health services when you are
47 interacting with communities about funding. So that's

1 hugely important.
2
3 But also the incentives - it's hugely important that
4 the incentives are aligned. I would like to know as
5 a chief executive whether or not the expenditure difference
6 between one small hospital and another is due to the
7 inefficient use of those resources locally, or at an LHD
8 level, or is it that, actually, they had no possibility of
9 being more efficient than they currently are, because my
10 interventions with that small facility will be
11 fundamentally different. If I think they are wasting
12 money, my intervention will have something to do with
13 eliminating waste.
14
15 But, actually, if the signals were telling me there is
16 no hope in hell of achieving whatever amount of money that
17 I gave them for whatever reason, my interventions would be
18 very different, because I will be worried about breaking
19 the ability to service a community in a way that is very
20 different between those two scenarios.
21
22 So that's why, to me, transparency, the joined-upness,
23 the absolute ability to be able to draw a line between the
24 component parts of various funding models and what actually
25 ends up in your service agreement - and I'm used to
26 a health system where, sometimes, I didn't like what ended
27 up in my service agreement and, sometimes, I would be asked
28 to provide services at a discount and I didn't want to do
29 that, you know, I would get NWAU with zero dollars attached
30 to it - this is a New Zealand example - but the reality was
31 I knew when that was happening. There was no artifice
32 about that.
33
34 In the interests of the greater good of the system,
35 I knew I had to be more efficient because I was going to
36 have to deliver more service for no real income, but I knew
37 what the problem was that I was trying to solve, because it
38 was clear and it was transparent. I don't think I would be
39 the only chief executive, and I'm sure you will get
40 testimony from others, so I'm giving you my perspective
41 with integrity here - a greater sense of how all of the
42 component parts of the funding for small rural community
43 hospitals and MPSs all fits together would be hugely
44 beneficial, not only within NSW Health but between us and
45 the Commonwealth. So we've done some work around MPSs, and
46 we've done two entirely independent pieces of work in
47 different parts of our district, almost a decade apart.

1 One was in Cobar, where we were evaluating whether or not
2 we were going to take over an older persons' residential
3 aged care facility provided by the council. The team that
4 looked at that worked out that actually to provide those
5 services with the kind of staffing that we would provide,
6 registered nurses and all of those things that the Royal
7 Commission into Aged Care said were a great thing to do for
8 quality benefits, we would lose about a million dollars
9 a year on that facility if we took it over. So decisions
10 were made about the wisdom or otherwise of doing that.
11
12 We did a very similar piece of work recently in
13 another MPS which we are about to redevelop, and we looked
14 at the income we were receiving from the Commonwealth for
15 residential aged care beds in the MPS and concluded - we
16 got a third party to do it, we really put it through the
17 wringer because we were trying to decide at that time
18 whether we lobbied the Commonwealth for more, or less, or
19 fewer of the same beds and all of those kinds of things, in
20 the context of a small town that was likely at that time,
21 but fortunately not now, to have a closure of a private
22 provider. Again, we concluded the differential between
23 what it was costing us and what we were being funded was
24 about $100 a bed day.
25
26 That's an enormous sum when you multiply that. It
27 will be different in different locations and different
28 set-ups, but it is nevertheless a multi-million dollar sum
29 when you multiply that by the 400-odd residential aged care
30 beds that we provide.
31
32 Again, I say in my statement, I understand there is an
33 official working party and group looking at MPS funding
34 right now, but it is another example of an issue that,
35 because of the lack of transparency in the funding model
36 for smaller services that are provided in smaller
37 communities, whether they are MPS or community hospitals,
38 in fact, you have to invest in an extraordinary amount of
39 effort using skills and abilities that many LHDs would
40 not - would have other uses for those staff to be
41 providing, to even try to work out what's going on.
42
43 So it would be no surprise to my colleagues in
44 NSW Health and the finance department, I value their
45 services, we work very collaboratively together, but there
46 are huge benefits that they and the system and LHDs could
47 obtain from greater transparency both between the

1 Commonwealth and the state about how these services are
2 being funded and how that translates and also, then, within
3 the NSW Health system about how that then translates
4 ultimately into dollars in the service agreement.
5
6 MR MUSTON: Thank you, Mr Spittal. Those are my questions
7 for this witness, Commissioner.
8
9 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
10 questions?
11
12 MR CHENEY: Just one briefly, Commissioner. .
13
14 **<EXAMINATION BY MR CHENEY:**
15
16 MR CHENEY: Q. Mr Spittle, you have referred in your
17 statement to Marathon Health and you gave some evidence
18 today about your relationship with it or dealings with
19 Marathon Health. Can I ask you to assume that Ms Callinan,
20 the CEO of Marathon gave evidence to this Inquiry that some
21 $13.7 million was allocated to an initiative in Western
22 New South Wales which aimed to link more than 11,000
23 patients to enhanced diabetes care over a three-year
24 period?
25 A. (Witness nods).
26
27 Q. And I ask you to assume further that on Monday this
28 week, Ms Callinan said that in relation to that
29 $13.7 million, she didn't have any visibility into how
30 those funds were spent. Have those funds been spent?
31 A. No. And that's entirely understandable that Megan,
32 who is a good colleague and we work very well together,
33 would not have visibility, because she is an NGO provider,
34 not a funder or responsible - not part of the heads of
35 agreement for that project.
36
37 Perhaps if I can elaborate very quickly, and
38 I appreciate the Commission's extended length of time that
39 they've given me, but - so this was a collaborative
40 commissioning project that was entered into between the
41 PHN, Far West LHD, the Western NSW LHD and the Rural
42 Doctors Network to try and undertake a project to
43 demonstrate that if we delivered services for people with
44 type 2 diabetes differently, that in fact there might be
45 both benefits for the Commonwealth and the state in terms
46 of long-term outcomes, with a view that the state would
47 bankroll this project and ultimately be able to demonstrate

1 out the other end of it to the Commonwealth that, in fact,
2 there was a different way of funding things that might be
3 beneficial if they took it up.
4
5 All of this started pre pandemic. We entered - we
6 began, I think it was 2020, from memory, we were getting
7 really intensively into some very detailed modelling about
8 how that might work through a dynamic simulation model and
9 so on. Pandemic came, I think there were two pauses
10 through that period of time, where work completely stopped.
11
12 Then I think, if my memory - if my recollection is
13 right, later in 2022, the four entities signed a heads of
14 agreement with the Ministry of Health which had a potential
15 value of $13.7 million, if all of it proceeded.
16
17 Since that time, there have been three extended pauses
18 to the project, and I think something like 14 months in
19 total over elapsed time. One was because we were asked to
20 navigate whether or not we addressed the co-payment issue,
21 because part of the project had people seen through GPs, so
22 we paused, and that's not a simple issue, and in fact we
23 concluded after a while that it would be illegal for
24 NSW Health to fund essentially a co-payment gap to
25 a private practice on top of MBS billing. That would be
26 out of order under the National Health Reform Agreement,
27 and lots of probity issues would arise. So I think that
28 took a couple of months.
29
30 We also, between the organisations, got to a point
31 where, at a governance level, we were concerned that the
32 governance of the project needed to be tightened. So we
33 paused, and in fact I was the chief executive who called
34 for that pause with my partners, and the PHN brought in an
35 independent consultancy firm to give us some advice on the
36 responsibilities, accountabilities and influence, so
37 a RACI-type model about making sure at multi levels of this
38 project we had those aligned and suggested some differences
39 in the approach that we should take.
40
41 The third pause that occurred across that period of
42 time was when both LHDs essentially looked at what we were
43 trying to do and concluded that there might well be
44 a smarter way of doing it and, in particular, that in our
45 more remote and rural communities where access to primary
46 care, even within the three or four years that we had been
47 trying to work out how we might approach this problem, had

1 become so much more difficult, and the original model had
2 a heavy reliance on general practice doing certain things,
3 well, parts of Far West and parts of remote New South
4 Wales, there is no point in building a model that is
5 heavily reliant on existing general practice, which is
6 overloaded, to do more.
7
8 So we paused and we currently have - we have done
9 a lot of work with our project teams, with the PHN, with
10 the RDN, the two LHDs and the Ministry of Health currently
11 have with them a revised proposition. If the ministry
12 accepts that revised proposition, then the total value
13 I think across the four-year period of that project will be
14 something like about $7 million, not 13.7, because we've
15 worked out a better way to do it.
16
17 Q. Of the 13.7, how much has been spent?
18 A. To date, as at the end of April - and there is very
19 strong governance around the expenditure of this between
20 the four parties, and we report that both to each other for
21 transparency and to the ministry - I think something like
22 2.87 million or something like that has been spent. It's
23 very clear where it's been spent. I think we would all
24 agree that what we have had, because we've kind of had -
25 for very good governance reasons we've needed to go through
26 the "Mmm, this is not working and it's unlikely to work in
27 changing circumstance, we had better pause and redo some
28 stuff", that has meant the LHD has carried
29 a disproportionately high staffing cost versus outputs,
30 because of course - when I say "pause", what I mean is
31 completely paused, or almost completely paused,
32 patient-facing services, so we've focused on a lot of
33 things like scholarships to upskill staff in primary care
34 or our services or NGO services, we've focused a lot on
35 training, we've focused a lot on developing pathways and
36 commencing some place-based planning work around a specific
37 disease. But where we're yet to get to is to really turn
38 on the interventions to patients that are a few - I think
39 there is about 100 who have come in, because we're still in
40 that hiatus, and the ministry has paused its funding. So
41 it's not like we're gathering a lot of funding. We have
42 all been transparent across the system and paused to reset
43 going forward.
44
45 MR CHENEY: Thank you. That's all I had, Commissioner.
46
47 THE COMMISSIONER: Nothing arose out of that, I assume?

1
2 MR MUSTON: No. I think the proposal was that we would
3 have a five-minute adjournment.
4
5 THE COMMISSIONER: Yes. We will take a 10-minute break.
6 My understanding is that we're not having Mr Carey today,
7 but tomorrow.
8
9 MR MUSTON: Mr Carey is coming at 9 o'clock.
10
11 THE COMMISSIONER: We are having Dr Spencer today?
12
13 MR MUSTON: That's my understanding.
14
15 THE COMMISSIONER: First of all, thank you very much for
16 your time and your evidence. We are very grateful. For
17 now, you are excused.
18
19 We will take an adjournment until 3.45, and we will
20 come back with Dr Spencer. Thank you. We'll adjourn until
21 then.
22
23 THE WITNESS: Thank you.
24
25 **<THE WITNESS WITHDREW**
26
27 **SHORT ADJOURNMENT**
28
29 THE COMMISSIONER: Are we ready?
30
31 MR FRASER: I think we are, Commissioner. Commissioner,
32 if I could call Dr Ian Spencer.
33
34 **<IAN GRANT SPENCER, sworn:** **[3.47pm]**
35
36 **<EXAMINATION BY MR FRASER:**
37
38 MR FRASER: Q. Doctor, could you give your full name,
39 please?
40 A. Dr Ian Grant Spencer.
41
42 Q. You are a general practitioner?
43 A. Yes, I'm a general practitioner in Bourke - in
44 Wellington.
45
46 Q. And just for completeness, you hold a Medal of the
47 Order of Australia; is that correct?

1 A. Yes, that's correct. OAM, that's correct.
2
3 Q. When was that conferred?
4 A. 2004, and it was for services to rural medicine.
5
6 Q. You, in terms of your practice in Wellington, are the
7 owner of that practice; is that right?
8 A. Yes. I established a practice in 1983 and it's grown
9 over a number of years and I'm still the owner and
10 principal supervisor mentor to the other doctors that work
11 with me.
12
13 Q. We'll come to some detail about that practice in a
14 moment, but prior to setting up that practice in
15 Wellington, is it the case you were in general practice
16 elsewhere in the district?
17 A. Yes, I was a general practitioner, I set up a practice
18 in Bourke in 1978. I came back from overseas, having been
19 trained appropriately for country practice, and then went
20 straight to Bourke.
21
22 Q. In terms of the growth of your current practice in
23 Wellington, how many other doctors currently work from that
24 practice?
25 A. The practice is basically set up to service about six,
26 and over the last couple of years it's dwindled, one
27 because of difficulty of getting fellow doctors, but also
28 the registrar numbers have depleted. So we're now
29 actually - we've got myself, we've got an international
30 graduate who is a fellow of the college, and he's been with
31 me now about five years and when I brought him out through
32 the independent pathway, he did nominate that at the end
33 of, say, five years, he would go and join some of his
34 Myanmar colleagues on the Gold Coast, and he's leaving the
35 practice on 30 November, which will then leave us just with
36 myself and a rural generalist trainee, Jean Littlewood.
37 She only works three days a week and works two days a week
38 in the hospital system in Wellington as a hospital doctor.
39
40 So we had application for our registrars, a new lot of
41 registrars, to start in the next few weeks. We had two
42 applicants, both of whom were absolutely excellent and very
43 interested in coming and, then, when we were allowed to
44 contact them, as far as contracts go, they both nominated
45 that they had chosen to stay in the country practices where
46 they were at the moment. One is staying in Cowra and the
47 other one is staying in Dubbo. We have no applicants, or

1 no apparent doctors that are looking to start with us in
2 the January/February of next year.
3
4 Q. Doctor, I think it is right that you have had a long
5 association with training GP registrars; is that right?
6 A. I've actually - I think I'm actually the oldest and
7 the longest-serving supervisor for general practice - rural
8 general practice training, in Australia.
9
10 Q. And in terms of putting - before this next intake
11 where you've been unsuccessful in obtaining any, how many
12 registrars would you usually have?
13 A. We would normally have about three. One would
14 probably have already passed their fellowship and have
15 chosen to either do an extended period for various
16 components of their training and interest, and then there
17 would be two registrars in training, and they would be
18 partly their way through either the Royal Australian
19 College of General Practitioner training pathway or through
20 ACRRM, the ACRRM pathway, mmm.
21
22 Q. In terms of the flow of trainees, has there been any -
23 you had two applicants, both of which were more than
24 suitable by the sound of it. Has there been any sort of
25 change in how many applicants you have seen over the recent
26 years?
27 A. Well, I think for reasons that I don't think any of us
28 really know, there's been quite a dramatic drop in the
29 number of people joining the Australian general
30 practitioner training scheme, be it ACRRM, RVTS, the
31 independent pathway, or RACGP, and so there are quite
32 a number of practices that are not getting registrars.
33 I was at a supervisor workshop a couple of weekends ago in
34 Orange and there were very few supervisors, and I asked why
35 that was, and the reason was that a lot of the supervisors
36 were really quite disheartened by the fact that they hadn't
37 been able to secure any registrars for this next term,
38 which goes in the second half of this year, and they were
39 quite worried about whether they would get registrars into
40 next year.
41
42 Q. I will just ask you about your practice a little more.
43 How many active patients would you have, practice wide, at
44 the moment?
45 A. We would have around about 6,000 active files, and one
46 of the things that is so important for everybody to
47 realise, and that is that modern general practice is a very

1 complicated specialty nowadays. Some people think it's
2 coughs and colds and sore ears, but they are actually the
3 quick things. Most of the patients we see have got several
4 disease processes in train; they need to be on various
5 health care programs, like the diabetes, the Aboriginal
6 pathway, aged care facilities and so on and so modern
7 general practice is a very complicated specialty nowadays.
8
9 Q. And that's something that has developed slowly over
10 the period you have been in practice or --
11 A. Well, when I first went into general practice, back in
12 1978, I was trained to fix broken things and sick things,
13 and that was basically fairly simple, really. Nowadays,
14 particularly with the advent of preventative care being
15 quite clearly shown worldwide to be the most effective way
16 and the cost effective way of managing population health,
17 general practice has been very much a matter of
18 preventative care and the management of complex medical
19 problems.
20
21 Q. Just in terms of you - you have said about 6,000
22 active files. How big is Wellington these days?
23 A. Wellington would be about - about 6,000, serving
24 probably about 9,000 people, with an Aboriginal population
25 probably of around about 23 per cent. It is a relatively
26 demographically poor town. The district itself might be
27 a very substantial rural, but the town itself is
28 a relatively deprived population.
29
30 Q. In terms of other GP services within - well, before
31 I come to that, about what proportion of your patients
32 would be bulk billed?
33 A. Well, I've always been a bulk billing practice, ever
34 since I set up a practice in Bourke, and we've agonised
35 over the last few years and, just before the Christmas
36 period we really sat down - my practice has actually been
37 non-financial for three years, and so we actually had to
38 make a very hard decision to change our business platform
39 and opt out of bulk billing.
40
41 We still bulk bill all the antenatal girls that we
42 see; we bulk bill the chronic mental health people; and all
43 of the doctors in the practice have got the right to say to
44 the secretarial staff "This consultation, I want to put it
45 through as bulk billing". So there is a little bit of
46 latitude, but basically, we've had to change the business
47 platform simply because the cost of running the practice

1 is - has not made it financial. As I say, we've been
2 running as a line-ball situation for the last three years.
3
4 Q. In terms of being in that position, is there any
5 particular cost that has driven that financial position?
6 A. Well, I think that - yes, the costs have certainly
7 gone up. Medical supplies and things like that have gone
8 up enormously. I think companies, as soon as they have
9 a medical stamp on it, they seem to double the price.
10 I think we know that. But the other side of it is that the
11 Medicare rebate, even though there has been a move recently
12 to try and rationalise it, the Medicare rebate in the last
13 five years has just not kept pace with the costs, and
14 I would think that the poor Medicare rebate is the single
15 most important reason why most doctors have had to opt out
16 of bulk billing and, as I say, I've been a bulk billing
17 doctor all my life, and basically, that was my philosophy
18 about what I thought was fair and reasonable as
19 a practitioner for Australia, and it did cause me quite
20 a lot of grief to opt out of bulk billing, because I knew
21 that there was going to be a group of people that would not
22 be able to afford it, and hence would not be able to have
23 easy access to primary health care.
24
25 Q. I have asked you about the doctors in your practice
26 and the trainee doctors. What other staff are employed at
27 the practice?
28 A. Well, the medical centre has got - it's got
29 administrative staff, it's got nursing staff, of course.
30 The nursing staff organise a lot of the immunisation
31 programs. We were very heavily involved in testing,
32 vaccinating and treating patients through the COVID
33 epidemic.
34
35 We have allied health personnel, we have podiatrists,
36 physiotherapists, psychologists, diabetic educators, and we
37 coordinate very closely with the Wellington Aboriginal
38 Community Health Centre, WACHS, particularly in regard to -
39 we run a antenatal clinic. I think Wellington would be
40 possibly the only town where there is a coordinated town
41 antenatal clinic, and that has actually been running for
42 the last 25 years.
43
44 Q. I will come back to the antenatal clinic. Just to be
45 clear, the allied health professionals of the various types
46 that you just listed, are they employed, or are they from
47 one of the NGOs that come out and use your rooms?

1 A. No, the - Marathon Health is one organisation that we
2 coordinate with. They send out psychologists. There is
3 a podiatry group here that come and rent a room once
4 a week. There is a private psychologist that also
5 services; the diabetic educators come from Marathon Health,
6 and - yeah. They basically all do - organise their own
7 appointments. They are facilitated by our administrative
8 staff. They rent a room, they service their patients. We
9 both collaborate with referral letters and letters back
10 from them.
11
12 Q. I will come back to the detail of the clinic in a
13 moment, but the Wellington - is it the Aboriginal health
14 centre or corporation?
15 A. Yes, it really is a medical centre, not simply a place
16 where you see doctors. It services most of the needs of
17 patients. I think mental health and social work is
18 probably one area that we would love to have a little bit
19 more involved in our medical centre, but of course, those
20 services are just so scarce on the ground, and those people
21 that are working in that area, there are the psychologists
22 that can deal with the sort of emotional problems that are
23 so frequent, but the chronic severe mental illness patients
24 are the ones that we need to be really careful for. We
25 bulk bill them and they tend to come and go and we help
26 them as best we can, with the mental health services from
27 the LHD.
28
29 Q. In terms of the Aboriginal Medical Service, in
30 Wellington, in addition to yourselves and that service, are
31 there any other primary health services in Wellington?
32 A. No, the two centres, Swift Street Medical Centre and
33 WACHS are the only providers in Wellington. As I say, we
34 work hand in glove with the WACHS organisation.
35
36 Q. Can you give a bit more detail about how the antenatal
37 clinic that you have referred to that you work together
38 with, with WACHS, to provide?
39 A. Well, I was the only obstetrician in Wellington for
40 about 10 years and when we downscaled it a little bit, we
41 needed to run the antenatal clinics, so initially it was
42 started at the hospital and then the hospital asked us to
43 move out because they couldn't provide the staff, the
44 midwife. So we set it up in - at the Swift Street Medical
45 Centre and the antenatal and maternity people from WACHS
46 came and joined us and we've been running this
47 collaborative antenatal clinic, bulk billed, for all girls

1 who are pregnant, and they come and they really have
2 a wonderful service, wonderfully well coordinated service,
3 and it coordinates, of course, with Dubbo maternity service
4 and Orange maternity service as well.
5
6 Q. And how long has that collaboration been --
7 A. It's been running for 30 years.
8
9 Q. You referred to being an obstetrician. You held -
10 were one of those GPs with additional qualifications; is
11 that right?
12 A. Yes. Well, when I graduated in 1972, I actually
13 always intended to go to the country, and in those years,
14 you couldn't get the appropriate training to give
15 anaesthetics, do obstetrics and some relatively minor/major
16 surgery, so I went to England for five years and got
17 sub-specialty degrees, and it was always my intention to
18 get trained in those specialties, because at that time, if
19 you went to work in the country, you knew that you would be
20 a doctor involved in the hospital and, if it was
21 a procedural hospital, as Wellington was, and as Bourke
22 was, too, there would be obstetrics, there would be an
23 operating theatre. In the early days we had a children's
24 ward and we looked after quite a busy emergency department.
25 So you needed anaesthetic skills, obstetric, and some
26 surgical skills.
27
28 Q. Wellington hospital - did you used to provide those
29 services at Wellington?
30 A. Yes, yes. I was the VMO providing most of those
31 services from 1983 through to 2020, the January of 2020.
32 Now, the thing is that the labour ward had been closed -
33 when the midwives and I decided to downgrade the complexity
34 of the ladies that were going to deliver, the LHD closed
35 the labour ward. Then, again, because they said that
36 labour ward was closed, therefore we didn't need an
37 anaesthetic service, therefore they closed the operating
38 theatre. Whether that was an intended agenda that they had
39 all along, but that's what actually happened.
40
41 Labour ward closed, then the operating theatre closed.
42 And some years before that, the College of Paediatrics
43 delineated the role of various hospitals as far as the care
44 for children, and hospitals like Wellington were not
45 appropriate to admit children under five, so the children's
46 ward got closed as well.
47

1 Q. Why was it that you stopped as a VMO? Was it because
2 those services were no longer being able to be provided
3 or --
4 A. No, it wasn't. It was really - I'm 76, but I was the
5 young boy on the block back in the early days, and around
6 about 15 years ago, all of my older colleagues were
7 starting to die off or retire, and I was left with the - as
8 the only senior VMO with my registrars, and I had two
9 registrars, and we were able to hold the hospital together
10 with that.
11
12 Then, when a lot of the registrars started to be more
13 interested in just general practice and not wanting to be
14 involved in the hospital, things changed dramatically, and
15 I was trying to hold up the roster with the fly-in locums,
16 which I'm sure you have heard of, and basically, now, it
17 really just got too dangerous and too difficult for me to
18 do that. So I had to - I retired, and now the hospital is
19 completely run by fly-in locums.
20
21 Q. Just returning, then, to your practice, from what you
22 have described earlier, it appears that there is a good
23 chance that it may be you and your rural generalist
24 colleague three days a week left at the practice; is that
25 right?
26 A. Yes. Come 1 December this year, it will be me and
27 a registrar, and the registrar is one of the procedural
28 registrars, and she only works three days a week, and she
29 works at the hospital two days a week. So the medical
30 centre, which is meant to have at least five doctors,
31 serving maybe 6,000 active records, it will be me and Jean
32 Littlewood, which I think will be very dysfunctional. If
33 we don't get some extra help - and we have been advertising
34 everywhere, internationally included, and through the RDRN,
35 through ACRRM, through locum agencies and so on, and so far
36 we've had no luck at all.
37
38 Q. Can I ask what types - what precise level of doctors
39 have you been advertising for, or is it literally any
40 doctors and GPs?
41 A. Well, a lot of the overseas doctors that would like to
42 come, particularly the ones from South Africa and some of
43 the ones from the UK, they've actually done quite a lot of
44 procedural work, and so one fellow that I was talking to,
45 who was keen to come, but he definitely wanted to work at
46 the hospital, and I've also been involved in the single
47 employer model of practice, and this would have worked very

1 well, except the idea of the single employer model would be
2 that me as the supervisor, while he was working in general
3 practice, I would also be his supervisor at the hospital,
4 and of course, as I'm not on the staff of the hospital
5 anymore, I can't.
6
7 So the LHD and I are trying to work out some sort of
8 way through that maze, but there probably would be more
9 international doctors that would be quite keen to work in
10 the country, particularly if they were able to work at the
11 hospitals. Now, the doctors that we desperately need in
12 our crisis are general practitioners and, really, the
13 hospital has got massive problems of fly-in locums at
14 enormous costs, which I believe are unsustainable, and it's
15 nobody's fault. The playing field has changed, but the
16 players haven't changed with it, and so what has happened
17 is that now we've got the hospital being run by fly-in
18 locums, we've got general practice desperately needing
19 general practitioners, and the crisis that we're heading
20 for is that there's going to be a very, very severe
21 inequity of people in country towns, like Wellington and
22 smaller, not having fair access to primary health care, and
23 primary health care is just so different to outpatient
24 medicine.
25
26 A lot of people think that if you go to an outpatient
27 department, if you are not an emergency, then, well, that's
28 general practice. But that's not general practice at all.
29 It might be a sore ear, it might be tonsillitis, it might
30 be a cut. But general practice is complicated and complex
31 and dealing with multi-modal sick people.
32
33 Q. How many doctors do you think your practice requires
34 to stay viable?
35 A. Well, we definitely need four. We need four doctors
36 to provide it.
37
38 Some of the really good programs, like health checks,
39 Aboriginal health checks, care plans, mental health care
40 plans - they are all wonderful programs, but you have to
41 have a doctor to oversee it. If you haven't got the
42 doctor, you can't run those programs. Those programs are
43 wonderful, and I think they are in line with the whole of
44 the WHO plan for population health, and they are also in
45 line with the appropriate funding of services, doctors,
46 nurses, allied health, for a population. But without the
47 doctors, you can't run those programs and, as I say, if we

1 are running on 1 December and into next year as me and
2 a registrar, that will be a very dysfunctional practice
3 and, to be honest, if we haven't got doctors lining up
4 through the various agencies that we're desperately trying
5 to access, if we haven't got adequate doctor numbers, I'm
6 going to have to be telling the community of Wellington
7 that, come 30 June 2025, my practice will have to close,
8 and the tragedy of that - and it causes me a terrible grief
9 and a lot of anxiety - and that is that all of the doctors
10 in Dubbo have got closed books; all of the doctors in
11 Orange have got closed books. So here's 6,000 people with
12 complex medical problems and nowhere to go.
13
14 Q. I presume that the Aboriginal Medical Service doesn't
15 have the capacity to cover all those patients?
16 A. No. Well, the Aboriginal Medical Service has closed
17 their books as well.
18
19 Q. In terms of other than doctors taking up the various
20 advertisements or training places, et cetera, are there
21 any - in terms of practices in a similar - or towns in a
22 similar position to Wellington, have there been any
23 approaches that you have given some thought to that might
24 help?
25 A. I think Wellington is a slightly one-off situation.
26 Mudgee is a bigger town, it's a bit more active and it's
27 got more doctors. So they look as though they're going to
28 be able to manage. Towns like Wellington are really in a
29 crisis. The towns further out - and they are suggestions,
30 which I think have also been implemented to a degree - are
31 the virtual practices and I think that possibly will be the
32 only way, you know, towns like Tottenham, Tullamore and
33 Trangie will survive, and I think the virtual general
34 practice is probably something of the future.
35
36 It will require committed doctors to be - wherever
37 they live, to be running a general practice on line. It
38 will need really well trained nursing staff to do the
39 triaging and the basic examination, like blood pressure,
40 blood sugars and so on, but I honestly think that that
41 probably will be the only way those towns will have
42 anything organised to service their primary health needs.
43
44 As far as procedural country towns go, I think
45 really - and I really say - I say this as an individual,
46 I'm not saying on behalf of ACRRM or RDA or anything, but
47 I think the long-term plan of the health department and

1 I think there is probably a lot of sense in it, and that is
2 that if you've got a one and a half hour ambulance ride
3 around all the truly procedural towns, the towns that are
4 left outside those circles are the towns where you have to
5 look and see whether they really need a proceduralist, and
6 I think the procedural - the doctors that want to be
7 involved in their hospitals, small and medium sized country
8 towns, they won't be giving anaesthetics, they won't be
9 doing obstetrics, they won't be doing surgery; they will be
10 very well trained in emergency and looking after people in
11 the wards. And I think towns like Wellington will act as
12 peninsula towns supporting Dubbo and Orange.
13
14 Now, for instance, speaking on behalf of them, having
15 known what happened, but an awful lot of the orthopaedic
16 patients who have a hip replacement or a knee replacement,
17 they get moved out of Dubbo Base and have all their
18 rehabilitation in Wellington. A lot of the elderly people
19 who were functioning well at home got sick and then no
20 longer can support themselves at home, the small to medium
21 sized country town hospitals are now organising the various
22 arrangements for them to either have compacts at home, or
23 be processed to go to nursing homes. It's a big part of
24 their work.
25
26 MR FRASER: Those are the questions I had for Dr Spencer.
27
28 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
29 questions?
30
31 MR CHENEY: No, Commissioner.
32
33 THE COMMISSIONER: Thank you very much for your time,
34 Dr Spencer. We're very grateful.
35
36 THE WITNESS: Okay, thank you very much.
37
38 THE COMMISSIONER: Cheers. All right.
39
40 **<THE WITNESS WITHDREW**
41
42 THE COMMISSIONER: The start time tomorrow is 9 or 9.30?
43
44 MR FRASER: It is 9 o'clock I understand, Commissioner.
45
46 THE COMMISSIONER: All right.
47

MR FRASER: Those either side of me are whispering, and I'm told 9.30 is actually achievable, because there can be one witness less. So if it could be 9.30, Commissioner.

THE COMMISSIONER: All right. We'll adjourn until 9.30 tomorrow, thank you.

AT 4.20PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO FRIDAY, 17 MAY 2024 AT 9.30AM

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