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

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THE COMMISSIONER: We will begin this morning.

MR MUSTON: I call Mark Spittal.

<MARK PHILLIP SPITTAL, sworn: [10am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. Mark Phillip Spittal.

Q. You are the chief executive of the Western New South Wales LHD?
A. That's correct.

Q. It's a role you have held since January 2022?
A. Correct.

Q. I think, prior to that, you acted in the role for a period of six months?
A. On and off; that's correct.

Q. Before that, you were - or perhaps coincidental with that period - the executive director of operations within the LHD?
A. Since the middle of 2018 that was my role.

Q. Which rounds out, or these are the most recent examples of over 30 years' worth of experience that you have had working in public health in New South Wales and New Zealand?
A. Correct.

Q. You have prepared two statements to assist the Commissioner in relation to his work. The first is a statement dated 6 February 2024, which is exhibit B.8 - there is no need to bring that up on to the screen, it was tendered during the procurement hearing - and more recently a statement dated 30 April 2024, [MOH.9999.1202.0001]. Have you had an opportunity to read and consider that statement?
A. I have, yes.

Q. I understand there is a correction that you may wish to make to an aspect of it. I also understand that, in order to assist you in doing that, a document may be able

to be brought up on to the screen next to you.
A. Correct, yes.

Q. So we can assume that any imperfections in the reproduction of the graph caused by using a mobile phone to take a photograph of it will be corrected in due course. Does that - am I right in understanding that paragraph 20 and the graph which appears immediately beneath it in that statement, you would wish to replace with the paragraph 20 and the graph which appears on the screen at the moment?
A. That's correct, and in a technical data review, we recognised an error in the way things were expressed. So this is a technical correction that doesn't alter the meaning of the previous paragraph but makes it more technically true.

Q. Other than that correction, are you satisfied that the content of your statement is true and correct to the best of your knowledge?
A. That's correct.

MR MUSTON: In due course, Commissioner, that will be tendered as part of the bulk tender.

THE COMMISSIONER: Yes.

MR MUSTON: Q. Can I ask, before we get into the substance of your evidence, one other small matter. Yesterday we heard some evidence from Professor Arnold, where he discussed the roles of various groups within the LHD insofar as service planning is concerned, and I think the evidence he gave was to the effect that it was service delivery that was involved in some of those planning operations. Accepting as correct the evidence that he gave, that it was not him or his group who were responsible for those activities, is it in fact the case that service delivery is responsible for that planning or is it another group within the LHD that does that?
A. There are multiple levels in planning in any large organisation like a local health district. The primary responsibility for planning is headed up by our strategic reform planning and partnerships team, and you heard from Maryanne Hawthorn, the executive director of that group, yesterday. The service delivery unit and the staff within the service delivery unit have input into that planning process, particularly clinical service planning or service planning across the district, and I can absolutely

understand how Professor Arnold, as a relative newcomer to the district, who in the last year has been busy both sorting out research and standing up voluntary assisted dying services in our district - he will see that planning coming to the executive group, which he is a member of, and as we review it on the way to the board, but in discussion with his medical colleagues, I can absolutely understand how he would have formed the impression it was primarily delivered out of the service delivery group because, of course, that's the group where the doctors are employed and that's the group from which they have interactions with the work of Maryanne's team.

Q. But the primary responsibility for that planning rests with Maryanne and her team?
A. That's correct.

Q. No doubt with input from service delivery?
A. Absolutely.

Q. And a range of other groups and individuals within the LHD?
A. Yes.

Q. We'll come back to service planning in a while. But I might take things a little bit in reverse. I want to ask you this question: if you were given an opportunity to start afresh and design what you regard to be the optimal - an optimal and equitable system for the delivery of health services to the people within your LHD, what would it look like?
A. No doubt we will traverse this in my statement during the course of the morning but, unsurprisingly, given my background and a lot of my early career until very recently has been in the context of the New Zealand health system, I have a slightly different perspective and a different history than had I grown up within the Australian health system. Fundamental to that, and a point of difference, is how you deal with the issue of planning at a population level, so services for populations.

In my evidence I suggest that there is a need for legislative reform at state level, and perhaps Commonwealth, although that's not the jurisdiction of this Inquiry, to make it fundamentally clearer who, which parts of the system and which individuals, whether they be ministers, secretaries, chief executives, have the

fundamental responsibility for improving the health outcomes of the populations that they serve.

New South Wales legislation is over 30 years old and it's very perfunctory and transactional in its nature, in my view, and non-aspirational, to be frank.

In modern legislation written in a different way that started with a very single question, "Who is accountable for improving the health outcomes for the population, for the people of New South Wales that we serve" - that would go a long way. So that would be the first thing that I would do.

The second thing - and this is not a perfect system, there are no perfect systems - I would then do what Maryanne suggested in her evidence yesterday, which is to have a far clearer understanding between governments, organisations like ours, others involved in the delivery of health services and the community at large about what we would expect in terms of the kind of services that might be available, for example, in a community of 18 houses like Weilmoringle in the north of our district, hundreds of kilometres from anywhere else - in their language, not remote; in mine, well and truly into the outback of New South Wales - versus a community like Orange, a large community in rural New South Wales, or Dubbo, capable of supporting a much larger population, much larger services, able to provide far more advanced services than might be on the ground.

That definition should include all kinds of services, whether they be access to community mental health, drug and alcohol services, primary care, secondary or hospital care, aged care, to have some rough prescription of roughly, given the constraints of our ability as taxpayers to afford to fund a system, but what should we expect for a community? So in other words, what's the - I hate to use this term but what's the civil contract, the psychological contract between taxpayers and the government about what might be received in a particular community or residents of a community.

I don't mean that in an overly prescribed way, because of course, what works and how the health system should work should be heavily interconnected and place based, to a degree, but every place has to be connected to another

place. So, in other words, it's just as important for me to understand how a community member in Weilmoringle might have access to cardiac surgery in RPA in Sydney, and that network and how that works and how that flows is just as important, as to understand how they might have access to a community drug and alcohol worker. So you can't plan any part of the system in isolation but neither can you be overprescriptive because that would be an impossible task.

Health is what we would describe as a complex adaptive system, like the human body, and you can intervene in all sorts of ways in the health system, and I think as Matthew Daley gave evidence earlier, health does not respond well to revolution. There are plenty of examples. My own country, dare I say without being too political, has tried to revolutionise its health system in very recent years and is paying the price and will for a number of years to come for trying to be too ambitious.

But it responds well to evolution, and it responds, and should respond, well to a much better and clearer set of constructs around at a high level how the systems should connect together, what a community should expect. Believe me, I've been doing this work for a long period of time and there is no community that would vote to have something that they perceive to be inferior as the community down the road. They will all want services that may not be safe to provide in their community. They won't understand, they will have very low health system literacy, let alone health literacy - and those are two very different things, it's an incredibly complex health system. But to have some basic and high level of understanding of "These things will be provided in this part of the district, these things will be provided in that part of the district", not our only services but other services, would go a very long way.

Having got that kind of political or public understanding, you would then go on to look at how are we going to fund, and you would also look at what's there already to identify the gaps. I won't labour that. I think Maryanne's evidence yesterday covered that well. I'm used to a health system that is capitated - that is, that a local health district, in New Zealand's case, the district health boards had a very similar function when I worked there - they received capitation funding. So that is every head of population had a certain amount of funding that came with them, and New Zealand runs a formula, it is

a very complex formula, that not only accounts for head count but it counts for a range of things such as social deprivation and differences in health outcomes in communities, differences in disease burden, differences in the disproportionate burden of inability to access and participate in society in the same way as some groups experience relative to others, and particularly in Australia, that is absolutely clear for First Nations people.

But having derived, for example, what is the fair share of the pie that a population of a particular size - and you can't do it at the level of a small town, you have to do it at the level of a large population, because otherwise you can't manage the risks - then you can then say, "Okay, what is the most efficient way to allocate that pie to get the best health outcomes for the people across that part of New South Wales?" You would, alongside that, undertake a very detailed analysis of what services are available. That would inform you about what are the gaps, what are the bits where we're providing services that in fact have very high cost and very low utilisation? How might we evolve some of those services so that that money was better spent to get a better outcome from the community and, believe me, that is not an easy journey to take, but it's an absolutely essential one given that so much of our health services and how they are delivered - by their very nature, these are dinosaurs, these are very large oil tankers, very hard to turn when they have got up a head of steam.

What is it that, in the future, we might evolve and gravitate towards, given that we know our population is changing. We know that their needs in 20 years' time will be different than they are today. I look at my own district. The infrastructure across my district is vastly differently proportioned than where it is provided and what is provided because it reflects health services of 50 years ago, not the health services of today or, indeed, the requirements of communities in 20, 30 years' time.

So, to me, a well planned and organised health system is always forward-looking. So it has a mind on the present about what is going well, how do we adjust the present, but it has a strategic orientation about how do we evolve the systems and the needs of our communities, the needs of patients and their families so that they are well served

into the future.

None of that is an easy conversation. It is made fundamentally more difficult in Australia because of the federal and state divide and how our health services are funded, and I would go so far as to say - and I will own this statement and I will probably be damned forever by it - the reality is that MBS funded systems preference the wealthy, and I passionately believe in democracy. One of the greatest threats to democracy is the growing divide between those who have an ability to access services of government to accumulate wealth in Australian society versus those who are being marginalised by that process.

That sounds controversial, but in fact, many of our systems drive them that way. I think you will see - and we've provided evidence, we've talked a little bit about it on the screen, to correcting evidence - where in fact that is exactly the outcome that is being driven, so in the context of regional and rural New South Wales, in our statement of evidence, in mine, I have proposed a different way of doing things, not to say that we have the solution but to say that in rural and regional New South Wales, and especially in remote rural and regional New South Wales, in districts like mine, there is a palpable need to do things differently in order to get better outcomes for our community, which is not to be dismissive of the extraordinary outcomes that are already being achieved, not to throw the baby out with the bath water but to recognise that going forward we need to do things differently.

My personal view is that we need to find mechanisms that bring together in a pooled kind of mechanism the funding between Commonwealth and state that enables for local service planning, local determination of the most efficient way to distribute funding, to achieve the outcomes from that funding in the best interests of the local population.

The New Zealand system that I referred to, of course - because many services, health services to people in our district are not provided by our district, we are hugely grateful for a range of highly specialised services provided by our colleague LHDs in the metropolitan basin. We couldn't survive, our patients would not get the level of care they get without those services.

In the New Zealand system, as a chief executive of a district health board or a local health district, I would receive the funding for my population, but I would be responsible for paying for those services that my population received irrespective of where they received them from a public hospital anywhere in New Zealand, and there was a wash-up process around that.

Equally in a capitated model - so there are those in New South Wales who would say, "Didn't we have some form of population funding a decade or so ago, and didn't that lead to inefficient services" - and I wasn't here then, so I can't comment, but no doubt all systems have a tendency of entropy and need a bit of a wake-up call from time to time - but my experience is that you can have systems that combine very effectively both population and capitation funding, both primary and secondary care, other services, tertiary care, as well as activity-based funding, which is a very, very good mechanism, particularly in larger entities and organisations such as larger hospitals, to drive efficiency in the system, and there is lots of very good evidence of Australian society benefiting very, very well from the introduction of ABF funding.

But on its own, it's not a panacea. It's not a solution. It's just one tool in a wide range of tool kits, and the thing that brings them together in a sensible way with other things, such as block funding or various other ways to fund services is, firstly, the idea that there is a transparent population based capitated distribution of the public purse, which deals with the issue of transparency and fairness from the point of view of the citizen, and then there is intensive, joined-up, good local planning, which is not only about what services should we have in the town of Bourke, but it's actually about the entire system.

So how should the people of Bourke best receive their services balancing quality, workforce issues, how the entire health system works? And I have to say, with the exception of the absence of the transparency about funding on a population basis, about the issues - and I have said in my submission and stand by this statement, that I think we've got a long way to learn how to deal with the issues of equity and how we fund services.

With those exceptions primarily, the New South Wales

health system is an - achieves extraordinary things. I can say with almost 40 years of work in health, two different countries, many different settings, it is by far the most collegial system that I've worked in.

The passion of people to try to make it work well, whether they be clinicians at the coalface, whether they be the secretary, whether they be senior people in the ministry, people in my LHD, is extraordinary, and I absolutely - while I call for reform, in no sense am I being dismissive of what is there. But there are tensions in the system and there are ways that are very, very clear in rural and regional New South Wales that we can and absolutely need to do things differently, because if we don't, the gap in health outcomes for rural and regional people and people in remote communities will only get larger.

Health services will only get more fragile - and we've heard a lot of evidence from GPs about just how fragile that part of the health system is, which is nothing to do with NSW Health in one sense, and everything in another, particularly in small towns. So I'm sorry, a very longwinded answer, but you asked an open question, so I gave you an honest perspective.

Q. Tempting as it is to sit down after that, I will ask another one. We might develop a couple of the consents that you have touched on in a little bit of detail. Perhaps if we start with funding and the funding model that you think would be better suited to the delivery of health care within rural and regional areas and perhaps more widely. The first point, though, is you tell us in paragraph 76 of your statement that your LHD is in a position of some deficit at the moment relative to the budget that has been allocated to it by NSW Health, and in paragraph 77 you identify some of the reasons for that, principal amongst them seemingly being the reliance, or heavy reliance, on premium labour in the form of locums and agency nursing staff.
A. (Witness nods).

Q. Would it be fair to say that, at least as you view it, the particular slice of the budgetary pie that is allocated to your LHD relative to others is more a creature of history than reflective of any clear assessment of the precise needs in terms of system delivery, and the means by

which and the cost that might be incurred in delivering on those needs?
A. I think all chief executives would probably say that. I think that's certainly true in our district.

Q. At some point in the past, someone has presumably made some assessment of what is needed by the LHD, either because that's what has been spent in some given year in the past, or - you have to answer out loud.
A. So my sense - and others more technically involved might correct this at some point - is when ABF funding was largely introduced into New South Wales, that essentially, we built - we've built from that point, about whatever was being spent, wherever it was being spent prior to that introduction, and there's been gradual evolution since then, but fundamentally within the New South Wales health system, it does not seem to me that the issue of equity of - in a population sense, and I don't mean equality, I mean equity - that as a consideration of the social determinants, the factors that drive differences in health outcomes, the differences in disease burden and a weighted model to allocate funding according to population - that's not a feature of the New South Wales health system in general. It is at the margins, in terms of some new programs.

There is very clear evidence of that. And it is very clear that this is an area of evolution within the ministry itself, senior people of NSW Health. There is a lot of debate going on.

The difficulty, of course - and this has to be acknowledged and I think again, as Matthew Daley gave in his evidence - there is a sense in which funding the base, by which we mean the services that already exist - you don't want to destroy what is working well while you move to something else. However, if the base has always been preferentially advantaging some parts of the state versus others, that's a really difficult problem to resolve over time.

In my evidence, I mentioned somewhere, it is analogous to when ABF funding was introduced which showed that different parts of the state, different hospitals had vastly different levels of efficiency in how they were using their funding. So there was a long period of transitional grants, if you like, technically the incorrect

word, but transitional funding which identified the inefficiency differences between health services at that time and gave them a pathway, over a decade or more, in order to get closer to where average efficiency for those kinds of services might be.

I suspect - in fact, I strongly encourage the New South Wales health system, and my own LHD for that matter, because this is equally an issue internally as for the system as a whole - it can reflect deeply on the issues of equity in terms of health outcomes, the distribution of resources, and then to firstly design really good models to determine that. Secondly, to plot a pathway towards a much more equitable health system in terms of health outcomes and the needs of the population which will not occur overnight, has to be a process over a number of years in order to ensure that what is working well already does not get fragmented and is unable to deliver high-quality services to the populations it serves.

Q. Without wanting to cast any doubt at all on your ability and the ability of those who work with you to generate efficiencies where they can be found, or deal with the premium labour situation to the extent that that is possible, do we take it from the answer that you have just given that it's your view that it's not really possible to deliver health care to the residents of your LHD which is, to use your term, "optimal and equitable", within the current budgetary envelope that has been allocated to your LHD?
A. Perhaps if I can comment on two aspects of that. Firstly, the budget that is not allocated to the LHD. So many of the things that my LHD is doing is grappling with a failure of other parts of the health system. It's no longer - people don't like to use the word "failure", they like to use the words "thin markets". The reality is in some places there are no markets at all.

So we're addressing those issues, so services that you would not expect to be the responsibility of NSW Health or the state government as well as --

Q. This, I gather, is a reference to primary care and potentially specialist outpatient clinics?
A. So those are two of a number of examples. We could expand to talk about aged care. There are a number of services where that dynamic is true.

Within the funding received from NSW Health, well, I can only reflect in this way: our LHD, until this current year - and we can talk specifically about why because I think it's insightful - we were one of a very small number of local health districts in New South Wales that met its budget, had consistently done so for half a decade or more. Prior to that, it had had some real financial problems.

Another example, which I think is still true today, would be the Far West LHD.

The health outcomes of the population served by both our health district and the Far West LHD and a number of other rural and regional LHDs are some of the worst in the state. So we've been financially good performers but poor performers in terms of health outcomes, and I think that the distinction of those two things answers your question.

Q. I will explore with you how it was that the LHD came to deliver services within its budget in a moment, but before coming to that, do we take it from the answer that you have just given and the health outcomes that you allude to within the LHD, that whilst it may have ticked the box in terms of the budgetary KPI, it was, nevertheless, failing to deliver an optimal and equitable health service to the population that it served?

A. So the evidence of our district is that over that period of time health outcomes did improve. So it was not all disastrous. There are many areas, and there are many indicators and we have some of those in the evidence, where it did improve over that time. There are also indicators where it got worse and in certain communities and for certain parts of our society out here in the central west, there's clear evidence that that was the case.

Q. So perhaps if it gets - in terms of that issue or the question about whether or not the health services being delivered were optimal and equitable, is it the case that the answer is different depending on which particular pocket or which particular sub-community within your LHD you might be looking at?

A. Absolutely, and the answer will be different not only on the basis of what services we provide and NSW Health funds within its jurisdictional mandate, but what services the Commonwealth provides and other providers provide or

the Commonwealth funds.

Q. Probably by using the terms "optimal and equitable", I might have unintentionally confused matters. Maybe the question would have been better put: for some communities or some groups within your LHD, the health service being delivered within budget over that period of time was no doubt optimal, or at least sufficiently good for their health to have been improving throughout that period? I note you are nodding. You need to give your answer out loud --
A. Yes.

Q. -- for the benefit of the transcript.
A. Yes.

Q. But for others, where health outcomes were declining across that period, clearly the health service that was being delivered was far from optimal?
A. If the measure is to improve health outcomes, and, as I said before, the current legislative framework in Australia, both at federal and state level, is completely unclear as to who has both a responsibility, let alone the primacy of responsibility, for improving health outcomes for Australian residents.

Q. But a system that produces optimal outcomes for some but less optimal outcomes for others, depending on social factors and where you happen to live, is, by definition, an inequitable system, isn't it?
A. Sorry, is --

Q. Is, by definition, inequitable?
A. Yes. Yes, it is.

Q. Can I just ask, something you touched on a moment ago and you deal with in paragraphs 28 to 32 of your statement, suggests that your view - and I don't for one moment suggest you are alone in this view - is that when one looks at the need to produce health outcomes - let's park for the moment who is responsible for it and accept that someone within the system should take primary responsibility for delivering health outcomes for the people of its population - the dividing up of that responsibility across different portfolios within government potentially compromises the ability to deliver on that objective, does it not?

A. Potentially it does, but it's not a necessary outcome of that division. So there are some enormous advantages in dividing portfolios across government. One might not expect ministers of government to be divine in their abilities, to be the master of everything, to know everything, to be all powerful and omniscient over everything is not what we expect either of bureaucrats like me or ministers. So we have to be pragmatic on how the system is designed in various portfolios within government to give focus to the services is an incredibly important architecture of government.

Having said that, there also need to be very strong incentives and mechanisms that those various portfolios come together around issues of common interest and, generally, that will be most effective when they come together at the location. So it's one thing to come together in a senior officials' group in Sydney, and those things certainly occur and they are very productive. It's quite another to come - for all of those agencies to come together at the level of a community or a sub-region or district, a part of a district.

There are good examples of when that does occur and there are some fantastic examples in our district of some really great outcomes that have occurred. I would suggest that they are the exception rather than the norm, and part of the evolution, both for health and for all other social and other government agencies, is learning how to collaborate and to work together within our jurisdictions in ways that make a meaningful difference for our communities.

Q. As you point out, issues like housing, education, community justice and a range of others that you list in those paragraphs, if they are all working together in a way that is harmonious and producing the best outcomes that each of those little siloed areas is capable of producing, then the overall health outcomes are going to be vastly better enhanced than would be the case if you had a perfectly funded and operated health system, but the rest were all still out there doing their own thing in a less coordinated way?

A. I think that's absolutely true. I think Maryanne Hawthorn gave evidence yesterday, statistically - and it is internationally observed in a number of studies - just how important addressing a range of factors that affect risks,

risk factors for people in the community, social determinants of health, is. In many respects, it will sometimes be more important in some communities than the interventions of the health system itself.

Q. You point out that where it has worked in your LHD and there has been a good collaboration between various branches of government, it has produced good outcomes. Can I ask, is that essentially because, at least in a practical sense, the parties with each of their various portfolios and the levers that they can pull, have sat down in a practical sense and pooled their resources to look at how those resources, having regard to the levers that each can pull, can be best spent to deliver the optimal outcome for a community?
A. Very frequently, it's not actually a question of pooling resources. More frequently, it is a question of building relationships, facilitating collaboration between the agencies. Let's not forget we're talking about staff who are overwhelmed with the day-to-day demands of their jobs. I will give an example that in our district a number of years ago worked extremely well. It worked well because there was a concentrated effort on building relationships and facilitation.

Q. The example that you gave, is that the example of the patients who were repeat visitors to emergency departments who then received the benefit of the wrap-around care?
A. It wasn't one that I was thinking of, but that is another example. The one that I was thinking of was the Coonamble Together Project. When the Commission visited Coonamble I think you received some evidence about that. That was a great project where a number of agencies, our own, Family and Community, DCJ, FACS, various others, came together - police, education. I think in those days it was FACS funded a person, a facilitator on the ground, who had some discretionary funds. The simple act of funding a facilitator for that community, who was a very, very effective facilitator, to bring together all the agencies on a regular basis out of that, became a project called the Coonamble Together Project.

What was actually happening is that on a weekly basis, it may have been fortnightly, the local police sergeant, the local principals of the local schools, the local health service manager, local representatives of FACS and so on, were getting - and the local government, various other

agencies in that town, the Aboriginal affairs and so on - were coming together around the table, talking about common issues and, in some cases, even to facilitate and spin off joint case management of the issues that some families or individuals were facing.

When one of those people didn't turn up - for example, the local police sergeant may have missed a meeting - well, the facilitator was empowered, and believe me the police sergeant turned up to the next meeting - or our health service manager got busy doing something else, and all agencies had empowered the facilitator to take a more than just fatherhood and apple pie approach, but actually had some ability to be quite assertive about the outcomes that they were receiving.

The outcome of that was a family might have had an issue that, for example, related to housing. That issue might have been expressed by them approaching the local emergency department with some kind of health related condition. So that was the door of the government system that they pushed open. But we had an interagency working, practical working on the ground, that meant that we would then make sure that we took responsibility for connecting that individual with Housing New South Wales or what other part of the system. It wasn't a paper-based referral that sat in someone's intray for a couple of months until they had the time to get around to it; it was actually picking up the phone, helping, navigating the individual through the parts of the system. They may have been in trouble with the police. But, actually, their issue might have actually been something related to health.

There are great examples of that across our district in aged care, where often an older citizen who is facing cognitive decline starts to express that in extremely antisocial behaviours in the community. It comes to the attention of the police or to neighbours who want the police to do a welfare check, and in Dubbo is a good example, there is an aged care crime prevention officer - I think we all hate the title but that's their function - who will then interact with our aged care services in the community and make sure that there is a combined approach between police and health about how we actually get proper and appropriate services to the individual, rather than just put them through the court system and incarcerate them for behaviours which might have an organic cause, which

health can address. And so on. So there are many examples of this at multiple levels in the system.

But there are very few examples of where, at the level of a local community, it is well resourced, it is well facilitated, and it keeps going.

Q. I think you have indicated that those instances of great collaboration that have produced and are producing good results, at least in terms of health outcomes from the perspective that you view it, are the exception rather than the norm?
A. At a community level they are an exception. There are other examples in our district led by different agencies or organisations, but they are not the norm. It's an area where we're learning and growing.

Another example you referred to, the Planned Care for Better Health program and our emergency department diversion, we recognise, so that program looks at people who have turned up to an emergency department 10 or more times. There are some algorithms that assess their risk for hospitalisation. We have a whole team that does an intensive amount of work with them, not based in the hospital, based in the community. We've discovered that many of those individuals have no connection with primary care at all. Many of them will be suffering significant social disadvantage - homelessness, couch surfing. Homelessness in the sense of people sleeping on a park bench or in a tent in the main street is relatively not that obvious in Australia, certainly compared to other countries, but homelessness in terms of couch surfing, 20 people to a household that is really designed for four, is absolutely endemic in some of our communities. We discovered that through COVID.

That service wraps people around, it will connect them if there issue is housing. If there is issue is - they may often have an encounter with the criminal justice system. If their issue is navigating access to primary care and how we get long-term connections with primary care, if their issue is fronting at the ED but really their needs would be better served by a community mental health team engagement or a community alcohol and drug service, they help those individuals navigate to the other part of either our system or other part of government system. It is very intensive, very, very expensive to deliver. It's hard work, because

the reality is that the system, by its nature, and unavoidably, is immensely complex from the perspective of a consumer. I find it complex and I know more than most other members of our community about how to work the system, just simply by the privilege of the work experience I've had over many, many years. So the need for us to join together and navigate, facilitate services across government is profound.

Q. You have given an example of Coonamble Together which, in the context of a small town like Coonamble can be achieved through a community facilitator role. In a large community like Dubbo, for example, do you have a view about ways in which that greater connectivity between different agencies might work?
A. So the principle is the same. In a community like Dubbo, there are large parts of the community for whom they don't need that assistance, so it is very targeted. We target it around individual circumstances, individual parts or family or individuals in our community. But the principles are the same, of facilitation between the agencies, which is a very different level of facilitation than, for example - and through regional New South Wales there is really good facilitation between senior leaders, myself, the police inspector, and so on, other parts of government which we come together in a formal regional leadership forum from time to time, facilitated by regional New South Wales.

That's effective at the level of policy, it is effective at the level of more generic projects, for example, how are we going to respond to the energy zones being developed in parts of our region together and the impact that might have on services. But there is a very different level of collaboration that occurs much closer to the coalface, and what it requires is recognition - there is no NWAU for bringing together agencies and communities to get our collective services to work together. There is no block funding to do that. And while it is an issue in all communities, I would suggest it is a far more pronounced issue in regional, rural and remote communities than in most parts of metropolitan New South Wales.

Q. Your reference to the fact that there is no NWAU or block funding for providing that connectivity carries with it an implication that it is the health ministry's responsibility to be the facilitator. They may be the

best, but do you have a view about that, whether health is well placed to be the facilitator of that whole of government coordination, or is it your view that maybe there is another body that's better placed to do that?
A. Unsurprisingly, my answer would be that I personally believe that health is well placed, if it was funded by government to do that, simply because, by the nature of the services that we provide, we often interact with exactly the most vulnerable members of our community who we're talking about targeting.

Having said that - and, for example, you could theoretically say that some other part of government should plan the distribution of health services across our district, which I would be strongly opposed to. Having worked in the system, it's taken me 40 years to really understand it. I think the Commission's ability to understand the nuance of how things come together in the system has been remarkable in a short period of time, but with absolutely no disrespect to the Commission, I can tell you that there are gaps in understanding and knowledge because you haven't worked in the system, and that's - there is nothing pejorative in what I'm saying, I'm just simply saying it takes a long period of time. But what I'm not saying is that health should do it alone.

Q. So whilst your view might be that the person who is funded to actually manage that facilitation may be well positioned within health, funding needs to be provided to each of the various branches of government who are required to collaborate to enable that collaboration to occur, in the sense of making sure that there are sufficient people delivering the workload that's already weighing heavily upon them, for each who needs to, to set aside some time to have that meeting once a fortnight with their colleagues and make sure everything's ticking along in a coordinated way?
A. I think it would be arrogant for me to make an assumption on behalf of other parts of government. What I can do is talk knowledgeably about the needs of our local health district. I would suggest that dedicated funding to support that process, to do it extremely well in our more vulnerable communities, would be an appropriate part of the health funding infrastructure, but I emphasise, from a whole of government outcome perspective, not merely from a health perspective. That's what we're trying to facilitate across these communities.

Q. I will come back to KPIs shortly, but the current KPIs don't contemplate any assessment being made of, say, the extent to which facilitation of the type you have spoken of is being attempted or achieved, do they? When I say KPIs, I'm referring to those contained in your service level agreement.
A. KPIs by themselves are very often a measure of process. There are lots of process KPIs. There are some in the service agreement which are measures of prevention of disease - for example, reduction of smoking rates in pregnant women. There aren't KPIs that are really about how we take our leadership role with our communities to improve health outcomes, and some would argue that they shouldn't be there, because as I said right at the start, the legislation is entirely unclear as to whether that's the responsibility of NSW Health or not.

Q. Is there not ultimately a risk that process-driven KPIs might lead to a focus on process which distracts attention from the ultimate objective of delivering good health outcomes for a community, or improved health outcomes for a community?
A. All health systems have multiple objectives and sometimes they have conflicting objectives. Process KPIs are really important in order to meet community expectations of certain kinds. For example, surgical waiting lists - something that community members having access to surgery require, it is incredibly important to them, so that's a really important process KPI. Community members' access to timely care in emergency department - really important KPIs that are very meaningful to the community. So those things are really important.

What's missing, however, are the KPIs that drive towards an ultimate outcome of improving health outcomes for communities. I would argue that they are rightly not in service agreements at this point in time. They can only be achieved if, in fact, the fundamentals of how you structure the health system is to have a population based mechanism for funding, at which point it might well be entirely reasonable to compare my activity as chief executive in my local health district with the activity or outcomes achieved by another chief executive in a local health district, because if our funding is equitable at a population basis weighted for the determinants of health, the inequalities of health outcomes, you are actually

starting from a level playing field in terms of if you are going to measure health outcomes as core KPIs.

Q. In terms of health outcomes as core KPIs, can I ask this practical question: is it your view that there are KPIs which would measure health outcomes which are actually capable of being objectively set?
A. Yes. Absolutely. Yes.

Q. Just in your view, what are the sorts of KPIs that might - were we dealing with a capitated system in the way that you have discussed, that might be set to actually assess the extent to which the funding, appropriately weighted funding that you might receive to deliver health outcomes for your community, is actually doing what it's intended to do?
A. Mortality, morbidity rates, disease burden, there are a whole range of them. You know, far more erudite people than me can answer this question. There are textbooks by the millions that have been written on this and there are some countries that have experimented with this not only for health but in other parts of government through social investment models. But there are - the essence, without getting into the detail and wasting time, it is entirely possible to envisage not only direct KPIs but also proxy KPIs.

At the moment one that we use within our own district, it is not part of our service agreement but it is part of our sense of community responsibility and passion to do things better that our LHD has would be around rates of morbidity, mortality, and with that also, increasingly looking at some - albeit process measures - access to services that we know make a difference across our various LGAs.

Q. Just coming back very briefly to the wrap-around whole of government approach, to the extent that costs incurred in health - for example, the provision of adequate primary care in a community that does not otherwise have it - reflect an experience within the health budget, are you aware of any assessment being made of the economic benefits that would be derived on a statewide level by paying whatever it costs, might cost, to deliver that primary care adequately within the community?
A. So there have been some attempts, very focused attempts, more at a disease-specific focus attempt,

collaborative commissioning is one of those, but they are very small-scale, and more to do with the specifics of a particular disease than the generality of all of the, by nature, general health services primary care provides.

In our district we have not done an economic modelling of the benefit of that in terms of outcomes for the community, yet. What we are early in the process - and Maryanne gave some evidence of the health needs analysis that we were doing and so and providing to the PHN - some of the work that we are now doing is looking at the rates of access to primary care and specialist medical care through MBS billing rates on a population basis across all of our LGAs.

Unsurprisingly, there is a correlation with the health outcomes in some of those LGAs. It's very much at the infancy in our district and requires a lot more sophistication, but we've recognised that's exactly where, in order to plan and deliver the services that our community needs, we need to go. Traditionally, planning in our system, quite rightly, has been focused on the services that we provide. It is often very focused on the need to rebuild an infrastructure over time - for example, a hospital - to meet the needs of its community. But where we are working, and we've invested heavily in our strategic reform, planning and partnerships team to take us on this journey, is to look at differential rates of access and then, beyond that, to try and draw a connection with the health outcomes for a community.

If I may, in my statement - as you can tell, I can talk, so please make sure the time is used in the way that you would like - but if I can draw your attention to paragraph 17, and above paragraph 17 in my statement a graph which shows general practice attendances between 2013 and 2023 across all of the local LGAs in our district. What that shows is that in every single one of the local government areas in Western NSW LHD, we have a lower rate of general practice attendances, particularly for children aged zero to 15 years, than is the average for New South Wales.

So the next step is to take that information and at an LGA level start a deep dive: so what are the health outcomes that we're seeing for young children? There has been a lot of work looking at health outcomes for young

children in our district, which is extremely important. We invest heavily - the New South Wales Government invests heavily in First 2000 Days services, because we all recognise that what happens in the first five years of a child's life will have a fundamental difference on how healthy, well they are in their 30s, 40s, 50s, 60s, 70s. It will have a fundamental difference in how productively they can participate in society, gain good jobs, good income, participate constructively in communities. We participate heavily in looking at that.

Q. You may not be able to answer this, but we did receive some evidence in an earlier block of hearings to the effect that The First 2000 Days was identified as a premier's priority, as a result of which all branches of government were able to attract additional funding at budget time, if they could identify The First 2000 Days outcomes as being something that would be achieved through the delivery of that funding. Is it your view that the First 2000 Days work that is being done by your LHD would have been done had it not been for the availability of that funding source through the budgetary process, or would have been done to the extent that it is?

A. It would have been impossible to do to the extent that it is in any local health district or other part of government. What you are essentially asking is that - does government have a leadership role, whatever form or shape or colour of government, in terms of the services and the way that government supports its population. Well, by definition, that's the definition of democracy.

Q. Coming to a slightly more practical, nuts and bolts point, though, in terms of producing good health outcomes, do you have a view about what might be a good priority or what might be a good objective to identify as a source whole of government for funding through this budgetary process that would actually result in better health outcomes for people within your LHD and perhaps others?

A. So there are many, and if I've learned anything about health, it's complex and multifactorial, and if anybody says there is a simple answer or a single-system answer, they are generally somebody you shouldn't pay too much attention to.

However, First 2000 Days, which is a priority for the government, was a priority for previous governments, is still being funded, is clearly, in anybody's language,

a priority for investment. The health outcomes and services for First Nations people, I would suggest, is and should be a priority.

Then there are a range of other priorities. So one of the particular issues in our district that, for our district, absolutely has to be a priority but may not necessarily need to be a priority for other parts of the New South Wales health system in quite the same way, would be services to older citizens, so services for those who are aged 70 years or older or First Nations people, perhaps 50 years and older.

How all of that comes together - again, it is a split responsibility between the Commonwealth and the state - we provide the acute health services for those parts of our community, we also provide a whole range of assessment services on behalf of the Commonwealth, and increasingly we subcontract community based providers to provide home based support services for older people, but in our district, the rapid ageing of our population, which is disproportionately greater than the rest of New South Wales, that will be an absolutely critical issue, so that people can age well in our communities to the best of their abilities.

Any health economist would tell you, given a choice between focusing on children and focusing on older people - and, please, I say this with absolute respect for our older citizens - but the return on investment across somebody's lifetime if you focus on them when they are two years of age will, by definition, be far greater than if you are focusing on their needs in the last one or two years of life.

Having said that, the care of the elderly in our community would be an absolute priority for our LHD, and absolutely is.

To give you an example of what that might mean and how the system needs to come together in a far better way, any day of the week - I will use Dubbo hospital because I'm in Dubbo today, it's only one example of many. There is a gentleman who has been in Dubbo hospital for over 110 days, with no acute health need to be in Dubbo hospital. It is an unsafe place for that gentleman to be, particularly going into winter. He will be exposed to diseases and illnesses in that hospital merely by the fact

he is in there and unable to get out of the hospital, that he would not be exposed to if he was living in the community, because, by definition, people who aren't well go to hospitals. That's our business.

We can't get him out of the hospital. He is perfectly ready for discharge into residential aged care. In Dubbo, there are many providers - and I will just use this example but I know there is one provider, and as well as this gentleman, on any given day of the week, there will be 12 or 13 or more people in Dubbo hospital who do not need to be there for their clinical treatment but are there because they are unable to access a place in residential aged care.

There is at least one provider - this is only one of many of residential aged care in Dubbo - who today has nine free bed places, but they are a private provider, they have no obligation to accept a discharge from the hospital, they are an independent business, and like all sensible independent businesses, given the range of different kinds of funding from the funding you'd receive for somebody with very low care needs to the funding that you would receive for somebody with very high care needs, there's actually a middle band that if you are a residential aged care provider, commercially, you are sensible only to take people in that middle band.

If their care needs are too low, well, actually, they should be in the community, and in fact you will consume a lot of resource for them relative to the income that you will get. If their care needs are too high, you will consume and need to put a lot of staffing around them that you won't necessarily want to do, and specialised staffing that you may not have. So as a private residential aged care provider, you will always aim to take people who are going to return for you the optimal return or profit on the fact of having them in your community.

The people who I'm talking about in Dubbo don't nicely fit into that band, so where do they go? There is nowhere for them to go.

Another example - I'm sorry, but these are the real world things that we really need to focus on in aged care, and there parts of the system where focusing on aged care isn't important, but in rural and regional LHDs it absolutely is. Because of the MPSs that we provide,

roughly half of the bed base across our entire districts, our hospital footprint or MPS footprint is residential aged care beds. So it's incredibly important for us.

Another example. Tuesday evening - I watched a testimony during the day from the hearing. Around about quarter to five I received an email from the general manager of the Parkes Shire Council who had just been informed by the provider of a residential aged care facility in Parkes, a 48-bed facility, so not small, that they were closing. Nothing to do with me. Nothing to do with my LHD. However, I'm the person on the spot that they know - I'm not an anonymous person in the Commonwealth department of aged care that they don't know. So they contact me, "What are we going to do about this? How are we going to respond to this?" In a small town like Parkes, a town of 10,000 people, taking out 48 residential aged care beds on the verge of winter will be enormous, and I can already tell you - and I used the example of the rest home that I referred to in Dubbo that had the nine free beds. So already, that provider, quite rightly, because they have to re-place their residents who are currently in Parkes, an hour and a half away, is in direct consultation with that provider to fill those nine beds. At one level, that's a great thing. But at another level, from the point of view of the acute healthcare system, that removes yet another opportunity for either Parkes hospital or Dubbo hospital to discharge older residents that they are going to need to, and who need to be into residential aged care, on the eve of going into winter. And removing those levels of capacity is going to be very difficult.

Now, the reason I've taken some time to paint that picture is because the reality is there is no joined-up planning between the Commonwealth and state about the delivery of services for older people, whether it be in primary care, whether it be in residential aged care, whether it be in community based care, they don't come together. They don't join. The two large systems of government that fund work from entirely different bases. We're about to see all of the community aged care services, whether it's assessment or the delivery of things like community home support across New South Wales, be put through an entirely contestable process by the federal government.

Well, you will see in a few days - and, believe me,

I'm a passionate believer in using contestability to drive efficiency of services, but in "thin markets", quote/unquote, or non-existent markets or fragile markets, those kind of processes actually just drive market dysfunction. They drive an inability to plan.

So I'm coming back to your question, you asked me what parts of society would I focus on? Those are the three for us in our district, and there are many others. One is services to young children, First 2000 Days of life. One is services to First Nations people. And the third one is services to the older people who, many of whom, and increasingly in our district an increasing proportion of our population - I think those over 70 will increase by 41 per cent or something between now and the early 2030s in our district - to have focus on services to older people are absolutely critical.

Q. I think we heard that particular group described as a populational speed bump yesterday. Do you, in terms of future planning, have a sense of the extent to which the need to provide for that particular burden of elderly residents within your broader district is a transitional issue in the sense that at the moment, there is a larger and possibly increasing proportion of the population which is elderly, but that that percentage, as time rolls on, will decrease relative to the overall population?
A. So demographic projections suggest that going into the 2040s. But it's proportionally very, very different across the footprint of our district. So we have towns - if I can describe it this way, we have some towns, I won't name them, they will get very upset if I do, some shires in our district, where the population is expected to more than half between now and the early 2040s, and mostly that's reflecting the older population who are just now coming into the 10, 15, 20 years where they will need intensive service support and increasingly intensive service support and, of course, they and their families want them to remain in those communities, it's where they have lived, it is where their networks of support are, and that will be pretty intensive in those towns and increasingly so for the next 15 to 20 years. And then, as their life takes its natural course, the need and the demand will reduce.

But at the same time, and equally opposite to that - I think our district is a perfect example of this - there are other towns, Parkes would be a case, I've spoken about

them, certainly all of the larger regional towns, and the further south you go in our district the more true this is - the population is actually rapidly increasing, and I think somebody yesterday spoke about Dubbo, which, you know, just over 40,000 people now within the early 2030s is expected to be somewhere about 65,000 people, and there are residential developments that would support those kind of numbers, they are not just plucked out of the air.

But what is happening is there is internal migration in our district from far more remote towns, and some of that is driven by the lack of access to services, particularly NDIS services, in small towns that enable people to stay in their own homes. I literally know of anecdotes of community members who have had to uproot their families and themselves and move to larger communities within our district, even though they lived their for decades, because they couldn't get home based services that they needed to support, despite having very well funded packages that they could have purchased services if they were available.

Q. That's a consequence of workforce challenges or workforce distribution; would that be right?
A. It is partly a consequence of workforce changes. I would also suggest it is a heavy consequence of if you have a thin and fragile market and you constantly disaggregate it through repetitive rounds of contestable "Let's go out and contract for this and give somebody a 12-month contract for this" - providers struggle to build capacity, and capacity over the long term. So it is not only about lack of workforce, it is, I would suggest, also a reflection of a fundamental miscalibration between some public policy approaches in more regional and rural and remote communities, compared to what would actually make services sustainable in those communities.

In saying that, and the point that I really wanted to make, because it will get us back to the core and the focus of the Inquiry, which is of course health care financing in New South Wales - we've talked a lot about Commonwealth services over the week, we've talked a lot about primary care, which is not the responsibility of the New South Wales Government - within our district, our population across the LHD is static, and in fact, the growth funding for population that I received last year as the local health district was negative, it was around about a million

dollars less. And that trend will continue for some time, and at one level you can say that's appropriate. At another level, because it is not equity adjusted, I would argue strongly it is not appropriate, given the needs of our community.

However, what that means is, I've got parts of our community that have an increasing need for services because of the increasing or increased health needs of the people who live in those communities - let's say older people - so that's going to be more expensive for me to deliver and support over a long period of time. And then I have other communities, and let's take Dubbo - I could equally take Orange or Bathurst as an example - where in fact the needs of the population to provide increasingly complex hospital services, specialist services, larger emergency departments, because the population is flowing into those communities, is also extreme.

So, in other words, I'm describing, in some ways, a sausage that is being squeezed at both ends.

THE COMMISSIONER: Q. Can I just ask you why you are saying, or what you mean by, primary care is not the responsibility of the New South Wales Government?
A. Just to divert slowly, and I will answer your question, Commissioner, of course - I have used the term "primary care" inclusive of a whole range of aspects of primary care, and that definition, what I said, is incorrect. There are clearly aspects of primary care that are the responsibility both of the local health district and the New South Wales Government.

Q. New South Wales Government, of course, doesn't do the MBS.
A. That's right. So that's what I was getting to. So general practice and the MBS. In fact, in the graph - and there are a number of graphs in my evidential statement, but the one that's on the screen, and I will just point out, that's about GP attendances, what that graph is showing you is MBS funded attendances. So it's telling you two things. Not only is, for most of the LGAs in my district, access to MBS funded GP services actually being taken up by consumers, by members of the public, less than the New South Wales average, but what the data source shows you, it's not only general practices in my district. These general practices, so these general practice encounters

between residents of Western New South Wales and a general practitioner, could have occurred anywhere in Australia, anywhere in New South Wales. So it's a true recognition, if you like, of the differential access to MBS funded GP services, and I show in my later evidence similar evidence related to specialist MBS funded services, and more correctly in my statement, Commissioner - and I do stand corrected - the provision of MBS or Commonwealth funded services, not all of which are MBS funded, there are some programmatic funding through the Commonwealth, is clearly not the - through the national health reform agreement is clearly not the responsibility of the state government.

MR MUSTON: Q. That's because there is a compact between the Commonwealth and the state, pursuant to which the Commonwealth has agreed to provide a funding source, via the MBS, to meet the primary care needs of the community?
A. Well, it's not only a funding source. The Commonwealth has also stood up its own intervention mechanism in Australia, we call them primary health networks, in order to facilitate the growth of general practice and to identify service gaps and to meet those service gaps through interventions, and that's the Commonwealth's primary agency on the ground in relation to general practice.

THE COMMISSIONER: Even your question about "The Commonwealth has agreed to provide a funding source via the MBS to meet the primary care needs of the community" - even that, it's not the entirety of primary care. Yes.

MR MUSTON: The compact provides that the Commonwealth will deliver to the holder of a provider number a particular amount of money - views about the adequacy of which we have heard a lot - to the extent that that holder of the provider number delivers a service which has an item number.

Q. Your point about the primary health networks being involved in identifying service gaps - it's not the role of the primary health networks, as you said, to deliver service, though, where those gaps are found?
A. No, but it is the role of the primary health network to advocate and to commission services on behalf of the Commonwealth to meet those gaps to the extent that the Commonwealth funds them to do so.

THE COMMISSIONER: Q. For example, an example of primary care being facilitated and funded that doesn't involve the Commonwealth or the state is Bogan shire, where the local government has stepped in to provide a means of their community having primary care where, if they hadn't have done anything, there might be none.
A. Sir, Bogan shire is a good example. However, they do receive MBS billing for that practice, of course, the Commonwealth has a role.

Q. Of course. If there is no GPs, there is no MBS.
A. That's right. But I would also reflect on the testimony of the Bogan shire. I think they are running - and this is a small shire, I don't know what their budget is - I think their evidence was that they were forecast to make about a half million dollar loss on their practice.

Q. That was what they told us, yes.
A. And they also proffered a view that it wasn't the responsibility of local government to fund what most taxpayers would assume they were paying taxes to the Commonwealth Government to do rather than rates, ie, they are being taxed twice. I would personally find that argument very, very difficult to refute - in fact I agree with it.

Q. It's not the first time that's been discussed.
A. However, what I would say is what an extraordinary thing on behalf of their community that the Bogan shire stepped in to that gap. One has to respect that. I think what we're saying here is that they ought not to have had to step into that gap, particularly not in a funding sense - perhaps in a facilitatory sense, but not in a funding sense to the extent that they are.

THE COMMISSIONER: Sure.

MR MUSTON: Q. I will come back to Bogan shire. Can I ask you to turn to paragraph 108 of your statement, just to round out --
A. I'm sorry?

Q. Paragraph 108 of your statement.

THE COMMISSIONER: Just keep going. We will take a break at 11.30.

MR MUSTON: Yes. I'm content to take a break whenever it is needed. We started at 10, I think, so I assumed 11.30.

THE COMMISSIONER: Deal with this point and then we'll take the break.

MR MUSTON: Q. You see in paragraph 108 there you point to successive governments in New South Wales, across all political persuasions, having arguably made comparatively less use of legislative regulatory intervention to improve health outcomes than many other jurisdictions internationally. The first question around that: do you have particular jurisdictions in mind where you think legislative intervention has been made effectively?
A. Well, New South Wales and Australia has used legislation to effect in certain situations, and I think Maryanne talked about some of those yesterday. My point is that, in fact, they could go a lot further, and there are many jurisdictions around the world where there is evidence of that. My familiarity is New Zealand, so a far from perfect society, let me say, and I don't like drawing comparisons between the two, but because that's my experience.

Q. I'm content for you to give us an example based on your New Zealand experience if that is one that you can call readily to mind.
A. Sure. So in New Zealand, it would be illegal to advertise gambling on television. In this community - again, because we're in Dubbo, I will just use an example - a million dollars a week departs the Dubbo community through pokie machines in this community. Why is that important? Why does that relate to health? Well, we know that the link between economic impoverishment in households and family violence is a clear correlation between those two things. We know that when families get economically stressed, that often, unfortunately, family violence erupts.

We know - and I have given evidence in my statement - that the link between family violence and harm to children, or to women particularly, and their long-term health and social outcomes is demonstrably lower because of being exposed - not always, not at the level of the individual, necessarily people can overcome extreme disadvantage and do extraordinary things - but, on average, the evidence from various studies of harm and maltreatment is that there will

be significant long-term disadvantage for people because of economic impoverishment. So that's an example of a different use of legislation between one jurisdiction and another.

Q. In relation to that one, do we take from that that there are obvious health-based legislative interventions like plain packaging with tobacco, for example, and I think some evidence was given of that yesterday.
A. Yes.

Q. But, equally, when one looks to, say, the social determinants of health, there are other levers, legislative levers, which could, and in your view should, be pulled in order to turn around health outcomes by influencing those social factors?
A. Yes. And I will give you another example, again to be controversial and, obviously, I don't want to stray too far into the realm of politics, but the evidence suggests that the return on investment from using sensible legislation in a sensible way around some of these things - return on investment is something like 53 to 1. It outweighs any other form of health intervention by an extraordinary amount.

So other interventions that might be useful, for example, the level of sugar in certain processed foods. I think it's true, but I will say this is anecdote because I'm on the stand, so anecdotally, I understand that the level of sugar in a bottle of Coke in Australia is significantly greater than the level of sugar of a bottle of Coke that you would buy in the United Kingdom. Why? Because the legislative framework is different.

Why is that important? Well, in the Western New South Wales PHN district, so our district and Far West, that PHN reports statistically as having the highest levels of obesity per capita of any primary health network district anywhere in Australia. We know about the links between obesity and long-term negative health outcomes. You've got to say, intervention that gets to the source - because a lot of what happens in health and a lot of what happens in our responses to health is the treatment of symptoms. What we think the health system should be designed to do, as best as it can within all of the compromises that we have to do in a democratic system, is try to address the root causes of long-term health outcomes as much as we also

address the immediate symptoms of some kind of dysfunction in the system.

Another example - and I will just use this because it did strike me when I came from a different country - when I was responsible for public health services in another country, a lot of their work was in fact - I would have public health physicians who would turn up, for example, in development applications for fast food outlets, and we would present to local government - and you wouldn't do it in Australia, the legislative framework is different - we would present countervailing arguments as to why the density of fast foods - and unhealthy fast foods I'm meaning in saying this - might be regarded differently by the local government in terms of awarding development applications than otherwise, or we would turn up to a liquor licensing process and again provide strong evidence about the social harm if liquor licensing was disproportionately allocated to one suburb within a community versus another.

And why are these things important? Well, there is ample evidence that the proportion per head of population of fast food outlets or liquor outlets is disproportionately concentrated in suburbs where the socioeconomic base is lower.

Q. When you say you would turn up, is it turn up because the institution responsible for health thought it was a good idea to do, or because legislatively it was a mandatory consideration, namely, the health impacts of whatever decision was being made about, say, the fast food or liquor outlet?
A. No, because as in Australia, public health physicians and public health professionals recognise actually it is a very sensible thing to do. So they were professionally driven to turn up. The difference was that the legislation required a broader set of factors to be considered in the process of awarding licences or applications for these things to occur than is the case in various parts of legislation in Australia. So those are two examples.

A third one, a very similar vein - and why is this example important? I'm about to give you an example of fluoridation of local water supplies. It is extremely important because we know there is a direct correlation between poor oral health and long-term heart disease,

cardiac issues. It is a proven correlation and it is also a very well proven correlation between the fluoridation of public water supplies and oral health over the long term of somebody's life.

So in another country, where they were empowered by law, to the extent that national legislation eventually got changed to require councils to do things differently than they had before, we would often turn up at public hearings, and public hearings being highly legal hearings such as this today, to advocate strongly about why a local council should be required to fluoridate its water supply in a way that it currently doesn't.

In Western New South Wales today, less than half of the publicly-supplied water supplies across our footprint are fluoridated, including Dubbo, as at today, does not have a fluoridated water supply. To give due deference to the Dubbo regional council when that deficit was pointed out to them a couple of years ago - they are investing heavily in order to supply and correct that deficit, so I take my hat off to them. But they are examples of legislative frameworks that exist in other jurisdictions, which are perhaps less well evolved in the New South Wales or the Australian context than they might be.

I note a period of caution, because I know what my detractors will say. I'm not arguing at all for the nanny state. But I am arguing that the frameworks of legislation should allow for a balanced consideration to the benefit to the community overall between the interests of private individuals wanting to promote businesses or conduct their public affairs in ways that are more beneficial to the individual or the public agency than they are to community as a whole - that there needs to be balanced conversation and debate about that in a legislative way.

MR MUSTON: I note the time, Commissioner. I'm going to move on to another topic.

THE COMMISSIONER: Yes. We will take a 20-minute break. So we'll adjourn until five to 12.

SHORT ADJOURNMENT

THE COMMISSIONER: Are we ready to resume?

MR MUSTON: Yes.

THE COMMISSIONER: Please do.

MR MUSTON: Q. I will just ask you one quick point of clarification around some evidence you gave before the morning tea adjournment. You gave some evidence about the 48-bed aged care facility in Parkes which is closing?
A. Mmm-hmm.

Q. I think you said in relation to that, that whilst you are the person on the spot who is called, "It's nothing to do with me, nothing to do with my LHD". I gather from that answer, you are essentially alluding to the fact that the funding stream for aged care is a Commonwealth responsibility, not something which forms part of your budgetary allocation as the Western NSW LHD?
A. It would be - what I'm meaning is both that the funding isn't the responsibility or the responsibility of NSW Health, neither is the provision of private residential aged care. That is the responsibility of a private enterprise. I think, essentially, the point that I was making is that fragility in that system will almost always, by default, fall to the chief executive of the local health district. They will get pulled in by all of the stakeholders to try and solve the consequences of the failure of a private business or the business decisions of - in this case, the business decisions to change where and how they invest in aged care relative to Parkes.

So we will be pulled in to try and help solve the issue because we are the people on the ground and our communities, our local shires will contact us, involve us in trying to provide parts of the solution, although specifically it has nothing to do with us.

But we'll also get drawn in to providing the downstream solutions to all of the downstream consequences. In the example I gave of Parkes, I know, as a result of Tuesday evening, that the pressure on Parkes hospital and, indeed, the pressure on Dubbo hospital to be able to discharge patients back into residential aged care in the middle of winter, which they will need to do in the coming months, will be fundamentally more difficult because of that closure than it was going to be on Monday evening.

It will take some time for that closure to occur, but

the point I'm making is that local health districts and New South Wales health system essentially plays the provider of last resort responsibility. The Commonwealth doesn't necessarily fund the New South Wales health system to be a provider of last resort. And there are many examples, whether it is in aged care - I just used that because it was an example in aged care - or primary care or general practice, where, in the interests of the community, in the interests of improving health outcomes, chief executives of local health districts and, indeed, officials in the Ministry of Health, will stray far beyond the traditional bounds that one might have expected of a chief executive, let's say, 10, 15 years ago within the New South Wales health system with problems to solve, simply because - and by "chief executive", I mean our teams, I don't mean solely rests with me - but the system, the New South Wales health system will respond simply because there is nobody else who is going to.

THE COMMISSIONER: Q. We can all guess, but were you given in indication as to the reasons why that 48 -bed facility was closing?
A. Again, at the level of anecdote, so it is third hand, I understand that the facility requires substantial infrastructure investment by the provider. I think the local shire had been pointing that out to them for half a decade or more. The provider has decided to rationalise their services and to sell off one of their facilities in an adjacent town in the central west, for which they have a buyer, but for this facility, given its infrastructural problems, they have no buyer, so they will close it.

THE COMMISSIONER: Thank you.

MR MUSTON: Q. Can I ask you some questions about primary care, which we've already discussed the divided funding responsibilities and where, in your view, primary care sits in relation to that divide, but you point in paragraph 124 of your statement to a decline in the availability of primary care as a fundamental challenge faced by your LHD.
A. Correct.

Q. I think you tell us, and I think it is most unlikely to be controversial, in paragraphs 18 and 19, of the importance of good accessible primary - and stable primary care for long-term health outcomes of a population?

A. It is the absolute bedrock of any western health system.

Q. In relation to the planning that you are undertaking as part of your LHD, you tell us in paragraph 129 that you are aware of the 41 towns within the LHD that are at significant risk of not having a GP within the next 10 years. Just pausing there, that was a 2019 study. Is that 10 years from 2019?
A. It would have been at that time, and that was a forecast, that study was done by the primary health network.

Q. So we're halfway there.
A. Mmm-hmm.

Q. What do you see as being the solution to the delivery of primary care in those 41 towns, assuming that allowing it to fail and not having accessible primary health care within those communities is not a viable solution.
A. Well, if I start at the stratosphere, clearly the way that funding is organised between the Commonwealth/state, it drives you to the conclusion that, in fact, it is a viable solution, at least in the perspective of those who fund MBS, because that's what it drives. Nevertheless --

Q. By that, I gather you mean if you are funding the MBS scheme and the MBS scheme is dependent upon an effective market to deliver health care funded by that funding stream, if there is no market and you have no funding obligation, then that's not necessarily a negative outcome from a funding point of view?
A. From a budgetary point of view, but from a social responsibility point of view quite different.

Q. From the point of view of the community in those towns radically different, I would suggest?
A. That's right. And I don't mean in any sense to be pejorative about the motivations of people in the system. It's not generally how it works. But that is the unavoidable technical conclusion of what's going on.

So what do I see the solution, which is really what your question is? And the reason I went there was right at the beginning I suggested a fundamentally different way of organising funding, recognising social determinants, social deprivation, rurality, all of those kind of things that

I had experienced elsewhere and under that model the local health district equivalent was responsible for funding primary care as well, so all of the funding was pooled. They had obligations around the percentage split of their funding that had to support primary care so that it wasn't all sucked up into the large hospitals, which are money rapacious at the best of times.

They also had obligations in terms of achieving health outcomes, which the current structures of the systems in Australia don't have.

So having sorted that - and I've suggested that part of the solution in rural and remote areas, and may I preface it this way, what I'm proposing in my evidence is a solution to the issues faced by remote, rural and regional New South Wales. They may not be appropriate solutions for a metropolitan area, and that's one of the differences between local health districts --

Q. Before we move on, would it be right to say that even within remote, rural and regional New South Wales, the particular solution that might be best suited to a particular town or community will depend very much on the circumstances of that community --
A. Yes.

Q. -- its needs --
A. Absolutely.

Q. -- the viability of the existing market, et cetera?
A. Yes. And I think, as you heard yesterday, any large organisation like a local health district should be very, very averse to moving into situations where they disrupt the viability of private enterprise in delivering healthcare services through general practice. So you have to be very mindful about that. There are some tests we could apply to when an intervention is good or not.

Q. Is a critical starting point, though, to the extent that there is any existing market in a town, close and careful consultation and collaboration with that existing market to find a solution which does not undermine the viability of it, yet meets the needs of the community insofar as they are not being met by that market-based solution?
A. Absolutely it is, and we refer - this term is poorly

used, you hear it often thrown away - place-based planning, but that's exactly what we're meaning, engagement with all of the stakeholders on the ground. In our district, we haven't seen any examples of high quality place-based planning to date. Our LHD has in its '24/'25 annual plan a particular shire in our district where we want to move on that journey. We've discussed that at a board level with the PHN board around one of the places that we may try an experiment to do things in a more joined-up way, but not only between us and the sectors that we represent but between the practitioners on the ground, community members, stakeholders on the ground, NGOs, GPs and so on, and we've chosen a particular shire, which I won't name because that would be premature, we've yet to finalise that agreement with the PHN, but a shire that has moderate levels of difficulty, ie, is not really a basket case. So, in fact, we've got somewhere that might be a test bed that has both strong general practice in some towns but not others.

Q. So without needing to get too far into the details, is this one of those towns that does not have a nice thick market of general practice that's meeting the needs adequately of its community --
A. It is a shire that has some towns that have really viable general practice and some that do not. So it's a mixture of towns of small and moderate size, and the towns that do not previously would have had - and did have - viable general practice.

Q. Being delivered through a long-serving and perhaps long suffering GP VMO who also delivered care into --
A. In some cases in some of those towns it was a GP not a GP VMO and in others it was a GP VMO, yes.

Q. I interrupted you.
A. The distinction between those two things, the GP who works solely in office-based general practice and one who is a rural generalist who might also provide services to a community hospital or an MPS. Sorry, could you just bring me back to your question?

Q. The ultimate question was: what's the solution to the failure of general practice within those 41 towns, but I think you were telling us about the project that you are undertaking with the shire of the place based planning?
A. About to undertake in the '24/'25 year. So that's part of the solution, joined-up planning in a really

authentic, well-engaged way, and you've seen members of my team, some of them, have got enormous capability in that area, and I'm confident will do a good job. But it's not us doing it alone; it is us doing it in collaboration and partnership with others across the system, whether it is NGOs, whether it is community members, whether it is shires, whether it is the PHN.

Another example of a model which you will be well aware of is the Four Ts where, in fact, we did have general practice failure. Might I say, there is a bit of a myth in Australia that local health districts - or local health networks if we're in other states - don't step in to providing general practice services. In fact, there are many examples, I can think of some in Victoria, obviously the Four Ts is an example, some in Queensland - in fact, I'm about to visit a very longstanding one in Longreach where that has been a way, in a rural and remote community, to provide both hospital-based MPS-type services as well as general practice for some time, an accepted model that works for those communities.

The Four Ts was our version of that. It was a pilot across four of our towns that, as you have heard I think in previous evidence, were going to lose their general practitioners.

What was different about that pilot was instead of dealing with a single town and a single general practice, we joined up four proximate towns to try and build a general practice, which was the amalgamation of four, and technically in a commercial sense, we've got four independent general practices across those towns, but we have an overarching licensing body, of which I'm a principal, so I'm a general practice owner in my job, along with other members of my organisation, and we are providing general practice services through a section 19(2) exemption in those communities.

That's an example of a model that has worked and arisen out of place-based planning in those communities of a very specific type, so we're just looking at general practice services, not the totality of all services in that community, that has worked very well. There is a caution.

Q. You give us the caution and then I will ask my next question.

A. So the caution is it relies on section 19(2), and we have got five communities, we've got section 19(2) in place, we've got about another seven, we're in the final stages with the PHN about trying to have section 19(2) availability in those towns and another seven on the list after that. So we're trying to progress --

Q. The question that I was going to ask relates to that, so at the risk of interrupting you, the section 19(2) exemption in the Four Ts model enables a salaried GP operating within the public health system to gain access to MBS money to the extent that they are delivering primary care in those towns.
A. Yes.

Q. To the extent that we've heard evidence or engaged with parties in relation to the potential role of LHDs in primary care, we're often told "That will involve a big fight with the Commonwealth." Are you aware of any situations in which an LHD has developed a model like your Four Ts model, or their own bespoke version of it, implemented it, asked the Commonwealth for a 19(2) exemption and been knocked back?
A. Well, the reality is an LHD would be unwise to implement a model without a section 19(2) exemption because they would carry the entire cost of general practice. And it's not quite that simple.

So in order to get a 19(2) exemption, you also, of course, have to consult with all of the private enterprises in that community and gain their agreement as well as the agreement of the PHN, even before you put a proposition to the Commonwealth, and that's part of the checks and balances. That's an appropriate mechanism, but you can, on occasion, run up against a conflict of interest, for example, with an existing practitioner who might be close to retirement, very keen to sell their practice for the maximum market value that they can obtain for it. Well, there is direct conflict, perhaps, between that motivation and the motivation to support a section 19(2) exemption.

What I would suggest, however - and the section 19(2) exemption is one mechanism, and then after having got local agreement you've then got to work with the Commonwealth, and I'm pretty sure, but again I will say this is anecdote, that there are some pauses in section 19(2) exemptions while Commonwealth policy is being reviewed, but others at

the ministry could give you more accurate advice on that - but it is only one model. So a far more elegant model - so section 19(2) is a highly bureaucratic - MBS is a highly bureaucratic mechanism to fund services and, as we've heard from evidence of a number of our GPs, in fact, the MBS rates don't cover their costs.

So the issue of co-payment and bulk billing and all of that kind of stuff comes into it, and I would suggest that a far more elegant mechanism between the Commonwealth and the state would be, for example, let's pick a community, let's look at its population and its access to general practice. Let's compare that community on a per-population basis with what the average MBS spend for general practice services might be in one of the eastern suburbs of Sydney, so metropolitan Sydney. Let's use that as the benchmark, and let's say that amount of money, per head of population, should go into a single pot to provide the general practice component of all of the services going into that community.

Let's then work out mechanisms that enable us to have good outcomes for the community, measure the health outcomes, measure the productivity, measure the funding is actually being used for the purpose that it is intended. But let's just strip out all of the bureaucracy, all of the layers of itemised billing that actually add nothing to the value of the care that the patient has received.

Q. Coming back, though, to your notional eastern suburbs per capita pot of money, I gather from what you have told us elsewhere in your statement that for a system to be working equitably, that pot of money would need to be adjusted, to the extent necessary, to take into account what might potentially be radically different social and health - the radically different social and health demographic of the population in the small town of your choosing on the one hand and the small suburb in the eastern suburbs on the other?

A. Yes, but it's also not quite that simple. So let's talk about where the starting point is, not even taking into account any of the socioeconomic factors. We know in our district, when we look at MBS billing compared to the average for metropolitan Sydney, for example, there is a $16 million gap every year between the rate of billing per head of population in our district compared to the rate of MBS billing per head of population in metropolitan Sydney.

If we took the average for Australia, it's a $12 million gap. So even without --

Q. Can I ask you --
A. What I'm really saying, sorry, is that even without considering the differential health outcomes and social deprivation and all of those kinds of things, even just on a per head of population basis, there is a fundamental differential that needs to be corrected, and the MBS, because it is driven on a private enterprise model, is completely incapable of addressing that.

Q. Without wanting to undermine what might nevertheless be a strong trend, that MBS data that you refer to, is that based on the location or residence of the person who is accessing the care, or is it based on the location at which the care is provided?
A. No. So in all of the MBS related graphs - I'm sure this is true, in all of the information that I have provided in my statement, technical detail, it is all based on the resident - on the person. The care could be delivered, whether it is by a general practitioner, a specialist, anywhere in Australia, so it is a true measure, and those graphs are true measures, if you like, of a wealth differential, and an access differential for MBS funded services, between residents of our communities compared to residents in communities on average in Australia and also on average in metropolitan Australia.

THE COMMISSIONER: Q. Sorry, I'm not quite following something you have said, and it's probably me, but when you said "when we look at MBS billing compared to the average for metropolitan Sydney, there is a $16 million gap every year between the rate of billing per head of population in our district" - is it per head of population?
A. Sorry.

Q. Per thousand?
A. Not per head of population, but population. Some of the graphs we show are per estimated residential population, so - but that figure, I'm sorry, is for the totality of our population.

Q. Is another way - and tell me if this is wrong or not your view - would another way of looking at it be for these rural communities or regions where primary health care is

failing, for everyone with an interest to get together and work out what are the primary care health needs for that community - and by "primary care", I mean GPs, allied health, the works; if there wasn't a failure of primary care, what would the Commonwealth have to pay, and approach it that way? Because if there wasn't a failure of primary care, the Commonwealth would be paying, it would be paying the MBS. Is that another way of looking at it?
A. Commissioner, that's a far more elegant way of saying what I was attempting to say.

Q. Not necessarily, but that's generally - you are nodding your head, so we will leave it at that.
A. Yeah.

MR MUSTON: Q. In terms of your $16 figure, now to make sure that I'm not more confused than I was at the outset, I gather what you are saying is if you take your average metropolitan person and identify the amount of MBS money which is spent on that person in a calendar year, and then you take that number and multiply it by the number of people in your population, what you will find is the result of that produces a figure $16 million higher than the actual MBS spend delivered to that population?
A. Yes.

Q. That is your population?
A. Yes, that is what I'm saying, and I'm sorry, I confused in my evidence by saying "per person". What I was meaning is at a population level.

Q. Yes. I assumed it wasn't $16 million per head of population. That would be a big funding deficit.

THE COMMISSIONER: That one we couldn't solve.

MR MUSTON: Q. Could I just quickly ask you, by way of clarification, in paragraph 132 of your statement, you tell us about - and following - the knock-on effect of the failure of primary care or increasing reduction in access to primary care is having an impact on emergency presentations within your LHD. You refer to some linear trend analysis. Could you just explain in layman's terms what that linear trend analysis is and what it shows?
A. So we have some extraordinarily clever mathematicians within our health intelligence unit who have taken the information about ED attendances and extrapolated it over

a five-year period. Because in that five-year period we had the impact of the pandemic, they needed to statistically adjust to make sure that the aberrations of, you know, ED attendance rates around the pandemic were adjusted for, and they have done that moving forward. Essentially, what that shows is over that five-year period there has been an 11 per cent increase in attendance at ED.

Another statistic in my statement that paints a very similar picture, and if I just take triage 4 and 5 categories, so these are the least urgent - it doesn't mean to say they are the least complex, it just means to say that when they turn up in ED they can wait the longest in clinical terms to be seen - in every local government area within Western New South Wales, we have a higher percentage of triage 4 and 5 presentations to our emergency departments than the New South Wales average, which I think most commentators in the system would suggest the evidence strongly correlates that with difficulties in accessing affordable primary care in a timely manner.

Q. You tell us a little bit later on in your statement that in Trangie and Tullamore there's been a reduction in ED presentation, or the trend has turned. It's tempting to infer that that - the fact that Trangie and Tullamore are two of the Four Ts is no coincidence. Do you have any analysis that actually enables you to more firmly conclude that the rolling out of the Four Ts model has in fact resulted in that reduction in ED presentations in those two towns?
A. So there is a strong association between the LHD stepping in to provide general practice that was otherwise failing and a reduction in attendances at the emergency department. A different model in a different community, where we fund a general practice company to provide general - GP VMO services into our MPSs across all of our northern - most northern six towns.

Q. Is that the arrangement with Ochre that you tell us about?
A. Yes, that's right. That is one of the things that we did entering into that contract as we recognised - we did a whole lot of data analysis, when are people turning up to the EDs. An example that stands out in my mind is Bourke, where we had a spike in presentations on a Friday evening after 5 o'clock and then through the weekend. So we deliberately contracted them in a way that it required them

to provide a presence on a Saturday morning, because when we looked at the data and spoke to the local community, many of the things that people were presenting after 5 o'clock on a Friday with were very basic things, like "I don't have a script", or "At least I have a script, but I haven't got medications to get me through the weekend and I need some", or "I've got a health condition that I don't want my kids to go through all the weekend because I'm a little bit concerned about it".

So we contracted them in a way that meant that their general practices or their services to us extended into the weekend and, again, that showed a dramatic - it showed that actually you can fundamentally change the presentation behaviour of people in the community to emergency departments according to how you structure and fund the health systems that they are trying to access.

Q. In terms of structural changes to emergency departments and emergency department presentations, in recent days we've heard quite a lot about urgent care centres and urgent care clinics. Do you have any of those facilities in your LHD?
A. There is one that has been funded by the state government, not the federal government, through the primary health network in Orange, which is just - I think it opened in about March of this year. So it will be still in its gearing-up phase.

Q. Do you have a view about the extent to which services like that are usefully addressing - well, do you have a view about how services like that fit within the broader health system in terms of whether they are a good addition or whether they are perhaps masking a bigger problem?
A. I spoke before that health has a tendency to address symptoms rather than root causes and I think that's relevant to this conversation. I will also refer back to some experience in New Zealand, because it's a model that actually I believe the Australian Government looked internationally before coming to that point.

There is no question that comprehensive long-term therapeutic relationships in general practice with a member of the community to avoid the exacerbation of illness, to the extent that it is possible to do so, is the best intervention of all. That's the first bedrock of the health system.

Second point over that, of course, somebody needs access to services, and the only place they can get it is an ED, but actually their need is a general practice ED. Well, we need to find different solutions to that without clogging up our EDs and the urgent care centres have a role to play in that, but I will give you some caveats.

So we see already - Brisbane would be an example. We see already the emergence for the first time in Australia of a FACEM-based private emergency department. So what we're really saying is, we're seeing the emergence of the privatisation of one of the very few specialties that had no private options that's absolutely essential to the running of emergency departments, and I'm not sure that that is in the long-term interests of Australia, or in fact any health system. No disrespect to the FACEMs. So it's a good model --

Q. When you say not in the long term interests of Australians, are there two aspects to that - first, the service being provided through those facilities is not stable and continuous --
A. No, no, not at all. The service provided through those facilities is fundamentally able to be accessed by wealthier members of society, not all members of society, because it has a huge out-of-pocket component. I understand they are fabulous services.

Q. As to the second potential problem, do you see it as impacting or exacerbating workforce challenges that already --
A. Absolutely. That's essentially the concern that I would have. You are suddenly creating a market that can only be inflationary in the context of supply and demand for emergency department doctors. And that's a different problem - sorry, it is a different solution on the back of urgent care, which was really intended to address the problem of lower acuity, more general practice patients.

So it has a place, and I am not at all arguing it doesn't have a place. But it has to be carefully managed and has to be done in a way that, as best as it possibly can, transfers patients back into long-term care.

If I can compare an example, a difference of how it works - and there are some other difficulties with the

model, particularly when it is corporate general practices, so corporate general practices are the one category of general practice in New South Wales that is less likely to contribute health information data to Lumos, which is a technical system whereby health planners are trying to join up general practice information about who is accessing what services to determine community need, and hospital based or LHD information, it is a fantastic initiative, but corporatised general practice has a much greater reluctance and, in reality, a much lower uptake of contributing data, so that's a problem.

Q. Why might that be? Are there any disincentives to a corporate-based general practice outfit to provide that information, or is it just another piece of work that needs to be done that's not being paid for through an item number?

A. I would suggest that information is power, and in an information age, if you are able to control access to the information that you have, you are able to have a leverage in the marketplace that you wouldn't otherwise have, and that's no different in health than it is in companies making biscuits.

What I was going to say, and as a comparison, just how the model works here and, again, I apologise, let me be very, very clear, the New South Wales health system, the Australian health system, is a fabulous system, it produces hugely beneficial outcomes and the Productivity Commission recently reported on that. Any government at any level would be very proud with the outcomes discussed in that report, by and large.

However, a difference between my experience in New Zealand, if I went to the equivalent of an urgent care centre in New Zealand as a consumer - and I did that, I broke bones in my foot on one occasion - I knew, because I knew the system, that they had perfect capability to deal with that issue in a way that would be entirely satisfactory to me, without clogging up the emergency department. I knew they would refer me to the orthopaedic department for follow-up care, all of those kind of things, so I would have a fantastic experience. So I went there. It cost me a little bit, didn't particularly matter because it was also funded.

But what I also knew was happening behind the scenes,

and that's a bad example because it was a trauma case, but let's say I had gone there because I had a chronic health condition that was being exacerbated. I was also at the time enrolled in a general practice that was being paid a capitation fee for me, for My Health Care across the course of the year. So that general practice that I was enrolled in would have received a negative adjustment to its capitation funding in order to pay the urgent care centre a portion of the fact that I had turned up out of hours in unplanned care. So, in other words, the general practice itself was highly incentivised financially to make sure that I didn't go to the urgent care centre unless I really needed to.

Now, in my example of a traumatic injury, it was entirely appropriate that I went there. But if I had gone there because my respiratory condition had got out of whack or because I needed a script filled that I hadn't - my general practice hadn't been able to deal with because I couldn't get an appointment in a timely enough manner to have that happen, the general practice itself was disincentivised for me turning up to the urgent care centre.

So, in other words, the system worked as a whole, not just as a component partial intervention to a particular problem, in this case overcrowding in EDs.

Q. Could I ask you to go to paragraph 135 of your statement where you refer to the MBS data that we've been talking about. Perhaps just turn over to the top of page 26. Do you see at the beginning of the last sentence, you refer to the evidence suggesting a reduced availability of affordable and timely access to Commonwealth funded primary care is failing to meet the needs of communities in remote, rural and regional New South Wales. I just want to ask you this question in relation to that. When you refer to the evidence pointing to that, just out of an abundance of certainty, what is the evidence that you are referring to there?
A. Well, it's multilevel. So in my statement I include some statistical analysis of MBS billing, and we've talked about that.

Q. Yes, so the evidence points to the disparity between the MBS billing.
A. Yes.

Q. As to the impact that that's having on health outcomes, could you identify the evidentiary sources that you would refer to which you say draw that correlation?
A. Again our health needs analysis, and you have heard a lot about that, and I think that may have been tendered into evidence, and if not, there are snippets of it right throughout my evidential statement which point to that. Also, the evidence from communities and general practitioners - and you have heard quite a lot of that.

In fact, for good reason in our context, but perhaps surprisingly in other contexts within NSW Health, the Commission itself has focused heavily on the issues of primary care rather than the New South Wales health system itself per se, while you have been in our district, and you have heard a lot of evidence from general practitioners. I know, in consultation with community members, both in the stand and outside of that, you have heard a lot of anecdotal evidence.

We certainly hear evidence in surveying consumers around their issues of access to primary care, and somewhere in my statement I also refer to our planned care - sorry, the study that we've done around, I think it's in particular Dubbo, who is presenting to Dubbo's ED, and what we have discovered is that a primary motivation and driver for that uptick in presentations, there were two factors that stood out, or three, actually. One was the completely disproportionate percentage of First Nations who were driving the increase, it's almost 50 per cent in that particular emergency department.

Secondly, the disproportionate lack of connection between primary care and the people who were turning up and driving that percentage increase, and the third - and I think this is really instructive - when those people were turning up. They weren't turning up late at night in extremis, they were turning up between the office hours, the normal office hours that you would expect general practice to be operating, and all - so those are just kind of factors that you could argue are they causative? They are highly associative, if not causative, between the issues and the accessing affordable primary care. If you go into some of our smaller communities, then, and particularly those that no longer have general practice, and whether it is through our vRGS service or through the

GP VMOs that we are putting into our emergency departments, then they have no other service, and the service they get from us is episodic care. It's not holistic, long-term, well-rounded primary care, both in terms of a general practitioner but also allied health professionals, all of the other kind of things that go into that generic description of primary care that we would have.

Q. When you say the care that they receive from you, that's the care that they would receive from you in the emergency setting?
A. That's right, yes.

Q. Where you have stepped in to, say, the Four Ts model, the care that patients within that model are receiving, is that more holistic care?
A. Absolutely. It's standard general practice, and as you have indicated before, there is a dramatic association with us doing that and a reduction in the rate of people turning up to the emergency departments in those sites.

Q. Whilst you point to the correlation between the emerging crisis in relation to accessibility to primary care and the increase in emergency department presentations, I don't understand you to be suggesting that a desire to shift or reduce ED presentation numbers should be the driver for addressing this primary health crisis?
A. In some settings it would be an appropriate driver, but it's only addressing a symptom. So in generality, the driver should be to improve the access of Australians to the health services that they pay taxes for, which is fundamentally and primarily and initially in primary care.

Q. Because addressing - it would be right that merely acting to address an increased - acting in a manner which seeks to decrease emergency department presentations would be reactionary and not really dealing with the underlying core problem?
A. That's right, yes. Still beneficial but reactionary.

Q. Is there an extent to which the urgent care centres, to the extent that one of their stated objectives is to reduce pressure on emergency departments, falls potentially into that category of not necessarily grappling with the core underlying problem in some settings?
A. It's grappling with an absolutely essential problem, which is the overburdening of emergency departments and in

that sense is a very valuable and worthwhile intervention, but it is not addressing the fundamental problem, which is the failure in the timely and affordable access to primary care.

Q. I think we've spoken quite a bit about the Four Ts. Could I ask you to tell us a little bit more about the HealthOne model, which its is something that is being rolled out in Canowindra?
A. Yes, and in fact we have a number of mature HealthOne models across our district. A HealthOne model differs slightly from the Four Ts. The Four Ts is an example of an LHD-owned general practice. The HealthOne model is essentially a facility-based model whereby we construct a facility or use an existing facility with the deliberate intention of bringing together general practice, that is, private general practice and the community based services delivered by our local health district, be they allied health staff in the community, community-based nurses, family health care nurses and so on.

We have a number of examples of that throughout our district. A very mature example would be in Molong, and I understand that Dr Robin Williams, who is also the chair of the PHN, will give evidence tomorrow. That's an example in his town of that practice working. That example is not collocated with the MPS in the town. It's not that far away, but it is a model where we've deliberately tried to bring together state funded community services and Commonwealth funded general practice and community services into one location to get the synergies of both.

We have similar versions of that model in a number of other towns, not all of them, and it is certainly a model that our planning suggests has great merit. Particularly where there is viable general practice, why on earth would our organisation want to step in and provide something that others could provide when we've got lots of other needs we can't meet in our community. But a good example right now is in Canowindra, where traditionally we had downtown in Canowindra a building which housed our community services staff, we had a community hospital up the hill in Canowindra, and we had general practice, in fact two general practices in the town in Canowindra.

So through a process of health planning with that community, we are now in the process of demolishing an

unused facility on the community hospital site in order to build a HealthOne and, when that is built, then the general practitioner, or at least one of them in the town, one practice in the town, will move on to the site, along with all of our community services. But it's also collocated with the community hospital.

Part of our long-term vision with the shire - and I say this with some aspiration but not certainty at this point in time - around that community hospital and the New South Wales Government owns, by reason of history, a substantial land holding in fields, a farm around the local community hospital, which is an accident of history, but actually you could imagine - and this is not something NSW Health would do, but you could absolutely imagine in a future iteration of services into that community, well planned and designed, we might encourage a private entrepreneur to come into that town to establish a retirement village, that graduated kind of retirement village between own your own apartment, moving through ultimately to residential aged care, that would sit absolutely beautifully on a campus with a HealthOne around it, pharmacy, all of those kinds of things, general practice, community-based allied health and district nursing services.

Now, that's not - we can't go that far at this point in time, but we've gone as far as funding the development through the New South Wales Government of a HealthOne, which was currently being built. But if you cast your mind and gave it a sort of five, 10-, 15-year vision, you could see how health services for older people and younger people in the community of Canowindra could be far more integrated, with far greater effect, without the need for the state to deliver them all, but with good place-based planning for that community and consultation with the local shire and the local practitioners and potentially even entrepreneurs who don't exist in that community today, how you could end up with a health precinct or a campus that was substantially superior than what is there today.

Q. Even to the extent that that work is being done to date, though, you have used the term "place-based planning" again. There is obviously more to it than just building buildings close to one another with a view to putting all of the health services on a similar footprint. There presumably is some close collaboration and consultation

with the existing general practice?
A. Yes. Of course, absolutely, and in fact, place-based planning I would suggest is not about building buildings. That may be one of many outcomes. And I think that, as I said earlier in my statement - in my evidence, sorry, the tendency of the New South Wales health system has been to plan for the services that we provide, and particularly to plan for the infrastructure required for those services, be it our hospitals or whatever else. Our aspiration, and I believe the correct aspiration of the New South Wales health system, or the Commonwealth Government health systems, would be to plan for the needs, the health needs of a community as the core thing that it does through place-based planning, and the infrastructure requirements or the service provider requirements to meet that need are secondary to the core purpose of planning. As I said right at the beginning, current legislation does not drive the system towards that goal when, in my view, clearly it should.

Q. Could I ask you to turn to paragraph 164 of your statement, where you tell us about some collaborative partnerships with larger NGO organisations using single employer models and the like. Could you just explain, perhaps by reference to some examples, what you are talking about there?
A. So a good example would be some work that is happening in our allied health space, and I think you touched on this with Marathon Health's testimony earlier in the week. So we have traditionally operated in silos. Through some very good leadership work both by the NGOs and our executive director of allied health, there has been a coming together at chief executive level and senior executive level across not only our organisation and one NGO - Marathon, and they are a large NGO, so that made sense - but a number of others, like the RFDS, LiveBetter and so on, to look at actually how might we do this.

A good example in our district would be we've had many areas where we've had vacancies in small towns, so it might be 0.2 of a physio, in a hypothetical example. There might be three or four NGOs going into that town to provide different services under different grants, Commonwealth or state funded, through different mechanisms, all of whom equally have a 0.2 vacancy for a physio, and none of us can recruit a 0.2 physio because it's not enough to make an income from.

So we are exploring, in fact, how we might have a single employer model. So one of the agencies - and in different towns it could be a different agency, sometimes it could be us, sometimes it could be the NGO - how we actually work out how we pool our respective needs and that contribution towards salaries to do that.

Now, obviously that's not simple. The awards and remuneration rates and all the conditions of employment need to be harmonised to do that to a certain extent, and so we're in the early days of exploring that.

Alongside that - and we currently have in front of the New South Wales Government at an agency level and have also briefed ministerial officers and in some cases ministers on it - a project on the back of the VET review that's under way in New South Wales, a review of vocational training through the TAFEs. We see a real opportunity for an employer-led collaborative model to train both care workers and health workers to get certification through the TAFE system in a way that enables people in that training pathway to staircase their time that they might spend, for example, in my organisation or at Marathon Health or RFDS or LiveBetter, in a kind of structured apprenticeship, for want of a better word, along with some academic input and training from the TAFE system or the Charles Stuart University, where and as it is relevant, so that their time spent in different organisations can count towards their qualification, but their qualification is also being re-engineered so that the practice experience on the ground, supervised by others in our organisation, counts towards their learning rather than them having to, for example, leave Cobar, where they live, for extend periods of time to go to TAFE to sit in a class environment in Dubbo, three hours away, three or four hours away, leaving their kids behind and for extended periods of time.

So it is a different employer - and we're calling it a Regional Workforce Activation Hub proposal. We've had very positive reception from both the officials in the Minister of Education and TAFE's office and in the Minister of Health's office. We believe - we currently have briefing up through TAFE New South Wales and executives in that organisation have very favourably responded to the proposal. We've done the same through NSW Health, both the workforce branch and the regional health division, and they

are currently evaluating, but again, very positive and supportive.

That's an example of a way that you come together - and ultimately in that, the trainees will be under a single employer model so that they can move freely between the organisations in a planned and staircased pathway of training, and we've got to work through. Our proposition is to establish a pilot so we can actually do all the hard work about working out how that model might work in Western New South Wales, fully minded that if we can work out the details between the NGOs, the TAFE and us that actually make a single employer model work for that category of worker, then that's entirely transportable to anywhere else in New South Wales and would be of huge interest to other regional local health districts.

Q. It may be something you haven't yet identified, in which case tell us, but on that single employer model, if you have got five people in a town or close cluster of towns, each of whom has a 0.2 of a physio that they want to fill, and they collectively have found someone who would happily take that 1 FTE worth of physio work and spread it across all of them - are there any legislative or structural impediments that you are aware of at the moment that could be cleared in order to make that happen, or need to be cleared in order to make that happen?
A. Well, clearly harmonisation of terms of employment would be one.

Q. That's award reform in the sense that --
A. Yes.

Q. -- whether you be employed by the Ministry of Health or Marathon Health or some other private enterprise that might be delivering physiotherapy care in a community, an impediment is the disconnect between the employment conditions that apply to each of them?
A. Yes, and it would make it simpler - not essential but simpler - for example, what you will find in our district, and certainly with a large and better equipped organisation like Marathon Health, they will tend to follow the state award lead. They need to do so if they wish to attract staff. Not all smaller NGOs are able to do that, and in some cases, particularly where NDIS is concerned, the state funded services have no possibility of competing with the rates of remuneration that somebody working for NDIS in a

small town would be able to earn under NDIS packages.

Q. Are these some of the challenges that you have identified or you allude to in paragraph 158 of your statement?
A. Paragraph 158 related specifically to visiting medical officers, staff specialists and the Rural Doctors' Settlement Package, but the same issue applies. There are many examples, and you heard one I think from Dr Harfield earlier in the week, where we are piloting the use of the staff specialist award in order to employ GP VMOs in Mudgee. If I can explain that in practical terms, to use that award to employ GP VMOs is substantially more expensive than using the Rural Doctors' Settlement Package, which was kind of a fee for service arrangement with GPs, but it's cheaper than employing locum GP VMOs - an order of many dollars different and cheaper, so it makes sense for the state to do it. But in doing it, what it is also doing, and to be clear, is hard-baking into the cost of delivering services in that procedural hospital an uplift in the cost of doing that that is greater than the historical cost of doing that, which would have been delivered because a GP got rung and pulled out of their general practice to come up to the hospital.

So it is a necessary evolution, but the awards that I'm referring to, across all of the medical specialty awards, have not been subject to award reform for over a decade. So the conditions that were relevant a decade ago - and in fact, that is true in many awards in New South Wales - are still the conditions, they will have been inflated through various government determinations since then, but the opportunity to have a meaningful dialogue between industrial organisations and the New South Wales health system that not only looked at rates of remuneration but looked at how might this all work effectively to the benefit of the community and the practitioners without one capturing all the benefits at the expense of the other but also lead to some productivity reform, so sensible improvements in how things are done so that the cost of services overall might reduce, simply hasn't suggested and I would suggest, as I do in my evidence, that there are innumerable examples that those awards are no longer fit for purpose.

What is happening instead - and our district's financial performance is the classic example of this, where

we've gone from balancing the books to a substantial forecast deficit, $48 million at the end of this financial year - and I say that with great grief, because I as chief executive, and I know many of my staff and our board, have an absolute commitment to use and be wise stewards of the resources that we receive, and it grieves us not to be able to balance the books, but we also have other objectives that we want to achieve, and delivering safe healthcare services to our communities is one of those - 60 per cent of that change in our financial circumstance is driven entirely by changes in the cost of employing medical staff as locums or under various other arrangements such as I have described, and in some cases, a necessary investment in gaps in medical workforce; 30 per cent of it is being driven by the cost of needing to employ agency nurses at rates which are phenomenally higher than they have ever been in New South Wales.

Q. When you refer to the 60 and 30 per cent, do we understand you to mean not that 60 per cent is the total income being paid to those doctors, it is the differential between --
A. No, no. When we look at what has changed the financial performance of our local health district, that's what I'm describing.

Q. So 60 per cent is the uplift in cost associated with delivering medical care through locums rather than --
A. Through medical staff of various types, of which primarily locums would be the primary driver; and 30 per cent is through the cost of employing nursing staff, particularly through agencies in order to close that gap.

Q. And again, the 30 per cent is the premium that you are paying for the agency staff - not the total cost associated with agency staff that are taking places not otherwise being --
A. No, these are differentials. So in other words, we stood back and said, "What on earth is going on? Where do we need to focus our attention to get some discipline back into expenditure?", and we pulled it apart, then at a macro level, those are the kinds of trends.

Now, there are a whole lot of other things underneath that. Some of our services aren't as efficient as they were, post the pandemic, that we need to focus on, and some areas we need to recalibrate levels of staffing and so on,

but in a general sense, the fundamental drivers of the difference in financial performance come from those two places.

Why is that hugely important to us? Well, obviously value for money. But what I'm also describing is a transfer of wealth from taxpayers to a very, very small portion of Australian society - ie, those who have the education and skill to capture that wealth through the income demands that they are making on the health system. That is not, I would suggest, a good and equitable use of public funds. So we desperately need to get into some solutions of that problem. We in our district - there are many, some which are local, some which are not able to be distributed locally. For example, it is impossible for all local health districts - I will just use agency nursing, or I could use locums, as an example. It is impossible for us, as a purchaser of those services, to form together under Australian or state commercial competition law - and there is good case law around this - in order to discipline that market, ie, to hold out, "No, we're not going to pay locum rates of this type as a system." It's impossible for New South Wales to stand out - it is less of an issue, well, it is an issue for me, but more of an issue for some of my colleagues in border towns - to attempt to discipline the locum medical market, for example, in Queensland and Victoria, South Australia, Northern Territory and Western Australia, let alone our own.

There have to be - and as you will be well aware, better aware than I - there are constitutional issues that have to be navigated, in order to navigate that, but those things don't help.

Where it is potentially possible, and a good example - and there is work at a whole of Commonwealth and state government level to try and look at some of those issues - what you find, and certainly has been the case in our district, we've had to create some alternative solutions, and Virtual Rural Generalist Service is one of those solutions, without which our district would not be functioning and our deficit would be substantially greater, which is why, in my view some parts of various professions are critical at times of services, like vRGS, because it has the ability to use virtual technologies to discipline the market, to provide a practitioner into a town which we would have otherwise had to physically do - and I, like

everybody else, would agree that the physical presence of a medical practitioner is a hugely beneficial thing, we don't want to undermine that, but it is absolutely true that the use of virtual means, in order to not be captured, in tiny town markets, by those who wish to maximise their income through excessive locum fees - it's a helpful intervention.

Another example of an intervention that we used in our district - we held our breath going into Christmas - we had been forced to pay extremely high agency nursing costs, and to give you some sense of that, there are today positions advertised in Townsville, or at least very recently, at an agency nursing rate, that if you annualised the salary, was over $430,000 a year that that individual would earn, if they were in town on the agency rate that was going to be paid to them on a daily basis, and they would get accommodation and travel supplied, driven in a highly specialised area by the absolute need of that community; it's not in our state. That is a real example. And I can absolutely understand why the organisation in that district was driven there, because if they did not do that, all hell would break loose around the inability to provide services that the community needed.

But it shows you how unsustainable some of that was, and the trajectory it was going in Australia. So just prior to Christmas - sorry, longwinded answer but it is the real world that we deal with - I made a determination, along with my executive, talking to staff, that we were no longer going to pay those rates, and they generally had been paid in some of the more remote parts of our district to provide nursing staff into our MPSs. We held our breath. Because the reality was, we were going into Christmas and it might well have been the case that we were unable to provide any service at all, which of course - so it was a bit of brinkmanship.

We discovered over time - and we had to do some horse trading in certain places in order to maintain service for a short period of time, but today we no longer pay those rates anywhere in our district, and we're still paying premium rates, we're not paying hyper premium rates because we had to, if you like, play chicken with the market, with the providers of agency nurses.

To a certain extent, all LHDs have done that, both for

medical staff and for agency nurses, but you cannot do that in its complete sufficiency moving forward. And it is not that agency nurses or locum staff don't have a role to play. They have an absolutely beneficial role to play into the system. They are vital. The system can't deal with the fact that somebody gives two weeks' notice when you are a nurse and they're gone, but it might take you three, four, five months to recruit a nurse to replace them in that town. You've got to have agency nurses as a viable part of the system, and it works incredibly well.

But what has happened since the pandemic and the floods and the various other things that have just decimated workforce, and that's starting to correct itself, is we've been forced - as you would expect, people saw an opportunity, they saw an ability to leverage. They're sensible, intelligent individuals in one sense and they maximised the opportunity, but the maximising has got to the point where it is to the complete detriment of health services in Australia. So the New South Wales Ministry of Health is currently running a statewide panel tender for nursing agencies, which we don't know the outcome, but we know that by trading as a state, in the sense of making it clear that you won't get any work with any LHD in the state unless you are providing a bid to that tender in a range that ultimately NSW Ministry of Health is going to find an acceptable rate under acceptable conditions through a panel tender process, then actually, the using commercial means to offer agencies the potential for wider market share in return for lower episodic - individual rates in supplying agency nurses, and then for those agency nurses to be providing a more secure and potential to work at various places across the state - there are nurses who just love being, if you like, the missionary nurse, they love flying in to a remote community for a couple of months and then being evacuated, for want of a better term, or extracted to another part of Australia.

It's - you know, there are nurses who, completely understandably, like to gain life experience and understanding of what remote, rural and regional Australia, not only New South Wales, is like by doing that. It's a fabulous way to expose nurses who might ultimately end up working in a metropolitan hospital, but then they will know when somebody comes from Enngonia or Weilmoringle - they will know what it is like and how different it is and what the community that those nurses - those patients might then

return to is like, and they will know not to assume the range of services in Enngonia is anything like the range of services that might be available to a patient in Northern Beaches.

So there is this real benefit the system can get from agency nurses, provided that the price of locums and agency nurses is correct. And in our evidence and our experience, there is a desperate need at both a Commonwealth level and across multiple states and through the Commonwealth and state mechanisms to bring discipline into the locum medical market in particular, and at a state level to bring discipline into the agency nursing market - not to remove those commercial opportunities entirely, but to ensure that the people who ultimately fund their wages are getting value for money.

MR MUSTON: I note the time, Commissioner. I've got a little while to go.

THE COMMISSIONER: We will adjourn until 2pm.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: All right, are we set to resume, Mr Muston?

MR MUSTON: Yes.

THE COMMISSIONER: Thank you. Please go ahead.

MR MUSTON: Q. I would just like to ask you quickly about specialist outpatient clinics. You tell us in paragraphs 21 and 22 of your statement about some internal analysis that has been done that reveals significant gaps in terms of the availability of outpatient medical services. I assume, much like other forms of primary health, to the extent that that might be regarded as an extension of primary health, that the consequences of not having a good and accessible specialist care available where it is genuinely needed has negative impacts on long-term health outcomes for members of the population who are experiencing that shortage?
A. Absolutely, it does.

Q. There are two challenges I perceive from your statement that are combining to result in these gaps. The

first is a funding shortage in the sense that if you don't have funding for a sufficient number of FTE to man or woman the clinics, you can't run them. That's one challenge. Would that be right?
A. That's one challenge.

Q. And a second challenge, and perhaps one that exists whether or not you have got adequate funding, is workforce maldistribution challenges, which means if you are in a position to fund a clinic, your ability to stand it up is dependent upon your ability to find a suitably qualified specialist who will work and deliver that clinic in the area where it is needed?
A. That's the second - agreed, that's a second challenge. There are other challenges.

Q. What are the others?
A. As per paragraph 20 of my statement, of course, specialist outpatients are both funded as part of private entrepreneurship through MBS billings and gap payments by individuals, and as I corrected in my evidence right at the start of today, there is a substantial differential between the average number of specialist attendances across our district compared to the average for New South Wales, and equally - so that's one aspect. So the private market itself is --

Q. Is that, in a way, its own form of maldistribution between private and public delivery of specialist care, albeit perhaps not a geographic one of the type that we've heard a lot about?
A. Well, it can be both geographic, but it is a maldistribution, because of course, MBS funded specialist outpatient care is also generally reliant on co payment. So if you have an inequality of wealth between different members of the community, their ability to access those services will be very, very different.

Q. Would it be right to assume that that disparity is exacerbated in a community, a rural or remote community, where the availability of specialist appointments is already significantly stretched, such that those that are available and can comfortably be absorbed by those willing to pay a large gap leave nothing left for those who are not able to pay that gap?
A. That's a reasonable assumption.

Q. Sorry, I think I interrupted you. You were telling us about there is the disparity between private and public --
A. So that's one aspect. And then there are also publicly funded specialist outpatient clinics, which of course local health districts will fund and provide. Of course, to be able to do so, you need to be able to attract a specialist workforce, and a specialist workforce will find it far more attractive to go to places where they can have a viable private practice with significant co payments met by members of the community in their private practice, as well as a bit of public practice on the side.

There's also - I would suggest that outpatient or specialist outpatient services, there are some substantial policy gaps across New South Wales. For example, on what basis should somebody have access to a publicly funded and free specialist attendance versus a private one? As chief executive of a local health district, if I stand up a publicly funded specialist service with no gap payment, essentially, I'm being asked to stand in the role of judge and adjudicator of who is worthy for that service, unless I make it available for everybody, which is generally what happens. It's on a referral and demand basis.

But that's an inefficient use of the public fund, to make public clinics available to those who could afford to go privately and have the insurance to do so, but may want to avoid the co payment, even though they are wealthy enough to pay it.

But if we get into the territory as a chief executive of saying "Person A can have access to a public clinic but person B can't", I would suggest that that is an inappropriate use of a chief executive's powers, unless there was a framework which was mandated by the parliament to determine the conditions under which one member of the community might have access to a preferentially freer or less expensive form of outpatient specialist attendance versus another, and I - the point I'm really making is that that's a policy gap in the system. I don't believe that should be left to the discretion of individual chief executives. I don't think that's the role of the public service. I think it's the role of the parliament to determine effectively where a welfare intervention should occur. None of that exists within the New South Wales system. It's not necessarily a fault of NSW Health, it's just a glaring gap, because the history and genesis of

specialist outpatient clinics has largely been derived from private practice through MBS billing.

Q. There might be some easy differentiators like holders of health cards, those who are on pensions of various sorts or recipients of welfare, but would you see that necessarily as - let me put it another way. If that were a differentiator in your community, would you see there to be a risk that there would still be a substantial group that fall somewhere between capable of paying for private outpatient services on the one hand, or holding a health card or being a welfare recipient of some sort on the other, who would still be missing out on those services, and need them?
A. So that could be possible. What I'm really suggesting - and today we don't have the time to get into the detail - is that there's a policy formulation to ensure that the community's expectation of fairness is met through whatever the intervention is.

Q. We have seen in your LHD some excellent examples of metropolitan based specialists who are delivering care through your facilities.
A. Mmm-hmm.

Q. Through networked arrangements which don't, on their face at least, appear to have a clear systemic or structural basis but, rather, seem to have arisen out of well-intentioned metropolitan based specialists liaising and collaborating with people from within your region to produce an outcome which delivers excellent services to the people of your region.
A. (Witness nods).

Q. Do you have a view about whether there might be a structure or more formal arrangement which could be put into place to try and deal with some workforce issues by requiring or making available to people in your LHD specialist care delivered by specialists who might, for a range of reasons, choose to live in a metropolitan area?
A. Well-designed, there could be some advantages of that. What you are essentially asking to do - is specialists in the metropolitan area to do, by and large, is to forgo a substantial portion of their income they would get through gap fees in order to provide services in rural locations where the possibility of significant gap fees doesn't exist. But the opposite is also true, the

specialists are not here because of that market dynamic.

So well-designed. However, there is a caveat, in that I think most rural LHDs and certainly ours and most specialists in rural areas would not be particularly welcoming of a style of delivery of care that effectively undermined the ability to grow local services, and from time to time, that can be exactly the outcome of FIFO-based services, that you don't grow a local service because you've got a great FIFO service. And an example, and no disrespect to any of the specialists who are doing fabulous work for us in this regard, would be our Dubbo orthopaedic service, which is largely provided by orthopaedic surgeons out of Northern Sydney. Great service. Fantastic people. They fly in, they fly out. They've been doing it for years and years and years and years. But the consequence is, there is no homegrown orthopaedic service in Dubbo.

Q. So were one to be looking to design a more systemic networking approach that at least provided potential access or availability of specialists from metropolitan hospitals to deliver care in rural and regional areas, an important component of that would be to ensure that part of that planning involved facilitating training opportunities for specialist registrars in rural and regional LHDs with a view to ideally growing one of your own and relieving the Sydney or metropolitan LHD of the need to continue delivering those services?

A. That would be true, and I must stress that there are many examples in our local health district where specialists do come out from metropolitan LHDs, hyper-sub-specialists come out. The question is around the formality of that, the planned nature of that as opposed to the individual has an interest in doing that, and in doing it in a way that's well structured, and of course - with trainees and so on, and of course when you get to that point, you also have to address the issue of funding. So there are - I would - it would not be difficult for me to imagine that there were specialists who would be prepared to come to rural and remote, larger centres, so we're talking Dubbos and Oranges and Bathurst potentially, or some of our other procedural sites - they might well be willing to come out here, but the LHD is unable to redistribute its funding across all of the services that it has to provide in order to free up the cash to support that expansion of service.

Q. Is that part of the problem that contributes to what you have told us at paragraph 84 of your statement, if you could turn to that? You identify some challenges.
A. So one of the challenges is the complete hyper fragmentation of many parts of the health system. There are many, many organisations that will bring in FIFO medical specialist services or other types of services into a town. Keeping track of that is impossible. Even from a local town - I remember, I went to the Warren shire not many years ago, community meeting with the shire and so on, and one of their big issues was "We're getting really frustrated because we hear after a specialist has been in town that they have been in town and, had we known, we could have done this". And the whole point that they were making was that, even at a community level, they didn't know.

And there are multiple agencies who may bring in those specialists. I remarked in testimony, I think - early in the week someone described the Commonwealth funding the Rural Doctors Network, who was funding RFDS to bring in specialist services into various parts, and that's a fabulous system. Our community benefits hugely from that, but I have just described multiple players who are doing hand-offs to each other in order to deliver the outcome on the ground and that does seem to me a rather fragmented approach. No disrespect to the partners, and I value hugely our relationship with the Rural Doctors Network and the work that they do and the way that that occurs, but alongside that, you will have an AMS that may be doing the same thing. You may well have a specialist who has a relationship with a general practice doing the same thing. You may well have a whole lot of private specialists who are just doing it off their own bat and you may have us doing something, and it changes all the time.

So trying to give our community - us, who work in the system, let alone our communities - a sense of a planned approach to the provision of outpatient medical specialist or specialist services is almost impossible and, again, I think it comes back to the way the system has been developed over many, many decades, has essentially emerged out of private practice, and private practice is a hugely important part of the Australian health system, I am not being pejorative in any sense about that, but there is certainly a role for both NSW Health, local health districts, all of the other players, through the kind of

planning processes we talked about earlier today, to have a more planned approach to the provision of those services.

Q. Let's come to the planning process. You have told us that your LHD has long recognised the limitations of a facility-centric view to planning an operation. Could you just explain in a little bit more detail what you had in mind when you referred to that facility-centric view and what it is that your LHD does which is a little bit different? That's paragraph 46, if that helps.
A. Thank you. A lot of the planning mechanisms that are used within NSW Health - I made the statement earlier this morning - they are really driven by the needs of capital processes to prioritise limited capital funds - which hospital needs to be renovated, rebuilt and so on - and there is nothing wrong with that. Those processes are fundamentally better today than they were, in my opinion, even in the five, six years I've been in western New South Wales. A lot of reform has gone on in making them better systems of prioritisation and allocation.

However, they are all based around the facility. A good example would be we have done a lot of work in health clinical service planning for the three towns of Wellington, Narromine and Dubbo. Narromine and Wellington are sort of 35, 40 minutes away from Dubbo. It makes absolute sense that we would operate those three facilities as a network. They could have sub-specialisation, for example, rehabilitation in one of them and perhaps care for older people, by which I mean - I don't mean residential aged care, I mean clinical medical care for older people - in another, for example.

So we did all of that planning process around a network of hospitals, based on the needs of the services. We've had to redo it all, because providing a networked approach across multiple communities and multiple hospitals didn't fit the modelling and the assessment processes that are used around these things. So we've literally spent a year, having done what I think was some pretty innovative work to bring things together, to segment them apart again to fit the process.

Another example might be, and I think we've made it pretty clear, it would be easier for me to justify a planning process around an MPS in a small community, putting resources into doing that, because I know that

there will be a capital funding process at some point, hopefully round 6 of an MPS program, jointly funded by the Commonwealth and state. So I can justify getting ready for that, putting staff into a planning process.

But what if the real planning need or the needs of that community had nothing to do with a facility? What if it had to do with the distribution of kind of resources and, in fact, infrastructure was not the need of that community, so it was in the provision of services in the community in a different way, let's say through extended general practice or extended roles of nurses or allied health or, indeed, even as we heard from our fabulous mental health team yesterday, I think, the involvement of peer workers in a community, et cetera. None of that fits easily into the traditional planning processes, which are quite rightly heavily based around this is the facility-based service that you have traditionally provided. We're going to have to upgrade those facilities at some point of time, or the community need has changed in a facility sense, so let's plan on that basis. I understand why NSW Health does that.

It's a very different basis of planning than you would plan if you started with the question of what are the health outcomes we want for this community and, secondary to that, asked what are the ways to deliver that, some of which might be through facilities.

Q. Is that further complicated by the reality - and correct me if it's not a reality - as I heard you say earlier that much of what exists out there in terms of infrastructure for the delivery of health care across your LHD, and no doubt many others, is the product of history and not some careful planning process?

A. Well, I wasn't here 50 years ago, and so I don't know what the planning processes were back then, but the point I was making is the community has shifted vastly. Much of the infrastructure across New South Wales, particularly in small towns, will reflect the needs of generations gone by. You know, we used to need TB hospitals, we used to need quarantine hospitals of one kind or another that we no longer need or use today.

Having said that - and I want to make this very, very clear - my view, and I think it's also - well, it is the LHD's view, there is far too much rigidity in the system to

enable sensible reinvestment or evolution of the ways in which we're investing to improve the health outcomes for our community.

What I'm not saying when I say that, because my community has some of the worst health outcomes in New South Wales, some of my communities, some of the poorest communities in New South Wales, and one of my great fears, and I have lived through this in a different country, where countries go into recession, we saw it in the UK, we certainly saw it in New Zealand - when a country goes into an extended recession economically, all of the things that the political processes have been avoiding get dealt to very, very quickly, because they are no longer affordable.

So the idea that you might no longer have a community hospital in this community because it is no longer needed, but you might have an investment in community-based services in that community that's really viable - general practice, viable general practice and all the rest - doesn't come to the table when you are closing things because the country is in recession, and one of the great difficulties in Australia is, of course, we've had several decades of no recession at all, and long may it continue, but what it means is that the reliance on adjusting and ceasing inefficient and uneconomic investments and ways of delivering services is not easy to progress, because of course the political will, or indeed even sometimes the will of the bureaucracy, people like me, to take on wicked problems that you know are going to be highly resisted and very difficult to work through in communities in a way that keeps them on board - we've got plenty of other problems in our day jobs to address instead.

So one of my fears is we will get forced there in circumstances where, in fact, resources depart from the very communities that need more resource, not less, on the back of forced change because of economic recession.

Q. That's to say, that during a time of austerity, you might have the closure of an inefficient hospital, for example, through necessity, but what you don't have at that time is the luxury of the reinvestment of the moneys which are needed to actually meet the genuine health needs of that particular community in the way that they could better be met?

A. Yes, and a very good and practical example of what I'm describing in our district, fabulous people, great staff, great communities, but I have seven emergency departments fully staffed 24/7, nursing and sometimes other staff, who see fewer than 1,000 patients a year. The consequence of that is I have emergency departments seeing 45,000 people a year, 25, whatever the numbers are, who I struggle to staff, or another consequence might be, because I've got a staff member who has to be there, so it's a stand-by cost, they - we want them there, we hugely value them, they have to be there, but the utility for the patients coming through the door or the community is really low, because they see a small number of patients per shift compared to any other part of the health system.

And if I was to hypothetically say "Actually, I would rather take all that money and invest it in a really great community-based intervention that reduced as far as possible the need for an ED in this town", for example, it really heavily invested in community drug and alcohol services, or whatever the issue was in using the same cash, it would be virtually impossible to do that without a substantial rigidity and substantial political push to and fro right throughout the system.

I'm not suggesting that - there is a real community need and interest that's very legitimate for both the parliament, political parties, bureaucrats to recognise. We're stewards and servants on behalf of our communities, but it does worry me that the flipside of that important public duty is also an ability to ignore very real and genuine ways to realign the system, until it is too late, and that's what I worry about within the New South Wales health system, not so much because of NSW Health but because the complexity of what I'm talking about, planning with communities, going on a journey of investment in the things that produce the best outcomes for that community, is not easy, it is not simple.

I could pick one small town in our district, and I've got many small towns in my district, and I could guarantee you that would be a full-time preoccupation for me as chief executive probably for 18 months to get from whoa to go, and that's the nature of doing it well. Now, none of that transition, none of that process of transition is necessarily catered for particularly well in an ABF model. If I can use the example of the Four Ts, which I have

spoken about before, it is a good example of where we have done something, although we have four poorly utilised EDs generally - that's unfair, two of the four are probably poorly utilised now because the model has been very, very successful. But all of the process, all of the manpower, the brain power, the whatever, to deal with that was funded by the LHD. In fact, somebody gave evidence the other day, I think it was the Lachlan Shire Councillor, of believing the Commonwealth had given a grant to them. That was not the case. That was all funded by the LHD. The Commonwealth gave a grant for an evaluation of that model post the event, which is great and we welcome that, but it was all bankrolled by the LHD in the days when we actually had a bit of head room to bankroll stuff which is not today, and the reality is the LHD, because we're not experienced in running general practice, we made substantial losses for a couple of years on the back of that while we were learning how to run complex general practices and bill in the right way, and I'm talking close to a million dollars a year on that transition across those four towns.

There's no other entity in the health system that could possibly have underwritten that change, but there was no underwriting of the LHD in making that change.

Q. In relation to that --

THE COMMISSIONER: Sorry to interrupt, can we just go back a step.

Q. The seven EDs that you mentioned that see fewer than 1,000 patients, I assume, one, you have got the data on this, but I will just ask you: I assume it is not a thousand people in triage category 1. What are they typically going into these EDs for?
A. As I think I indicated earlier, Commissioner, every LGA, or every facility, rather, in Western New South Wales has a much higher presentation of category 4 and 5 patients than New South Wales as an average.

Our district maintains a comprehensive database of activity, a whole range of issues, distances to other sites and all those kind of things, where we're looking intensively at the services that we provide and what might be better, but I hasten to rapidly add, having made that statement, so we do have a lot of information and data that

we've deliberately pulled together, because it is a real issue for us, we do not have a plan, there is no deliverable plan, we have some ideas. We are not so arrogant as to assume that we would have the right answer for a community. It is a place-based planning process with the community that determines that answer. But we certainly have, and I am led to believe by colleagues in the ministry that Western New South Wales probably has the most mature and advanced database that would support place-based planning around the services that we provide, not only EDs but other kinds of services, of any LHD in New South Wales.

MR MUSTON: Q. Let me ask a quick question about the Four Ts. You indicated that there was, I think, a $1 million per annum shortfall during a process where you, as a traditionally non-operator of a GP practice were learning how to deal with the billing and the efficiencies of an enterprise like that. Is that continuing, or is that something which, through that process of learning, has abated?

A. Definitely abated and still being worked on. So we did both evaluations but also economic evaluations and then got an independent third party who really understands primary care to look at how we were billing and what we were doing and our practice manager is actively working through with our staff, general practitioners and making sure that we maximise the billing opportunities through our primary care services.

Our sense is at the end of that we will still have a slight deficit per annum, but compared to the alternative of having to supply locum GP VMOs into those towns to run effectively episodic crisis services rather than general practice, it's still a cheaper option. So it's an underwriting that we're prepared to live with it. It's of the order of $100,000 or so, maybe 200,000 a year, across those sites, but nothing of the order that our learning curve in delivering general practice exposed us to.

Q. Acknowledging that without any sort of formal modelling it's probably not much more than an educated guess, but the deficit, such as it might be, which is referable to operating the Four Ts program, would be eclipsed, would it not, by whole of government savings derived through the health benefits delivered to the population that are receiving adequate primary care in

circumstances where they would not otherwise be receiving it?
A. Oh, unquestionably.

Q. Could I just take you to the place-based planning and the service planning. I take it that when we're dealing with place-based planning, what you are telling us is the best way to approach the planning of a health service is to start at the bottom, smaller communities, smaller areas, and move your way up to look globally at the way in which they all interact - would that be right - as opposed to what might traditionally have been done, which was either provide a global solution for everyone, that's a top-down, or to use your term, the facility-centric view, which is let's identify a hospital, we've gone into planning processes around that, without thinking more widely - somewhere in the middle is a more appropriate approach. Would that be right?
A. That's right. You don't want to plan at too small a level because you will never get agreement around realignment of the investment or all those kind of things, and everyone will want a cardiac unit in a town of 100 people, given the opportunity.

Q. The starting point is identifying your health needs, certainly not on a street-by-street basis, maybe not even on a town-by-town basis, but within blocks of the community where you think you have identified a reasonably homogeneous group of health needs which could be met by the provision of - the local provision of services which should be delivered locally?
A. We will tend to do that at an LGA level. Sometimes that's not granular enough. So, for example, if we were looking at Weilmoringle, we would want to do that at a far more granular level than an LGA. But generally an LGA is about the right size of constituency to try and plan across.

Q. So having mapped out your health needs in a way in which those needs are distributed across the region, next step in the process is to map out what might be considered the optimal and equitable health system that will deliver on those needs to that community, accepting that precisely what that might look like could be contested?
A. That's right, and they could be concurrent, because one is a question of philosophy and the other is a question of scientific evidence.

Q. So is that a process that you currently undertake in a place-based way, or in an LHD-wide way?
A. I think as you heard from both Maryanne and myself previously, there isn't a clear definition of what is the appropriate kinds of services for any particular sized population in its context, and I would suggest that would beneficially be done, at the very least, at an LHD level, but I would actually suggest it's, to be honest, more of a state level of issue, because of course the questions we're grappling with are fundamentally political ones, they are ones of the nature of the implied contract between voters and the government.

Q. There comes a point, doesn't there, where in order to give, say, an LHD or a health service flexibility in delivering the needs which are actually there, something that hovers a little bit lower than that political level in terms of deciding what is an optimal health service for the delivery of those health needs is --
A. In the example that I gave, and this is prospective, so it has not yet happened, where we want to undertake what we understand to be really thorough place-based planning, that will be supported by a health needs assessment, it will be supported by an interactive series of dialogues about what, for these communities in this particular part of our district, is an appropriate distribution of not - not distribution, but what kind of services should be available for the people in the particular towns in these communities, which could be anything from no service to some service, or service that comes in on an ambulatory basis through to something that's permanently there, then overlaying that - so what's there now, which may be not only our services but services provided by other providers, as best we're able to determine that, given the multiple funding sources that go on --

Q. Coming back to an example that we've discussed already, primary care, to the extent that you regarded primary care as a not negotiable for a health system that adequately meets the health - optimally meets the health needs of a population, if it's not there at all and you see that as a gap, which is part of your planning process, you think at least in terms of putting on paper that optimal health service, "How are we going to fill that gap". If there is something there in the form of a market, and it's a viable market, then presumably you take the view not

unreasonably, "Well, there is a gap we don't need to fill"?
A. Not only not unreasonably, I think the role of the government is not necessarily to try and do all things which private enterprise can do satisfactorily.

Q. Certainly not things that private enterprise are already doing perfectly adequately?
A. That's right. Absolutely.

Q. And I think you mentioned a moment ago, obviously enough, you can't provide every service in every location, otherwise everyone would want a cardiac unit and everyone would want all manner of other things, which on no rational view are needed. So at some point, whether it be at a political level or at an LHD level, someone has to make a hard decision about what is going to be or needs to be provided as part of the optimal health service for a population?
A. That's right, and taking into account clinical safety, what should sensibly be provided, because we know we can safely do it versus what we sensibly should not provide because we know we safely cannot.

Q. So you have identified the needs of the population, you have identified, starting with place-based assessments but considering each of those separate places as a system or a network that feed into one another, what the actual optimal health system might look like for the delivery of equitable health care to the populations across the LHD, and then I think the next step, you say, is you identify from all of the sources, both what you are delivering yourself, what other entities, including the private market, might be delivering, and then you look at the gaps?
A. Yes. The absolutely essential component that we haven't talked about is then you not only have to think about the local place base that you are planning, but you have to think about how it connects with the rest of the health system. So, for example, if I was planning services in Bourke, I would need to understand how we meet the needs of health - of the community of Bourke in the context of where the regional hospitals are and what they provide, in the context of the transport infrastructure, both emergency and non-emergency between those communities. And then I would have to understand that in the context of the relationships between, in this case, the hospital in Dubbo, and the rest of the NSW Health, tertiary and quaternary system, delivered out of metropolitan Sydney, and how all

of that connects together. Because it is the overall way that you're going to meet the health needs of the community in Bourke that you are trying to solve and some of those, sensibly, would never be met outside of metropolitan Sydney. So it is the escalation, and that's the beauty of NSW Health, I have to say, having worked in many other systems - the ability to work as a cohesive whole and plan together.

We have, in our case, in our district, not all services but the vast majority of tertiary services are provided out of Royal Prince Alfred or Sydney Local Health District, and we have a very close and interactive relationship, both in a day-to-day sense, how we transfer patients to and fro and between specialists picking up the phone, talking to each other about the care needs of an individual, but also in terms of how that network flows between the two LHDs in terms of the planning and design of services, and you will see a very good example of that when you go to Far West, with the virtual support into their critical care services there.

Q. In terms of - I won't use the term disinvestment - the evolution of existing facilities into facilities that might better meet the needs of a population in a system-wide way, how do you deal with that? You talk about a lot of rigidity, but do you have a view about how best to push through that rigidity and produce results which are to the benefit of the health system but also to the population in these small communities?

A. You can only do that with open and transparent dialogue. But, also there has to be system transparency, which is why, to me, it is so important that we look at how the Commonwealth and the state health funding systems come together, particularly for small rural and remote towns. So that you can actually get to the point of saying, "Actually, the funding available to you in this community is equitable compared to the funding available to a similar sized part of Northern Beaches", for example. So that the community understands that, in fact, they are not being short done by, adjusting not only for head of population but the equity in their health status and whatever, and from that sense of transparency across the whole system, you can then start to have very transparent conversations around, actually, you know, the value of an emergency department that sees triage five patients largely, a thousand a year, compared to all of that money going into

something else, in terms of the health outcomes for our community, let's have a conversation about does that work. We've only talked about EDs, but there are many other examples that I could talk about in terms of the way that historically services have been delivered and I think, I don't want to leave the impression it is only about EDs; it is actually about everything provided in that service, in that community.

Q. I think you have told us in paragraph 148 that the MPS model has not continued to evolve with changing demographics and health care delivery trends. What did you have in mind when you --

A. So the MPS model was an absolutely fantastic model for rural communities. It was a solution to a set of problems back - I think it was around the '90s some time when it started to evolve, and particularly around the sustainability of more acute services in those towns.

The contemporary situation, as such, is that the real crisis that requires solution is primary care in those towns. So I'm a very strong advocate that, in fact, the consideration of how we grow and develop MPSs in towns that don't have viable sustainable primary care should absolutely evolve and mature to be a model that is about aligning aged care, primary care, community services and that kind of - because that's the core of what a service - the services that a community need in place.

Now, there may also be considerations of the ED and all of those kinds of bits, but it is a fundamentally different - the core of what you are trying to do is provide aged care and primary care that's really robust, and primary care, I'm meaning far more than general practice. Some of that may not be in any institution, it might be in people's homes in the community, or whatever. That's the core that the MPS model should be, in my opinion, evolving towards in future rounds of MPS funding, and in some towns, the MPS may end up not having an ED or sub-acute beds at all, because it is the better solution, whereas in another town, in fact, they may be entirely important things because, in fact, the presentation rates and the needs for that may be entirely important.

Of course, for every service that you take out, then you have to work through, so what's the alternative, what's the risk that the community's prepared to wear, how do we

address those kind of issues. But, again, I just come back to, and I in no sense - do any of my staff or any of my communities should be hearing me to be dismissive of the hugely important work that they do, but the reality is the value to the community of a well-staffed bed in an MPS facility that has nobody in it is zero.

Q. Important in that process, though, is, I think you said earlier, a strong process of dialogue with the community that is most directly affected by the decisions that we're talking about. We often hear the distinction between doing things for people or to people, on the one hand, and doing things with people on the other. It's the latter that's most effective, is it not, in terms of bringing a community along on the journey towards shifting that slow-moving oil tanker that is their branch of the local health service?
A. Unquestionably. We are servants of the community, we're public servants. It is a public health system. We need to work with our communities and bring them with us.

Q. Similarly, in a system that's always going to be dynamic, having planned, it's important to carefully monitor the extent to which whatever services have been planned and are in the process of being delivered are actually meeting the needs or achieving the objectives that are intended?
A. Absolutely.

Q. Continuous and careful consultation with the community that is being served by that system, again, is an important part of that process?
A. Yes.

Q. How, in your view, is that best done, that consultation process within, say, a small community that's had - gone through an evolution, they have at least, by and large, come along on the journey, how do you consult with them and continue --
A. In the hypothetical example that we've talked about this morning.

Q. In the hypothetical example that you are soon going to be looking at --
A. That's right.

Q. -- as part of your place-based planning.

A. So on the assumption that we've moved beyond a "Let's just let lack of workforce make all of the tough decisions that a lot of other people are paid to make" and we get into a better world, then I think Maryanne spoke to you about something we're trialling here in the district and progressively expanding, it's very intensive work in terms of meaningful community engagement, we've started a regional planning committee or regional committee process, we have one around Dubbo and we have one around a number of the northern towns in our district and we want to expand into another area. It is hugely intensive work. I would argue - I've been unable to adequately resource it in the LHD yet, we will find a way to do that as we expand forward.

The difference between that and the old hospital board - they were fantastic, but the local health committee type of structure tended, over time, to become non-representative of its community. We would have the local pharmacist, it would have people of the type who naturally gravitate to being community leaders who may be very, very different in every aspect of who they are compared to the community at average. So we've tried very hard to work with a range of bodies to make sure we've got very representative people. In fact, on both of those committees I've described, the northern one, I think, 57 per cent of the participants in that community are First Nations people and in Dubbo I think it's about 50 per cent.

Trying to get into having genuine members of the community - sorry, that's a terrible phrase, to have people of the community who reflect the diversity of the community rather than just a part of it. And that's an ideal framework, both to support planning, as we move forward, but also to support monitoring and evaluation, and as we've heard over the course of the week here, sometimes the views of how well things are going in communities - that the community have, differ fundamentally from how well the views that organisations might have at a distance, people like me.

So we have to be open to be on the ground, to hear in a respectful and an open way about the reality of what's going on and to provide those committees with information around actually how are the outcomes from the community being achieved over time; what is happening to the health of the local community; listening to their concerns. And

a really good example of that has come out of the Dubbo regional committee, committee members in Narromine were very, very concerned about vaping, particularly by adolescents in their community, and it spanned a whole community project, education got on board, the schools got on board, we got on board. That was the one thing that they really wanted to see an intervention in health in Narromine - there were many other things, but that was the really big top of mind thing. And it spawned an actual, very visible series of interventions into that community that will be ongoing around vaping.

Now, we simply don't have the resource to do that everywhere, but we did have the resource to focus on something that had arisen from the community and it will now feed into the outcomes ongoing for the people involved in that community, and you can imagine, as you get into a more mature and stable state of realigned services, you have rebalanced between primary and hospital services where investment was running, assuming that you've got the state and Commonwealth to agree to take a pooled funding approach and all of these kind of very achievable but very difficult to achieve things, then you can have a conversation about "This is what the health of our people looks like. This is what the service gap is this year compared to last year, or last five years. This is where the needs of the community are shifting because the demographics of the community are shifting, and this is where we should be investing".

Q. It is particularly important in your region to engage in a genuine collaborative way with First Nations communities?
A. Absolutely.

Q. Their particular circumstances, particularly where, as I think you have mentioned earlier, if you have large First Nations communities living in remote areas, the way in which you might approach the engagement and planning of services for what might be regarded as a small population in a remote area could actually be quite different, having regard to the objectives that you are seeking to achieve through that engagement and delivery of health care?
A. It will be fundamentally different.

Q. Did you have an opportunity to hear the evidence given by the Murdi Paaki assembly?
A. Yes, I did.

Q. Without wanting to go into any of the specifics of it, one was left with the sense that at least the chairs of the community working groups or working parties who appeared did not have a sense that they were being well engaged in relation to service planning and the adequacy of the delivery of service within their areas. Is that something that you were alive to before that evidence?
A. Perhaps I can step back.

Q. Please do.
A. One of the reasons that the Murdi Paaki Regional Assembly and the local decision-making community chairs presented evidence to the Commission was because the LHD suggested that, in fact, the Commission should reach out to them. Because in our LHD, we believe that giving a voice to our Aboriginal communities is fundamentally important. We were in a position of power in this process to open the door. We didn't know what they would say.

But, in opening the door, nothing that I'm about to say - I absolutely do not wish to reject the testimony that was heard, because, as you will know from any other court process, you can have two witnesses to an event who have entirely different views of what actually occurred as a matter of fact, and my responsibility as chief executive, and I think the health system's responsibility, is not only to open the door so that people can have a voice, but when they speak, to listen, rather than refute.

So in that context, I think they gave hugely valuable evidence for us as a committee. It was extremely distressing, some of their stuff. I found it distressing at times, and I know a number of our Aboriginal staff found it distressing for differing reasons.

However, having said all of that, there is also a reality that some of those present are on our regional planning committee in the north, we're evaluating that, and I think Maryanne spoke about that yesterday, and in fact, we know - I know from early conversation about the evaluation - that it is actually being very positively received by both Aboriginal and non-Aboriginal people involved in that process. We agree, and I absolutely agree - and it had already been raised with us by the regional assembly - that we could improve that engagement by involving the chairs of the community working parties

moving forward, and so we're - and we had already begun and we're in dialogue over how we might bring the community working party chairs into that process. That will occur and I actually think from the evidence that we heard yesterday, or whatever day it was, it made me even more convinced of the absolute importance to make sure that First Nations people have a voice in our planning processes.

Alongside that, of course, we have for many years had accords that we have entered into with our regional assemblies, both Murdi Paaki, Three Rivers assembly, they are accords that happen at a higher multi-agency level of government, but they have schedules in them and one of them relates to health and, through that process, Aboriginal health and wellness directorate, executive director, will enter into negotiations about what should be in a schedule, issues of importance related to health, and out of that comes action plans that we try and progress together, moving forward.

We would all say that we've got to do a lot more work to actually achieve the aspirations and outcomes. Our organisation has a Reconciliation Action Plan, it is the second one, I think, or one of very few parts of NSW Health that is now on to its second, next tier up Reconciliation Action Plan that we're absolutely committed to, to delivering better outcomes, and part of that is about listening, giving agency, giving voice to our First Nations people, whether they be staff, whether they be consumers, whether they be communities, and working out how we're going to deal with what are sometimes very uncomfortable learnings for when different cultures that have vastly different histories and vastly different experiences of modern Australia, let alone historical Australia, try and come together to work out how we move forward together.

Q. Could I move to another issue very briefly. Could you go to paragraph 41 of your statement where you deal with or reach some conclusions in relation to mental health issues. I just want to ask you if you could expand upon the last sentence there where you say there is a suggestion that people are being exposed to harm because of deeply ingrained silos that exist between mental health services and other types of clinical care within the health system generally. What did you have in mind when you were --

A. Well, the evidence that we give in our statement and

indeed in the diagram following on - on the page following is that for people who have a mental health condition, their personal health outcomes - that is, their non - you know, their physical conditions - I think at the top of that graph we show life expectancy on average. It would be fundamentally different for people with a mental health condition than people who do not have a diagnosed mental health condition. There are a whole range of factors that might lead to that. It could be their medication and so on. It might also be, in fact, the stereotypes that come with people when they interact with other parts of the health system about the quality of care that they receive.

This is very new evidence within NSW Health. I take my hat off to the Ministry of Health, the mental health branch, who have been doing a really deep dive project on behalf of mental health consumers to look at what their experiences are in terms of health outcomes in other parts of the health system, and what the evidence shows is that they are far more likely - consumers, on average, with a mental health condition, are far more likely to be admitted to a hospital for a condition that could have been prevented; far more likely to turn up to an ED with a condition that could have been prevented; far less likely to be undertaking some kinds of sensible screening activities or disease prevention activities than other members of the community. And the net result is, in our district, something like 13 years difference in life expectancy for those with a mental health condition than those who don't.

We have similar analyses, which are much better known around, for example, First Nations people. But this is new work, and what it has meant for us is we have picked that up locally, we have started to target some interventions between our mental health team, our Planned Care for Better Health team, because there is a huge correlation, as you heard from Helen and Warren the other day, between people with a risk of hospitalisation and mental health conditions and a whole range of other social determinants - the ability to, if you like, take control of society rather than be on the ebb and flow of just opportunity in society, including housing and everything else. And to wrap around services for those people, which may have nothing to do with health - housing would be a great example - but to help them navigate the system, because one of the things about health is it is such a complex system, I - the best

thing that anybody who works in health can do is be a patient in a hospital. If every nurse, if every doctor, if every allied health person, if every manager, if every bureaucrat or whatever label we want to put on anyone would find themselves in an emergency department in dire need, or their family in dire need, and then navigate through the health system with them, they will come out the other end with a fundamentally different view of the kind of care and the way that they should provide care and an understanding of how that care is provided than prior to that experience, because they'll have lived experience of it and they'll see it warts and all in a way that you don't see it when you are just a practitioner in a part of the system.

The same is true for mental health people, which is there is this hugely important research, hugely important that we pick it up and do something with it, and what it really points to is, in fact, if we think about the mental health services traditionally, the argument - I will make a pantomime of it, but for purpose, the argument would have been "They don't have a mental health - that's not a mental health problem, that's a physical problem, go and see the general medicine team".

Well, the general medicine team would say "That's not a physical problem, that's a mental health problem, go and see the mental health team". The consumer is stuck in the middle. And, at scale, the kinds of indications that we're seeing here, are in part that kind of siloing going on before, but equally in part, and you heard a bit of this in a way from Martin in his testimony - these people, well, many of them won't have a general practice attachment. If they do, it's highly likely that they won't be seeing the same general practitioner when they turn up. It's far more likely they can't afford to turn up, and it's far more likely that, for whatever reason, they feel marginalised from the primary care system so they don't have a connection anyway.

And many of the things that we're talking about here are the impact of chronic diseases for those people that are far better addressed somewhere else in the health system. And traditionally mental health services would not have looked at that. I think you heard some wonderful evidence from Helen and Warren the other day, and in my statement, and I'm not sure about anybody else's, but certainly in mine, I allude to some of the interventions of

the Planned Care for Better Health team that we have underway in mental health services, working with them, precisely to wrap services around people in a way that overcome some of those really intense silos that exist between specialties in the New South Wales health system, or any western - that's not a New South Wales health system - that is the way that hyper specialisation which deals with body parts not with human beings drives you, unavoidably.

All western health systems recognise the need to try and reintegrate, without losing the advantages of hyper specialisation, because that's how you get better treatment for individual diseases, but if you lose the human being in the middle of that process, you end up treating body parts and nobody comes as a body part. In fact, the body part doesn't need to be treated because, most appropriately, a body part is in the morgue.

Q. The wraparound service that you have referred to obviously comes at a cost to deliver. Is that a cost which is recognised by existing funding models?
A. There are some funding models that support that kind of activity and some of it will be activity funded, some of it won't and we're just navigating that. There is a whole series of changes going on around how mental health services are funded, potentially at this point in time, for their component. Mostly, this is programmatic funded, so it's funded on a "We'll do this for the next year or the next two or three years", so many of our staff who work in this kind of work are actually on temporary contracts.

Q. Does that present particular challenges for the LHD, the programmatic and time limited nature of some of these funding sources?
A. Yes, because in order to be fiscally responsible, we will only enter contracts with staff for the duration that we can avoid being exposed to, for example, redundancy costs if the program ends and is not replaced. I would suggest - and we're doing some internal work - that actually we've been a little more tight in that respect, and provided we enter into employment contracts with people that allows an upfront agreement that if the program ends they will be willing to be redirected into some other kind of work within their capability within the LHD - and of course not everybody will agree to that, but if we were to have that kind of agreement in a mutually legally binding

and agreeable way, then that would overcome some of these difficulties. We're just starting to look at that in some of our services moving forward.

Q. What's the origin of the time limited program funding? Is it state funding, Commonwealth funding or --
A. It could be either. So, for example, our aged care assessment services in the district are Commonwealth funded. Literally - literally, it was about two weeks ago that we received advice from the Commonwealth that contracts that were ending on 30 June could be ended to 30 December, because the Commonwealth has agreed to extend the funding for another six months.

You know, these are specialised staff, and I have to say that I take my hat off to registered nurses, others, who have got a choice of career, that you would be prepared to take the entirety of the risk of the longevity of your employment on short-term funding arrangements.

Q. So in terms of the challenges presented to the LHD, there is a challenge associated with the time limited nature of the project funding, that is, a year or two years, which in and of itself creates workforce complexities?
A. So that can be part of it. I think what the real issue I'm trying to point to is I think we need more sophisticated mechanisms to address that risk rather than expect that risk to be entirely carried by the employee.

Q. But to the extent that the risk is being carried by the employee, do I hear you to say that that risk is being in the administration of the schemes or in a practical sense exacerbated by the fact that not only are the programs or projects time limited in their funding, but decisions around whether or not to extend it or roll it over for another term are being made so late in the piece that it does literally leave employees in a position where they are wondering whether they are going to have a job in a fortnight or a month's time?
A. Yes, and unavoidably so, because many of those programs will be reliant on government processes that establish budgets very close or after the end of the financial year. So to give you an example, and I think in the evidence there's example of the funding, the starting budget for the LHD, which - somewhere in the evidence bundle that was requested and provided. But that starting

budget that's outlined there in the service agreement was actually $22 million less than the closing budget of the prior year, because of the programmatic funding, which was then waiting for a subsequent budget process or indeed program decisions, and that happens every year, and it will happen again this year. Sometimes you've got a sense forward for a few years.

NSW Health is doing the best it can to give chief executives a three-year horizon where they can, but in many cases, they can't, around some programmatic funding.

To a degree, that is entirely appropriate. Some of this is pilots, let's try this, let's do that. Some of it is very much determined by the discretion of governments, which may of course change in their emphasis of where they - on a policy basis between one government and another.

Q. I asked you a question a moment ago whether decisions around whether or not the funding of a project would be extended were being made so late in the piece that it literally receives employees in a position where they are wondering whether they are going to have a job in a fortnight's or a month's time, and your answer was "Yes, and unavoidably so". Can I ask for this clarification in relation to the answer. When you say it's unavoidably so, I presume you are saying, from the perspective of the LHD, there is nothing that you have the power to do which would avoid that situation?
A. I'm actually saying from the perspective of NSW Health. So NSW Health is unable to spend money for which it has yet to be appropriated.

Q. But in terms of decisions around project funding, if they were made earlier by those who have the power to make those decisions, be they Commonwealth or state based, not the LHD, that would avoid the situation that these employees are being put in, would it not?
A. So that's one possible mechanism, perhaps unfair to a degree, because we all expect government process to readjust priorities and budget at both Commonwealth and state level. What I also alluded to is perhaps there are some more sophisticated mechanisms than we have historically used, both at a NSW Health level and at an LHD level, which might better share the risk, should employees in those roles be prepared to enter into employment

arrangements which gave perhaps them less discretion about, if the program ends, within the scope and capability and professional qualifications they have, about work that they might be redeployed to do than is currently the case.

Q. If I take you to infrastructure planning and delivery, we've canvassed the issue of a site-based or facility-based planning and the potential challenges that that introduces when it comes to your ability to roll out a more holistic health system that meets the variety of health needs of a population. I just want to get down to some specific questions about Dubbo Base Hospital. Like many that we have seen, it is an amalgam of old and new buildings joined together by an arterial network of corridors. The new sections are a phenomenal facility, at least through the eyes of a layperson --

A. Mmm-hmm.

Q. -- who visited it. The old parts of the hospital are, in some cases, in serious need of renovation. Is there anything about the way in which planning and the delivery of infrastructure projects operate within NSW Health which creates particular challenges for you in relation to the way in which the redevelopment of a hospital like that happens - that is, particularly having regard to the significant disparity between the new and the old bits?

A. I would hope that today - and I don't know this for certain but it is a hope, and I think it's probably more reflective of today's reality - that what happened at Dubbo was not occurring elsewhere, which is essentially that Dubbo was funded in tranches without any guarantee of the next tranche. I think they've completed stage 4 of a multi-year program over about 12, 15 years in Dubbo.

We need to do at least another stage. It's not a small investment. Our estimation in today's dollars, we're probably talking well north of 300 million to complete the job.

Generally today, and there are many examples of that both in our district and others, the entirety of a job would be committed to at the commencement. So that's some learnings of history.

Moving forward - and of course the commencement of that process is clinical services planning, and we have, as we've indicated before, done the clinical services planning

for Dubbo, Narromine and Wellington, precisely so that we - and we do have on our strategic asset management plan, our asset management plan and CIP process, capital investment proposals through NSW Health, we do have Dubbo there. That is, of course, not a guarantee that that will be funded. Ultimately, those are decisions for Dubbo to complete the job. But, by and large, across most large hospital redevelopments these days, you would attempt to do the entirety of the job.

The difficulty with that is of course the elephant in the room for everybody at all levels of society who are trying to build anything at the moment. I will use Bathurst hospital as an example. We did a similar process to get a redevelopment at Bathurst, an extension of the hospital to meet community demand. Great process with the community. We were successful in getting substantial money from the New South Wales Government in the budget process, 200 million or thereabouts, and at the time we thought that was an enormous amount of money that had great head room for it.

The reality is that the estimated inflation in construction costs, that job's 3 million dollars a month, every month for the last six months. So all of our head room that we thought we might be able to achieve - and I just use that as a particular example that we're working through how we're going to address this issue, but it would apply across any major construction project anywhere in Australia, whether it's a road, whether it is a rail network, whether it is a hospital, whether it is a school - the hyper inflation in the construction industry at this point in time is a significant concern, and I think even the Productivity Commission and Treasury has, at both state and Commonwealth levels, recognised the significant impost, the amount of investment in public infrastructure is occurring, and of course the problem that we've all got is we all want the infrastructure, we all need it, but in the post pandemic era there is enormous inflation occurring that we have to navigate and make the best value for money out of.

And I take my hat off to those in health infrastructure, those in NSW Health finance department, those in Treasury, those in our own LHD who are grappling with that very, very real and very human issue. Because, of course, all of us want the best outcomes for the

communities that we serve.

Q. You have canvassed a lot of challenges. Are there any that we've missed, significant ones, that you think ought be brought to the attention of the Commission and made the subject of its consideration?
A. You can tell I'm aspirational that the Commission might achieve some really substantial improvements across the system, which is not to denigrate what is there, and I just come back to it, the system is an extraordinarily good system, but there are some fundamental weaknesses and, as time goes on, they will get more profound, particularly around the way the Commonwealth and state work together.

It would not be surprising as a rural chief executive and not surprising I spoke about the deficit, that this LHD was now encountering, what I didn't mention, I gave the figures on the occupational issues driving that or the - what I didn't mention is that, in our district, 75 per cent of that deficit arises from our rural facilities, either MPSs, community hospitals, procedural hospitals, and similar - obviously, the drivers I'm talking about are particularly connected in saying that.

But I do think that one of the real issues in NSW Health that does need to be looked at far more closely is the funding of small community and MPS hospitals, so the rural funding model. There is a model. There is a model that typically works quite well but, in the interests of time, I might give you two analogies to try and perhaps give you insights. One is perhaps of a painting of Escher's staircase on the wall of an art gallery, the Dutch painter. Two people can look at that. One can say "That's a fantastic staircase. Look at the perspective. Look at the way it works. That's a beautiful picture", and they would be correct.

Another person could look at the same painting and say "That's not a staircase at all". And they would be perfectly honest and perfectly correct. And the difference between two, one is looking at form, so the artistic form of the drawing of Escher's staircase, which, by the way, doesn't go anywhere, you cannot walk up Escher's staircase in the way that it is drawn; and one will be looking at the function and saying "Actually, does this achieve the actual outcome that you want?" One will say "Yes, that's a fantastic staircase". Another will say "No, it's not",

and they will both be completely honest and completely true in their assessments.

If I can put it in a different way, given the multi layers starting from the Commonwealth down, you might have two different people with two different cars. One can say "This is a fantastic Ford. It is a great Ford car. Look at it. It's all connected. I turn the motor. It goes. Fantastic. I can get from A to B and in the journey from A to B, I can tell whether or not I've had a lead foot on the accelerator and have been inefficient in getting there", or "I can tell that actually I've driven really well and I've consumed no more than I needed to get from A to B", and someone else can tell "Yeah, you got from A to B, but in that car you went through C", and whatever, so there is that kind of model or sense of a car. And they can look at that and say "That's a fantastically working car".

Another person can come along with a car that's in kit set form, so all the parts of a car, but they are not joined together. They can say "I've got a car", and both people will be absolutely true, but they are talking about something fundamentally different.

So there are people in this system who rightly will look and say "We've got a car that works", and others in the system will look at the same thing and say "We don't have a car that works". What they are really saying, I will give you an example, in the kit set version, you might have a process that takes out the starter motor and turns the starter motor over and the starter motor works, at which point you conclude you've got a car. That's great. This piece works, it's fantastic. You might even connect it to the engine block and turn the engine block over and say "Great, we've got a car, it works". And they will be true in saying that.

I will make the point that I'm making in a far more precise way shortly but I'm trying to draw a story because you will get conflicting advice on this.

As a rural chief executive, I'm a pragmatist. I'm only interested in a car that I can jump in, turn the ignition, drive from A to B and know that I'm not going to be lost somewhere in the middle of the road because the parts of the car are not connected. That's my definition of a rural funding model for small hospitals. I know in a

practical and functional sense that it works.

Others will have a definition of a rural funding model for small hospitals, which is about a starter motor. So let's break that down.

How do rural hospitals get funded, because it is very complex. So at a state level you can get - sorry, Commonwealth to state, NRH level, national health reform level, there are two different kind of mechanisms that you can get funded. One of course is through the national efficient price, NWAU price, it gets broken down into a state efficient price and so on, and that funds ABF activity. The other is through a national efficient cost model, which is of course designed for small hospitals and so on, and there is a variant of that which is designed for MPSs.

So that model works. And it comes into the state government at the level of the state government and, then, within NSW Health, there is a model, the district network return model whereby we will submit evidence as to the cost of providing services in small community rural hospitals, and that will have its own model, it will have different weights and different levels of fixed versus variable cost in it than the Commonwealth model has. Then underneath - so those two processes already are there, independently of each other.

Then, underneath, you will have an annual budget expressed in your service agreement, and of course that process may or may not be connected to the district network return process within NSW Health.

So I've just described to you only three of multiple parts of a kit set, which in their splendid isolation of one another actually look like they work really well and they do work really well and there are plenty of people who put enormous effort with great integrity to try to make them work really well. But I'm interested in a transparent connection between knowing that when I jump in a car, that all of the component parts have been connected and the petrol flows in the way it should. Why is that hugely important? Well, firstly, transparency. We spoke about the importance of transparency when it comes to long-term structural reform about health services when you are interacting with communities about funding. So that's

hugely important.

But also the incentives - it's hugely important that the incentives are aligned. I would like to know as a chief executive whether or not the expenditure difference between one small hospital and another is due to the inefficient use of those resources locally, or at an LHD level, or is it that, actually, they had no possibility of being more efficient than they currently are, because my interventions with that small facility will be fundamentally different. If I think they are wasting money, my intervention will have something to do with eliminating waste.

But, actually, if the signals were telling me there is no hope in hell of achieving whatever amount of money that I gave them for whatever reason, my interventions would be very different, because I will be worried about breaking the ability to service a community in a way that is very different between those two scenarios.

So that's why, to me, transparency, the joined-upness, the absolute ability to be able to draw a line between the component parts of various funding models and what actually ends up in your service agreement - and I'm used to a health system where, sometimes, I didn't like what ended up in my service agreement and, sometimes, I would be asked to provide services at a discount and I didn't want to do that, you know, I would get NWAU with zero dollars attached to it - this is a New Zealand example - but the reality was I knew when that was happening. There was no artifice about that.

In the interests of the greater good of the system, I knew I had to be more efficient because I was going to have to deliver more service for no real income, but I knew what the problem was that I was trying to solve, because it was clear and it was transparent. I don't think I would be the only chief executive, and I'm sure you will get testimony from others, so I'm giving you my perspective with integrity here - a greater sense of how all of the component parts of the funding for small rural community hospitals and MPSs all fits together would be hugely beneficial, not only within NSW Health but between us and the Commonwealth. So we've done some work around MPSs, and we've done two entirely independent pieces of work in different parts of our district, almost a decade apart.

One was in Cobar, where we were evaluating whether or not we were going to take over an older persons' residential aged care facility provided by the council. The team that looked at that worked out that actually to provide those services with the kind of staffing that we would provide, registered nurses and all of those things that the Royal Commission into Aged Care said were a great thing to do for quality benefits, we would lose about a million dollars a year on that facility if we took it over. So decisions were made about the wisdom or otherwise of doing that.

We did a very similar piece of work recently in another MPS which we are about to redevelop, and we looked at the income we were receiving from the Commonwealth for residential aged care beds in the MPS and concluded - we got a third party to do it, we really put it through the wringer because we were trying to decide at that time whether we lobbied the Commonwealth for more, or less, or fewer of the same beds and all of those kinds of things, in the context of a small town that was likely at that time, but fortunately not now, to have a closure of a private provider. Again, we concluded the differential between what it was costing us and what we were being funded was about $100 a bed day.

That's an enormous sum when you multiply that. It will be different in different locations and different set-ups, but it is nevertheless a multi-million dollar sum when you multiply that by the 400-odd residential aged care beds that we provide.

Again, I say in my statement, I understand there is an official working party and group looking at MPS funding right now, but it is another example of an issue that, because of the lack of transparency in the funding model for smaller services that are provided in smaller communities, whether they are MPS or community hospitals, in fact, you have to invest in an extraordinary amount of effort using skills and abilities that many LHDs would not - would have other uses for those staff to be providing, to even try to work out what's going on.

So it would be no surprise to my colleagues in NSW Health and the finance department, I value their services, we work very collaboratively together, but there are huge benefits that they and the system and LHDs could obtain from greater transparency both between the

Commonwealth and the state about how these services are being funded and how that translates and also, then, within the NSW Health system about how that then translates ultimately into dollars in the service agreement.

MR MUSTON: Thank you, Mr Spittal. Those are my questions for this witness, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: Just one briefly, Commissioner. .

<EXAMINATION BY MR CHENEY:

MR CHENEY: Q. Mr Spittle, you have referred in your statement to Marathon Health and you gave some evidence today about your relationship with it or dealings with Marathon Health. Can I ask you to assume that Ms Callinan, the CEO of Marathon gave evidence to this Inquiry that some $13.7 million was allocated to an initiative in Western New South Wales which aimed to link more than 11,000 patients to enhanced diabetes care over a three-year period?
A. (Witness nods).

Q. And I ask you to assume further that on Monday this week, Ms Callinan said that in relation to that $13.7 million, she didn't have any visibility into how those funds were spent. Have those funds been spent?
A. No. And that's entirely understandable that Megan, who is a good colleague and we work very well together, would not have visibility, because she is an NGO provider, not a funder or responsible - not part of the heads of agreement for that project.

Perhaps if I can elaborate very quickly, and I appreciate the Commission's extended length of time that they've given me, but - so this was a collaborative commissioning project that was entered into between the PHN, Far West LHD, the Western NSW LHD and the Rural Doctors Network to try and undertake a project to demonstrate that if we delivered services for people with type 2 diabetes differently, that in fact there might be both benefits for the Commonwealth and the state in terms of long-term outcomes, with a view that the state would bankroll this project and ultimately be able to demonstrate

out the other end of it to the Commonwealth that, in fact, there was a different way of funding things that might be beneficial if they took it up.

All of this started pre pandemic. We entered - we began, I think it was 2020, from memory, we were getting really intensively into some very detailed modelling about how that might work through a dynamic simulation model and so on. Pandemic came, I think there were two pauses through that period of time, where work completely stopped.

Then I think, if my memory - if my recollection is right, later in 2022, the four entities signed a heads of agreement with the Ministry of Health which had a potential value of $13.7 million, if all of it proceeded.

Since that time, there have been three extended pauses to the project, and I think something like 14 months in total over elapsed time. One was because we were asked to navigate whether or not we addressed the co-payment issue, because part of the project had people seen through GPs, so we paused, and that's not a simple issue, and in fact we concluded after a while that it would be illegal for NSW Health to fund essentially a co-payment gap to a private practice on top of MBS billing. That would be out of order under the National Health Reform Agreement, and lots of probity issues would arise. So I think that took a couple of months.

We also, between the organisations, got to a point where, at a governance level, we were concerned that the governance of the project needed to be tightened. So we paused, and in fact I was the chief executive who called for that pause with my partners, and the PHN brought in an independent consultancy firm to give us some advice on the responsibilities, accountabilities and influence, so a RACI-type model about making sure at multi levels of this project we had those aligned and suggested some differences in the approach that we should take.

The third pause that occurred across that period of time was when both LHDs essentially looked at what we were trying to do and concluded that there might well be a smarter way of doing it and, in particular, that in our more remote and rural communities where access to primary care, even within the three or four years that we had been trying to work out how we might approach this problem, had

become so much more difficult, and the original model had a heavy reliance on general practice doing certain things, well, parts of Far West and parts of remote New South Wales, there is no point in building a model that is heavily reliant on existing general practice, which is overloaded, to do more.

So we paused and we currently have - we have done a lot of work with our project teams, with the PHN, with the RDN, the two LHDs and the Ministry of Health currently have with them a revised proposition. If the ministry accepts that revised proposition, then the total value I think across the four-year period of that project will be something like about $7 million, not 13.7, because we've worked out a better way to do it.

Q. Of the 13.7, how much has been spent?
A. To date, as at the end of April - and there is very strong governance around the expenditure of this between the four parties, and we report that both to each other for transparency and to the ministry - I think something like 2.87 million or something like that has been spent. It's very clear where it's been spent. I think we would all agree that what we have had, because we've kind of had - for very good governance reasons we've needed to go through the "Mmm, this is not working and it's unlikely to work in changing circumstance, we had better pause and redo some stuff", that has meant the LHD has carried a disproportionately high staffing cost versus outputs, because of course - when I say "pause", what I mean is completely paused, or almost completely paused, patient-facing services, so we've focused on a lot of things like scholarships to upskill staff in primary care or our services or NGO services, we've focused a lot on training, we've focused a lot on developing pathways and commencing some place-based planning work around a specific disease. But where we're yet to get to is to really turn on the interventions to patients that are a few - I think there is about 100 who have come in, because we're still in that hiatus, and the ministry has paused its funding. So it's not like we're gathering a lot of funding. We have all been transparent across the system and paused to reset going forward.

MR CHENEY: Thank you. That's all I had, Commissioner.

THE COMMISSIONER: Nothing arose out of that, I assume?

MR MUSTON: No. I think the proposal was that we would have a five-minute adjournment.

THE COMMISSIONER: Yes. We will take a 10-minute break. My understanding is that we're not having Mr Carey today, but tomorrow.

MR MUSTON: Mr Carey is coming at 9 o'clock.

THE COMMISSIONER: We are having Dr Spencer today?

MR MUSTON: That's my understanding.

THE COMMISSIONER: First of all, thank you very much for your time and your evidence. We are very grateful. For now, you are excused.

We will take an adjournment until 3.45, and we will come back with Dr Spencer. Thank you. We'll adjourn until then.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

SHORT ADJOURNMENT

THE COMMISSIONER: Are we ready?

MR FRASER: I think we are, Commissioner. Commissioner, if I could call Dr Ian Spencer.

<IAN GRANT SPENCER, sworn: [3.47pm]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Doctor, could you give your full name, please?
A. Dr Ian Grant Spencer.

Q. You are a general practitioner?
A. Yes, I'm a general practitioner in Bourke - in Wellington.

Q. And just for completeness, you hold a Medal of the Order of Australia; is that correct?

A. Yes, that's correct. OAM, that's correct.

Q. When was that conferred?
A. 2004, and it was for services to rural medicine.

Q. You, in terms of your practice in Wellington, are the owner of that practice; is that right?
A. Yes. I established a practice in 1983 and it's grown over a number of years and I'm still the owner and principal supervisor mentor to the other doctors that work with me.

Q. We'll come to some detail about that practice in a moment, but prior to setting up that practice in Wellington, is it the case you were in general practice elsewhere in the district?
A. Yes, I was a general practitioner, I set up a practice in Bourke in 1978. I came back from overseas, having been trained appropriately for country practice, and then went straight to Bourke.

Q. In terms of the growth of your current practice in Wellington, how many other doctors currently work from that practice?
A. The practice is basically set up to service about six, and over the last couple of years it's dwindled, one because of difficulty of getting fellow doctors, but also the registrar numbers have depleted. So we're now actually - we've got myself, we've got an international graduate who is a fellow of the college, and he's been with me now about five years and when I brought him out through the independent pathway, he did nominate that at the end of, say, five years, he would go and join some of his Myanmar colleagues on the Gold Coast, and he's leaving the practice on 30 November, which will then leave us just with myself and a rural generalist trainee, Jean Littlewood. She only works three days a week and works two days a week in the hospital system in Wellington as a hospital doctor.

So we had application for our registrars, a new lot of registrars, to start in the next few weeks. We had two applicants, both of whom were absolutely excellent and very interested in coming and, then, when we were allowed to contact them, as far as contracts go, they both nominated that they had chosen to stay in the country practices where they were at the moment. One is staying in Cowra and the other one is staying in Dubbo. We have no applicants, or

no apparent doctors that are looking to start with us in the January/February of next year.

Q. Doctor, I think it is right that you have had a long association with training GP registrars; is that right?
A. I've actually - I think I'm actually the oldest and the longest-serving supervisor for general practice - rural general practice training, in Australia.

Q. And in terms of putting - before this next intake where you've been unsuccessful in obtaining any, how many registrars would you usually have?
A. We would normally have about three. One would probably have already passed their fellowship and have chosen to either do an extended period for various components of their training and interest, and then there would be two registrars in training, and they would be partly their way through either the Royal Australian College of General Practitioner training pathway or through ACRRM, the ACRRM pathway, mmm.

Q. In terms of the flow of trainees, has there been any - you had two applicants, both of which were more than suitable by the sound of it. Has there been any sort of change in how many applicants you have seen over the recent years?
A. Well, I think for reasons that I don't think any of us really know, there's been quite a dramatic drop in the number of people joining the Australian general practitioner training scheme, be it ACRRM, RVTS, the independent pathway, or RACGP, and so there are quite a number of practices that are not getting registrars. I was at a supervisor workshop a couple of weekends ago in Orange and there were very few supervisors, and I asked why that was, and the reason was that a lot of the supervisors were really quite disheartened by the fact that they hadn't been able to secure any registrars for this next term, which goes in the second half of this year, and they were quite worried about whether they would get registrars into next year.

Q. I will just ask you about your practice a little more. How many active patients would you have, practice wide, at the moment?
A. We would have around about 6,000 active files, and one of the things that is so important for everybody to realise, and that is that modern general practice is a very

complicated specialty nowadays. Some people think it's coughs and colds and sore ears, but they are actually the quick things. Most of the patients we see have got several disease processes in train; they need to be on various health care programs, like the diabetes, the Aboriginal pathway, aged care facilities and so on and so modern general practice is a very complicated specialty nowadays.

Q. And that's something that has developed slowly over the period you have been in practice or --
A. Well, when I first went into general practice, back in 1978, I was trained to fix broken things and sick things, and that was basically fairly simple, really. Nowadays, particularly with the advent of preventative care being quite clearly shown worldwide to be the most effective way and the cost effective way of managing population health, general practice has been very much a matter of preventative care and the management of complex medical problems.

Q. Just in terms of you - you have said about 6,000 active files. How big is Wellington these days?
A. Wellington would be about - about 6,000, serving probably about 9,000 people, with an Aboriginal population probably of around about 23 per cent. It is a relatively demographically poor town. The district itself might be a very substantial rural, but the town itself is a relatively deprived population.

Q. In terms of other GP services within - well, before I come to that, about what proportion of your patients would be bulk billed?
A. Well, I've always been a bulk billing practice, ever since I set up a practice in Bourke, and we've agonised over the last few years and, just before the Christmas period we really sat down - my practice has actually been non-financial for three years, and so we actually had to make a very hard decision to change our business platform and opt out of bulk billing.

We still bulk bill all the antenatal girls that we see; we bulk bill the chronic mental health people; and all of the doctors in the practice have got the right to say to the secretarial staff "This consultation, I want to put it through as bulk billing". So there is a little bit of latitude, but basically, we've had to change the business platform simply because the cost of running the practice

is - has not made it financial. As I say, we've been running as a line-ball situation for the last three years.

Q. In terms of being in that position, is there any particular cost that has driven that financial position?
A. Well, I think that - yes, the costs have certainly gone up. Medical supplies and things like that have gone up enormously. I think companies, as soon as they have a medical stamp on it, they seem to double the price. I think we know that. But the other side of it is that the Medicare rebate, even though there has been a move recently to try and rationalise it, the Medicare rebate in the last five years has just not kept pace with the costs, and I would think that the poor Medicare rebate is the single most important reason why most doctors have had to opt out of bulk billing and, as I say, I've been a bulk billing doctor all my life, and basically, that was my philosophy about what I thought was fair and reasonable as a practitioner for Australia, and it did cause me quite a lot of grief to opt out of bulk billing, because I knew that there was going to be a group of people that would not be able to afford it, and hence would not be able to have easy access to primary health care.

Q. I have asked you about the doctors in your practice and the trainee doctors. What other staff are employed at the practice?
A. Well, the medical centre has got - it's got administrative staff, it's got nursing staff, of course. The nursing staff organise a lot of the immunisation programs. We were very heavily involved in testing, vaccinating and treating patients through the COVID epidemic.

We have allied health personnel, we have podiatrists, physiotherapists, psychologists, diabetic educators, and we coordinate very closely with the Wellington Aboriginal Community Health Centre, WACHS, particularly in regard to - we run a antenatal clinic. I think Wellington would be possibly the only town where there is a coordinated town antenatal clinic, and that has actually been running for the last 25 years.

Q. I will come back to the antenatal clinic. Just to be clear, the allied health professionals of the various types that you just listed, are they employed, or are they from one of the NGOs that come out and use your rooms?

A. No, the - Marathon Health is one organisation that we coordinate with. They send out psychologists. There is a podiatry group here that come and rent a room once a week. There is a private psychologist that also services; the diabetic educators come from Marathon Health, and - yeah. They basically all do - organise their own appointments. They are facilitated by our administrative staff. They rent a room, they service their patients. We both collaborate with referral letters and letters back from them.

Q. I will come back to the detail of the clinic in a moment, but the Wellington - is it the Aboriginal health centre or corporation?
A. Yes, it really is a medical centre, not simply a place where you see doctors. It services most of the needs of patients. I think mental health and social work is probably one area that we would love to have a little bit more involved in our medical centre, but of course, those services are just so scarce on the ground, and those people that are working in that area, there are the psychologists that can deal with the sort of emotional problems that are so frequent, but the chronic severe mental illness patients are the ones that we need to be really careful for. We bulk bill them and they tend to come and go and we help them as best we can, with the mental health services from the LHD.

Q. In terms of the Aboriginal Medical Service, in Wellington, in addition to yourselves and that service, are there any other primary health services in Wellington?
A. No, the two centres, Swift Street Medical Centre and WACHS are the only providers in Wellington. As I say, we work hand in glove with the WACHS organisation.

Q. Can you give a bit more detail about how the antenatal clinic that you have referred to that you work together with, with WACHS, to provide?
A. Well, I was the only obstetrician in Wellington for about 10 years and when we downscaled it a little bit, we needed to run the antenatal clinics, so initially it was started at the hospital and then the hospital asked us to move out because they couldn't provide the staff, the midwife. So we set it up in - at the Swift Street Medical Centre and the antenatal and maternity people from WACHS came and joined us and we've been running this collaborative antenatal clinic, bulk billed, for all girls

who are pregnant, and they come and they really have a wonderful service, wonderfully well coordinated service, and it coordinates, of course, with Dubbo maternity service and Orange maternity service as well.

Q. And how long has that collaboration been --
A. It's been running for 30 years.

Q. You referred to being an obstetrician. You held - were one of those GPs with additional qualifications; is that right?
A. Yes. Well, when I graduated in 1972, I actually always intended to go to the country, and in those years, you couldn't get the appropriate training to give anaesthetics, do obstetrics and some relatively minor/major surgery, so I went to England for five years and got sub-specialty degrees, and it was always my intention to get trained in those specialties, because at that time, if you went to work in the country, you knew that you would be a doctor involved in the hospital and, if it was a procedural hospital, as Wellington was, and as Bourke was, too, there would be obstetrics, there would be an operating theatre. In the early days we had a children's ward and we looked after quite a busy emergency department. So you needed anaesthetic skills, obstetric, and some surgical skills.

Q. Wellington hospital - did you used to provide those services at Wellington?
A. Yes, yes. I was the VMO providing most of those services from 1983 through to 2020, the January of 2020. Now, the thing is that the labour ward had been closed - when the midwives and I decided to downgrade the complexity of the ladies that were going to deliver, the LHD closed the labour ward. Then, again, because they said that labour ward was closed, therefore we didn't need an anaesthetic service, therefore they closed the operating theatre. Whether that was an intended agenda that they had all along, but that's what actually happened.

Labour ward closed, then the operating theatre closed. And some years before that, the College of Paediatrics delineated the role of various hospitals as far as the care for children, and hospitals like Wellington were not appropriate to admit children under five, so the children's ward got closed as well.

Q. Why was it that you stopped as a VMO? Was it because those services were no longer being able to be provided or --
A. No, it wasn't. It was really - I'm 76, but I was the young boy on the block back in the early days, and around about 15 years ago, all of my older colleagues were starting to die off or retire, and I was left with the - as the only senior VMO with my registrars, and I had two registrars, and we were able to hold the hospital together with that.

Then, when a lot of the registrars started to be more interested in just general practice and not wanting to be involved in the hospital, things changed dramatically, and I was trying to hold up the roster with the fly-in locums, which I'm sure you have heard of, and basically, now, it really just got too dangerous and too difficult for me to do that. So I had to - I retired, and now the hospital is completely run by fly-in locums.

Q. Just returning, then, to your practice, from what you have described earlier, it appears that there is a good chance that it may be you and your rural generalist colleague three days a week left at the practice; is that right?
A. Yes. Come 1 December this year, it will be me and a registrar, and the registrar is one of the procedural registrars, and she only works three days a week, and she works at the hospital two days a week. So the medical centre, which is meant to have at least five doctors, serving maybe 6,000 active records, it will be me and Jean Littlewood, which I think will be very dysfunctional. If we don't get some extra help - and we have been advertising everywhere, internationally included, and through the RDRN, through ACRRM, through locum agencies and so on, and so far we've had no luck at all.

Q. Can I ask what types - what precise level of doctors have you been advertising for, or is it literally any doctors and GPs?
A. Well, a lot of the overseas doctors that would like to come, particularly the ones from South Africa and some of the ones from the UK, they've actually done quite a lot of procedural work, and so one fellow that I was talking to, who was keen to come, but he definitely wanted to work at the hospital, and I've also been involved in the single employer model of practice, and this would have worked very

well, except the idea of the single employer model would be that me as the supervisor, while he was working in general practice, I would also be his supervisor at the hospital, and of course, as I'm not on the staff of the hospital anymore, I can't.

So the LHD and I are trying to work out some sort of way through that maze, but there probably would be more international doctors that would be quite keen to work in the country, particularly if they were able to work at the hospitals. Now, the doctors that we desperately need in our crisis are general practitioners and, really, the hospital has got massive problems of fly-in locums at enormous costs, which I believe are unsustainable, and it's nobody's fault. The playing field has changed, but the players haven't changed with it, and so what has happened is that now we've got the hospital being run by fly-in locums, we've got general practice desperately needing general practitioners, and the crisis that we're heading for is that there's going to be a very, very severe inequity of people in country towns, like Wellington and smaller, not having fair access to primary health care, and primary health care is just so different to outpatient medicine.

A lot of people think that if you go to an outpatient department, if you are not an emergency, then, well, that's general practice. But that's not general practice at all. It might be a sore ear, it might be tonsillitis, it might be a cut. But general practice is complicated and complex and dealing with multi-modal sick people.

Q. How many doctors do you think your practice requires to stay viable?
A. Well, we definitely need four. We need four doctors to provide it.

Some of the really good programs, like health checks, Aboriginal health checks, care plans, mental health care plans - they are all wonderful programs, but you have to have a doctor to oversee it. If you haven't got the doctor, you can't run those programs. Those programs are wonderful, and I think they are in line with the whole of the WHO plan for population health, and they are also in line with the appropriate funding of services, doctors, nurses, allied health, for a population. But without the doctors, you can't run those programs and, as I say, if we

are running on 1 December and into next year as me and a registrar, that will be a very dysfunctional practice and, to be honest, if we haven't got doctors lining up through the various agencies that we're desperately trying to access, if we haven't got adequate doctor numbers, I'm going to have to be telling the community of Wellington that, come 30 June 2025, my practice will have to close, and the tragedy of that - and it causes me a terrible grief and a lot of anxiety - and that is that all of the doctors in Dubbo have got closed books; all of the doctors in Orange have got closed books. So here's 6,000 people with complex medical problems and nowhere to go.

Q. I presume that the Aboriginal Medical Service doesn't have the capacity to cover all those patients?
A. No. Well, the Aboriginal Medical Service has closed their books as well.

Q. In terms of other than doctors taking up the various advertisements or training places, et cetera, are there any - in terms of practices in a similar - or towns in a similar position to Wellington, have there been any approaches that you have given some thought to that might help?
A. I think Wellington is a slightly one-off situation. Mudgee is a bigger town, it's a bit more active and it's got more doctors. So they look as though they're going to be able to manage. Towns like Wellington are really in a crisis. The towns further out - and they are suggestions, which I think have also been implemented to a degree - are the virtual practices and I think that possibly will be the only way, you know, towns like Tottenham, Tullamore and Trangie will survive, and I think the virtual general practice is probably something of the future.

It will require committed doctors to be - wherever they live, to be running a general practice on line. It will need really well trained nursing staff to do the triaging and the basic examination, like blood pressure, blood sugars and so on, but I honestly think that that probably will be the only way those towns will have anything organised to service their primary health needs.

As far as procedural country towns go, I think really - and I really say - I say this as an individual, I'm not saying on behalf of ACRRM or RDA or anything, but I think the long-term plan of the health department and

I think there is probably a lot of sense in it, and that is that if you've got a one and a half hour ambulance ride around all the truly procedural towns, the towns that are left outside those circles are the towns where you have to look and see whether they really need a proceduralist, and I think the procedural - the doctors that want to be involved in their hospitals, small and medium sized country towns, they won't be giving anaesthetics, they won't be doing obstetrics, they won't be doing surgery; they will be very well trained in emergency and looking after people in the wards. And I think towns like Wellington will act as peninsula towns supporting Dubbo and Orange.

Now, for instance, speaking on behalf of them, having known what happened, but an awful lot of the orthopaedic patients who have a hip replacement or a knee replacement, they get moved out of Dubbo Base and have all their rehabilitation in Wellington. A lot of the elderly people who were functioning well at home got sick and then no longer can support themselves at home, the small to medium sized country town hospitals are now organising the various arrangements for them to either have compacts at home, or be processed to go to nursing homes. It's a big part of their work.

MR FRASER: Those are the questions I had for Dr Spencer.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Dr Spencer. We're very grateful.

THE WITNESS: Okay, thank you very much.

THE COMMISSIONER: Cheers. All right.

<THE WITNESS WITHDREW

THE COMMISSIONER: The start time tomorrow is 9 or 9.30?

MR FRASER: It is 9 o'clock I understand, Commissioner.

THE COMMISSIONER: All right.

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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