Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Thursday, 13 June 2024 at 10.00am

(Day 034)

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

Also present:

Mr Hilbert Chiu for NSW Health
Mr Oliver Jones for St Vincent's Health Australia

1 THE COMMISSIONER: Good morning.
2
3 MR MUSTON: This morning's witness, Commissioner, is Anna
4 Mary McFadgen.
5
6 **<ANNA MARY McFADGEN, sworn: [10.01am]**
7
8 **<EXAMINATION BY MR MUSTON:**
9
10 MR MUSTON: Q. Could you state your full name for the
11 record, please?
12 A. Anna Mary McFadgen.
13
14 Q. And you're the chief executive officer of St Vincent's
15 Hospital Sydney?
16 A. Yes, I am.
17
18 Q. A role that you held, I think, since August 2023?
19 A. Yes.
20
21 Q. You prepared a statement dated 4 June 2024 to assist
22 the Commission with its work?
23 A. Yes, I have.
24
25 Q. Have you had a opportunity to read that statement
26 before giving your evidence today?
27 A. I have.
28
29 Q. And you're satisfied that the contents of it are, to
30 the best of your knowledge, true and correct?
31 A. Yes.
32
33 MR MUSTON: That statement will be tendered in due course.
34
35 THE COMMISSIONER: Sure.
36
37 MR MUSTON: Q. Do you have a copy of your statement with
38 you?
39 A. I do.
40
41 Q. Could I ask you to go to paragraph 10 of that
42 statement. You tell us there that St Vincent's Sydney, as
43 a wholly owned subsidiary of St Vincent's Health Australia,
44 operates two different facilities - that's the hospital at
45 Darlinghurst and the Sacred Heart Health Service.
46 A. Yes.
47

1 Q. Up until relatively recently, it also operated
2 St Joseph's, at Auburn?
3 A. Yes.
4
5 Q. Just so we can understand from a structural point of
6 view how the funding of those various entities operated,
7 would we be right in assuming that a single service
8 agreement between the ministry and St Vincent's Sydney is
9 entered into?
10 A. Yes.
11
12 Q. That single agreement provides for or contemplates the
13 purchase by the ministry of a particular amount of
14 activity --
15 A. Yes.
16
17 Q. -- from St Vincent's?
18 A. Yes.
19
20 Q. And that activity is then distributed by St Vincent's
21 across each of the formerly three facilities that it
22 operated, now two?
23 A. That's right, yes.
24
25 Q. Just in relation to St Joseph's, if we can touch on
26 that fairly briefly, at the time that St Vincent's elected
27 not to continue operating St Joseph's, there was some
28 discussion about the way in which the services formerly
29 offered at St Joseph's might be reallocated to St Vincent's
30 Darlinghurst?
31 A. Yes.
32
33 Q. As I recall the documentation, there was also some
34 discussion, at least from the ministry's perspective, about
35 the possibility that some of those services might instead
36 be offered through Western Sydney LHD or facilities
37 operated by Western Sydney LHD?
38 A. Yes.
39
40 Q. Do you, at least at a high level, before we dive into
41 some of the detail, have a recollection of whether the
42 closure of St Joseph's had an impact on or perhaps, put
43 differently, resulted in a reduction in the activity
44 purchased from St Vincent's within its annual service level
45 agreement?
46 A. Yes. So the key element around the activity transfer
47 was that the vast majority of patients that St Joseph's

1 looked after were from the Western Sydney catchment, and so
2 the decision was taken that the most appropriate course of
3 action was to transfer that activity that was previously
4 delivered at St Joseph's to Western Sydney LHD and various
5 facilities within Western Sydney LHD.
6
7 As a result of that, there were changes to our service
8 level agreement in terms of the amount of activity and
9 funding that then flowed to St Vincent's, because that
10 activity and the responsibility for service delivery, was
11 transferred to Western Sydney LHD.
12
13 Q. And that process, was that a collaborative arrangement
14 where decisions were made by both St Vincent's and the
15 ministry, as to where the service would best be delivered
16 in a geographic sense?
17 A. Yes, and I think we had a steering committee that we
18 set up with the ministry and Western Sydney LHD and we met
19 weekly on a weekly basis to work through the transition
20 process, and ultimately, you know, the view of St Vincent's
21 was that we needed to do the right thing for the community
22 and for our patients and it was clear to us that the vast
23 majority, as I said, of patients who came to St Joseph's,
24 and indeed staff who worked at St Joseph's, lived and
25 worked in the Western Sydney community, so it was
26 appropriate for those services to remain in that community.
27
28 Q. In paragraph 70 and following of your statement, you
29 have described in those paragraphs the nature of the
30 services that were being provided at St Joseph's. In terms
31 of the services that are offered at St Vincent's
32 Darlinghurst, there's some highly specialist services that
33 you've told us about in paragraph 13, and then in
34 paragraph 19, you develop your description of those, or
35 some of those highly specialist services, but also allude
36 to the proportion of the inpatient activity which is
37 delivered through St Vincent's. Could you just give us
38 a broad description, beyond the very special services that
39 are offered through St Vincent's, of the business-as-usual
40 day-to-day hospital services provided through the facility
41 in Darlinghurst?
42 A. Yes, of course. So we are a tertiary referral
43 hospital located in Darlinghurst, as you say, and we have
44 the St Vincent's Hospital and also Sacred Heart Health
45 Service, which is a provider of palliative care and
46 rehabilitation services. We see, just to give you a sense
47 of kind of size and scale, about 50,000 emergency

1 presentations a year. We have about 400,000 outpatient
2 occasions of service a year and 40,000 admitted inpatient
3 occasions of service a year, so that gives you a bit of
4 a sense. We have about 350 beds in total that we operate
5 on any given day and we're highly integrated into the
6 NSW Health delivery system, both from an emergency and
7 a planned care perspective.
8
9 Q. Do you have paragraph 19 open in front of you?
10 A. I do.
11
12 Q. Does that broadly cover off what is contemplated in
13 the description you've given of the emergency and inpatient
14 activity in (a)?
15 A. Yes, it does. So it covers, as I said, the kind of
16 broad breadth and scale of services that we provide but
17 also articulates the specialist and statewide services that
18 we provide, not only to our local community but across
19 New South Wales.
20
21 Q. Can I just come to some of those specialist services,
22 and this may be my misunderstanding of what you've said in
23 the statement, so don't interpret this as me saying that
24 there is an inconsistency or a problem necessarily, but if
25 you look at (b)(i), you tell us that St Vincent's is the
26 sole provider of heart and lung transplantation services.
27 Can I just ask, when we roll over to paragraph (c), you
28 refer to one of three hospitals in New South Wales who
29 perform adult heart and lung transplantation services?
30 A. Yes.
31
32 Q. The other two --
33 A. That is in fact an error. Please excuse me. So we
34 are the sole provider of heart-lung transplantation for
35 New South Wales and we are one of three hospitals
36 responsible for organ retrieval in New South Wales.
37
38 Q. So just again for the laypeople tasked with
39 responsibility for making decisions about health, what is
40 the important difference between the transplantation
41 services on the one hand and the organ retrieval services
42 on the other?
43 A. So organ - so heart transplantation is obviously
44 a very specialist, low volume, high complexity service, and
45 where those services - the nature of those services mean
46 that there's a very, very clear relationship between volume
47 and outcome. So in order to get the best patient outcomes

1 you can for those very high complexity services, it's
2 important to have the expertise, the infrastructure,
3 research, for example, concentrated to a single provider
4 because the volumes are so low. So that's why we're the
5 only designated provider of heart-lung transplantation in
6 New South Wales.
7
8 Organ retrieval, obviously, has a slightly broader
9 role in terms of servicing not only heart transplants but
10 other organ transplantation, so there will be several
11 providers, or people - organisations responsible for organ
12 retrieval across the state.
13
14 Q. And that's organs including, say, livers and kidneys
15 and various other --
16 A. That's my understanding, yes.
17
18 Q. -- things that are transplanted?
19 A. Yes.
20
21 Q. I think we may have seen some of the evidence that
22 liver transplants are performed at RPA?
23 A. They're not performed at St Vincent's, and I'm not
24 actually a hundred per cent sure if it's just RPA for
25 livers, yes.
26
27 Q. To the extent that your retrieval service my retrieve
28 a liver from a patient, it would, through some arrangement
29 with the ministry or that other - whichever facility it is,
30 arrange for that organ to be delivered promptly to where it
31 needs to go?
32 A. Correct. Correct. And obviously organ retrieval
33 teams are also specialist teams who have particular
34 expertise in organ retrieval.
35
36 Q. Could we track down to subparagraph (e) where you tell
37 us about cardiology, neurology, mental health, alcohol and
38 drug and a range of other services provided in rural and
39 regional areas through outreach. Can I ask, how are
40 those - what's the genesis of the networks through which
41 those services are provided, as you understand it?
42 A. So we have a particular - we have a broad statewide
43 role, and as you've articulated, a number of statewide
44 services. About half of the patients that come to
45 St Vincent's Sydney come from beyond our local catchment,
46 and that's part of what differentiates us as a networked
47 AHO compared to some of our peers.

1
2 For some services, particularly haematology, neurology
3 and cardiac, where we have particular specialist expertise
4 at St Vincent's, we have specific what we call "networked
5 care arrangements" with other particularly rural and
6 regional LHDs. One example of that is Murrumbidgee LHD and
7 we've had a longstanding relationship with Murrumbidgee LHD
8 for the provision of some of those services in a very
9 formalised arrangement where we have a memorandum of
10 understanding and we have formal referral pathways for
11 provision of those services, where, for example, we will
12 send our medical, nursing and other clinical experts out to
13 the area and we will also make sure that we have
14 appropriate pathways in place for transfer of patients into
15 St Vincent's Sydney, where they need that level of expert
16 care.
17
18 Q. Just seizing on that as an example, the arrangement
19 with Murrumbidgee, are you aware of what it was that
20 actually led to that arrangement coming about? I mean, in
21 asking that question, I acknowledge there's a range of
22 possibilities. It may be two people who had been at
23 university together in the 1980s or '70s might have had
24 a good idea that there was a gap that needed to be filled
25 in the Murrumbidgee area and from that this program has
26 sprung, or alternatively there might be a more formal
27 structure which has led to this sort of network. Do you
28 know which it is?
29 A. I'm actually not aware of the genesis, no, only that
30 the arrangement has been in place for some time now.
31
32 Q. At least as matters currently stand, is there any
33 particular process that you're aware of or planning
34 process, that you've been involved in, at least, in which
35 consideration is given to how services which might
36 potentially be provided through clinicians employed by
37 St Vincent's Sydney could be well deployed in other areas
38 across the state?
39 A. Yes, so we - there's a number of avenues through which
40 we do that. So, for example, in 2021, we undertook a joint
41 service planning process with Ministry of Health. That's
42 a 10-year clinical services plan. So that outlines the
43 level and mix of services that St Vincent's Health Network
44 Sydney provides across the state, not only to our local
45 community, the role of St Vincent's within the system.
46
47 It also projects over that 10-year horizon the type

1 and the level and mix of services that we will provide over
2 that time period, and that's driven - the modelling that
3 underpins that is driven by factors like population growth,
4 need, new technologies, novel therapies, and also
5 historical activity projections. So that's a really
6 collaborative process.
7
8 Q. Who at the ministry was involved in that process?
9 A. So that's the system planning, system service planning
10 branch in the ministry.
11
12 Q. And were LHDs that might potentially be the recipients
13 of those services involved in that planning process?
14 A. Yes, absolutely. So --
15
16 Q. In what way?
17 A. So we undertake - so that process was undertaken in
18 consultation with neighbouring LHDs as well, and other LHDs
19 like Murrumbidgee LHD, where we have particular networked
20 arrangements.
21
22 We also have some more localised planning structures
23 in place, particularly with neighbouring LHDs, so, for
24 example, South Eastern Sydney LHD and Sydney LHD where we
25 have formalised joint planning committees. One example is
26 that we have a joint executive planning committee with
27 South Eastern Sydney LHD and our local primary health
28 network, Central and Eastern Sydney Primary Health Network,
29 where we meet regularly throughout the year and we
30 undertake joint needs assessments and other kinds of
31 analyses to inform how we provide services to our
32 collective catchment, if you will.
33
34 Q. Acknowledging it's a little bit before your time as
35 the CE, but the documents suggests that there was some
36 discussion between St Vincent's and Western Sydney directly
37 about the way in which St Joseph's might fit within the
38 patchwork of health services provided in that area. Are
39 you aware of what those discussions involved?
40 A. I'm afraid I'm not because that was before my time,
41 yes.
42
43 Q. We touched on this a moment ago, but St Vincent's
44 Darlinghurst, you acknowledge, sits broadly within the
45 wider catchment which is administered by the South Eastern
46 Sydney LHD, and is surrounded by a range of hospital and
47 health services delivered by that LHD.

1 A. Yes.
2
3 Q. In relative terms, or at least geographic terms,
4 a number of the hospitals administered by South Eastern
5 Sydney LHD and probably Sydney LHD are quite close to
6 St Vincent's?
7 A. Yes.
8
9 Q. Other than the joint executive discussion that
10 you've - or arrangements that you've told us about, is
11 there any other formal planning process that you are
12 involved in, or that anyone at St Vincent's is involved in,
13 where careful consideration is given to exactly how the
14 service mix delivered by hospitals across all of those
15 LHDs, including St Vincent's, might look in the next five
16 to 10 years, so as to ensure that they are complementary
17 and best meeting the needs of the community that at least
18 geographically they serve?
19 A. To some extent. So one other example is that our
20 local head of strategy and planning at St Vincent's is part
21 of the statewide - there's a statewide planning network
22 that's administered and coordinated by the Ministry of
23 Health, and that network gets oversight of planning data
24 that might impact on the way the LHDs undertake their
25 planning, inform those exercises, and they will also
26 discuss matters that pertain to all the LHDs in relation to
27 planning. The extent to which that then translates into
28 a coordinated plan is something I'm not aware of.
29
30 Q. So insofar as you're aware, for example, there's no
31 process by which, say, discussion occurs between the
32 ministry, the CE of South Eastern Sydney or potentially the
33 CE of Sydney or someone working within them and someone
34 from St Vincent's around which of those organisations
35 should be offering a particular procedure or, say, cardiac
36 surgery, for example, it might not be efficient to offer it
37 at all of them?
38 A. Yes, that happens on a basis that is coordinated
39 directly by the LHDs and by us. For example, it's not
40 centrally coordinated, to be clear. So I have a regular
41 meeting with the South Eastern Sydney LHD where we do talk
42 about our operational context, challenges, issues,
43 planning, particularly planning opportunities, but that's
44 coordinated between ourselves and the LHD in particular.
45
46 Q. I think prior to your commencing in your current role,
47 you had a depth of experience in the Victorian health

1 system?
2 A. Yes.
3
4 Q. From a planning perspective, your experience in
5 Victoria, was it done differently?
6 A. Not particularly, no, actually. In fact, the
7 Victorian system is a more devolved system than the
8 New South Wales system, generally speaking. I actually
9 think there's better coordination, particularly from a
10 planning perspective, in the New South Wales context than
11 in the Victorian context.
12
13 Q. What about the New South Wales structure do you think
14 are its particular strengths when compared, say, with your
15 experience in Victoria?
16 A. Particularly that coordination, cohesion and
17 collaboration. So New South Wales is a more centralised
18 system than the Victorian system, and that brings with it
19 a level, as I said, of collaboration, cohesion and
20 coordination that's not evident to the same extent in the
21 Victorian system. And I think that's a great strength of
22 the New South Wales system and I think you saw - we saw
23 that brought to light, really, in the COVID response times,
24 where the coordination amongst the New South Wales system -
25 my observation is that it was a more coordinated response
26 than the Victorian response. So there are strengths and
27 weaknesses of both approaches.
28
29 Q. I infer from that answer that you see that there's
30 value in taking a system-wide, or at least a larger than
31 a facility view, or wider than a facility view of the
32 services being offered through facilities across the LHDs
33 and at St Vincent's within that wider Sydney catchment?
34 A. Yes, absolutely, and I think in the context of an
35 environment where, you know, there's a scarcity of
36 resources in health care, having that additional level of
37 coordination and particularly around service provision,
38 planning, I think is essential.
39
40 Q. And when you talk about "service provision planning",
41 presumably you are referring to a forward-looking plan that
42 extends beyond the current 12-month budgetary cycle?
43 A. Very much so, yes.
44
45 Q. The advantage of that would be that it enables all of
46 the particular deliverers of services to a geographic
47 community to identify areas of overlap?

1 A. Yes.
2
3 Q. Unnecessary overlap?
4 A. Yes, and areas particularly for collaboration and for
5 scaling of novel ideas, new models of care, and making sure
6 that those ideas that might be seeded or piloted, if you
7 will, in a particular area, can be scaled across the system
8 for broader benefit.
9
10 Q. It also enables a slightly more system-wide view to be
11 taken which has the benefit of identifying any gaps or any
12 cracks between the services offered by the various
13 administrators of health services across that geographic
14 area?
15 A. Yes.
16
17 Q. Do you think there's anything that could be done to
18 improve or create perhaps a more formal structure around
19 that coordination and planning insofar as you're involved
20 in it?
21 A. Yes, I do, and I do think that would be of value for
22 the reasons that you've articulated, and we've spoken
23 about, and I think particularly, as you say, that
24 longer-term perspective, it is important for us to respond
25 to what is a very rapidly evolving environment and dynamic
26 in health care. And so whilst it's important to have -
27 whilst it would be ideal to have a very long-term view from
28 a planning perspective, and there are some elements of the
29 planning context that lend themselves to that long-term
30 view, I also think it's important that there's a relatively
31 agile and flexible - there's a level of agility and
32 flexibility within that to respond to things that might,
33 you know, arise - for example, a pandemic - within that
34 environment.
35
36 Q. And perhaps putting that more bluntly than you have,
37 the idea that you might have a 10-year planning horizon
38 which results in a plan is not something that should then
39 be revisited in 10 years' time, it's something that should
40 be revisited next year?
41 A. Correct.
42
43 Q. And the year after?
44 A. Yes.
45
46 Q. And the year after?
47 A. Yes.

1
2 THE COMMISSIONER: Q. The rapidly evolving environment
3 for health care, what do you see as the big issues or
4 challenges that make it a rapidly evolving environment?
5 A. Look, I think, you know, the dynamic in public health
6 care, be it New South Wales or any kind of other
7 jurisdiction, is that it's characterised by increasing
8 scarcity of resources on the supply side, for want of
9 a better term, and a very rapidly and escalating need on
10 the demand side, and so that creates a fundamental sort of
11 misalignment, which is a very, very complex problem to
12 solve.
13
14 Q. In simplistic terms, does that mean funding plateauing
15 but demand increasing?
16 A. Yes. Yes. And so the challenge for us, and
17 particularly there are - the two particular challenges
18 I think we face, and there are several others that have
19 been, you know, well documented, are increasing scarcity of
20 workforce, so workforce is probably the biggest challenge,
21 I think, facing the system at the moment.
22
23 Q. Even in metropolitan?
24 A. Absolutely. Absolutely. And a very rapidly
25 increasing demand for services, as the population ages and
26 as there are more complex - people with complex
27 comorbidities and the confluence of those factors has
28 really led us to the point now where we need to make some
29 very substantial system changes in order to be able to
30 continue to provide the level of care and services that the
31 community expect from us.
32
33 Q. Just on what you've said there in terms of workforce
34 challenges, it's clinicians across the board - it's nurses,
35 doctors, specialists?
36 A. Almost across the board. There would be very few
37 exceptions, in my experience, where we're not facing
38 significant workforce constraints.
39
40 Q. And the demand issues - we're regularly told this - by
41 that, I take it you mean we live a long time but we're
42 living a long time - many people, too many, are living
43 a long time with one or more chronic diseases, many of
44 which mean they have to be hospitalised, and all of that
45 requires a great deal of (a) services, which (b) means
46 a lot of money?
47 A. Yes.

1
2 MR MUSTON: Q. In terms of the existing planning of
3 clinical services, is St Vincent's involved, as an entity,
4 in the same sort of clinical planning or clinical services
5 planning process as applies to other LHDs or other
6 facilities within other LHDs?
7 A. Yes, it's my experience that we're involved in all of
8 the same forums and committees and structures and processes
9 for planning as the other LHDs.
10
11 Q. One view of the current planning arrangements or the
12 policies that result in particular planning episodes
13 occurring might be that they are very facility-centric -
14 that is to say, the clinical services plans, which
15 facilities are required to produce as part of their
16 planning cycle, are very facility-centric. Would you agree
17 with that view?
18 A. I think the context for St Vincent's Health Network
19 Sydney is a little bit different to the other LHDs. So
20 obviously I'm less familiar with the other LHD planning
21 environment but it's my understanding that because they're
22 a local health district and therefore expressly responsible
23 for the health and wellbeing of a particular population, of
24 their catchment population, that they would undertake
25 a planning process that's designed to plan for the needs of
26 that population as a catchment.
27
28 At St Vincent's Sydney, we don't have a catchment as
29 such, save for some subsets of the services we provide,
30 mental health being one of them, so the planning process
31 that we undertake is, by its nature, much more
32 broad-ranging, I think, than potentially what an LHD is
33 planning for, purely because we're not a local health
34 district in the sense of looking after a particular
35 population.
36
37 Q. So when you refer to what you apprehend that local
38 health districts are doing, do we infer from that that you
39 think a well-administered system would require an LHD to
40 make an assessment as part of its regular planning of the
41 wider health needs of its population?
42 A. I would have thought so, yes, but as I said, I'm not
43 familiar with the way the LHDs undertake their planning
44 processes.
45
46 Q. Your experience in health administration suggests to
47 you that that would be a good idea?

1 A. Yes.
2
3 Q. And when we refer there to the wider health needs of
4 the population, we're not just talking about the needs for
5 particular procedures in particular facilities?
6 A. No, and, in fact, I think that's one of the
7 opportunities going to our point around how we can start to
8 solve some of the wicked problems that we have in health
9 care, public health care, that we need to take
10 a system-wide focus when we undertake planning with very
11 much a focus on, for example, prevention, diversion
12 strategies and other strategies that aim to keep people, as
13 far as that's clinically appropriate, outside of a hospital
14 setting, and cared for in the most appropriate setting for
15 them.
16
17 So I think if we take a system view that encompasses
18 almost the entire spectrum of the healthcare system in
19 terms of the different elements of care provision, primary
20 care, prevention, tertiary acute care and other hospital
21 care, and indeed aged care and other settings, that we
22 would get a better lens around how - what the opportunities
23 are for system reform and where the scarce resources are
24 best allocated.
25
26 Q. So the logical starting point for any planning process
27 should be an identification of what those wider needs are
28 across all of those various - the full spectrum of health
29 services that you've just outlined, including, say, primary
30 care?
31 A. Mmm-hmm, yes.
32
33 Q. Next step would be to --
34
35 THE COMMISSIONER: Q. With primary care being really
36 important?
37 A. Primary care is critical, obviously. And I think
38 that's a significant opportunity for us, to take that more
39 of a system perspective, as I said, in terms of that
40 planning piece, and how primary care interfaces with
41 hospital-based care and other types of care.
42
43 MR MUSTON: Q. Next step, look at the way in which all
44 of those needs are currently being met or capable of being
45 met by deliverers of health services within the broader
46 catchment?
47 A. Yes.

1
2 Q. Including, for example, health services delivered
3 through St Vincent's where you're not part of an LHD?
4 A. Yes.
5
6 Q. An important part of that step, or the step of
7 identifying where or how those health needs might be met,
8 is to collaborate and talk about it with the potential
9 providers of those health services?
10 A. Yes, yes.
11
12 Q. With a view, as we've already canvassed, to ensuring
13 that there's no overlaps, no gaps?
14 A. Yes.
15
16 Q. And things that are capable of being delivered by any
17 one of them are - the person or entity that ends up
18 delivering is that which is best placed both in terms of
19 efficiencies and in terms of quality of service to deliver
20 them?
21 A. Correct, and expertise and that we're optimising and
22 leveraging the strengths of the different elements and
23 providers within the system to provide the best care we can
24 for the community.
25
26 Q. And after one has identified that patchwork of
27 existing services and worked out how best to lay them on
28 the ground to meet the anticipated needs of the community,
29 if gaps exist, then, real thinking and money needs to be
30 deployed towards working out how best to quickly fill those
31 gaps?
32 A. Yes.
33
34 Q. As a general, albeit very high level, approach to the
35 planning of health services, does that general timeline
36 make sense?
37 A. I think it does, yes.
38
39 Q. One very, very important thing that has potentially
40 been excluded is the need to actually communicate properly
41 and in a collaborative way with the community that's being
42 served about what it perceives its health needs to be?
43 A. Yes.
44
45 Q. Possible that its perception about its health needs
46 will diverge from what the data is telling the health
47 administrators?

1 A. Potentially, although I think, in my experience as
2 a hospital administrator, generally speaking, the level of
3 understanding, knowledge and health literacy in the
4 population is increasing, for various factors, and so what
5 we're finding, too, is that the population have a very
6 clear - or certainly clearer - expectation of their health
7 care providers and of the system, and they're, generally
8 speaking, very well informed in terms of how they can
9 access care and what sort of care they expect to be
10 delivered.
11
12 Q. To the extent that there's a divergence between
13 perceptions about health needs and what the data tells
14 health administrators the health needs of the population
15 are, it doesn't necessarily mean that the data is wrong?
16 A. No, it doesn't mean that the data is wrong.
17
18 Q. It's possible, sometimes, that there's a gap between
19 the data and the on-the-ground lived experience, which
20 means whatever people are - a community is telling planners
21 about what they perceive their health needs to be and what
22 their priorities are has to be taken seriously?
23 A. Yes, and I think the other challenge is that most of
24 the planning data to inform the way we plan and deliver our
25 services is, by its nature, historical data, so it
26 represents historical patterns.
27
28 It's very difficult, as we've discovered, certainly
29 recently, to predict the future of health care in terms of
30 either the type of service delivery, innovations that might
31 completely disrupt the way we deliver services, either from
32 a technological perspective or models of care, and so that
33 comes to my point around maintaining a level of agility and
34 flexibility in the system to be able to pivot to respond to
35 those changing needs, which can often happen quite quickly.
36
37 THE COMMISSIONER: Q. You may have - and please tell me
38 if you have much broader experience than this, but the
39 opinion you expressed about the health literacy of the
40 population, you think it's increasing, is that in part
41 informed by the catchment that St Vincent's might have?
42 A. It very possibly is, yes. It's my experience.
43 Although, in my experience as working in other
44 jurisdictions and across other health services, again,
45 it's certainly a very general comment but there's certainly
46 abetter awareness, I think, and understanding and
47 expectation from the community.

1
2 Q. It may be something you have discussed with
3 colleagues, too -- -
4 A. Yes.
5
6 Q. -- that have catchments different to the eastern
7 suburbs?
8 A. Certainly, yes.
9
10 Q. And metropolitan area of Sydney?
11 A. Yes, yes.
12
13 MR MUSTON: Q. Certain population groups, including some
14 of the marginalised groups that St Vincent's delivers
15 health care to, for example, homeless people, First Nations
16 people, are often not well captured by some of the data?
17 A. That's right, yes.
18
19 Q. In the case of those populations, do you perceive
20 there to be a greater need to ground-check what the data is
21 telling you about the particular health needs before
22 forging ahead and planning and delivering services in an
23 expectation that that data is right?
24 A. Yes, absolutely, and actually, one of the core
25 focuses, as you mentioned, for St Vincent's is that we have
26 a particular focus in caring for communities that we
27 consider to be the most vulnerable and marginalised within
28 our society, and that even goes to capturing data and
29 information about those particular groups.
30
31 So in terms of a health equity research program, for
32 example, that's something that we do at St Vincent's to try
33 and improve the level of information that we have about
34 those marginalised communities so that we can make more
35 informed decisions and that we can better deliver and plan
36 our services to meet the needs of those communities.
37
38 Q. Sometimes a divergence between a community's
39 perception about its health needs and what the data is
40 telling us that the health needs are comes down to a lack
41 of appreciation of the data or those real health needs by
42 the community - sometimes?
43 A. Sometimes.
44
45 Q. Collaboration and proper communication, both -
46 bi-directional communication with those communities as part
47 of a health planning process can also have the benefit of

1 assisting them to understand what the data is telling
2 health administrators so as they can better get a sense of
3 at least what the data is suggesting relative to what they
4 might perceive the health needs of their community to be?
5 A. Yes, absolutely, and it is a fundamental component of
6 any planning process, is consultation with the communities
7 for whom you are planning the service delivery. And we
8 have a number of, you know, structures and processes in
9 place at St Vincent's, and I'm certainly aware that those
10 processes exist across the system, to engage with our
11 communities and to understand the needs of the community
12 and to plan services and deliver services that meet those
13 needs.
14
15 Q. So it should go without saying that that process of
16 consultation often involves more listening than talking?
17 A. It should ideally, yes.
18
19 Q. And picking up on something you said a moment ago,
20 having potentially gone through this process and identified
21 a suite of - or come up with a plan for the delivery of
22 health services to a particular population, it's critically
23 important, isn't it, that the health administrators check
24 in regularly with the population to make sure that the plan
25 actually is delivering on its objectives and, if it's not,
26 what might be changed in order to better deliver on those
27 objectives?
28 A. Yes, absolutely. And I also think that is an
29 excellent opportunity for us as a system to improve, is as
30 you say, not only delivering a plan but then measuring the
31 outcomes and outputs of that - of those plans, and how we
32 measure - what measurements do we use to actually indicate
33 that we are having an impact in terms of the services that
34 we're delivering, how we're improving health outcomes, how
35 we're improving equity and access to those services.
36
37 We have some measures that we use now, and they're
38 pretty consistent across the system, for how we measure
39 access, outcomes, for example, but I think there's
40 certainly opportunity for us to further expand those.
41
42 Q. Do you perceive there to be any challenge in measuring
43 health outcomes in a vaguely objective way, presented by
44 the siloed nature of information and data within the wider
45 health system across the various tiers through which that
46 health care is delivered - so acute, primary care, allied
47 health, et cetera?

1 A. Certainly measuring health outcomes is more
2 challenging than measuring process - health processes, for
3 want of a better term, or inputs, and I think in some parts
4 of the system, we're starting to be - we're starting to
5 have an evolved and sophisticated approach to measuring
6 health outcomes. So for example, just in my context we
7 measure what we call "patient reported outcome measures",
8 so we survey our patients at particular points post their
9 intervention, surgery, or whatever it is they have come to
10 our hospital for, to measure the outcomes of those
11 interventions. But that is a fairly embryonic - we're at
12 a fairly embryonic stage in terms of measuring outcomes
13 compared to how we measure inputs and processes and that's
14 definitely an opportunity for us as a system to further
15 evolve that.
16
17 Q. The measurement of those outcomes in any really
18 meaningful way is a longer-term process, isn't it?
19 A. Yes, exactly. So it's actually - you know, there's
20 a logistical challenge, even at that basic level of
21 measuring those outcomes over a long period of time, which
22 I guess is an additional challenge from an outcomes
23 measurement perspective.
24
25 Q. Let's take the hypothetical patient at St Vincent's
26 who might have had a valve put in to their heart, working
27 out whether they've had a good experience during their few
28 days staying at St Vincent's is important?
29 A. Yes.
30
31 Q. But that's almost measuring process rather than
32 measuring outcomes?
33 A. Correct, yes.
34
35 Q. Making an assessment of whether they feel or seem to
36 be better as they walk out the door than they were when
37 they walked in the door, that is a measurement of health
38 outcomes to a degree?
39 A. Yes.
40
41 Q. But in order to work out the value which really lies
42 in the procedure that has been delivered to them, one needs
43 to get access to data that travels well beyond that?
44 A. That's right. And have seamless - and have
45 a connectivity across the system to enable access to that
46 data. So that's another challenge across the system,
47 particularly coming back to that point around the full

1 system perspective. So not just the tertiary or the
2 hospital system, but also across other elements of the
3 healthcare system and how we can get access to that full
4 suite of data to enable us to really measure the
5 trajectory, if you will, or the kind of long-term outcomes
6 of an intervention.
7
8 Q. It's not necessarily confined to those things that,
9 within the medical sphere, are often easily measurable,
10 like blood tests and ECG recordings and the like; it might
11 extend to something like whether that particular patient is
12 now able to walk up the hill to the shops?
13 A. Exactly.
14
15 Q. Which is something that they weren't able to do
16 before?
17 A. Exactly, go about their daily lives, and to the extent
18 that we - we can capture some of that information but, as
19 you say, that's at a specific level, either to our facility
20 or our particular service that we provide, particular
21 patients that have been within our care and we still have
22 access to engage with that patient that we can measure
23 those things. But the complexity lies in measuring those
24 things on a much more longitudinal basis at a system level.
25
26 Q. Dealing with that complexity, and without inviting you
27 to tell us which particular software or how it might be
28 done, do you have a view about the particular levers that
29 might, at a high level, be pulled in order to better enable
30 that complex challenge to be addressed?
31 A. I'm afraid that might be somewhat beyond my scope of
32 expertise, other than having an idea that it's a good idea.
33
34 Q. Well, if you've got a good one, your expertise is no
35 doubt greatly significant --
36
37 THE COMMISSIONER: Are we the lay people you were
38 referring to before, are we?
39
40 THE WITNESS: I'm not aware, but I'm sure the experts
41 are, of any particular application or platform that would
42 enable that full-system level data access.
43
44 MR MUSTON: Q. I'm not so much interested in platforms
45 and the like. More at a high level, are there any systemic
46 impediments at the moment, whether it be just personality
47 based impediments, privacy law based impediments, practical

1 impediments - is there anything that you see as preventing
2 us at the moment from actually letting those smart people
3 identify a way of pulling together all of that data that
4 could be shifted?
5 A. I think only insofar as to your point there would be
6 some legislative impediments, probably. There would also
7 be a challenge that would have come - would have to
8 overcome in terms of responsibility for health care, so,
9 for example, the Commonwealth/state arrangements in respect
10 to delivery of health care might be one of the challenges
11 that we would need to overcome, particularly, obviously, as
12 it pertains to the interface between primary care and
13 hospital based care.
14
15 Q. Could I take you to page 96 of your statement. It's
16 a copy of the 2023/2024 service agreement which, for the
17 benefit of the operator, it's AM-9. It has a range of
18 different numbers on mine. The easiest number is
19 [SVH.0002.0001.0285], or if that doesn't work, you could
20 try [SVH.9999.0002.0096].
21
22 THE COMMISSIONER: Yours has two numbers too, does it?
23
24 MR MUSTON: Mine does, yes.
25
26 THE WITNESS: Is this the 2023/2024 service level
27 agreement?
28
29 THE COMMISSIONER: Q. Yes.
30 A. Yes, got it, thanks.
31
32 MR MUSTON: Q. If you have a hard copy of it and the
33 Commissioner has a hard copy of it, we can forge along
34 while the poor operators are grappling with my complicated
35 series of no doubt conflicting numbers. Could we go to
36 page 107. I say not dismissively of what appears before
37 107, but it appears to be boilerplate --
38 A. Yes.
39
40 Q. At 107 you see under the subheading "NSW Health
41 services and networks", there's a reference to the fact
42 that each NSW Health service is part of an integrated
43 network or networks of clinical services that aim to ensure
44 timely access to appropriate care --
45
46 THE COMMISSIONER: Sorry to interrupt, in the tender
47 bundle it's got the 0096 number, I think, G.029.9, if that

1 helps the operators.
2
3 MR MUSTON: That's [SVH.0009.0002.0096].
4
5 THE COMMISSIONER: Yes.
6
7 MR MUSTON: The one on the screen also has two numbers,
8 so --
9
10 THE COMMISSIONER: Yes, there we go.
11
12 MR MUSTON: Q. I should probably ask, you recognise that
13 document as the 2023/2024 service level agreement between
14 the secretary of NSW Health and St Vincent's?
15 A. Yes.
16
17 Q. If we turn over to page 97, it appears that that
18 agreement was executed by the chair of St Vincent's
19 Hospital Sydney board on 15 November 2023?
20 A. Yes.
21
22 Q. And Susan Pearce, in her capacity as secretary of
23 NSW Health, on 16 November 2023?
24 A. Yes.
25
26 Q. We'll come back to the circumstances leading to and
27 following on from the execution of this agreement, but for
28 present purposes, could I ask you to go back to page 107 of
29 the pages in the document, but it's also the 0107 in the
30 top SVH number. Do you see there the subheading,
31 "NSW Health services and networks"?
32 A. Yes.
33
34 Q. Could I ask you to read the first sentence to
35 yourself. You don't need to read it out loud. That's
36 a noble ambition. Could I ask how, at least from your
37 perspective, do you understand that aim as it's described,
38 to be approached, or how is that aim being approached?
39 A. Well, I think there are several aspects to that, and
40 as I said earlier, it's my experience that the New South
41 Wales health system is a very well coordinated and cohesive
42 and collaborative system, and I think there are a number of
43 structures and mechanisms in place to enable that level of
44 coordination and to the reference there around integrated
45 networks of clinical services and effective contribution to
46 the statewide - the operation of statewide and - service
47 delivery.

1
2 So, I mean, I can only obviously speak to my
3 experience as the CEO of Sydney network, but our experience
4 is very much that we are very integrated in with the system
5 and on a day-to-day sort of operational - from an
6 operational perspective, we coordinate very closely with
7 our system colleagues and with the ministry to manage
8 demand, both planned and unplanned demand, and that
9 happens, as I say, on a daily basis, but also, you know, on
10 a more prospective and kind of planned basis as we look to
11 the year ahead in terms of what that demand might look like
12 and what level of mix of services each of us are going to
13 provide to meet that demand.
14
15 Q. In terms of the mix of services, there's not much in
16 the service level agreement that actually identifies what
17 mix of services are actually going to be provided by
18 St Vincent's through any of its facilities. Would that be
19 a fair observation?
20 A. That's a fair - that's a fair comment, yes.
21
22 Q. Just while we're on page 107, and with that thought in
23 mind, what do you understand the next paragraph to mean,
24 where it says:
25
26 *NSW Health acknowledges that the Network's*
27 *strategic and operational planning is also*
28 *developed as part of the strategic and*
29 *operational plan for St Vincent's Health*
30 *Australia group.*
31
32 A. Yes, I think that's a really important statement and
33 it's my experience that NSW Health certainly acknowledge
34 the fact that St Vincent's Hospital Sydney is part of the
35 St Vincent's Health Australia group and therefore we
36 operate within both the NSW Health environment and the
37 St Vincent's Health Australia environment. For example, we
38 align our operational and strategic priorities with both
39 the St Vincent's Health Australia strategy and with the NSW
40 Health Future Health strategy.
41
42 Now, those strategies are highly aligned and so the
43 approach to making sure that we are meeting our obligations
44 to both NSW Health and St Vincent's Health Australia is
45 helped by the fact that those strategies are highly aligned
46 in terms of their philosophy and their approach and their
47 focus on meeting the needs of the community.

1
2 Q. The NSW Health Future Health strategy is cast at
3 a relatively high level?
4 A. Yes.
5
6 Q. Having regard to the very broad nature of the
7 ambitions that it identifies, how does one really go about
8 ascertaining whether something which might be - perhaps let
9 me express this in a different way. Is there much that can
10 be done in terms of the delivery of health services that
11 could not in some way, shape or form be characterised as
12 advancing the objectives of the NSW Health Future Health
13 strategy?
14 A. Look, it is a high-level strategy, so it's the
15 responsibility of networks and LHDs and other participants
16 in the system to localise and understand what is the
17 delivery - how do we deliver health services that then, as
18 you say, meet the needs, meet the objective of that
19 strategy.
20
21 It is a broad-ranging strategy, and I think that's
22 broadly appropriate for a strategy that is a fairly
23 long-term, forward-looking strategy. I think the key,
24 then, is to say - as we've talked about earlier, is how do
25 we cascade those broad objectives down to a system level
26 and to a facility level, at network or LHD level, and
27 understand what that - what we really need to deliver on
28 a kind of more tactical basis.
29
30 Q. Recognising that there's a balance to be struck
31 between the central and the devolved in terms of how things
32 are achieved and delivered, do you think there might be
33 value in a future health strategy identified by the central
34 ministry having some slightly more tangible targets or
35 objectives?
36 A. I think for any strategy to be a good strategy, it has
37 to identify tangible outcomes and measurables, and, you
38 know, to the extent that we were talking about earlier in
39 terms of how we measure outcomes, that's still an evolving
40 space in health care, but I certainly think the strategy
41 does, as it cascades down, and the service level agreement
42 is one of that, identify tangible outcomes and measures for
43 how they - how we can measure the fact that we're
44 delivering on that strategy and we're delivering the sorts
45 of outcomes and experiences that the community expect of us
46 as a system.
47

1 Q. Tracking down to 3.1, "Cross district referral
2 networks", without needing you to tell us in any detail
3 what they involve, is St Vincent's, as an entity, involved
4 in the delivery of care through any of those networks?
5 A. Not specifically.
6
7 Q. 3.2 tells us about the supra LHD services which
8 I think St Vincent's is involved in the delivery of?
9 A. Yes.
10
11 Q. If we turn over to page 108, we see a description of
12 what those services comprise, and then there's a reference
13 to what's being delivered as part of them by each of
14 a range of different hospitals. Taking, for example, adult
15 intensive care unit beds, St Vincent's there is identified
16 as providing 21 into the network?
17 A. Yes, yes.
18
19 Q. In relation to that, can I ask, is there any formal
20 obligation imposed upon St Vincent's by any document or
21 arrangement that it has pursuant to which it has to deliver
22 those 21 intensive care beds?
23 A. Yes. So --
24
25 Q. What is that arrangement?
26 A. Yes, so that's part of the detail in the service level
27 agreement in terms of the amount of activity and therefore
28 funding that we get provided to deliver against those, for
29 example, as you said, the intensive care, 21 beds, and
30 other specific statewide services purchase volumes that are
31 articulated in this SLA.
32
33 Q. But when we get into the detail of it, though, are you
34 referring to the budget which commences at page 112, or is
35 there a separate document full of detail that sits behind
36 this?
37 A. Yes, no, I'm referring to the broader budget, yes. So
38 I guess, coming back to your question, there's no specific
39 dedicated funding allocation specifically for the intensive
40 care beds, because it's the responsibility of, in our case,
41 the network to allocate the funding required to intensive
42 care to deliver against those 21 beds.
43
44 Q. Again, it may be that someone has a far greater
45 understanding of how the NWAU targets contained at page 112
46 and following are to be interpreted, but as I look through
47 the table commencing on page 108, we've got, for example,

1 the 21 intensive care beds. Turn over the page, there's
2 the ECMO --
3 A. ECMO. ECMO, yes, extracorporeal membrane oxygenation.
4
5 Q. St Vincent's is providing that; obviously the only
6 provider of 106 heart, lung and heart-lung transplants, and
7 so on?
8 A. Yes.
9
10 Q. It's not entirely clear to me to - tell me if there's
11 a way of interpreting what follows that will make it clear.
12 It's not entirely clear to me, from what appears at
13 page 112 and following, that any aspect of the numbers
14 which are set out there really requires St Vincent's to
15 deliver any of those particular services, beyond
16 a particular amount of activity within, say, acute
17 admitted, which is pretty broad church?
18 A. Yes.
19
20 Q. A particular amount of activity, 7,616 NWAU, for
21 emergency department. We can understand that very broad
22 bust-up of the activity that's to be delivered, but in
23 terms of the actual services which are being delivered by
24 St Vincent's, as what would seem to be an important part of
25 the matrix in that table which appears and commences at
26 page 108, is there anything that requires St Vincent's to
27 do that?
28 A. Only insofar as it's a condition of subsidy, of
29 course, through the SLA, that we deliver that level of
30 capacity, and there is an expectation from the system and
31 from the ministry that that level of capacity is delivered.
32 We do have quarterly performance meetings with the
33 ministry, as do all the other LHDs, where we review our
34 activity, and whilst it's not specific to, for example,
35 ICU, it is at a level of granularity that's more granular
36 than what's in this table on page 112, for example. So we
37 do get visibility over some of the subsets, for example, of
38 the acute admitted category and how much activity we're
39 delivering against those particular subsets. So there is
40 a level of monitoring and acquittal, if you will, if you
41 want to use that term, that we are delivering that level of
42 capacity for the system as per our SLA.
43
44 Q. So is it right that to the extent that you are, in a
45 slightly more blunt way, delivered parcels of activity
46 through this budget, somewhere within back of house at the
47 ministry and in discussions with St Vincent's, there is

1 a slightly more detailed reckoning of exactly what that
2 activity is broken up into?
3 A. Yes, yes.
4
5 Q. Such that whether the agreement, the service
6 agreement, explicitly provides for it or not, there is an
7 understanding on one side, at least - probably both - that
8 that activity is provided so as to enable you to,
9 inter alia, deliver 21 intensive care beds, deliver
10 106 heart and heart and lung transplants, et cetera?
11 A. That's right, yes.
12
13 Q. If you didn't deliver your 21 intensive care beds
14 because, for example, financially it seemed not to be
15 sustainable for you to do it, do you have any sense of what
16 any consequences would be for St Vincent's?
17 A. I think there would be a process of review as part of
18 the SLA process for the following year, where there would
19 be an analysis done of the level of activity we did provide
20 in the previous year and if it was demonstrated that, for
21 whatever reason, as you say, we were unable to provide that
22 level of activity, I think there would probably most
23 likely - unless there were particular extenuating
24 circumstances - that there'd be a redistribution of that
25 activity elsewhere in the system, if it was that we
26 couldn't continue to provide that level of service
27 prospectively.
28
29 Q. At a practical level, putting, say, intensive care
30 beds to one side, something like heart and heart and lung
31 transplantation services, were St Vincent's to reach the
32 view that it was not economically viable to deliver them
33 under the current arrangement, what are the practicalities
34 that would be associated with some other entity within the
35 public health network picking up those 106 procedures?
36 A. It would be very, very challenging, logistically, to
37 redistribute that activity, and that's for several reasons.
38 The first is that we've been providing heart-lung
39 transplantation for around about 40 years, or slightly
40 longer, at St Vincent's, and so over that period we've
41 built up a critical mass of expertise, infrastructure,
42 research, for example, in heart-lung transplantation, and
43 so to redistribute that service elsewhere in the system
44 would be an incredibly challenging undertaking.
45
46 Q. And presumably not something that could be done
47 overnight?

1 A. It certainly wouldn't be done overnight.
2
3 Q. We'll come shortly to some of the budgetary challenges
4 that St Vincent's has been facing, but as part of its
5 internal thinking around how to deal with those budgetary
6 challenges, has consideration been given to changing the
7 service mix offered at St Vincent's to perhaps reduce the
8 emphasis that currently lies on some of those types of
9 procedures and patient cohorts which you've told us are not
10 well captured by ABF funding models?
11 A. I think as part of any annual planning and budget
12 cycle, there's always, in my experience anyway, a process
13 of review of the level and mix of services provided -
14 what's still current, does it still meet the needs of the
15 community and is it still logistically and operationally
16 appropriate and possible to deliver that same level and mix
17 of services. So that's a standard process that we would go
18 through every year.
19
20 Certainly with something as critical to St Vincent's
21 and to the community as heart-lung transplantation, there
22 would be a very, very significant discernment process that
23 we would go through if there were to be any change to our
24 level of service delivery for that particular service.
25
26 THE COMMISSIONER: Just before you go on, just for the
27 record, your question, which included "which you've told us
28 are not well captured by ABF funding", and there's part of
29 Ms McFadgen's statement that deals with her heading
30 "Limitations in ABF funding model", we're not dealing with
31 that specifically in this hearing; that's for later?
32
33 MR MUSTON: The extent to which particular types of
34 service are captured or not captured well by ABF is going
35 to be dealt with in the funding block.
36
37 THE COMMISSIONER: Yes, okay.
38
39 MR MUSTON: The extent to which, if it be the case - and
40 we can proceed on the hypothesis that it may be[, that's
41 certainly Ms McFadgen's perception - that there are certain
42 types of service that are not well captured by ABF, I am
43 interested in exploring with her today the impact that that
44 has on the way in which an entity like St Vincent's goes
45 about its operations.
46
47 THE COMMISSIONER: Understood. There's probably no other

1 sensible way of dealing with it.
2
3 MR MUSTON: No, mainly to avoid having to bring her back.
4
5 THE COMMISSIONER: Right. Okay. Given that other people
6 are covering this topic.
7
8 MR MUSTON: Yes. But whether Ms McFadgen's perception be
9 right or wrong is probably a matter for a group of health
10 economists looking at the ABF model and breaking down the
11 costs of delivering, for example, a heart-lung transplant
12 in the way that the research that has been recently
13 undertaken and is alluded to in her statement sets out.
14
15 THE COMMISSIONER: Am I making findings about that, am I?
16
17 MR MUSTON: I'm not sure about that.
18
19 THE COMMISSIONER: Keep going.
20
21 MR MUSTON: Q. Let's just put heart-lung transplants to
22 one side for a moment because they perhaps fit into
23 a special category both - pardon the pun - in the heart of
24 St Vincent's and in the heart of the state. The issues
25 that you've identified as part of your regular process, an
26 assessment of whether services that are being delivered are
27 still current, whether they're still needed by the
28 community and whether they're still being provided in the
29 best way that they can be, recognising that that's
30 a sensible regular piece of retrospection, but the next
31 question that I'm trying to get to is, is there a further
32 question which St Vincent's finds itself having to ask at
33 the moment in the light of its budgetary constraints, which
34 is: to the extent that we might be able to tick all of
35 those boxes, if it's not possible to provide those slightly
36 more expensive or more poorly captured services in a way
37 which is sustainable financially, do we, nevertheless, have
38 to move away from them and increase our focus on services
39 which are well captured by ABF, putting it very sort of
40 loosely, the easy stuff?
41 A. I think as a tertiary referral provider it is critical
42 for us, and the community would expect us, to continue to
43 provide those highly specialised services, irrespective of
44 whether the ABF funding model, in particular, is
45 appropriate for those services.
46
47 There are other funding models available, too, for

1 those very high complexity low volume services that we
2 would seek to explore to augment the ABF funding - for
3 example, block funding is one example, and the study that's
4 referred to in my statement, particularly in relation to
5 heart transplantation, reflects the fact that the other
6 aspect of complexity with heart transplantation is that
7 there are significant stand-by costs for any
8 transplantation, heart transplantation included. So you
9 have to have a team of people essentially at the ready at
10 any given time to provide a transplantation service,
11 because you're never quite sure when the opportunity, so to
12 speak, will arise. And so for those sorts of services,
13 I think a block funding arrangement that augments the
14 activity based funding, which is designed to fund purely
15 that particular - the actual transplantation intervention,
16 would be our first port of call in terms of exploring
17 a more appropriate funding model for those services.
18
19 THE COMMISSIONER: Just in relation to your question,
20 which had the phrase "more poorly captured services",
21 should I understand that to mean, with the best coding in
22 the world, there's still a limitation as to how well the
23 cost is captured?
24
25 MR MUSTON: That's, in essence, as I understand the
26 witness's evidence, but I'll explore that.
27
28 Q. I can take you to the paragraphs if it would help, but
29 when you tell us in paragraphs 58 and following that there
30 are some services that are not well captured by the ABF
31 funding model, are we to infer from that that what you're
32 saying is if the ABF funding model is working perfectly -
33 that is to say, every little bit of activity which is
34 associated with a patient has been captured in a way that
35 it is capable under that model of being captured - the
36 funding or the moneys paid in respect of that captured
37 activity, is received, there will nevertheless be a deficit
38 between the moneys received on the one hand, through that
39 funding model, and the costs of delivering the service on
40 the other?
41 A. Certainly for heart transplantation, that is the case,
42 and that is because there are two elements to heart
43 transplantation, that is, the actual transplantation
44 episode, and ABF covers that technically, but there are
45 some deficiencies with that, which I can talk to, and
46 they're in my statement. And then there's the, if you
47 will, wrap-around, peripheral, peri transplantation costs,

1 both pre and post transplantation, and particularly in
2 relation to organ retrieval, that are not covered by
3 activity based funding well. So that's where something
4 like a block funding agreement, a block funding
5 arrangement, could work.
6
7 Q. What about - just moving away from the heart and lung
8 transplants - some of the more sort of business-as-usual
9 procedures, like those you've identified in
10 paragraph 59(a)?
11 A. So activity - my experience, my understanding - and
12 I appreciate that that's my particular perspective - is
13 that activity based funding is most appropriate for
14 high volume, low complexity services, and there are good
15 mechanisms in place for annual but certainly regular review
16 of the factors that drive activity based funding, like the
17 cost weight, so the amount of money you get paid, and the
18 kind of - it's called a cost weight, it's very hard to
19 explain, but the weight that a particular intervention or
20 admission will receive through activity based funding.
21
22 So I think, though, that process is fairly well
23 understood and well managed, there is a delay between those
24 weights and the activity based funding components being
25 updated and, I guess, the sort of day-to-day reality of
26 running a hospital, so there is the delay that could be
27 improved, which would make ABF more contemporary, I guess,
28 in the sense of the payments reflecting the true cost of
29 providing those particular services. So for a large part
30 of the services that we provide, ABF is an appropriate
31 funding mechanism.
32
33 Q. To the extent that there is a deficit between -
34 a budget deficit that we're coming to, is that referable to
35 that other section of the services provided by St Vincent's
36 which are not well captured by ABF funding?
37 A. Yes, it's largely that. There are a couple of
38 components to that. So the first is that I think there's
39 a - St Vincent's has a concentration, if you will, of
40 services like transplantation, highly specialised services,
41 and services that are expressly designed to meet the needs
42 of very vulnerable and marginalised people in our community
43 who have the large social complexity, and so for those
44 services, ABF is not the most appropriate funding model,
45 and so because we have a concentration of those sorts of
46 services at St Vincent's, I think the impacts of the
47 deficiencies of the ABF model are concentrated, which does

1 contribute to some of our budgetary challenges, yes.
2
3 Q. Coming back to my earlier question, as part of
4 decision-making within St Vincent's around the services
5 that it offers going forward, accepting that taking away or
6 moving out of any of those areas is probably inconsistent
7 with St Vincent's core mission, but, nevertheless,
8 financial realities prevail, don't they?
9 A. I think that, you know, St Vincent's has been
10 providing public healthcare services for 167 years to the
11 community and it is absolutely, as you say, core and
12 integral to our mission to provide those services. So we
13 will - it is incumbent on us to explore every option to
14 appropriately fund those services in an environment of
15 increasingly scarce resources.
16
17 Q. The exploration of those options, I think, if I take
18 from an earlier answer you gave, would involve going to the
19 ministry and saying, "Here are some alternate funding
20 arrangements for some of the services we're providing that
21 would better capture, in an equitable way, the cost of
22 actually delivering the services that we are providing in
23 these areas not well captured by ABF?
24 A. That's right, yes, that would be one avenue.
25
26 Q. It would be your hope that that would result in a
27 meeting of the minds?
28 A. Yes.
29
30 Q. If it doesn't, what other avenues, if any, are
31 available to St Vincent's?
32 A. Well, we would need to, as we always have been for 167
33 years, be very creative, innovative in the way we
34 approach - we might need to change our models of care, we
35 might need to work with other community organisations,
36 other funders, for example, to see if we could secure
37 appropriate funding to continue to deliver those services.
38
39 Q. When you refer to "other funders", what funding
40 sources do you have in mind, if any?
41 A. We receive funding from a range of different sources,
42 obviously including philanthropic sources, so we're very
43 privileged at St Vincent's to have strong community
44 support, and we have generally had that support
45 particularly for some of those services that we provide to
46 very, very vulnerable and marginalised people in our
47 community, because it is core to our mission.

1
2 Q. To the extent that we just focus our attention on the
3 delivery of public health care through that part of the
4 public system which is currently being administered by
5 St Vincent's, do you have a view on whether philanthropy
6 should play any role in the funding of those services?
7 A. I do. I think that there is a very clear role for
8 philanthropy, and that is to fund innovation, new
9 technologies, new models of care and to seed fund, for
10 example, those sorts of things to enable us to continue to
11 innovate. In fact, you know, we have historically had very
12 strong community support for exactly those purposes, and
13 a number of the innovations and inventions and new
14 technologies and new models of care that have come out of
15 St Vincent's have been initially seed funded or supported
16 for proof of concept by philanthropy, and I think that's
17 something that has been a very strong partnership between
18 St Vincent's and the community.
19
20 But importantly, for us to maximise and optimise the
21 use of those funds, which we're very privileged to receive,
22 we need to be able to leverage that philanthropic support
23 for broader scale, and that requires a partnership between
24 St Vincent's, our philanthropic supporters and the state,
25 to be able to really say, "Okay, you might pilot or
26 seed-fund something at St Vincent's through philanthropy,
27 but if you want to see the benefits of that innovation
28 rolled out more broadly, then, you know, that requires
29 a partnership with the state to enable that to happen."
30
31 Q. So is your point philanthropic funds are appropriately
32 used as seed funding for innovation and developing new ways
33 of delivering health care?
34 A. Yes.
35
36 Q. But to the extent that that process of innovation or
37 the testing that has been achieved throughout seed funding
38 reveals that the new model of care or the new way of
39 delivering health care is an efficient or the best way to
40 deliver that health care, philanthropic funds should play
41 no role in the continuing delivery of health care through
42 that model as business as usual?
43 A. Ideally. I mean, I think that's the best way that we
44 can use those philanthropic funds, is to support
45 innovation, not to support what then becomes eventually
46 basic clinical operations or embedded models of care in an
47 operational sense.

1
2 Q. Undoubtedly, there are an array of different
3 philanthropic arrangements that you have, but would it be
4 fair to assume that some of them or perhaps a significant
5 portion of the philanthropic money at the disposal of
6 St Vincent's is not available to be used for just any old
7 part of St Vincent's business?
8 A. That's correct, yes.
9
10 Q. Tied to particular projects, sometimes?
11 A. Yes, predominantly to research, education, ongoing
12 professional development for some of our workforce, and
13 particularly capital redevelopment, asset replenishment.
14
15 MR MUSTON: I'm about to move to another topic. I know it
16 is a little bit earlier than usual, but we have all been
17 speaking quite quickly this morning.
18
19 THE COMMISSIONER: You would like to take the break now?
20
21 MR MUSTON: If we took a short adjournment it might be
22 appreciated by those who are taking down our fast-paced --
23
24 THE COMMISSIONER: All right. We will adjourn until
25 11.30.
26
27 **SHORT ADJOURNMENT**
28
29 THE COMMISSIONER: Yes, please proceed.
30
31 MR MUSTON: Q. Can I come now to just ask you some
32 questions about the process of setting the '23/24 and soon
33 to be '24/25 budgets and some the correspondence that has
34 been exchanged between St Vincent's and the ministry around
35 that.
36
37 Could we go to the document at G.052 in the
38 Commissioner's bundle [SVH.0001.0001.0780]. We'll get
39 a copy of it up on the screen for you shortly. That's
40 a letter from Paul McClintock to Susan Pearce - sorry, it's
41 a letter to Paul McClintock from Susan Pearce. It doesn't
42 seem to be dated, in a way that I'm growing increasingly
43 accustomed to seeing in some of these documents, but it's
44 probably more my OCD obsession with chronologies than
45 anything else.
46
47 That document, if you have a look at it - it should be

1 up on the screen now --
2 A. Yes.
3
4 THE COMMISSIONER: The "interim 2023-24" probably at least
5 means, what, from July onwards in '23, until the budget?
6
7 MR MUSTON: Q. I'm assuming it's some time prior to
8 19 September 2023, is what I have gathered from the first
9 line in the letter.
10 A. Correct, yes.
11
12 Q. Are you familiar with this process of a budget
13 deferral or budget delay by reason of political matters
14 within New South Wales?
15 A. My experience only extends to this particular
16 instance, because of the new incoming government, they
17 deferred the full budget to September. That would be the
18 only time, in my experience, that there's been a deferment
19 of annual budget cycles and SLA discussions.
20
21 Q. When you say that, during the lengthy period of time
22 that you were working within health administration in
23 Victoria, was there ever a change of government?
24 A. Yes.
25
26 Q. Was delayed delivery of funding for hospitals that you
27 were administering during that period a feature of that
28 transition?
29 A. I must admit I don't recall the specifics of when
30 correspondence and budgets and funding was provided and the
31 timing of that at the - in that context.
32
33 Q. Coming back to the particular instance that you're
34 most acutely familiar with, is there an impact that a delay
35 in the budget of the type which is reported in this letter
36 has on the way in which an organisation like St Vincent's
37 Sydney goes about its operations?
38 A. Yes, so I think the primary impact was that we made -
39 we had to develop a modelled budget for this financial year
40 on the basis of a series of assumptions related to the
41 interim funding agreement, which was essentially a rollover
42 from the previous year's funding with some minor
43 adjustments for factors that were known at the time. So we
44 made a series of assumptions, informed assumptions but
45 assumptions to build the preliminary FY24 budget on the
46 basis of that interim agreement.
47

1 Q. In terms of future planning, though, you had no
2 certainty, at the time of this correspondence and in fact
3 until the final budget was provided, about how much money
4 would actually be at St Vincent's disposal in the 2023/2024
5 budgetary period for the purpose of delivering services at
6 St Vincent's Darlinghurst and at the Sacred Heart?
7 A. Not over and above what was essentially the rollover
8 from the previous year.
9
10 Q. Does that hinder in any way or did that hinder in any
11 way your capacity at St Vincent's to plan or provision for
12 the delivery of services?
13 A. Well, ultimately, as it transpired, the modelled
14 budget and the SLA that we ultimately received in November
15 was - there were some differences in the parameters of that
16 service level agreement as distinct from the interim
17 budget. Some of the assumptions we had made around the
18 interim budget proved not to be evident in the final budget
19 allocation. So we then did have to go through a process of
20 realignment, re-review of that budget, and in terms of the
21 impacts that then flowed on from that, from ultimately the
22 SLA that we provided in November.
23
24 Q. When you say that some of those assumptions ultimately
25 proved not to be evident, is that a reference to moneys
26 that you thought might be forthcoming in fact weren't?
27 A. Correct.
28
29 Q. And by the time you reached November, which we'll come
30 to shortly, when you received the service level agreement,
31 by that stage you'd, in fact, been delivering the services
32 contemplated by it for several months, hadn't you?
33 A. Yes.
34
35 Q. Is that something which causes any challenges for
36 a private organisation like St Vincent's operating within
37 the public health system?
38 A. It does. It provides a number of challenges and, you
39 know, as we've said earlier, health is a very dynamic
40 environment and in the environment of scarce resources,
41 every month counts for us in terms of our annual budget
42 allocation and making sure we can meet that budget
43 allocation with the level of service delivery that we
44 provide and the efficiencies that we will deliver as part
45 of that process.
46
47 For St Vincent's - so that's not necessarily unique to

1 St Vincent's. For St Vincent's, the uniqueness is we are
2 part of St Vincent's Health Australia, of course, private
3 not-for-profit company, we operate within the environment
4 of the Corporations Act at the St Vincent's Health
5 Australia level, so we do have other obligations incumbent
6 upon us that some of the other LHDs, for example, don't
7 have in terms of making sure that we are a financially
8 viable and sustainable organisation. So having a situation
9 where we had essentially a delayed final budget allocation
10 to November did create some additional challenges for us,
11 yes.
12
13 Q. Cutting to the chase on that, the directors of
14 St Vincent's Sydney and St Vincent's Australia have an
15 obligation not to trade whilst insolvent?
16 A. Correct.
17
18 Q. And despite the fact that there's not a group of
19 shareholders looking for a profit who might bring
20 a shareholders class action against St Vincent's, it,
21 nevertheless, presumably enters into a very large number of
22 commercial arrangements with external parties through the
23 course of a year?
24 A. Yes.
25
26 Q. The provision of machinery and services and the like?
27 A. Yes.
28
29 Q. The total value of those contracts at any given time
30 is no doubt very large?
31 A. I expect so, yes. I don't have full visibility over
32 those numbers, yes.
33
34 Q. The need to ensure that the entity is, in fact,
35 solvent at the time when those arrangements are being
36 entered into is important to insulate the directors from
37 the ever-present risk that the third parties on the other
38 end of those agreements might say, "Whilst the company
39 can't pay because things have gone catastrophically wrong,
40 you, as the director, must, because you committed yourself
41 to this expenditure at a time when the company was not
42 solvent"?
43 A. Yes.
44
45 MR MUSTON: Can we turn, then, to G.081. I might come
46 back to G.081 when it materialises. Let's go to G.034,
47 which is --

1
2 THE COMMISSIONER: Sorry, we're not going to G.081?
3
4 MR MUSTON: If it's up on the screen, I'll work
5 something --
6
7 THE COMMISSIONER: It's not on the screen.
8
9 MR MUSTON: It's back.
10
11 Q. G.081 is another letter to Mr McClintock from I think
12 Ms Pearce. If we scroll down, I think the handwriting in
13 the top will prove me correct. Yes. So it's 19 September
14 2023?
15 A. If we could scroll back to the top of that, that's the
16 communication by which you received a copy, or St Vincent's
17 received a copy of its 2023/2024 service level agreement?
18 A. Yes.
19
20 Q. In relation to that, other than the helpful
21 information which is contained in the letter about the
22 wider health landscape and challenging budgetary
23 circumstances and the like, what process did that initiate
24 within St Vincent's - that is, the receipt of that?
25 A. So once we receive the final service agreement from
26 the ministry, we then undertake a process of detailed
27 analysis of the information contained in that agreement,
28 not just in relation to the financial element activity but
29 also in relation to the key performance indicators that are
30 contained in the SLA in terms of our performance parameters
31 with the state.
32
33 Once we've undertaken that analysis and we know what
34 the impact is and what the expectations are of the ministry
35 and of the state for us to deliver for that year, we then
36 provide a recommendation to the board, ultimately, to
37 either endorse the service level agreement or to not
38 endorse the service level agreement.
39
40 Q. Could we just scroll down to the second page of the
41 document. Do you see there in that paragraph commencing
42 "In a challenging financial landscape"", what did you
43 understand that to be a reference to - that is to say, the
44 "challenging financial landscape"? What was the challenge
45 that you understood, at least, the author of the letter to
46 be alluding to?
47 A. I think there have been some key financial challenges

1 across the system which have been particularly pronounced
2 in the post-pandemic state, if you will, and some of those
3 we referred to earlier, in the sense of we're experiencing
4 extraordinarily constrained workforce environment,
5 certainly increased escalation in price, goods and
6 services; escalation over that period was quite pronounced.
7 Those would be the two key - kind of key constraints around
8 the financial landscape.
9
10 So I think, you know, the purpose of this paragraph
11 obviously is to set the expectation that those constraints
12 are system-wide and that there's an expectation on LHDs,
13 networks, certainly entities like St Vincent's, that we
14 will use those scarce resources as judicially and wisely as
15 we should.
16
17 Q. One implication that one might take from that
18 paragraph is a message that despite that challenging
19 financial landscape and the escalation in those costs, the
20 escalation is not matched in the funding that's being
21 provided to provide those services; is that how you
22 understood that paragraph?
23 A. Yes.
24
25 Q. Therefore, you're going to have to try and find some
26 other ways to make that limited pool of funding work to
27 deliver the services that you're otherwise required to
28 deliver?
29 A. Correct.
30
31 Q. Did that have a particular consequence in the context
32 of the way St Vincent's was operating its business?
33 A. I don't think so necessarily. I think it's
34 a fairly common experience as a health care administrator
35 to be continually looking for innovations, efficiencies
36 and savings in what has always really been a
37 resource-constrained environment. Obviously there have
38 been some escalating factors as I spoke about for this
39 particular year. So I don't think that situation is
40 particularly specific to St Vincent's.
41
42 Q. If you go to G.034, which is [SVH.0002.0001.0208],
43 it's a letter of 24 October 2023 from yourself to Mr
44 D'Amato, albeit dealing with some decommissioning costs
45 associated with closure or disinvestment of St Joseph's
46 hospital. That process was happening in parallel with the
47 discussions which are emerging in relation to the service

1 level agreement for '23/24?
2 A. Yes.
3
4 Q. Can I ask how, if at all, did the decommissioning of
5 St Joseph's fit with those discussions around the service
6 level agreement '23/24?
7 A. So there were two key aspects to that. The first is
8 that, as we referred to earlier, there was a transfer of
9 activity and therefore the funding associated with that
10 activity from St Vincent's Health Network to Western Sydney
11 LHD --
12
13 Q. Resulting in a reduction of funding to St Vincent's?
14 A. Resulting in a reduction of funding to St Vincent's
15 because essentially the activity was being transferred, so
16 that was one impact, and that took some time to work
17 through with the ministry, which is ultimately why we
18 didn't execute our service level agreement until November,
19 despite receiving that in September.
20
21 Q. Just in relation to that, the divestment of, the
22 closure of, an entity like St Joseph's, presumably, is not
23 something that involves closing the door and walking away?
24 A. Definitely not.
25
26 Q. There are costs associated with that decommissioning
27 process?
28 A. Yes.
29
30 Q. Was there discussion had as part of the '23/24 service
31 level agreement with the ministry around how some of those
32 costs of decommissioning St Joseph's in an efficient way
33 might be met?
34 A. Yes, and those are encapsulated and articulated in
35 that - in the letter.
36
37 Q. What was the response to that, not necessarily in
38 detail, but was a position reached where some accommodation
39 was arrived at between St Vincent's and the ministry about
40 how the costs of those decommissioning costs would be
41 shared between those parties?
42 A. Ultimately, no.
43
44 Q. So where did it end up?
45 A. St Vincent's Health Network Sydney have incurred the
46 costs of decommissioning St Joseph's Hospital.
47

1 Q. In a ballpark, what were those costs?
2 A. Ballpark at the moment, around about $12 million.
3
4 Q. Those costs presumably eat away at the funding that
5 you otherwise receive for the delivery of public care
6 through other facilities, the two remaining facilities?
7 A. So those costs - obviously they're one-off costs
8 associated with the decommissioning and we won't be
9 incurring those costs next year, but certainly for this
10 financial year those costs did contribute to the particular
11 challenges, financial challenges, we've faced this year,
12 yes.
13
14 Q. Could we jump forward to G.044. I'm working roughly
15 chronologically through this sequence of correspondence.
16 That's [SVH.0002.0001.0281]. It's a letter from yourself
17 to Ms Pearce dated 15 November 2023.
18 A. Yes.
19
20 Q. The first paragraph of that letter makes clear that
21 the subject that you are wanting to engage in relation to
22 is the service level agreement and presumably the funding
23 component of it?
24 A. Yes.
25
26 Q. You indicate your desire to express some concern about
27 the ongoing sustainability of St Vincent's under the
28 proposed service level agreement?
29 A. Yes.
30
31 Q. Could you expand on what those concerns were to the
32 extent, if it all, that they're not captured by this item
33 of correspondence?
34 A. Yes. So as I mentioned earlier, once we had
35 undertaken the detailed analysis of the parameters of the
36 service level agreement and understood ultimately the
37 revenue that would be generated through the activity
38 encapsulated in that agreement, and then assessed those
39 against our anticipated cost of service, so we, you know,
40 had an interim modelled budget for the year, it was evident
41 at that stage that there was a material deficit projected
42 for this financial year as a result of the misalignment
43 between the revenue provided and the cost of service and --
44
45 Q. Just dealing with that deficit, was any part of that
46 the St Joseph's close-down costs or was that quarantined
47 from this process?

1 A. No, that would have been included, yes, yes.
2
3 Q. Sorry, I interrupted you. So in addition to the
4 St Joseph's, after that figure was taken into account,
5 there was still a remaining deficit?
6 A. Still a remaining deficit, yes. And the other key
7 constraint that we reference in the letter is that there
8 was a projected deficit for this financial year and also
9 that we were - we had some concern about our cash position
10 commencing early in this current calendar year.
11
12 Q. If we could move forward to the document which is
13 annexure AM-19 to your statement, we find a hard copy at
14 page 255. And for the operator, I think, it will probably
15 be found at [SVH.9999.0002.0255] also known as
16 [SVH.0001.0001.1410]. Any or all of the above will work,
17 hopefully.
18 A. I have it.
19
20 Q. That's a letter from you to Mr D'Amato dated
21 19 February 2024?
22 A. Yes.
23
24 Q. Just in relation to that --
25
26 THE COMMISSIONER: Just so I understand the chronology,
27 though, the letter that you took Ms McFadgen to that's
28 G.044, 15 November 2023, which requests a formal review of
29 funding --
30
31 MR MUSTON: You've apprehended my next question.
32
33 Q. Other than Christmas, what happened between
34 15 November 2023 and 19 February 2024, insofar as the
35 funding available to St Vincent's or discussions around
36 that funding was concerned?
37 A. Specifically, I don't recall expressly what happened
38 between those dates, but I would imagine that the next
39 important milestone was us then reviewing what our sort of
40 forecast budget position was.
41
42 THE COMMISSIONER: Q. In the documents that are in the
43 tender bundle, there's no written response to your
44 15 November 2023 letter. Do I take it that there wasn't
45 one?
46 A. I don't recall.
47

1 . Was there a meeting between anyone relevant at the
2 ministry and you or other relevant people at St Vincent's,
3 between 15 November 2023 and 19 February 2024, to discuss
4 the review of funding that you've requested?
5 A. Not to my knowledge, no. Nothing that I was involved
6 in.
7
8 MR MUSTON: Q. You mentioned a moment ago that one thing
9 that might have happened between 15 November 2023 and
10 19 February was a review of the budgetary position within
11 St Vincent's. Perhaps if I could just show you the
12 document, 15 November 2023 letter, that was G.044, that we
13 had up on the screen a moment ago, [SVH.0002.0001.0281].
14 Just looking at the second paragraph of that letter, does
15 that jog your memory as to whether by the time you wrote
16 that there had already been some assessment made of the
17 budgetary position, this being some two months or near to
18 two months after the service level agreement had been
19 received?
20 A. Yes, there certainly would have been and, in fact,
21 we - given the very constrained financial environment and
22 particularly the context for this year, which is
23 encapsulated in that letter and others, we undertake very
24 regular budget forecast reviews, particularly around the
25 cash position, to the extent that we would do that at least
26 monthly, if not more frequently.
27
28 Q. So what appears from the 19 February 2024 letter,
29 which is at page 255 of your statement - if you just move
30 forward to the second page, firstly, you see there there's
31 a subheading, "Cash Forecast", in which you identify what
32 projections indicate the negative cash flow position will
33 be for the hospital going forward, ultimately culminating
34 in a $60.2 million hole in the budget?
35 A. Yes, yes.
36
37 Q. In response to that you identify that St Vincent's had
38 implemented a program of efficiency improvement initiatives
39 and structural reform across the hospital?
40 A. Yes.
41
42 Q. Could you just tell us what that program of efficiency
43 improvement initiatives and structural reform involved?
44 Having received the service level agreement, was some step
45 then taken to then work out how tightly things could be
46 squeezed in order to make sure they were running as
47 efficiently as possible?

1 A. Yes, and --
2
3 Q. What was that process?
4 A. Again, that's not an unusual process in my experience
5 as a hospital administrator, it's certainly incumbent on us
6 to continually look for those efficiencies. This
7 particular focus, this particular efficiency improvement
8 program, really had two kind of key focus areas. One is
9 obviously cost reduction and efficiencies, and the other is
10 around revenue generation, obviously both of those designed
11 to close the gap between cost and revenue.
12
13 From a cost perspective, we look predominantly at
14 workforce salaries and wages because they make up 70 to
15 80 per cent of our cost base, but also the other key
16 opportunity is around procurement contracting, making sure
17 we're very, very tight, sophisticated and focused on our
18 contracting and procurement efficiencies, so they are
19 probably the two key programs from a cost perspective.
20
21 From a revenue perspective, we're always looking at
22 how we can optimise our revenue. That relates to how we -
23 I think we referenced it before, particularly how we code
24 and capture our activity based funding, but also any other
25 revenue streams that might be available to us, and we're
26 always looking to diversify our revenue streams insofar as
27 that is possible in our context.
28
29 Q. Are there any particular challenges that St Vincent's
30 faced in respect of the capturing of that activity or the
31 coding? I have in mind perhaps its particular form of
32 medical records that it used in its hospitals?
33 A. Yes. And there are some parts, components of our
34 activity which are better captured than others. So our
35 acute admitted activity and our emergency activity,
36 generally speaking, is quite well captured. Again that's
37 probably not unique to St Vincent's.
38
39 Mental health activity, non-admitted activity, the
40 systems and structures we have for activity capture in
41 those particular streams are less evolved as in the acute
42 admitted and emergency stream, so we tend to focus on how
43 we can improve our activity capture in those streams.
44
45 The situation for St Vincent's is compounded, which
46 I think is what you're referring to, by the fact that we
47 don't have an electronic medical record at St Vincent's,

1 and so our systems and our processes are paper based and,
2 therefore, capturing the activity does have an additional
3 layer of complexity for us, in terms of how we capture the
4 activity in the paper record and then translate that into
5 our coding, which then, of course, informs our activity
6 capture and ultimately our revenue.
7
8 Q. You said that the searches for efficiencies that might
9 be won is something which most hospital administrators
10 would have constantly sitting on their to-do list.
11 Presumably, some of these projects were under way before
12 you received the to 2023/2024 proposed service level
13 agreement?
14 A. Yes.
15
16 Q. Was the evolution of those projects accelerated by the
17 receipt of that service level agreement and the funding
18 that it promised?
19 A. Yes, and additionally, we - once we understood the
20 size of the forecast deficit, we implemented a further
21 program of workforce reform to augment those underlying
22 efficiency initiatives to try and generate additional
23 savings.
24
25 Q. So we touched on the coding and own source revenue.
26 That's about maximising the amount of revenue that's
27 capable of being generated by capturing as much activity as
28 is delivered, as best as one can.
29 A. Yes.
30
31 Q. Own source revenue, is that a reference to private
32 health revenue?
33 A. Correct.
34
35 Q. And other sources of revenue that might be available
36 to --
37 A. That's right, yes.
38
39 Q. -- any public hospital delivering care to public
40 patients?
41 A. Yes.
42
43 Q. Or perhaps public patients who elect to be private?
44 A. Correct.
45
46 Q. Enhanced bed management, what did that project
47 contemplate?

1 A. So that's really around focusing on length of stay
2 savings. So really making sure that we are operating as
3 efficiently as we can be in terms of the - our sort of
4 general operating tempo. And length of stay for us, and
5 indeed any kind of public health service, is a really key
6 area of focus, making sure that we are optimising the
7 length of stay for people who are in our care - it's not
8 too short or too long, it's just the right length of stay,
9 and making sure we're generating the level of throughput
10 that we can to optimise not only access to our facilities
11 but also making sure that we are capturing as much activity
12 as we can.
13
14 THE COMMISSIONER: Q. Just so I understand it, obviously
15 I understand broadly you want to optimise coding, but at
16 a detailed level, what's involved in that program to
17 optimise coding? What was actually done as part of that
18 program?
19 A. So by way of some examples, we - it's largely about
20 education. It's about education of our clinicians, in
21 particular, our medical staff, in terms of the important
22 aspects of a person's care that need to be captured in the
23 medical record in order to fully understand and document
24 and therefore kind of capture from an activity and revenue
25 perspective all the various interventions, care packages
26 and other aspects of their care that are provided during
27 that time. And it's particularly important for our junior
28 medical staff, who are often the people who are documenting
29 in the medical record.
30
31 Q. Can I just ask, was the driver for that program to
32 optimise coding the fact that you were, in the '23/24
33 financial year, facing this very large financial deficit or
34 had that been something - has either a program or at least
35 some form of initiative being commenced before that?
36 A. Certainly to some level it had been commenced before
37 that, and again, that would be something that would be
38 relatively routine in a public hospital context. As
39 I alluded to earlier, for this particular initiative, we
40 were focusing mostly on those streams of care where we
41 historically haven't captured activity particularly well,
42 being mental health, drug and alcohol and non-admitted
43 services. So whilst we would routinely undertake coding
44 education for our clinical staff, this was a kind of
45 additional level of focus, particularly on those streams.
46
47 Q. And in relation to what Mr Muston was asking you about

1 the program for enhanced bed management, which you started
2 to explain, I take it probably for a lot longer than the
3 '23/24 financial year, you would have wanted not to have
4 people in hospital longer than they clinically need to be.
5 What did that program involve at a more detailed level?
6 A. Yes, and absolutely, obviously again that's a fairly
7 routine course of business for public hospitals. I think,
8 in this case, we were focused on probably particular models
9 of care, so again, particular areas of focus where we felt
10 that we needed to improve the way we were managing the
11 capacity that we have. Emergency is a particular focus for
12 us, given the volume of emergency presentations that we
13 have; geriatric care is another area where we focused
14 heavily on --
15
16 Q. I was going to ask, did this program relate to people
17 with particular health conditions? Because I imagine
18 there's not a lot you can do for someone that has had
19 a heart or lung transplant in terms of how quickly they can
20 leave the hospital?
21 A. Correct.
22
23 Q. But was there particular --
24 A. Yes, yes.
25
26 Q. -- people with certainly health conditions focused on.
27 You just mentioned geriatrics.
28 A. Geriatric care, exactly, and it's really about
29 capturing new models of care that allow us to provide more
30 efficient but also more effective care.
31
32 THE COMMISSIONER: Thank you.
33
34 MR MUSTON: Q. Just picking up on that, is the end game
35 in terms of improving your efficiencies from a bed
36 management point of view capturing more activity through
37 those beds - that is to say, if someone generates
38 a particular amount of activity and you can get them out in
39 two days, then you can get someone else in there for the
40 next two days to capture that activity?
41 A. Yes.
42
43 Q. Again?
44 A. Yes.
45
46 Q. Whereas someone who might stay for four days might get
47 the first two days' worth of notional activity and then for

1 the next two days there's not a huge amount of activity
2 that can actually be collected referable to the continuing
3 care that they're receiving at a time when they ideally
4 don't need to be there?
5 A. That's certainly part of the consideration, and linked
6 to that is, coming to the models-of-care piece, how we can
7 provide - we can work sort of smarter and more innovatively
8 to provide wrap-around services. So, for example, virtual
9 and home health care and other kind of transition
10 arrangements or sub-acute care pathways, so that we can
11 still provide the care that someone needs but in a more -
12 better environment from a patient outcome and experience
13 perspective, but also a more cost-effective, often,
14 environment.
15
16 Q. In terms of the coding, own source revenue is
17 self-evident but in terms of optimising coding, the key is
18 to increase the amount of activity which you are capturing
19 by reference to the services which, as part of your
20 business as usual, are delivered day-to-day through the
21 hospital?
22 A. Yes.
23
24 Q. In terms of the extent to which either of those things
25 can result in an increase in revenue for the hospital,
26 there's another step in that process, isn't there, which is
27 you need to have that additional activity purchased from
28 you by the ministry?
29 A. Correct. Correct. So there is ultimately a limit or
30 a cap, if you will, on how much activity, and therefore
31 revenue, you can generate. So there needs to be an ongoing
32 dialogue, negotiation and collaboration process with the
33 ministry in terms of, you know, what ultimately that looks
34 like and how much additional services, if you will, or
35 activity, that they can - they have the ability to
36 purchase.
37
38 Q. To the extent that you have visibility of it in the
39 past, are you aware of St Vincent's having fallen short in
40 terms of delivering the amount of activity which had been
41 notionally purchased through service level agreements in
42 years gone past?
43 A. I'm not aware of what may have happened before my time
44 at St Vincent's, but certainly my experience is that we're
45 currently ahead of target for the year.
46
47 Q. And so any improvements that can be won through better

1 coding or more efficient bed management will not
2 necessarily result in any further funding for St Vincent's,
3 unless an agreement is reached by the ministry to purchase
4 that additional activity from St Vincent's?
5 A. That's correct.
6
7 Q. In fact, are there potential consequences from
8 a KPI point of view if St Vincent's overruns its activity
9 significantly by reason of the excellent efficiency drive
10 that --
11 A. Yes.
12
13 Q. -- has been undertaken?
14 A. Yes, that could be an unintended consequence. So the
15 way the service level agreement operates is there's sort of
16 a parameter, a low boundary point, high boundary point
17 around the activity, so as long as we deliver within those
18 points, then we will receive our full funding allocation
19 and may, in fact, as you say, receive additional revenue to
20 reflect that activity. If we overachieve beyond that high
21 boundary, that high point, then there's a risk, certainly
22 a material risk, that we won't receive any additional
23 funding for that activity.
24
25 Q. Just coming back to page 256, the second page of the
26 19 February 2024 letter, under the heading "Response", you
27 frankly identified that, at least as you saw it, there was
28 a capacity to generate a $24 million positive turnaround in
29 terms of the efficiency gains that were afoot?
30 A. Yes, yes.
31
32 Q. That comprised two things: first, a reduction in
33 costs?
34 A. Yes.
35
36 Q. So when we're dealing with improved workforce
37 management and procurement/purchasing efficiencies in the
38 next two bullet points at the top of the following page --
39 A. Yes.
40
41 Q. -- it is anticipated that they would potentially
42 produce a reduction in your costs?
43 A. Yes.
44
45 Q. And then through the optimised coding, own source
46 revenue and enhanced bed management, subject to the issues
47 that we've just canvassed, a potential increase in the

1 funding that was available to the hospital thus closing the
2 delta?
3 A. (Witness nods).
4
5 Q. Just very quickly, the workforce management issues
6 alluded to at the top of page 257, what did that involve -
7 that is to say, the improvements in workforce management?
8 A. Yes, so three elements to that. The first is
9 optimising how we use overtime. The second element is
10 leave management, so making sure that people take their
11 leave as it's accrued, obviously not only get a break, but
12 we also - it helps to management our budget; and enhanced
13 rostering.
14
15 One of the challenges we've had, in fact, with this
16 particular stream, in delivering the savings that we
17 identified for this, is that in the context of the
18 workforce, you know, scarcity, particularly very
19 unprecedented challenges we've had this year, it's been
20 very challenging for us to deliver these savings because of
21 the vacancies that we've had across the breadth of our
22 workforce.
23
24 THE COMMISSIONER: Q. What should I understand by what
25 you said - you said "how we use overtime"; what should
26 I understand by that?
27 A. So that is really related to how we optimally roster,
28 particularly junior medical staff. So sometimes what
29 happens is if you have rostering inefficiencies in the way
30 you roster junior medical staff, you can inadvertently
31 create overtime because you don't have an optimal, if you
32 will, pattern of coverage over a 24-hour period, and this
33 is a perennial problem for health services, in terms of
34 making sure that that rostering pattern is optimised, and
35 there are now some pretty clever sort of tools, AI and
36 others, that help health services to optimally roster
37 particularly junior medical staff, but not only junior
38 medical --
39
40 Q. So there is an algorithm that can help you with this
41 now?
42 A. (Witness nods).
43
44 MR MUSTON: Q. Assuming from an efficiency perspective
45 and applying some of these clever tools these things are
46 theoretically able to be achieved, are there industrial
47 problems that come with them?

1 A. Yes, absolutely, and it's important that we work
2 within the parameters of the industrial instruments,
3 regulations, requirements, and that we're providing, you
4 know, a great work experience, of course, for our people.
5 So that is a challenge definitely. I don't think that's
6 particularly new, though, in the context of health
7 services, with the exception of the fact that the resource,
8 the workforce constraints, are certainly at a level which
9 we haven't seen previously.
10
11 Q. And it's probably fairly self-evident but the
12 procurement purchasing efficiencies involves procuring
13 things in a way that result in you getting the best price
14 possible?
15 A. Reduced cost, yes, correct.
16
17 Q. So you tell us, going back to page 256 - or you told
18 Mr D'Amato, that you anticipated that there could be
19 a $24 million worth of upside --
20 A. Yes.
21
22 Q. -- achieved through these various objectives by the
23 closing of the delta?
24 A. Yes.
25
26 Q. Was that something that you anticipated could be
27 achieved overnight or was it going to take a bit of time?
28 A. No, it certainly will take time and I think I might
29 reference that in the letter, that, you know, the size of
30 the deficit, particularly for this year, certainly exceeded
31 any gains that I - as an experienced hospital
32 administrator, I think can be achieved reasonably in what
33 was at this point a sort of six-month period. So we have
34 certainly undertaken to ministry and the board and others
35 that we will make every endeavour to achieve those savings,
36 and we have made some very good inroads into those but, as
37 I said, the workforce pressures that we're experiencing,
38 particularly vacancies and others, have certainly impacted
39 on our ability to fully deliver what we thought we could
40 deliver from an efficiency perspective.
41
42 Q. Just projecting a little bit ahead of this particular
43 letter, have you or did you communicate to the ministry in
44 any discussions after this letter that this $24 million
45 gain was there to be made but would take some time and was
46 a work in progress?
47 A. Yes, and we certainly talk about this explicitly when

1 we have our quarterly performance meetings with the
2 ministry. So as part of those performance meetings, we
3 talk about our financial position and we talk about any
4 efficiency initiatives that we are undertaking and the
5 status of those, what's at risk, for example.
6
7 We also - so the efficiency improvement program is
8 a formal program of - as part of the ministry. So we also
9 provide regular reporting around the status of what we call
10 "EIPs", efficiency improvement programs, to the ministry.
11 So they have full visibility of the trajectory of those
12 anticipated savings.
13
14 Q. Just on page 257, you identify the support that was
15 being sought was supplementary funding of $60 million?
16 A. Yes.
17
18 Q. That figure, I take it from what appeared on the
19 page before, was to cover the $60 million hole in the
20 budget which had been identified, and assumed, did it, that
21 the $24 million worth of savings/additional revenue was not
22 going to be achieved within the '23/24 budgetary period?
23 A. Yes, that's correct.
24
25 Q. Could we move forward to page 262 of your statement.
26 In fact, sorry, 259 of your statement, which is
27 [SVH.9999.0002.0259]. Do you have that letter in front of
28 you?
29 A. Yes.
30
31 Q. It's a letter or an email from Susan Pearce to
32 yourself, dated 28 February 2024.
33 A. Yes.
34
35 Q. Just before we get into the detail of that, do you
36 recall whether there were any discussions between you or
37 anyone else from St Vincent's and Ms Pearce or anyone else
38 from the ministry, between 19 February '24, when you sent
39 your letter, and 28 February, 2024, when this communication
40 was received?
41 A. Yes, I had a couple of conversations with Adjunct
42 Professor D'Amato about the request in my letter.
43
44 Q. Doing the best you can, what was discussed during
45 those conversations?
46 A. It was really a discussion related to the letter that
47 I had drafted, why I was asking for additional support and

1 the drivers for that additional support, and then
2 clarification on some of those drivers for the particular
3 financial position for this year.
4
5 Q. In that discussion, did Mr D'Amato suggest to you that
6 you'd got your numbers wrong in any way or that there was
7 something incorrect about the way in which you'd assessed
8 the potential hole in the budget?
9 A. No.
10
11 Q. Did Mr D'Amato suggest to you during those
12 conversations, as best as you can recall, that the hole in
13 the budget, save for the $24 million efficiencies that you,
14 over the longer term, were hoping to achieve, were
15 referable to anything other than a difference between the
16 funding which was being provided on the one hand and the
17 cost of actually delivering the services required to be
18 delivered through the prior service level agreement on the
19 other?
20 A. No.
21
22 Q. We'll come to the document at page 259. It's
23 obviously, I gather from the first paragraph, a response to
24 your 19 February letter.
25 A. Yes.
26
27 Q. If we go down to the next paragraph commencing,
28 "Having carefully reviewed", you see there is an offer
29 there of an "additional subsidy of $30 million, (one off)"?
30 A. Yes.
31
32 Q. Upon receiving this communication, was it your view
33 that the $30 million, would be adequate to close the hole
34 in your budget?
35 A. No.
36
37 Q. That's basic arithmetic.
38 A. So obviously the request in my letter was 60 million,
39 and ultimately the additional subsidy provided was
40 30 million.
41
42 Q. And I see it is described as a "one-off". In any part
43 of your communications with Mr D'Amato, was there
44 discussion around whether, assuming that the $24 million
45 efficiencies and further revenue for the services already
46 being delivered could be won, when the remaining
47 $36 million hole, if my arithmetic is correct, would still

1 exist?
2 A. Not explicitly, and I think - you know, it's not for
3 me to comment on the discernment process within the
4 ministry and the ultimate decision around the volume of
5 money ultimately provided.
6
7 Q. I'm interested in your discussion with Mr D'Amato. So
8 just again, it may be my arithmetic, and correct me if it's
9 wrong, but you had a $60 million hole in your budget?
10 A. Yes.
11
12 Q. $24 million worth of it, you frankly conceded, was
13 referable to some inefficiencies and a failure to capture
14 revenue that was capable of being captured from the
15 delivery of the services being delivered?
16 A. Yes.
17
18 Q. That leaves about $36 million worth of unaccounted-for
19 gap?
20 A. Yes.
21
22 Q. Right?
23 A. Yes.
24
25 Q. Which I think, I gather from an answer that you gave
26 a moment ago - well, let me ask this in two parts. Your
27 view was, was it, that that $36 million remaining hole was
28 referable to a gap between the funding provided for the
29 delivery of services on the one hand and the cost at
30 St Vincent's of actually delivering them on the other?
31 A. Yes.
32
33 Q. Referable to inefficiencies in the ABF system and
34 maybe just an inadequacy in the number which was being
35 plugged in to the equation used for the ABF?
36 A. Largely around - I think there are two components to
37 that. So ABF is one part of the picture. The other part
38 of the picture is the capital funding that is received by
39 Sydney - St Vincent's Sydney, and the extent to which,
40 because we receive relatively limited capital funding,
41 there's a scenario that plays out for us where, on some
42 level, we need to use operational funding to supplement
43 capital - asset replenishment and facilities maintenance,
44 and so I think that contributes to some of the challenges
45 that we face.
46
47 Q. So if a particular piece of machinery, for example,

1 that's mission critical in delivering intensive care
2 services on one of those 21 beds dies, you have to replace
3 it?
4 A. Yes.
5
6 Q. And unless some capital funding is received from the
7 ministry with respect to that particular piece of possibly
8 quite expensive equipment, the cost of replacing or
9 repairing that machine has to come out of St Vincent's
10 budget?
11 A. Yes.
12
13 Q. Which, in turn, is populated by the funding provided
14 for the delivery of the activity generated through the use
15 of that particular machine?
16 A. Yes.
17
18 THE COMMISSIONER: Q. This letter has your email
19 address. Was it emailed to you?
20 A. Yes, it was.
21
22 Q. On 28 February?
23 A. I can't recall the exact date, but I presume so from
24 the date on the letter.
25
26 Q. That's not a typo, "Please inform us of your
27 decision ... before 29 February" - so on the day, is that
28 how you understood?
29 A. Yes, thank you. I do recall this, now that you point
30 it out, yes. So obviously there has been a delay in the
31 ministry sending me the letter, because, you're right, it's
32 dated 28/2 but it says, "Please inform us of your decision
33 before the 29th".
34
35 Q. Would this sort of proposal that's in here be
36 something - given the $60 million deficit, something you'd
37 have to discuss at board level?
38 A. Yes, absolutely, yes.
39
40 MR MUSTON: Q. In relation to that issue, was your
41 inability, in a perfectly understandable practical sense,
42 to respond by 29 February something that was communicated
43 to --
44
45 THE COMMISSIONER: Before; "before the 29th".
46
47 MR MUSTON: Q. -- to Ms Pearce prior to the 29th?

1 A. Yes, yes, of course, it was, and we had a discussion
2 with the ministry about some additional time, obviously, to
3 consider the conditions outlined in the letter and provide
4 a formal response.
5
6 Q. Can I just take you down to the last bullet point,
7 which refers to some of the conditions which are said to
8 attach to the $30 million one-off payment. I invite you to
9 read that last bullet point to yourself. What did you
10 understand that to mean?
11 A. So my interpretation of this point is that the
12 $30 million subsidy will be essentially recouped from this
13 coming year's SLA, and that we need to make additional
14 efficiency improvements in order to generate that
15 additional $30 million savings going into next financial
16 year.
17
18 Q. Just working through the arithmetic of that, you start
19 with a $60 million hole in the budget, of which $24 million
20 can, over a period of time, be found internally?
21 A. Yes.
22
23 Q. That leaves the $36 million figure that we've talked
24 about as an ongoing hole in the budget. The proposal, as
25 you understood it, at least, was, "We'll give you
26 $30 million" - that is half of the hole that you currently
27 have in the budget --
28 A. Yes.
29
30 Q. -- "on condition that it be repaid next year,
31 notionally, through us giving you $30 million than we
32 otherwise would next year"?
33 A. Yes.
34
35 Q. Your arithmetic is no doubt better than mine, but for
36 those of us who became lawyers because we weren't good at
37 maths, where did that actually leave you in a net position
38 come the '24/25 year?
39 A. Well, without knowing the parameters of the
40 forthcoming service level agreement --
41
42 Q. As projected, at least?
43 A. -- if we assume, for example, the parameters of that
44 agreement will be very similar to this current year's
45 agreement, that would obviously leave a significant, circa
46 $100 million, deficit going into next year.
47

1 Q. Is that something that was canvassed with anyone at
2 the ministry following receipt of the 28 February 2024
3 email?
4 A. We've certainly had discussions with the ministry
5 around our ability to add that $30 million requirement of
6 efficiency savings to our already, as you say - the level
7 of efficiency savings we need to make just to kind of stand
8 still, if you will, yes.
9
10 Q. Can we move forward to the document which is at
11 page 262 of your statement, which for the operator is
12 [SVH.9999.0002.0262]. That's a letter of 25 March 2024
13 from Mr McClintock AO to Ms Pearce AM.
14 A. Yes.
15
16 Q. First question: between 28 February, when Ms Pearce's
17 letter was sent, and 25 March 2024, when this letter was
18 sent, putting to one side any discussion you might have
19 had about your ability to respond within the contemplated
20 time frame, were there discussions between St Vincent's and
21 the ministry around the acceptability of the proposal being
22 put forward in Ms Pearce's email, from St Vincent's
23 perspective?
24 A. Not that I recall.
25
26 Q. So the next step in the process, as best as you can
27 recall, was on 25 March, Mr McClintock wrote to Ms Pearce
28 indicating that whilst the board has executed the 2023/24
29 service level agreement in recognition of an enduring
30 partnership - just pausing there, are we to infer from that
31 that it was commercially disadvantageous to St Vincent's to
32 execute it, but in the spirit of the ongoing relationship
33 of 167 years between St Vincent's and the State of New
34 South Wales, it was decided to do it?
35 A. That's correct, yes.
36
37 Q. But as at 25 March 2024, it could not be expected that
38 St Vincent's would be able to execute the 2024/2025 service
39 level agreement under the current funding parameters?
40 A. Correct.
41
42 Q. In terms of the current funding parameters, did you
43 understand - first question: did you see the letter at the
44 time it was sent?
45 A. Yes.
46
47 Q. Where it refers to the "current funding parameters",

1 did you understand that to be a reference to the
2 $36 million hole, the $60 million hole, or the
3 $100-ish million hole?
4 A. My interpretation of that is that on an assumption
5 that the parameters of the forthcoming SLA will be largely
6 the same as the parameters of this year's SLA, that then it
7 would be - obviously as the chair points out in the
8 letter - very challenging for the board to endorse us to
9 execute next year's SLA.
10
11 Q. Can we move to a document G.073, which is
12 [MOH.9999.1580.0001].
13
14 That should be on the screen for you, hopefully?
15 A. Yes, thank you, yes.
16
17 Q. That's a letter to Paul McClintock from Ms Pearce
18 dated 3 May 2024. Insofar as you are aware, is that the
19 next communication that occurred between St Vincent's and
20 the ministry in respect of this funding, the brewing
21 funding discussion, as between - after Mr McClintock's
22 letter?
23 A. Yes.
24
25 Q. Was there any discussion or meetings had where the
26 issue was discussed between 25 March and 3 May that you're
27 aware of or were involved in?
28 A. Not that I can recall, over and above the monthly -
29 you know, sorry, the quarterly performance meeting we have
30 regularly with the ministry where these matters are
31 certainly regularly raised.
32
33 Q. I'm just looking at the content of that letter. I see
34 in the second paragraph there's a reference to a meeting on
35 19 March 2024, where executives from the ministry and
36 St Vincent's Hospital met to start discussions on the
37 2024/25 service agreement?
38 A. Yes. So we started our FY25 service level agreement
39 discussions, and that's part of the normal course of
40 business that the ministry and LHDs, and in our context
41 networks, and AHOs go through to negotiate and ultimately
42 agree the service level agreement process. So that's just
43 the standard process.
44
45 Q. Just looking at that, does that refresh your memory
46 that there may have been a meeting to start that process
47 which happened some six days before Mr McClintock wrote his

1 25 March 2024 letter?
2 A. Yes, although the meeting on 19 March was part of the
3 standard SLA process that we go through. So the meeting on
4 19 March, if I recall that meeting correctly, was probably
5 the first of our SLA meetings, and we have several with the
6 ministry as we go into the negotiation process.
7
8 The first is called the "purchasing roadshow", and
9 it's generally where the ministry explain the context, the
10 financial context for the coming year, any major changes to
11 either performance parameters or the funding environment
12 that the network needs to be aware of going into next
13 financial year. It's very much a sort of information
14 sharing discussion. It certainly wasn't a discussion where
15 we got to the point of talking about the matters outlined
16 in this letter.
17
18 Q. It is said at the end of that paragraph commencing
19 "I am advised" that:
20
21 *... a key outcome of this was an agreement*
22 *to discuss a sustainable level and mix of*
23 *services for [St Vincent's Hospital*
24 *network].*
25
26 Just building on the answer you gave a moment ago, was that
27 a reference to some agreement reached in respect of the
28 $60 million hole or was it more a general discussion around
29 what the service mix might look like?
30 A. It was more a general discussion about what the
31 service mix might look like, and in the context of
32 St Vincent's, we've certainly, you know, highlighted
33 through this letter and others, and indeed in that
34 discussion, the challenges with the parameters of the
35 service level agreement from a financial perspective, and
36 the ministry have certainly acknowledged that as part of
37 that meeting, yes.
38
39 Q. Tracking down two paragraphs, there is a reference to
40 Mr Portelli, as a person who you might need to contact to
41 discuss these matters?
42 A. Yes.
43
44 Q. Is Mr Portelli someone who has had any involvement in
45 discussions around the bigger issue, the $60 million issue?
46 A. So Mr Portelli is pivotal in those SLA discussions,
47 leads those discussions, and certainly would have led the

1 discussion, if I recall correctly, on the 19th. So insofar
2 as Mr Portelli leads the service level agreement
3 discussions, negotiations, then yes. I think the specifics
4 of the exact volume of services purchased and the revenue
5 that then flows from that, that's a discussion that's
6 pretty much live at the moment. So that happens a bit
7 later in the process.
8
9 Q. If we can jump forward to the document at G.086, which
10 is [MOH.9999.1651.0001], that's a letter from you to
11 Mr D'Amato?
12 A. Yes.
13
14 Q. Dated 13 May 2024?
15 A. Yes.
16
17 Q. Do you recognise that letter as one that you wrote?
18 A. Yes.
19
20 Q. Was there any discussion - before we come to the
21 content of that letter, do you recall any particular
22 discussion with Mr D'Amato or anyone else from the ministry
23 which might have occurred between the date of the last
24 letter we were looking at and 13 May 2024?
25 A. I don't recall any specific discussion, but again,
26 these matters are regularly raised and discussed as part of
27 our quarterly performance meetings with the ministry.
28
29 Q. Who attends the St Vincent's network quarterly
30 performance meetings?
31 A. Sorry, I didn't --
32
33 Q. Who usually attends the performance meetings?
34 A. Myself, my chief operating officer, our director of
35 finance, our executive director quality performance and
36 improvement, and more often than not our executive director
37 Aboriginal health.
38
39 Q. And from the ministry side?
40 A. The deputy secretary system performance, certainly
41 representatives from mental health, finance, either
42 Mr D'Amato or his deputy will attend, Sharon Smith will
43 often attend from system purchasing, and there may well be
44 others that attend depending on the topics that will be
45 covered in the meeting.
46
47 Q. Deputy secretary system performance is Mr Daly?

1 A. Sorry, Mr Matthew Daly, yes.
2
3 Q. Mr Daly, I think, was copied in to this letter of
4 13 May 2024?
5 A. Yes.
6
7 Q. This letter, reading through it, talks about the
8 achievements of St Vincent's but it doesn't appear to
9 grapple directly with the $30 million one-off repayable
10 supplement as a solution to the $60 million problem?
11 A. No.
12
13 Q. Have there, since 13 May, been any other discussions
14 around that issue?
15 A. So indirectly, this letter does, in part, deal about
16 that. So one of the drivers of our current financial
17 forecast position is our activity performance, and we are
18 ahead of target year to date, so we're doing more activity
19 than has been purchased, but we are still within that
20 boundary point that I talked about earlier, in terms of
21 being in the sort of performing range, if you will.
22
23 So after a discussion with ministry, I believe it was
24 at one of our performance meetings where that performance
25 trajectory was well recognised, I wrote to Mr D'Amato
26 seeking support, financial support, to recognise that
27 performance in activity for the year. Part of that, of
28 course, would support our overall forecast budget deficit
29 position for the year.
30
31 Q. Other than reporting that to him, has there been
32 anything - has anything come back from the ministry in
33 relation to that issue from your --
34 A. Not formally at this stage, no.
35
36 Q. Has it come back informally?
37 A. No.
38
39 Q. So as matters stand, you've received no response or
40 no indication from the ministry as to how the
41 $30 million/$60 million/possibly $100 million hole in the
42 budget is going to be filled from a --
43 A. No.
44
45 Q. If at all, from a funding perspective?
46 A. Not as today, no.
47

1 Q. Does that introduce any particular challenges to the
2 way in which St Vincent's plans and goes about the delivery
3 of healthcare services through its facility at Darlinghurst
4 and Sacred Heart?
5 A. Of course. And, you know, if we assume that the
6 parameters of next year's SLA will be largely the same as
7 this year's, we will certainly need to deeply consider the
8 way we provide our services - the models of care in which
9 we provide our services; what our workforce structure and
10 model is to provide those services; do we have the right
11 level and mix of services; do we have the right workforce
12 structure? We'll have to go through all of those
13 processes. The extent to which those processes will elicit
14 answers to the size of that projected deficit is not clear
15 to me at this stage.
16
17 Q. Has anyone from the ministry suggested to you, putting
18 to one side the $24 million worth of efficiencies that
19 might be won, that it is possible to deliver the healthcare
20 services that are currently being - currently required
21 under the service level agreements for the amount of money
22 that is currently provided by way of funding?
23 A. Not explicitly. We have talked about, as part of our
24 financial recovery plan which we discuss regularly with the
25 ministry, a scenario in which we review the level and mix
26 of services that we provide to better align with the
27 purchase volume - so, you know, do we need to change the
28 services that we provide to align with the amount of
29 revenue that we receive? As yet, we haven't had to
30 activate that scenario, but it's a scenario that has been
31 discussed with the ministry.
32
33 Q. Does that come back to a topic that we were exploring
34 a little bit earlier today around possibly changing the mix
35 of services being delivered through St Vincent's so you do
36 more of the easy stuff and leave more of the hard stuff for
37 someone else's budget to deal with?
38 A. I mean, theoretically, that would be part of that
39 discernment process but, as I said earlier, you know, there
40 are some services that we provide which we consider to be
41 core and crucial to our mission and history and so it would
42 be a very, very careful discernment process around those
43 particular services.
44
45 Q. If one starts from the proposition that those
46 services, in a properly functioning society, need to be
47 delivered to those people who might be more expensive to

1 deliver health care to, whether you're delivering them or
2 someone else is delivering them under their budget, the
3 cost will be largely the same?
4 A. Correct. Correct. And in fact, you know, given that
5 we have been delivering services to those particular groups
6 in society for a long period of time, I would argue that
7 we've built up an efficient - a level of efficiency and
8 effectiveness in delivering those services that, if those
9 services were to be provided by another provider without
10 that level of expertise, that there would be - there would
11 be, most likely, a less efficient model.
12
13 Q. Which would manifest itself in one of two ways - it
14 would either cost more?
15 A. Yes.
16
17 Q. Or the service would not be delivered as well?
18 A. Or the service - correct.
19
20 Q. Could I come back to paragraph 79 of your statement,
21 which is on page 14. Do you see you allude there in the
22 last sentence to changes that may be necessary to the
23 ongoing sustainability of St Vincent's Sydney so as to
24 enable it to continue making its important contribution to
25 public health in New South Wales. The challenges,
26 I gather, are those that we've canvassed in some detail --
27 A. Yes.
28
29 Q. -- over the last hour?
30 A. Yes.
31
32 Q. What are the changes that you think might be necessary
33 and appropriate to meet some of those challenges?
34 A. I think there are several opportunities, some of which
35 specifically relate to St Vincent's Sydney, but some are
36 sort of broader system opportunities. Insofar as they
37 relate specifically to St Vincent's Sydney, one of the
38 opportunities I think which would significantly enhance the
39 sustainability and longevity viability of the network would
40 be a longer-term partnership agreement with the state,
41 through NSW Health.
42
43 At the moment, we have, like all the other LHDs do,
44 a rolling annual agreement, the service level agreement,
45 and I think, you know, my observation is that that prevents
46 a level of long-term planning, partnership and investment
47 that would better position both St Vincent's Sydney and the

1 system for both parties to be making investments in the
2 system and in that partnership for the betterment of the
3 community.
4
5 The second aspect, I think, the opportunity, would be
6 around sort of system reform, and I think there are
7 probably two key aspects to that. The first is the extent
8 to which we really genuinely incentivise what I would
9 describe broadly as substitution and diversion models. So,
10 you know, we know that hospitals, particularly hospitals,
11 tertiary hospitals like St Vincent's, are generally
12 high-cost places to deliver services, and that's
13 appropriate for some groups of patients that we've talked
14 about, but for a large group of the community, there are
15 other more cost-effective places of care, if you will, that
16 can also deliver better outcomes and experiences.
17
18 One example would be to heavily incentivise virtual
19 and home health care and really invest in pathways from -
20 and connectivity and connection between acute tertiary
21 hospitals like St Vincent's and virtual - and other virtual
22 and home health care environments, so that we can better
23 flex capacity, if you will, and treat patients in the most
24 appropriate place.
25
26 Q. In what way is that not currently being incentivised,
27 looking at those different ways of treating patients?
28 A. It's incentivised to some extent, but there are -
29 activity based funding, by its nature, is designed to
30 incentivise activity, right, throughput, as opposed to
31 a bundle of care, if you will. So I think there's an
32 opportunity through some different funding models - block
33 funding, bundled care, however you kind of want to term
34 it - that you could provide to a health service and LHD,
35 a network, for more flexible use, which would then enable
36 that health service to either deliver care where it's
37 appropriate to do so in a hospital setting, but actually
38 also potentially deliver care in other settings, which, as
39 I say, is more cost effective. So that's - I don't think -
40 I think whilst we've - you know, we've certainly explored
41 those sorts of models, I think there's much more
42 opportunity to do that.
43
44 Q. So insofar as the St Vincent's arrangement with the
45 state is concerned, if there was an agreement reached in
46 relation to, say, block funding for a particular model of
47 care like that, there's nothing about an agreement to

1 a block funding arrangement which would prevent
2 St Vincent's from, nevertheless, capturing, as best as it
3 could be captured, all of the activity that was properly
4 recognised as part of the delivery of that service, so that
5 the state could secure from the Commonwealth its
6 contribution of that activity?
7 A. Absolutely. Yes. So they're not mutually exclusive.
8 You could absolutely have a combined funding model. I was
9 involved in a pilot in Victoria several years ago which was
10 expressly designed to incentivise diversion and prevention
11 and substitution models for health care, and it was a pilot
12 program, so there was a shadow funding arrangement that was
13 put in place at that time, obviously to, you know, prove
14 the concept, so to speak, and I think those sorts of
15 opportunities would be a great augmentation to the system
16 here.
17
18 Q. And at the risk of delving into the measurement of
19 process rather than outcomes, there's no reason why KPIs
20 couldn't be set for an organisation like St Vincent's, for
21 example, that said, "You've received block funding for this
22 particular type of care that you're providing, a KPI in
23 respect of which is an obligation that you capture, as part
24 of the delivery of that service, a particular amount of
25 activity which, between you and the ministry, worked out,
26 seems to be a fair and achievable target" --
27 A. Mmm.
28
29 Q. -- such that the ministry can then secure from the
30 Commonwealth, or the treasury can secure from the
31 Commonwealth, its contribution towards the funding of that
32 model of care?
33 A. Yes, that's right. And I mean, those KPIs would
34 extend to both, as you say, process and outcome. You could
35 certainly measure outcomes as part of that arrangement as
36 well.
37
38 THE COMMISSIONER: Q. Just pausing there, you said in
39 response to a question from Mr Muston, "I was involved in a
40 pilot in Victoria several years ago", et cetera - remember
41 that? One, what was the pilot; and, two, was it evaluated
42 and did it go anywhere?
43 A. It was called "Better at Home". It was an initiative
44 of the Victorian Department of Health at the time. I left,
45 unfortunately, Victoria before the evaluation process of
46 that initiative, but certainly the experience - to the
47 extent that I was involved in that pilot, and my experience

1 when I was working at St Vincent's Melbourne at the time,
2 was that it was looking very promising.
3
4 MR MUSTON: Q. Can I come to the issue of capital
5 funding briefly?
6 A. Yes.
7
8 Q. Can we turn to paragraph 45 of your statement, on
9 page 8, which, just to orient you, comes very shortly after
10 a heading, "Limitations of the AHO model"?
11 A. Thank you.
12
13 Q. Actually, before we come to capital, just insofar as
14 the limitations of the AHO model are concerned, do any
15 limitations arise as a result of the fact that employees at
16 St Vincent's are not - that is to say, the staff at
17 St Vincent's Hospital Sydney are not employed by the
18 secretary but, rather, are employed by St Vincent's?
19 A. Not really, in practice. Our awards mirror the state
20 awards and we have provisions in place for transferability
21 of staff across the system. So to my knowledge and
22 understanding, there is no real impediment to those
23 arrangements.
24
25 Q. So such challenges as might, at least at a theoretical
26 level, exist there have been sensibly resolved?
27 A. Yes.
28
29 Q. In a collaborative way by the state and St Vincent's?
30 A. Yes.
31
32 Q. Coming then to capital, looking at paragraph 45, could
33 I just invite you to expand on what you mean when you tell
34 us that St Vincent's Sydney does not have good visibility
35 of the capital funding that may be available to
36 St Vincent's as a networked AHO, and what further
37 transparency you think would be useful?
38 A. Yes, and I preface my comments with the fact that my
39 experience in the system is obviously still limited to
40 being around about 12 months, so what I've expressed in my
41 statement and what I'll express now is based on my limited
42 understanding. But my understanding is that there are
43 several avenues to access capital funding from NSW Health,
44 from the state. They range from, you know, programs
45 designed for minor, very minor sort of equipment
46 replenishment, facilities maintenance, et cetera, through
47 to more significant capital redevelopments and upgrades

1 through health infrastructure and the capital investment
2 proposal framework.
3
4 Certainly St Vincent's has been involved in, as far as
5 I'm aware, all of those different programs and initiatives,
6 and we submit every year - last year was the first year,
7 admittedly - a capital - sorry, an asset management plan to
8 the ministry, which is as part of the standard capital
9 process for the system, and from that, there's
10 a determination made, is how I've interpreted it, in terms
11 of the capital allocation that needs to be provided through
12 to the system across those various different programs.
13
14 We've also historically, even before my time, from
15 what I can tell from the documentation, submitted capital
16 investment proposals to the ministry across a range of
17 different initiatives.
18
19 Q. So in terms of the additional transparency, what could
20 or in your view should be more transparent?
21 A. So whilst I think there is again, in my experience,
22 relatively good visibility about the avenues for which,
23 through which, you can seek capital funding, I think --
24
25 Q. Pausing there, you understand the forms you need to
26 fill out and what needs to go into those forms in order to
27 make an application for funding at different levels?
28 A. Yes, yes. What's less visible to me is the amount, at
29 a global level, of capital funding that is available and
30 how that capital funding is apportioned, and on what basis,
31 what's the framework for making those decisions.
32
33 Q. So as a part of the public health system which is
34 operated not by the ministry but by a private organisation,
35 do I gather from that answer that it would be - you think
36 it would be useful to you, and perhaps important from your
37 understanding of the process, to see how much money is
38 being allocated for capital improvement across the system,
39 where that money has been allocated --
40 A. Yes.
41
42 Q. -- so that you can make an assessment of whether you
43 think, on a fair and equal distribution of what's always
44 going to be a limited pool of funds, a decision not to
45 allocate any of it to you is understandable and reasonable?
46 A. That's right. And there is some visibility to the
47 extent that some of the capital funding that is provided to

1 the system is encapsulated in service level agreements, so
2 there's some visibility to the extent that those service
3 level agreements are public documents. But it's my
4 observation - and again, limited to the time that I've been
5 in this role and in this system - that there is other
6 capital funding provided into the system over which there
7 is less visibility.
8
9 Q. So starting with the very big items, the
10 redevelopments, we've heard some evidence which suggests
11 that decisions around that are an inherently political
12 process, which might not necessarily be amenable to the
13 sort of transparency that is alluded to in paragraph 45,
14 but - maybe it should be, I'm not expressing a view one way
15 or the other in relation to that or asking you to at this
16 stage --
17 A. Thank you.
18
19 Q. -- but in relation to other aspects of capital, for
20 example, minor works expenditure of the type that you refer
21 to in paragraphs 47 and 48, what are some of the challenges
22 presented to St Vincent's by what you perceive, at least
23 possibly, without transparency and knowledge of how it's
24 distributed, to be an inequitable distribution of that
25 money across the system such that none of it's being
26 received or not much of it has been received by
27 St Vincent's?
28 A. And I think that's the crux of it. Certainly very
29 little of it is received by St Vincent's. Now, that may be
30 the - the reasons for that, there may be deficiencies in
31 our submissions, for example, something that I don't fully
32 understand about the way the decision-making is undertaken,
33 the full framework or assessment criteria under which -
34 against which those proposals are submitted.
35
36 There is some high-level information available, I must
37 say, so it's not complete misunderstanding, but I think
38 that what would help, certainly me in my role at
39 St Vincent's Sydney, is if we had some better understanding
40 of how we could improve the way we seek the funding, then
41 that would help us, I hope, to receive more funding.
42
43 Q. So to the extent that decisions not to provide funding
44 to St Vincent's for, for example, a piece of intensive care
45 equipment we hypothesised about earlier that broke, if
46 there's something about the way in which you're seeking it,
47 and the information you are putting in the form which is

1 the reason for you not getting that funding, it would be
2 useful for that to be shared with you?
3 A. Yes. Yes.
4
5 Q. And if it is not that, and, rather, it's just
6 policy-based decision-making around how funds, capital
7 funds, are distributed across the system as between the
8 publicly owned component of it and that which is owned and
9 operated by St Vincent's, whilst it might not change the
10 way you go about filling out your forms, it would be good
11 to know?
12 A. It would.
13
14 Q. Good to know not just out of prurient interest but
15 because it would no doubt inform you about the way you
16 approach budgeting and decision-making going forward about
17 the services and the way in which you use the capital items
18 which you have at your disposal?
19 A. Yes, that's right.
20
21 Q. Could I ask you to go to paragraph 52 of your
22 statement where you tell us a little bit about having
23 sought funding from NSW Health to enable St Vincent's
24 Sydney to participate in the single digital patient record
25 initiative?
26 A. Yes.
27
28 Q. I gather that a lot of, at least, the earlier
29 applications for that funding were made prior to your
30 arrival on the scene at St Vincent's?
31 A. Yes, yes.
32
33 Q. Have you, in your time as a CE of St Vincent's, been
34 involved in any discussions around that with the ministry?
35 A. Yes, several. We worked very closely with the
36 ministry over the last six months or so to develop both
37 what we call an implementation planning study, so really an
38 initial assessment of the potential for St Vincent's to
39 join the single digital patient record, and more recently
40 a business case, which obviously includes the funding
41 element, again, for us to join the single digital patient
42 record. So we've had several discussions and worked very
43 closely with eHealth NSW on those.
44
45 Q. I think you've told us already the current system
46 which is operated at St Vincent's is predominantly
47 a paper-based system?

1 A. Correct.
2
3 Q. Presumably with elements of electronic medical record
4 that get produced by those of the intensive care machines
5 that are not hypothetically broken, for example?
6 A. Yes, yes. We do have pockets across the hospital
7 where we have a more digital - digitally enabled operation.
8
9 Q. In terms of St Vincent's proposal for introducing
10 electronic medical record, start with the concept of the
11 EMR itself, what are the benefits from the point of view of
12 both the delivery of health care and also the quality of
13 the health care received that could be gained through
14 proper use of a quality electronic medical record system?
15 A. I mean, for St Vincent's, the benefits would be very
16 literally transformative. We're one of only two health
17 services around the state without an electronic medical
18 record currently, and so for us, the benefits extend across
19 patient care, so, for example, we would have better
20 ability, to our discussion earlier, to monitor quality and
21 safety of our care; better connectivity of care both within
22 our organisation and also with the partners who are also
23 able to be connected into that system, so from a seamless -
24 from a patient's perspective, from an experience and
25 outcomes perspective, providing seamless care where the
26 information, critical information, is transferred between
27 providers to enable better care, basically, would be
28 transformative.
29
30 It would also be transformative in the sense of our
31 workforce. So as you might imagine, most, particularly
32 junior staff that come to work at St Vincent's are used to
33 operating in a digitally enabled environment with an EMR,
34 and so from a value proposition and a workforce
35 perspective, you know, not having that available to us is
36 a significant disadvantage from a recruitment and retention
37 perspective. So it would be a huge advantage for us from
38 that perspective.
39
40 The other advantage would be around research
41 connectivity. So as you know in my statement, we are part
42 of St Vincent's Sydney health innovation precinct. We work
43 very closely with our research partners in the precinct,
44 and being able to capture data electronically to use and
45 also create connectivity from a research and innovation
46 perspective would be another benefit of an EMR.
47

1 Q. You're aware, obviously, from the discussions you
2 allude to in paragraph 52, that the ministry has embarked
3 upon a long-term transformative single digital patient
4 record project?
5 A. Yes.
6
7 Q. The ambition, as we understand it, is to have a single
8 system which is accessible at any public health facility
9 across New South Wales, such that if a patient presents in
10 hospital in, say, Bathurst, with a broken pinky, and has
11 their initial treatment delivered there --
12 A. Yes.
13
14 Q. -- when they then re-present at, say, Royal Prince
15 Alfred Hospital or Children's Hospital Westmead, wherever
16 it might most convenient to them, someone can bash away at
17 a computer and get all of the records that they need to
18 enable that care to pick up where it was left off in
19 Bathurst?
20 A. Exactly.
21
22 Q. Are you aware that the particular platform, that no
23 doubt after many meetings and much consideration, eHealth
24 and the ministry has decided to proceed with, is a platform
25 described as the "Epic platform"?
26 A. Yes, yes.
27
28 Q. To the extent that St Vincent's Sydney has proposed
29 joining the digital revolution, is it proposed that
30 St Vincent's Sydney would use the same platform as has been
31 chosen by the ministry or a different one?
32 A. The same platform.
33
34 Q. So the current proposal, at least, is that
35 St Vincent's Sydney would wish to have the Epic platform
36 rolled out within its public hospital in exactly the same
37 way as it is rolled out in every other - or hoped to be
38 rolled out by 2029, in every other public hospital across
39 New South Wales?
40 A. Correct, correct. And that goes to the point around
41 our integration with the system and the way we connect with
42 our peers across the system and also to your point around
43 seamless patient care and connectivity. I mean, the vast
44 majority of our patients obviously, you know, to the extent
45 that they need to seek health care in another facility,
46 will move around the New South Wales public health system,
47 so it makes perfect sense for us to be digitally integrated

1 with the New South Wales health system.
2
3 Q. Some of the earlier applications for capital funding
4 surrounding the development of an electronic medical
5 record, as I understood them at least, proposed that
6 St Vincent's would utilise a different platform, likely
7 MEDITECH?
8 A. Yes.
9
10 Q. It's before your time, but is it your understanding
11 that, at least at an earlier point, there was consideration
12 being given by St Vincent's to using a different platform
13 to that which was being used or intended to be used by
14 eHealth and the ministry for the rolling out of its single
15 digital patient record?
16 A. Yes, and as you say, it was before my time, so
17 I certainly wasn't involved in those discussions. What -
18 my understanding, you know, extends to what's in the
19 documentation as well, but it's certainly the current view
20 of St Vincent's Sydney and also St Vincent's Health
21 Australia and the board, that it is our strong preference
22 to join the single digital patient record and the Epic
23 platform.
24
25 Q. Review of the documents reveals that earlier attempts
26 to secure capital funding for the development of an
27 electronic medical record possibly based on a different
28 platform were, in any event, unsuccessful?
29 A. Yes.
30
31 Q. As matters currently stand, what is the status of
32 discussions that you've had with ministry or eHealth around
33 St Vincent's being rolled in to the rollout of the single
34 digital patient record platform built on the Epic system?
35 A. So we've had several discussions, as I articulated.
36 The ministry are very supportive of us joining the single
37 digital patient record and to that end we've been certainly
38 involved in some of the preliminary planning activities
39 even though we're not formally part of the program at this
40 stage. So there's very strong in-principle support for us
41 to join. We haven't resolved the funding strategy and we
42 are in active discussions at the moment with NSW Health
43 about receiving a funding allocation to join the SDPR.
44
45 Q. At a conceptual level is there any reason that you can
46 see why at least the public side of St Vincent's Hospital
47 should not be funded to receive a single digital patient

1 record in exactly the same way as any other public hospital
2 delivering care to public patients within New South Wales
3 is?
4 A. Yes, well, as you said, I mean, to the extent that we
5 deliver public health services for the benefit of the
6 New South Wales community, which we certainly do, I think
7 it's fair and reasonable that there's a funding allocation
8 made to support us to integrate into that program and
9 continue to deliver that level of service in a contemporary
10 fashion to the community.
11
12 Q. To the extent that that funding was not forthcoming,
13 does St Vincent's (a) have the financial capacity to build
14 its own version of the Epic platform to plug in to the
15 single digital patient record?
16 A. No.
17
18 Q. Building on that, does St Vincent's have at its
19 ready disposal the technological depth and capacity to
20 build a mirror of the Epic single digital patient record
21 system such that if you did have the money to do it,
22 you could seamlessly plug it into whatever the ministry
23 might be building on the other side of that wall between
24 St Vincent's and the rest of the public health system?
25 A. The technical elements of that question are somewhat
26 beyond my level of expertise.
27
28 Q. I won't press it with you.
29 A. But from an operational perspective, I guess
30 theoretically, without understanding the technical
31 requirements, that may be possible. I still think that it
32 would be in our interests, and indeed in the state's
33 interests, for us to join the broader statewide rollout,
34 simply because they are amassing a critical mass of
35 expertise, resourcing and focus around the rollout and
36 I think it would make sense from an efficiency and an
37 effectiveness perspective for us to be part of that program
38 rather than us to do it ourselves, to the extent that
39 that's even technically possible.
40
41 Q. From the perspective of the patient, say, who might
42 have come and had a heart and lung transplant in
43 St Vincent's Hospital and then after a period of recovery
44 returned to their home in, say, Wagga, if they presented
45 with chest pains at Wagga hospital, the absence of a proper
46 integration of St Vincent's within the single digital
47 patient record would, at a practical sense, mean that the

1 clinicians dealing with that patient's care at Wagga would
2 not have ready and immediate access to all of that no doubt
3 important health information around the procedure and its
4 sequelae which had been delivered through St Vincent's
5 hospital. Am I right or is that overly simplistic?
6 A. No, that's correct. I think that would indeed be
7 a limitation.
8
9 MR MUSTON: I have no further questions for this witness.
10
11 THE COMMISSIONER: Thank you. Do you have any questions,
12 and if you do have some, do you have many, Mr Chiu?
13
14 MR CHIU: I have some questions but no more than a few
15 minutes.
16
17 THE COMMISSIONER: No more than a few minutes? It is
18 probably convenient to the witness, then, that we keep
19 going.
20
21 **<EXAMINATION BY MR CHIU**:
22
23 MR CHIU: Q. Ms McFadgen, I represent NSW Health in this
24 Inquiry. I want to take you back to your earlier evidence
25 about the pilot in Victoria that you talked about. Was
26 that a pilot that operated within St Vincent's Melbourne
27 hospital only?
28 A. No, it was a pilot that was operated across a number
29 of different health services and coordinated centrally by
30 the Victorian Department of Health. So St Vincent's
31 Melbourne was one of the pilot sites but not the only pilot
32 site.
33
34 Q. Earlier you said that it was designed - that there was
35 a funding model designed to incentivise preventative care.
36 Could you explain how that worked?
37 A. So what happened was the pilot sites were given
38 a block of funding, but as I said, there was a shadow
39 model, given that it was a pilot arrangement, and then
40 there were several care pathways that were piloted around
41 what I broadly call substitution and diversion models - so,
42 for example, the Virtual ED, which you may have heard
43 about, was one of the pilot models of care that came out of
44 that "Better at Home" program, and that was initiated by
45 Northern Health, which is a health service within Victoria,
46 but St Vincent's Melbourne was one of the collaborators on
47 that particular initiative.

1
2 So the health services were provided a block of
3 funding on a fixed-term basis to pilot a model such as the
4 Virtual ED, prove the concept, make sure that it was
5 obviously safe, effective, cost-effective, et cetera - and
6 in fact the Virtual ED is a model that is still going and
7 is growing at the moment in Victoria, but there were other
8 models also that were looked at as part of that pilot
9 program.
10
11 THE COMMISSIONER: Q. Sorry to interrupt, what year was
12 this pilot program, to the best you can do? We can find
13 out, but --
14 A. Okay, this is really testing my memory. Twenty - it
15 was just pre-COVID, actually. So 2018/19, at a guess.
16 Please don't hold me to that.
17
18 MR CHIU: Q. So besides block funding the initiation of
19 a model of care, did the pilot then look at the ongoing
20 funding of that model of care once it had been instituted?
21 A. Yes, and that was part of the - so there was a formal
22 evaluation as part of the pilot that was obviously
23 initiated at the beginning in terms of setting the
24 parameters of what that evaluation might look like, and
25 a sustainable funding model was absolutely one of those.
26
27 It's fair to say the assumption that was made - and as
28 I said, I left before the evaluation process was concluded,
29 but it's fair to say the assumption that was made was that
30 the diversion and substitution models would be more
31 cost-effective than hospital, especially tertiary hospital
32 based care, which is probably some of the most expensive
33 health care that you can provide, and so that there would
34 be a funding redistribution ultimately, if those models
35 were proven to be effective, safe, et cetera, between -
36 away from tertiary hospital funding to those other models,
37 so that there would be no net increase in funding
38 requirements for the system.
39
40 Q. And to your knowledge - I appreciate you are not
41 involved directly in the evaluation - did the evaluation
42 test the shadow model versus the actual funding model and
43 reach any conclusions on that matter?
44 A. I must admit I don't - I don't recall, I'm sorry.
45
46 Q. Okay. Is there anyone within St Vincent's Health
47 Australia who might be the lead or the representative on

1 this pilot who might know the specific answers?
2 A. If the pilot is still under way - and as I said
3 before, now I recall, I think it possibly was interrupted
4 by the COVID pandemic response in Victoria - so to the
5 extent to which the pilot is still under way or has been
6 concluded or extended, yes, I would certainly be able to
7 provide some details as to who might be aware of what's
8 happened, yes.
9
10 MR CHIU: Thank you very much. No further questions.
11
12 THE COMMISSIONER: Just before I ask Mr Jones, Mr Chiu,
13 just to help you, the letter at page 259 of the witness's
14 statement - do you have that? It is the letter from the
15 secretary of 28 February 2024.
16
17 MR CHIU: I do, with the deadline.
18
19 THE COMMISSIONER: Just to help you, I'm going to need a
20 more detailed response about the context of that letter,
21 and let me just give you my thinking.
22
23 MR CHIU: Yes.
24
25 THE COMMISSIONER: One of the things we have to do in this
26 Inquiry is look at, inquire into, how NSW Health funds
27 health services to, amongst other things, achieve optimal
28 health outcomes. St Vincent's, we know, is an AHO which
29 has its own obligations under the Act to provide - whatever
30 this means - adequate services for the services it
31 provides.
32
33 It's saying to the ministry, "We're in a $60 million
34 black hole. We'll put our hands up, we can make some
35 efficiency savings, but we're still left with this
36 deficit". And without making a finding today, obviously,
37 about 60 million, 24 million, 36 million or whatever,
38 having said that in detail to the ministry, the ministry
39 must appreciate there is either a real risk, or a risk of
40 some kind that is real, that they are underfunded, or there
41 is a certainty that they are. Prima facie, it doesn't seem
42 to me how a not-for-profit health organisation running
43 a public hospital can be adequately delivering services and
44 fulfilling its own obligations under the Act if it's not
45 funded to do that, and on its face, the letter of
46 28 February 2024, without saying anything inflammatory on
47 its own, is, I think currently, sitting here, an inadequate

1 response to all of those issues I just raised.
2
3 Now, there may be a much bigger story here and more
4 context that your client can provide, but I think it's
5 going to need to.
6
7 MR CHIU: Yes.
8
9 THE COMMISSIONER: And the sooner the better. And by
10 saying "sooner the better", I don't mean tomorrow and I'm
11 not fixing a date, but the sooner the better, because this
12 isn't the first time we've had an organisation saying
13 "We're doing the best we can but we don't have enough
14 funding", and others have said, "We have to rely on
15 philanthropy to do it". But I'm going to need a fuller
16 story - and there may well be one, and I'm assuming there
17 actually is - but I'm going to have to hear it at an
18 evidentiary level.
19
20 And I will just finish with this: please don't think
21 that I am approaching this, or anyone on the Inquiry is
22 approaching this, in relation to the funding the ministry
23 provides, on the basis that the secretary, the ministry,
24 the LHDs grow their own money. They get their money from
25 treasury, and no doubt, at a matter of certainty, someone
26 from treasury will, at an appropriate time in this Inquiry,
27 be required to come along and explain what they do in terms
28 of funding to ensure that statutory obligations are met.
29
30 But does that help you?
31
32 MR CHIU: It does, Commissioner. Indeed, part of the
33 explanation might be that process of how the request is
34 then passed on to treasury.
35
36 There were a number of --
37
38 THE COMMISSIONER: And I'm conscious there are other
39 meetings we haven't had detail on, but we will need to hear
40 that from your client at an evidentiary level, not
41 forgetting that we know where the money ultimately comes
42 from.
43
44 MR CHIU: Commissioner, there were a number of ministry
45 witnesses who originally were on for this block. They
46 weren't required.
47

1 THE COMMISSIONER: Sure.
2
3 MR CHIU: But what I will do is I will obtain
4 supplementary statements from them to make sure that covers
5 these issues.
6
7 THE COMMISSIONER: That can all be worked out with
8 Mr Muston and the team.
9
10 MR CHIU: Of course and they will be done as quickly as
11 possible.
12
13 THE COMMISSIONER: Thank you.
14
15 Is there anything you wanted to ask, Mr Jones?
16
17 MR JONES: No, Commissioner, thank you.
18
19 THE COMMISSIONER: Thank you very much for your time.
20 We're very grateful. You are excused for now.
21
22 THE WITNESS: Thank you.
23
24 THE COMMISSIONER: All right. I didn't mean that to
25 frighten you. It might be that you are permanently
26 excused.
27
28 **<THE WITNESS WITHDREW**
29
30 THE COMMISSIONER: That's it for today?
31
32 MR MUSTON: Yes.
33
34 THE COMMISSIONER: So 10 o'clock tomorrow?
35
36 MR MUSTON: Yes.
37
38 THE COMMISSIONER: All right. We'll adjourn until
39 10 o'clock tomorrow.
40
41 **AT 1.09PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
42 **TO FRIDAY, 14 JUNE 2024 AT 10AM**
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