Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 19 November 2024 at 10.00am

(Day 062)

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 SC with Ms Joanna Davidson for NSW Health

THE COMMISSIONER: Good morning, Mr Muston.

MR MUSTON: Good morning. We've got a large panel of --

THE COMMISSIONER: I can see.

MR MUSTON: -- chief executives or predominantly chief executives this morning. Sitting I think from your left to right is Jude Constable, the acting chief executive of Central Coast LHD; Margot Mains, the chief executive of Illawarra Shoalhaven LHD; Peter Collins, the board chair of Nepean Blue Mountains LHD; Lee Gregory, the acting chief executive of Nepean Blue Mountains LHD; Tobi Wilson, the chief executive of South East Sydney LHD; Dominic Morgan, the chief executive of New South Wales Ambulance - did look up to make sure that my list matches up with who's there - Cathryn Cox, the chief executive of the Sydney Children's Hospitals Network; and Wendy Hoey, the acting chief executive of Justice Health.

THE COMMISSIONER: Any more and we would run out of room, I think.

MR MUSTON: That's true.

THE COMMISSIONER: So, yes, good luck.

MR MUSTON: And I have a list that tells me that Jude Constable, Dominic Morgan, Cathryn Cox and Wendy Hoey will take an affirmation and the balance will take an oath.

<JUDE CONSTABLE, affirmed [10.01 am]

<DOMINIC MORGAN, affirmed

<CATHRYN COX, affirmed

<WENDY HOEY, affirmed

<MARGOT MAINS, sworn

<PETER COLLINS, sworn

<LEE GREGORY, sworn

<TOBI WILSON, sworn

<EXAMINATION BY MR MUSTON:

THE COMMISSIONER: I think we know who everyone is. Do you need to go through --

MR MUSTON: The only reason I was going to ask each of them to give us their name is for the benefit of the people who are transcribing it today, who are offsite, just to make sure that they know who's --

THE COMMISSIONER: All right. As usual, it's better I don't interfere. So you go ahead and do it your way.

MR MUSTON: I was going to do it in a short-circuited way. Could I ask each of you, going along the table, just to state your name for the record so the people who are transcribing this remotely today can recognise your voice and make sure they know who's talking when you're speaking.

MS CONSTABLE: Jude Constable.

MS MAINS: Margot Mains.

MR COLLINS: Peter Collins,

MR GREGORY: Lee Gregory.

MR WILSON: Tobi Wilson.

DR MORGAN: Dominic Morgan.

MS COX: Cathryn Cox.

MS HOEY: Wendy Hoey.

MR MUSTON: Can I quickly start with you, Wendy. A number of you have prepared statements, which have been tendered previously in the Inquiry, and you've each adopted them. Wendy, I think - I should say Ms Hoey, you've prepared a --

THE COMMISSIONER: One more "Wendy" and I was going to say something.

MR MUSTON: We're very relaxed and friendly down here. It's an exchange of ideas. You've prepared a statement dated 13 November 2024 to assist the Inquiry. It's your

most recent statement; is that correct?

MS HOEY: Yes.

MR MUSTON: Have you had an opportunity to review that this morning before giving your evidence?

MS HOEY: Yes.

MR MUSTON: You're satisfied that its contents are to the best of your knowledge true and correct?

MS HOEY: I have one change, which I think we probably informed you of.

MR MUSTON: Yes, sorry. I also have that. That is paragraph 55?

MS HOEY: Yes. Yes.

MR MUSTON: Just tell us what the correction that you wish to make to paragraph 55 is.

MS HOEY: Where it says that the delivered cost saving has been delivered primarily to Justice Health New South Wales, that's actually to the justice sector.

THE COMMISSIONER: Sorry, I've just missed that. What line are we looking at?

MS HOEY: It's on page 13 of - paragraph 55, just at the end there, Commissioner.

THE COMMISSIONER: Right. Okay. Thank you.

MR MUSTON: I might start, Ms Hoey, just by asking you some questions about Justice Health.

MS HOEY: Sure.

MR MUSTON: Could you, just in broad outline, explain to us the services that are provided by Justice Health to the New South Wales prison population?

MS HOEY: Yes. So we're Justice Health and Forensic Mental Health Network, and we've got sort of two arms of our services. So there's the forensic mental health

system, which we'll park just now and think about the custodial system. So there's over a hundred locations but 37 I think just now custodial centres and seven youth justice centres, and we provide primary care, mental health care, population health and public health, drug and alcohol services, and a range of other primary care services to the inmates across New South Wales.

MR MUSTON: And I think you tell us in your statement that adds up to approximately 13,000 patients?

MS HOEY: Yes, the population of adult centres is roughly about - sits around 13,000 - it can go up and down by a thousand or two every so often - and I think just now there's about 220 in youth detention centres.

MR MUSTON: So that's the prison population. What about forensic mental health?

MS HOEY: Yes. The forensic mental health, so that prison population we would also do custodial mental health to there, which is almost like a general mental health service within a forensic setting. Then we have - within our control in our budget is a 135-bed high secure forensic hospital at Malabar and also our primary care - our primary court diversion centre - service both for adults and for youth, also our community forensic mental health service, which provides advice, risk assessment to all the LHDs across New South Wales, and also have a sort of relationship responsibility to all the medium secures and low secures across the state and also all the forensic patients that are within LHDs, which - where the majority of forensic mental health patients are.

MR MUSTON: In terms of the forensic patients, when we had our trip out to the forensic hospital you were describing to us issues of bed block which affect the forensic hospital in much the same way as they affect - or we've been told they affect hospitals around the state. Could you just explain to us the way in which bed block operates in the context of the forensic hospital?

MS HOEY: So if somebody comes before the court and is given defence under the Mental Health and Cognitive Impairment Forensic Provisions Act, so they would be detained in - or the MHRT, the Mental Health Review Tribunal, would detain them, so that could be to a forensic

mental health high secure hospital, medium secure, low secure. They can also detain within the prison setting as well, and unfortunately we have 27 forensic patients in our prison setting just now awaiting health beds, not under a custodial order but under a health order, and that's because within our high secure forensic mental health setting we have patients waiting for medium secure, and as well in medium secure, which is from where the LHDs, they have patients awaiting to get out and to do that rehabilitation. So they're just general bed block across the system.

MR MUSTON: So in a practical sense that means if you're not able to move patients through the high secure setting when they are theoretically ready to be transitioned into a medium secure and then to a lower secure setting from within the forensic hospital, bed block means a mental health patient or a patient who enters the justice system through the mental health track will end up in a prison setting unless and until such time as a vacancy becomes available or a bed becomes available in a mental health hospital?

MS HOEY: Correct. And, if you look at our sort of policy of least restriction, it's hard to uphold that when people are being held in prison when they should be in high secure, and in high secure when they should be in medium through. So falling through.

MR MUSTON: It would seem logical - and perhaps it's more a question for your psychiatrist colleagues, but the consequences in terms of the progress of one's mental illness of being sent into a prison rather than placed into a mental health facility would seem to be negative; would that be a fair assumption?

MS HOEY: Yes, I think we would all agree that the best place to be cared for for a health presentation or for health rehabilitation is in a health environment.

MR MUSTON: What are some of the challenges that you face in transitioning patients out of that high secure mental health setting into a medium secure setting at a time when they are perhaps ready to move medically?

MS HOEY: I think generally there's lack of beds and bed movement, but also moving from a high secure to a medium

secure, these patients that we're managing have got quite high risk factors and that's always - you know, moving them down to a lower acuity is a big decision to make, and sometimes if there's not the resources to be able to adequately manage that risk or the perceived risk that people are presenting it can be difficult to get them through. It's also the fact that we have civil patients who have, you know, been very difficult to manage and they've sometimes harmed people within general mental health services that we would take into our high secure, and stepping those people back down into the environments is hard because people are often - they've had really bad experiences or people have been hurt and that makes it even more challenging, I think.

MR MUSTON: Stepping them transitionally through high security to medium security within the setting of the forensic hospital is something presumably you're able to do as soon as you're able to move people out at the bottom, as it were?

MS HOEY: Yes.

MR MUSTON: And what about moving patients from a forensic hospital into forensic settings or mental health settings within the LHDs? Where that's possible, how does that work?

MS HOEY: All the medium secures are run by the LHDs. So if we are moving anybody out of our high secure hospital they're always going into an LHD environment, so they're going out with our clinical governance into an LHD's unit. So it's a change of treating team, change of psychiatry going through there.

MR MUSTON: Are there any particular barriers that you have experienced in transitioning patients from the high secure setting at the forensic hospital out into wards within the LHDs?

MS HOEY: We would generally from high secure go into a medium secure. We wouldn't generally be moving from - apart from our civil patients, from a high secure into a general ward within an LHD. But it's the same, I think, it's access to beds, access to expertise, and the risk that sometimes our patients carry can be quite daunting.

MR MUSTON: You said that the medium secure facilities are run by the LHDs.

MS HOEY: Yes.

MR MUSTON: Do you think there might be some advantage to Justice Health, albeit in a different setting, having perhaps a greater involvement in the operation of medium secure facilities across the state?

MS HOEY: Yes, we have developed a new forensic mental health strategy and policy, which gives a little bit more strength to our New South Wales clinical director for forensic psychiatry, and also through the SWMHIP program. So there's been investment in builds. We have been - Justice Health has been given beds within that. So we'll be trialing that soon to see if it does help for Justice Health to have that governance over the patient journey, if you like, and I suppose be the ones to make the decisions about where people are going after the forensic hospital.

MR MUSTON: So, in addition to the decision-making power potentially resting with Justice Health, there's also presumably going to be a funding consequence. Would it be right that under that arrangement the staffing of those facilities would come out of Justice Health's budget rather than out of the budget of the LHDs?

MS HOEY: Yes. So the unit that we've been allocated through the SWMHIP program, we'll have the operational budget for that when it comes, when it's built, and we get the operational budget for that. Yes, that will come into Justice Health's control.

MR MUSTON: You mentioned a moment ago diversion programs that are run by Justice Health. Could you just explain to us what those programs are in a nutshell?

MS HOEY: Yes. So we have adult and youth, so - diversion programs, which is we work within the local courts where people who have non-indictable offences we can divert to mental health services, and with the adults we've been lucky enough to secure funding and we're rolling out over a three-year program to be in every court in New South Wales, and we're getting some really, really good outcomes from that, particularly in the regional areas, where there's a high level of Aboriginal diversions occurring. And then

with the youth courts, unfortunately we're only in 10 per cent of the youth courts, but the courts that we are in we've got really good outcomes with diverting kids from the criminal justice system into mental health care.

MR MUSTON: When you say "good outcomes", obviously transferring someone who's got a mental health problem into a mental health setting is probably a good outcome in and of itself. But, in terms of broader outcomes of that, do you have any measured outcomes in terms of recidivism and a re-presentation within the justice system?

MS HOEY: Yes, we do. I don't have the figures for recidivism here, but there's been a number of research papers published around the efficacy of the adult - more than the kids - the adult program. But I think probably one of our better pieces of work was the cost-benefit analysis around adult court diversion, where I think it was every dollar spent we get $4 back to the government around the reducing of custodial. I mean, anybody going into custody or into the criminal justice system, it's criminogenic in itself and certainly is not helpful from a health perspective. So reducing the costs for custodial care, reducing the costs to society longer term, reducing recidivism, so reducing crime. So I think we do a good job, and the benefit's across government, it's not all to health, and then obviously there's a longer term reduction to the health burden as we get them into health care earlier and all their associated comorbidities as well as mental health associated with that.

MR MUSTON: So the diversion program not only potentially diverts individuals on a longer term out of the criminal justice system but also perhaps provides an interventional opportunity to deal with some of the social determinants of health which might be sending them down a spiral?

MS HOEY: Definitely. Yes. We know that the social determinants of justice are the same as the social determinants of health. So if we can address them then there's a double win, I suppose, yes.

MR MUSTON: Whilst you don't have the figures at a headline level, I gather from what you've told us of levels recidivism and the like, when assessed against those who have not been through programs like this are much --

MS HOEY: Much lower, much lower, yes. And I think - it's in my statement - there has been some Australian work done and published around the savings that could be achieved with more youth diversion, and I think it's in the level of billions from an Australian perspective. We've not necessarily done it specifically in New South Wales, but certainly from an Australian perspective.

MR MUSTON: In terms of the - you mentioned a moment ago the ability to intervene in people's health at a time when they're either diverted through the mental health system or, alternatively, when they are incarcerated. What are the potential benefits as you see it of intervening from a health perspective in these people's lives?

MS HOEY: Yes, often by the time somebody gets to us there's been a lot of - there's been a lot of trauma in their life, and if you look at what drives - what drives somebody into custody is often, you know, out-of-home care, housing, education. From a health perspective, we know that people coming into prison have had less health interventions, so general practitioner intervention, dental intervention. So there's much higher rates of chronic disease, there's much higher rates of drug and alcohol. So anything that we --

THE COMMISSIONER: I'm pretty sure I was told when we visited out to Malabar that 20 per cent of the prison population have what could be described as complex mental health issues.

MS HOEY: Yes.

THE COMMISSIONER: And it's often those - I was told those mental health issues is what is causing them to end up in prison in the first place; correct?

MS HOEY: Definitely as well, yes, yes.

THE COMMISSIONER: And what stuck in my mind is - I've forgotten who it was, but being told that prisons are becoming like asylums because it's the mental health issue that's driving many people to committing crimes, they end up in prison and then we don't have the resourcing to properly treat the condition that is actually causing them to offend and in many cases re-offend. Is that your memory of what I was told?

MS HOEY: That would be a really good summary of the psychiatrist's conversations with you, and I would agree with that. The demand for mental health care in prisons is relentless.

MR MUSTON: In terms of the mental health care and the demand for mental health care in prisons you have told us in paragraph 21 of your statement about the divide between psychiatric care on the one hand and psychological care on the other. I just wonder if you could explain how that actually operates and what you see the consequences of that as being for the prison population and the health outcomes for the prison population?

MS HOEY: Yes, it's a very strange split in the way things are managed, and I just know that ourselves and Corrective Services and Youth Justice are trying to work through this as best we can, but it is a tension point between our services where Justice Health has predominantly been funded for psychiatry and for nursing, and that's about prescribing and providing medication, and Corrective Services are funded for psychology, so psychological interventions across mental health and drug and alcohol, and behavioural management, and there's a little bit of a tension point there because Corrective Services provides psychological services within our criminogenic framework. So they commence that at sentencing. So then you've got all your remand folks who come in and out, and there's quite a trend of coming in and out at the remand stage, who don't necessarily get that psychological intervention from a health perspective that we feel could really be beneficial for them.

MR MUSTON: So, just unpacking that, the concept of psychological care being delivered through a criminogenic lens, that is psychologists who are retained principally through Justice to try and prevent people from committing a crime when they leave?

MS HOEY: Correct, yes, yes.

MR MUSTON: As opposed to - and not suggesting that there may not be some overlap, but as opposed to providing psychological care with the objective of treating the mental illness - a mental illness that a patient might have?

MS HOEY: Yes, or dealing with holistically that person's psychological presentation or trauma. And it's not to say that Corrective Services psychologists don't do mental health. They do, but it's just from a different lens, and I think particularly in the remand environment, where people are going back out into health services, that that continuity of care would be better if it's provided by Health.

MR MUSTON: And so the consequence of the timing of the delivery of this psychological care means people who are in remand sometimes potentially for quite a lengthy period of time awaiting sentence will not receive psychological care within a prison setting?

MS HOEY: Correct, yes. They do certainly for behavioural disturbance where it's a security issue within the prison.

MR MUSTON: So to the extent that a prisoner might be demonstrating some behaviour - a prisoner on remand might be demonstrating some behavioural problems --

MS HOEY: Yes.

MR MUSTON: -- which are posing a threat to other prisoners or --

MS HOEY: Or themselves.

MR MUSTON: -- making it difficult to deal with them --

MS HOEY: Or themselves.

MR MUSTON: -- they might receive some psychological care?

MS HOEY: Yes, yes.

MR MUSTON: Is there any interface between the psychiatric care that's delivered through Justice Health on the one hand and the psychological care, that is to say are there multidisciplinary team meetings and the like that happen between the psychologists or the psychiatrists with respect to the care of a particular patient?

MS HOEY: Yes, definitely. We do have MDTs, and the psychology and the officers and everybody's involved in

that as much as we can. However, there is always a barrier around the sharing of health information across the divide of Health and Corrections or Health and Justice, and that's really the medical legal and the responsibility of Health to keep that information private and for what it's been provided for, which is for health purposes, and the role of the reporter as a psychologist working for Corrections and the treatment - therapeutic treatment from Health. So there's always - there's always been issues. We're trying to work through it as best we can. We definitely share risk and we do share patients and we do share treatment plans, particularly for those most disturbed within the system.

MR MUSTON: But just to unpack that a little bit in terms of the information barrier, information which is provided to psychologists in the context of a program delivered for criminogenic purposes is available for use in decision making around the way in which a prisoner might be - or an inmate might be moved from one prison to another, classified as high risk or low risk --

MS HOEY: Yes, self-placement, yes, yes.

MR MUSTON: Whereas information provided to medical professionals who deliver care through Justice Health is subject to the usual doctor/patient or clinician/patient confidentiality such that --

MS HOEY: Yes, yes, but we do have - I mean, we've got processes in place, a Health notification where we can tell Corrective Services what we think needs to be done from a risk mitigation perspective around self-placement or medical holds perhaps to a metropolitan area if we believe they need to be nearer one of the tertiary hospitals that we share with.

MR MUSTON: Does the fact that information provided to psychologists who are delivering these criminogenic programs is able to be used for that wider range of purposes compromise the extent to which those programs can deliver good psychological care from a mental health point of view rather than a purely criminogenic point of view, do you think?

MS HOEY: They're different - you know, they're different aims and so - I mean, Corrective Services - I don't want to

comment on their program, but they value what they're doing, and from their perspective whether they're working or not they can comment on. I'm not going to comment on that. It's about recidivism. But certainly we have evidence-based health programs that we believe would be helpful.

MR MUSTON: In addition to the mental health work there's obviously a range, as you've told us, of other primary care which is delivered to inmates within the prison system?

MS HOEY: Yes.

MR MUSTON: That includes in a number of cases providing anti-psychotic medication and the like to prisoners?

MS HOEY: For mental health, yes. Yes.

MR MUSTON: Which results in a large number of prisoners or a larger number of prisoners perhaps than in the wider society suffering from metabolic disease?

MS HOEY: Yes, we know that mental health in its own but also combined with medication there's an increased risk of metabolic disorder, so, you know, obesity and diabetes, everything that goes with it.

THE COMMISSIONER: My note was - which I want to check - is 95 per cent of the prison population have metabolic disorder or disease; is that --

MS HOEY: Ninety-five per cent probably of mental health, I would think, yes.

MR MUSTON: Meaning that a large proportion of the prison population suffers from metabolic disease of some type?

MS HOEY: Yes, yes, and a high level of chronic disease particularly within the Aboriginal cohorts that we manage, which is 32 per cent of prison.

MR MUSTON: In terms of metabolic disease and other co-morbidities, it's not just the delivery of primary health care which is important in terms of trying to keep these patients well and reducing long term their morbidity?

MS HOEY: Correct, yes.

MR MUSTON: Also --

MS HOEY: Prevention, health - health literacy, prevention and health promotion.

MR MUSTON: Diet?

MS HOEY: Yes, diet definitely. We saw examples of that in Long Bay.

MR MUSTON: That's what I was going to ask you about. In essence you have a captive audience when it comes to the delivery of a good diet. Is that something which Justice Health is involved in from a dietetics point of view, or is it something that's dealt with by Justice?

MS HOEY: Yes, it's got to be dealt with by both of us because Corrections provide the food, or Justice provides the food. We're providing the advice, if you like. So we have developed our health --

THE COMMISSIONER: Your advice, I assume, doesn't extend to "it's a good idea to give the prisoners a loaf of white bread before they are locked down for the night"?

MS HOEY: No, that's not actually our advice. But we are working together with them to try and change some of the habits that are happening through our healthy prisons framework. So we're starting with what we would call buy-up, so that's the prison shop, if you like, and at least having healthy alternatives available.

THE COMMISSIONER: Your organisation is responsible for the health of the prison population, and did you say 13,000? You did?

MS HOEY: Yes.

THE COMMISSIONER: And not many of those people are what are called lifers?

MS HOEY: No.

THE COMMISSIONER: Some will die in prison simply because they might have committed a crime 30 years ago and they --

MS HOEY: Correct. The majority of people come --

THE COMMISSIONER: If you get a 20-year sentence when you're in your 70s, you're probably not leaving prison. But most people are getting out; correct?

MS HOEY: Correct, yes.

THE COMMISSIONER: And as a matter of logic when people are released from prison it would be better if, as far as possible, their mental health conditions have been addressed and they're healthy?

MS HOEY: Correct.

THE COMMISSIONER: Because it would be better if they're not becoming a burden on the public hospitals, is one thing?

MS HOEY: That's correct.

THE COMMISSIONER: And it would be better if they had the best possible chance to become economically active, productive members of society?

MS HOEY: Correct.

THE COMMISSIONER: So if you're in charge of health why wouldn't you be in charge of diet, given it's so related to health? Why is Corrections in charge of diet?

MS HOEY: I think we provide health care.

THE COMMISSIONER: Yes.

MS HOEY: To the prison population.

THE COMMISSIONER: Yes.

MS HOEY: Corrections have the broader responsibility to provide a roof over their head, a safe environment.

THE COMMISSIONER: Yes.

MS HOEY: Their food. So it's with Corrections.

THE COMMISSIONER: Does food make sense, though?

MS HOEY: Yes, because Corrective Services --

THE COMMISSIONER: It depends what it is, I suppose, doesn't it?

MS HOEY: Yes. Yes, that's right, Corrective Services. I think we have a responsibility from a health perspective to work with Corrections to ensure that we're advising and promoting healthy environments, and that's what we're doing. I mean, they're linking in well --

THE COMMISSIONER: Would your advice in relation to the diet that prisoners have be different to the diet that's actually provided to them?

MS HOEY: Yes. Yes.

THE COMMISSIONER: In the sense that it would be --

MS HOEY: Wouldn't be white bread.

THE COMMISSIONER: It would be a healthier diet?

MS HOEY: Definitely a healthier diet.

THE COMMISSIONER: In the way we understood a good, healthy --

MS HOEY: Correct.

THE COMMISSIONER: -- balanced diet to maintain a good levels of weight instead of obesity?

MS HOEY: Yes, and exercise as well. You know, the fundamentals of good health is what we'd be trying to push through our healthy prisons framework.

MR MUSTON: You tell us in your statement of the proportion of inmates who are First Nations people and you mentioned it a moment ago. From that truly bleak statistic on one view there emerges an opportunity to do some potentially valuable work when it comes to closing the gap in --

MS HOEY: Yes, I think fundamentally we have to say that people in prison and the overrepresentation of Aboriginal

people is something that we need to address as a state and as a country, and it's increasing. I think the fact that people are in prison is an opportunity to intervene, but shouldn't be the opportunity to intervene, and I think, conversely, prison is not a healthy environment, so although as the Commissioner's pointed out with the food that's provided and exercise and the impacts on mental health - so, while we're trying to improve somebody's mental health, prison impacts on somebody's mental health, and while we're trying to improve health literacy for people then the opportunities to practise that health literacy and practise that empowerment with the prisoners is not there. So it's sort of a double-edged sword. But, yes, we do want to be able to intervene as much as we can while somebody's in prison, although I'd prefer to be doing it in the community for them.

MR MUSTON: Which brings me to my next question. When one looks to the statistics that you give us in relation to the percentage of the youth prison population who are First Nations people, that is even bleaker. That, on one view, points to a real potential value in accelerating these diversion programs within the youth setting that you've mentioned?

MS HOEY: Yes, definitely. I think the diversion - and we've seen by the experience of the expansion of the adult into regional areas, so we've increased the number of Aboriginal people who have been diverted because there's a higher percentage in the regions, and within the children's courts the regions were not in yet. So extending out to those regional environments I think would be really good. The thing with the youth is that they cycle through very, very quickly, so it doesn't really give us the opportunity to really assess and do something before they're out again. So, yes, that's a - there's an opportunity of following up into the community as well, I think.

MR MUSTON: When you say "cycle through quickly", how quickly is quickly? Are we talking about hours, days or --

MS HOEY: It could be 24, 48 hours. So, yes - I haven't got the figures with me. Dr Haysom was talking to me last week about it, but there's a lot - the majority of youth are in for a very short period of time.

MR MUSTON: So that's on remand effectively?

MS HOEY: Yes. Yes, yes, and, you know, they've not had a - they've had police bail refused and they've come in, been brought into the centre, and then court, and then out on bail very, very quickly.

MR MUSTON: And so in order to - I gather from the evidence you gave a moment ago, in order for these diversion programs to work well, ideally you need to have a period of time with the individual to actually work out exactly what their needs are and how best to divert them?

MS HOEY: There's two parts of that, is we need clinicians in the court. We know that it works best when we're in the court working with the magistrate and giving the magistrate options and treatment plans and assessing. It's hard for a magistrate to decide if somebody needs a diversion. It's much more efficacious if we are there doing that. So being in the courts is really important.

THE COMMISSIONER: They don't know it's available or they don't know what to do unless you've got that advice?

MS HOEY: That's right, yes, and, you know, our youth clinicians - our psychiatrists and our clinicians are really expert at this, and that's what the - magistrates are not expert at that, and we have much more success of people being accepted by the mental health service if they're deferred by us because that communication and that assessment is I suppose a little bit about professional trust as well. So there's the stopping them coming in in the first place; that's where we'd like to be. But, once they're in, that's where it's hard to actually do anything because they rattle through quite quickly and back out again before we've managed to do release planning or got them linked into care or whatever. So it's a very - the youth justice environment is very complex.

MR MUSTON: In terms of that transition from the short period of time when you have access to these individuals and when they are released, is there more that could be done or is there more that could be done with greater resources in terms of transitioning these individuals into community-based forms of care that might be available?

MS HOEY: Yes, we've spoken a lot about what we can do, and we work very closely with Youth Justice and trying to,

you know, pivot in what we're doing. I think some of our concerns are around people coming in with undiagnosed developmental disorders or neurodivergent presentations where it's been missed until they've actually come into the centre. So that takes a bit to assess and to work out and to go through, so - and then referring them on to community services for that is quite difficult to get them in. They're complex kids that take a lot of work, so that can be quite difficult.

MR MUSTON: Similar issues arise in relation to the adult prison population or the longer-term prison population, including those who are in the forensic hospital, when it comes to discharging from prison, a prison health environment, into a community-based health environment?

MS HOEY: Yes, it's an area that we've probably got a bit of laser focus on just now, and that interaction between the custodial services and the primary care services is hard. We can't often get a - we have some measures that we do to make sure that anybody with chronic - I think it's more than two chronic diseases and all Aboriginal people that we're seeing are linked into a GP within seven days. That's hard to do. It's hard to get an appointment with a GP within seven days. So getting them linked and getting accepted by community is very, very difficult.

MR MUSTON: We've heard a lot of evidence in our travels about the thin and failing GP or primary care markets particularly within the regions. That presumably contributes to the challenges that you have in linking up inmates who are being discharged with a primary care - moving to a primary care setting?

MS HOEY: Definitely. It (indistinct) is that getting GPs to actually work for us because there's not a lot of GPs around and then linking in. We have had some success recently with partnering with Aboriginal medical services so that their GPs are working within their service and then into the prison, and it gives a really good transition for a lot of the Aboriginal folks that are - that we're releasing into the community. But it is definitely a challenge.

MR MUSTON: You're all here to ask you about funding, so I might start again with you just to touch on some of the funding issues that you've addressed in your statement.

MS HOEY: Thank you.

MR MUSTON: Justice Health is block funded?

MS HOEY: Apart from the forensic hospital, which is block ABF funded, but the rest is all block.

MR MUSTON: And there is - that block funding, I think you tell us, comes - well, has its origins in some historical base figure that was at some point in the past identified as the cost of delivering health care to the prison population of New South Wales?

MS HOEY: That's my holy grail. I'm not quite sure where it originated from, but it is what it is.

MR MUSTON: You might not - might not be Robinson Crusoe. But at some point in the past an assessment was made that there was a particular amount of money that was required to deliver health care to the prison population of New South Wales?

MS HOEY: Correct.

MR MUSTON: And at least during your time with the organisation has it been your observation that the base figure as at the updated base figure has added to a growth figure of some sort each year to increase the block year on year?

MS HOEY: Yes, yes, yes. So we get block, and then growth and the CPI.

MR MUSTON: In terms of what that base covers I assume that, much like the wider population within a prison health setting, there is almost no limit to the amount of money that you could spend on health and produce good outcomes; that is to say, even if with perfect efficiency every additional dollar that you spend on health will potentially produce a good health outcome?

MS HOEY: A benefit, I would say, and I just call it an uncapped demand.

MR MUSTON: Obviously we don't live in a Utopian world where we can continue to pour money into it until that

wonderful day when the demand is met, so decisions need to be made about exactly what within a budgetary envelope we're going to be spending money on?

MS HOEY: Correct, yes.

MR MUSTON: Within the prison population is it the case that the cost of delivering health care has continued to increase over the years, not only because of inflation and those usual things that make costs increase, but also because medicine's become more complex, the range of interventions that we have available to us are wider, people are living longer, et cetera?

MS HOEY: Yes, definitely, and our population is changing. So the prison population is aging, so we've got a lot more aged people within our prison population, which takes more help. We've got an increased Aboriginal population, which takes more help. We've also got higher expectations as well, I think, about the health care that we provide within prison. Our chronic disease management has increased, you know, the expectation of what we do is increasing, and certainly our interventions with drug and alcohol and the expectations of that and our management of and some, you know, aims about - you know, eliminating hep C, for example, has increased our requirement to do screening and treatment of that disease.

MR MUSTON: Just in relation to that, screening initiatives which might be introduced with a view to identifying hepatitis C in the hope that we can eliminate it within the population presumably also has the consequence particularly within your setting of increasing the cost of delivering health care because once something's found through a screening program you need to spend money dealing with it?

MS HOEY: That's correct, and we have - I think the figures are in here, but we have increased our treatment rate by an extraordinary amount in the last two to three years, yes.

MR MUSTON: Just diverting ever so slightly, other policy changes within the wider government policy changes like crackdowns on domestic violence and the like within the population, whilst necessary and appropriate, do have a knock-on effect, do they, for your organisation?

MS HOEY: Yes, it's one of the things that makes this job so interesting, is that we're not necessarily in control of our - definitely in control, but decisions by other parts of government really impact on us, and the discussions around bail, domestic violence has certainly impacted on our ability to keep up with the demand. Following the government changes, which, you know, we have to crack down on domestic violence, it's a good thing to do, the remand population increased by I think it was by a thousand in about six months, and the remand is new people coming in, so that takes more care. Unfortunately, the changes impacted most heavily in Aboriginal people, the Aboriginal female people. So our female population increased dramatically, which again increases the health care required, but also --

THE COMMISSIONER: Women are the fastest growing cohort, aren't they?

MS HOEY: Yes, and Aboriginal women at that, unfortunately.

THE COMMISSIONER: Yes.

MS HOEY: Yes. So the changes to the conversations around domestic violence and then the changes to the Bail Act resulted in an increased demand for us.

MR MUSTON: And similarly - so changes in the Bail Act result in the prison population growing because - or at least the remand prison population growing because individuals who might once have been on bail are not?

MS HOEY: Refused, yes, that's right. So I think it kind of shot up quite quickly. But it's steadied again, but it's not come back down again.

MR MUSTON: Has the range of factors that we've just walked through that have increased the cost and complexity and demand on the health services being delivered within the prison population been adequately met by the growth figure which has been applied to the historical base, whatever it - wherever it might have come from?

MS HOEY: I would say no, but just now we're really trying to have a look at that base funding and try and work out

what are we actually funded for, where's the cap, what are we funded for, and to do that is to properly understand the population that we're serving and their needs. We don't have a funding methodology per se. We don't have a way of understanding the models of care that we need in funding to go into those services, particularly coming out of COVID. There's been changes. It's been complex with an influx of funding and then pulling funding out. So we're working through that just now, and hopefully we'll be able to work or we will work very closely with the ministry to make sure that we get an understanding of the services that we can provide within the budget envelope.

THE COMMISSIONER: What I take from your answer there is that, whatever the historical funding has been based on, it hasn't been - there's not much evidence to suggest it's been based on service need?

MS HOEY: Correct.

THE COMMISSIONER: Yes.

MR MUSTON: Working out whether or not funding is adequate, to use that word, really depends largely on what it is that you're being asked to or needing to deliver through that funding envelope?

MS HOEY: Yes, yes. And, you know, in the last couple of years certainly we've worked really hard with the ministry to get some key performance indicators into our service agreement that actually reflects our demand as opposed to, you know, the incentive funding that we get and our base demand that we're not able to meet, we're not able to meet our wait list at this point in time, so --

MR MUSTON: Could you explain what those changes to the KPIs have been?

MS HOEY: So we had never reported on wait lists. So now we report on all our wait lists across all our domains, so primary care, mental health, and drug and alcohol, and categories 1s, 2s, and 3s, and really try to ensure that we can look at our demand and our matrix in a way that's able to be used by the system to acknowledge the demand that we're trying to meet, and then we can have the conversation about where is it that - where is that peak, you know, where are we efficient and we can't do any more with what

we've got, and what are we going to do with the gap.

MR MUSTON: And so is that to say, much like within the emergency setting that we've heard lots of evidence and read lots of documents about waiting times in emergency, you've sought to identify, as it were, triage categories within the prison population in terms of their need for primary care services, be it mental health, dentistry, GP care?

MS HOEY: Correct. Dentistry is a little bit different. We have changed that to wait list as well. We were previously - in our service agreement we were provided a DWAU to meet, and we met it every year, it was really good, but then we had another 2,000 people still waiting on our wait list that we didn't get to in time. So we changed that to wait list as well, and it's just I think to reflect and be transparent about the needs of the population that we're trying to serve and --

THE COMMISSIONER: Meeting the level of activity doesn't mean there's not a lot of people that aren't actually being seen in a timely fashion.

MS HOEY: Correct, yes, yes.

MR MUSTON: So if your level - just so I can understand it in lay terms, if you've been given a level which says you've got to treat 2,000 people for their dental problems each year and that's your KPI and you satisfy that KPI each year, then that might look good on the surface. But if there's actually 10,000 people who need to have dental treatment each year and the rest of them are not being treated then that actually is on one view an epic fail on the part of the health system which should be at least recognised?

MS HOEY: Definitely. It's in our service agreement as a wait list, and that demand is definitely in there now, and discussions with the ministry opens up that discussion to be able to have a look at what we do and what we don't do.

MR MUSTON: So part of that is identifying - using these KPIs to both identify demand for service and the extent to which that demand's not being met?

MS HOEY: Correct.

MR MUSTON: Within the existing funding envelope?

MS HOEY: Yes.

MR MUSTON: The second part of it you tell us about in your statement is an attempt, which has I gather proved challenging, to work out exactly what it costs to deliver or would cost to meet that demand?

MS HOEY: Yes, we're certainly going through that. So there's been a sort of staffing model used and - we call it the Shane model after our director of nursing who made it. But then when you look at it the model's made to fit what we've been given within our funding envelope, not actually what needs to be provided. So we're sort of taking a step back and trying to build what is the population, what's the need, what's the best model of care to provide that, and then how much money do we need to provide that so we can start to build it from the bottom. We've tried the last couple of years since I've been in the chief executive, but we just need to step back and start at the very beginning. I think we tried to start too high. We need to go back a step.

MR MUSTON: So, to put that in sort of fairly blunt terms, in effect what has historically happened is you've been given an envelope of money and your organisation has year on year done the best that it can do with that amount of money?

MS HOEY: They're good at doing that.

MR MUSTON: And the way in which the system operates and thinking around the way in which the system operates has perhaps historically been informed by that driver, namely what's the best that we can do for this amount of money, rather than, well, what is the actual need and to what extent does this amount of money enable us to meet that need and, if so, in what ways?

MS HOEY: Correct. So we've been working with a capped financial environment but not necessarily having a look at the need and the demand and what does that mean, and then that's where you make your decisions about what services you provide or not.

MR MUSTON: And so within the nicely confined environment that you have to deal with at least to the extent you're dealing with people within the prison population --

MS HOEY: The bubble.

MR MUSTON: -- the ideal approach is to say what is the total health needs of this population?

MS HOEY: Correct.

MR MUSTON: Let's accept that they are probably going to be greater than can ever be met by whatever budgetary envelope is available, regrettably, but that's life. To what extent or what services are required to meet all of those health needs? What's the patchwork of services that we could be providing to this population to meet all of those needs?

MS HOEY: Yes. Yes, it is, and what services do we provide to meet the population's needs, what services do we also need to provide to make sure that we're setting people up for success in the future as well. So I think it's really important to think about the sort of active services that we do to address diabetes, to address that, but also - and the preventative services that we have in place around health literacy, prevention, health promotion, and empowering people to take care of their own health, that's really important to us.

MR MUSTON: We then work out what it costs to provide each of those pieces of patchwork that sit across the table?

MS HOEY: Yes.

MR MUSTON: And difficult decisions need to be made about which ones we're going to - whatever the available budgetary envelope is, will be provided and which ones won't?

MS HOEY: That's right, and you need solid information to do that. Just now we don't have that. So we're working towards that, and then we'll have a look at what's - and that will be done from an economic perspective, what's the best inputs for - to get the best output from the population that we serve.

MR MUSTON: And those decisions will involve at a local level a prioritisation of what those who work on the ground, as it were, within the Justice Health system think both economically and in terms of the health outcomes produced would be - are things that we should be spending our money on and which things fall off the table, as it were?

MS HOEY: Yes, and I think that comes down to we've got a really solid strategic plan for the next 10 years but our clinical services plan is the one that will inform us about what services are a priority or not, and obviously in collaboration with the ministry we would sit down, you know, and, "This is probably next year or the year after, and this is what we've got, this is what we can provide," and have that negotiation.

MR MUSTON: And ideally that probably becomes something more like a five-year, 10-year plan that, whilst dynamic, gives you an ability to look forward as to what you should be providing as a service?

MS HOEY: Correct. Definitely. I think, you know, our strat plan's 10 years, we do it in two-year blocks, but our clinical service plan has been yearly. I think we need to do two to three years to make sure that we get some continuity going through.

MR MUSTON: And with that 10-year planning and the identification of which pieces of the patchwork within the existing funding environment you can provide and which pieces you can't you would have a greater ability, presumably, to go to government - well, to the ministry, and perhaps the ministry to government, to say, "Well, here is what we can provide. Here is what we have identified that we can't and won't provide within the current funding envelope. We think it's good, but if you want it you'll have to give us more money"?

MS HOEY: And that's - yes, you have pipeline and proposals in place to say, "To do this this is what we need."

MR MUSTON: But you need a little bit of planning and head space to do that?

MS HOEY: Definitely the planning. We don't have the

information to do that right now. It's really difficult.

MR MUSTON: And gathering that information is in part - involves, obviously, a targeted attempt to collect it but also involves a degree of financial and personnel headroom, as it were, to enable that task to actually be performed?

MS HOEY: Yes, definitely, and as well I think the clinicians give us information, but I think it's really important that we have an economics head on when we're doing it, not just a clinical head. So the clinicians inform us, but I think those decisions need to be done from a cost-benefit analysis as well, which is sometimes hard for the clinicians to do because they want to do it all, and quite rightly. They want to provide everything that their patient needs. That isn't always possible.

MR MUSTON: That might be a nice segue to - well, actually one last question to you. In terms of at the moment to the extent that you do have an assessment of what services you might be able to provide which are not currently being provided within the funding envelope, do they feature in discussions that you have around your service level agreement or the funding discussion that you have? I think it's characterised as a roadshow

MS HOEY: I think the ministry are quite aware of my concerns, and the way we're changing the service agreement is really helping to demonstrate that. So I do have discussions with the ministry. Obviously, until we get ourselves in a position to be able to really accurately reflect that, it's difficult. But, yes, we do have discussions about the - I call it the underlying underfunding.

MR MUSTON: Do those discussions or have those discussions in your tenure resulted in changes in the budgetary envelope that you've delivered or the block of funding that you receive?

MS HOEY: From the block we have received some funding for custodial mental health, and that was the results of coroner's recommendations for funding.

MR MUSTON: So in that case a combination of coroner's recommendations, which tend to be compelling, and the discussions that you've had as part of the negotiation

process?

MS HOEY: Yes, but certainly not enough to really make a - you know, make a big difference, which is what we want to do for our patients.

MR MUSTON: Can I explore with others - perhaps, Mr Wilson, I'll start with you as a large metro LHD. This concept that we've just walked through in the context of the Justice Health bubble of identifying the need, identifying the services that might be put in place to provide for that need and making strategic decisions within a funding envelope as to which ones we are going to do and do properly and which ones with the available funds we perhaps should not be doing, how does that - is that something that happens within a larger LHD or, if not, should it be?

MR WILSON: Absolutely, and it's not a dissimilar process to what Wendy described. So we do a range of planning exercises that talk about where we would like to get. So we've got a district-wide health services plan that talks around what our services should look like over the next 10 years. It calls out services and areas that we believe we should be growing our services or addressing some of those needs within the community. It also calls out some of the challenges that we are going to have going forward to deliver some of the specialised services and how we might be able to set up our services differently to address those challenges, talks about some of the workforce implications that we're going to have to address. So very much from a district perspective we have those plans, and then within each of our sites we would have a site-based plan that would also talk to those local clinical services.

MR MUSTON: So you also start with a base of funding which is - would I be right to say it's largely tied to a level of activity that's going to be purchased?

MR WILSON: Yes, it's again not dissimilar. It's an historical activity target that gets adjusted year on year for the variations that come through. So for us as a district we've been fortunate over the last few years to have some new builds come on - become operational and, as such, our baseline budget has been updated to reflect that through a combination of initially block but predominantly activity now.

MR MUSTON: We have heard some evidence in our travels to the effect that with new builds you can have a substantial increase in the cost of running a facility that's not matched by an increase in activity because, for example, larger wards become single rooms and footprints get larger, you need more cleaners, you need more personnel to man facilities. Is that something which in your experience is accurately captured by growth funding to the extent it's provided?

MR WILSON: I think it's challenging. I think it's better, and I think the system has been learning over the last few years about how best to do this. Early in my time in the role we had commissioned St George as an acute services building with the emergency department that came on line a few years before that, and generally when you're bringing on a new service your emergency department is where your growth comes through. So if you're just bringing on ward facilities you incur most of the additional costs without really an awful lot of additional activity because it's coming either through the front door or through your elective surgery anyway.

So that was a pretty challenged time for us as a district with the cost, and I think everybody - the district ministry learnt a lot through St George and some other similar projects at that particular time, and there's been a lot of work that's been done to try to improve the understanding of what that initial cost looks like for commissioning a new building, and then how you potentially convert that to activity in time.

We're definitely not there yet, and it still feels like there's a challenge with how that is managed in the growth envelope when you're commissioning new buildings. Certainly my experience of that has been that that has been most of the growth that we have seen come into the district, so you're basically tied to a new building coming on line, and we therefore have to run that new building, and that is the only opportunity that we have for growth within the district, and that makes it difficult to meet other challenges.

MR MUSTON: And in terms of the other challenges that are most difficult to meet in those circumstances, the fact that you are, through your KPIs, incentivised and the

funding arrangements more generally incentivised to deliver as much activity as can reasonably be delivered through your facilities, does that mean that activities - community-based activities that don't accrue activities, so - I think I have used the word "activities" too many times. Let me start again. Does that mean that a community-based service that might not be recognised under the ABF system but nevertheless might be pretty important is something that is more at risk of falling off the table, to use a term I used earlier?

MR WILSON: I think it's - so from a principal's perspective, yes, probably. I think the reality, though, is slightly different in what we actually see because a number of those community-based services that we offer - our prevention services, our population services - a lot of them are program funded out of the ministry. So they tend to have a different funding source that comes in, and locally us having to make decisions around how we distribute our funds.

Now, that's not to say we wouldn't like to make more decisions, and there's certainly some pressure that I am aware of within my district around services that - and I think we spoke about it when you came out and visited us last week or the week before - around waiting lists for access around community-based allied health services. That is very much on our radar as something that we ideally would like to be investing in, but it gets pretty challenged when you're listing all the things that you need to be trying to cover off.

MR MUSTON: Does it produce a system where, to pick up on something Ms Hoey said, you are effectively structuring the services that you are delivering or choosing which pieces of the patchwork you're going to provide by reference essentially to the different funding streams that are available? So your acute care and your activity, you're doing that. To the extent that there's community care that might not be delivering activity, if there is a funding stream or some program funding that can be accessed to deliver that, then you'll deliver it. But if there's no program funding that could be accessed to deliver that then that's something which, even if you at a local level think, "This really is what my community needs or would benefit from. If I was able to prioritise which pieces to provide and which pieces not to provide, I'd have this one up

higher, but without funding I can't"?

MR WILSON: Yes, I think the starting position that we certainly come from is you need to fund the services you're already committed to to a large extent. Now, there is some opportunity to divest from services, but it's a pretty challenging space. So basically we would work through a process of funding the things that we're already committed to fund and the community is already expecting us to provide. So the services that we currently run out of our facilities and services we run out of the community, and by the time we work through that process there's not a lot left for discretion. In fact, most of it would have to come from being offset by efficiencies or other reductions somewhere else to be able to do that.

MR MUSTON: Has it been your experience, like Ms Hoey's, that the cost of delivering health care to patients, not only because of new builds and the like, but also complexities associated with delivering medicine, the wide array of services that we can now deliver, sub-specialisation, meaning you need lots more people to deliver it, ultimately means that there's been a very significant increase in the cost of providing care to the community as compared with perhaps at the time when the base was identified?

MR WILSON: Yes, and I think all the same factors that Wendy called out, but probably the other one that we are certainly seeing, and I'm sure Wendy is seeing it as well, is the impact of COVID and delays in people accessing their care over that period, and there is certainly a higher level of complexity around our patients that are presenting to our facilities at the moment, quite often further down their disease pathology than what they would have been previously, just because that two-year period was quite disruptive for health care. So, yes, generally the complexity is up in the patients as well.

MR MUSTON: I'll give you an opportunity to say this, Ms Hoey, but I suspect that whilst you might have that COVID spike you also have the burden of dealing with a patient population who have not only dropped off receiving their care during COVID but in fact had never received it; would that be right?

MS HOEY: That's correct, and we still have to manage

COVID in the prisons too. So we're still every day managing COVID. COVID's still out there. So it hasn't gone away for us either. But it is - you know, we've missed that sort of two - was it two years? I can't even remember, it's a bit foggy. But that time, you know, there wasn't many people going to their GPs.

MR MUSTON: To the extent that there has been a cost increase, this cost increase has occurred at a rate that's potentially not been captured by the growth factor that's been applied to the funding year on year, has that meant that - this is my basic maths, which could be wrong, but does that mean that in essence the gap between the funding and the actual cost of delivering on all of the care that's sought to be delivered through a service is growing?

MR WILSON: I think you could draw that conclusion, yes. I think what we - I mean, I think if we just talk about the costs of service and if we just start with the basic CPI application, the health CPI is well north of 4 per cent, 2.5 per cent doesn't get us very far around that. We're seeing increases in some of our contracts and some of our services of 15 per cent. So that's all stuff that we generally need to absorb and find a way to pay for, which eats into the certain of the dollars that you have to provide to your services elsewhere.

MR MUSTON: You mentioned a moment ago that you need to focus - of the need to focus on delivering the care that's being delivered, but does that - let me just understand that. That means there's essentially an array of clinicians who are working within your facilities who have it within their particular skill sets to provide a particular suite of services, and to a large extent that dictates the services which are being provided at any given moment within your setting?

MR WILSON: Yes, there's not a lot of shift year on year. You run an emergency department, you run elective surgery program. You may juggle a little bit around who's doing what particular list, but generally it's going to be fairly consistent around all of those things. So you kind of start with building up to the same position as you were the previous year. You will pick up some local changes. You will pick up how those things move. But they don't move a lot. So you're pretty much fixed to a number of these costs each year.

MR MUSTON: And, much like the base figure, the precise reason why the service array that's come organically to develop in a particular hospital or a particular setting is something which has its origins a long time ago and, whilst it may have been steered a little bit through the planning, has not readily been within the control of, say, the chief executives of health of the LHD to say, "We're going to offer this but we're not going to offer that"?

MR WILSON: Yes, there's a number of historical decisions that were made, or not even decisions that were made, historical precedents that were set about the services, and, I mean, a number of them make sense, like you will offer an array of services out of most hospitals that you run, so how they're set up and what those funding decisions were made at the time are pretty much set, and as a chief executive you've got some ability to influence that, but limited, and generally more of your ability is around those changes of service and what decisions you do make at the time.

MR MUSTON: And in terms of making those decisions it's not, I would assume, an overnight decision necessarily, but it might be part of a five- or 10-year plan to say, "Here's a service we're offering. We actually as at today don't think we should necessarily be offering that because there's another thing that might have a slightly higher priority, but we have some clinicians who are performing that procedure or who are running that little unit, and we can't tell them tomorrow we've decided we're not going to do that." So you look to change management over a period of time, people retiring, not being replaced, sort of progressive change of services; would that be right?

MR WILSON: Yes, absolutely, and that's why having that long-term plan around 10 years and what this looks like helps us with those decisions, because you can't plan when you're going to make those changes, but when those opportunities present themselves you do need to be able to respond, and so being organised to be able to respond to those opportunities is important.

MR MUSTON: Is part of the challenge also from a funding perspective the fact that a lot of these services that are being offered are, for historical reasons, there now and will for at least the short-term future be there until such

time as change can progressively be made to re-adjust priorities, say, in the way that we've been discussing, but does that mean, if the cost of providing those services increases and you have to keep providing those services because they're there, that the available funding that you have just gets spread thinner and thinner across the array of services that are being provided?

MR WILSON: Yes, but I would argue that most of this stuff isn't going to be changed. Most of this stuff is the right services that we are offering in each of our facilities.

MR MUSTON: Yes.

MR WILSON: And it's rare that unless you're replacing a service with a new better version of that service that provides the care that you're actually going to move away from that service entirely, so there are some opportunities around how you offer your services, and generally that's around mainly other drivers, things like workforce availability and how you can make these services sustainable, where you might structure a service slightly differently. But it's pretty rare that you're getting out of a service entirely.

MR MUSTON: So in the case at least of the large metro LHD that's providing an array of services, whilst there might be some tweaks and changes, it's not likely to be the case that there will be a broad-scale reduction of services to enable you to provide a smaller suite but do it as well as it can be done within the funding envelope that's available?

MR WILSON: Yes, it's pretty hard to think of cases for the large volume services where that would occur.

MR MUSTON: Can I maybe ask any one of you from the outer metro LHDs whether you have a slightly different view on that, that is to say to the extent that there are services which might be available in large metro LHDs but you are for historical reasons continuing to provide within your LHDs, whether the consequence of that historical need to continue to provide a service which on one view if you were to prioritise the services that you were to deliver within the limited funding envelope you might put below the line, but because they're still there it does result in your ability to fund everything else that you're doing being

stretched thinner and thinner? Any one of you can start. Mr Collins, maybe? You're looking intently at me.

MR COLLINS: Well, okay. Let's take the current financial year. We received a budget increase in our service agreement, but basically the entire budget increase was already taken up by existing commitments, providing us basically no capacity whatsoever for expansion or any sort of innovation that we might like to take on a local basis. So all of the funding is locked in. We are very aware of the state's financial position, with Treasury's position, and that, if anything, while the demand for health services is increasing, the availability of funds is not keeping pace with the demand.

We certainly feel in Nepean Blue Mountains that we are disadvantaged compared to inner Sydney LHDs, and I - my guess is that the other peripheral LHDs - so Central Coast, Nepean Blue Mountains, South West Sydney, Illawarra - are similarly in the outer ring and therefore are unable to really add the kind of specialised services that are taken for granted in the inner circle of LHDs. I guess I'm not - I don't want to appear to be too critical of the ministry in this. There's a capital city advantage in that, and I understand historically the city has spread, urbanisation has spread. I think that the way you make the outer LHDs function more effectively is to take some of the specialised services from the inner city LHDs and locate those in some of the outer LHDs. But I think that would be a way of building capacity, building medical communities around the teaching hospitals that are the centrepiece of the LHDs.

MR MUSTON: A couple of things flow from that. The first is, to pick up on something we were discussing a moment ago, you need to identify what the needs of your community are. You need to identify the services that in order to meet those needs should be provided and make some attempt at working out what it would cost to provide each of those services if you were conducting a planning exercise. You then take your budgetary envelope such as it might be and you work out as an exercise in prioritisation what can you actually deliver well within that envelope and what can't be delivered within that envelope. So that's step 1. And some of those services that are currently being delivered in the larger metro LHDs, the specialist services that you refer to, might actually fall on the wrong side of that

line. They might say, "We can't deliver them within the budgetary envelope that we've got because not only can we not deliver them and deliver them well, but it would compromise our ability to deliver those things that we've actually prioritised"; would that be right?

MR COLLINS: That's correct.

MR MUSTON: And at one level --

THE COMMISSIONER: Sorry to interrupt, but just to pick up on your point about the disadvantages you feel your LHDs and outer metropolitan LHDs suffer, the things - tell me if I've missed anything, the things we discussed on our visit were there are some workforce issues that are multifactorial, including the number of registrars that are available for your ED, given the number of presentations you have compared to other similar public hospitals to Nepean, at least in terms of presentations to the ED. There are the social determinants of health in your LHD that you talked about being top of the table, I think was your expression, and things you don't want to be at the top of the table for, like obesity, like DV, et cetera. There's the influx of NDIS participants that we talked about and the strain that puts on - can put on the EDs when people come from the share homes, go into the ED and then they find there's no place to send them back to. And the bed flow issues in relation to your ED in terms of the length of time that some people are staying in there that are partly a common problem of aged care people with no aged care beds to go to. And I think we also discussed thinning GP markets as well as having an impact. Is that the general picture?

Mr Gregory, you feel free to say as well, but that's what I recall Mr Collins addressing in our introduction as the sort of challenges that are probably the ones that result in Mr Collins feeling as though you're disadvantaged compared to some LHDs. Is that broadly right?

MR COLLINS: Yes, Commissioner. And, look, I think as I set out in the statement to the Commission, which is a true and accurate record of what we discussed on a previous occasion, I think that the block funding model that we have does not really capture some of the issues that we face in Nepean Blue Mountains. For example, we do not qualify for any rural adjustment. Now, what does that mean? There's a

sign at the bottom of the Blue Mountains that says "Welcome to Sydney". So when you go west of that sign you're driving into a World Heritage national park, and the local council there takes great pride in that and want to keep it pretty much that way.

But what that means is a very rural environment immediately. So Katoomba hospital, for example, which is a centenary hospital, is well and truly past - in terms of physical infrastructure, well and truly past its use-by date, and yet the rural/metro boundary is about 10 kilometres west of Katoomba, and you could drive - I mean, most people driving through the Blue Mountains would think it's a pretty rural environment except for the villages that are dotted along the Great Western Highway or Bells Line of Road, fewer of, but we don't qualify for any rural adjustment under block funding. We do not qualify - we don't have specialised services which attract block funding.

So, for example, to take what you've just said, Commissioner, unfortunately we head the league table in things like obesity and diabetes. We're right up there. Domestic violence is another one. These are areas where it would be open to the ministry to say, "All right, you're not going to get a heart-lung transplant facility at Penrith, but maybe you should be the state's expert LHD in terms of domestic violence, in terms of obesity, diabetes, all sorts of dietary issues which go to the socioeconomic disadvantage of the LHD." That's a snapshot of our LHD. I'm sure the other LHDs would also gain a great advantage if they were able to specialise in something.

We can't even specialise in trauma. The state trauma plan is now over 30 years old, and there are three state - there are three trauma centres in Sydney. But we are in a situation where we can have a serious accident within walking distance of the hospital and the patient will be transferred to Westmead, which is one of the trauma centres. We'd like to get back in the trauma game because that would attract funding, it would attract - we think it would build the reputation, it would build medical training in the LHD. But we're not able to cut through there. So there are a number of definitional factors that really prevent us going to a higher level.

MR MUSTON: So we start with our identifying the needs.

Trauma obviously is one of the needs that your population has. People have accidents within your LHD, just as they do in others. We work out what can be provided within the budgetary envelope, and there are things that can be and things that can't be. So, to use your example of trauma at the moment, accepting that there's a statewide plan that intervenes to some extent, a view's been taken that Westmead is near enough to Nepean Blue Mountains for trauma patients within your LHD by and large to be taken there. The same might be said for other services. For example, types of elective surgery that might happen in your facilities at the moment, a view might be taken by you on the ground that, "Within the existing funding envelope, if people within our LHD can access those types of elective surgery at Westmead, then we might not provide them here anymore and those patients can go to Westmead, because trying to stretch to everything takes our funding so thin that it means that we're perhaps not doing any of them as well as we would ideally like to be." Would that be right?

MR COLLINS: Yes. That's basically correct, yes.

MR MUSTON: You've got other challenges that intervene --

THE COMMISSIONER: Sorry to interrupt. One thing I - this is my fault, I should have said at the start, if any of you want to make an addition or say something on a topic that one witness is talking about, please don't hesitate to put your hand up or make some other signal that you'd like to say something on a topic that's being discussed. That was my oversight at the beginning. I apologise.

MR MUSTON: Probably mine too. But definitely do feel free because we would like it to be conversional. You all have these issues presenting themselves in their own unique ways in your settings. Mr Gregory?

MR GREGORY: Yes, just a comment around your example of services being provided or not providing services at Nepean and, if you like, letting people go to Westmead. Historically, it's been more - historically some of the more specialist services for Nepean have been provided by Westmead, and we don't consciously, if you like - you characterised it that we withdraw a service and people go to Westmead. We don't consciously do that. I think just to correct that.

MR MUSTON: That's largely for historical reasons, because there are clinicians at the moment who are within your network providing services that would no doubt react poorly to the idea of the services that they are providing being withdrawn from the suite available within the Nepean Blue Mountains?

MR GREGORY: Yes, that would be true as well, yes, definitely, yes.

MR MUSTON: And, being sort of realistic about it, clinicians who are unhappy about the fact that a service they are providing within your LHD has been withdrawn will no doubt result in sections of the community also being made to feel pretty unhappy about that fact because it seems like a bad thing?

MR GREGORY: Potentially, yes.

MR MUSTON: And these are the human challenges that we need to navigate in system planning and managing change where it's needed. I think we've heard evidence from some of the regional LHDs about emergency departments in small rural hospitals that should, on any rational view, be closed, but for largely sort of politico-social reasons are still there using a slice of the health budget. No doubt - Ms Constable?

MS CONSTABLE: Thank you. I was just going to I suppose reflect on the point that the community expectation would be they can provide every - that they can receive every health service they need within 20 minutes of their home address, and I think that one of the reflections that I would have is that we have to create an efficiency in the use of public funds at a local level but also at a state level, and therefore there is some sense in narrowing the location of certain highly specialised services so that we can deliver them to a volume that makes them efficient. So if we were to --

THE COMMISSIONER: And safe?

MS CONSTABLE: And safe.

MR MUSTON: Just pausing there, though, safety and economically efficient, they don't necessarily go hand in hand. It may well be that you can maintain safety by doing

a procedure 20 times within a hospital, say, in Central Coast LHD whereas - and so the CEC might say, "Yes, that's safe to do it in that way," and you've got a team of people who are an appropriately experienced team that you have doing that, but doing it 50 times a year within that hospital might not be economically efficient if someone could go to Northern Sydney, where they do it 550 times a year. Sure, they'd have to do it 600 times a year if they went down there, but the system would need to work out how to accommodate that. Would that be right?

MS CONSTABLE: Yes, that's correct. So we have - there are certain services we don't deliver in the district. We don't do neurosurgery. We don't do cardiac surgery on the Central Coast. There would be a desire of some clinicians to do that. But either side of our district we have John Hunter, we have Royal North Shore, and so across that population of 350,000 in the Central Coast do we need to meet the need - every health need locally, because distributing and creating and attracting the workforce and doing it sufficient times could create some challenges in us around scarce workforce and that sort of thing to make it operational and effective and safe and efficient.

MR MUSTON: So you raise the next issue. The first issue is what services can you deliver and deliver adequately within the budgetary envelope, and you need to make some prioritising decisions. Again, we're assuming that the human factors are not intervening here, if we're just planning in the Utopia. You make your decisions there.

The second factor that comes into it is workforce. It may well be that you would prioritise a particular service in a way that sees it being delivered in your LHD but the reality is you're not going to be able to get at least in the short term the workforce to enable you to do that because workforce maldistribution issues are rife within health and they're just a reality. So that factors into your thinking about what is or is not able to be provided in facilities within your LHD, I gather?

MS CONSTABLE: Yes. So - and, for example, attracting workforce might be about the whole range of services that are available. So particularly if we think about surgical procedures, you know, many surgeons also work in the private. So the private hospitals locally to attract somebody to live and work and be part of the Central Coast

community would need to mean that there's private capacity and public capacity, and then we're starting to take a really big step up in the range of things that are available locally, and that big step up is a big investment.

MR MUSTON: These nuanced decisions about what services to offer taking into account all of those different factors within the ecosystem of your LHD are best made by people who have that experience on the ground in the LHD, they know about the private hospitals, they know what's being offered at the private hospitals, they know what synergies might exist to enable services to be provided in a public hospital and what synergies don't exist; would that be fair?

MS CONSTABLE: I think we need to understand the local context and we need to understand the bigger context as well. So that's that point that the system has to be efficient as well as the individual districts in meeting the needs of the population, and the more rural or regional you go, just reflecting on the other comments that have been made, the more challenging it is. But at times I know - I've worked in a number of health districts and have been involved in circumstances in other rural health districts where we had an individual clinician who happened to live there who happened to offer to provide a service that was then funded and supported by the health district and then that clinician leaves, and the expectation of the community is that that highly specialised service is continued to be delivered because it's part of what the health service delivers, and that becomes highly political and challenging for the health district to manage. But is it the right thing that we're delivering a service because we happen to have a clinician that has the expertise?

MR MUSTON: You've jumped to my next question, really, which is, having identified on the ground the way in which you think, taking into account all of those factors, including an available workforce, is there an ear, nose and throat specialist living in your area who might be able to provide care, for example, maybe that means ENT surgery is on the right side of the line. Maybe it doesn't. That's a local decision that needs to be informed by local knowledge. But then there needs to be some broader system oversight. So each of the LHDs brings to the ministry their patchwork of services, what's above the line and

what's below the level. So at a system level there's an ability to say, "Okay, well, this is what's provided across the system. Everyone's cut their elective surgery A. We don't have anyone delivering it anymore, but we really need it, so someone's going to have to do it. Where's it going to be? How are we going to fund it?" Those sorts of decisions can actually be made in a more transparent way and in a way that means funding discussions at the roadshow each year could perhaps be better informed by a, "This is what we're funded for. This is what we're providing. If you want us to provide something more than this, either tell us what we can drop because it's being provided elsewhere or, alternatively, tell us what we can drop and not provide, and deal with the consequences of that decision which has not been made at a local level, or give us more funding." Would that be a good way of doing it?

MS CONSTABLE: Well, I think it is getting everyone around the table, and looking at things from a variety of perspectives with transparency and clarity is absolutely key.

MR MUSTON: Ms Mains, I think you --

MS MAINS: I go back to - thank you - systematic planning at all levels is fundamental to taking us forward, and Tobi Wilson referred to this, I think, having a strong healthcare services plan and we've also got a clinical network plan which itemises what services will be provided on what sites so that they connect together, because we cannot provide all services on every site, just like you can't provide all services throughout the state. You need the volume, you need the expertise and the competence to deliver those.

So I think what's really important is that population needs analysis, demand analysis, socio-demographic factors, all of that that you're looking from a population, and then identifying what the needs are, and then getting really down also to service planning is absolutely critical, and I think --

MR MUSTON: And service planning involves identifying the cost of delivering a service or the resources, financial and otherwise, required to deliver a particular service and do it properly?

MS MAINS: So a service plan would look to the future to identify what the nature of the services should be for that particular service. So if you took cardiology, what is going to be the demand and the need for cardiology, factor around your population, your socio-demographic factors, then go down further and identify what are the models of care, what are the models of service delivery for now and for the future, what are the new technology developments, what AI is going to impact on, and then working out what's the nature of the service that you could deliver throughout the state or deliver locally, because not all services, as I said, can be provided, and what's the nature of the workforce, and financially how is it sustainable, because there's always going to be prioritisation decisions about what's sustainable and what isn't, and what we should invest in and what we should disinvest in. So - sorry, I --

MR MUSTON: I was going to say those decisions need to be made in the first instance locally but then informed by an overarching planning exercise which --

MS MAINS: I think that it needs to be done across the board. So there's statewide planning and then there's also local planning, and they need to feed into each other, yes, from a funding, planning basis.

MR MUSTON: In your experience is that something that's happening at the moment?

MS MAINS: I think it's evolving. I can speak about my local experience. I think we've done a lot of focus on district-wide healthcare services plans, on then developing a network plan, and now we're doing a service plan because, as Jude was talking about and also Peter was talking about, there's a lot of challenges in organisations like ours as to what are we, and that sometimes we have a slight "are we metro or are we regional" because we are growing and we are evolving in our service delivery, and what's really important is to try and get systematic planning, because Jude spoke about the doctor that might come to town and therefore you evolve the service around them. But for quality and safety and value for money you've actually got to make sure you've got the right - you need that service and that you're evolving it the right way, and that's why at the moment we're doing 12 specialist service plans, because we are definitely growing more as a tertiary

service than we were previously. We were - for example, at Wollongong, as someone said to me that's lived there for many years, we were a district hospital. Well, that's now grown very similar to a metro, but are we going to be all tertiary and quaternary or are we focusing on particular tertiary, and you have to work with the State and your colleagues about that.

So, for example, when we were looking at cardiothoracic surplus development we were working with South East Sydney because it required redirection of funds from South East Sydney to our local health district to be able to provide those services.

MR WILSON: I clarify for the record that there wasn't funds transferred out of South East Sydney, but that's (indistinct) clinicians come after me.

MS MAINS: You stayed the same and the State made a commitment to fund us because there was a really strong basis. But you need to have strong systematic planning to work that through, otherwise you can develop services on an ad hoc way, which is not appropriate from patient safety or fiscal responsibility.

MR MUSTON: I just want to pick up on one issue you raised, the clinician who moves into town who's able to provide a service and generously offers to do so. You said we should first be asking ourselves whether we need that service. I assume that if you - much like most other areas of health, if you create a service the demand will be there for it. So in that sense of the word "need" it probably is a needed service, but is what you were really - were you really trying to get at not only is there a potential demand for it but in this prioritisation exercise that we embark upon is this something that we should be providing to meet whatever need is out there within our community, having regard to the competing priorities on our funds?

MS MAINS: Because we've got to commit that the service we're providing is safe and it's doable at all levels and we have the workforce.

MR MUSTON: But also is there not also a consideration safe, doable and such that in the prioritisation exercise it justifies being included amongst the things that we can afford within our budgetary envelope as opposed to

something which would be great but if we don't have enough money to do priorities 1 to 6 then we shouldn't be sticking priority 7 in because that either means something in 1 to 6 goes or, alternatively, everything is spread thin and what you're delivering is compromised across the board?

MS MAINS: Yes.

MR MUSTON: I note the time, Commissioner.

THE COMMISSIONER: Yes, sure. We'll adjourn until noon. Come back at 12. Adjourn until then.

SHORT ADJOURNMENT

THE COMMISSIONER: When you're ready.

MR MUSTON: I'll just close the door. I think, Ms Mains, I had asked you whether you thought that this broader system planning is happening, and I think your indication was that it was developing. Do others have a view about the extent to which that broader system planning is actually happening, that is to say broad system identification of what as a public health service we should be offering, the extent to which it's - let me take it back - what are the needs of the wider population, including in each of the LHDs; to what extent are those needs being met by services external to the LHDs, so private market based solutions, funded by the Commonwealth or not; to the extent that they're not, should we as a public system be including them as part of the public system, and ideally the answer is yes for everything, but maybe that's not realistic; and, if we are including them, where are they going to be delivered. Is that sort of planning happening in an organised way across the LHDs and within the ministry at the moment?

MS MAINS: I'll just carry on, if you like, because we just finished off, and I think there's a lot of planning around the ABF environment and what the level of acute and elective activity should be and built on that, and there was - we were talking - if you look at trauma services and what's been raised, there was some quite strong planning done in New South Wales around trauma service, where it should actually position, but, like anything, we need to continue to update it as organisations grow, and who is best doing what, because there's a lot of evidence you

should be highly specialised to be a really good tertiary centre, and what levels can we all be is important.

MR MUSTON: Part of that also is - at least the sense we've got in our travels is with every small change you make to the system it has 50 consequences. So from the point of view of trauma, for example, it may well be that there is a real value in identifying the Nepean Blue Mountains, hypothetically, as a trauma centre. That might bring clinicians into the LHD. But that might have other consequences elsewhere within the system, which need to be identified and assessed as to whether or not a change like that would be justified, and that's not - they're not necessarily going to be visible within the Nepean Blue Mountains LHD, for example. You need that system oversight to say --

MS MAINS: And that's where I think when you're doing - for example, focusing on population based funding formula you've actually got to go right back to looking at what your need, your demand, your socio-demographic factors are, what your allocations are then per district and then what can be delivered upon that, and just like we need to look locally at what we can do and where and what we can't do because it doesn't meet all the parameters that it should be, there's also room and opportunity through that to itemise the allocation of money but also the allocation of services and what should be done at what level, which needs to be looked at on an ongoing and regular basis.

MR MUSTON: Mr Collins?

MR COLLINS: No LHD expects to specialise in everything, and even if you've got a teaching hospital which is going to specialise in a lot of things you won't get everything, and I really think it would be very useful for the ministry to be permitted to spell out the allocation of specialised projects and services across the state. I mean, obviously that's the province of the government, probably be done by or through the minister. But all large bureaucracies develop their own ongoing departmental policies, practices in the way they do things and the way they allocate resources. I mean, I'm someone who's seen this fairly closely, the amount of room to move with funding available to the minister of the day, whichever side, is probably less than 5 per cent wriggle room. The other 95 per cent is completely locked in and known to the ministry.

So I think it would be useful to have the ministry say, "Look, okay, in terms of diabetes we really think, you know, Penrith should do that. In terms of skin cancer, maybe it should be a eastern seaboard LHD does that," and I think that if there was that transparency and clarity where people were given - the LHDs were given priorities, I think there would be a good response to that.

If I can just make one other observation. We have - through the funding formula I think we've got - the ministry makes a very good effort at equality, but they don't achieve equity in terms of the Sydney Basin, anyway, the greater Sydney Basin.

MR MUSTON: We might come back to that. Mr Wilson?

MR WILSON: Yes, I think it's - so, in answer to your question, it's complicated, like it always is. I think the bit that would be really useful, and we've got most of this in place, is really - is a lot of clarity around where the line sits between those statewide services and where do we need to have a system view around things and what needs to be - is just core business for an LHD to be planning for. That's how we think about it within our district. There is - probably 90 per cent of what our hospitals offer is core business for those hospitals, and they need to plan how they're sustainable in offering that. There is a small bit that sits on the top that we need to worry about from a district perspective because of workforce implications or cost of service or whatever. That would be the piece, and I think as a state there's some really good examples where we do this really well, and I think the trauma piece is a good example. It's just around how do you stay on top of that and how do you keep that lens on what this is going to look like in 10 or 15 years time, because that's the lead time for all of these sort of things.

So if there was to be a revision around trauma, either an up or down, you kind of need to call it out sort of five, 10 years in advance to be able to start planning for it because there's an infrastructure component that sits with that, there's a recruitment issue around how you build that, there's a number of other associated services. It's not just that you drop a trauma surgeon and then you're away. It's where's your ICU capacity at, what type of theatres do you need. So these things have a long

gestation, and I think that long-term thinking in these spaces is actually probably the bit that we need to get a little bit better at.

Like I said, I think we do it really well in some pockets, but I think there are some other areas where we're probably not as advanced around. And then to some of those emerging pathologies that you talked about and how we deal with that, I think that applies the same kind of lens, is where are we going to go with this as this starts to come into common practice in health.

MR MUSTON: And is there potentially a middle piece? You've got your sort of services which are broadly characterised as statewide services at the moment. You've got business as usual which is done locally. But then is there possibly some extent to which what might be business as usual in one LHD doesn't need quite to be business as usual there because an adjacent LHD is actually doing that well and maybe that adjacent LHD is where you go for your orthopaedic surgery, whereas if you need your ear, nose and throat, people from that LHD come in to you. That's that overarching planning?

MR WILSON: Yes, and again I think there's really good examples where that does work. I think probably the bit that I would talk about in that middle is there's some things that probably five or 10 years ago we talked about as being - so maybe if we take TAVIs as an example, which was originally very expensive, very much cutting edge, and a few centres set it up, and now the State has got more involved in making sure that there's access more broadly, and probably if we're having this conversation, and certainly my cardiologist would talk to me now, about that this is just routine care, and how do we then make that transition from this being a statewide funded service or a component of this statewide to actually this now starts to become more core and we move there now. I don't think we're there for TAVIs at the moment, as an example. But at some time in the next five to 10 years that's going to be routine care for a number of interventional cardiology services across the state, and so that's how do we start to move towards that just being part of what the LHD now is --

MR MUSTON: But, to pick up on that, the dynamic nature of your planning has to be able to identify, as and when it happens, that, say, interventional radiology is an emerging

and potentially soon-to-be business-as-usual approach to cardiac care. Whilst that might need to be rolled out across a wider range of centres within New South Wales, centres within New South Wales that crack open sternums might actually contract at the same time?

MR WILSON: Absolutely, yes, that's right.

MR MUSTON: Mr Morgan, I think you had your hand up first.

DR MORGAN: Thank you. I think I was actually just going to add really a vote for this notion of the statewide service really - statewide planning, that the fundamental issue is I think what's changed over the last 30 years is this advent of what I've loosely referred to, clinical systems networking, the fact that there's been recognition usually on safety grounds that all places can't do all things, and so these high acuity, low occurrence procedures that we talk about, whether it be cardiology, whether it be trauma, whether it be mental health, whether it be obstetrics, where we know our patients do better in centres that are consolidated with people that are doing high volumes, and the extent to which there are a number of these that are consolidating - certainly motor vehicle trauma is significantly down on historical times, and yet there are growing cutting-edge technologies that will in the future years actually become more and more routine, and I think it's really only at the state-based view that you can actually plan that for a state and really get that right.

The extent then that it actually flows down into the local health services planning, that's the fidelity that I think we could strengthen, is how geographically as statewide health services or LHDs we actually get that intersection back to the statewide planning, and it is a medium-term horizon that I think the State needs to take.

MR MUSTON: And having regard to what's already been said this morning about the often inherently political nature of some of these decisions or the challenges associated, say, with withdrawing a service over time from one area because it's being provided in another area, if there was transparent planning around it and that planning was happening in a more centralised way, you'd actually - it lands, the consequences of that decision politically, closer to the point at which it's being made; would that

not be right? We hear a lot about decisions closer to the patient producing better outcomes, which is great, but if a decision to withdraw a service is made at a state level and in a transparent way it reduces the risk that a local health district CE will be - that the person who is effectively being held responsible for making a decision which might be in the interest of the State, even if some of their local --

THE COMMISSIONER: It's close to a submission, I think, you're making rather than a question.

MR MUSTON: Well, I'm inviting you to agree with it. I've seen lots of nodding.

MR WILSON: I think it makes the conversation easier at the time if there's a signpost that this is the direction the State is going. I still don't think it makes it easy, but it certainly at least - and I think it would be really helpful, like, because I think, again, the lead time on capital redevelopments is eight, 10 years the plan is done before we actually open the door on the building. So you've got to be talking 10, 15 years around what services are going to look like, otherwise you do run the risk of either building redundancy into your build or not building the technology that you actually need, which is probably more likely because you're not proper future scanning, and again that's where some of these documents actually would be really helpful.

MR MUSTON: Something like a new build that was planned eight to 10 years ago that didn't include, say, a cath lab that once it's finally built you're thinking, "Gosh, well, this is now the future of cardiac care and we need to find somewhere to put it"?

MR WILSON: Or how we think about intervention or any kind of interventional spaces I think is really - I know some of the districts have got some really good ways that they've managed that interventional workload, which is massively growing compared to more traditional open theatres, but others, we just haven't thought that way through enough at the time when we were doing the planning of what the future actually starts to look like.

MR MUSTON: Ms Mains, I think you had your hand up.

MS MAINS: Just a few comments. Look, I have just been reflecting. I think - I've worked in three health systems, and I have to say New South Wales has some of the strongest planning I've seen. We have a lot of plans. But I think the key challenges particularly in a fiscal environment that's getting tight is the prioritisation of those plans and where does the priority lie in terms of what we're going to invest in service wise and where are we going to (indistinct), because those are always difficult discussions to have.

In terms of configurations, I do think local leadership is critical. We've been in the process of closing down three hospitals and reconfiguring, and it's been the discussions at a local level, particularly clinicians and management with communities, and working together with multiple stakeholders that have been crucial to be able to develop that. It's the local knowledge, it's the trust and the people that's really crucial.

MR MUSTON: That sort of leads me to the next little question I have, which is, whilst, to pick up on what you said, New South Wales might have an excellent set of plans or strategic documents that identify the way planning should be done, it hits up against that human element of where you have clinicians who potentially are in a particular site, they're delivering a particular type of care, they've got perhaps some succession plans themselves of registrars coming through to replace them, they want to innovate and discover new ways of doing what they do, and that obviously needs to be encouraged, but how do you manage that situation where in essence the way the health system grows, whatever the planning documents might tell you, is driven in an inherently organic way by the clinicians who are delivering that health care on the ground? How do you deal with that?

MS CONSTABLE: I'd make two comments. One would be that you have to engage the clinicians in the clinical service planning, and then the clinical service planning has to be what drives, unless there's an exceptional change to the population or the issues or the context, and COVID obviously would be an exceptional change to the system that required a review. But I have exactly the circumstance where there was a build at Gosford Hospital six years ago which included a piece of equipment that has sat there for six years underutilised or not utilised at all to deliver

electrophysiology, and in fact we've invested in that with the partnership of the clinicians to try and get that service operational now. But the day that that service turned on the clinician then came and said, "Cardiothoracic surgery is next," and so managing that expectation, because cardiothoracic surgery is not in our recently completed clinical services plan, we don't think that's a priority for our district to do given accessibility to those services close by. But it is a relationship management and it is about that trust and ongoing communication, and encouraging those clinicians to keep shouting out for what's important because they will drive innovation in our system and will help us deliver better outcomes. But we're also in that relationship managing expectations.

MR COLLINS: Just further to clinical services plans, I know that the Commission was given evidence last week regarding Blue Mountains Hospital by the chair of the medical staff council in the Blue Mountains, who was critical of the role of the Nepean Blue Mountains LHD in furthering that clinical services plan. So I want to set the record straight on that.

The LHD has bent over backwards to work with the medical staff council at Blue Mountains Hospital to deliver an optimistic clinical services plan. When I say "optimistic", it's human nature for clinicians - and your train of thought about building practices and building legacies and so on. I mean it's human nature to want to build and expand and add to. And so the clinical services plan which has gone forward to the ministry encapsulates a lot of that sort of aspirational growth. Whether it can be sustained, though, is a matter for the ministry to look at demographics, and that's the ministry's job to say, "The population growth that we see is perhaps different to the population growth you see," and to make the final determinant about the funding that flows from that.

And just on that particular hospital, which was the outlier of the 140 or so infrastructure projects in New South Wales over the last decade in health, the one that wasn't done was Blue Mountains, and it really does need replacing, and it was Lee Gregory's predecessor, Kay Hyman, as chief executive and myself who called the community meeting in Katoomba to get that going two years ago, which has resulted in the funding that the hospital has attracted from Minister Park. So there is a very important role to

play in getting clinical services plans right and I guess trying to herd medical staff councils to take them along on that journey.

MR MUSTON: In fairness to the clinicians, each of them, focused on their own unique area of endeavour, can see a need for their services and would say, advocating for their patients or potential patients, "If I had more money and more resources diverted to my little field of endeavour, then I would be able to do some great work for those patients," and that's again human nature, which goes beyond - the sort of empire building, as it were. But that's where we come into this, the difficult job that a system manager and individual sort of managers of individual parts of the system have where there is a limited funding envelope and you have to work out what to prioritise and what not to.

But to pick up on what you said, I think, Mr Wilson, that an important part of it is this 10-year horizon and bringing clinicians along, recognising that change can't happen tomorrow or maybe even next year but in 10 years time, would it be right to say that with careful management you might be actually able to steer the direction of services in a way that makes them - the changes in the way that it should be changed?

MR WILSON: Yes, certainly that would be my view of how you'd drive some of these things, is you need to take a long-term view around the strategy and where you're trying to get to, and bring the clinicians with you on that journey.

MR MUSTON: To do that, though, recognising that sometimes it's not a change that can be made immediately, there might be a period where funding of an imperfect service set is needed because if you're not funding that service set then everything, including those things you're trying to build, become challenged?

MR WILSON: Yes, but again I think this is where you - the relationship with your clinical teams is so important, because we're all making choices, and a majority of our clinicians understand the challenge, that there is a finite funding bucket available, and bringing some of these things to the table and actually having the conversation around the opportunity cost of continuing with certain things is

normally a productive conversation if you engage clinicians the right way through that process.

MR MUSTON: Yes, Ms Hoey?

MS HOEY: I was just going to add I think an area that's done this well, although we're only in the early bits, and it's when you were saying we have to hold the situation for a while, is in the mental health area where they've done that in the SWMHIP program, where they've done a long-term plan around the required beds, particularly in forensic mental health, and the builds are coming. I think workforce aside, because it's kind of put a little bit of a spanner in the works at this point in time, it is about holding that plan and knowing where you're heading while it's not quite right, and having the strategy and the policy to go with infrastructure build, and then having I think the levers to hold us all to account to what's going to happen when - for the clinical services to go forward.

So I think the mental health branch in conjunction with the LHDs and ourselves have done that - have done the planning pretty well. Execution's hard because of obviously the budget situation and the workforce situation with mental health. But I think from a sort of centralised planning perspective I think they've done a good job. We just have to execute it, and that's the hard bit, isn't it?

MR MUSTON: Can I come to you, Ms Cox, as the person currently responsible for the entity that might be receiving some of these centralised services that are being delivered - well, you're already delivering centralised services through the children's network. What would the impacts of this sort of planning be on an organisation like yours?

MS COX: For me it's really about the transparency and the statewide perspective. So everyone in the system - so not just within the network, but everyone in the system understands what services I'm accountable for and we're providing, how that links to - because I don't have that geographic catchment. So the needs analysis is actually quite challenging for a statewide service, but that the LHDs where I'm providing the tertiary and quaternary care for their paediatric population actually have a really clear pathway and understand what I'm doing. But it's

really hard when I don't have the authorising environment to go into that LHD and say, "This is what I'm doing for you." So we try to mutually develop that through some of those heads of agreement, memorandums of understanding. But I think transparency, consistency, really clear about the priorities, like how are we making those prioritisation decisions, really help.

But I also want to pick up on horizon scanning because there's a whole world of precision medicine that is sitting in the research paradigm that is coming out and coming out quickly, and we really don't have an implementation plan around that, and they are big costs. I think the spinal muscular atrophy, that's 2.5 million for a child that would have died three years ago. So that sort of research into clinical practice is getting shorter and shorter, and, again, we don't really have a statewide plan about how we - weighing up that priority versus community paediatrics, so, you know, what's the State's position on things like that.

For mental health, again for me it's about in the statewide mental health world what do you want the tertiary and quaternary service to be doing in the context of all your other service configurations? I'm not sure. So, you know, we provide very specialised services, but how does that sit within a systematised approach for mental health for children and young people? So I think some of those things being more explicit and clear would really help.

MR MUSTON: And in the ideal world that wouldn't be fostered through memoranda of understanding between your network and LHDs and other networks within the system; would that be right?

MS COX: Yes, that's right. We would have a statewide direction that would be quite clear about what's where and what's being provided. So we now do all our statewide planning with John Hunter Children's so that we actually make sure we've got that - we're coordinated. But again that's coming from bottom up, not top down.

MR MUSTON: And, equally, from a funding perspective there would be aspects of the work that your network does which might be important to keep the system functioning and perhaps keep things out in the regions but is not readily picked up by activity-based funding, for example providing

a phone-a-friend service, as it were, to, you know, hardworking paediatricians out in the regions who might be able to deal with a situation locally but just be on that cusp of, "Is this one we should be dealing with locally and, if so, how, or should we be sending them to the kids' network"?

MS COX: Yes, absolutely. So that's the consultation advice that's provided. Nets, the neonatal retrieval service, is a really good example where there's a really significant proportion of their calls that actually a child's not retrieved, and that's great because they've watched that child in that emergency department, they've worked with the local clinicians and that child is kept there. But because we don't have a retrieval that's not funded for activity.

And similarly when the - they'll do an outpatient clinic for oncology, for example, but when the treating clinician wants to talk to the consultant back at, say, Sydney Children's that's not counted as activity, even though that's really important for that child to stay locally. The training that they do on behalf of the State, that's not activity. So those sorts of things. It's how do you manage block or how do you tier it. Those sorts of things are really critical.

MR MUSTON: So a more clear delineation of roles across different parts of the network would have as one of its benefits at least an identification of who was doing what so that funding decisions, be they good ones or bad ones, are at least made on a properly informed basis and on a transparent basis?

MS COX: Yes. And there might be some services that we can absolutely provide. I think we've got some models where we're providing developmental assessments because it's easier for us to get the staff, so we can support the local paediatrician to provide those assessments. Again, doing that in a really much more structured way, transparent way would be helpful.

MR MUSTON: From your perspective, what at a systemic level needs to be changed or could be adjusted to make that work better?

MS COX: I think - I'm loath to say after Margot saying we

do have lots of plans. I think it's specificity, actually, in plans. At the moment they're often led fairly high level, principle based, and really then the decision making still sits at the local level, and I think it's the fidelity - there needs to be that closer combination rather than sort of saying, "Here are some principles. Now you can go and apply."

MR MUSTON: So do I take from that that you've got your high level plan that usually has a particular sentence or principle expressed at a high level, and as one works down through the cascading array of plans which come out of it you've got to do a little bit more than just repeat that sentence in each of those pieces of paper in order to satisfy the requirement or to achieve the objectives of the plan?

MS COX: Yes. It's the execution and the implementation is really hard, and that's where you've all got to be in lockstep.

MR MUSTON: Well, in relation to that, both from a planning point of view and also an execution point of view, would there be benefit in some quarantine funding provided for the purpose of that being done or so as to enable that to be done? Any of you can answer that question. All of you, if you want to. I'll tell you why I ask that question --

MS HOEY: I think you know my thoughts about quarantine funding, and certainly for things like forensic mental health, mental health area I think it's really important, and if we want to make sure that we do stay in pace with our planning, you know, objectives then I think in some of these areas that are not necessarily driven by ABF funding and not necessarily driven by what the clinicians want or the services that needed - I think quarantine funding has got at least until the services are established.

MR MUSTON: Do others have a view on the potential benefits of quarantine funding for planning? Mr Gregory?

MR GREGORY: Yes, I was just going to - the comment I was going to make is I think there is something in terms of looking again at are we achieving - if you look at the social - the health of the population in Nepean as opposed to, say, Northern Sydney, I think there is something around

looking at that again and are we achieving the equity that Peter talked of before in terms of - and that maybe points to some quarantine funding. So, yes.

MR MUSTON: My question is more directed at in order to look at that you need some resources, human resources principally; would that be right? In order to sit back and actually look at what's happening within your district and to look at what's happening and for others to look at what's happening in their respective districts to work out where the synergies lie you need someone who has got the time and skill set to do it.

MR GREGORY: I think we've got a lot of those resources anyway. There's people who are doing planning within the system, you know, both at ministry level and district level. I think it might be a bit of a change of emphasis, possibly.

MS MAINS: I think it will be people that do systematic planning. That's what we need to - where we are actually positioning ourselves. And I think planning is the foundation of identifying what is needed going forward and what we can prioritise. And if I just pick aged care, which is a personal area that's impacted us significantly, careful planning between the State and the Commonwealth and locally, and aged care facilities and PHNs and GPs is fundamental to actually getting the system right.

MR COLLINS: Just on quarantine funding, sometimes that's the only way you do break through. That's sometimes the only way you do turn things around. There was a time when Aboriginal health funding was seen as a hollow log that could be raided and money could be taken from Aboriginal health funding, and I'm talking about three decades ago, and that money could be used to top up other services like emergency departments and so on. That money was then quarantined and used exclusively for Aboriginal health, and I believe that remains the case now.

So I think there is a case for quarantine funding to achieve priorities set by the ministry. But probably the offset to that would be when LHDs are told to achieve efficiency dividends, and they save 1 or 2 per cent, usually in admin and directed to front-line services, then I think that there needs to be a bit of a counterbalance where those efficiency dividends could be allocated by the

LHD rather than central office.

MR MUSTON: The efficiency directives are what I had in mind when I asked the question. In the context of your LHD I know you've been informed of the fact that there's - your FTE has grown at a rate which exceeds your activity, and that's implicitly said to be evidence of inefficient operations. But things like planning don't actually produce activity but nevertheless are important.

MR COLLINS: Yes. And I invite - I mean, Lee is across the micro detail. While we have not met activity projections in certain respects, we've got I think it's a 15 per cent increase in bed occupation, isn't it, over the last 12 months or so?

MR GREGORY: Yes, I was just going to comment on the FTE growth. We, like many other districts, have the redevelopment. You know, there's, say, a given level of activity, you end up with more staff to do the same number of patients, and then more cleaners, blah, blah, blah. So that's part of the story at Nepean, I think.

In terms of activity growth, I think we're doing about 22 per cent more through the ED than two years ago at Nepean; increasingly busy.

MR MUSTON: An increase in emergency activity, that can be a good thing or a bad thing from the point of view of the public health system. On one view it suggests an increasing failure of the primary care market within your region.

MR GREGORY: Yes, well - yes, potentially, yes. I mean, there's no doubt there's issues in primary care, so yes.

MS COX: Just two things. I think the more and more you quarantine the less flexibility you've actually got. And some of the challenges that we have had is increasingly allocations which have a specific purpose. That means it's very hard to do that prioritisation and actually identify, "Actually my need was there, not what I got as a specific allocation". So I think there's just some caution around how far we go down that path, because that has been hard to manage in the last couple of iterations.

MR MUSTON: Can I just explore that. In that sense, what

you're referring to is a funding stream that's been provided, say, for a particular - or quarantined for a particular program or service that you've been asked to deliver, and you on the ground might take the view, "Well, in my district" - well, within your field of operations, "If I actually had to prioritise the spend, that would not be up there in the on the table priorities; it would be something that would be a nice extra if we had some more money." But you don't have any choice around that because the funding stream has been tied to it.

MS COX: That's right, or if it was actually focused on the outcome I might configure that in a different way than it coming and sort of saying, you know, "It will be this exact program." I might have had a slightly different way of configuring my service to respond to that. So, yes, I'm agreeing with what you're saying. I think there's that lack of flexibility then in how you would respond. And would it have been my top priority? Maybe not. So I think there's a communication from the system again about priorities and why that's been deemed to be the system priority that we're all going to get behind and why we should do that.

The other bit - I think you were saying about quarantining money for planning purposes. I think, as Margot said, we do have those resources and we plan - every day we have to plan for our redevelopments. We're all doing clinical services planning all the time. Again, it's the statewide picture, because I don't necessarily know what northern New South Wales might be wanting to do in paediatrics and where they see me fitting. So that would be helpful because I don't have that broader perspective to understand that linkage. That's the sort of planning that's --

THE COMMISSIONER: Just on that, so the transcript's not cryptic, when Ms Mains was talking about systematic planning and you said you wanted to pick aged care, which was you said a personal area that's impacted your LHD significantly, and you talked about the need of careful planning between the State, the Commonwealth, aged care facilities and GPs is fundamental to actually getting the system right. I'm right, aren't I, that what you're referring to there is wards of your hospital full of people that could be or should be in aged care facilities but there's no bed available?

MS MAINS: So fundamentally 20 per cent of our current beds are occupied by people either awaiting through an acute phase waiting for a bed, or close to aged care assessment for waiting a bed, or needing access to (indistinct) to a more suitable assessment case management and access back to high-level packages in the community so that they can be supported in their own homes.

THE COMMISSIONER: And in no way am I attributing blame to anyone, but that's a failure, that number of patients you've got.

MS MAINS: It is (indistinct).

THE COMMISSIONER: Yes, exactly. And it's a failure that results, first of all, being a final burden on your LHD and the State; correct?

MS MAINS: The most important thing is it is a burden on the older person who is deconditioning and --

THE COMMISSIONER: It's a cascading thing. It's a burden on the patient. It's a burden on your workforce.

MS MAINS: Yes, it's a huge burden on the workforce. But we're also seeing people staying now on an average of 66 days. The average stay is normally 4.5; slightly longer for people awaiting aged care. It has a huge significant burden on access and flow for acute beds, and back-up on ED. So last night we had 48 people in Wollongong ED awaiting to get a bed that were in the ED. So it flows right through the system.

THE COMMISSIONER: But that is an example where planning involves not just the ministry or you but, because we're talking aged care and the same as if we were talking primary care, it involves the Commonwealth.

MS MAINS: Yes.

THE COMMISSIONER: Sorry for the interruption.

MR COLLINS: Can I just add one thing about aged care facilities. I mean, this is something which the Commonwealth is nominally responsible but I think that they are very happy to rely on using state facilities to provide

aged care services exactly as Margot has described.

THE COMMISSIONER: By state facilities you're talking public hospitals.

MR COLLINS: Yes.

THE COMMISSIONER: Which are not aged care facilities.

MR COLLINS: Yes. And so there is a serious supply issue because the alternative - the funding alternatives is hard to come by and mostly in private hands, and we've seen some of the consequences of that in the - with the pandemic and a lack of control by some of those private facilities. There are a whole range of issues. So I really think it is something that does require a lot more attention by the Commonwealth.

MS MAINS: And, sorry, if I could --

MR MUSTON: No, please go.

MS MAINS: So the area we're planning and modelling on what the projections are going ahead are fundamental because we're about to hit the biggest five years ahead of us to 2029 in term of aging and baby boomer, and it's really significant. And so good planning, good demand modelling, good planning, working out the roles is really critical, whereas it's a very supply driven market at the moment.

MR COLLINS: Sorry to come back. I do not advocate that the State walk away from aged care, because there is no alternative at the moment for these elderly people; there's nowhere else for them to go. And one of the consequences is if you do close down existing facilities, and there are many across New South Wales and Australia, you collapse the economy of the towns and villages in which they operate and which they serve. And that is not in anybody's interests and is not - would not generate any cheaper solution, because if you collapse those economies they end up going to bigger towns where there might be facilities but they cost more to expand those facilities to accommodate those people who have got to migrate to larger towns --

MR MUSTON: That's further away from their families. Migrating to larger towns potentially also means moving

further away from their families.

MR COLLINS: Yes.

MR MUSTON: I just want to pick up something, Ms Cox, you said. I raised a question around quarantine funding, and you indicated that one needs to be careful about quarantining funding because it can take some nimble decision-making away from those on the ground. I certainly wasn't advocating through my question the idea that particular services - that funding be allocated to LHDs to deliver particular services but rather that there be some parcel of funding which was available either to LHDs or through the ministry or some combination thereof to actually facilitate this statewide planning that we've been talking about which, despite an array of plans and strategies and blue documents with lots of smiling people in them, doesn't - I gather from what you're telling us, it doesn't seem to be being implemented on the ground in quite the way that it could be, and I wonder whether funding for that purpose might make a difference. Does that change anyone's answer to --

DR MORGAN: I might weigh in on that. One of the realities is that - and I go to Cathryn's point - many of these high-level statements are done for the very reason that, once you get past the forward estimates, everything's basically in the never-never, subject to change of political parties, subject to change of the government of the day, subject to changes both federally and at a state level.

And they're deliberately constructed in many ways, I think, that depending on what actually occurs in 10 years' time you can still satisfy the terms of the plan. But is it specific? Is it measurable? Is it really achievable, realistic and time band? Well, the answer to that is it depends on whether you get the funding for it.

And I think that's why there is always this challenge. It's actually only partly about the plan. It's about all of the circumstances that impact the execution of that plan. And you can have the best intention in the world that would optimise the delivery of arguably medical services but, if that's not accepted by the local community, if that's not acceptable as a potential policy position of the government of the day, the best plan in the

world is going to fail. And I think so it's only partly about the documents and it's about partly what is written today. It's about those and, when the rubber hits the road, what's it going to look like.

No-one would have ever seen the impact that Margot's experienced in Illawarra through the NDIS changes and through residential aged care. I think you guys are, sadly, an exemplar of when it goes wrong it really goes wrong. But, again, a vote in favour of the central planning argument is that we've talked a lot about the long-term plans. I also think that there is a very good case to be made for the tactical and medium-term planning at the centre.

Now, whilst there's a lot of collaboration I think between the LHDs and the other statewide health services, the simple reality is that decisions around what role ambulance services do in terms of keeping people out of emergency departments these days was a case in point. When it particularly hit the Illawarra, ambulance was able to provide extended care paramedics that have an increased ability to actually divert off to optimise community resources.

But if we're all sitting back going, "Well, the job of the ministry is to have a 10-year plan," we're going to miss the boat. It's far more tactical than that these days, I think.

MR MUSTON: Can I ask in relation to that the funding of the ambulance service and the extent to which that funding accommodates or enables the resources available through paramedics to be utilised in the way that best meets the needs of the system in a system wide planning perspective, how does that work?

DR MORGAN: Well, look, I think, you know, we kind of discussed before the reality is ambulance is block funded. That's exceptionally problematic for us.

MR MUSTON: Can I ask a question about that. By being block funded presumably the ambulance service at some point in history was given a base of funding which has been increased progressively over the years by a growth factor?

DR MORGAN: No, and that has been our problem.

MR MUSTON: So when you say "no" can I ask you two questions. First, there was a base at some point in the past: yes or no?

DR MORGAN: Correct.

MR MUSTON: Second, has growth been applied to that base?

DR MORGAN: Not as the growth factor as you would describe it.

MR MUSTON: Can I ask a question before you come to this point.

DR MORGAN: Yes.

MR MUSTON: In terms of the base, do you have any idea of when in history that base was identified as a reasonable cost of delivering ambulance services?

DR MORGAN: No. That's not visible.

MR MUSTON: Is it possible or perhaps even probable that at the time that the base was identified as being the reasonable cost of delivering ambulance services the ambulance service was more of a group of highly skilled first aiders who drove well rather than the very technically capable and well-trained clinicians that they are today?

DR MORGAN: Correct. So --

MR MUSTON: Just in relation to that, the cost of delivering that technical and well-trained workforce of paramedics presumably is greater than, through both them and the equipment that they use, what might once have been the case when the nature of the ambulance service was a little bit different?

DR MORGAN: Yes, it's incomparable. The reality is 1 December 2018 they became a registered health profession. The net effect of that has been twofold. One, COVID demonstrated that ambulance was a significant value proposition to the entire health system in its ability to actually keep patients out of emergency departments.

The other thing is the recognition of the aging population right around the developed countries around the world, and it is just unsustainable to taking people to emergency departments for conditions that could otherwise be treated within the community settings. And that's where there's been a strong recognition by health, I think it's fair to say, over the last five years that the ambulance service has a role far, far beyond the traditional notion of two people in a van.

And if you said to me what do I think would be the role of the ambulance service within a decade it would not be the organisation that drives you to the emergency department; it will be the organisation that actually makes you go to the right disposition for the medical condition that you now have.

So this changing proposition means that block funding with ever-increasing demand and that only being met by ad hoc political announcements lends us to a situation of really disproportionate FTE growth to demand growth. And I remember when we were meeting we were discussing the - back in 2011 the numbers were sort of 0 per cent FTE growth and 0.1, and it wasn't really until COVID that the numbers changed. And I had the team map out the percentage growth, and what that gives you is our workload against percentage increase in demand. And what that just says is that the current block funding and ad hoc investment is not fit for purpose.

MR MUSTON: I might call for that.

THE COMMISSIONER: You're going to have to tender that.

DR MORGAN: I knew you were going to say that. I actually helpfully did the actual numbers. You should only look at that as illustrative.

MR MUSTON: Do you helpfully have a copy of that for me?

DR MORGAN: We do. We do. So when you look at the fact --

MR MUSTON: Just before you finish that answer I'll deal with the technicalities of it. That graph that we've just been shown, we might mark that as MFI - 14 months in.

THE COMMISSIONER: Yes. Does anyone know what MFI we're up to? There actually hasn't been that many MFIs. Don't worry.

MR MUSTON: We'll mark it as an MFI that will be given a number in due course and then thereafter we'll tender it.

DR MORGAN: So I make this point that what we do know over the past five years is that, leaving aside variability for the fact of COVID, but ambulance demand has basically increased by about 2.75 per cent per year. Now, what we also know is that over the last decade we have been precisely 25 per cent of ED attendance. So one year it goes from 24 per cent, another 26 per cent, but over the period we've represented 25 per cent of all ED attendance.

Now, if I was to say to this Commission what would change ambulance services in this state tomorrow was exactly the point that you raised around just being funded for the state average growth factor. The state average growth factor tends to be, setting aside escalation, 2.5 per cent per year. If ambulance had been exposed to that same level of growth we move from an ad hoc, periodic political announcement to sitting down with the Ministry of Health and negotiating what is it that we would invest that money in most, and it may be paramedics on the road, but more likely these days it is going to be into virtual clinical care.

Some of the overseas systems are very sophisticated now with employing social workers, occupational therapists, mental health workers/professionals all aimed at getting patients to the most appropriate disposition for their medical condition. Now, I think our colleagues in Queensland have a social worker dealing in their - equivalent of a virtual clinical care centre that as soon as they get someone identified as social work and NDIS they actually refer them to the Commonwealth critical care team.

Now, what we do know is if you get someone who is in NDIS into an acute care hospital their length of stay tends to exceed almost every other category. So there's a significant benefit and maturing of the system where ambulance through the service delivery - sorry, the service agreement process be able to negotiate with health where they saw the best medium and long-term priority investment as well as consistency in planning for us.

THE COMMISSIONER: I've forgotten from our visit, but I'm sure I was told. I mean, obviously if paramedics are attending a car crash with traumatic injuries the people involved are being taken to an ED. But there was to me a surprising number of calls to the centre where the paramedics go out and what's not required is a trip to the ED but something else, as you say, the most appropriate disposition for the health service. But I've forgotten what the figures were.

DR MORGAN: Yes, so we get about 1.25 million triple 0 calls per year. That translates into what we would say is about 1,052,000 incidents. So that's just two calls to the same incident. But only about 784,000 of those last year actually ended up in an ED. So we actually make on average between 25 per cent and 30 per cent of all incidents don't result in us transporting someone to an ED.

Now, we have some really clever and innovative programs, and I think this is part of the evolving of ambulance, around we have specialties of what we call complex and chronic care; so some patients that actually need someone to go and connect them to the system, a really good example might be palliative care patient in the community or a mental health patient. The last thing you want to do if you can avoid it is take a mental health patient to an emergency department. They're busy, they're chaotic and generally not great places for mental health patients, unless they have concomitant other conditions.

Allowing us to actually identify these patients early in the call cycle means we've got a better connection to send them off in partnership with the LHDs to services that either they run or the community run. And there's been a lot of work done centrally in the cooperation with the ministry and all of the LHDs about building these referral networks for us. But this is where the fidelity of where our funding I think will go into the future is far more about how we optimise community services rather than building more and more big EDs.

MR MUSTON: I note the time, Commissioner. I was about to move to a slightly different topic.

THE COMMISSIONER: Okay. All right. Yes, we'll adjourn for lunch and come back at 2 o'clock. Adjourn until then.

LUNCHEON ADJOURNMENT

UPON RESUMPTION

MR MUSTON: Commissioner, I just have another table which Mr Morgan has provided. Shortly before lunch he gave an indication of the percentage of emergency department presentations that arrive by ambulance, and you'll recall the evidence was to the effect that it sort of hovered around 25, 26 one year, 24 another year per cent. I've got a table that actually charts that. We might incorporate that into MFI-18.

THE COMMISSIONER: Of course.

MR MUSTON: Mr Morgan, I might just ask you one other question about the ambulance service in particular. In our travels around the state we've heard quite a lot of evidence about the role played particularly in regional areas by the ambulance service in patient transfers and the potential challenges that that can present in circumstances where ambulances are required to do that more urgent work that ambulances do on the ground but might be deployed somewhere transporting a patient who's not necessarily in need of acute care from one setting to another. Is that a feature of the system at the moment and a problematic one if that?

DR MORGAN: I think again it's just demonstrative of the maturing nature of the system. If you go back to the original tenets of the Ambulance Services Act, which was 1982, which has now been subsumed into the Health Services Act, it was all about ambulance services being the first aid and transport of the sick and injured. So it didn't delineate between emergency and non-emergency.

As the years went by the system became so large in certain large areas there was economies of scale to split the system, and you could efficiently use, you know, a van and two people to do low acuity work and it was, you know, a very efficient way of doing it and that preserved your emergency vehicles for going to emergency calls. But you can imagine as you get smaller and smaller populations the ability to efficiently have two different systems sitting side by side becomes less economical.

Where some jurisdictions have done it quite well in regional areas has been around this notion of a hub and spoke. So large regional areas that would have and house patient transport vehicles, as we know it, they would actually travel outwards for an hour or two to small rural communities and pick up patients. That's not a feature that we've adopted yet in New South Wales. There are some attempts within the LHDs to pick up the sort of overflow of moving patients largely between their own facilities. But there does remain a gap, particularly in regional, for non-emergency patient transport.

MR MUSTON: Is that because the patient transport services which are delivered through HealthShare are largely confined to metropolitan areas?

DR MORGAN: That's largely right and, apart from the metropolitan areas, up into Hunter New England provided by HealthShare. But all the other LHDs have some footprint, but it's limited for patient transport. And I defer to my LHD colleagues, but I think they predominantly only do between their own facilities, which again leaves a gap. If people are being discharged, they'll often have to go home - if they can't get other transport - by the emergency ambulance within that community with obvious risks associated with that.

MR MUSTON: And with any increase in system wide planning that saw certain services being offered in some LHDs but not others in a synergistic systemic way the need for that patient transport would presumably increase?

DR MORGAN: I think in those communities that are certainly growing and aging that would absolutely be true. I am aware that there is some planning happening at the HealthShare level with the Ministry of Health around what a broader rural model for patient transport would look like, and I think it's fair to say we'd all be looking forward to the outcomes of that.

MR MUSTON: Do you have a view about whether the ambulance service should be involved in that patient transport service in the sense that you have a resource which is currently being used for transporting patients, perhaps not the best resource for that purpose, but is it - would there be any sense in having the ambulance service dealing with patient transport as well or should all patient transport

be dealt with separately to the ambulance service?

DR MORGAN: I think we need to be really cautious not to have absolute lines. The reason why is I think every individual circumstance will vary on the situation. If you think about it, you know, infirmed patients may not be acutely ill but may still need an ambulance. People with gross disfigurement may need an ambulance. People who are incontinent may need an ambulance. And sometimes - sometimes - it is efficient to simply take that patient from the place of care to their residence.

So I would hate to have an arbitrary line of, "We never do," but I think that having the option of having patient transport in regional New South Wales to do the vast majority of that work would be strongly appreciated by everybody.

MR MUSTON: No doubt much like the views expressed by your LHD colleagues about a clear service delineation, it would be useful to the extent that there is overlap between the two different services for the point at which that overlap occurs or the point at which the delineation occurs perhaps to be spelled out with some level of clarity so it's clear to everyone, both the LHDs who are moving patients around and also the ambulance service, what in the ideal world is a patient transferring, what is an ambulance trip.

DR MORGAN: Yes, I think the big difference is that patient transport, beginning as literally just taking a person on a stretcher who can't otherwise mobilise, that probably was closer to the alignment of an ambulance service in 1982. Now it is a registered healthcare profession practising paramedicine, and its duties and roles and expectations within the community are vastly different from today.

And there is a truism about regional service delivery. In some of these small - sorry, not some, in the vast majority of these small rural communities there is a single ambulance. And if that single emergency ambulance is unavailable for any reason, whether that be a long distance transfer, whether it be a routine patient discharge home, that ambulance is not available to provide ambulance service in that community and that's as if the service never existed.

MR MUSTON: Can I come to the discussions around - well the negotiation around the service level agreements and the funding roadshows that you each have. Just trying to understand perhaps starting with you, Ms Constable, what is the nature of that discussion or negotiation? How does it play out on an annual basis?

MS CONSTABLE: So we have a roadshow that's planned. At the LHD level we would prepare for that by having a look at some of the challenges we faced in the previous year and some of the goals and objectives we have over the coming year.

MR MUSTON: So, just pausing there, when you refer to challenges and goals and objectives what sort of things are we talking about?

MS CONSTABLE: So we might have had a particular pressure point of service delivery that really came to the fore in the last year's performance, whether the increase in activity or a difficulty providing that service to the need presented by the community, or it might be aligned with our service plan. So our goal to address the needs of our community over the next year means that we have a new service model that we want to implement and change, and that might require an investment before we demonstrate the activity or the impact in that initial year.

So we would consolidate a few items, generally probably three top things, and we would include those in our information that we would meet with the ministry about. The ministry would generally share the broader context; so the pressures on the system, budget, some of the challenges expected there, likely sort of - where negotiations were up to with Treasury, if you like --

MR MUSTON: "Challenging budgetary environments" is a phrase we've heard a few times this year.

MS CONSTABLE: Yes. So definitely that broader context about, "We've got money to give/we've got no money to give," or there are some particular targeted areas of interest. Through the course of that discussion - and generally there's a few of those follow-ups, at least a couple of those meetings - we would - sometimes they would say, "Look, we want to see that proposal in more detail." So we provide potentially to the ministry a much more

detailed business case about what exactly we're intending to do, what are all the costs associated that will be and what outcomes we would expect to see from that, and the outcomes might be in relation to delivering on performance objectives like access indicators or they might be on patient outcomes, impacts on flow et cetera, but also the generated level of activity we would see out of that.

MR MUSTON: So, just pausing there, do we take from that that effectively the base plus whatever growth factor is applied to it is in ordinary circumstances required to continue to just deliver the business as usual services that you're delivering and there's a need for them within the community or perceived need for them within the community, and so you continue doing what you've done year on year and then in order to make change or propose adjustments to that by either adding a service or changing a service you make a proposal through this roadshow process for the additional funding that you would need in order to bring that about?

MS CONSTABLE: Yes. So you can expect year on year the cost of delivering exactly the same service will increase both due to CPI, which we know has gone through the roof post COVID, and also we're in a complex industrial environment so the cost of staffing is also increasing. So just to do what we did yesterday is going to cost us more today and tomorrow. And so --

MR MUSTON: So is that adequately captured by the growth factor that tends to be applied to the budget or in your experience not?

MS CONSTABLE: I would say not. I think it assumes there is a degree of ongoing efficiency, and there is absolutely opportunities for ongoing efficiency. And the other factor in there is also the revenue through private insurance through the new - to the service as well. So there's a combination of challenges in the budget about delivering on revenue, achieving increasing efficiency with the resources we've got. And the reason I say there's always opportunities is because we deliver services across a 24-hour clock. That means we have a high volume of staff. That means we have challenging periods where we're required to use premium labour cost to deliver services, for example.

So there's always opportunities to try and look at how we have our staffing model so that we can reduce the need to rely on premium labour, for example. There's always ways to look at other new products we could be using that are cheaper to use than the ones we've got but don't impact detrimentally on patient care, those range of things. Can we go back to negotiation?

MR MUSTON: Certainly.

MS CONSTABLE: So we might present a business case for a particular service model, and I can think of an example. A couple of years ago we came up with a model around frail and elderly, our vulnerable population. We wanted to change the model of care. It required investing more before we could change or see the impact of that service model at the back end. So releasing the capacity would take longer than just turning one off and one on. So we wanted support.

In that circumstance we were able to negotiate some investment for a 12-month period with some specific deliverables agreed with the ministry about what we would deliver at the end of that 12 months. And that would be determined whether it would be funded as a recurrent model or we could release some capacity in our own system to fund it or what would be required. So it's just an example where there are opportunities to do that.

On other occasions we've presented, for example, I've talked about some of the challenges from the previous year. In the negotiations coming into this year we have increasing activity at Wyong emergency department. We're seeing over 200, 220 presentations a day here, the equivalent to somewhere like Westmead Hospital. So for a relatively small hospital in a regional area quite a challenging volume of activity and it had been quite a significant increase on the previous year.

So we presented that in the roadshow as a particular initiative we felt we needed investment to ensure we had adequate staffing to be able to respond to that demand and as a significant priority; clearly a vulnerable community, high levels of disadvantage, and low numbers of bulk billing GPs. So we are going to continue to see those people presenting.

We didn't get quite the activity that we hoped to have supported for there. But we did receive some funding through more of a statewide initiative in the emergency department relief package. So two short stay beds, emergency department short stay beds, were funded for Wyong that actually allows us to invest in some of the staff and have a response that enables us to manage those patients through and impact on flow.

So I suppose it's an example where we presented the challenge we're facing, the activity, all of that wasn't funded in that way; but through the negotiations it was clear our challenge was heard, it was observed, and there was able to be as part of that more broader statewide initiative some resources flow back to enable us to respond.

MR MUSTON: Just looking at that emergency department situation, was that increase in demand manifesting itself as longer waiting times within emergency departments in Wyong?

MS CONSTABLE: Yes.

MR MUSTON: And I think you've indicated that one of the drivers of it was a disadvantaged population and challenges in that population accessing bulk billing GPs.

MS CONSTABLE: That's correct. It's not solely explaining the increase in presentations, though, because we certainly also saw a reduction in our triage 4 and 5 category patients and, proportionally, the number of patients presenting in triage categories 1, 2 and 3 at the more acute end were actually increasing. So it's not totally explainable by people wanting primary health care not being able to access it and so attending the ED. The point was they were not attending their GP; they were becoming sicker, and so when they presented they were more unwell.

MR MUSTON: But the origin of both problems is challenges in getting access to the GP. So with your category 4 and 5s, accepting that some category 4 and 5 emergency presentations will actually be admitted so they're probably not a GP trip, but your category 4 and 5s potentially include a cohort who, if GPs were available and readily accessible, could go and see them instead of coming to emergency?

MS CONSTABLE: Yes.

MR MUSTON: And your categories 1, 2 and 3 includes a cohort who perhaps if they had had access to good primary care through a bulk billing GP in the years leading up to their unfortunate presentation might have avoided that presentation because they wouldn't have got as sick as they got.

MS CONSTABLE: Yes.

MR MUSTON: In terms of the decision-making around how to deal with that you indicated that this increased presentation was something that was inevitable and you would always need to deal with it. That assumes that the situation with primary care and the availability of primary care remains as it is or gets worse; would that be right?

MS CONSTABLE: And that's based on looking backwards and looking forward; so certainly a deterioration in the number of GPs available, and a worsening and projected worsening increase of the vulnerability of that local community. So for Wyong it's a fast-growing Aboriginal population. It's a young Aboriginal population. There are some of the most significantly disadvantaged areas in the country in the northern part of our district. And so it's not necessarily an ideal place to attract a GP to work in. We do have a close alliance with our primary health network and work closely with them on attracting GPs to the region. But it is a worsening problem over several years.

MR MUSTON: You've seen an example in Bowraville in the north coast of the LHD stepping in and delivering primary care through, in effect, a bulk billed multidisciplinary GP style clinic.

THE COMMISSIONER: It came across as Bowral.

MR MUSTON: It's definitely not Bowral. Bowraville. I'm sure there are people in Bowral who can't get access to bulk billing GPs as well. But Bowraville I suspect the problem is more challenging.

In Bowraville we saw the LHD stepping in and delivering a clinic like that which channelled some Commonwealth funding through a 19(2) exemption but,

nevertheless, filled what was a significant service gap creating the same challenges as you have experienced in Wyong. Is that something that you think if funding were available might actually make a significant difference to the challenge that you are presented with at the moment in Wyong?

MS CONSTABLE: I think it could if we can attract someone to pick that model up. So the workforce is always going to be the challenge. Any and all things can work. If we can get the right people and the framework around it, then absolutely.

MR MUSTON: Accepting that workforce challenges, particularly within the GP market, are going to bite everywhere, it might be seen as more desirable for someone who is a fellow of the RACGP to take on a salaried position with your LHD than, say, hanging up their (indistinct) and setting up business in Wyong as a bulk billing GP?

MS CONSTABLE: Yes, and we certainly have employed GPs. So we have employed - in the establishment of our urgent care centre at Long Jetty we have actually employed GPs into that model as salaried staff to help provide oversight and clinical care and those services.

THE COMMISSIONER: That's a state facility, isn't it, rather than the Commonwealth?

MS CONSTABLE: Yes.

MR MUSTON: Just in relation to the urgent care clinics, they're aimed at picking up that overflow in the emergency departments where, say, category 4 and 5 presentations that probably could go to a GP if one were available - obviously overnight maybe not - but it is in effect diverting a cohort of people who would otherwise be presenting in emergency into a different channel?

MS CONSTABLE: Yes, they are intended to pick that up. I'm not sure of all of the people presenting, and we are seeing a really good uptake of that. So in the Long Jetty service in about nine months we saw over 5,000 patients attend that service. So it is absolutely being accessed by the community. I think some of them would otherwise have gone to the emergency department. Many of them have actually just accessed what is the care that they would

have received had they had a bulk billing GP available for certain conditions. So I think some of it is a direct diversion and some of it is a sort of longer term improving the health of the community earlier.

MR MUSTON: In relation to longer term improving the health of the community, though, the urgent care centres aren't really providing a substitute for continuous primary care of the type that would better improve the health of the community over the long-term, are they?

MS CONSTABLE: No, that's correct. They deal with --

MR MUSTON: Episodic.

MS CONSTABLE: -- single episode care, they treat an injury or a particular limited range of conditions that need urgent treatment.

MR MUSTON: Someone, say, who can't get their blood pressure medication because they can't get access to a GP to write another script might go to the urgent care centre and get that script filled for them.

MS CONSTABLE: Yes, they could.

MR MUSTON: But if they did that they're not necessarily going to have the benefit of a doctor who has been monitoring the progress of their blood pressure over the period of years and potentially other comorbidities to make sure that they're actually being treated in a way - I say this entirely uncritically of the urgent care centre doctors - but in a way which holistically best meets the health needs of that patient. They come in, they get their script. If it's roughly within the boundaries, then they go.

MS CONSTABLE: Yes, correct.

MR MUSTON: As part of the discussion - just one more question before I get to the discussion. The funding that you received to increase the number of doctors that you could employ within the emergency department at Wyong, that was tied to or quarantined for that purpose, was it?

MS CONSTABLE: It was funding short stay beds. So the outcomes expected in the service agreement are an

appropriate turnover of those beds, so targets that we would utilise those beds on an average turnover of 2.5 times a day. And so we look at our overall performance. How we actually spend the dollars was not dictated by the ministry, except that there were going to be those beds available and the turnover and utilisation of the beds will be monitored. But it's up to us whether we employ nurses, doctors, allied health or what we do to deliver that outcome.

MR MUSTON: So the two metrics there that we're looking at are essentially waiting times in emergency departments which have blown out and you're endeavouring to get back within the range specified in your service agreement, and in relation to this additional funding the short stay beds have been funded in a way that requires you to churn people through them within a particular timeframe so as to keep that metric within the boundaries whilst, hopefully, achieving a reduction in the waiting times within emergency. They're the things that are measured.

Are those things which you think accurately reflect or capture whether or not as a local health district you're securing the best outcomes for your community's patients in terms of their longer term health needs - with both their immediate and longer term health needs?

MS CONSTABLE: So I think the turnover of the beds is probably not measuring the outcome on the community because you could fundamentally turn over the beds without having a positive impact. That might create other ripple effects like increased readmissions or re-presentations if you were inappropriately turning over those beds to deliver that outcome.

I think the outcomes, like our ED hospital access targets, are clinically based on evidence that shorter times in ED for certain discharged or admitted patients et cetera do have an impact on patient outcomes and morbidity and mortality and overall length of stay, for example, for admitted patients. So there's quite a lot of clinical evidence that the longer you stay in the emergency department, particularly for an admitted patient, then the poorer your outcomes are likely to be. So those drivers are absolutely driving the health outcomes, and they're very strongly led through the College of Emergency Medicine.

MR MUSTON: That would depend, though, wouldn't it, on what the source of the presentation was?

MS CONSTABLE: Not necessarily. I think the general research that is available would indicate that ideally you come in, you're assessed as promptly as possible, and you get to definitive treatment and care as quickly as possible, and that that will more likely give a more effective outcome for the condition that you've presented for, regardless of what that condition is. I'm happy to be corrected.

THE COMMISSIONER: I think we've been told that many times, and particularly for even more so for elderly people going into EDs, not having to wait long periods of time before they're given a bed rather than having to spend 24 hours or more in an ED.

MR WILSON: The only thing I would add to that is that's also why the targets aren't 100 per cent, is to recognise that there is a cohort of patients that would benefit from extended work-up in the emergency department, and that's where the wiggle room comes within the target.

MR MUSTON: Accepting there may be clinical benefits associated with seeing patients within those targets, is it nevertheless the best measure of the outcomes in terms of the extent to which the LHD is delivering on the health needs of its population through the money that it has available to spend?

MS CONSTABLE: Well, it's only one of a number of measures --

THE COMMISSIONER: It is a measure.

MS CONSTABLE: Yes.

THE COMMISSIONER: There are others that are important.

MS CONSTABLE: Absolutely.

THE COMMISSIONER: Just like there's other metrics for - I mean, one metric of whether the health system is working well is, you know, your planned surgery is done within clinically appropriate times. That's a measure.

But reducing rates of chronic disease might be another measure. Time to see children who might need some sort of paediatric intervention, how long they're waiting for that would be another measure; correct?

MS CONSTABLE: Yes. As well as things like quality - other quality measures.

THE COMMISSIONER: Of course.

MS CONSTABLE: Rates of hospital acquired complications and various other (indistinct).

MR MUSTON: In terms of those things we are measuring, do they - and any of you can answer this - but do you have a sense that they are capturing in any sense the unmet need within the community for health services or are they just capturing the extent to which we are, as a system, delivering on the needs that we've always delivered on within the budgetary envelope that's made available to us?

MS CONSTABLE: I don't think they're necessarily capturing all unmet need. I think if you're not performing in some of those timely access measures it can be an indication of unmet need that then requires, I think, further exploration. But I think a lot of the unmet needs (indistinct) because are unknown and unquantified, and that's one of the things that we do try to assess and evaluate in terms of the expected level of certain prevalence of conditions in our community based on the age and cohort, and that comes back to the conversation with regard to clinical services plans and trying to understand what are the vulnerabilities of this community and therefore what would you expect to see, and are you seeing more or less of that than you would expect to see. And so that's part of the ongoing process.

And a good example for us is we have a high level of smoking in our community, particularly the northern part of the Central Coast; a high level of smoking. We've targeted that quite a lot. We're having some success with accessing Quitline and getting very good results about ceasing smoking in pregnancy. But at the same time we recently met with the Cancer Institute and reviewed the Reporting for Better Cancer Outcome results, and we have one of the highest prevalence of lung cancer in the state. So those factors are all an indication we're not quite getting to

the right level of impacting on that smoking range yet to bring our cancer - lung cancer rates down.

THE COMMISSIONER: When you use the term "part of the ongoing process" do you mean part of the ongoing process of discussions about budget or something?

MS CONSTABLE: Probably more the ongoing process of how we as health districts try to assess the needs of our community, utilise the resources we've got and deliver, put plans in place, evaluate our progress against the delivery of those plans by looking at their health outcomes, and then working with the ministry on how we prioritise and allocate resources to address the area's most critical need.

THE COMMISSIONER: Can I ask a question about that that's been plaguing me. This can be for any of you, but I'm going to ask Ms Cox or direct it in first instance to you. You're not an LHD, I know you're a network, but LHDs have this statutory obligation for promoting, protecting and maintaining the health of residents of the area. And if any of you know what that means precisely please let me know, but we sort of know what it doesn't mean. It doesn't mean that every LHD should be doing, you know, heart-lung transplants, for example.

But what it certainly does mean, and I have complete confidence this happens, if a child turns up at Westmead or Randwick and they've suffered a trauma or, you know, they might have symptoms of their appendix rupturing or they're not breathing, all those sorts of serious type things, I know they're going to be seen quickly and probably by highly skilled clinicians. So that's going to happen, and the funding is there for that to happen.

But when we were at the round table at --

MR MUSTON: Sydney?

THE COMMISSIONER: No, at Westmead was one and also at Sydney LHD where Professor Wolfenden, I think - there was discussions about children with a variety of conditions. They might need to see a neurologist, they might need to have an intervention because of something that might cause a learning disability and delay their schooling. And all of those clinicians told me that the wait lists are beyond

the time that they - are at times they consider to be clinically significant; that is, there is not the resourcing for children that need those services to be seen in a time - or they're seen after - the wait list is so long that they're seen at a time after which they should be seen, and the delay is clinically significant.

I get from a headline perspective why if a child has suffered a trauma they're going to be seen immediately when they turn up in ED because no-one's going to absurdly say, "Our budget's been blown for this year so we can't see that child that's got a life-threatening condition." Obviously that doesn't happen. But we don't seem to - the conditions I'm talking about where intervention is required but might be such that - there's plenty of evidence about this, might be the kind of interventions that mean that they become an economically active, productive member of society, but we don't seem to have the funding necessary for those people to be seen with the same urgency so that it's not clinically significant in terms of delay that we see a child with a trauma.

Do those discussions take place when your budget is set? And for anything that's analogous to any of the rest of you please feel free to answer that dilemma I am thinking about.

MS COX: So there's a couple of issues embedded in that. One, a lot of those services are allied health; so speech therapy, hearing, you know, delays language, you know, those sorts of things, impact school, so they are very significant. So there is certainly an element of workforce availability.

THE COMMISSIONER: Yes.

MS COX: There's an issue around community paediatricians, and particularly in rural and regional that's very difficult.

THE COMMISSIONER: Yes.

MS COX: We are certainly doing a lot --

THE COMMISSIONER: Bearing in mind the workshops I have in mind, one was at your network out at Westmead and the other one was at the Sydney LHD. So we're not regional there,

but I understand the point you're making.

MS COX: And I think that came up with, you know, Murrumbidgee and John Preddy in his testimony earlier as well. So issues of workforce; issues that we are screening, so first 2,000 days; and probably what we're doing is identifying in that mix, you know, more children with behavioural and neurodevelopmental issues, and then we don't necessarily have a treatment capacity to respond to what we're identifying, and so there is definitely an unmet need.

Now, in terms of the roadshow discussions, because the network's tertiary/quaternary we tend to talk about our base, our acute services, and we probably have more of the discussions with our LHD colleagues around how can we help because we've got paediatricians and gen med and things like that, how can we actually help them with some of the gaps that they've identified from their own clinical services planning. So Sydney local health district, for example, if they identify they've got a long wait list, they might like to approach us to see if we can help them, and then we sort of negotiate that amongst ourselves.

THE COMMISSIONER: Tell me if this impression is - first of all, with a lot of these - if we're talking paediatric services, and maybe it extends beyond that, but there are many a things that were discussed at the round table - well, at least some of them are beyond health's control; for example, public education, housing, regulations concerning junk food, and drug and alcohol.

MS COX: Yes.

THE COMMISSIONER: But the sense I got from the clinicians, the paediatricians and other relevant clinicians, talking about this general issue was one of - and I don't think I was misreading the room - was one of, "We are really seriously underfunded and very unhappy about that because it's affecting the outcomes of the patients we're treating." Was I misreading the room?

MS COX: No, that's exactly what they were saying because you know that if you can help a child - make sure they can hear, make sure they've got language, make sure they're in stable housing, out of juvenile justice, in a safe home environment, then you'll get them to school, you'll get

them to stay at school and then you'll actually have an impact on their life trajectory. That is well known.

THE COMMISSIONER: Just stopping there, I hope this isn't unfair, but I didn't get the - this is not meant as a - I'll just say this. I didn't get the impression yesterday from Treasury that the potential benefits of extra investment in that are actually modelled as to how it might - what the secondary benefits might be of interventions like that in terms of people leading more productive lives if there's early interventions like this. But does that happen or is that a consideration when you have your discussions with health about your budget?

MS COX: Not about my budget, but I'm pretty confident that my LHD colleagues would certainly have some of those discussions around that. But we've been talking about prioritisation, and I think we know - and I know this from LHD colleagues as well - that it's often very hard for the paediatric voice to be heard because the population aging effect is so significant and, you know, there's lots of issues that Margot is dealing with, then we realise that we're a small cohort in that big picture.

THE COMMISSIONER: Yes.

MS COX: And so sometimes that's not front and centre in those discussions.

THE COMMISSIONER: Yes.

MR MUSTON: Can I ask whether that is a feature of the other LHDs' discussions around the roadshows, that is the extent of this unmet need?

MR WILSON: I comment because I think it is a really good example because it is one that we do have the evidence and I think is well understood through Brighter Beginnings around this, and I think there is a legitimate need and benefit that is flagged through that program and work. I think that's quite classically a program of work, though, that - and I wasn't in any way part of this process, so I'm just assuming this - that the cloth was cut to fit the budget. And a number of us have raised concerns around that we've created a great screening program, but the actual follow-through with treatment is really challenged.

That probably because of its very nature, though, because it's a statewide program, isn't necessarily something that would always bubble up through the roadshow conversations because generally our roadshow conversations are more focused on what are our challenges within our district and where does this sit on the priorities. So, personally, I would take that up through to the branch and have a conversation with the branch and up through the ministry that way to say, "We think this is an amazing initiative. We absolutely need to get behind it. We're all supportive of it. But there's a risk here that we're screening and we haven't necessarily invested in the treating arm and what's our approach to that," and that probably needs to be a separate conversation to government.

Because there is not a lot of value in me solving that within South East Sydney if Sydney LHD is going to have the problem and Western Sydney is going to have the problem. This is where we need to have that broader approach around how we're going to address this, and in some ways it's around what are we going to trade off in that space as well.

MR MUSTON: One approach to that issue --

THE COMMISSIONER: Sorry, I think Ms Mains wanted to add a comment on that.

MR MUSTON: Sorry.

THE COMMISSIONER: You had your hand up.

MS MAINS: So what was being said about children and the impact, I was involved - not in New South Wales, in New Zealand - in a major exercise with inter-agencies - housing, employment, education and so on, treasury - and I was the health representative. And there was 238 members of extended families with significant histories of not going to school, truancy, not having enough food, poor hearing, and significant imprisonment and so on.

What was interesting about that exercise is in the top six things they felt they needed to turn around their lives health did not feature, because the fundamental things that actually made the impact on health was actually housing, and education, and food on the table. And we were trying to get a multi-agency approach. The trouble is it needs a

medium to longer term solution to turn that around; whereas we tend to be focusing on more measurable solutions with immediacy to medium term. And it's similar to some of the situations we face now with significant complexity with people with their comorbidities and chronic disease, and the need to find ways to measure outcomes relative to funding investment and what - they are not easy to establish, but we do - we need to evolve --

MR MUSTON: Does that potentially bring into consideration an adjustment to the KPIs so we are confronted with some of these issues more directly? For example, Mr Wilson raised the point of, "We increase our level of screening of children, it identifies a greater level of developmental issues within the population that are not able to be met because we don't have currently the budget to meet those needs," that's fine to a point but there's no KPI within any of the LHDs' service agreements - at least to my memory of reading them - that says, "We have a screening program. How many children are there who have developmental issues which have been identified and how many of them have been seen by community paediatrics or by a public paediatrician" within sometimes up to three years, which we're told is reaching the point where you lose the benefit of the intervention.

But can I contrast that and just invite you to comment on this, contrast that with a slightly more sophisticated screening program that we've long had which is the inclusion of older people onto elective surgery waiting lists for, say, knee replacements and the like where a doctor has screened those people who had a sore knee and said, "I have decided that this person is appropriate for a knee replacement." They are on the list and then we are quite assiduous in our attempts to measure just how quickly they get to the top of that list and get their surgery. Why are they different?

MR WILSON: So why are they different? Again, it's probably a bit of custom and practice around what we've been measuring. I would probably, though, reflect - and someone else will probably know the exact number - but last count there's 119 KPIs or performance measures in the service agreement; 120 is probably not going to make a huge difference to some of these things, I think. I was going to comment earlier around some of that questioning with Jude around the KPI piece.

It would be - I think one of the challenges with having longer term measures of population health and what are you affecting is that they are long-term measures. They don't move quickly and easily, and they don't lend themselves to some of the monitoring the way that we work at the moment. So I think it would be worth a rethink of the service agreements and what the measures are. But I guess I get nervous when - like, it feels like every new thing we do there's another KPI that gets put in there and, there are so many KPIs that sit in there, you're left juggling an awful lot and at the end of the day you fall back to the ones that you tend to talk about. So I'm not sure --

THE COMMISSIONER: You're absolutely right. But, on the other hand, if I read out to you what's in the last New South Wales Intergenerational Report or the Commonwealth one there will be at least a few paragraphs devoted to the fact that if we're going to reduce the growth in the rate of the health care spend then we need to - as one example - compress the period of morbidity people have in relation to chronic disease, and that obviously requires the sort of long-term planning and long-term investment that you've mentioned.

MR WILSON: Yes, I completely agree with where you're going. I think it requires a bit of a rethink around how we set up our service agreements and maybe there are five-year or 10-year measures. But I guess my nervousness with that is our history is that on a quarterly basis we are reporting against our progress against a 10-year measure that doesn't move an awful lot and we get stuck in a reporting cycle that doesn't necessarily help us.

But I think some of these signposts of where we're trying to get to will drive the right investment both at a system level but at a local level as well. Like, if we are measuring this and it is - and it shouldn't be - I would argue it shouldn't be the number of people on a waiting list but it should be a metric that is more around the number of people that are now actively participate - number of children that are actively participating in school or something like that that would start to drive some of the behaviours that we're looking around.

THE COMMISSIONER: And when you're using the phrase

"system level" in my head I'm hearing the Commonwealth as well because they also - they have a very big role to play in relation to issues like compressing the period of morbidity because they take responsibility for primary care, as an example; and prevention, they've got a role in that under the NHRA.

MR WILSON: And it's interagency like Margot spoke about because, again, a number of these issues - health generally is the safety net that catches people that fall through every other area. We need others in this space helping us. And I guess some of this was sort of the Premier's priority concept a few years ago called out some of those things to try to drive some of that cross-sector collaboration to get some of these things moving.

MS HOEY: I just wanted to comment I suppose the service that is - you know, we pick up the sort of results of the missed opportunities, especially from the kids, and we do see a lot of kids coming through with, you know, lack for literacy with undiagnosed - whether it be behavioural disorders or whether it be neurodevelopmental or development disorders. And, you know, we've put in a number of proposals to try and intervene upstream.

But I think, really, I don't think there's clarity about whose responsibility it is. And so is it state health's responsibility? Is it primary care's responsibility? Is it the Commonwealth's responsibility? And I don't think that's necessarily agreed, therefore nobody's stepping into that sort of ring, if you like, to do that.

And I think when you see the funding coming down and what we're being funded for, whether it be ABF or whether it be incentive funding, it's not necessarily around the intervention of these kids who need - and the support. We know clearly, the research tells us, which kids are going to come into the justice system, for example. We can tell that from a very early age. But we're just not - there's not, I think, the coordination, the funding and the responsibility allocated to actually intervene.

MS COX: So that's important we link back to the roadshow process in that it falls between the cracks, probably, because the LHDs - I'm not having it in my discussion; I'm having them to the side. The other LHDs are having them

outside the purchasing. But we don't know collectively if that's a statewide issue around children getting developmental assessments and all sorts of things. Like, where's that happening and how does it relate to our roadshow discussions so that we know I don't have to identify it on behalf of the state or Tobi might raise it, Margot might not?

MR MUSTON: Acknowledging what Mr Wilson said about not burdening you with too many unnecessary KPIs, just to test this, I would imagine - and correct me if this is wrong - but if your wait lists for elective surgery had blown out beyond what the KPIs required of you that would form part of the discussion at the roadshow; would that be right?

MS MAINS: Prior to the roadshow on a more regular basis.

MR WILSON: Yes. I would also reflect there's a number of waiting lists that we don't necessarily talk and capture as well. So there are a lot of waiting lists in health. We very much focus on one. As a washed-up elective surgery manager, I don't particularly like wait lists; I like wait times and other things that are much more accurate measures. Like, it doesn't matter how many people are in front of you in the queue for the bank teller. If you're served within two minutes it's a good experience. If you're served in two hours it's not. That's what we're measuring at the moment. So there's a sophistication which we need to apply to all of these kind of things which I think we could extend out to a lot of the areas that we have.

MR MUSTON: Leaving with that analogy, if you're two hours and you're waiting for a bus, and it's the last bus, it's a catastrophe. If it's two hours and - it's two hours at the end of the day which is suboptimal but you can then get in your car and drive home, it's probably less of a catastrophe. But that's measuring outcomes not process.

MR WILSON: Yes.

MR GREGORY: We heard a lot around paediatrics where a really good example for us of exactly the same thing is in obesity and your point around KPIs and service agreements to really give transparency to it and our ability to intervene at the right time so the patient doesn't go downhill in their chronic disease. Obesity is a really

massive one for us and a really good example of exactly the same thing we've heard around the Commissioner's example on paediatrics.

MR MUSTON: Coming back, Ms Constable, to your example, if my memory of the service agreements is correct, there is a KPI in there that measures the number of First Nations women who are pregnant and have been persuaded to stop smoking.

MS CONSTABLE: Yes.

MR MUSTON: That's a very process driven measurement but doesn't necessarily assess whether or not they've taken it up again?

MS CONSTABLE: No.

MR MUSTON: But there is no KPI that actually contemplates the other statistic you gave us which was the epidemic of lung cancer which exists within your population. It may be going up; it may be going down; who knows from a KPI point of view?

MS CONSTABLE: Not a specific KPI in our service agreement, but clearly we do monitor these because we monitor cancer outcomes with our partnership with the Cancer Institute.

MR MUSTON: Things like that, incidence of cancers that are being monitored and figures exist out there and the incidence of diabetes and obesity, say, within the Nepean Blue Mountains, are they things that feature in discussions around the roadshow? For example, "You should increase our funding this year because here is the percentage of our population which is obese and in need of" --

MR GREGORY: Yes, there's no reason why they can't --

MR MUSTON: My question is do they.

MR GREGORY: Well, I've not actually experienced a roadshow as part of the Nepean Blue Mountains because it's (indistinct) my appointment. But there's no reason why we couldn't raise it as one of the priority for us for funding through the roadshow process, yes.

MR MUSTON: Maybe in terms of a roadshow that you have participated in, has the discussion around the incidence of lung cancer within your LHD been a feature of that roadshow which has resulted in any increase in the funding made available to you for, say, smoking cessation or screening programs?

MS CONSTABLE: Not cost-effectively in the last couple of years that I've been involved. But we might integrate some of that sort of information in the rationale for a particular model or priority we're putting up at times. So it might be the flow-on beds of that high incidence impacting on the capacity of our service to meet cancer treatment demands. And so we might come up with a model, for example, around having rapid access clinics for medical oncology patients to prevent them coming into hospital, and that might be because we have a higher incidence of lung cancer receiving treatment through medical oncology, and then the risks associated with that treatment journey and then coming into the hospital and how that impacts on overall patient flow.

So it's such a complex network of what is that big health to the little health treating the condition through the journey through the services sort of thing, and one of the things we're trying to do is both of those things on an annual funding cycle. And that's the challenge I think that we're talking about: the long-term impact on the health of the community versus an annual funding cycle and delivery against a set of KPIs this year, and how those things occur simultaneously and yet in a meaningful way so we do the long-term better.

MS MAINS: I just would like to raise that the roadshow is not the only discussions that we have in the build-up to any contract. So we, for example, have presented a number of proposals and discussions to the ministry, whether it's around aged care, whether it's around the fact we're 6 per cent over activity and our demand with the Cancer Institute over cancer, the rates and what's actually happening, and then taking those back into discussion.

So I think it's not - to me the discussion is not one point in time. It's the work you continuously are doing; the ministry. It's the work we've no doubt all done during all of our service plans for new developments where we've gone back and done modelling and done service plans for the

new hospitals. So to me the roadshow is one discussion. And then it's not the end point of discussion.

DR MORGAN: Yes, actually, I think that's a really important point to make. I certainly have spoken about the challenges of the block funding process. But it is an absolute fact we've had significant support from the ministry around addressing some of these historical issues created by block funding. But, as we sort of heard earlier today, we've demonstrated we clearly experience the same growth as the local health districts for demand of services. But through the service agreement process and the roadshows, because we're block funded and therefore only deal with escalation and the CPI, we don't actually even discuss demand at all because there's no way of dealing with the demand. And so therefore it doesn't feature in our service agreement despite that we will absolutely go up at the same percentage as everybody else.

MR MUSTON: Is there an extent to which - well, let me ask this question first. Activity and the ABF system, to what extent does that drive discussions around the level of funding that the LHDs receive? Accepting that there is the ABF component of your funding and then there is grant funding for other programs, but to what extent at least as viewed from the perspective of the LHDs is ABF a central driver of the funding?

MS MAINS: The ABF is currently 83 per cent of our funding base. So it's a significant discussion, but there are other discussions. But it is a significant discussion.

MR WILSON: In my experience, generally the conversation is a dollars conversation first and then a mix between what would be activity and what would be block funding that needs to come through, which is a bit of a case by case piece. So a service that we know is going to generate activity we would be happy to take. Activity for a service that we know we need to fund which isn't going to generate activity there's generally a negotiation through that process. There's certainly a preference - I think all of us would have a preference in the current funding environment that activity would be preferable because we know that would mean the Commonwealth contributes to that as well. But there are some limitations obviously with ABF that make it difficult in some situations, particularly either starting up a new service or some of those services

that don't quite fit the ABF model.

MR MUSTON: Is there an extent to which ABF funding as currently structured at least pushes us a little bit in the direction of treating problems once they've emerged rather than dealing with them and intervening in a way that might prevent them from emerging; that is to say, it's not well suited to dealing with the prevention of chronic health issues?

MR WILSON: I'll start because everybody knows ABF is one of my favourite topics. ABF has its limitations around some of those prevention - some chronic disease. Depending on how you structure your ABF, though, it can be more flexible than how we currently structure it within New South Wales. And there are - I certainly have had experience in the past where you've been able to use ABF to drive much more timely decisions because in a true ABF environment there's a funding source that you can access pretty much in real-time if you're doing more activity that would actually fund the ability to make some of those calls at the time that needs to happen.

MR MUSTON: What's the flexibility that would need to be built into the system in New South Wales to enable that to better occur?

MR WILSON: So you need to move to a model where there's a recall policy associated with that so you don't just have a hard target of 100 per cent of your activity is what you're going to get. But if you go above your target - like, I think a number of people on the panel today have talked about being over their activity target. That over your activity target in the current climate is - my understanding, because I'm not one of the people that's over their activity target, but is a negotiation around, "Can we get some more dollars to reflect the additional activity we're doing," whereas you could set up a structure where actually, "Well, we know that we're over and, if we're over by this much, this is how much money that we are going to get."

So that allows you to make decisions in real-time that says, "Well, if I'm going to do this and I'm going to generate 100 additional NWAU, I know the funding environment means I'm going to take home $100,000. I'll be able to claim that straight away and I can make decisions

in real-time rather than having to go through a negotiation process."

MR MUSTON: Does that not potentially drive you into a position, though, where those activities or those forms of care which attract activity then become the preferred thing to deliver when you're engaging in that prioritising exercise of, "How am I going to spend my budgetary envelope," you might say something like "our community based paediatric care that doesn't necessarily readily attract activity doesn't get prioritised", perhaps consciously, perhaps unconsciously, because doing some more elective surgery has the double-whammy benefit of reducing your waiting times, which is a tick from a KPI point of view, but also increasing your activity and thereby increasing your revenue?

MR WILSON: Potentially. But, again, it depends how you choose to structure this. So if you're doing something around how you're funding those community based services long term and setting long-term agendas and having dedicated funding that's available to deliver on those or quite often how I've seen this play out in other jurisdictions where these models have existed is we wouldn't have a conversation around something that's going to drive activity because the immediate response back from the ministry was, "Well, you've got a funding policy. You know your rules, Tobi. You go and do that." And it would be those things that we would be talking about because we would be highlighting that, "This doesn't fit within the funding policy so this is a problem for me. So I can't generate the activity to do this. So I need to have a conversation with you around this." But if I can generate the activity because the funding policy says you're in control of it, we wouldn't have those conversations in that space.

DR MORGAN: This is a really important point and it's one of the distinctions why I sort of talk about in our world activity based funding actually is not the answer for us and why I make the distinction to state average growth factor. A number of the ambulance services in Australia and overseas have tried to develop an activity based funding model for ambulance services. The truth of the matter is every single time - including here and Victoria quite extensively. And every time they've tried to do it it's basically ended up in a count of something as distinct

from true activity.

London ambulance service, who also in the 90s saw a distinct benefit in actually disincentivising transporting patients to emergency departments, ended up creating a perverse incentive for riskier behaviours; and so the system was abandoned.

And I think that's why it's got to be a more nuanced conversation about horses for courses. We do know that growth in health care expenditure is a reality. There were deep cuts through the NHS in the UK through the 90s, and I think the general consensus is it remains a challenged system. But this notion --

THE COMMISSIONER: I don't know whether there were cuts to the NHS in the 1990s. I reckon there might have been increases to the NHS in the 1990s. I think the cuts might have come later. Or are you talking about the period 1990 to 1997?

DR MORGAN: So I'll continue.

THE COMMISSIONER: I've got a feeling when Blair got in there was an increase in funding for the NHS. It might have been cut before that, and it was certainly cut in the period 2011 onwards, as were social services cut, which has had a big impact on the NHS. But I just want to make sure Mr Blair and Mr Brown get credit for what --

DR MORGAN: I think we could characterise health care as always going through cycles. I think that's the one thing --

THE COMMISSIONER: I'll accept it from 1999.

DR MORGAN: Suffice to say I think this more nuanced discussion about the fact that there is growth, there is growth in health care and how is that serviced best within what you purchase to deliver is the much more nuanced one than something, for example, how many emergency calls are ambulance going to drive to, how many paramedics are you going to employ. And I think this is why I quite like Jude's model about what's the outcome that you're seeking to purchase, and then how you actually deliver that outcome - i.e. the model of care - that's a lot more sophisticated, in my mind, than just purchasing widgets, as it were.

MR COLLINS: Could I come in on activity based funding. I think there are certain things that ABF is not able to cover. Rurality is one of those; I have spoken about that earlier. Specialised services I've spoken about earlier. If you're a place like Nepean, you don't have that specialised service. You certainly don't have the concentration you have in the inner areas. Also infrastructure maintenance. And the other thing that ABF conveniently ignores, side steps is philanthropy, the impact of philanthropy.

THE COMMISSIONER: Your LHD doesn't get a hell of a lot of philanthropy, I understand.

MR COLLINS: Yes. I think there is a strong case for an audit of philanthropy because that's a factor in healthcare funding and it's something that needs to be taken into consideration in terms of trying to strike the right balance.

So the ministry will tell us that we're paid the same NWAU as the eastern suburbs - now, I just want to take you through this for a sec - and so the ABF is a fair system. Look, I'm not saying the ABF should be completely replaced, but I think that there are more factors that need to be taken in consideration in the ABF, and block funding is the counter to the imbalance caused by the existing ABF - by the ABF missing out on those areas that I've specified.

Then you get to the historical imbalance which is never addressed by the ABF; in other words, the advantage of simply being there and being better resourced for a very long time and having historical funding directed your way, and that is the east-west divide in Sydney.

So if I can talk specifically about the Nepean Blue Mountains, unlike Northern Sydney. For example, Northern Sydney has got three private hospitals: North Shore Private, the Mater and the San. The Mater and the San have been there a very, very long time. They're deeply established, great connections, great community support, and great alternatives to public health. And they have got supporting public hospitals, too: Northern Beaches, Ryde, Hornsby.

In South East Sydney you've got Prince of Wales,

public and private; St George, public and private; Sutherland; Hurstville.

In Nepean you've got Nepean. All right, there's a small private hospital alongside which you've seen, and it's relatively new. And we've got Blue Mountains 50 kilometres away and Hawkesbury. And they do not have the resources of those hospitals that I have just enumerated in Northern Sydney and South East Sydney. And there is no decanting for us. There is no capacity to take a strain off Nepean. Nepean has to take all the strain.

So they're things that aren't taken into account in the funding model, and that what it boils down to is NWAU can come up with, "You get the same money as everybody else. Therefore it's fair. So what are you complaining about?" But it doesn't address any of those issues that I've raised. Therefore you end up with an inequitable system, an inequitable funding system. Despite its equality, it lacks equity.

MR MUSTON: Can I just test a couple of aspects of that. The first is you raise philanthropy. Philanthropy should not, in a properly functioning system, form part of the funding for business as usual activity, should it?

MR COLLINS: It doesn't form part of the funding base of an LHD; that's correct. Were it to do so, we don't - we have none. So we have a foundation. The foundation has - Lee, I think the figure is about 250,000 in its account, something like that. I stand to be corrected on that, but it's a modest amount. Even if it were a million it would be quite insignificant.

Philanthropy gives existing and well-established and historically long-running LHDs an advantage because it can provide a top-up capacity. It can be something that, well, assists in recruitment, for example. If you can say to somebody, "Look, you know, we've got a research foundation we can chip in 100,000, 200,000, we can get you another staff member, whatever," it gives an advantage that we simply don't have at the moment.

So I suppose a question is: does the ministry, does the government need to look at some seed funding to establish a philanthropic core in the LHDs that currently lack that, including obviously Nepean Blue Mountains LHD,

so that a bit of seed money so it can be used to go out and try to get more money in to I won't say even up the philanthropic scale, I mean that will obviously continue to advantage the east and the north, but we do need to do something to kick-start that area. And it's not something that can show in the budget, but I do think it's a factor that - it's a hidden factor and it needs to be talked about.

MR MUSTON: Ms Mains?

MS MAINS: Philanthropy has always played a key role in health services, and if I just think of a couple of things. One is supporting research, which has been really important for communities and bringing multifactor people together supported by businesses and so on has been really key.

The second thing, and this is a question that you asked, I get asked regularly by the Illawarra Community Foundation that runs Convoy, the truck thing that's just happened last weekend to raise over 4 million for us to redo our children's ward, which enabled us to introduce new outpatient areas, new family rooms, and they said to me, "Why does this not come from government funding?" And I said, "It's a matter of priority," because in this district we've got 1.25 billion currently of government funding doing new developments, and this was not our highest priority.

So the fact they made a real commitment to it, they wanted to do it, but they needed to understand why it didn't fit where it fitted. And we were able to explain that this would expedite it; they would be able to create something special for children and families ahead of any planned schedule that we actually could accommodate given the massive amount of funding that we have got at the moment. They accepted that and they have generously changed service for children and families in our area.

MR MUSTON: To Mr Collins' point, though, does that not potentially create a system where LHDs that enjoy the benefit of philanthropy are able to provide better services through the public health system to members of their community than those that can't generate that level of philanthropy?

MS MAINS: It's interesting because previously

(indistinct) in South Australia with philanthropy and I was a CEO in an area which had the highest health needs and unmet demand. The given of that community was phenomenal. So there's this philanthropy everywhere. It's harder now than it used to be because there is less money and there is a lot of financial pressures for people. But there's a (indistinct) giving in kind as well. And it's like volunteers; it's a fundamental part of services of (indistinct).

MR MUSTON: Ms Cox, do you have a view about the place of philanthropy as an operator for a section of the health service that we were told receives very generous philanthropy?

THE COMMISSIONER: I think we were told that some philanthropy is going on call services.

MS COX: That's right. So for the two redevelopments that we've got going there's a $75 million contribution from philanthropy. I don't think there's probably any other government project, hospital project, in New South Wales that's getting that level of contribution. That would be a general fund. But, again, like Margot's saying, there were areas in both those facilities that could not be delivered within the funding envelope that we had, and philanthropy helped do that.

In relation to - we've got a number of core services, so certainly in relation to child life therapy and cancer services in our diagnostic services, they are all supported by soft funding. So that's great that you have that opportunity. But they are also positions that have no permanency. So it's challenging. It's not a panacea to all things.

But all children's hospitals in Australia have very significant foundations and are expected to contribute significantly from philanthropy for a range of core services that covers our cancer services, a lot of our fellows, you know, so the junior medical staff to train them, and that actually becomes a resource for services all around Australia. You know, neurology fellows that have been trained through a program at the network are in New Zealand, in Adelaide, in Perth. So we're actually making sure that there is access to those skills and expertise much more broadly than just wholly within the network.

MR MUSTON: Coming back to the discussion we were having this morning around service planning and perhaps some of the difficult decisions that need to be made about what does form part of the public health system and what doesn't, is there an extent to which too great a reliance on philanthropy can result in that process being perverted by the philanthropic process or donors?

MS COX: So we've got a very close relationship with our foundation where we indicate our priorities. The issue, though, around being best endeavours - so even if there's money this year, it might not be there next year because the donor might have another interest. So, as I said, it's not a panacea. And so my approach is that we don't establish core clinical services with soft funding because I actually have no way of transitioning them on. And you can't just rely on having - there's a particular statewide gastric motility service that we would love to establish, and the clinicians again would love to establish, absolutely needed. But we shouldn't do that from philanthropy because it's actually core business and if I don't - and I need to talk to the ministry about that in terms of growth funding so that that's got a sustainable funding trajectory.

So philanthropy is good for some of those one-off type, you know, equipment, capital, those sorts of things can make contributions. But it really shouldn't underpin service provision.

MR MUSTON: So the point that you make is if you allow a clinician who has perhaps managed to attract some philanthropic funding to develop a new service which is interesting, exciting for the clinician, no doubt meeting a need of some description within the community, the problem is once that starts your ability, particularly having regard to the fact that some philanthropic body has generously given money to enable it to start, your ability to wind it back and say, "This is actually not part of the public health system as we currently envisage it," is constrained.

MS COX: I can't say in two years' time, "Sorry, that donor is no longer willing to support that. So I'm going to shut the service."

MR MUSTON: Or in two years' time, if the donor remains willing to support it but the extent to which the LHD's money is being used to supplement that service, if that LHD money could be better utilised somewhere else your ability to say, "Thank you very much for your kind donation over the past few years. We're not going to do that anymore. You can have your machine back," that's just not a practical reality and would no doubt cause pandemonium within the body of clinicians who are delivering that no doubt much needed and innovative procedure.

Mr Wilson, you're another LHD that I think enjoys the benefit of some philanthropy. Is that your broad experience?

MR WILSON: Yes, and not to the same extent as Cathryn, and probably we're a broad district, so we see the full impact. We certainly don't have a strong philanthropic presence in the south of the district. So St George and Sutherland - Sutherland's doing a bit of local work, but they don't have the benefit of what we see in the north.

The only thing I would add to what Cathryn's got to say is even from the - I think we need to keep this in context because in many ways it also a double-edged sword for us in that a number of conversations we have around equipment and capital with the ministry will be, "Well, where is your foundation first or where are you able to access other funds to do this?" So I think everybody is aware that this is a funding source that is available to us, and I think it is a more nuanced conversation that we do have around actually how do we use that which ultimately benefits - yes, benefits us but benefits the broader system because we're stretching health dollars more broadly to do that.

The other thing, I'll just pick up on Mr Collins' point before. I think the private hospital piece is a really interesting one to unpick and understand what the impact of having private hospitals is, because there certainly would be an argument the other way that there's a significant volume of low complexity elective surgery that currently gets funded through elective - the private hospitals that would be a winner for us from an activity point of view that we don't see coming through our facilities.

We know that our complexity at Prince of Wales is very high compared to a number of facilities around the state, and that is due to some of these things that there is work that just doesn't venture into our front doors and you get left with - if you've got a strong private hospital partner you will be left with a higher complexity of work that naturally falls to the public hospital because it's just going to go there because it is more complicated and the private hospital can't make money out of it. So it's not as simple as if you've got a private hospital it's great; it makes life easy. There's definitely two sides to that discussion as well.

MR MUSTON: Is there an element to which some of that potentially is part of a broader normative discussion because that super low complexity work elective surgery being done through the private system which might be excellent from a remuneration point of view, if it was done in the public system would also clog up waiting lists and the like and, frankly, should not be part of the public health system?

MR WILSON: We certainly aren't making a play for it to come back; just making a point that it does skew the complexity of the work that we do in the public hospitals.

MR MUSTON: Mr Collins raised or made the suggestion that philanthropy should be effectively audited and the extent to which LHDs enjoy the benefit of philanthropy is something that should perhaps be taken into account when making overall funding decisions about the amount of funds that go from one LHD to another. Do any of you want to venture a comment on that?

MR WILSON: I mean, the foundations that we have within our district are all at arms length for us. A bit like Cathryn's discussion, we have some really good working relationships with them. But they are their own entities and our ability to influence exactly where and how they're spending their money is - there's no direct line there. So we negotiate, we encourage, we say "no" to certain things, which we know - to Cathryn's point - are going to cause us problems in the future. But to a large degree this is outside of our direct control.

The other thing, because we've had this conversation quite a bit within the district as well around what would

this start to look like if we were to work more collaboratively, because these relationships actually sit at a hospital level, they don't sit at a district level, the donors have an affiliation with who they're donating to. Randwick is a really good example; obviously the Sydney Children's Hospital; The Prince of Wales has got a foundation; the Royal Hospital for Women's got a foundation; there's two large MRIs in the University of the New South Wales; all with very strong philanthropic arms. And the donor is looking to buy a product at the end of the day. They would like to contribute and see the value for their money. And it's not as simple as, "We've got this great idea and we want to do this." In some cases it will come in through the university. In some cases it comes through an MRI. In some cases it comes in through a different form. So I think it is an interesting factor to consider. I'm not sure there's a direct benefit that you could audit and say, "This district is that much better off because it has it."

MS COX: So I think that's quite important. They are completely independent. So I do not direct the foundation in any way, shape or form. They report and comply with ACNC. And then I have to - I tell them the priorities, we give them information to help them with fundraising. But at the end of the day it is - and I took your earlier point about can a donor's particular intent maybe skew priorities? We do that through a negotiation process. But, yes, there might be a donor whose child was treated by a particular clinician who says, "I would like to contribute to that department."

But it's usually not so random that it wouldn't be appropriate, because they've had those discussions. But they are independent. And so I have to write to the foundation and say, "These are my requests," and then they allocate funding to me. But they don't - they're not obliged to. So I think that's actually quite important.

MS MAINS: I was just wanting to clarify if Peter was meaning that if you get money you actually then wanted to increase your activity allocation negotiations from the ministry because you might have got it from elsewhere, but the trouble is most of our - not our trouble, our value is most of it is not around service activity; it's related to things that support service activity.

MR COLLINS: Philanthropy should not reduce the budget of any LHD by a cent; not by a single cent.

MS MAINS: Correct.

MR COLLINS: But it provides a capacity. I mean, okay, to me - and I spent six years on the Advisory Council of St Vincent's Mater Health (indistinct). For me the ideal hospital campus is a really big significant public hospital, a really big high net worth individual private hospital, and the kind of, I mean, almost unparalleled research facilities backed by philanthropy as part of that campus mean that provides enormous impetus and gravitas and pull for a workforce. And I think that in a lot of ways that the way the New South Wales health system has developed over the last 30 years has tried to replicate that in other places by putting private hospitals alongside public hospitals, tried to attract - tried to set up foundations and research facilities, some more successful than others. But that's the journey.

MR MUSTON: There are a number of such hospitals that exist or such campuses that exist across the network in the metro area.

THE COMMISSIONER: He just described one. St Vincent's private, St Vincent's public, Victor Chang, and Garvan all together.

MR MUSTON: But the reality is that's never going to exist everywhere within the network.

MR COLLINS: That's right.

MR MUSTON: And is your point that at the moment to the extent that they exist within the inner metro they should probably expand out and at least pop one in Nepean Blue Mountains somewhere?

MR COLLINS: Correct.

MR MUSTON: I mean, how do decisions like that get made? That's part of infrastructure planning ultimately, isn't it, about where these large sort of co-located hospital facilities exist? Do you have a view about how that decision-making should happen? Because is it Nepean or is it Wollongong Hospital or is it Central Coast? Each has an

equal claim to it.

MR COLLINS: Every LHD would like one of those. If you could have one of those in every LHD, problem solved.

MS MAINS: There's a lot of discussion on this in the health precinct work that's been undertaken in New South Wales, and certainly we're looking at it in Wollongong and Shellharbour with both private hospitals, universities, primary care operators, commercial operators, and what you can actually do on one site. So there's a lot of discussions going along. I know health precincts have been evolving right through New South Wales.

MR MUSTON: I take from that you generally agree with the proposition that, where possible, co-locating public hospitals, private hospitals, research institutes, universities, has the capacity to produce greater synergies and potentially deliver better bang for your buck in terms of the public health spend?

MS MAINS: Look, it has the potential. And I know I came to explore Australia to actually look at the private/public co-locations a number of years ago because it was leading edge in New South Wales. But I'm not sure we've optimised the full cooperation that we can get to maximise dual service delivery and things like that. So I do see benefits of co-location if you maximise (indistinct).

MR WILSON: So just a couple of points. I think one is the decisions that drive a lot of these are commercial decisions that are outside of health's control. We can facilitate those decisions, but if you look at Randwick there's university investment on that campus. There's significant interest around the private, interest around others expanding. So they are commercial decisions that are not necessarily - we facilitate but we don't necessarily drive.

I think the reflection on New South Wales is interesting with my experience in South Australia. One of the things that I think we struggle with in New South Wales is we've got quite a few of these, and in the Victorian system it's a bit more consolidated. Like, you've kind of got Parkville as kind of the big hub. There's Monash and Monash partners and some relationships out there, but there's not as many of these precincts as we probably have

defined in New South Wales. And the challenge is we're all competing with each other for similar workforce and similar - in many ways similar services and similar things that we're trying to specialise in.

So there's real potential in New South Wales if we can find a way to really work together and maximise the opportunity that we have here. But the risk is also there that we've got a lot of these that we run the risk that none of them actually elevate to the level that a Parkville maybe has elevated to over the past 20 years.

MR MUSTON: Does that bring us nicely back to the point we started with this morning which is that that slightly greater level of planning and system coordination at a central level whilst maintaining devolved decision-making might actually mean the competition between LHDs for workforce, services and the spreading of funding thinly across that workforce and those sometimes duplicated services could be reduced?

MR WILSON: I think it does to a point. But I think when we're talking precincts we're getting to the really pointy end of this is a highly, highly, highly specialised service that you have one of, and where does that need to go, and that quite often is a very complicated discussion because, again, a large part of this is driven by university and research and what else is wrapped around that and how that plays in. But, yes, it is back to the same thing.

MR MUSTON: Accepting it's at the pointy end, ultimately it's the public health system and money devoted to the public health system has to be used to provide that highly, highly specialised service and, if there are two different places within the public health system no doubt prodded on by universities who both want to be doing it, choose to do it, it doesn't mean that it shouldn't happen at both, does it?

MR WILSON: No, it does not.

MR MUSTON: So somewhere a decision needs to be made, whether it be a particular type of elective surgery which is more run of the mill, it might need to happen within two LHDs or this super high-end newfangled technology that's about to be unravelled in the health system, someone has to make a decision about where it is and the only person who

can make that decision - I say person - is someone who sits centrally and has oversight of the whole system rather than people sitting within each of its constituent parts?

They were all of the questions I had. I think you nodded your head, and that was a "yes"?

MR WILSON: That was a "yes".

MR MUSTON: Those were all of the questions I had for these witnesses, Commissioner. I'm content to ask them whether there is anything that has been left unsaid. Now is your opportunity to tell us anything that you want to about the way you each interact with the funding system and ways in which you think it could be adjusted or improved, for the benefit of your LHD or the system more generally.

THE COMMISSIONER: Anything important not covered that you think --

MS MAINS: Some of this has been covered probably, but --

THE COMMISSIONER: It doesn't matter.

MS MAINS: Funding is complex in health, and many systems have worked really hard to try to find a multitude of approaches. But I think we need to recognise ABF - ABM does play an important role in technical efficiency and allocation and targeting activity and throughput and, you know, it can be adjusted for population and so on.

But I think for transparency we need to do work to look at a model that reflects that the population is actually getting the funding relative to sociodemographics relative to the need, and it does vary significantly. And, therefore, the funding needs to actually relate - and it makes it much more transparent so you've got a basis on what you can actually talk with your communities that it's been allocated.

But you need - there's a complexity around the fact you also need to make sure it's aligned to prioritisation as well as quaternary and tertiary because they are - we used to top slice those, regional, rural and remote areas that need their particular areas of funding and so on. So it's how you get a balance between all of those and develop a model that can ensure your community is meeting its level

of need and demand, but you're also promoting technical - you've got allocated funding and efficiency and technical funding through ABM, and it's how you match that but also recognise some of the special things that you need to do because of the highly specialised hospitals or regional, rural and remote circumstances. That's the balance that is challenging.

MR MUSTON: Have we struck that balance in the right place at the moment, or are those things in the current funding arrangements not really being adequately picked up?

MS MAINS: Look, I think there's - I know there's been a lot of discussion around rurality and how you actually recognise particular diseconomies of scales and the fact you have lower throughput and diseconomies and the staffing you get tend to be higher premium, so there's discussions around that in block and actually moving that and how you do that.

I know there's a way that quaternary and tertiary is done, but it's how do you manage that in a population formula. The thing that - this is just my experience, and everyone has different opinions. I think the population-based funding formula as a basis is actually really important to ensure there's equity for a population relative to need and demand, in particular the socio-demographic factors in society, because demand is driven by people with higher needs, lower socioeconomic, lower other factors and we need to reflect --

MR MUSTON: So ideally --

MS MAINS: And ABF ABM will have picked that up in time in terms of what we're seeing, the number of people we're seeing through facilities, but that there is a level of unmet need in our communities.

MR MUSTON: Ideally decisions around funding of local health districts would have regard to the size and health needs of the population resident within the area of the local health district concerned and the extent to which health services provided to patients from outside the area might be being delivered by that local health district and the extent to which the needs of that population might be met by services delivered external to the LHD, whether it be a neighbouring LHD or the private sector, for example.

Is it your view that those things under the current arrangements are not really being captured in the way in which decision making around the funding of LHDs --

MS MAINS: I think (indistinct). I think it's degrees, do you know what I mean? So I just think - and we've talked a lot today about how can you impact - ABM serves a real purpose but how can you impact allocation to make sure you are promoting, maintaining and preventing disease and be the chief of your community and making sure that that actually happens, and what models would enable you to do it, and, as we know, ABM was particularly excellent at managing certain things but not everything, and we've talked about people with chronic disease, we've talked about what we've spent on prevention and promotion and activity like that. It's really sitting down and looking at the whole. I've been asked by a board member of mine every year for the time that she was on the board, "How do you know that this district is getting its best share of funding," and I can't answer that. Relative to a population base --

MR MUSTON: Is that because there's some lack of transparency in the way in which the decision --

MS MAINS: No, I - look, I think there's transparency on the ABM model. I don't think it's a desire to hide anything. I think funding models take a lot of time to get transparency, and they're not easy to get the right model and it's going to take - there is a balance between population allocated and technical efficiency --

MR MUSTON: But is there a risk - just coming to the question that your board member was asking you, is there a risk that applying the ABF model, the amount of activity that might be being purchased from your LHD and therefore forming the basis of at least the ABF portion of the budget - 83 per cent I think you told us - it's meeting a need because it's all being delivered and purchased, but there might be a huge amount of unmet need out there that if you had twice as much money you would be able to deliver twice as much activity to a very needy population?

MS MAINS: Health can always absorb anything it's given. To be honest with you, there will never be enough money in health, and that's anywhere in the world. That's a common language that's spoken everywhere. So that's where you've

got to prioritise what you're trying to get the maximum benefits and outcomes for. It's a bit like the other area to me that needs to be looked at is the (indistinct) allocated model between the State and the Commonwealth, because the Commonwealth had such a huge impact on older people, people with disabilities, specialist clinics, primary care which also impacts local districts in terms of what can be done and what can't be done. So having - but that's - you've always got to dream it's a way that you can pull something bigger together that actually looks at it.

But I think trying to strike the balance between do we - are we very much focused on the priorities of our particular populations and having both ABM and other adjusters I think are important, and the State does do degrees of that, and some of it it's a lot stronger than a lot of places I've lived.

MR COLLINS: I think Australia has a platinum standard health system. I take gross offence when I hear media in particular talking about we are a like Third World country. We are nothing like a Third World country. We are so fortunate to be examining these issues about healthcare funding in Australia, not the United States, the United Kingdom for that matter or let alone the developing world or the undeveloped world. I mean, we are so lucky.

However, that said, there are still structural problems that need to be finetuned. For example, with Medicare, which I think is a fantastic system, while I think there has been a great improvement in the relationship between public and private over the time Medicare has existed, you've still got some log jams in Medicare. It's still a bit of a lottery system. But that hasn't been addressed. That remains for some future government to address some time.

THE COMMISSIONER: It also only - it only provides a funding stream where the GPs are there.

MR COLLINS: Yes.

THE COMMISSIONER: If that's gone, primary care goes.

MR MUSTON: Or specialist.

THE COMMISSIONER: Yes. Exactly. Yes.

MR COLLINS: Yes. So I think there is that issue. Margot has mentioned the aged care issue that the Commonwealth does not meet its fiscal responsibilities in aged care full stop and it needs to. So the State has to pick that up. But in terms of this exercise I think this has been an exceptionally valuable exercise and a very important mission established by the government to try to improve things. If you are an inner city dweller in Sydney or Melbourne, Adelaide, any capital city in Australia, you're very lucky. You would probably walk to a number of really good hospital options, public and private. This is really about the fringe dwellers. This is about the peripheral areas and remote areas, where you don't have that direct access, and whatever we can do to improve that and to tilt the scales a bit and to progress the decentralisation of some of the great assets that we do have I think therein lies the value of this Commission, and I hope that, you know, what we've contributed today might do something to that.

DR MORGAN: Just in the spirit of not leaving anything on the bench, I just want to underscore this really important point here about the notion of pegging health services that are, you know, directly driven by activity or demand. When you don't do that the impacts are very quickly felt across the system, and I had some figures that are publicly available from the report on government services, and if you're in New South Wales, New South Wales Ambulance employs 58 paramedics per 100,000 population. But if you're in South Australia it's 68. If it's in Victoria it's 70. If it's in Northern Territory it's 73. In Tasmania and Queensland it's 75. So what that in effect means that, you know, if you're a paramedic in New South Wales you're probably working at least 20 per cent harder than someone in Queensland doing similar workload.

THE COMMISSIONER: Have you raised those ratios in forums other than this hearing?

DR MORGAN: I beg your pardon? I'm sorry.

THE COMMISSIONER: Have you raised those ratios in forums other than today?

DR MORGAN: It would be fair to say consistently.

THE COMMISSIONER: What's the general nature of the response?

DR MORGAN: We've been well supported is the truth of it. That is absolutely the truth of it. But against - when I wind the clock back to 10 years ago the challenge ambulance had was its ability to look, move, feel like the rest of the health system. It very much was the two person in a van. It was a cost on the health system. Why would you invest in that? The change of ambulance becoming now a significant opportunity to manage demand for the health system, of course you'd invest in that and we're seeing that. So nobody would complain.

But what we do know is that's because of a significant number of people very much leaning into a value proposition today that didn't exist in the past. But that's about people. And, if this Inquiry's about a system, then the system would see that we would move with the rest of the local health districts in terms of investing in services and demand.

MS HOEY: I just wanted to say that just listening, I mean, it doesn't really pertain to us because ABM is not appropriate, but I think that there's no easy answer and I think it's got to be - there's got to be a bit of everything and applied. But what I do worry about when we're looking at, you know, what funding model is going to work that we forget the impact of the Commonwealth and this contribution that should be coming through from them, particularly in primary care, and the cost that has to the state public health system.

And then also around access to universal services, so access to housing, access to education, and also access to employment in the different areas and the impact that that then has on health. And if we keep trying to change our health funding system without actually quantifying what the cost to us is for that and taking that forward, then we might head into a funding system that is trying to bridge a gap rather than actually fund what public health services within the state should be funding.

MS MAINS: Could I just make one - sorry.

MR MUSTON: Please do.

MS MAINS: I'm a Kiwi by birth and I'm a backer of the Old Blacks, but I back the New South Wales health system. And I know that's very (indistinct), but I have worked in a number of systems. This is a strong system. And, yes, we have got challenges and there are ways we could continuously improve, but I think it's a very good system.

THE COMMISSIONER: Mr Chiu, are there any questions that you have?

MR CHIU: No, thank you, Commissioner.

THE COMMISSIONER: All right. So all eight of you - I think it's eight - to all of you, I'll just say, we know your time's valuable. Thank you very much for your attendance today. We are very grateful, and it's been of great assistance to the Inquiry. So thank you for that. And we'll adjourn until 10 o'clock tomorrow. Thank you.

AT 3.49PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 20 NOVEMBER 2024 AT 10AM

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