

**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

1 THE COMMISSIONER: Good morning, Mr Muston.

2

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

4

5 THE COMMISSIONER: I can see.

6

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

20

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

23

24 MR MUSTON: That's true.

25

26 THE COMMISSIONER: So, yes, good luck.

27

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

31

32 <JUDE CONSTABLE, affirmed [10.01 am]

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34 <DOMINIC MORGAN, affirmed

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36 <CATHRYN COX, affirmed

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38 <WENDY HOEY, affirmed

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40 <MARGOT MAINS, sworn

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42 <PETER COLLINS, sworn

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44 <LEE GREGORY, sworn

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46 <TOBI WILSON, sworn

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<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

1 most recent statement; is that correct?
2
3 MS HOEY: Yes.
4
5 MR MUSTON: Have you had an opportunity to review that
6 this morning before giving your evidence?
7
8 MS HOEY: Yes.
9
10 MR MUSTON: You're satisfied that its contents are to the
11 best of your knowledge true and correct?
12
13 MS HOEY: I have one change, which I think we probably
14 informed you of.
15
16 MR MUSTON: Yes, sorry. I also have that. That is
17 paragraph 55?
18
19 MS HOEY: Yes. Yes.
20
21 MR MUSTON: Just tell us what the correction that you wish
22 to make to paragraph 55 is.
23
24 MS HOEY: Where it says that the delivered cost saving has
25 been delivered primarily to Justice Health New South Wales,
26 that's actually to the justice sector.
27
28 THE COMMISSIONER: Sorry, I've just missed that. What
29 line are we looking at?
30
31 MS HOEY: It's on page 13 of - paragraph 55, just at the
32 end there, Commissioner.
33
34 THE COMMISSIONER: Right. Okay. Thank you.
35
36 MR MUSTON: I might start, Ms Hoey, just by asking you
37 some questions about Justice Health.
38
39 MS HOEY: Sure.
40
41 MR MUSTON: Could you, just in broad outline, explain to
42 us the services that are provided by Justice Health to the
43 New South Wales prison population?
44
45 MS HOEY: Yes. So we're Justice Health and Forensic
46 Mental Health Network, and we've got sort of two arms of
47 our services. So there's the forensic mental health

1 system, which we'll park just now and think about the
2 custodial system. So there's over a hundred locations but
3 37 I think just now custodial centres and seven youth
4 justice centres, and we provide primary care, mental health
5 care, population health and public health, drug and alcohol
6 services, and a range of other primary care services to the
7 inmates across New South Wales.

8
9 MR MUSTON: And I think you tell us in your statement that
10 adds up to approximately 13,000 patients?

11
12 MS HOEY: Yes, the population of adult centres is roughly
13 about - sits around 13,000 - it can go up and down by a
14 thousand or two every so often - and I think just now
15 there's about 220 in youth detention centres.

16
17 MR MUSTON: So that's the prison population. What about
18 forensic mental health?

19
20 MS HOEY: Yes. The forensic mental health, so that prison
21 population we would also do custodial mental health to
22 there, which is almost like a general mental health service
23 within a forensic setting. Then we have - within our
24 control in our budget is a 135-bed high secure forensic
25 hospital at Malabar and also our primary care - our primary
26 court diversion centre - service both for adults and for
27 youth, also our community forensic mental health service,
28 which provides advice, risk assessment to all the LHDs
29 across New South Wales, and also have a sort of
30 relationship responsibility to all the medium secures and
31 low secures across the state and also all the forensic
32 patients that are within LHDs, which - where the majority
33 of forensic mental health patients are.

34
35 MR MUSTON: In terms of the forensic patients, when we had
36 our trip out to the forensic hospital you were describing
37 to us issues of bed block which affect the forensic
38 hospital in much the same way as they affect - or we've
39 been told they affect hospitals around the state. Could
40 you just explain to us the way in which bed block operates
41 in the context of the forensic hospital?

42
43 MS HOEY: So if somebody comes before the court and is
44 given defence under the Mental Health and Cognitive
45 Impairment Forensic Provisions Act, so they would be
46 detained in - or the MHRT, the Mental Health Review
47 Tribunal, would detain them, so that could be to a forensic

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

12
13 MR MUSTON: So in a practical sense that means if you're
14 not able to move patients through the high secure setting
15 when they are theoretically ready to be transitioned into a
16 medium secure and then to a lower secure setting from
17 within the forensic hospital, bed block means a mental
18 health patient or a patient who enters the justice system
19 through the mental health track will end up in a prison
20 setting unless and until such time as a vacancy becomes
21 available or a bed becomes available in a mental health
22 hospital?

23
24 MS HOEY: Correct. And, if you look at our sort of policy
25 of least restriction, it's hard to uphold that when people
26 are being held in prison when they should be in high
27 secure, and in high secure when they should be in medium
28 through. So falling through.

29
30 MR MUSTON: It would seem logical - and perhaps it's more
31 a question for your psychiatrist colleagues, but the
32 consequences in terms of the progress of one's mental
33 illness of being sent into a prison rather than placed into
34 a mental health facility would seem to be negative; would
35 that be a fair assumption?

36
37 MS HOEY: Yes, I think we would all agree that the best
38 place to be cared for for a health presentation or for
39 health rehabilitation is in a health environment.

40
41 MR MUSTON: What are some of the challenges that you face
42 in transitioning patients out of that high secure mental
43 health setting into a medium secure setting at a time when
44 they are perhaps ready to move medically?

45
46 MS HOEY: I think generally there's lack of beds and bed
47 movement, but also moving from a high secure to a medium

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

15

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

21

22 MS HOEY: Yes.

23

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

28

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

35

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

40

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

47

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

3
4 MS HOEY: Yes.

5
6 MR MUSTON: Do you think there might be some advantage to
7 Justice Health, albeit in a different setting, having
8 perhaps a greater involvement in the operation of medium
9 secure facilities across the state?

10
11 MS HOEY: Yes, we have developed a new forensic mental
12 health strategy and policy, which gives a little bit more
13 strength to our New South Wales clinical director for
14 forensic psychiatry, and also through the SWMHIP program.
15 So there's been investment in builds. We have been -
16 Justice Health has been given beds within that. So we'll
17 be trialing that soon to see if it does help for Justice
18 Health to have that governance over the patient journey, if
19 you like, and I suppose be the ones to make the decisions
20 about where people are going after the forensic hospital.

21
22 MR MUSTON: So, in addition to the decision-making power
23 potentially resting with Justice Health, there's also
24 presumably going to be a funding consequence. Would it be
25 right that under that arrangement the staffing of those
26 facilities would come out of Justice Health's budget rather
27 than out of the budget of the LHDs?

28
29 MS HOEY: Yes. So the unit that we've been allocated
30 through the SWMHIP program, we'll have the operational
31 budget for that when it comes, when it's built, and we get
32 the operational budget for that. Yes, that will come into
33 Justice Health's control.

34
35 MR MUSTON: You mentioned a moment ago diversion programs
36 that are run by Justice Health. Could you just explain to
37 us what those programs are in a nutshell?

38
39 MS HOEY: Yes. So we have adult and youth, so - diversion
40 programs, which is we work within the local courts where
41 people who have non-indictable offences we can divert to
42 mental health services, and with the adults we've been
43 lucky enough to secure funding and we're rolling out over a
44 three-year program to be in every court in New South Wales,
45 and we're getting some really, really good outcomes from
46 that, particularly in the regional areas, where there's a
47 high level of Aboriginal diversions occurring. And then

1 with the youth courts, unfortunately we're only in
2 10 per cent of the youth courts, but the courts that we are
3 in we've got really good outcomes with diverting kids from
4 the criminal justice system into mental health care.

5
6 MR MUSTON: When you say "good outcomes", obviously
7 transferring someone who's got a mental health problem into
8 a mental health setting is probably a good outcome in and
9 of itself. But, in terms of broader outcomes of that, do
10 you have any measured outcomes in terms of recidivism and a
11 re-presentation within the justice system?
12

13 MS HOEY: Yes, we do. I don't have the figures for
14 recidivism here, but there's been a number of research
15 papers published around the efficacy of the adult - more
16 than the kids - the adult program. But I think probably
17 one of our better pieces of work was the cost-benefit
18 analysis around adult court diversion, where I think it was
19 every dollar spent we get \$4 back to the government around
20 the reducing of custodial. I mean, anybody going into
21 custody or into the criminal justice system, it's
22 criminogenic in itself and certainly is not helpful from a
23 health perspective. So reducing the costs for custodial
24 care, reducing the costs to society longer term, reducing
25 recidivism, so reducing crime. So I think we do a good
26 job, and the benefit's across government, it's not all to
27 health, and then obviously there's a longer term reduction
28 to the health burden as we get them into health care
29 earlier and all their associated comorbidities as well as
30 mental health associated with that.
31

32 MR MUSTON: So the diversion program not only potentially
33 diverts individuals on a longer term out of the criminal
34 justice system but also perhaps provides an interventional
35 opportunity to deal with some of the social determinants of
36 health which might be sending them down a spiral?
37

38 MS HOEY: Definitely. Yes. We know that the social
39 determinants of justice are the same as the social
40 determinants of health. So if we can address them then
41 there's a double win, I suppose, yes.
42

43 MR MUSTON: Whilst you don't have the figures at a
44 headline level, I gather from what you've told us of levels
45 recidivism and the like, when assessed against those who
46 have not been through programs like this are much --
47

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

8
9 MR MUSTON: In terms of the - you mentioned a moment ago
10 the ability to intervene in people's health at a time when
11 they're either diverted through the mental health system
12 or, alternatively, when they are incarcerated. What are
13 the potential benefits as you see it of intervening from a
14 health perspective in these people's lives?

15
16 MS HOEY: Yes, often by the time somebody gets to us
17 there's been a lot of - there's been a lot of trauma in
18 their life, and if you look at what drives - what drives
19 somebody into custody is often, you know, out-of-home care,
20 housing, education. From a health perspective, we know
21 that people coming into prison have had less health
22 interventions, so general practitioner intervention, dental
23 intervention. So there's much higher rates of chronic
24 disease, there's much higher rates of drug and alcohol. So
25 anything that we --

26
27 THE COMMISSIONER: I'm pretty sure I was told when we
28 visited out to Malabar that 20 per cent of the prison
29 population have what could be described as complex mental
30 health issues.

31
32 MS HOEY: Yes.

33
34 THE COMMISSIONER: And it's often those - I was told those
35 mental health issues is what is causing them to end up in
36 prison in the first place; correct?

37
38 MS HOEY: Definitely as well, yes, yes.

39
40 THE COMMISSIONER: And what stuck in my mind is - I've
41 forgotten who it was, but being told that prisons are
42 becoming like asylums because it's the mental health issue
43 that's driving many people to committing crimes, they end
44 up in prison and then we don't have the resourcing to
45 properly treat the condition that is actually causing them
46 to offend and in many cases re-offend. Is that your memory
47 of what I was told?

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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?

1
2 MS HOEY: Yes, or dealing with holistically that person's
3 psychological presentation or trauma. And it's not to say
4 that Corrective Services psychologists don't do mental
5 health. They do, but it's just from a different lens, and
6 I think particularly in the remand environment, where
7 people are going back out into health services, that that
8 continuity of care would be better if it's provided by
9 Health.
10
11 MR MUSTON: And so the consequence of the timing of the
12 delivery of this psychological care means people who are in
13 remand sometimes potentially for quite a lengthy period of
14 time awaiting sentence will not receive psychological care
15 within a prison setting?
16
17 MS HOEY: Correct, yes. They do certainly for behavioural
18 disturbance where it's a security issue within the prison.
19
20 MR MUSTON: So to the extent that a prisoner might be
21 demonstrating some behaviour - a prisoner on remand might
22 be demonstrating some behavioural problems --
23
24 MS HOEY: Yes.
25
26 MR MUSTON: -- which are posing a threat to other prisoners
27 or --
28
29 MS HOEY: Or themselves.
30
31 MR MUSTON: -- making it difficult to deal with them --
32
33 MS HOEY: Or themselves.
34
35 MR MUSTON: -- they might receive some psychological care?
36
37 MS HOEY: Yes, yes.
38
39 MR MUSTON: Is there any interface between the psychiatric
40 care that's delivered through Justice Health on the one
41 hand and the psychological care, that is to say are there
42 multidisciplinary team meetings and the like that happen
43 between the psychologists or the psychiatrists with respect
44 to the care of a particular patient?
45
46 MS HOEY: Yes, definitely. We do have MDTs, and the
47 psychology and the officers and everybody's involved in

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

14
15 MR MUSTON: But just to unpack that a little bit in terms
16 of the information barrier, information which is provided
17 to psychologists in the context of a program delivered for
18 criminogenic purposes is available for use in decision
19 making around the way in which a prisoner might be - or an
20 inmate might be moved from one prison to another,
21 classified as high risk or low risk --

22
23 MS HOEY: Yes, self-placement, yes, yes.

24
25 MR MUSTON: Whereas information provided to medical
26 professionals who deliver care through Justice Health is
27 subject to the usual doctor/patient or clinician/patient
28 confidentiality such that --

29
30 MS HOEY: Yes, yes, but we do have - I mean, we've got
31 processes in place, a Health notification where we can tell
32 Corrective Services what we think needs to be done from a
33 risk mitigation perspective around self-placement or
34 medical holds perhaps to a metropolitan area if we believe
35 they need to be nearer one of the tertiary hospitals that
36 we share with.

37
38 MR MUSTON: Does the fact that information provided to
39 psychologists who are delivering these criminogenic
40 programs is able to be used for that wider range of
41 purposes compromise the extent to which those programs can
42 deliver good psychological care from a mental health point
43 of view rather than a purely criminogenic point of view, do
44 you think?

45
46 MS HOEY: They're different - you know, they're different
47 aims and so - I mean, Corrective Services - I don't want to

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

7
8 MR MUSTON: In addition to the mental health work there's
9 obviously a range, as you've told us, of other primary care
10 which is delivered to inmates within the prison system?

11
12 MS HOEY: Yes.

13
14 MR MUSTON: That includes in a number of cases providing
15 anti-psychotic medication and the like to prisoners?

16
17 MS HOEY: For mental health, yes. Yes.

18
19 MR MUSTON: Which results in a large number of prisoners
20 or a larger number of prisoners perhaps than in the wider
21 society suffering from metabolic disease?

22
23 MS HOEY: Yes, we know that mental health in its own but
24 also combined with medication there's an increased risk of
25 metabolic disorder, so, you know, obesity and diabetes,
26 everything that goes with it.

27
28 THE COMMISSIONER: My note was - which I want to
29 check - is 95 per cent of the prison population have
30 metabolic disorder or disease; is that --

31
32 MS HOEY: Ninety-five per cent probably of mental health,
33 I would think, yes.

34
35 MR MUSTON: Meaning that a large proportion of the prison
36 population suffers from metabolic disease of some type?

37
38 MS HOEY: Yes, yes, and a high level of chronic disease
39 particularly within the Aboriginal cohorts that we manage,
40 which is 32 per cent of prison.

41
42 MR MUSTON: In terms of metabolic disease and other
43 co-morbidities, it's not just the delivery of primary
44 health care which is important in terms of trying to keep
45 these patients well and reducing long term their morbidity?

46
47 MS HOEY: Correct, yes.

1
2 MR MUSTON: Also --
3
4 MS HOEY: Prevention, health - health literacy, prevention
5 and health promotion.
6
7 MR MUSTON: Diet?
8
9 MS HOEY: Yes, diet definitely. We saw examples of that
10 in Long Bay.
11
12 MR MUSTON: That's what I was going to ask you about. In
13 essence you have a captive audience when it comes to the
14 delivery of a good diet. Is that something which Justice
15 Health is involved in from a dietetics point of view, or is
16 it something that's dealt with by Justice?
17
18 MS HOEY: Yes, it's got to be dealt with by both of us
19 because Corrections provide the food, or Justice provides
20 the food. We're providing the advice, if you like. So we
21 have developed our health --
22
23 THE COMMISSIONER: Your advice, I assume, doesn't extend
24 to "it's a good idea to give the prisoners a loaf of white
25 bread before they are locked down for the night"?
26
27 MS HOEY: No, that's not actually our advice. But we are
28 working together with them to try and change some of the
29 habits that are happening through our healthy prisons
30 framework. So we're starting with what we would call
31 buy-up, so that's the prison shop, if you like, and at
32 least having healthy alternatives available.
33
34 THE COMMISSIONER: Your organisation is responsible for
35 the health of the prison population, and did you say
36 13,000? You did?
37
38 MS HOEY: Yes.
39
40 THE COMMISSIONER: And not many of those people are what
41 are called lifers?
42
43 MS HOEY: No.
44
45 THE COMMISSIONER: Some will die in prison simply because
46 they might have committed a crime 30 years ago and they --
47

1 MS HOEY: Correct. The majority of people come --
2
3 THE COMMISSIONER: If you get a 20-year sentence when
4 you're in your 70s, you're probably not leaving prison.
5 But most people are getting out; correct?
6
7 MS HOEY: Correct, yes.
8
9 THE COMMISSIONER: And as a matter of logic when people
10 are released from prison it would be better if, as far as
11 possible, their mental health conditions have been
12 addressed and they're healthy?
13
14 MS HOEY: Correct.
15
16 THE COMMISSIONER: Because it would be better if they're
17 not becoming a burden on the public hospitals, is one
18 thing?
19
20 MS HOEY: That's correct.
21
22 THE COMMISSIONER: And it would be better if they had the
23 best possible chance to become economically active,
24 productive members of society?
25
26 MS HOEY: Correct.
27
28 THE COMMISSIONER: So if you're in charge of health why
29 wouldn't you be in charge of diet, given it's so related to
30 health? Why is Corrections in charge of diet?
31
32 MS HOEY: I think we provide health care.
33
34 THE COMMISSIONER: Yes.
35
36 MS HOEY: To the prison population.
37
38 THE COMMISSIONER: Yes.
39
40 MS HOEY: Corrections have the broader responsibility to
41 provide a roof over their head, a safe environment.
42
43 THE COMMISSIONER: Yes.
44
45 MS HOEY: Their food. So it's with Corrections.
46
47 THE COMMISSIONER: Does food make sense, though?

1
2 MS HOEY: Yes, because Corrective Services --
3
4 THE COMMISSIONER: It depends what it is, I suppose,
5 doesn't it?
6
7 MS HOEY: Yes. Yes, that's right, Corrective Services.
8 I think we have a responsibility from a health perspective
9 to work with Corrections to ensure that we're advising and
10 promoting healthy environments, and that's what we're
11 doing. I mean, they're linking in well --
12
13 THE COMMISSIONER: Would your advice in relation to the
14 diet that prisoners have be different to the diet that's
15 actually provided to them?
16
17 MS HOEY: Yes. Yes.
18
19 THE COMMISSIONER: In the sense that it would be --
20
21 MS HOEY: Wouldn't be white bread.
22
23 THE COMMISSIONER: It would be a healthier diet?
24
25 MS HOEY: Definitely a healthier diet.
26
27 THE COMMISSIONER: In the way we understood a good,
28 healthy --
29
30 MS HOEY: Correct.
31
32 THE COMMISSIONER: -- balanced diet to maintain a good
33 levels of weight instead of obesity?
34
35 MS HOEY: Yes, and exercise as well. You know, the
36 fundamentals of good health is what we'd be trying to push
37 through our healthy prisons framework.
38
39 MR MUSTON: You tell us in your statement of the
40 proportion of inmates who are First Nations people and you
41 mentioned it a moment ago. From that truly bleak statistic
42 on one view there emerges an opportunity to do some
43 potentially valuable work when it comes to closing the gap
44 in --
45
46 MS HOEY: Yes, I think fundamentally we have to say that
47 people in prison and the overrepresentation of Aboriginal

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

17
18 MR MUSTON: Which brings me to my next question. When one
19 looks to the statistics that you give us in relation to the
20 percentage of the youth prison population who are First
21 Nations people, that is even bleaker. That, on one view,
22 points to a real potential value in accelerating these
23 diversion programs within the youth setting that you've
24 mentioned?

25
26 MS HOEY: Yes, definitely. I think the diversion - and
27 we've seen by the experience of the expansion of the adult
28 into regional areas, so we've increased the number of
29 Aboriginal people who have been diverted because there's a
30 higher percentage in the regions, and within the children's
31 courts the regions were not in yet. So extending out to
32 those regional environments I think would be really good.
33 The thing with the youth is that they cycle through very,
34 very quickly, so it doesn't really give us the opportunity
35 to really assess and do something before they're out again.
36 So, yes, that's a - there's an opportunity of following up
37 into the community as well, I think.

38
39 MR MUSTON: When you say "cycle through quickly", how
40 quickly is quickly? Are we talking about hours, days or --

41
42 MS HOEY: It could be 24, 48 hours. So, yes - I haven't
43 got the figures with me. Dr Haysom was talking to me last
44 week about it, but there's a lot - the majority of youth
45 are in for a very short period of time.

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47 MR MUSTON: So that's on remand effectively?

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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,

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

10
11 MR MUSTON: Similar issues arise in relation to the adult
12 prison population or the longer-term prison population,
13 including those who are in the forensic hospital, when it
14 comes to discharging from prison, a prison health
15 environment, into a community-based health environment?
16

17 MS HOEY: Yes, it's an area that we've probably got a bit
18 of laser focus on just now, and that interaction between
19 the custodial services and the primary care services is
20 hard. We can't often get a - we have some measures that we
21 do to make sure that anybody with chronic - I think it's
22 more than two chronic diseases and all Aboriginal people
23 that we're seeing are linked into a GP within seven days.
24 That's hard to do. It's hard to get an appointment with a
25 GP within seven days. So getting them linked and getting
26 accepted by community is very, very difficult.
27

28 MR MUSTON: We've heard a lot of evidence in our travels
29 about the thin and failing GP or primary care markets
30 particularly within the regions. That presumably
31 contributes to the challenges that you have in linking up
32 inmates who are being discharged with a primary
33 care - moving to a primary care setting?
34

35 MS HOEY: Definitely. It (indistinct) is that getting GPs
36 to actually work for us because there's not a lot of GPs
37 around and then linking in. We have had some success
38 recently with partnering with Aboriginal medical services
39 so that their GPs are working within their service and then
40 into the prison, and it gives a really good transition for
41 a lot of the Aboriginal folks that are - that we're
42 releasing into the community. But it is definitely a
43 challenge.
44

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

1
2 MS HOEY: Thank you.
3
4 MR MUSTON: Justice Health is block funded?
5
6 MS HOEY: Apart from the forensic hospital, which is block
7 ABF funded, but the rest is all block.
8
9 MR MUSTON: And there is - that block funding, I think you
10 tell us, comes - well, has its origins in some historical
11 base figure that was at some point in the past identified
12 as the cost of delivering health care to the prison
13 population of New South Wales?
14
15 MS HOEY: That's my holy grail. I'm not quite sure where
16 it originated from, but it is what it is.
17
18 MR MUSTON: You might not - might not be Robinson Crusoe.
19 But at some point in the past an assessment was made that
20 there was a particular amount of money that was required to
21 deliver health care to the prison population of New South
22 Wales?
23
24 MS HOEY: Correct.
25
26 MR MUSTON: And at least during your time with the
27 organisation has it been your observation that the base
28 figure as at the updated base figure has added to a growth
29 figure of some sort each year to increase the block year on
30 year?
31
32 MS HOEY: Yes, yes, yes. So we get block, and then growth
33 and the CPI.
34
35 MR MUSTON: In terms of what that base covers I assume
36 that, much like the wider population within a prison health
37 setting, there is almost no limit to the amount of money
38 that you could spend on health and produce good outcomes;
39 that is to say, even if with perfect efficiency every
40 additional dollar that you spend on health will potentially
41 produce a good health outcome?
42
43 MS HOEY: A benefit, I would say, and I just call it an
44 uncapped demand.
45
46 MR MUSTON: Obviously we don't live in a Utopian world
47 where we can continue to pour money into it until that

1 wonderful day when the demand is met, so decisions need to
2 be made about exactly what within a budgetary envelope
3 we're going to be spending money on?
4

5 MS HOEY: Correct, yes.
6

7 MR MUSTON: Within the prison population is it the case
8 that the cost of delivering health care has continued to
9 increase over the years, not only because of inflation and
10 those usual things that make costs increase, but also
11 because medicine's become more complex, the range of
12 interventions that we have available to us are wider,
13 people are living longer, et cetera?
14

15 MS HOEY: Yes, definitely, and our population is changing.
16 So the prison population is aging, so we've got a lot more
17 aged people within our prison population, which takes more
18 help. We've got an increased Aboriginal population, which
19 takes more help. We've also got higher expectations as
20 well, I think, about the health care that we provide within
21 prison. Our chronic disease management has increased, you
22 know, the expectation of what we do is increasing, and
23 certainly our interventions with drug and alcohol and the
24 expectations of that and our management of and some, you
25 know, aims about - you know, eliminating hep C, for
26 example, has increased our requirement to do screening and
27 treatment of that disease.
28

29 MR MUSTON: Just in relation to that, screening
30 initiatives which might be introduced with a view to
31 identifying hepatitis C in the hope that we can eliminate
32 it within the population presumably also has the
33 consequence particularly within your setting of increasing
34 the cost of delivering health care because once something's
35 found through a screening program you need to spend money
36 dealing with it?
37

38 MS HOEY: That's correct, and we have - I think the
39 figures are in here, but we have increased our treatment
40 rate by an extraordinary amount in the last two to three
41 years, yes.
42

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

1
2 MS HOEY: Yes, it's one of the things that makes this job
3 so interesting, is that we're not necessarily in control
4 of our - definitely in control, but decisions by other
5 parts of government really impact on us, and the
6 discussions around bail, domestic violence has certainly
7 impacted on our ability to keep up with the demand.
8 Following the government changes, which, you know, we have
9 to crack down on domestic violence, it's a good thing to
10 do, the remand population increased by I think it was by a
11 thousand in about six months, and the remand is new people
12 coming in, so that takes more care. Unfortunately, the
13 changes impacted most heavily in Aboriginal people, the
14 Aboriginal female people. So our female population
15 increased dramatically, which again increases the health
16 care required, but also --

17
18 THE COMMISSIONER: Women are the fastest growing cohort,
19 aren't they?

20
21 MS HOEY: Yes, and Aboriginal women at that,
22 unfortunately.

23
24 THE COMMISSIONER: Yes.

25
26 MS HOEY: Yes. So the changes to the conversations around
27 domestic violence and then the changes to the Bail Act
28 resulted in an increased demand for us.

29
30 MR MUSTON: And similarly - so changes in the Bail Act
31 result in the prison population growing because - or at
32 least the remand prison population growing because
33 individuals who might once have been on bail are not?

34
35 MS HOEY: Refused, yes, that's right. So I think it kind
36 of shot up quite quickly. But it's steadied again, but
37 it's not come back down again.

38
39 MR MUSTON: Has the range of factors that we've just
40 walked through that have increased the cost and complexity
41 and demand on the health services being delivered within
42 the prison population been adequately met by the growth
43 figure which has been applied to the historical base,
44 whatever it - wherever it might have come from?

45
46 MS HOEY: I would say no, but just now we're really trying
47 to have a look at that base funding and try and work out

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

13
14 THE COMMISSIONER: What I take from your answer there is
15 that, whatever the historical funding has been based on, it
16 hasn't been - there's not much evidence to suggest it's
17 been based on service need?

18
19 MS HOEY: Correct.

20
21 THE COMMISSIONER: Yes.

22
23 MR MUSTON: Working out whether or not funding is
24 adequate, to use that word, really depends largely on what
25 it is that you're being asked to or needing to deliver
26 through that funding envelope?

27
28 MS HOEY: Yes, yes. And, you know, in the last couple of
29 years certainly we've worked really hard with the ministry
30 to get some key performance indicators into our service
31 agreement that actually reflects our demand as opposed to,
32 you know, the incentive funding that we get and our base
33 demand that we're not able to meet, we're not able to meet
34 our wait list at this point in time, so --

35
36 MR MUSTON: Could you explain what those changes to the
37 KPIs have been?

38
39 MS HOEY: So we had never reported on wait lists. So now
40 we report on all our wait lists across all our domains, so
41 primary care, mental health, and drug and alcohol, and
42 categories 1s, 2s, and 3s, and really try to ensure that we
43 can look at our demand and our matrix in a way that's able
44 to be used by the system to acknowledge the demand that
45 we're trying to meet, and then we can have the conversation
46 about where is it that - where is that peak, you know,
47 where are we efficient and we can't do any more with what

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

2

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

10

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

20

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

24

25 MS HOEY: Correct, yes, yes.

26

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

37

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

42

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

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47 MS HOEY: Correct.

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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.

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

4
5 MS HOEY: The bubble.

6
7 MR MUSTON: -- the ideal approach is to say what is the
8 total health needs of this population?

9
10 MS HOEY: Correct.

11
12 MR MUSTON: Let's accept that they are probably going to
13 be greater than can ever be met by whatever budgetary
14 envelope is available, regrettably, but that's life. To
15 what extent or what services are required to meet all of
16 those health needs? What's the patchwork of services that
17 we could be providing to this population to meet all of
18 those needs?

19
20 MS HOEY: Yes. Yes, it is, and what services do we
21 provide to meet the population's needs, what services do we
22 also need to provide to make sure that we're setting people
23 up for success in the future as well. So I think it's
24 really important to think about the sort of active services
25 that we do to address diabetes, to address that, but
26 also - and the preventative services that we have in place
27 around health literacy, prevention, health promotion, and
28 empowering people to take care of their own health, that's
29 really important to us.

30
31 MR MUSTON: We then work out what it costs to provide each
32 of those pieces of patchwork that sit across the table?

33
34 MS HOEY: Yes.

35
36 MR MUSTON: And difficult decisions need to be made about
37 which ones we're going to - whatever the available
38 budgetary envelope is, will be provided and which ones
39 won't?

40
41 MS HOEY: That's right, and you need solid information to
42 do that. Just now we don't have that. So we're working
43 towards that, and then we'll have a look at what's - and
44 that will be done from an economic perspective, what's the
45 best inputs for - to get the best output from the
46 population that we serve.

47

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

8
9 MS HOEY: Yes, and I think that comes down to we've got a
10 really solid strategic plan for the next 10 years but our
11 clinical services plan is the one that will inform us about
12 what services are a priority or not, and obviously in
13 collaboration with the ministry we would sit down, you
14 know, and, "This is probably next year or the year after,
15 and this is what we've got, this is what we can provide,"
16 and have that negotiation.

17
18 MR MUSTON: And ideally that probably becomes something
19 more like a five-year, 10-year plan that, whilst dynamic,
20 gives you an ability to look forward as to what you should
21 be providing as a service?

22
23 MS HOEY: Correct. Definitely. I think, you know, our
24 strat plan's 10 years, we do it in two-year blocks, but our
25 clinical service plan has been yearly. I think we need to
26 do two to three years to make sure that we get some
27 continuity going through.

28
29 MR MUSTON: And with that 10-year planning and the
30 identification of which pieces of the patchwork within the
31 existing funding environment you can provide and which
32 pieces you can't you would have a greater ability,
33 presumably, to go to government - well, to the ministry,
34 and perhaps the ministry to government, to say, "Well, here
35 is what we can provide. Here is what we have identified
36 that we can't and won't provide within the current funding
37 envelope. We think it's good, but if you want it you'll
38 have to give us more money"?

39
40 MS HOEY: And that's - yes, you have pipeline and
41 proposals in place to say, "To do this this is what we
42 need."

43
44 MR MUSTON: But you need a little bit of planning and head
45 space to do that?

46
47 MS HOEY: Definitely the planning. We don't have the

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

2

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

7

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

17

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

26

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

35

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

40

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

44

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

1 process?

2

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

6

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

18

19 MR WILSON: Absolutely, and it's not a dissimilar process
20 to what Wendy described. So we do a range of planning
21 exercises that talk about where we would like to get. So
22 we've got a district-wide health services plan that talks
23 around what our services should look like over the next
24 10 years. It calls out services and areas that we believe
25 we should be growing our services or addressing some of
26 those needs within the community. It also calls out some
27 of the challenges that we are going to have going forward
28 to deliver some of the specialised services and how we
29 might be able to set up our services differently to address
30 those challenges, talks about some of the workforce
31 implications that we're going to have to address. So very
32 much from a district perspective we have those plans, and
33 then within each of our sites we would have a site-based
34 plan that would also talk to those local clinical services.

35

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

39

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

1
2 MR MUSTON: We have heard some evidence in our travels to
3 the effect that with new builds you can have a substantial
4 increase in the cost of running a facility that's not
5 matched by an increase in activity because, for example,
6 larger wards become single rooms and footprints get larger,
7 you need more cleaners, you need more personnel to man
8 facilities. Is that something which in your experience is
9 accurately captured by growth funding to the extent it's
10 provided?

11
12 MR WILSON: I think it's challenging. I think it's
13 better, and I think the system has been learning over the
14 last few years about how best to do this. Early in my time
15 in the role we had commissioned St George as an acute
16 services building with the emergency department that came
17 on line a few years before that, and generally when you're
18 bringing on a new service your emergency department is
19 where your growth comes through. So if you're just
20 bringing on ward facilities you incur most of
21 the additional costs without really an awful lot of
22 additional activity because it's coming either through the
23 front door or through your elective surgery anyway.

24
25 So that was a pretty challenged time for us as a
26 district with the cost, and I think everybody - the
27 district ministry learnt a lot through St George and some
28 other similar projects at that particular time, and there's
29 been a lot of work that's been done to try to improve the
30 understanding of what that initial cost looks like for
31 commissioning a new building, and then how you potentially
32 convert that to activity in time.

33
34 We're definitely not there yet, and it still feels
35 like there's a challenge with how that is managed in the
36 growth envelope when you're commissioning new buildings.
37 Certainly my experience of that has been that that has been
38 most of the growth that we have seen come into the
39 district, so you're basically tied to a new building coming
40 on line, and we therefore have to run that new building,
41 and that is the only opportunity that we have for growth
42 within the district, and that makes it difficult to meet
43 other challenges.

44
45 MR MUSTON: And in terms of the other challenges that are
46 most difficult to meet in those circumstances, the fact
47 that you are, through your KPIs, incentivised and the

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

11
12 MR WILSON: I think it's - so from a principal's
13 perspective, yes, probably. I think the reality, though,
14 is slightly different in what we actually see because a
15 number of those community-based services that we offer -
16 our prevention services, our population services - a lot of
17 them are program funded out of the ministry. So they tend
18 to have a different funding source that comes in, and
19 locally us having to make decisions around how we
20 distribute our funds.

21
22 Now, that's not to say we wouldn't like to make more
23 decisions, and there's certainly some pressure that I am
24 aware of within my district around services that - and
25 I think we spoke about it when you came out and visited us
26 last week or the week before - around waiting lists for
27 access around community-based allied health services. That
28 is very much on our radar as something that we ideally
29 would like to be investing in, but it gets pretty
30 challenged when you're listing all the things that you need
31 to be trying to cover off.

32
33 MR MUSTON: Does it produce a system where, to pick up on
34 something Ms Hoey said, you are effectively structuring the
35 services that you are delivering or choosing which pieces
36 of the patchwork you're going to provide by reference
37 essentially to the different funding streams that are
38 available? So your acute care and your activity, you're
39 doing that. To the extent that there's community care that
40 might not be delivering activity, if there is a funding
41 stream or some program funding that can be accessed to
42 deliver that, then you'll deliver it. But if there's no
43 program funding that could be accessed to deliver that then
44 that's something which, even if you at a local level think,
45 "This really is what my community needs or would benefit
46 from. If I was able to prioritise which pieces to provide
47 and which pieces not to provide, I'd have this one up

1 higher, but without funding I can't"?
2

3 MR WILSON: Yes, I think the starting position that we
4 certainly come from is you need to fund the services you're
5 already committed to to a large extent. Now, there is some
6 opportunity to divest from services, but it's a pretty
7 challenging space. So basically we would work through a
8 process of funding the things that we're already committed
9 to fund and the community is already expecting us to
10 provide. So the services that we currently run out of our
11 facilities and services we run out of the community, and by
12 the time we work through that process there's not a lot
13 left for discretion. In fact, most of it would have to
14 come from being offset by efficiencies or other reductions
15 somewhere else to be able to do that.
16

17 MR MUSTON: Has it been your experience, like Ms Hoey's,
18 that the cost of delivering health care to patients, not
19 only because of new builds and the like, but also
20 complexities associated with delivering medicine, the wide
21 array of services that we can now deliver,
22 sub-specialisation, meaning you need lots more people to
23 deliver it, ultimately means that there's been a very
24 significant increase in the cost of providing care to the
25 community as compared with perhaps at the time when the
26 base was identified?
27

28 MR WILSON: Yes, and I think all the same factors that
29 Wendy called out, but probably the other one that we are
30 certainly seeing, and I'm sure Wendy is seeing it as well,
31 is the impact of COVID and delays in people accessing their
32 care over that period, and there is certainly a higher
33 level of complexity around our patients that are presenting
34 to our facilities at the moment, quite often further down
35 their disease pathology than what they would have been
36 previously, just because that two-year period was quite
37 disruptive for health care. So, yes, generally the
38 complexity is up in the patients as well.
39

40 MR MUSTON: I'll give you an opportunity to say this,
41 Ms Hoey, but I suspect that whilst you might have that
42 COVID spike you also have the burden of dealing with a
43 patient population who have not only dropped off receiving
44 their care during COVID but in fact had never received it;
45 would that be right?
46

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

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

7
8 MR MUSTON: To the extent that there has been a cost
9 increase, this cost increase has occurred at a rate that's
10 potentially not been captured by the growth factor that's
11 been applied to the funding year on year, has that meant
12 that - this is my basic maths, which could be wrong, but
13 does that mean that in essence the gap between the funding
14 and the actual cost of delivering on all of the care that's
15 sought to be delivered through a service is growing?
16

17 MR WILSON: I think you could draw that conclusion, yes.
18 I think what we - I mean, I think if we just talk about
19 the costs of service and if we just start with the basic
20 CPI application, the health CPI is well north of
21 4 per cent, 2.5 per cent doesn't get us very far around
22 that. We're seeing increases in some of our contracts and
23 some of our services of 15 per cent. So that's all stuff
24 that we generally need to absorb and find a way to pay for,
25 which eats into the certain of the dollars that you have to
26 provide to your services elsewhere.
27

28 MR MUSTON: You mentioned a moment ago that you need to
29 focus - of the need to focus on delivering the care that's
30 being delivered, but does that - let me just understand
31 that. That means there's essentially an array of
32 clinicians who are working within your facilities who have
33 it within their particular skill sets to provide a
34 particular suite of services, and to a large extent that
35 dictates the services which are being provided at any given
36 moment within your setting?
37

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

1
2 MR MUSTON: And, much like the base figure, the precise
3 reason why the service array that's come organically to
4 develop in a particular hospital or a particular setting is
5 something which has its origins a long time ago and, whilst
6 it may have been steered a little bit through the planning,
7 has not readily been within the control of, say, the chief
8 executives of health of the LHD to say, "We're going to
9 offer this but we're not going to offer that"?

10
11 MR WILSON: Yes, there's a number of historical decisions
12 that were made, or not even decisions that were made,
13 historical precedents that were set about the services,
14 and, I mean, a number of them make sense, like you will
15 offer an array of services out of most hospitals that you
16 run, so how they're set up and what those funding decisions
17 were made at the time are pretty much set, and as a chief
18 executive you've got some ability to influence that, but
19 limited, and generally more of your ability is around those
20 changes of service and what decisions you do make at the
21 time.

22
23 MR MUSTON: And in terms of making those decisions it's
24 not, I would assume, an overnight decision necessarily, but
25 it might be part of a five- or 10-year plan to say, "Here's
26 a service we're offering. We actually as at today don't
27 think we should necessarily be offering that because
28 there's another thing that might have a slightly higher
29 priority, but we have some clinicians who are performing
30 that procedure or who are running that little unit, and we
31 can't tell them tomorrow we've decided we're not going to
32 do that." So you look to change management over a period
33 of time, people retiring, not being replaced, sort of
34 progressive change of services; would that be right?

35
36 MR WILSON: Yes, absolutely, and that's why having that
37 long-term plan around 10 years and what this looks like
38 helps us with those decisions, because you can't plan when
39 you're going to make those changes, but when those
40 opportunities present themselves you do need to be able to
41 respond, and so being organised to be able to respond to
42 those opportunities is important.

43
44 MR MUSTON: Is part of the challenge also from a funding
45 perspective the fact that a lot of these services that are
46 being offered are, for historical reasons, there now and
47 will for at least the short-term future be there until such

1 time as change can progressively be made to re-adjust
2 priorities, say, in the way that we've been discussing, but
3 does that mean, if the cost of providing those services
4 increases and you have to keep providing those services
5 because they're there, that the available funding that you
6 have just gets spread thinner and thinner across the array
7 of services that are being provided?
8

9 MR WILSON: Yes, but I would argue that most of this stuff
10 isn't going to be changed. Most of this stuff is the right
11 services that we are offering in each of our facilities.
12

13 MR MUSTON: Yes.
14

15 MR WILSON: And it's rare that unless you're replacing a
16 service with a new better version of that service that
17 provides the care that you're actually going to move away
18 from that service entirely, so there are some opportunities
19 around how you offer your services, and generally that's
20 around mainly other drivers, things like workforce
21 availability and how you can make these services
22 sustainable, where you might structure a service slightly
23 differently. But it's pretty rare that you're getting out
24 of a service entirely.
25

26 MR MUSTON: So in the case at least of the large metro LHD
27 that's providing an array of services, whilst there might
28 be some tweaks and changes, it's not likely to be the case
29 that there will be a broad-scale reduction of services to
30 enable you to provide a smaller suite but do it as well as
31 it can be done within the funding envelope that's
32 available?
33

34 MR WILSON: Yes, it's pretty hard to think of cases for
35 the large volume services where that would occur.
36

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

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

3
4 MR COLLINS: Well, okay. Let's take the current financial
5 year. We received a budget increase in our service
6 agreement, but basically the entire budget increase was
7 already taken up by existing commitments, providing us
8 basically no capacity whatsoever for expansion or any sort
9 of innovation that we might like to take on a local basis.
10 So all of the funding is locked in. We are very aware of
11 the state's financial position, with Treasury's position,
12 and that, if anything, while the demand for health services
13 is increasing, the availability of funds is not keeping
14 pace with the demand.

15
16 We certainly feel in Nepean Blue Mountains that we are
17 disadvantaged compared to inner Sydney LHDs, and I - my
18 guess is that the other peripheral LHDs - so Central Coast,
19 Nepean Blue Mountains, South West Sydney, Illawarra - are
20 similarly in the outer ring and therefore are unable to
21 really add the kind of specialised services that are taken
22 for granted in the inner circle of LHDs. I guess I'm
23 not - I don't want to appear to be too critical of the
24 ministry in this. There's a capital city advantage in
25 that, and I understand historically the city has spread,
26 urbanisation has spread. I think that the way you make the
27 outer LHDs function more effectively is to take some of the
28 specialised services from the inner city LHDs and locate
29 those in some of the outer LHDs. But I think that would be
30 a way of building capacity, building medical communities
31 around the teaching hospitals that are the centrepiece of
32 the LHDs.

33
34 MR MUSTON: A couple of things flow from that. The first
35 is, to pick up on something we were discussing a moment
36 ago, you need to identify what the needs of your community
37 are. You need to identify the services that in order to
38 meet those needs should be provided and make some attempt
39 at working out what it would cost to provide each of those
40 services if you were conducting a planning exercise. You
41 then take your budgetary envelope such as it might be and
42 you work out as an exercise in prioritisation what can you
43 actually deliver well within that envelope and what can't
44 be delivered within that envelope. So that's step 1. And
45 some of those services that are currently being delivered
46 in the larger metro LHDs, the specialist services that you
47 refer to, might actually fall on the wrong side of that

1 line. They might say, "We can't deliver them within the
2 budgetary envelope that we've got because not only can we
3 not deliver them and deliver them well, but it would
4 compromise our ability to deliver those things that we've
5 actually prioritised"; would that be right?
6

7 MR COLLINS: That's correct.
8

9 MR MUSTON: And at one level --
10

11 THE COMMISSIONER: Sorry to interrupt, but just to pick up
12 on your point about the disadvantages you feel your LHDs
13 and outer metropolitan LHDs suffer, the things - tell me if
14 I've missed anything, the things we discussed on our visit
15 were there are some workforce issues that are
16 multifactorial, including the number of registrars that are
17 available for your ED, given the number of presentations
18 you have compared to other similar public hospitals to
19 Nepean, at least in terms of presentations to the ED.
20 There are the social determinants of health in your LHD
21 that you talked about being top of the table, I think was
22 your expression, and things you don't want to be at the top
23 of the table for, like obesity, like DV, et cetera.
24 There's the influx of NDIS participants that we talked
25 about and the strain that puts on - can put on the EDs when
26 people come from the share homes, go into the ED and then
27 they find there's no place to send them back to. And the
28 bed flow issues in relation to your ED in terms of the
29 length of time that some people are staying in there that
30 are partly a common problem of aged care people with no
31 aged care beds to go to. And I think we also discussed
32 thinning GP markets as well as having an impact. Is that
33 the general picture?
34

35 Mr Gregory, you feel free to say as well, but that's
36 what I recall Mr Collins addressing in our introduction as
37 the sort of challenges that are probably the ones that
38 result in Mr Collins feeling as though you're disadvantaged
39 compared to some LHDs. Is that broadly right?
40

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

1 sign at the bottom of the Blue Mountains that says "Welcome
2 to Sydney". So when you go west of that sign you're
3 driving into a World Heritage national park, and the local
4 council there takes great pride in that and want to keep it
5 pretty much that way.
6

7 But what that means is a very rural environment
8 immediately. So Katoomba hospital, for example, which is a
9 centenary hospital, is well and truly past - in terms of
10 physical infrastructure, well and truly past its use-by
11 date, and yet the rural/metro boundary is about
12 10 kilometres west of Katoomba, and you could
13 drive - I mean, most people driving through the Blue
14 Mountains would think it's a pretty rural environment
15 except for the villages that are dotted along the Great
16 Western Highway or Bells Line of Road, fewer of, but we
17 don't qualify for any rural adjustment under block funding.
18 We do not qualify - we don't have specialised services
19 which attract block funding.
20

21 So, for example, to take what you've just said,
22 Commissioner, unfortunately we head the league table in
23 things like obesity and diabetes. We're right up there.
24 Domestic violence is another one. These are areas where it
25 would be open to the ministry to say, "All right, you're
26 not going to get a heart-lung transplant facility at
27 Penrith, but maybe you should be the state's expert LHD in
28 terms of domestic violence, in terms of obesity, diabetes,
29 all sorts of dietary issues which go to the socioeconomic
30 disadvantage of the LHD." That's a snapshot of our LHD.
31 I'm sure the other LHDs would also gain a great advantage
32 if they were able to specialise in something.
33

34 We can't even specialise in trauma. The state trauma
35 plan is now over 30 years old, and there are three
36 state - there are three trauma centres in Sydney. But we
37 are in a situation where we can have a serious accident
38 within walking distance of the hospital and the patient
39 will be transferred to Westmead, which is one of the trauma
40 centres. We'd like to get back in the trauma game because
41 that would attract funding, it would attract - we think it
42 would build the reputation, it would build medical training
43 in the LHD. But we're not able to cut through there. So
44 there are a number of definitional factors that really
45 prevent us going to a higher level.
46

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

1 Trauma obviously is one of the needs that your population
2 has. People have accidents within your LHD, just as they
3 do in others. We work out what can be provided within the
4 budgetary envelope, and there are things that can be and
5 things that can't be. So, to use your example of trauma at
6 the moment, accepting that there's a statewide plan that
7 intervenes to some extent, a view's been taken that
8 Westmead is near enough to Nepean Blue Mountains for trauma
9 patients within your LHD by and large to be taken there.
10 The same might be said for other services. For example,
11 types of elective surgery that might happen in your
12 facilities at the moment, a view might be taken by you on
13 the ground that, "Within the existing funding envelope, if
14 people within our LHD can access those types of elective
15 surgery at Westmead, then we might not provide them here
16 anymore and those patients can go to Westmead, because
17 trying to stretch to everything takes our funding so thin
18 that it means that we're perhaps not doing any of them as
19 well as we would ideally like to be." Would that be right?
20

21 MR COLLINS: Yes. That's basically correct, yes.
22

23 MR MUSTON: You've got other challenges that intervene --
24

25 THE COMMISSIONER: Sorry to interrupt. One thing I - this
26 is my fault, I should have said at the start, if any of you
27 want to make an addition or say something on a topic that
28 one witness is talking about, please don't hesitate to put
29 your hand up or make some other signal that you'd like to
30 say something on a topic that's being discussed. That was
31 my oversight at the beginning. I apologise.
32

33 MR MUSTON: Probably mine too. But definitely do feel
34 free because we would like it to be conversational. You all
35 have these issues presenting themselves in their own unique
36 ways in your settings. Mr Gregory?
37

38 MR GREGORY: Yes, just a comment around your example of
39 services being provided or not providing services at Nepean
40 and, if you like, letting people go to Westmead.
41 Historically, it's been more - historically some of the
42 more specialist services for Nepean have been provided by
43 Westmead, and we don't consciously, if you like - you
44 characterised it that we withdraw a service and people go
45 to Westmead. We don't consciously do that. I think just
46 to correct that.
47

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

7
8 MR GREGORY: Yes, that would be true as well, yes,
9 definitely, yes.

10
11 MR MUSTON: And, being sort of realistic about it,
12 clinicians who are unhappy about the fact that a service
13 they are providing within your LHD has been withdrawn will
14 no doubt result in sections of the community also being
15 made to feel pretty unhappy about that fact because it
16 seems like a bad thing?

17
18 MR GREGORY: Potentially, yes.

19
20 MR MUSTON: And these are the human challenges that we
21 need to navigate in system planning and managing change
22 where it's needed. I think we've heard evidence from some
23 of the regional LHDs about emergency departments in small
24 rural hospitals that should, on any rational view, be
25 closed, but for largely sort of politico-social reasons are
26 still there using a slice of the health budget. No doubt -
27 Ms Constable?

28
29 MS CONSTABLE: Thank you. I was just going to I suppose
30 reflect on the point that the community expectation would
31 be they can provide every - that they can receive every
32 health service they need within 20 minutes of their home
33 address, and I think that one of the reflections that
34 I would have is that we have to create an efficiency in the
35 use of public funds at a local level but also at a state
36 level, and therefore there is some sense in narrowing the
37 location of certain highly specialised services so that we
38 can deliver them to a volume that makes them efficient. So
39 if we were to --

40
41 THE COMMISSIONER: And safe?

42
43 MS CONSTABLE: And safe.

44
45 MR MUSTON: Just pausing there, though, safety and
46 economically efficient, they don't necessarily go hand in
47 hand. It may well be that you can maintain safety by doing

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

11
12 MS CONSTABLE: Yes, that's correct. So we have - there
13 are certain services we don't deliver in the district. We
14 don't do neurosurgery. We don't do cardiac surgery on the
15 Central Coast. There would be a desire of some clinicians
16 to do that. But either side of our district we have John
17 Hunter, we have Royal North Shore, and so across that
18 population of 350,000 in the Central Coast do we need to
19 meet the need - every health need locally, because
20 distributing and creating and attracting the workforce and
21 doing it sufficient times could create some challenges in
22 us around scarce workforce and that sort of thing to make
23 it operational and effective and safe and efficient.

24
25 MR MUSTON: So you raise the next issue. The first issue
26 is what services can you deliver and deliver adequately
27 within the budgetary envelope, and you need to make some
28 prioritising decisions. Again, we're assuming that the
29 human factors are not intervening here, if we're just
30 planning in the Utopia. You make your decisions there.

31
32 The second factor that comes into it is workforce. It
33 may well be that you would prioritise a particular service
34 in a way that sees it being delivered in your LHD but the
35 reality is you're not going to be able to get at least in
36 the short term the workforce to enable you to do that
37 because workforce maldistribution issues are rife within
38 health and they're just a reality. So that factors into
39 your thinking about what is or is not able to be provided
40 in facilities within your LHD, I gather?

41
42 MS CONSTABLE: Yes. So - and, for example, attracting
43 workforce might be about the whole range of services that
44 are available. So particularly if we think about surgical
45 procedures, you know, many surgeons also work in the
46 private. So the private hospitals locally to attract
47 somebody to live and work and be part of the Central Coast

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

6
7 MR MUSTON: These nuanced decisions about what services to
8 offer taking into account all of those different factors
9 within the ecosystem of your LHD are best made by people
10 who have that experience on the ground in the LHD, they
11 know about the private hospitals, they know what's being
12 offered at the private hospitals, they know what synergies
13 might exist to enable services to be provided in a public
14 hospital and what synergies don't exist; would that be
15 fair?

16
17 MS CONSTABLE: I think we need to understand the local
18 context and we need to understand the bigger context as
19 well. So that's that point that the system has to be
20 efficient as well as the individual districts in meeting
21 the needs of the population, and the more rural or regional
22 you go, just reflecting on the other comments that have
23 been made, the more challenging it is. But at times
24 I know - I've worked in a number of health districts and
25 have been involved in circumstances in other rural health
26 districts where we had an individual clinician who happened
27 to live there who happened to offer to provide a service
28 that was then funded and supported by the health district
29 and then that clinician leaves, and the expectation of the
30 community is that that highly specialised service is
31 continued to be delivered because it's part of what the
32 health service delivers, and that becomes highly political
33 and challenging for the health district to manage. But is
34 it the right thing that we're delivering a service because
35 we happen to have a clinician that has the expertise?

36
37 MR MUSTON: You've jumped to my next question, really,
38 which is, having identified on the ground the way in which
39 you think, taking into account all of those factors,
40 including an available workforce, is there an ear, nose and
41 throat specialist living in your area who might be able to
42 provide care, for example, maybe that means ENT surgery is
43 on the right side of the line. Maybe it doesn't. That's a
44 local decision that needs to be informed by local
45 knowledge. But then there needs to be some broader system
46 oversight. So each of the LHDs brings to the ministry
47 their patchwork of services, what's above the line and

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

17
18 MS CONSTABLE: Well, I think it is getting everyone around
19 the table, and looking at things from a variety of
20 perspectives with transparency and clarity is absolutely
21 key.

22
23 MR MUSTON: Ms Mains, I think you --

24
25 MS MAINS: I go back to - thank you - systematic planning
26 at all levels is fundamental to taking us forward, and
27 Tobi Wilson referred to this, I think, having a strong
28 healthcare services plan and we've also got a clinical
29 network plan which itemises what services will be provided
30 on what sites so that they connect together, because we
31 cannot provide all services on every site, just like you
32 can't provide all services throughout the state. You need
33 the volume, you need the expertise and the competence to
34 deliver those.

35
36 So I think what's really important is that population
37 needs analysis, demand analysis, socio-demographic factors,
38 all of that that you're looking from a population, and then
39 identifying what the needs are, and then getting really
40 down also to service planning is absolutely critical, and
41 I think --

42
43 MR MUSTON: And service planning involves identifying the
44 cost of delivering a service or the resources, financial
45 and otherwise, required to deliver a particular service and
46 do it properly?

47

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

18
19 MR MUSTON: I was going to say those decisions need to be
20 made in the first instance locally but then informed by an
21 overarching planning exercise which --

22
23 MS MAINS: I think that it needs to be done across the
24 board. So there's statewide planning and then there's also
25 local planning, and they need to feed into each other, yes,
26 from a funding, planning basis.

27
28 MR MUSTON: In your experience is that something that's
29 happening at the moment?

30
31 MS MAINS: I think it's evolving. I can speak about my
32 local experience. I think we've done a lot of focus on
33 district-wide healthcare services plans, on then developing
34 a network plan, and now we're doing a service plan because,
35 as Jude was talking about and also Peter was talking about,
36 there's a lot of challenges in organisations like ours as
37 to what are we, and that sometimes we have a slight "are we
38 metro or are we regional" because we are growing and we are
39 evolving in our service delivery, and what's really
40 important is to try and get systematic planning, because
41 Jude spoke about the doctor that might come to town and
42 therefore you evolve the service around them. But for
43 quality and safety and value for money you've actually got
44 to make sure you've got the right - you need that service
45 and that you're evolving it the right way, and that's why
46 at the moment we're doing 12 specialist service plans,
47 because we are definitely growing more as a tertiary

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

8
9 So, for example, when we were looking at
10 cardiothoracic surplus development we were working with
11 South East Sydney because it required redirection of funds
12 from South East Sydney to our local health district to be
13 able to provide those services.

14
15 MR WILSON: I clarify for the record that there wasn't
16 funds transferred out of South East Sydney, but that's
17 (indistinct) clinicians come after me.

18
19 MS MAINS: You stayed the same and the State made a
20 commitment to fund us because there was a really strong
21 basis. But you need to have strong systematic planning to
22 work that through, otherwise you can develop services on an
23 ad hoc way, which is not appropriate from patient safety or
24 fiscal responsibility.

25
26 MR MUSTON: I just want to pick up on one issue you
27 raised, the clinician who moves into town who's able to
28 provide a service and generously offers to do so. You said
29 we should first be asking ourselves whether we need that
30 service. I assume that if you - much like most other areas
31 of health, if you create a service the demand will be there
32 for it. So in that sense of the word "need" it probably is
33 a needed service, but is what you were really - were you
34 really trying to get at not only is there a potential
35 demand for it but in this prioritisation exercise that we
36 embark upon is this something that we should be providing
37 to meet whatever need is out there within our community,
38 having regard to the competing priorities on our funds?

39
40 MS MAINS: Because we've got to commit that the service
41 we're providing is safe and it's doable at all levels and
42 we have the workforce.

43
44 MR MUSTON: But also is there not also a consideration
45 safe, doable and such that in the prioritisation exercise
46 it justifies being included amongst the things that we can
47 afford within our budgetary envelope as opposed to

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

7 MS MAINS: Yes.
8

9 MR MUSTON: I note the time, Commissioner.
10

11 THE COMMISSIONER: Yes, sure. We'll adjourn until noon.
12 Come back at 12. Adjourn until then.
13

14 **SHORT ADJOURNMENT**

15 THE COMMISSIONER: When you're ready.
16
17

18 MR MUSTON: I'll just close the door. I think, Ms Mains,
19 I had asked you whether you thought that this broader
20 system planning is happening, and I think your indication
21 was that it was developing. Do others have a view about
22 the extent to which that broader system planning is
23 actually happening, that is to say broad system
24 identification of what as a public health service we should
25 be offering, the extent to which it's - let me take it
26 back - what are the needs of the wider population,
27 including in each of the LHDs; to what extent are those
28 needs being met by services external to the LHDs, so
29 private market based solutions, funded by the Commonwealth
30 or not; to the extent that they're not, should we as a
31 public system be including them as part of the public
32 system, and ideally the answer is yes for everything, but
33 maybe that's not realistic; and, if we are including them,
34 where are they going to be delivered. Is that sort of
35 planning happening in an organised way across the LHDs and
36 within the ministry at the moment?
37

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

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

3
4 MR MUSTON: Part of that also is - at least the sense
5 we've got in our travels is with every small change you
6 make to the system it has 50 consequences. So from the
7 point of view of trauma, for example, it may well be that
8 there is a real value in identifying the Nepean Blue
9 Mountains, hypothetically, as a trauma centre. That might
10 bring clinicians into the LHD. But that might have other
11 consequences elsewhere within the system, which need to be
12 identified and assessed as to whether or not a change like
13 that would be justified, and that's not - they're not
14 necessarily going to be visible within the Nepean Blue
15 Mountains LHD, for example. You need that system oversight
16 to say --

17
18 MS MAINS: And that's where I think when you're doing -
19 for example, focusing on population based funding formula
20 you've actually got to go right back to looking at what
21 your need, your demand, your socio-demographic factors are,
22 what your allocations are then per district and then what
23 can be delivered upon that, and just like we need to look
24 locally at what we can do and where and what we can't do
25 because it doesn't meet all the parameters that it should
26 be, there's also room and opportunity through that to
27 itemise the allocation of money but also the allocation of
28 services and what should be done at what level, which needs
29 to be looked at on an ongoing and regular basis.

30
31 MR MUSTON: Mr Collins?

32
33 MR COLLINS: No LHD expects to specialise in everything,
34 and even if you've got a teaching hospital which is going
35 to specialise in a lot of things you won't get everything,
36 and I really think it would be very useful for the ministry
37 to be permitted to spell out the allocation of specialised
38 projects and services across the state. I mean, obviously
39 that's the province of the government, probably be done by
40 or through the minister. But all large bureaucracies
41 develop their own ongoing departmental policies, practices
42 in the way they do things and the way they allocate
43 resources. I mean, I'm someone who's seen this fairly
44 closely, the amount of room to move with funding available
45 to the minister of the day, whichever side, is probably
46 less than 5 per cent wriggle room. The other 95 per cent
47 is completely locked in and known to the ministry.

1
2 So I think it would be useful to have the ministry
3 say, "Look, okay, in terms of diabetes we really think, you
4 know, Penrith should do that. In terms of skin cancer,
5 maybe it should be a eastern seaboard LHD does that," and
6 I think that if there was that transparency and clarity
7 where people were given - the LHDs were given priorities,
8 I think there would be a good response to that.
9

10 If I can just make one other observation. We have -
11 through the funding formula I think we've got - the
12 ministry makes a very good effort at equality, but they
13 don't achieve equity in terms of the Sydney Basin, anyway,
14 the greater Sydney Basin.
15

16 MR MUSTON: We might come back to that. Mr Wilson?
17

18 MR WILSON: Yes, I think it's - so, in answer to your
19 question, it's complicated, like it always is. I think the
20 bit that would be really useful, and we've got most of this
21 in place, is really - is a lot of clarity around where the
22 line sits between those statewide services and where do we
23 need to have a system view around things and what needs to
24 be - is just core business for an LHD to be planning for.
25 That's how we think about it within our district. There
26 is - probably 90 per cent of what our hospitals offer is
27 core business for those hospitals, and they need to plan
28 how they're sustainable in offering that. There is a small
29 bit that sits on the top that we need to worry about from a
30 district perspective because of workforce implications or
31 cost of service or whatever. That would be the piece, and
32 I think as a state there's some really good examples where
33 we do this really well, and I think the trauma piece is a
34 good example. It's just around how do you stay on top of
35 that and how do you keep that lens on what this is going to
36 look like in 10 or 15 years time, because that's the lead
37 time for all of these sort of things.
38

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

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

4
5 Like I said, I think we do it really well in some
6 pockets, but I think there are some other areas where we're
7 probably not as advanced around. And then to some of those
8 emerging pathologies that you talked about and how we deal
9 with that, I think that applies the same kind of lens, is
10 where are we going to go with this as this starts to come
11 into common practice in health.

12
13 MR MUSTON: And is there potentially a middle piece?
14 You've got your sort of services which are broadly
15 characterised as statewide services at the moment. You've
16 got business as usual which is done locally. But then is
17 there possibly some extent to which what might be business
18 as usual in one LHD doesn't need quite to be business as
19 usual there because an adjacent LHD is actually doing that
20 well and maybe that adjacent LHD is where you go for your
21 orthopaedic surgery, whereas if you need your ear, nose and
22 throat, people from that LHD come in to you. That's that
23 overarching planning?

24
25 MR WILSON: Yes, and again I think there's really good
26 examples where that does work. I think probably the bit
27 that I would talk about in that middle is there's some
28 things that probably five or 10 years ago we talked about
29 as being - so maybe if we take TAVIs as an example, which
30 was originally very expensive, very much cutting edge, and
31 a few centres set it up, and now the State has got more
32 involved in making sure that there's access more broadly,
33 and probably if we're having this conversation, and
34 certainly my cardiologist would talk to me now, about that
35 this is just routine care, and how do we then make that
36 transition from this being a statewide funded service or a
37 component of this statewide to actually this now starts to
38 become more core and we move there now. I don't think
39 we're there for TAVIs at the moment, as an example. But at
40 some time in the next five to 10 years that's going to be
41 routine care for a number of interventional cardiology
42 services across the state, and so that's how do we start to
43 move towards that just being part of what the LHD now is --

44
45 MR MUSTON: But, to pick up on that, the dynamic nature of
46 your planning has to be able to identify, as and when it
47 happens, that, say, interventional radiology is an emerging

1 and potentially soon-to-be business-as-usual approach to
2 cardiac care. Whilst that might need to be rolled out
3 across a wider range of centres within New South Wales,
4 centres within New South Wales that crack open sternums
5 might actually contract at the same time?
6

7 MR WILSON: Absolutely, yes, that's right.
8

9 MR MUSTON: Mr Morgan, I think you had your hand up first.
10

11 DR MORGAN: Thank you. I think I was actually just going
12 to add really a vote for this notion of the statewide
13 service really - statewide planning, that the fundamental
14 issue is I think what's changed over the last 30 years is
15 this advent of what I've loosely referred to, clinical
16 systems networking, the fact that there's been recognition
17 usually on safety grounds that all places can't do all
18 things, and so these high acuity, low occurrence procedures
19 that we talk about, whether it be cardiology, whether it be
20 trauma, whether it be mental health, whether it be
21 obstetrics, where we know our patients do better in centres
22 that are consolidated with people that are doing high
23 volumes, and the extent to which there are a number of
24 these that are consolidating - certainly motor vehicle
25 trauma is significantly down on historical times, and yet
26 there are growing cutting-edge technologies that will in
27 the future years actually become more and more routine, and
28 I think it's really only at the state-based view that you
29 can actually plan that for a state and really get that
30 right.
31

32 The extent then that it actually flows down into the
33 local health services planning, that's the fidelity that
34 I think we could strengthen, is how geographically as
35 statewide health services or LHDs we actually get that
36 intersection back to the statewide planning, and it is a
37 medium-term horizon that I think the State needs to take.
38

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

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

9
10 THE COMMISSIONER: It's close to a submission, I think,
11 you're making rather than a question.

12
13 MR MUSTON: Well, I'm inviting you to agree with it. I've
14 seen lots of nodding.

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

30
31 MR MUSTON: Something like a new build that was planned
32 eight to 10 years ago that didn't include, say, a cath lab
33 that once it's finally built you're thinking, "Gosh, well,
34 this is now the future of cardiac care and we need to find
35 somewhere to put it"?

36
37 MR WILSON: Or how we think about intervention or any kind
38 of interventional spaces I think is really - I know some of
39 the districts have got some really good ways that they've
40 managed that interventional workload, which is massively
41 growing compared to more traditional open theatres, but
42 others, we just haven't thought that way through enough at
43 the time when we were doing the planning of what the future
44 actually starts to look like.

45
46 MR MUSTON: Ms Mains, I think you had your hand up.
47

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

11
12 In terms of configurations, I do think local
13 leadership is critical. We've been in the process of
14 closing down three hospitals and reconfiguring, and it's
15 been the discussions at a local level, particularly
16 clinicians and management with communities, and working
17 together with multiple stakeholders that have been crucial
18 to be able to develop that. It's the local knowledge, it's
19 the trust and the people that's really crucial.

20
21 MR MUSTON: That sort of leads me to the next little
22 question I have, which is, whilst, to pick up on what you
23 said, New South Wales might have an excellent set of plans
24 or strategic documents that identify the way planning
25 should be done, it hits up against that human element of
26 where you have clinicians who potentially are in a
27 particular site, they're delivering a particular type of
28 care, they've got perhaps some succession plans themselves
29 of registrars coming through to replace them, they want to
30 innovate and discover new ways of doing what they do, and
31 that obviously needs to be encouraged, but how do you
32 manage that situation where in essence the way the health
33 system grows, whatever the planning documents might tell
34 you, is driven in an inherently organic way by the
35 clinicians who are delivering that health care on the
36 ground? How do you deal with that?

37
38 MS CONSTABLE: I'd make two comments. One would be that
39 you have to engage the clinicians in the clinical service
40 planning, and then the clinical service planning has to be
41 what drives, unless there's an exceptional change to the
42 population or the issues or the context, and COVID
43 obviously would be an exceptional change to the system that
44 required a review. But I have exactly the circumstance
45 where there was a build at Gosford Hospital six years ago
46 which included a piece of equipment that has sat there for
47 six years underutilised or not utilised at all to deliver

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

15
16 MR COLLINS: Just further to clinical services plans,
17 I know that the Commission was given evidence last week
18 regarding Blue Mountains Hospital by the chair of
19 the medical staff council in the Blue Mountains, who was
20 critical of the role of the Nepean Blue Mountains LHD in
21 furthering that clinical services plan. So I want to set
22 the record straight on that.

23
24 The LHD has bent over backwards to work with the
25 medical staff council at Blue Mountains Hospital to deliver
26 an optimistic clinical services plan. When I say
27 "optimistic", it's human nature for clinicians - and your
28 train of thought about building practices and building
29 legacies and so on. I mean it's human nature to want to
30 build and expand and add to. And so the clinical services
31 plan which has gone forward to the ministry encapsulates a
32 lot of that sort of aspirational growth. Whether it can be
33 sustained, though, is a matter for the ministry to look at
34 demographics, and that's the ministry's job to say, "The
35 population growth that we see is perhaps different to the
36 population growth you see," and to make the final
37 determinant about the funding that flows from that.

38
39 And just on that particular hospital, which was the
40 outlier of the 140 or so infrastructure projects in New
41 South Wales over the last decade in health, the one that
42 wasn't done was Blue Mountains, and it really does need
43 replacing, and it was Lee Gregory's predecessor, Kay Hyman,
44 as chief executive and myself who called the community
45 meeting in Katoomba to get that going two years ago, which
46 has resulted in the funding that the hospital has attracted
47 from Minister Park. So there is a very important role to

1 play in getting clinical services plans right and I guess
2 trying to herd medical staff councils to take them along on
3 that journey.
4

5 MR MUSTON: In fairness to the clinicians, each of them,
6 focused on their own unique area of endeavour, can see a
7 need for their services and would say, advocating for their
8 patients or potential patients, "If I had more money and
9 more resources diverted to my little field of endeavour,
10 then I would be able to do some great work for those
11 patients," and that's again human nature, which goes
12 beyond - the sort of empire building, as it were. But
13 that's where we come into this, the difficult job that a
14 system manager and individual sort of managers of
15 individual parts of the system have where there is a
16 limited funding envelope and you have to work out what to
17 prioritise and what not to.
18

19 But to pick up on what you said, I think, Mr Wilson,
20 that an important part of it is this 10-year horizon and
21 bringing clinicians along, recognising that change can't
22 happen tomorrow or maybe even next year but in 10 years
23 time, would it be right to say that with careful management
24 you might be actually able to steer the direction of
25 services in a way that makes them - the changes in the way
26 that it should be changed?
27

28 MR WILSON: Yes, certainly that would be my view of how
29 you'd drive some of these things, is you need to take a
30 long-term view around the strategy and where you're trying
31 to get to, and bring the clinicians with you on that
32 journey.
33

34 MR MUSTON: To do that, though, recognising that sometimes
35 it's not a change that can be made immediately, there might
36 be a period where funding of an imperfect service set is
37 needed because if you're not funding that service set then
38 everything, including those things you're trying to build,
39 become challenged?
40

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

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

3
4 MR MUSTON: Yes, Ms Hoey?

5
6 MS HOEY: I was just going to add I think an area that's
7 done this well, although we're only in the early bits, and
8 it's when you were saying we have to hold the situation for
9 a while, is in the mental health area where they've done
10 that in the SWMHIP program, where they've done a long-term
11 plan around the required beds, particularly in forensic
12 mental health, and the builds are coming. I think
13 workforce aside, because it's kind of put a little bit of a
14 spanner in the works at this point in time, it is about
15 holding that plan and knowing where you're heading while
16 it's not quite right, and having the strategy and the
17 policy to go with infrastructure build, and then having
18 I think the levers to hold us all to account to what's
19 going to happen when - for the clinical services to go
20 forward.

21
22 So I think the mental health branch in conjunction
23 with the LHDs and ourselves have done that - have done the
24 planning pretty well. Execution's hard because of
25 obviously the budget situation and the workforce situation
26 with mental health. But I think from a sort of centralised
27 planning perspective I think they've done a good job. We
28 just have to execute it, and that's the hard bit, isn't it?

29
30 MR MUSTON: Can I come to you, Ms Cox, as the person
31 currently responsible for the entity that might be
32 receiving some of these centralised services that are being
33 delivered - well, you're already delivering centralised
34 services through the children's network. What would the
35 impacts of this sort of planning be on an organisation like
36 yours?

37
38 MS COX: For me it's really about the transparency and the
39 statewide perspective. So everyone in the system - so not
40 just within the network, but everyone in the system
41 understands what services I'm accountable for and we're
42 providing, how that links to - because I don't have that
43 geographic catchment. So the needs analysis is actually
44 quite challenging for a statewide service, but that the
45 LHDs where I'm providing the tertiary and quaternary care
46 for their paediatric population actually have a really
47 clear pathway and understand what I'm doing. But it's

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

8
9 But I also want to pick up on horizon scanning because
10 there's a whole world of precision medicine that is sitting
11 in the research paradigm that is coming out and coming out
12 quickly, and we really don't have an implementation plan
13 around that, and they are big costs. I think the spinal
14 muscular atrophy, that's 2.5 million for a child that would
15 have died three years ago. So that sort of research into
16 clinical practice is getting shorter and shorter, and,
17 again, we don't really have a statewide plan about how
18 we - weighing up that priority versus community
19 paediatrics, so, you know, what's the State's position on
20 things like that.

21
22 For mental health, again for me it's about in the
23 statewide mental health world what do you want the tertiary
24 and quaternary service to be doing in the context of all
25 your other service configurations? I'm not sure. So, you
26 know, we provide very specialised services, but how does
27 that sit within a systematised approach for mental health
28 for children and young people? So I think some of those
29 things being more explicit and clear would really help.

30
31 MR MUSTON: And in the ideal world that wouldn't be
32 fostered through memoranda of understanding between your
33 network and LHDs and other networks within the system;
34 would that be right?

35
36 MS COX: Yes, that's right. We would have a statewide
37 direction that would be quite clear about what's where and
38 what's being provided. So we now do all our statewide
39 planning with John Hunter Children's so that we actually
40 make sure we've got that - we're coordinated. But again
41 that's coming from bottom up, not top down.

42
43 MR MUSTON: And, equally, from a funding perspective there
44 would be aspects of the work that your network does which
45 might be important to keep the system functioning and
46 perhaps keep things out in the regions but is not readily
47 picked up by activity-based funding, for example providing

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

7
8 MS COX: Yes, absolutely. So that's the consultation
9 advice that's provided. Nets, the neonatal retrieval
10 service, is a really good example where there's a really
11 significant proportion of their calls that actually a
12 child's not retrieved, and that's great because they've
13 watched that child in that emergency department, they've
14 worked with the local clinicians and that child is kept
15 there. But because we don't have a retrieval that's not
16 funded for activity.

17
18 And similarly when the - they'll do an outpatient
19 clinic for oncology, for example, but when the treating
20 clinician wants to talk to the consultant back at, say,
21 Sydney Children's that's not counted as activity, even
22 though that's really important for that child to stay
23 locally. The training that they do on behalf of the State,
24 that's not activity. So those sorts of things. It's how
25 do you manage block or how do you tier it. Those sorts of
26 things are really critical.

27
28 MR MUSTON: So a more clear delineation of roles across
29 different parts of the network would have as one of its
30 benefits at least an identification of who was doing what
31 so that funding decisions, be they good ones or bad ones,
32 are at least made on a properly informed basis and on a
33 transparent basis?

34
35 MS COX: Yes. And there might be some services that we
36 can absolutely provide. I think we've got some models
37 where we're providing developmental assessments because
38 it's easier for us to get the staff, so we can support the
39 local paediatrician to provide those assessments. Again,
40 doing that in a really much more structured way,
41 transparent way would be helpful.

42
43 MR MUSTON: From your perspective, what at a systemic
44 level needs to be changed or could be adjusted to make that
45 work better?

46
47 MS COX: I think - I'm loath to say after Margot saying we

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

8
9 MR MUSTON: So do I take from that that you've got your
10 high level plan that usually has a particular sentence or
11 principle expressed at a high level, and as one works down
12 through the cascading array of plans which come out of it
13 you've got to do a little bit more than just repeat that
14 sentence in each of those pieces of paper in order to
15 satisfy the requirement or to achieve the objectives of the
16 plan?

17
18 MS COX: Yes. It's the execution and the implementation
19 is really hard, and that's where you've all got to be in
20 lockstep.

21
22 MR MUSTON: Well, in relation to that, both from a
23 planning point of view and also an execution point of view,
24 would there be benefit in some quarantine funding provided
25 for the purpose of that being done or so as to enable that
26 to be done? Any of you can answer that question. All of
27 you, if you want to. I'll tell you why I ask that
28 question --

29
30 MS HOEY: I think you know my thoughts about quarantine
31 funding, and certainly for things like forensic mental
32 health, mental health area I think it's really important,
33 and if we want to make sure that we do stay in pace with
34 our planning, you know, objectives then I think in some of
35 these areas that are not necessarily driven by ABF funding
36 and not necessarily driven by what the clinicians want or
37 the services that needed - I think quarantine funding has
38 got at least until the services are established.

39
40 MR MUSTON: Do others have a view on the potential
41 benefits of quarantine funding for planning? Mr Gregory?

42
43 MR GREGORY: Yes, I was just going to - the comment I was
44 going to make is I think there is something in terms of
45 looking again at are we achieving - if you look at the
46 social - the health of the population in Nepean as opposed
47 to, say, Northern Sydney, I think there is something around

1 looking at that again and are we achieving the equity that
2 Peter talked of before in terms of - and that maybe points
3 to some quarantine funding. So, yes.
4

5 MR MUSTON: My question is more directed at in order to
6 look at that you need some resources, human resources
7 principally; would that be right? In order to sit back and
8 actually look at what's happening within your district and
9 to look at what's happening and for others to look at
10 what's happening in their respective districts to work out
11 where the synergies lie you need someone who has got the
12 time and skill set to do it.
13

14 MR GREGORY: I think we've got a lot of those resources
15 anyway. There's people who are doing planning within the
16 system, you know, both at ministry level and district
17 level. I think it might be a bit of a change of emphasis,
18 possibly.
19

20 MS MAINS: I think it will be people that do systematic
21 planning. That's what we need to - where we are actually
22 positioning ourselves. And I think planning is the
23 foundation of identifying what is needed going forward and
24 what we can prioritise. And if I just pick aged care,
25 which is a personal area that's impacted us significantly,
26 careful planning between the State and the Commonwealth and
27 locally, and aged care facilities and PHNs and GPs is
28 fundamental to actually getting the system right.
29

30 MR COLLINS: Just on quarantine funding, sometimes that's
31 the only way you do break through. That's sometimes the
32 only way you do turn things around. There was a time when
33 Aboriginal health funding was seen as a hollow log that
34 could be raided and money could be taken from Aboriginal
35 health funding, and I'm talking about three decades ago,
36 and that money could be used to top up other services like
37 emergency departments and so on. That money was then
38 quarantined and used exclusively for Aboriginal health, and
39 I believe that remains the case now.
40

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

1 LHD rather than central office.

2

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

10

11 MR COLLINS: Yes. And I invite - I mean, Lee is across
12 the micro detail. While we have not met activity
13 projections in certain respects, we've got I think it's a
14 15 per cent increase in bed occupation, isn't it, over the
15 last 12 months or so?

16

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

23

24 In terms of activity growth, I think we're doing about
25 22 per cent more through the ED than two years ago at
26 Nepean; increasingly busy.

27

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

33

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

36

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

46

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

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

11
12 MS COX: That's right, or if it was actually focused on
13 the outcome I might configure that in a different way than
14 it coming and sort of saying, you know, "It will be this
15 exact program." I might have had a slightly different way
16 of configuring my service to respond to that. So, yes, I'm
17 agreeing with what you're saying. I think there's that
18 lack of flexibility then in how you would respond. And
19 would it have been my top priority? Maybe not. So I think
20 there's a communication from the system again about
21 priorities and why that's been deemed to be the system
22 priority that we're all going to get behind and why we
23 should do that.

24
25 The other bit - I think you were saying about
26 quarantining money for planning purposes. I think, as
27 Margot said, we do have those resources and we plan - every
28 day we have to plan for our redevelopments. We're all
29 doing clinical services planning all the time. Again, it's
30 the statewide picture, because I don't necessarily know
31 what northern New South Wales might be wanting to do in
32 paediatrics and where they see me fitting. So that would
33 be helpful because I don't have that broader perspective to
34 understand that linkage. That's the sort of planning
35 that's --

36
37 THE COMMISSIONER: Just on that, so the transcript's not
38 cryptic, when Ms Mains was talking about systematic
39 planning and you said you wanted to pick aged care, which
40 was you said a personal area that's impacted your LHD
41 significantly, and you talked about the need of careful
42 planning between the State, the Commonwealth, aged care
43 facilities and GPs is fundamental to actually getting the
44 system right. I'm right, aren't I, that what you're
45 referring to there is wards of your hospital full of people
46 that could be or should be in aged care facilities but
47 there's no bed available?

1
2 MS MAINS: So fundamentally 20 per cent of our current
3 beds are occupied by people either awaiting through an
4 acute phase waiting for a bed, or close to aged care
5 assessment for waiting a bed, or needing access to
6 (indistinct) to a more suitable assessment case management
7 and access back to high-level packages in the community so
8 that they can be supported in their own homes.
9
10 THE COMMISSIONER: And in no way am I attributing blame to
11 anyone, but that's a failure, that number of patients
12 you've got.
13
14 MS MAINS: It is (indistinct).
15
16 THE COMMISSIONER: Yes, exactly. And it's a failure that
17 results, first of all, being a final burden on your LHD and
18 the State; correct?
19
20 MS MAINS: The most important thing is it is a burden on
21 the older person who is deconditioning and --
22
23 THE COMMISSIONER: It's a cascading thing. It's a burden
24 on the patient. It's a burden on your workforce.
25
26 MS MAINS: Yes, it's a huge burden on the workforce. But
27 we're also seeing people staying now on an average of
28 66 days. The average stay is normally 4.5; slightly longer
29 for people awaiting aged care. It has a huge significant
30 burden on access and flow for acute beds, and back-up on
31 ED. So last night we had 48 people in Wollongong ED
32 awaiting to get a bed that were in the ED. So it flows
33 right through the system.
34
35 THE COMMISSIONER: But that is an example where planning
36 involves not just the ministry or you but, because we're
37 talking aged care and the same as if we were talking
38 primary care, it involves the Commonwealth.
39
40 MS MAINS: Yes.
41
42 THE COMMISSIONER: Sorry for the interruption.
43
44 MR COLLINS: Can I just add one thing about aged care
45 facilities. I mean, this is something which the
46 Commonwealth is nominally responsible but I think that they
47 are very happy to rely on using state facilities to provide

1 aged care services exactly as Margot has described.
2
3 THE COMMISSIONER: By state facilities you're talking
4 public hospitals.
5
6 MR COLLINS: Yes.
7
8 THE COMMISSIONER: Which are not aged care facilities.
9
10 MR COLLINS: Yes. And so there is a serious supply issue
11 because the alternative - the funding alternatives is hard
12 to come by and mostly in private hands, and we've seen some
13 of the consequences of that in the - with the pandemic and
14 a lack of control by some of those private facilities.
15 There are a whole range of issues. So I really think it is
16 something that does require a lot more attention by the
17 Commonwealth.
18
19 MS MAINS: And, sorry, if I could --
20
21 MR MUSTON: No, please go.
22
23 MS MAINS: So the area we're planning and modelling on
24 what the projections are going ahead are fundamental
25 because we're about to hit the biggest five years ahead of
26 us to 2029 in term of aging and baby boomer, and it's
27 really significant. And so good planning, good demand
28 modelling, good planning, working out the roles is really
29 critical, whereas it's a very supply driven market at the
30 moment.
31
32 MR COLLINS: Sorry to come back. I do not advocate that
33 the State walk away from aged care, because there is no
34 alternative at the moment for these elderly people; there's
35 nowhere else for them to go. And one of the consequences
36 is if you do close down existing facilities, and there are
37 many across New South Wales and Australia, you collapse the
38 economy of the towns and villages in which they operate and
39 which they serve. And that is not in anybody's interests
40 and is not - would not generate any cheaper solution,
41 because if you collapse those economies they end up going
42 to bigger towns where there might be facilities but they
43 cost more to expand those facilities to accommodate those
44 people who have got to migrate to larger towns --
45
46 MR MUSTON: That's further away from their families.
47 Migrating to larger towns potentially also means moving

1 further away from their families.

2

3 MR COLLINS: Yes.

4

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

23

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

32

33 And they're deliberately constructed in many ways,
34 I think, that depending on what actually occurs in
35 10 years' time you can still satisfy the terms of the plan.
36 But is it specific? Is it measurable? Is it really
37 achievable, realistic and time band? Well, the answer to
38 that is it depends on whether you get the funding for it.

39

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

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

5
6 No-one would have ever seen the impact that Margot's
7 experienced in Illawarra through the NDIS changes and
8 through residential aged care. I think you guys are,
9 sadly, an exemplar of when it goes wrong it really goes
10 wrong. But, again, a vote in favour of the central
11 planning argument is that we've talked a lot about the
12 long-term plans. I also think that there is a very good
13 case to be made for the tactical and medium-term planning
14 at the centre.

15
16 Now, whilst there's a lot of collaboration I think
17 between the LHDs and the other statewide health services,
18 the simple reality is that decisions around what role
19 ambulance services do in terms of keeping people out of
20 emergency departments these days was a case in point. When
21 it particularly hit the Illawarra, ambulance was able to
22 provide extended care paramedics that have an increased
23 ability to actually divert off to optimise community
24 resources.

25
26 But if we're all sitting back going, "Well, the job of
27 the ministry is to have a 10-year plan," we're going to
28 miss the boat. It's far more tactical than that these
29 days, I think.

30
31 MR MUSTON: Can I ask in relation to that the funding of
32 the ambulance service and the extent to which that funding
33 accommodates or enables the resources available through
34 paramedics to be utilised in the way that best meets the
35 needs of the system in a system wide planning perspective,
36 how does that work?

37
38 DR MORGAN: Well, look, I think, you know, we kind of
39 discussed before the reality is ambulance is block funded.
40 That's exceptionally problematic for us.

41
42 MR MUSTON: Can I ask a question about that. By being
43 block funded presumably the ambulance service at some point
44 in history was given a base of funding which has been
45 increased progressively over the years by a growth factor?

46
47 DR MORGAN: No, and that has been our problem.

1
2 MR MUSTON: So when you say "no" can I ask you two
3 questions. First, there was a base at some point in the
4 past: yes or no?
5
6 DR MORGAN: Correct.
7
8 MR MUSTON: Second, has growth been applied to that base?
9
10 DR MORGAN: Not as the growth factor as you would describe
11 it.
12
13 MR MUSTON: Can I ask a question before you come to this
14 point.
15
16 DR MORGAN: Yes.
17
18 MR MUSTON: In terms of the base, do you have any idea of
19 when in history that base was identified as a reasonable
20 cost of delivering ambulance services?
21
22 DR MORGAN: No. That's not visible.
23
24 MR MUSTON: Is it possible or perhaps even probable that
25 at the time that the base was identified as being the
26 reasonable cost of delivering ambulance services the
27 ambulance service was more of a group of highly skilled
28 first aiders who drove well rather than the very
29 technically capable and well-trained clinicians that they
30 are today?
31
32 DR MORGAN: Correct. So --
33
34 MR MUSTON: Just in relation to that, the cost of
35 delivering that technical and well-trained workforce of
36 paramedics presumably is greater than, through both them
37 and the equipment that they use, what might once have been
38 the case when the nature of the ambulance service was a
39 little bit different?
40
41 DR MORGAN: Yes, it's incomparable. The reality is
42 1 December 2018 they became a registered health profession.
43 The net effect of that has been twofold. One, COVID
44 demonstrated that ambulance was a significant value
45 proposition to the entire health system in its ability to
46 actually keep patients out of emergency departments.
47

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

10
11 And if you said to me what do I think would be the
12 role of the ambulance service within a decade it would not
13 be the organisation that drives you to the emergency
14 department; it will be the organisation that actually makes
15 you go to the right disposition for the medical condition
16 that you now have.

17
18 So this changing proposition means that block funding
19 with ever-increasing demand and that only being met by ad
20 hoc political announcements lends us to a situation of
21 really disproportionate FTE growth to demand growth. And
22 I remember when we were meeting we were discussing
23 the - back in 2011 the numbers were sort of 0 per cent FTE
24 growth and 0.1, and it wasn't really until COVID that the
25 numbers changed. And I had the team map out the percentage
26 growth, and what that gives you is our workload against
27 percentage increase in demand. And what that just says is
28 that the current block funding and ad hoc investment is not
29 fit for purpose.

30
31 MR MUSTON: I might call for that.

32
33 THE COMMISSIONER: You're going to have to tender that.

34
35 DR MORGAN: I knew you were going to say that. I actually
36 helpfully did the actual numbers. You should only look at
37 that as illustrative.

38
39 MR MUSTON: Do you helpfully have a copy of that for me?

40
41 DR MORGAN: We do. We do. So when you look at the
42 fact --

43
44 MR MUSTON: Just before you finish that answer I'll deal
45 with the technicalities of it. That graph that we've just
46 been shown, we might mark that as MFI - 14 months in.

47

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

4
5 MR MUSTON: We'll mark it as an MFI that will be given a
6 number in due course and then thereafter we'll tender it.

7
8 DR MORGAN: So I make this point that what we do know over
9 the past five years is that, leaving aside variability for
10 the fact of COVID, but ambulance demand has basically
11 increased by about 2.75 per cent per year. Now, what we
12 also know is that over the last decade we have been
13 precisely 25 per cent of ED attendance. So one year it
14 goes from 24 per cent, another 26 per cent, but over the
15 period we've represented 25 per cent of all ED attendance.

16
17 Now, if I was to say to this Commission what would
18 change ambulance services in this state tomorrow was
19 exactly the point that you raised around just being funded
20 for the state average growth factor. The state average
21 growth factor tends to be, setting aside escalation,
22 2.5 per cent per year. If ambulance had been exposed to
23 that same level of growth we move from an ad hoc, periodic
24 political announcement to sitting down with the Ministry of
25 Health and negotiating what is it that we would invest that
26 money in most, and it may be paramedics on the road, but
27 more likely these days it is going to be into virtual
28 clinical care.

29
30 Some of the overseas systems are very sophisticated
31 now with employing social workers, occupational therapists,
32 mental health workers/professionals all aimed at getting
33 patients to the most appropriate disposition for their
34 medical condition. Now, I think our colleagues in
35 Queensland have a social worker dealing in their
36 - equivalent of a virtual clinical care centre that as soon
37 as they get someone identified as social work and NDIS they
38 actually refer them to the Commonwealth critical care team.

39
40 Now, what we do know is if you get someone who is in
41 NDIS into an acute care hospital their length of stay tends
42 to exceed almost every other category. So there's a
43 significant benefit and maturing of the system where
44 ambulance through the service delivery - sorry, the service
45 agreement process be able to negotiate with health where
46 they saw the best medium and long-term priority investment
47 as well as consistency in planning for us.

1
2 THE COMMISSIONER: I've forgotten from our visit, but I'm
3 sure I was told. I mean, obviously if paramedics are
4 attending a car crash with traumatic injuries the people
5 involved are being taken to an ED. But there was to me a
6 surprising number of calls to the centre where the
7 paramedics go out and what's not required is a trip to the
8 ED but something else, as you say, the most appropriate
9 disposition for the health service. But I've forgotten
10 what the figures were.

11
12 DR MORGAN: Yes, so we get about 1.25 million triple 0
13 calls per year. That translates into what we would say is
14 about 1,052,000 incidents. So that's just two calls to the
15 same incident. But only about 784,000 of those last year
16 actually ended up in an ED. So we actually make on average
17 between 25 per cent and 30 per cent of all incidents don't
18 result in us transporting someone to an ED.

19
20 Now, we have some really clever and innovative
21 programs, and I think this is part of the evolving of
22 ambulance, around we have specialties of what we call
23 complex and chronic care; so some patients that actually
24 need someone to go and connect them to the system, a really
25 good example might be palliative care patient in the
26 community or a mental health patient. The last thing you
27 want to do if you can avoid it is take a mental health
28 patient to an emergency department. They're busy, they're
29 chaotic and generally not great places for mental health
30 patients, unless they have concomitant other conditions.

31
32 Allowing us to actually identify these patients early
33 in the call cycle means we've got a better connection to
34 send them off in partnership with the LHDs to services that
35 either they run or the community run. And there's been a
36 lot of work done centrally in the cooperation with
37 the ministry and all of the LHDs about building these
38 referral networks for us. But this is where the fidelity
39 of where our funding I think will go into the future is far
40 more about how we optimise community services rather than
41 building more and more big EDs.

42
43 MR MUSTON: I note the time, Commissioner. I was about to
44 move to a slightly different topic.

45
46 THE COMMISSIONER: Okay. All right. Yes, we'll adjourn
47 for lunch and come back at 2 o'clock. Adjourn until then.

1
2 **LUNCHEON ADJOURNMENT**

3
4 **UPON RESUMPTION**

5
6 MR MUSTON: Commissioner, I just have another table which
7 Mr Morgan has provided. Shortly before lunch he gave an
8 indication of the percentage of emergency department
9 presentations that arrive by ambulance, and you'll recall
10 the evidence was to the effect that it sort of hovered
11 around 25, 26 one year, 24 another year per cent. I've got
12 a table that actually charts that. We might incorporate
13 that into MFI-18.

14
15 THE COMMISSIONER: Of course.

16
17 MR MUSTON: Mr Morgan, I might just ask you one other
18 question about the ambulance service in particular. In our
19 travels around the state we've heard quite a lot of
20 evidence about the role played particularly in regional
21 areas by the ambulance service in patient transfers and the
22 potential challenges that that can present in circumstances
23 where ambulances are required to do that more urgent work
24 that ambulances do on the ground but might be deployed
25 somewhere transporting a patient who's not necessarily in
26 need of acute care from one setting to another. Is that a
27 feature of the system at the moment and a problematic one
28 if that?

29
30 DR MORGAN: I think again it's just demonstrative of the
31 maturing nature of the system. If you go back to the
32 original tenets of the Ambulance Services Act, which was
33 1982, which has now been subsumed into the Health Services
34 Act, it was all about ambulance services being the first
35 aid and transport of the sick and injured. So it didn't
36 delineate between emergency and non-emergency.

37
38 As the years went by the system became so large in
39 certain large areas there was economies of scale to split
40 the system, and you could efficiently use, you know, a van
41 and two people to do low acuity work and it was, you know,
42 a very efficient way of doing it and that preserved your
43 emergency vehicles for going to emergency calls. But you
44 can imagine as you get smaller and smaller populations the
45 ability to efficiently have two different systems sitting
46 side by side becomes less economical.

47

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

12
13 MR MUSTON: Is that because the patient transport services
14 which are delivered through HealthShare are largely
15 confined to metropolitan areas?

16
17 DR MORGAN: That's largely right and, apart from the
18 metropolitan areas, up into Hunter New England provided by
19 HealthShare. But all the other LHDs have some footprint,
20 but it's limited for patient transport. And I defer to my
21 LHD colleagues, but I think they predominantly only do
22 between their own facilities, which again leaves a gap. If
23 people are being discharged, they'll often have to go home
24 - if they can't get other transport - by the emergency
25 ambulance within that community with obvious risks
26 associated with that.

27
28 MR MUSTON: And with any increase in system wide planning
29 that saw certain services being offered in some LHDs but
30 not others in a synergistic systemic way the need for that
31 patient transport would presumably increase?

32
33 DR MORGAN: I think in those communities that are
34 certainly growing and aging that would absolutely be true.
35 I am aware that there is some planning happening at the
36 HealthShare level with the Ministry of Health around what a
37 broader rural model for patient transport would look like,
38 and I think it's fair to say we'd all be looking forward to
39 the outcomes of that.

40
41 MR MUSTON: Do you have a view about whether the ambulance
42 service should be involved in that patient transport
43 service in the sense that you have a resource which is
44 currently being used for transporting patients, perhaps not
45 the best resource for that purpose, but is it - would there
46 be any sense in having the ambulance service dealing with
47 patient transport as well or should all patient transport

1 be dealt with separately to the ambulance service?
2

3 DR MORGAN: I think we need to be really cautious not to
4 have absolute lines. The reason why is I think every
5 individual circumstance will vary on the situation. If you
6 think about it, you know, infirmed patients may not be
7 acutely ill but may still need an ambulance. People with
8 gross disfigurement may need an ambulance. People who are
9 incontinent may need an ambulance. And
10 sometimes - sometimes - it is efficient to simply take that
11 patient from the place of care to their residence.
12

13 So I would hate to have an arbitrary line of, "We
14 never do," but I think that having the option of having
15 patient transport in regional New South Wales to do the
16 vast majority of that work would be strongly appreciated by
17 everybody.
18

19 MR MUSTON: No doubt much like the views expressed by your
20 LHD colleagues about a clear service delineation, it would
21 be useful to the extent that there is overlap between the
22 two different services for the point at which that overlap
23 occurs or the point at which the delineation occurs perhaps
24 to be spelled out with some level of clarity so it's clear
25 to everyone, both the LHDs who are moving patients around
26 and also the ambulance service, what in the ideal world is
27 a patient transferring, what is an ambulance trip.
28

29 DR MORGAN: Yes, I think the big difference is that
30 patient transport, beginning as literally just taking a
31 person on a stretcher who can't otherwise mobilise, that
32 probably was closer to the alignment of an ambulance
33 service in 1982. Now it is a registered healthcare
34 profession practising paramedicine, and its duties and
35 roles and expectations within the community are vastly
36 different from today.
37

38 And there is a truism about regional service delivery.
39 In some of these small - sorry, not some, in the vast
40 majority of these small rural communities there is a single
41 ambulance. And if that single emergency ambulance is
42 unavailable for any reason, whether that be a long distance
43 transfer, whether it be a routine patient discharge home,
44 that ambulance is not available to provide ambulance
45 service in that community and that's as if the service
46 never existed.
47

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

7
8 MS CONSTABLE: So we have a roadshow that's planned. At
9 the LHD level we would prepare for that by having a look at
10 some of the challenges we faced in the previous year and
11 some of the goals and objectives we have over the coming
12 year.

13
14 MR MUSTON: So, just pausing there, when you refer to
15 challenges and goals and objectives what sort of things are
16 we talking about?

17
18 MS CONSTABLE: So we might have had a particular pressure
19 point of service delivery that really came to the fore in
20 the last year's performance, whether the increase in
21 activity or a difficulty providing that service to the need
22 presented by the community, or it might be aligned with our
23 service plan. So our goal to address the needs of our
24 community over the next year means that we have a new
25 service model that we want to implement and change, and
26 that might require an investment before we demonstrate the
27 activity or the impact in that initial year.

28
29 So we would consolidate a few items, generally
30 probably three top things, and we would include those in
31 our information that we would meet with the ministry about.
32 The ministry would generally share the broader context; so
33 the pressures on the system, budget, some of the challenges
34 expected there, likely sort of - where negotiations were up
35 to with Treasury, if you like --

36
37 MR MUSTON: "Challenging budgetary environments" is a
38 phrase we've heard a few times this year.

39
40 MS CONSTABLE: Yes. So definitely that broader context
41 about, "We've got money to give/we've got no money to
42 give," or there are some particular targeted areas of
43 interest. Through the course of that discussion - and
44 generally there's a few of those follow-ups, at least a
45 couple of those meetings - we would - sometimes they would
46 say, "Look, we want to see that proposal in more detail."
47 So we provide potentially to the ministry a much more

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

8
9 MR MUSTON: So, just pausing there, do we take from that
10 that effectively the base plus whatever growth factor is
11 applied to it is in ordinary circumstances required to
12 continue to just deliver the business as usual services
13 that you're delivering and there's a need for them within
14 the community or perceived need for them within the
15 community, and so you continue doing what you've done year
16 on year and then in order to make change or propose
17 adjustments to that by either adding a service or changing
18 a service you make a proposal through this roadshow process
19 for the additional funding that you would need in order to
20 bring that about?

21
22 MS CONSTABLE: Yes. So you can expect year on year the
23 cost of delivering exactly the same service will increase
24 both due to CPI, which we know has gone through the roof
25 post COVID, and also we're in a complex industrial
26 environment so the cost of staffing is also increasing. So
27 just to do what we did yesterday is going to cost us more
28 today and tomorrow. And so --

29
30 MR MUSTON: So is that adequately captured by the growth
31 factor that tends to be applied to the budget or in your
32 experience not?

33
34 MS CONSTABLE: I would say not. I think it assumes there
35 is a degree of ongoing efficiency, and there is absolutely
36 opportunities for ongoing efficiency. And the other factor
37 in there is also the revenue through private insurance
38 through the new - to the service as well. So there's a
39 combination of challenges in the budget about delivering on
40 revenue, achieving increasing efficiency with the resources
41 we've got. And the reason I say there's always
42 opportunities is because we deliver services across a
43 24-hour clock. That means we have a high volume of staff.
44 That means we have challenging periods where we're required
45 to use premium labour cost to deliver services, for
46 example.
47

1 So there's always opportunities to try and look at how
2 we have our staffing model so that we can reduce the need
3 to rely on premium labour, for example. There's always
4 ways to look at other new products we could be using that
5 are cheaper to use than the ones we've got but don't impact
6 detrimentally on patient care, those range of things. Can
7 we go back to negotiation?
8

9 MR MUSTON: Certainly.

10
11 MS CONSTABLE: So we might present a business case for a
12 particular service model, and I can think of an example. A
13 couple of years ago we came up with a model around frail
14 and elderly, our vulnerable population. We wanted to
15 change the model of care. It required investing more
16 before we could change or see the impact of that service
17 model at the back end. So releasing the capacity would
18 take longer than just turning one off and one on. So we
19 wanted support.
20

21 In that circumstance we were able to negotiate some
22 investment for a 12-month period with some specific
23 deliverables agreed with the ministry about what we would
24 deliver at the end of that 12 months. And that would be
25 determined whether it would be funded as a recurrent model
26 or we could release some capacity in our own system to fund
27 it or what would be required. So it's just an example
28 where there are opportunities to do that.
29

30 On other occasions we've presented, for example,
31 I've talked about some of the challenges from the previous
32 year. In the negotiations coming into this year we have
33 increasing activity at Wyong emergency department. We're
34 seeing over 200, 220 presentations a day here, the
35 equivalent to somewhere like Westmead Hospital. So for a
36 relatively small hospital in a regional area quite a
37 challenging volume of activity and it had been quite a
38 significant increase on the previous year.
39

40 So we presented that in the roadshow as a particular
41 initiative we felt we needed investment to ensure we had
42 adequate staffing to be able to respond to that demand and
43 as a significant priority; clearly a vulnerable community,
44 high levels of disadvantage, and low numbers of bulk
45 billing GPs. So we are going to continue to see those
46 people presenting.
47

1 We didn't get quite the activity that we hoped to have
2 supported for there. But we did receive some funding
3 through more of a statewide initiative in the emergency
4 department relief package. So two short stay beds,
5 emergency department short stay beds, were funded for Wyong
6 that actually allows us to invest in some of the staff and
7 have a response that enables us to manage those patients
8 through and impact on flow.
9

10 So I suppose it's an example where we presented the
11 challenge we're facing, the activity, all of that wasn't
12 funded in that way; but through the negotiations it was
13 clear our challenge was heard, it was observed, and there
14 was able to be as part of that more broader statewide
15 initiative some resources flow back to enable us to
16 respond.
17

18 MR MUSTON: Just looking at that emergency department
19 situation, was that increase in demand manifesting itself
20 as longer waiting times within emergency departments in
21 Wyong?
22

23 MS CONSTABLE: Yes.
24

25 MR MUSTON: And I think you've indicated that one of the
26 drivers of it was a disadvantaged population and challenges
27 in that population accessing bulk billing GPs.
28

29 MS CONSTABLE: That's correct. It's not solely explaining
30 the increase in presentations, though, because we certainly
31 also saw a reduction in our triage 4 and 5 category
32 patients and, proportionally, the number of patients
33 presenting in triage categories 1, 2 and 3 at the more
34 acute end were actually increasing. So it's not totally
35 explainable by people wanting primary health care not being
36 able to access it and so attending the ED. The point was
37 they were not attending their GP; they were becoming
38 sicker, and so when they presented they were more unwell.
39

40 MR MUSTON: But the origin of both problems is challenges
41 in getting access to the GP. So with your category 4 and
42 5s, accepting that some category 4 and 5 emergency
43 presentations will actually be admitted so they're probably
44 not a GP trip, but your category 4 and 5s potentially
45 include a cohort who, if GPs were available and readily
46 accessible, could go and see them instead of coming to
47 emergency?
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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,

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

7
8 MS CONSTABLE: I think it could if we can attract someone
9 to pick that model up. So the workforce is always going to
10 be the challenge. Any and all things can work. If we can
11 get the right people and the framework around it, then
12 absolutely.

13
14 MR MUSTON: Accepting that workforce challenges,
15 particularly within the GP market, are going to bite
16 everywhere, it might be seen as more desirable for someone
17 who is a fellow of the RACGP to take on a salaried position
18 with your LHD than, say, hanging up their (indistinct) and
19 setting up business in Wyong as a bulk billing GP?

20
21 MS CONSTABLE: Yes, and we certainly have employed GPs.
22 So we have employed - in the establishment of our urgent
23 care centre at Long Jetty we have actually employed GPs
24 into that model as salaried staff to help provide oversight
25 and clinical care and those services.

26
27 THE COMMISSIONER: That's a state facility, isn't it,
28 rather than the Commonwealth?

29
30 MS CONSTABLE: Yes.

31
32 MR MUSTON: Just in relation to the urgent care clinics,
33 they're aimed at picking up that overflow in the emergency
34 departments where, say, category 4 and 5 presentations that
35 probably could go to a GP if one were available - obviously
36 overnight maybe not - but it is in effect diverting a
37 cohort of people who would otherwise be presenting in
38 emergency into a different channel?

39
40 MS CONSTABLE: Yes, they are intended to pick that up.
41 I'm not sure of all of the people presenting, and we are
42 seeing a really good uptake of that. So in the Long Jetty
43 service in about nine months we saw over 5,000 patients
44 attend that service. So it is absolutely being accessed by
45 the community. I think some of them would otherwise have
46 gone to the emergency department. Many of them have
47 actually just accessed what is the care that they would

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

5
6 MR MUSTON: In relation to longer term improving the
7 health of the community, though, the urgent care centres
8 aren't really providing a substitute for continuous primary
9 care of the type that would better improve the health of
10 the community over the long-term, are they?

11
12 MS CONSTABLE: No, that's correct. They deal with --

13
14 MR MUSTON: Episodic.

15
16 MS CONSTABLE: -- single episode care, they treat an
17 injury or a particular limited range of conditions that
18 need urgent treatment.

19
20 MR MUSTON: Someone, say, who can't get their blood
21 pressure medication because they can't get access to a GP
22 to write another script might go to the urgent care centre
23 and get that script filled for them.

24
25 MS CONSTABLE: Yes, they could.

26
27 MR MUSTON: But if they did that they're not necessarily
28 going to have the benefit of a doctor who has been
29 monitoring the progress of their blood pressure over the
30 period of years and potentially other comorbidities to make
31 sure that they're actually being treated in a way - I say
32 this entirely uncritically of the urgent care centre
33 doctors - but in a way which holistically best meets the
34 health needs of that patient. They come in, they get their
35 script. If it's roughly within the boundaries, then they
36 go.

37
38 MS CONSTABLE: Yes, correct.

39
40 MR MUSTON: As part of the discussion - just one more
41 question before I get to the discussion. The funding that
42 you received to increase the number of doctors that you
43 could employ within the emergency department at Wyong, that
44 was tied to or quarantined for that purpose, was it?

45
46 MS CONSTABLE: It was funding short stay beds. So the
47 outcomes expected in the service agreement are an

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

10
11 MR MUSTON: So the two metrics there that we're looking at
12 are essentially waiting times in emergency departments
13 which have blown out and you're endeavouring to get back
14 within the range specified in your service agreement, and
15 in relation to this additional funding the short stay beds
16 have been funded in a way that requires you to churn people
17 through them within a particular timeframe so as to keep
18 that metric within the boundaries whilst, hopefully,
19 achieving a reduction in the waiting times within
20 emergency. They're the things that are measured.

21
22 Are those things which you think accurately reflect or
23 capture whether or not as a local health district you're
24 securing the best outcomes for your community's patients in
25 terms of their longer term health needs - with both their
26 immediate and longer term health needs?

27
28 MS CONSTABLE: So I think the turnover of the beds is
29 probably not measuring the outcome on the community because
30 you could fundamentally turn over the beds without having a
31 positive impact. That might create other ripple effects
32 like increased readmissions or re-presentations if you were
33 inappropriately turning over those beds to deliver that
34 outcome.

35
36 I think the outcomes, like our ED hospital access
37 targets, are clinically based on evidence that shorter
38 times in ED for certain discharged or admitted patients
39 et cetera do have an impact on patient outcomes and
40 morbidity and mortality and overall length of stay, for
41 example, for admitted patients. So there's quite a lot of
42 clinical evidence that the longer you stay in the emergency
43 department, particularly for an admitted patient, then the
44 poorer your outcomes are likely to be. So those drivers
45 are absolutely driving the health outcomes, and they're
46 very strongly led through the College of Emergency
47 Medicine.

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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.

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

5
6 MS CONSTABLE: Yes. As well as things like quality -
7 other quality measures.

8
9 THE COMMISSIONER: Of course.

10
11 MS CONSTABLE: Rates of hospital acquired complications
12 and various other (indistinct).

13
14 MR MUSTON: In terms of those things we are measuring, do
15 they - and any of you can answer this - but do you have a
16 sense that they are capturing in any sense the unmet need
17 within the community for health services or are they just
18 capturing the extent to which we are, as a system,
19 delivering on the needs that we've always delivered on
20 within the budgetary envelope that's made available to us?

21
22 MS CONSTABLE: I don't think they're necessarily capturing
23 all unmet need. I think if you're not performing in some
24 of those timely access measures it can be an indication of
25 unmet need that then requires, I think, further
26 exploration. But I think a lot of the unmet needs
27 (indistinct) because are unknown and unquantified, and
28 that's one of the things that we do try to assess and
29 evaluate in terms of the expected level of certain
30 prevalence of conditions in our community based on the age
31 and cohort, and that comes back to the conversation with
32 regard to clinical services plans and trying to understand
33 what are the vulnerabilities of this community and
34 therefore what would you expect to see, and are you seeing
35 more or less of that than you would expect to see. And so
36 that's part of the ongoing process.

37
38 And a good example for us is we have a high level of
39 smoking in our community, particularly the northern part of
40 the Central Coast; a high level of smoking. We've targeted
41 that quite a lot. We're having some success with accessing
42 Quitline and getting very good results about ceasing
43 smoking in pregnancy. But at the same time we recently met
44 with the Cancer Institute and reviewed the Reporting for
45 Better Cancer Outcome results, and we have one of the
46 highest prevalence of lung cancer in the state. So those
47 factors are all an indication we're not quite getting to

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

3
4 THE COMMISSIONER: When you use the term "part of
5 the ongoing process" do you mean part of the ongoing
6 process of discussions about budget or something?

7
8 MS CONSTABLE: Probably more the ongoing process of how we
9 as health districts try to assess the needs of our
10 community, utilise the resources we've got and deliver, put
11 plans in place, evaluate our progress against the delivery
12 of those plans by looking at their health outcomes, and
13 then working with the ministry on how we prioritise and
14 allocate resources to address the area's most critical
15 need.

16
17 THE COMMISSIONER: Can I ask a question about that that's
18 been plaguing me. This can be for any of you, but I'm
19 going to ask Ms Cox or direct it in first instance to you.
20 You're not an LHD, I know you're a network, but LHDs have
21 this statutory obligation for promoting, protecting and
22 maintaining the health of residents of the area. And if
23 any of you know what that means precisely please let me
24 know, but we sort of know what it doesn't mean. It doesn't
25 mean that every LHD should be doing, you know, heart-lung
26 transplants, for example.

27
28 But what it certainly does mean, and I have complete
29 confidence this happens, if a child turns up at Westmead or
30 Randwick and they've suffered a trauma or, you know, they
31 might have symptoms of their appendix rupturing or they're
32 not breathing, all those sorts of serious type things,
33 I know they're going to be seen quickly and probably by
34 highly skilled clinicians. So that's going to happen, and
35 the funding is there for that to happen.

36
37 But when we were at the round table at --

38
39 MR MUSTON: Sydney?

40
41 THE COMMISSIONER: No, at Westmead was one and also at
42 Sydney LHD where Professor Wolfenden, I think - there was
43 discussions about children with a variety of conditions.
44 They might need to see a neurologist, they might need to
45 have an intervention because of something that might cause
46 a learning disability and delay their schooling. And all
47 of those clinicians told me that the wait lists are beyond

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

7
8 I get from a headline perspective why if a child has
9 suffered a trauma they're going to be seen immediately when
10 they turn up in ED because no-one's going to absurdly say,
11 "Our budget's been blown for this year so we can't see that
12 child that's got a life-threatening condition." Obviously
13 that doesn't happen. But we don't seem to - the conditions
14 I'm talking about where intervention is required but might
15 be such that - there's plenty of evidence about this, might
16 be the kind of interventions that mean that they become an
17 economically active, productive member of society, but we
18 don't seem to have the funding necessary for those people
19 to be seen with the same urgency so that it's not
20 clinically significant in terms of delay that we see a
21 child with a trauma.

22
23 Do those discussions take place when your budget is
24 set? And for anything that's analogous to any of the rest
25 of you please feel free to answer that dilemma I am
26 thinking about.

27
28 MS COX: So there's a couple of issues embedded in that.
29 One, a lot of those services are allied health; so speech
30 therapy, hearing, you know, delays language, you know,
31 those sorts of things, impact school, so they are very
32 significant. So there is certainly an element of workforce
33 availability.

34
35 THE COMMISSIONER: Yes.

36
37 MS COX: There's an issue around community paediatricians,
38 and particularly in rural and regional that's very
39 difficult.

40
41 THE COMMISSIONER: Yes.

42
43 MS COX: We are certainly doing a lot --

44
45 THE COMMISSIONER: Bearing in mind the workshops I have in
46 mind, one was at your network out at Westmead and the other
47 one was at the Sydney LHD. So we're not regional there,

1 but I understand the point you're making.

2

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

12

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

24

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

32

33 MS COX: Yes.

34

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

42

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

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

3
4 THE COMMISSIONER: Just stopping there, I hope this isn't
5 unfair, but I didn't get the - this is not meant as
6 a - I'll just say this. I didn't get the impression
7 yesterday from Treasury that the potential benefits of
8 extra investment in that are actually modelled as to how it
9 might - what the secondary benefits might be of
10 interventions like that in terms of people leading more
11 productive lives if there's early interventions like this.
12 But does that happen or is that a consideration when you
13 have your discussions with health about your budget?

14
15 MS COX: Not about my budget, but I'm pretty confident
16 that my LHD colleagues would certainly have some of those
17 discussions around that. But we've been talking about
18 prioritisation, and I think we know - and I know this from
19 LHD colleagues as well - that it's often very hard for the
20 paediatric voice to be heard because the population aging
21 effect is so significant and, you know, there's lots of
22 issues that Margot is dealing with, then we realise that
23 we're a small cohort in that big picture.

24
25 THE COMMISSIONER: Yes.

26
27 MS COX: And so sometimes that's not front and centre in
28 those discussions.

29
30 THE COMMISSIONER: Yes.

31
32 MR MUSTON: Can I ask whether that is a feature of the
33 other LHDs' discussions around the roadshows, that is the
34 extent of this unmet need?

35
36 MR WILSON: I comment because I think it is a really good
37 example because it is one that we do have the evidence and
38 I think is well understood through Brighter Beginnings
39 around this, and I think there is a legitimate need and
40 benefit that is flagged through that program and work.
41 I think that's quite classically a program of work, though,
42 that - and I wasn't in any way part of this process, so I'm
43 just assuming this - that the cloth was cut to fit the
44 budget. And a number of us have raised concerns around
45 that we've created a great screening program, but the
46 actual follow-through with treatment is really challenged.

1 That probably because of its very nature, though,
2 because it's a statewide program, isn't necessarily
3 something that would always bubble up through the roadshow
4 conversations because generally our roadshow conversations
5 are more focused on what are our challenges within our
6 district and where does this sit on the priorities. So,
7 personally, I would take that up through to the branch and
8 have a conversation with the branch and up through the
9 ministry that way to say, "We think this is an amazing
10 initiative. We absolutely need to get behind it. We're
11 all supportive of it. But there's a risk here that we're
12 screening and we haven't necessarily invested in the
13 treating arm and what's our approach to that," and that
14 probably needs to be a separate conversation to government.
15

16 Because there is not a lot of value in me solving that
17 within South East Sydney if Sydney LHD is going to have the
18 problem and Western Sydney is going to have the problem.
19 This is where we need to have that broader approach around
20 how we're going to address this, and in some ways it's
21 around what are we going to trade off in that space as
22 well.
23

24 MR MUSTON: One approach to that issue --
25

26 THE COMMISSIONER: Sorry, I think Ms Mains wanted to add a
27 comment on that.
28

29 MR MUSTON: Sorry.
30

31 THE COMMISSIONER: You had your hand up.
32

33 MS MAINS: So what was being said about children and the
34 impact, I was involved - not in New South Wales, in New
35 Zealand - in a major exercise with inter-agencies -
36 housing, employment, education and so on, treasury - and
37 I was the health representative. And there was 238 members
38 of extended families with significant histories of not
39 going to school, truancy, not having enough food, poor
40 hearing, and significant imprisonment and so on.
41

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

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

9
10 MR MUSTON: Does that potentially bring into consideration
11 an adjustment to the KPIs so we are confronted with some of
12 these issues more directly? For example, Mr Wilson raised
13 the point of, "We increase our level of screening of
14 children, it identifies a greater level of developmental
15 issues within the population that are not able to be met
16 because we don't have currently the budget to meet those
17 needs," that's fine to a point but there's no KPI within
18 any of the LHDs' service agreements - at least to my memory
19 of reading them - that says, "We have a screening program.
20 How many children are there who have developmental issues
21 which have been identified and how many of them have been
22 seen by community paediatrics or by a public paediatrician"
23 within sometimes up to three years, which we're told is
24 reaching the point where you lose the benefit of
25 the intervention.

26
27 But can I contrast that and just invite you to comment
28 on this, contrast that with a slightly more sophisticated
29 screening program that we've long had which is the
30 inclusion of older people onto elective surgery waiting
31 lists for, say, knee replacements and the like where a
32 doctor has screened those people who had a sore knee and
33 said, "I have decided that this person is appropriate for a
34 knee replacement." They are on the list and then we are
35 quite assiduous in our attempts to measure just how quickly
36 they get to the top of that list and get their surgery.
37 Why are they different?

38
39 MR WILSON: So why are they different? Again, it's
40 probably a bit of custom and practice around what we've
41 been measuring. I would probably, though, reflect - and
42 someone else will probably know the exact number - but last
43 count there's 119 KPIs or performance measures in the
44 service agreement; 120 is probably not going to make a huge
45 difference to some of these things, I think. I was going
46 to comment earlier around some of that questioning with
47 Jude around the KPI piece.

1
2 It would be - I think one of the challenges with
3 having longer term measures of population health and what
4 are you affecting is that they are long-term measures.
5 They don't move quickly and easily, and they don't lend
6 themselves to some of the monitoring the way that we work
7 at the moment. So I think it would be worth a rethink of
8 the service agreements and what the measures are. But
9 I guess I get nervous when - like, it feels like every new
10 thing we do there's another KPI that gets put in there and,
11 there are so many KPIs that sit in there, you're left
12 juggling an awful lot and at the end of the day you fall
13 back to the ones that you tend to talk about. So I'm not
14 sure --

15
16 THE COMMISSIONER: You're absolutely right. But, on the
17 other hand, if I read out to you what's in the last New
18 South Wales Intergenerational Report or the Commonwealth
19 one there will be at least a few paragraphs devoted to the
20 fact that if we're going to reduce the growth in the rate
21 of the health care spend then we need to - as one
22 example - compress the period of morbidity people have in
23 relation to chronic disease, and that obviously requires
24 the sort of long-term planning and long-term investment
25 that you've mentioned.

26
27 MR WILSON: Yes, I completely agree with where you're
28 going. I think it requires a bit of a rethink around how
29 we set up our service agreements and maybe there are
30 five-year or 10-year measures. But I guess my nervousness
31 with that is our history is that on a quarterly basis we
32 are reporting against our progress against a 10-year
33 measure that doesn't move an awful lot and we get stuck in
34 a reporting cycle that doesn't necessarily help us.

35
36 But I think some of these signposts of where we're
37 trying to get to will drive the right investment both at a
38 system level but at a local level as well. Like, if we are
39 measuring this and it is - and it shouldn't be - I would
40 argue it shouldn't be the number of people on a waiting
41 list but it should be a metric that is more around the
42 number of people that are now actively participate - number
43 of children that are actively participating in school or
44 something like that that would start to drive some of the
45 behaviours that we're looking around.

46
47 THE COMMISSIONER: And when you're using the phrase

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

7
8 MR WILSON: And it's interagency like Margot spoke about
9 because, again, a number of these issues - health generally
10 is the safety net that catches people that fall through
11 every other area. We need others in this space helping us.
12 And I guess some of this was sort of the Premier's priority
13 concept a few years ago called out some of those things to
14 try to drive some of that cross-sector collaboration to get
15 some of these things moving.

16
17 MS HOEY: I just wanted to comment I suppose the service
18 that is - you know, we pick up the sort of results of the
19 missed opportunities, especially from the kids, and we do
20 see a lot of kids coming through with, you know, lack for
21 literacy with undiagnosed - whether it be behavioural
22 disorders or whether it be neurodevelopmental or
23 development disorders. And, you know, we've put in a
24 number of proposals to try and intervene upstream.

25
26 But I think, really, I don't think there's clarity
27 about whose responsibility it is. And so is it state
28 health's responsibility? Is it primary care's
29 responsibility? Is it the Commonwealth's responsibility?
30 And I don't think that's necessarily agreed, therefore
31 nobody's stepping into that sort of ring, if you like, to
32 do that.

33
34 And I think when you see the funding coming down and
35 what we're being funded for, whether it be ABF or whether
36 it be incentive funding, it's not necessarily around the
37 intervention of these kids who need - and the support. We
38 know clearly, the research tells us, which kids are going
39 to come into the justice system, for example. We can tell
40 that from a very early age. But we're just not - there's
41 not, I think, the coordination, the funding and the
42 responsibility allocated to actually intervene.

43
44 MS COX: So that's important we link back to the roadshow
45 process in that it falls between the cracks, probably,
46 because the LHDs - I'm not having it in my discussion; I'm
47 having them to the side. The other LHDs are having them

1 outside the purchasing. But we don't know collectively if
2 that's a statewide issue around children getting
3 developmental assessments and all sorts of things. Like,
4 where's that happening and how does it relate to our
5 roadshow discussions so that we know I don't have to
6 identify it on behalf of the state or Tobi might raise it,
7 Margot might not?
8

9 MR MUSTON: Acknowledging what Mr Wilson said about not
10 burdening you with too many unnecessary KPIs, just to test
11 this, I would imagine - and correct me if this is wrong -
12 but if your wait lists for elective surgery had blown out
13 beyond what the KPIs required of you that would form part
14 of the discussion at the roadshow; would that be right?
15

16 MS MAINS: Prior to the roadshow on a more regular basis.
17

18 MR WILSON: Yes. I would also reflect there's a number of
19 waiting lists that we don't necessarily talk and capture as
20 well. So there are a lot of waiting lists in health. We
21 very much focus on one. As a washed-up elective surgery
22 manager, I don't particularly like wait lists; I like wait
23 times and other things that are much more accurate
24 measures. Like, it doesn't matter how many people are in
25 front of you in the queue for the bank teller. If you're
26 served within two minutes it's a good experience. If
27 you're served in two hours it's not. That's what we're
28 measuring at the moment. So there's a sophistication which
29 we need to apply to all of these kind of things which I
30 think we could extend out to a lot of the areas that we
31 have.
32

33 MR MUSTON: Leaving with that analogy, if you're two hours
34 and you're waiting for a bus, and it's the last bus, it's a
35 catastrophe. If it's two hours and - it's two hours at the
36 end of the day which is suboptimal but you can then get in
37 your car and drive home, it's probably less of a
38 catastrophe. But that's measuring outcomes not process.
39

40 MR WILSON: Yes.
41

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

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

4

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

10

11 MS CONSTABLE: Yes.

12

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

16

17 MS CONSTABLE: No.

18

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

24

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

29

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

37

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

39

40 MR MUSTON: My question is do they.

41

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

47

1 MR MUSTON: Maybe in terms of a roadshow that you have
2 participated in, has the discussion around the incidence of
3 lung cancer within your LHD been a feature of that roadshow
4 which has resulted in any increase in the funding made
5 available to you for, say, smoking cessation or screening
6 programs?
7

8 MS CONSTABLE: Not cost-effectively in the last couple of
9 years that I've been involved. But we might integrate some
10 of that sort of information in the rationale for a
11 particular model or priority we're putting up at times. So
12 it might be the flow-on beds of that high incidence
13 impacting on the capacity of our service to meet cancer
14 treatment demands. And so we might come up with a model,
15 for example, around having rapid access clinics for medical
16 oncology patients to prevent them coming into hospital, and
17 that might be because we have a higher incidence of lung
18 cancer receiving treatment through medical oncology, and
19 then the risks associated with that treatment journey and
20 then coming into the hospital and how that impacts on
21 overall patient flow.
22

23 So it's such a complex network of what is that big
24 health to the little health treating the condition through
25 the journey through the services sort of thing, and one of
26 the things we're trying to do is both of those things on an
27 annual funding cycle. And that's the challenge I think
28 that we're talking about: the long-term impact on the
29 health of the community versus an annual funding cycle and
30 delivery against a set of KPIs this year, and how those
31 things occur simultaneously and yet in a meaningful way so
32 we do the long-term better.
33

34 MS MAINS: I just would like to raise that the roadshow is
35 not the only discussions that we have in the build-up to
36 any contract. So we, for example, have presented a number
37 of proposals and discussions to the ministry, whether it's
38 around aged care, whether it's around the fact we're
39 6 per cent over activity and our demand with the Cancer
40 Institute over cancer, the rates and what's actually
41 happening, and then taking those back into discussion.
42

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

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

3
4 DR MORGAN: Yes, actually, I think that's a really
5 important point to make. I certainly have spoken about the
6 challenges of the block funding process. But it is an
7 absolute fact we've had significant support from the
8 ministry around addressing some of these historical issues
9 created by block funding. But, as we sort of heard earlier
10 today, we've demonstrated we clearly experience the same
11 growth as the local health districts for demand of
12 services. But through the service agreement process and
13 the roadshows, because we're block funded and therefore
14 only deal with escalation and the CPI, we don't actually
15 even discuss demand at all because there's no way of
16 dealing with the demand. And so therefore it doesn't
17 feature in our service agreement despite that we will
18 absolutely go up at the same percentage as everybody else.

19
20 MR MUSTON: Is there an extent to which - well, let me ask
21 this question first. Activity and the ABF system, to what
22 extent does that drive discussions around the level of
23 funding that the LHDs receive? Accepting that there is the
24 ABF component of your funding and then there is grant
25 funding for other programs, but to what extent at least as
26 viewed from the perspective of the LHDs is ABF a central
27 driver of the funding?

28
29 MS MAINS: The ABF is currently 83 per cent of our funding
30 base. So it's a significant discussion, but there are
31 other discussions. But it is a significant discussion.

32
33 MR WILSON: In my experience, generally the conversation
34 is a dollars conversation first and then a mix between what
35 would be activity and what would be block funding that
36 needs to come through, which is a bit of a case by case
37 piece. So a service that we know is going to generate
38 activity we would be happy to take. Activity for a service
39 that we know we need to fund which isn't going to generate
40 activity there's generally a negotiation through that
41 process. There's certainly a preference - I think all of
42 us would have a preference in the current funding
43 environment that activity would be preferable because we
44 know that would mean the Commonwealth contributes to that
45 as well. But there are some limitations obviously with ABF
46 that make it difficult in some situations, particularly
47 either starting up a new service or some of those services

1 that don't quite fit the ABF model.

2
3 MR MUSTON: Is there an extent to which ABF funding as
4 currently structured at least pushes us a little bit in the
5 direction of treating problems once they've emerged rather
6 than dealing with them and intervening in a way that might
7 prevent them from emerging; that is to say, it's not well
8 suited to dealing with the prevention of chronic health
9 issues?

10
11 MR WILSON: I'll start because everybody knows ABF is one
12 of my favourite topics. ABF has its limitations around
13 some of those prevention - some chronic disease. Depending
14 on how you structure your ABF, though, it can be more
15 flexible than how we currently structure it within New
16 South Wales. And there are - I certainly have had
17 experience in the past where you've been able to use ABF to
18 drive much more timely decisions because in a true ABF
19 environment there's a funding source that you can access
20 pretty much in real-time if you're doing more activity that
21 would actually fund the ability to make some of those calls
22 at the time that needs to happen.

23
24 MR MUSTON: What's the flexibility that would need to be
25 built into the system in New South Wales to enable that to
26 better occur?

27
28 MR WILSON: So you need to move to a model where there's a
29 recall policy associated with that so you don't just have a
30 hard target of 100 per cent of your activity is what you're
31 going to get. But if you go above your target - like,
32 I think a number of people on the panel today have talked
33 about being over their activity target. That over your
34 activity target in the current climate is - my
35 understanding, because I'm not one of the people that's
36 over their activity target, but is a negotiation around,
37 "Can we get some more dollars to reflect the additional
38 activity we're doing," whereas you could set up a structure
39 where actually, "Well, we know that we're over and, if
40 we're over by this much, this is how much money that we are
41 going to get."

42
43 So that allows you to make decisions in real-time that
44 says, "Well, if I'm going to do this and I'm going to
45 generate 100 additional NWAU, I know the funding
46 environment means I'm going to take home \$100,000. I'll be
47 able to claim that straight away and I can make decisions

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

3
4 MR MUSTON: Does that not potentially drive you into a
5 position, though, where those activities or those forms of
6 care which attract activity then become the preferred thing
7 to deliver when you're engaging in that prioritising
8 exercise of, "How am I going to spend my budgetary
9 envelope," you might say something like "our community
10 based paediatric care that doesn't necessarily readily
11 attract activity doesn't get prioritised", perhaps
12 consciously, perhaps unconsciously, because doing some more
13 elective surgery has the double-whammy benefit of reducing
14 your waiting times, which is a tick from a KPI point of
15 view, but also increasing your activity and thereby
16 increasing your revenue?

17
18 MR WILSON: Potentially. But, again, it depends how you
19 choose to structure this. So if you're doing something
20 around how you're funding those community based services
21 long term and setting long-term agendas and having
22 dedicated funding that's available to deliver on those or
23 quite often how I've seen this play out in other
24 jurisdictions where these models have existed is we
25 wouldn't have a conversation around something that's going
26 to drive activity because the immediate response back from
27 the ministry was, "Well, you've got a funding policy. You
28 know your rules, Tobi. You go and do that." And it would
29 be those things that we would be talking about because we
30 would be highlighting that, "This doesn't fit within the
31 funding policy so this is a problem for me. So I can't
32 generate the activity to do this. So I need to have a
33 conversation with you around this." But if I can generate
34 the activity because the funding policy says you're in
35 control of it, we wouldn't have those conversations in that
36 space.

37
38 DR MORGAN: This is a really important point and it's one
39 of the distinctions why I sort of talk about in our world
40 activity based funding actually is not the answer for us
41 and why I make the distinction to state average growth
42 factor. A number of the ambulance services in Australia
43 and overseas have tried to develop an activity based
44 funding model for ambulance services. The truth of the
45 matter is every single time - including here and Victoria
46 quite extensively. And every time they've tried to do it
47 it's basically ended up in a count of something as distinct

1 from true activity.

2

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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.

1
2 MR COLLINS: Could I come in on activity based funding.
3 I think there are certain things that ABF is not able to
4 cover. Rurality is one of those; I have spoken about that
5 earlier. Specialised services I've spoken about earlier.
6 If you're a place like Nepean, you don't have that
7 specialised service. You certainly don't have the
8 concentration you have in the inner areas. Also
9 infrastructure maintenance. And the other thing that ABF
10 conveniently ignores, side steps is philanthropy, the
11 impact of philanthropy.

12
13 THE COMMISSIONER: Your LHD doesn't get a hell of a lot of
14 philanthropy, I understand.

15
16 MR COLLINS: Yes. I think there is a strong case for an
17 audit of philanthropy because that's a factor in healthcare
18 funding and it's something that needs to be taken into
19 consideration in terms of trying to strike the right
20 balance.

21
22 So the ministry will tell us that we're paid the same
23 NWAU as the eastern suburbs - now, I just want to take you
24 through this for a sec - and so the ABF is a fair system.
25 Look, I'm not saying the ABF should be completely replaced,
26 but I think that there are more factors that need to be
27 taken in consideration in the ABF, and block funding is the
28 counter to the imbalance caused by the existing ABF - by
29 the ABF missing out on those areas that I've specified.

30
31 Then you get to the historical imbalance which is
32 never addressed by the ABF; in other words, the advantage
33 of simply being there and being better resourced for a very
34 long time and having historical funding directed your way,
35 and that is the east-west divide in Sydney.

36
37 So if I can talk specifically about the Nepean Blue
38 Mountains, unlike Northern Sydney. For example, Northern
39 Sydney has got three private hospitals: North Shore
40 Private, the Mater and the San. The Mater and the San have
41 been there a very, very long time. They're deeply
42 established, great connections, great community support,
43 and great alternatives to public health. And they have got
44 supporting public hospitals, too: Northern Beaches, Ryde,
45 Hornsby.

46
47 In South East Sydney you've got Prince of Wales,

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

3
4 In Nepean you've got Nepean. All right, there's a
5 small private hospital alongside which you've seen, and
6 it's relatively new. And we've got Blue Mountains 50
7 kilometres away and Hawkesbury. And they do not have the
8 resources of those hospitals that I have just enumerated in
9 Northern Sydney and South East Sydney. And there is no
10 decanting for us. There is no capacity to take a strain
11 off Nepean. Nepean has to take all the strain.
12

13 So they're things that aren't taken into account in
14 the funding model, and that what it boils down to is NWAU
15 can come up with, "You get the same money as everybody
16 else. Therefore it's fair. So what are you complaining
17 about?" But it doesn't address any of those issues that
18 I've raised. Therefore you end up with an inequitable
19 system, an inequitable funding system. Despite its
20 equality, it lacks equity.
21

22 MR MUSTON: Can I just test a couple of aspects of that.
23 The first is you raise philanthropy. Philanthropy should
24 not, in a properly functioning system, form part of
25 the funding for business as usual activity, should it?
26

27 MR COLLINS: It doesn't form part of the funding base of
28 an LHD; that's correct. Were it to do so, we don't - we
29 have none. So we have a foundation. The foundation
30 has - Lee, I think the figure is about 250,000 in its
31 account, something like that. I stand to be corrected on
32 that, but it's a modest amount. Even if it were a million
33 it would be quite insignificant.
34

35 Philanthropy gives existing and well-established and
36 historically long-running LHDs an advantage because it can
37 provide a top-up capacity. It can be something that, well,
38 assists in recruitment, for example. If you can say to
39 somebody, "Look, you know, we've got a research foundation
40 we can chip in 100,000, 200,000, we can get you another
41 staff member, whatever," it gives an advantage that we
42 simply don't have at the moment.
43

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

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

9
10 MR MUSTON: Ms Mains?

11
12 MS MAINS: Philanthropy has always played a key role in
13 health services, and if I just think of a couple of things.
14 One is supporting research, which has been really important
15 for communities and bringing multifactor people together
16 supported by businesses and so on has been really key.

17
18 The second thing, and this is a question that you
19 asked, I get asked regularly by the Illawarra Community
20 Foundation that runs Convoy, the truck thing that's just
21 happened last weekend to raise over 4 million for us to
22 redo our children's ward, which enabled us to introduce new
23 outpatient areas, new family rooms, and they said to me,
24 "Why does this not come from government funding?" And
25 I said, "It's a matter of priority," because in this
26 district we've got 1.25 billion currently of government
27 funding doing new developments, and this was not our
28 highest priority.

29
30 So the fact they made a real commitment to it, they
31 wanted to do it, but they needed to understand why it
32 didn't fit where it fitted. And we were able to explain
33 that this would expedite it; they would be able to create
34 something special for children and families ahead of any
35 planned schedule that we actually could accommodate given
36 the massive amount of funding that we have got at the
37 moment. They accepted that and they have generously
38 changed service for children and families in our area.

39
40 MR MUSTON: To Mr Collins' point, though, does that not
41 potentially create a system where LHDs that enjoy the
42 benefit of philanthropy are able to provide better services
43 through the public health system to members of their
44 community than those that can't generate that level of
45 philanthropy?

46
47 MS MAINS: It's interesting because previously

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

10
11 MR MUSTON: Ms Cox, do you have a view about the place of
12 philanthropy as an operator for a section of the health
13 service that we were told receives very generous
14 philanthropy?

15
16 THE COMMISSIONER: I think we were told that some
17 philanthropy is going on call services.

18
19 MS COX: That's right. So for the two redevelopments that
20 we've got going there's a \$75 million contribution from
21 philanthropy. I don't think there's probably any other
22 government project, hospital project, in New South Wales
23 that's getting that level of contribution. That would be a
24 general fund. But, again, like Margot's saying, there were
25 areas in both those facilities that could not be delivered
26 within the funding envelope that we had, and philanthropy
27 helped do that.

28
29 In relation to - we've got a number of core services,
30 so certainly in relation to child life therapy and cancer
31 services in our diagnostic services, they are all supported
32 by soft funding. So that's great that you have that
33 opportunity. But they are also positions that have no
34 permanency. So it's challenging. It's not a panacea to
35 all things.

36
37 But all children's hospitals in Australia have very
38 significant foundations and are expected to contribute
39 significantly from philanthropy for a range of core
40 services that covers our cancer services, a lot of our
41 fellows, you know, so the junior medical staff to train
42 them, and that actually becomes a resource for services all
43 around Australia. You know, neurology fellows that have
44 been trained through a program at the network are in New
45 Zealand, in Adelaide, in Perth. So we're actually making
46 sure that there is access to those skills and expertise
47 much more broadly than just wholly within the network.

1
2 MR MUSTON: Coming back to the discussion we were having
3 this morning around service planning and perhaps some of
4 the difficult decisions that need to be made about what
5 does form part of the public health system and what
6 doesn't, is there an extent to which too great a reliance
7 on philanthropy can result in that process being perverted
8 by the philanthropic process or donors?
9

10 MS COX: So we've got a very close relationship with our
11 foundation where we indicate our priorities. The issue,
12 though, around being best endeavours - so even if there's
13 money this year, it might not be there next year because
14 the donor might have another interest. So, as I said, it's
15 not a panacea. And so my approach is that we don't
16 establish core clinical services with soft funding because
17 I actually have no way of transitioning them on. And you
18 can't just rely on having - there's a particular statewide
19 gastric motility service that we would love to establish,
20 and the clinicians again would love to establish,
21 absolutely needed. But we shouldn't do that from
22 philanthropy because it's actually core business and if
23 I don't - and I need to talk to the ministry about that in
24 terms of growth funding so that that's got a sustainable
25 funding trajectory.
26

27 So philanthropy is good for some of those one-off
28 type, you know, equipment, capital, those sorts of things
29 can make contributions. But it really shouldn't underpin
30 service provision.
31

32 MR MUSTON: So the point that you make is if you allow a
33 clinician who has perhaps managed to attract some
34 philanthropic funding to develop a new service which is
35 interesting, exciting for the clinician, no doubt meeting a
36 need of some description within the community, the problem
37 is once that starts your ability, particularly having
38 regard to the fact that some philanthropic body has
39 generously given money to enable it to start, your ability
40 to wind it back and say, "This is actually not part of the
41 public health system as we currently envisage it," is
42 constrained.
43

44 MS COX: I can't say in two years' time, "Sorry, that
45 donor is no longer willing to support that. So I'm going
46 to shut the service."
47

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

11
12 Mr Wilson, you're another LHD that I think enjoys the
13 benefit of some philanthropy. Is that your broad
14 experience?

15
16 MR WILSON: Yes, and not to the same extent as Cathryn,
17 and probably we're a broad district, so we see the full
18 impact. We certainly don't have a strong philanthropic
19 presence in the south of the district. So St George and
20 Sutherland - Sutherland's doing a bit of local work, but
21 they don't have the benefit of what we see in the north.

22
23 The only thing I would add to what Cathryn's got to
24 say is even from the - I think we need to keep this in
25 context because in many ways it also a double-edged sword
26 for us in that a number of conversations we have around
27 equipment and capital with the ministry will be, "Well,
28 where is your foundation first or where are you able to
29 access other funds to do this?" So I think everybody is
30 aware that this is a funding source that is available to
31 us, and I think it is a more nuanced conversation that we
32 do have around actually how do we use that which ultimately
33 benefits - yes, benefits us but benefits the broader system
34 because we're stretching health dollars more broadly to do
35 that.

36
37 The other thing, I'll just pick up on Mr Collins'
38 point before. I think the private hospital piece is a
39 really interesting one to unpick and understand what the
40 impact of having private hospitals is, because there
41 certainly would be an argument the other way that there's a
42 significant volume of low complexity elective surgery that
43 currently gets funded through elective - the private
44 hospitals that would be a winner for us from an activity
45 point of view that we don't see coming through our
46 facilities.

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

13
14 MR MUSTON: Is there an element to which some of that
15 potentially is part of a broader normative discussion
16 because that super low complexity work elective surgery
17 being done through the private system which might be
18 excellent from a remuneration point of view, if it was done
19 in the public system would also clog up waiting lists and
20 the like and, frankly, should not be part of the public
21 health system?

22
23 MR WILSON: We certainly aren't making a play for it to
24 come back; just making a point that it does skew the
25 complexity of the work that we do in the public hospitals.

26
27 MR MUSTON: Mr Collins raised or made the suggestion that
28 philanthropy should be effectively audited and the extent
29 to which LHDs enjoy the benefit of philanthropy is
30 something that should perhaps be taken into account when
31 making overall funding decisions about the amount of funds
32 that go from one LHD to another. Do any of you want to
33 venture a comment on that?

34
35 MR WILSON: I mean, the foundations that we have within
36 our district are all at arms length for us. A bit like
37 Cathryn's discussion, we have some really good working
38 relationships with them. But they are their own entities
39 and our ability to influence exactly where and how they're
40 spending their money is - there's no direct line there. So
41 we negotiate, we encourage, we say "no" to certain things,
42 which we know - to Cathryn's point - are going to cause us
43 problems in the future. But to a large degree this is
44 outside of our direct control.

45
46 The other thing, because we've had this conversation
47 quite a bit within the district as well around what would

1 this start to look like if we were to work more
2 collaboratively, because these relationships actually sit
3 at a hospital level, they don't sit at a district level,
4 the donors have an affiliation with who they're donating
5 to. Randwick is a really good example; obviously the
6 Sydney Children's Hospital; The Prince of Wales has got a
7 foundation; the Royal Hospital for Women's got a
8 foundation; there's two large MRIs in the University of
9 the New South Wales; all with very strong philanthropic
10 arms. And the donor is looking to buy a product at the end
11 of the day. They would like to contribute and see the
12 value for their money. And it's not as simple as, "We've
13 got this great idea and we want to do this." In some cases
14 it will come in through the university. In some cases it
15 comes through an MRI. In some cases it comes in through a
16 different form. So I think it is an interesting factor to
17 consider. I'm not sure there's a direct benefit that you
18 could audit and say, "This district is that much better off
19 because it has it."
20

21 MS COX: So I think that's quite important. They are
22 completely independent. So I do not direct the foundation
23 in any way, shape or form. They report and comply with
24 ACNC. And then I have to - I tell them the priorities, we
25 give them information to help them with fundraising. But
26 at the end of the day it is - and I took your earlier point
27 about can a donor's particular intent maybe skew
28 priorities? We do that through a negotiation process.
29 But, yes, there might be a donor whose child was treated by
30 a particular clinician who says, "I would like to
31 contribute to that department."
32

33 But it's usually not so random that it wouldn't be
34 appropriate, because they've had those discussions. But
35 they are independent. And so I have to write to the
36 foundation and say, "These are my requests," and then they
37 allocate funding to me. But they don't - they're not
38 obliged to. So I think that's actually quite important.
39

40 MS MAINS: I was just wanting to clarify if Peter was
41 meaning that if you get money you actually then wanted to
42 increase your activity allocation negotiations from the
43 ministry because you might have got it from elsewhere, but
44 the trouble is most of our - not our trouble, our value is
45 most of it is not around service activity; it's related to
46 things that support service activity.
47

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

3
4 MS MAINS: Correct.

5
6 MR COLLINS: But it provides a capacity. I mean, okay, to
7 me - and I spent six years on the Advisory Council of
8 St Vincent's Mater Health (indistinct). For me the ideal
9 hospital campus is a really big significant public
10 hospital, a really big high net worth individual private
11 hospital, and the kind of, I mean, almost unparalleled
12 research facilities backed by philanthropy as part of that
13 campus mean that provides enormous impetus and gravitas and
14 pull for a workforce. And I think that in a lot of ways
15 that the way the New South Wales health system has
16 developed over the last 30 years has tried to replicate
17 that in other places by putting private hospitals alongside
18 public hospitals, tried to attract - tried to set up
19 foundations and research facilities, some more successful
20 than others. But that's the journey.

21
22 MR MUSTON: There are a number of such hospitals that
23 exist or such campuses that exist across the network in the
24 metro area.

25
26 THE COMMISSIONER: He just described one. St Vincent's
27 private, St Vincent's public, Victor Chang, and Garvan all
28 together.

29
30 MR MUSTON: But the reality is that's never going to exist
31 everywhere within the network.

32
33 MR COLLINS: That's right.

34
35 MR MUSTON: And is your point that at the moment to the
36 extent that they exist within the inner metro they should
37 probably expand out and at least pop one in Nepean Blue
38 Mountains somewhere?

39
40 MR COLLINS: Correct.

41
42 MR MUSTON: I mean, how do decisions like that get made?
43 That's part of infrastructure planning ultimately, isn't
44 it, about where these large sort of co-located hospital
45 facilities exist? Do you have a view about how that
46 decision-making should happen? Because is it Nepean or is
47 it Wollongong Hospital or is it Central Coast? Each has an

1 equal claim to it.

2

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

5

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

14

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

21

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

29

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

39

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

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

5
6 So there's real potential in New South Wales if we can
7 find a way to really work together and maximise the
8 opportunity that we have here. But the risk is also there
9 that we've got a lot of these that we run the risk that
10 none of them actually elevate to the level that a Parkville
11 maybe has elevated to over the past 20 years.

12
13 MR MUSTON: Does that bring us nicely back to the point we
14 started with this morning which is that that slightly
15 greater level of planning and system coordination at a
16 central level whilst maintaining devolved decision-making
17 might actually mean the competition between LHDs for
18 workforce, services and the spreading of funding thinly
19 across that workforce and those sometimes duplicated
20 services could be reduced?

21
22 MR WILSON: I think it does to a point. But I think when
23 we're talking precincts we're getting to the really pointy
24 end of this is a highly, highly, highly specialised service
25 that you have one of, and where does that need to go, and
26 that quite often is a very complicated discussion because,
27 again, a large part of this is driven by university and
28 research and what else is wrapped around that and how that
29 plays in. But, yes, it is back to the same thing.

30
31 MR MUSTON: Accepting it's at the pointy end, ultimately
32 it's the public health system and money devoted to the
33 public health system has to be used to provide that highly,
34 highly specialised service and, if there are two different
35 places within the public health system no doubt prodded on
36 by universities who both want to be doing it, choose to do
37 it, it doesn't mean that it shouldn't happen at both, does
38 it?

39
40 MR WILSON: No, it does not.

41
42 MR MUSTON: So somewhere a decision needs to be made,
43 whether it be a particular type of elective surgery which
44 is more run of the mill, it might need to happen within two
45 LHDs or this super high-end newfangled technology that's
46 about to be unravelled in the health system, someone has to
47 make a decision about where it is and the only person who

1 can make that decision - I say person - is someone who sits
2 centrally and has oversight of the whole system rather than
3 people sitting within each of its constituent parts?
4

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

7
8 MR WILSON: That was a "yes".
9

10 MR MUSTON: Those were all of the questions I had for
11 these witnesses, Commissioner. I'm content to ask them
12 whether there is anything that has been left unsaid. Now
13 is your opportunity to tell us anything that you want to
14 about the way you each interact with the funding system and
15 ways in which you think it could be adjusted or improved,
16 for the benefit of your LHD or the system more generally.
17

18 THE COMMISSIONER: Anything important not covered that you
19 think --
20

21 MS MAINS: Some of this has been covered probably, but --
22

23 THE COMMISSIONER: It doesn't matter.
24

25 MS MAINS: Funding is complex in health, and many systems
26 have worked really hard to try to find a multitude of
27 approaches. But I think we need to recognise ABF - ABM
28 does play an important role in technical efficiency and
29 allocation and targeting activity and throughput and, you
30 know, it can be adjusted for population and so on.
31

32 But I think for transparency we need to do work to
33 look at a model that reflects that the population is
34 actually getting the funding relative to sociodemographics
35 relative to the need, and it does vary significantly. And,
36 therefore, the funding needs to actually relate - and it
37 makes it much more transparent so you've got a basis on
38 what you can actually talk with your communities that it's
39 been allocated.
40

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

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

8
9 MR MUSTON: Have we struck that balance in the right place
10 at the moment, or are those things in the current funding
11 arrangements not really being adequately picked up?
12

13 MS MAINS: Look, I think there's - I know there's been a
14 lot of discussion around rurality and how you actually
15 recognise particular diseconomies of scales and the fact
16 you have lower throughput and diseconomies and the staffing
17 you get tend to be higher premium, so there's discussions
18 around that in block and actually moving that and how you
19 do that.
20

21 I know there's a way that quaternary and tertiary is
22 done, but it's how do you manage that in a population
23 formula. The thing that - this is just my experience, and
24 everyone has different opinions. I think the
25 population-based funding formula as a basis is actually
26 really important to ensure there's equity for a population
27 relative to need and demand, in particular the
28 socio-demographic factors in society, because demand is
29 driven by people with higher needs, lower socioeconomic,
30 lower other factors and we need to reflect --
31

32 MR MUSTON: So ideally --
33

34 MS MAINS: And ABF ABM will have picked that up in time in
35 terms of what we're seeing, the number of people we're
36 seeing through facilities, but that there is a level of
37 unmet need in our communities.
38

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

1 Is it your view that those things under the current
2 arrangements are not really being captured in the way in
3 which decision making around the funding of LHDs --
4

5 MS MAINS: I think (indistinct). I think it's degrees, do
6 you know what I mean? So I just think - and we've talked a
7 lot today about how can you impact - ABM serves a real
8 purpose but how can you impact allocation to make sure you
9 are promoting, maintaining and preventing disease and be
10 the chief of your community and making sure that that
11 actually happens, and what models would enable you to do
12 it, and, as we know, ABM was particularly excellent at
13 managing certain things but not everything, and we've
14 talked about people with chronic disease, we've talked
15 about what we've spent on prevention and promotion and
16 activity like that. It's really sitting down and looking
17 at the whole. I've been asked by a board member of mine
18 every year for the time that she was on the board, "How do
19 you know that this district is getting its best share of
20 funding," and I can't answer that. Relative to a
21 population base --
22

23 MR MUSTON: Is that because there's some lack of
24 transparency in the way in which the decision --
25

26 MS MAINS: No, I - look, I think there's transparency on
27 the ABM model. I don't think it's a desire to hide
28 anything. I think funding models take a lot of time to get
29 transparency, and they're not easy to get the right model
30 and it's going to take - there is a balance between
31 population allocated and technical efficiency --
32

33 MR MUSTON: But is there a risk - just coming to the
34 question that your board member was asking you, is there a
35 risk that applying the ABF model, the amount of activity
36 that might be being purchased from your LHD and therefore
37 forming the basis of at least the ABF portion of the
38 budget - 83 per cent I think you told us - it's meeting a
39 need because it's all being delivered and purchased, but
40 there might be a huge amount of unmet need out there that
41 if you had twice as much money you would be able to deliver
42 twice as much activity to a very needy population?
43

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

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

11
12 But I think trying to strike the balance between do
13 we - are we very much focused on the priorities of our
14 particular populations and having both ABM and other
15 adjusters I think are important, and the State does do
16 degrees of that, and some of it it's a lot stronger than a
17 lot of places I've lived.

18
19 MR COLLINS: I think Australia has a platinum standard
20 health system. I take gross offence when I hear media in
21 particular talking about we are a like Third World country.
22 We are nothing like a Third World country. We are so
23 fortunate to be examining these issues about healthcare
24 funding in Australia, not the United States, the United
25 Kingdom for that matter or let alone the developing world
26 or the undeveloped world. I mean, we are so lucky.

27
28 However, that said, there are still structural
29 problems that need to be finetuned. For example, with
30 Medicare, which I think is a fantastic system, while
31 I think there has been a great improvement in the
32 relationship between public and private over the time
33 Medicare has existed, you've still got some log jams in
34 Medicare. It's still a bit of a lottery system. But that
35 hasn't been addressed. That remains for some future
36 government to address some time.

37
38 THE COMMISSIONER: It also only - it only provides a
39 funding stream where the GPs are there.

40
41 MR COLLINS: Yes.

42
43 THE COMMISSIONER: If that's gone, primary care goes.

44
45 MR MUSTON: Or specialist.

46
47 THE COMMISSIONER: Yes. Exactly. Yes.

1
2 MR COLLINS: Yes. So I think there is that issue. Margot
3 has mentioned the aged care issue that the Commonwealth
4 does not meet its fiscal responsibilities in aged care full
5 stop and it needs to. So the State has to pick that up.
6 But in terms of this exercise I think this has been an
7 exceptionally valuable exercise and a very important
8 mission established by the government to try to improve
9 things. If you are an inner city dweller in Sydney or
10 Melbourne, Adelaide, any capital city in Australia, you're
11 very lucky. You would probably walk to a number of really
12 good hospital options, public and private. This is really
13 about the fringe dwellers. This is about the peripheral
14 areas and remote areas, where you don't have that direct
15 access, and whatever we can do to improve that and to tilt
16 the scales a bit and to progress the decentralisation of
17 some of the great assets that we do have I think therein
18 lies the value of this Commission, and I hope that, you
19 know, what we've contributed today might do something to
20 that.

21
22 DR MORGAN: Just in the spirit of not leaving anything on
23 the bench, I just want to underscore this really important
24 point here about the notion of pegging health services that
25 are, you know, directly driven by activity or demand. When
26 you don't do that the impacts are very quickly felt across
27 the system, and I had some figures that are publicly
28 available from the report on government services, and if
29 you're in New South Wales, New South Wales Ambulance
30 employs 58 paramedics per 100,000 population. But if
31 you're in South Australia it's 68. If it's in Victoria
32 it's 70. If it's in Northern Territory it's 73. In
33 Tasmania and Queensland it's 75. So what that in effect
34 means that, you know, if you're a paramedic in New South
35 Wales you're probably working at least 20 per cent harder
36 than someone in Queensland doing similar workload.

37
38 THE COMMISSIONER: Have you raised those ratios in forums
39 other than this hearing?

40
41 DR MORGAN: I beg your pardon? I'm sorry.

42
43 THE COMMISSIONER: Have you raised those ratios in forums
44 other than today?

45
46 DR MORGAN: It would be fair to say consistently.
47

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

3
4 DR MORGAN: We've been well supported is the truth of it.
5 That is absolutely the truth of it. But against - when
6 I wind the clock back to 10 years ago the challenge
7 ambulance had was its ability to look, move, feel like the
8 rest of the health system. It very much was the two person
9 in a van. It was a cost on the health system. Why would
10 you invest in that? The change of ambulance becoming now a
11 significant opportunity to manage demand for the health
12 system, of course you'd invest in that and we're seeing
13 that. So nobody would complain.

14
15 But what we do know is that's because of a significant
16 number of people very much leaning into a value proposition
17 today that didn't exist in the past. But that's about
18 people. And, if this Inquiry's about a system, then the
19 system would see that we would move with the rest of
20 the local health districts in terms of investing in
21 services and demand.

22
23 MS HOEY: I just wanted to say that just listening,
24 I mean, it doesn't really pertain to us because ABM is not
25 appropriate, but I think that there's no easy answer and
26 I think it's got to be - there's got to be a bit of
27 everything and applied. But what I do worry about when
28 we're looking at, you know, what funding model is going to
29 work that we forget the impact of the Commonwealth and this
30 contribution that should be coming through from them,
31 particularly in primary care, and the cost that has to the
32 state public health system.

33
34 And then also around access to universal services, so
35 access to housing, access to education, and also access to
36 employment in the different areas and the impact that that
37 then has on health. And if we keep trying to change our
38 health funding system without actually quantifying what the
39 cost to us is for that and taking that forward, then we
40 might head into a funding system that is trying to bridge a
41 gap rather than actually fund what public health services
42 within the state should be funding.

43
44 MS MAINS: Could I just make one - sorry.

45
46 MR MUSTON: Please do.

47

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

7
8 THE COMMISSIONER: Mr Chiu, are there any questions that
9 you have?

10
11 MR CHIU: No, thank you, Commissioner.

12
13 THE COMMISSIONER: All right. So all eight of you -
14 I think it's eight - to all of you, I'll just say, we know
15 your time's valuable. Thank you very much for your
16 attendance today. We are very grateful, and it's been of
17 great assistance to the Inquiry. So thank you for that.
18 And we'll adjourn until 10 o'clock tomorrow. Thank you.

19
20 **AT 3.49PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
21 **TO WEDNESDAY, 20 NOVEMBER 2024 AT 10AM**

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