

**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, 10 December 2024 at 11.00am

(Day 067)

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 Richard Cheney SC with Mr Hilbert Chiu SC for NSW Health

1 THE COMMISSIONER: Good morning.

2

3 MR MUSTON: Commissioner, the first witness today is
4 Professor Kathy Eagar.

5

6 THE COMMISSIONER: Good morning.

7

8 <KATHY EAGAR, affirmed: [11.05am]

9

10 <EXAMINATION BY MR MUSTON:

11

12 MR MUSTON: Q. Professor Eagar, do you still hold the
13 role of an adjunct professor of health services research at
14 the University of New South Wales?

15

16 A. I do.

17 Q. Could you just give us a little bit of background as
18 to your experience within the area of health research and
19 policy which has brought you to that role?

20

21 A. Yes. I started my life as a clinician in the New
22 South Wales health system and then I moved into a range of
23 management roles, both in Sydney and in the Illawarra,
24 which is what took me there. Then I did a PhD in public
25 health and health economics and then, by that stage, I was
26 very interested in funding and how you create funding
27 systems to create the right incentives for the sort of care
28 we want to deliver and I became the foundation professor of
29 health services research at the University of Wollongong,
30 a position I was in for almost 30 years before my
31 retirement for age at the beginning of 2023.

32

33 Q. And I understand you have held some roles which have
34 seen you being involved in the admission of the public
35 health system in New South Wales?

36

37 A. I have.

38 Q. What are those roles?

39

40 A. I've been in both management positions, but I also had
41 very key roles over time in the resource distribution
42 formula and I sat on - I was a member of the NSW Health
43 Resource Distribution Formula for 15 years or so.

44

45 Q. What did that role involve?

46

47 A. It was an advisory role to the then department
identifying those factors among populations which drive
need for care and how to design a fair and efficient
funding model that distributed the money between what were

1 then local health districts in proportion to population
2 size and need. Importantly, it wasn't designed to
3 incentivise particular types of care, but to give each
4 district a global allocation and then, under the public
5 health - the Health Services Act, they were then required
6 to spend that money in a way which would maximise health
7 gain for the population.

8
9 Q. We might come back to that aspect of it. Have you
10 held other roles that have seen you being involved in the
11 administration of public health?

12 A. Yes. Back in the 1990s I got very interested in case
13 mix and case mix funding - in fact in the 80s - and I was
14 one of two people who established what was then the
15 New South Wales case mix area network, which had all of the
16 area health services working together to develop an
17 activity based funding model for New South Wales and that
18 predated the National Health Reform Agreement by some 16 or
19 18 years, and we actually implemented activity based
20 funding in New South Wales early on.

21
22 When the department then took on that role, I worked
23 as a consultant to the department, and I worked with the
24 funding branch and actually wrote the episode funding
25 guidelines for New South Wales on behalf of the department
26 for nearly 10 years.

27
28 Q. Just in very broad terms, that form of activity based
29 funding, how did it operate within the system and how were
30 the amounts payable assessed?

31 A. The big change came in the introduction of the health
32 reform agreement in 2014, and that was agreement towards
33 a national ABF model, which is an activity based funding
34 model, and New South Wales made a decision to ditch the
35 two-pronged health system that it had, which was resource
36 distribution formula to distribute the money to the
37 districts and area health services, and then area health
38 services funding their hospitals and health services based
39 on an agreed quantum and range of activity, and with the
40 introduction of the health reform agreement, New South
41 Wales made a voluntary decision, which it didn't need to do
42 but it did, to simply adopt the national model developed by
43 the Independent Hospital Pricing Authority, and use
44 activity based funding from the centre to the districts.

45
46 Q. Insofar as the districts are concerned, I understand
47 you've held a role more recently with the Illawarra

1 Shoalhaven Local Health District?

2 A. Yes, for the last - for 10 years up until 2022, I was
3 a member of the board of the Illawarra Shoalhaven Local
4 Health District. At the moment I'm currently doing
5 a project partnering with the health service and others,
6 trying to understand the demand for aged care in our region
7 and what are the costs and other patient outcome
8 implications of the huge issues to do - unresolved issues
9 to do with unmet need for aged care.

10
11 Q. We might come back to that in a moment as well.

12
13 THE COMMISSIONER: You may be going to ask, but I'll ask
14 now.

15
16 Q. When you say with the introduction of the health
17 reform agreement, you said:

18
19 *New South Wales made a voluntary decision,*
20 *which it didn't need to do but it did, to*
21 *simply adopt the national model developed*
22 *by [IHACPA] and use [ABF] ...*

23
24 A. Yes.

25
26 Q. What do you mean by "voluntary decision which it
27 didn't need to do but it did"? What do you mean by that?

28 A. What I mean by that is that the New South Wales
29 activity based funding model pre that was much more
30 sophisticated than the national model that the Independent
31 Hospital Pricing Authority adopted and it necessarily
32 needed to adopt a lowest common denominator model that
33 could be used across the whole country and that lacked the
34 sophistication and nuance that we had already in place in
35 New South Wales.

36
37 And IHPA could afford to do that, the Independent
38 Hospital Pricing Authority, because its goal was to
39 distribute funding, the Commonwealth's share, to the states
40 and territories rather than fund individual hospitals, and
41 everybody was always very aware that any foibles in that
42 model would be compensated for via the grants commission in
43 terms of GST allocations.

44
45 So, for example, if I just use an obvious one, not
46 New South Wales, Northern Territory, there is no way that
47 Northern Territory can deliver care at the national

1 efficient price, but it doesn't matter because they get
2 that bit of money and then they get compensated for that
3 via the grants commission.
4

5 New South Wales could have maintained that more
6 sophisticated approach and a couple of those elements that
7 were lost - one is to pay a different price for each peer
8 group of hospitals, that is that the major teaching
9 hospitals actually have a different cost structure to
10 district hospitals or country hospitals or the women's and
11 children's hospital; we ditched the concept of that. We
12 ditched the idea of seeing intensive care as a rare but
13 important, incredibly expensive resource, that should be
14 seen as a resource for every hospital rather than just the
15 one it was in, and we used to fund intensive care separate
16 from the rest of acute care.
17

18 We also had a model where we paid for renal dialysis
19 on a per annum per patient basis rather than on each
20 discrete activity. There were some other details as well.
21 But the purpose was that we were trying to be much more
22 precisely identifying what drives costs, in order to ensure
23 that hospitals got a budget that was transparent and
24 actually reflected their cost structure.
25

26 That went, necessarily went, when IHPA brought in one
27 model that says, "There's one nationally efficient price",
28 which is, of course, not a nationally efficient price, it
29 is just the average of everybody in the whole of Australia
30 and doesn't actually reflect anyone's price.
31

32 THE COMMISSIONER: Just before you follow up, just for the
33 purposes of the transcript, I think it's worth recording
34 that when Professor Eagar was talking about the Northern
35 Territory and getting compensated by the grants commission,
36 that's consistent with, I think, the evidence that
37 Professor Duckett gave and the paper he prepared, the name
38 of which currently escapes me, but we all know what I'm
39 talking about.
40

41 MR MUSTON: Yes, I think that's right.
42

43 Q. Just exploring that, in terms of the activity based
44 funding model adopted through IHACPA, so the less nuanced
45 model that you referred to, that's the mechanism, I think
46 you indicated, through which the extent to which the
47 Commonwealth makes a contribution to the delivery of acute

1 care within the state is governed or determined?

2 A. Yep.

3
4 Q. Would you agree that harnessing as much of that
5 Commonwealth contribution as one can, at least through that
6 mechanism, is valuable?

7 A. The Commonwealth contribution to health, which I think
8 in New South Wales is about 38 per cent, is absolutely
9 critical. But you can have a more nuanced model which maps
10 to the cruder model, whereas you can't do the reverse.

11
12 Q. You've sort of anticipated my next question, which is
13 that the more nuanced model that was operating prior to the
14 introduction of the IHACPA approach to activity based
15 funding - would it have been possible to have continued to
16 use that model whilst, at the same time, collecting the
17 data that was needed to be collected in order to identify,
18 for the Commonwealth exactly how much it should be paying?

19 A. Absolutely it was possible to map it, and if I go back
20 to the conversations at that period, essentially, it was
21 the ministry caving in to central agencies who were
22 Premier's Department and treasury, who wanted the model
23 just to roll down.

24
25 I think what that did - and I understand the pressure
26 on the ministry to keep the central agencies happy, because
27 they didn't want the National Health Reform Agreement to
28 come unstuck - but it had quite detrimental, in my view,
29 quite detrimental effects on funding for equity and outcome
30 and efficiency in New South Wales.

31
32 Q. Can I explore that with you, and we might come to it
33 in a bit more detail, but the evidence we have received
34 suggests that the base funding that local health districts
35 receive to deliver the care that they do has a historical
36 origin that no-one can really recall, but it dates well
37 back beyond the introduction of the ABF model?

38 A. Mmm-hmm.

39
40 Q. Is that generally consistent with your experience, to
41 the extent that your experience would enable to you venture
42 a view on that?

43 A. Absolutely. The reality is that governments across
44 every state and territory work out how much money they've
45 got with health - for health, they divide it by a unit
46 price and then they calculate - they retrofit the volume.
47 So if the total cost of the health service, total price,

1 equals volume by unit price, when the budget is fixed and
2 you can't change the unit price, you just change the
3 activity target.
4

5 Q. Again, correct me if this proposition is wrong, but
6 does that mean that, at that point at which New South Wales
7 made the voluntary decision to shift from the RDF approach
8 to funding districts to the ABF approach, the amount of
9 money, from day one to day two, that local health districts
10 received, at least at that point, didn't change radically
11 but, rather, the way in which it was sliced up changed, so
12 there was a population based assessment which was used to
13 justify the amount of money which was provided on day one?

14 A. Yep.
15

16 Q. The voluntary decision is made, day two, the same
17 amount of money, or thereabouts, is provided but it's
18 carved up into activity units instead of a population based
19 multiplier. Is that roughly right?

20 A. Yeah, in practice, the amount of discretionary work
21 you do in health is actually quite limited. We actually
22 know - every emergency department, tonight, we've got
23 a pretty good idea how many people are going to turn up,
24 and that won't change, whether you fund them by population
25 need or on the basis of activity. But I think what we lost
26 when we moved away from population need as the basis of
27 health system funding is that we lost the principle of
28 equity, that we have some really disadvantaged groups in
29 our communities, and their needs got lost in that model -
30 Indigenous people, but others as well, homeless people.
31

32 We also lost our capacity to move funding around in
33 response to population growth. Before I was in the
34 Illawarra I was in Western Sydney and the early work I did
35 was because we were arguing that Western Sydney, South West
36 Sydney, did not get its fair share, and one of the things
37 we achieved in the RDF, which I don't think has been
38 sufficiently recognised, but I did include it in my
39 submission, is that districts were plus or minus
40 10 per cent distant from their fair share of the funding.
41

42 Within a reasonable time, we gradually brought those
43 down so that every part of this state was within plus or
44 minus 2 per cent of their share of funding, and not only
45 that, but everybody knew where they stood, and that's the
46 other thing that's been lost. That was a very transparent
47 process, you knew, and I knew that when I was working in a

1 district, I knew it when I was on the board, what - you
2 know, whether we got our share of mental health money or
3 acute care funding, or whatever. Ten years on, I wouldn't
4 use that same model, I would make some changes, but the
5 principle of funding for equity and outcomes is really,
6 really important, and we don't want a health system that is
7 incentivised just to produce activity.

8
9 Q. That's what I'm trying to explore. So the change in
10 the model, at least in the early days, I gather from what
11 you've said, did not result in any substantial change in
12 the actual pot of money that was delivered to, say,
13 Illawarra Shoalhaven Local Health District?

14 A. Yep.

15
16 Q. The people who were managing that money were the same
17 people, subject to the usual sort of process of evolution
18 that occurs within any organisation; would that be right -
19 at least in those early days?

20 A. Yes, I think one of the things we lost almost
21 immediately was a commitment to area self-sufficiency,
22 that - not for quaternary and the high-level services, but
23 for basic services, you should be able to get your hip
24 replacement or your cataract close to home, and you
25 shouldn't - so part of the resource distribution formula
26 was explicitly predicting and providing districts with the
27 money to revert - what to do, it was flow reversal.
28 Illawarra was a case in point. But Western Sydney, where
29 I had come from, was a much bigger case in point.

30
31 Q. I might come back to that. But I'm just trying to
32 understand from a model point of view what it was that
33 actually changed, at least in your view, in an adverse way?
34 Same amount of money, same, by and large, people running
35 the system?

36 A. Mmm-hmm.

37
38 Q. Presumably, overnight, there was not a radical
39 reconfiguration of the services that were being delivered
40 by local health districts to their communities?

41 A. I think we lost a couple of things, and it was -
42 nothing happened overnight.

43
44 Q. Yes.

45 A. The first thing that happened is that we have lost the
46 concept of equity, and based on - and I included my best
47 case analysis that I could do on the data, the system is

1 now significantly more inequitable on a geographic basis
2 than it used to be.

3
4 Q. Why is that?

5 A. Because when you fund on activity and the activity is
6 based on the activity you did the year before, it is always
7 a retrospective and retrograde model. It reinforces
8 current practice and it reinforces the location where
9 current activity is provided. That is really a problem if
10 you are looking at how to improve allocative efficiency and
11 outcomes, but it rewards those people already doing a lot
12 of activity, and if you are in a growth area where your
13 population is growing, you actually have to do the activity
14 in one year first before you get it in your budget the next
15 year, presuming you do.

16
17 Q. We are told that the growth figure that's applied to
18 the base each year takes into account things like changes
19 in population size, for example.

20 A. Mmm. It might. I have no idea. I mean, I do think
21 that - and I don't say that in a flippant way, I spent 10
22 years on the board asking a basic question every year,
23 "Does Illawarra Shoalhaven get its fair share of the
24 funding?" And I never got that answer in the 10 years.

25
26 THE COMMISSIONER: Q. Can I just ask, so we're clear,
27 what we mean by "we lost the concept of equity"? Should
28 I understand that to mean we've lost the - we lost some of
29 the capacity to address inequality in the system?

30 A. Yeah, we actually know that some parts of the state
31 have much poorer health status than others; that some parts
32 are much older than others; that some have particular
33 Indigenous communities and culturally and linguistically
34 diverse communities --

35
36 Q. Where there are worse health outcomes, yes.

37 A. -- who have greater measures of need. When all you do
38 is treat that as a loading in an ABF model, you lose the
39 nuance - you lose the sophistication and you lose the
40 ability to track whether you're achieving anything.

41
42 I think the other issue, going back to your comment,
43 I've not seen anything about the material - what is the
44 impact of putting those factors in ABF? Does it shift
45 money a half a per cent or 10 per cent? Knowing the
46 materiality of that adjuster, for me, would be essential in
47 being able to comment on whether it's a good idea.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

MR MUSTON: Q. And so is it the lack of transparency around these things which is fundamental to your view that there is, at least potentially, a lack or we are losing equity as a driver of funding decisions?

A. No, I think --

THE COMMISSIONER: Q. Or is it a lack of precision as well and adjustments?

A. It's a lack of all those things. There is a lack of transparency, there is a lack of precision, but there's also the creation of the wrong incentives, and I - you know, I said my life - I started off doing clinical work and got interested in the whole issue of equity but I also got interested in the issue of how - what sort of incentives, and where you have performance agreements that are all based on activity targets, what you measure matters. We stopped measuring things before that I thought were really important things to answer some of these questions.

MR MUSTON: Q. Like what?

A. What is the health differential? How much does it cost to close the gap in Far West New South Wales? That's a really important question. Another question: to what degree has the availability of private hospitals and private health insurance reduced the demand for the public system and how should we account for that in a funding model?

Third issue: to what degree does the availability of Commonwealth funded services - aged care, disability, primary care, medical specialists in their rooms - reduce or change the need for public health system?

I mean, I could go on. But these are examples which, from my point of view, coming back after a 10-year break, what are the big gaps, those sorts of things, I still think. Somebody in the ministry may be doing it, but in the 10 years that I was on the board, I did ask for it every year and nobody ever could answer it.

Q. So just going through those factors, the examples you've just given, as part of an approach to the planning of the delivery of health services within a local health district, each of those factors should be taken into account in determining what the service mix should be in a

1 particular location or local health district; would that be
2 right?

3 A. I just want to step back a bit. Funding system design
4 is not a set of free choices where we have a smorgasbord
5 and we say, "I will have a bit of this and a bit of that";
6 the system has to be designed coherently as a whole, and it
7 can't be designed devoid of a governance framework.

8
9 I think the other issue we haven't talked about is who
10 is accountable for achieving outcomes and best bang for the
11 buck? Because one of the things that happened - and
12 I think it's the most important - was that the ministry
13 took on the role of determining the volume of widgets that
14 were produced, and that really raises fundamental issues
15 about what's the role of the ministry and what's the role
16 of the districts and the degree to which you have
17 a centralised or decentralisation, and the funding model
18 should reflect that bigger purpose.

19
20 If you want the ministry to be running the operations
21 of the health system, getting them to fund by activity
22 based funding - that is, become the purchaser - is
23 a perfectly sensible thing to do. But if you see that the
24 ministry's role is primarily in policy and
25 intergovernmental relations and Commonwealth-state
26 relations and servicing the minister of the day, and that
27 the role of the districts is to identify what local people
28 need and how best to deliver it, then you don't use
29 activity based funding at that level.

30
31 Q. You have prepared a submission to assist the Inquiry
32 with its work, which was dated October 2023?

33 A. Yes.

34
35 Q. Before giving your evidence today, have you had a more
36 recent opportunity to review that submission?

37 A. Yes. Given it's 14 months ago, yes, I did re-read it.

38
39 Q. Are you satisfied that the contents of it are still,
40 to the best of your knowledge, reflecting beliefs that you
41 hold?

42 A. Yes, they do.

43
44 MR MUSTON: Commissioner, that document is
45 [SCI.0011.0718.0001]. It properly commences at 0002.

46
47 THE COMMISSIONER: Yes.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

MR MUSTON: We might tender that document in due course.

Q. I might take you to that, Professor. Could we go to page 2, which I think is page 3 in the coding. Do you see there under the heading "The balance between central oversight and locally devolved decision making", in the first paragraph you tell us about the cyclic waves of centralisation and decentralisation?

A. Yes.

Q. I just want to ask you, I gather from what you go on to tell us in the next few paragraphs that your view is decentralisation is to be preferred over centralisation in terms of the running of a health system?

A. Yes, I've been following this issue with great interest over 40 years, not just in this state but in the rest of the country and also internationally and following the international evidence.

We've certainly seen in New South Wales cyclic waves of centralisation and decentralisation, and the interesting observation I would make about that is that the reasons that governments give to centralise are identical to the reasons that they give to decentralise, which is, "We want to have a better focus on efficiency and effectiveness and consumer engagement", blah, blah, blah.

My observation over that time is that the New South Wales health system is one of the biggest public health systems in the world. It is ridiculous to think that a group of people sitting in Artarmon know best what's the best way to deliver care and meet the needs of the people who live in the Murrumbidgee or the north coast.

It makes much more sense to me that you have a ministry - and I think we've got some international evidence on this as well - a ministry that is full of the sharpest policy people you can get, whose job is to develop a policy framework within which districts can work, that can meet the needs of the government of the day, keep the central agencies happy in the case of New South Wales, look after government relations and Commonwealth-state relations, and also some logical central functions, for example, quaternary services planning is best done statewide, but working out where to put maternity services is best done locally. So there's a horses for courses on

1 the planning, and it is a shared responsibility.

2
3 But the idea that the ministry can ever really improve
4 allocative efficiency of a system as big as New South Wales
5 I think is very optimistic, although I know that there are
6 people in the ministry who think that that's their goal and
7 that that is what the future role should be for the
8 ministry. But I don't share that view.

9
10 Q. In relation to the planning side of it, accepting what
11 you say about the logicality of the ministry dealing with
12 quaternary services, the sort of pointy-end low-turnover
13 high-complexity procedures like heart-lung transplants and
14 the like, they're only going to be provided in one location
15 and it's logical that the ministry is involved in
16 decision-making around that, but is there a role for the
17 ministry in system planning that goes a little bit deeper
18 than that, in your view?

19 A. I think the ministry has got a role in a number of
20 discrete areas. One is workforce planning, but again, that
21 needs to be a shared function. You know, our workforce
22 planning - our workforce issues in rural New South Wales
23 are quite different to Sydney and we actually need a rural
24 workforce strategy where the districts are working
25 together. So I think there's a case in workforce for
26 a more shared role.

27
28 But I think, if I go back to the bigger principles
29 just for a second, in a sense, I think the more sensible
30 arrangement for me is to go back to a bit of language that
31 has fallen out of fashion but it is still quite accurate,
32 the role of the ministry is as the funder and the role of
33 the districts is as the purchaser and the role of the
34 hospitals and health services is as the provider. Whereas
35 I think what we're seeing at the moment is the ministry
36 really sees itself as both the funder and the purchaser,
37 and the districts as providers.

38
39 But I do think there are functions like workforce,
40 like occ health and safety, some of the central functions
41 of HETI, for example, do make best sense - the Health
42 Education and Training Institute - to run on a statewide
43 basis. But I don't think that the role of the ministry is
44 to require districts to come along and argue the case of
45 why they need to set up a new clinic or why they need to -
46 whatever. They should be able to plan that level of
47 services locally and be accountable for their money.

1
2 I'm not suggesting that they should just have
3 a free-for-all, but the ministry's main job is to set the
4 accountability framework and to be satisfied that the
5 district is achieving best bang for buck.
6

7 Q. Accepting that the notion of a district coming forward
8 and arguing for a clinic, for example, carries with it an
9 implicit assumption that it's the ministry who makes the
10 ultimate decision about whether or not the clinic should or
11 shouldn't be delivered, if we walk it back a step from
12 that, is there not a role for the ministry in
13 collaborative, system-wide - participating with all of the
14 local health districts in collaborative system-wide
15 planning to work out in a way which makes best and most
16 efficient use of the money available what should be
17 delivered and where?

18 A. Look, I think we need to not think that there are two
19 levels. There's a third level, which is the provider
20 level, and a lot of the system issues we're talking about
21 really need provider and consumer engagement, and we don't
22 want that all being orchestrated. You're absolutely right,
23 we need a collaborative issue, but I want to come back to
24 the basic principle that power and responsibility need to
25 be linked together.
26

27 Collaborative doesn't mean - you don't need an inquiry
28 to say everybody should collaborate, and people try to do
29 that to the best of their knowledge anyway. But the issue
30 for me is who is responsible for making decisions and what
31 are the - who is accountable for what? And at the moment,
32 I don't see - if somebody said to me, "Gee, the people who
33 live in this region are not getting very good health care",
34 it's not clear to me anymore who is responsible for that.
35 Is that the district's problem or is that the ministry's
36 problem?
37

38 Q. Let me proffer an example that has come from the
39 evidence, Central Coast LHD, from memory, don't offer
40 neurosurgery.

41 A. Mmm-hmm.
42

43 Q. They have made that decision based on a range of
44 factors, including what they perceive to be challenges in
45 getting neurosurgery delivered in their local health
46 district, the balance or the prioritisation of the spend of
47 their limited envelope of money and the fact that they

1 perceive those services can be provided to their community
2 adequately out of either Northern Sydney or John Hunter in
3 Newcastle. That's an assumption that they have made, but
4 is there not a role for the ministry in that planning
5 process to actually determine whether that assumption is
6 correct, and, if it is, perhaps increase the funding that's
7 going to Northern Sydney or Newcastle to accommodate the
8 fact that they are dealing with all of Central Coast's
9 neurosurgery patients or, alternatively, say to Central
10 Coast, "We're looking at your numbers and, whilst you have
11 autonomy of decision-making here, we think maybe there is
12 a case for setting up a neurosurgery clinic in your local
13 health district and we could try and help you, through this
14 workforce planning process, to achieve that"?

15 A. In a population needs based funding model, the
16 district is still responsible for meeting the neurosurgical
17 needs of its population and it exercises that
18 responsibility by either delivering it locally or entering
19 into, explicitly, a service agreement with another
20 district, or many districts, to provide it, and there is
21 a role for the ministry in facilitating those networks to
22 make sure that that's in place.

23
24 It shouldn't be - and it currently is under ABF - that
25 you can say, "Well, we've got no responsibility for the
26 neurosurgical needs of our population"; in a population
27 needs based funding model, you would say "You have to make
28 a decision. Can you provide it efficiently and get good
29 outcomes and, if not, what service arrangements are you
30 entering into with other districts?" And the ministry's
31 got a very important role in that.

32
33 Now, some of that is in feeding in the evidence that
34 says, "Well, for this particular procedure, we've got good
35 evidence that you need to be doing 800 of these a year to
36 get good outcomes, therefore, in terms of an outcomes
37 perspective, you need to show cause how you can run
38 a quality unit with less than - doing less than 800 of
39 those." That's part of the accountability that the
40 ministry should have.

41
42 Q. Just dealing with that example you give of the
43 800 units, hypothetically, it's a hypothetical number, but
44 that presumably is a measure of safety and quality of
45 procedure?

46 A. Mmm-hmm.

47

1 Q. That is to say, if 800 units is what a CEC, for
2 example, has determined is the safe and appropriate number
3 of procedures to be done in a year in order for a facility
4 to be operating safely --

5 A. Yep.

6
7 Q. -- then you would need to - are you saying you would
8 need to put forward a pretty sound argument as to why you
9 should be offering less than that or why you should be
10 allowed to stand up a service that offers less than that?

11 A. That's right. But it's not just that. It's also that
12 there are other middle courses. It's not like you go to
13 the headmaster or the headmistress and they say, "Yes, you
14 can do it", or not.

15
16 If I go back to some of the treatments for rare
17 cancers, in the Illawarra, when I was on the board, we had
18 a couple of rare cancers which we didn't really have the
19 volume to do, so we entered into a partnership with South
20 West Sydney district to share the care for those patients.
21 We did the same thing when I was working at the Illawarra,
22 in terms of renal transplants, where we provided all the
23 pre-surgical care, the patients literally went to Prince of
24 Wales on the day of the surgery and they were back a couple
25 of days later, and I think we've lost that nuance of
26 districts working across districts. The principle of close
27 to home is really important, but it has to be close and
28 safe.

29
30 Q. So there's close and safe, but there's also - let me
31 test this proposition: within any health service, you
32 could stand up a particular service and it would create
33 demand for that service, within reasons?

34 A. Within reason, yes. I mean, we're not going to set up
35 a new heart transplant service and generate demand for
36 a new heart, but yes, but for most services.

37
38 Q. So neurosurgery, for example, to stick with that
39 example, if you were to set up a neurosurgery service in
40 the Central Coast, there would likely be a demand for that
41 service and you could continue to meet that demand through
42 that service?

43 A. I would want to distinguish between need and demand,
44 because one of the weaknesses I think in the activity based
45 funding model is that it assumes that need equals demand,
46 and there is a level of latent need, latent demand, in the
47 community, and you open up a new service and those people

1 come along. That doesn't mean, though - I mean,
2 neurosurgery is a bit more straightforward, but in a lot of
3 other things, that doesn't mean that the fact that people
4 are demanding a joint replacement service, that all we
5 should do is just set up a sausage factory and do more and
6 more joints.

7
8 There are things we can do to change the nature of the
9 demand and to channel that demand into more appropriate
10 service responses, if we can achieve better value for
11 money. And what I mean by that is that services are not -
12 services of equal cost are not of equal value. All things
13 being equal, you do the one that's the most valuable. And
14 services of equal value are not of equal cost. All things
15 being equal, if two services are of equal value, you do the
16 cheap one.

17
18 Q. Let's use take that joint replacement example and
19 let's use Central Coast again as a guinea pig.

20 A. Yes.

21
22 Q. You might have a demand for people wanting - perhaps
23 have a perception that they need - a joint replacement
24 procedure?

25 A. Yep.

26
27 Q. I take it that what you're telling us is you need to
28 assess that potential patient base and make an assessment
29 of whether the best bang for buck spend is delivering joint
30 replacement surgery to all of these people as opposed to
31 some earlier or alternative intervention, physiotherapy,
32 diet management --

33 A. Yep.

34
35 Q. -- a range of things that might actually have people
36 walking around comfortably without needing their joint
37 replacement surgery?

38 A. Yes. Two things, I think, two aspects of that: one
39 is if they don't provide enough joint replacement services
40 now, people go over the border and that's a free good for
41 Central Coast, because they're not required, nor held
42 accountable, for meeting the needs for joint replacements
43 for their residents, and that's because you fund on the
44 activity, basis of activity rather than need, and that
45 comes back to my earlier comment.

46
47 The second issue is that we talk about activity based

1 funding. "Activity" can mean whatever you want it to mean,
2 but the national model defines "activity" very narrowly,
3 and that has created a very narrow perception of what is
4 worth doing. For the joint replacement, we have very good
5 evidence of what is called pre-habilitation - people who
6 are sitting on a wait list, who are overweight, should be,
7 you know, helped to lose weight and they should actually
8 improve their fitness, because even if they go ahead with
9 the surgery, they'll have a better and quicker
10 postoperative recovery if they're fitter, and a lot of
11 those - some of those people, at least - will come off the
12 waiting list.

13
14 We need to create a model which actually incentivises
15 clinicians saying, "We need to set up a pre-habilitation
16 clinic", and the district has got a mechanism to pay for
17 it. But at the moment, all that happens is that somebody
18 writes to the district and says, "Here's the evidence on
19 pre-habilitation", and they've got to keep producing hip
20 replacements because that's what they're funded to do under
21 the activity based funding model. So you need
22 a circuit-breaker.

23
24 Q. A circuit-breaker is one way of dealing with it.
25 Another way of dealing with it would be a somewhat more
26 sophisticated service planning process that involves both
27 the local health districts, who know their communities and
28 are able to make the best and most informed decision of
29 what their communities need and what suite of services are
30 required across the board for the delivery of care to their
31 communities, coupled with proper planning input from the
32 centre, whereby decisions are made as to where,
33 system-wide, the best way of delivering - that all of those
34 services should be provided.

35
36 Can I back that up with just an example. Let's say in
37 Central Coast, limited budgetary envelope, they take the
38 view that the best spend for their money is on
39 pre-habilitation. They put the money into
40 pre-habilitation, but there will always be a residual
41 number of patients who do require their joint replacement
42 treatment. There then comes a question about whether or
43 not that joint replacement treatment should be provided in
44 the Central Coast or whether it should be provided and can
45 adequately and perhaps more efficiently be provided in
46 either John Hunter or Northern Sydney. Maybe what Central
47 Coast has to do is introduce adequate patient transport to

1 make sure that that person who does have to go and have
2 their operation either in Newcastle or in St Leonards is
3 able to get there, have their procedure and get brought
4 back to recover in a hospital close to home. But for that
5 to work, it requires some central involvement in the system
6 planning, doesn't it?

7 A. Look, I think you can use words like "involvement",
8 and "collaboration", and the obvious answer is "yes", but
9 the issue is about who is accountable - who is responsible
10 and who is accountable.

11
12 If you go back to that example you just gave, when you
13 have activity based funding, what you measure matters, and
14 you incentivise the things you can count. You can't count
15 the transport to send somebody to Northern Sydney or the
16 rehabilitation assessment or whatever it is, and that's
17 why, I guess what I've been watching through the course of
18 the Inquiry - I have browsed some of your submissions -
19 there is no shortage of good plans people have put to you
20 about how you need to invest more in prevention and early
21 intervention, there is no shortage of those good ideas and
22 pretty good evidence for them, too.

23
24 But I think at the end of the day, the question for
25 this Inquiry is: what's the shape of the system? Is it in
26 basically pretty good shape and you need to do a bit of
27 tinkering at the edges? In which case, let's tinker the
28 ABF model, and I could give you some ideas on how I would
29 improve it after 15 years, not looking at it too much; or
30 if you think it requires more fundamental reform, that is,
31 there are bigger problems, then you need to design
32 a funding model that achieves those bigger objectives.
33 It's really straightforward. The worst outcome is to come
34 up with a said set of recommendations that says, "Well, we
35 can tinker ABF but we want the districts to do all these
36 other things". Though two things can't - need to be
37 aligned.

38
39 Q. Coming back to your concept of responsibility, one way
40 of dealing with that responsibility is through key
41 performance indicators?

42 A. Mmm-hmm.

43
44 Q. And I gather from your submission, consistent with
45 a lot of evidence we've heard, that the key performance
46 indicators at the moment are fairly uniform across all of
47 the health districts and are, to use your term, measuring

1 things that are easy to measure but perhaps not the things
2 that we should be measuring.

3
4 With service planning, and whether you use
5 "involvement" or "collaboration" it probably doesn't
6 matter, if you do have a process of slightly more nuanced
7 service planning which identifies what services are going
8 to be provided within a health district, what services are
9 going to be provided external to the health district, the
10 formulation of which will take into account all of those
11 earlier factors you have identified - need, the
12 availability of care through the private system,
13 et cetera - you've worked out what your population needs to
14 be delivered through the public health system and then you
15 work out how that's going to be delivered either within the
16 boundaries of your LHD or externally, KPIs can be set that
17 measure some of those things that you identified a bit
18 earlier as being immeasurable, can't they?

19
20 For example, if you've got your knee replacement
21 surgery happening in Newcastle and Northern Sydney, then
22 KPIs that measure waiting times for elective surgery are
23 probably appropriate, particularly if they are perhaps
24 targeted to elective surgery of that particular type,
25 whereas in Central Coast, a KPI that measures waiting time
26 for elective surgery might, at least in that instance, not
27 be particularly useful, it might drive people to think they
28 should be doing elective surgery when they don't really
29 need to be, but you can measure things like wait times for
30 a physio appointment in a public clinic or wait time to
31 receive an assessment, can't you?

32 A. Absolutely you can. I mean, I think it's about the
33 selective use of KPIs. What we know, you know, the last
34 time I saw a list, it was 200 KPIs, every bit of ministry's
35 goal in life is to get a KPI in for the district, and there
36 are these things on it that are within your control and
37 there are things on it that are completely outside your
38 control, but at the end of the day, the activity targets
39 drive everything, because that's what drives the budget.

40
41 Q. But does it really, in the sense that activity is
42 important, but the way in which that activity is delivered
43 remains at the discretion of the local health district?

44 A. Only within a framework for the five national case mix
45 classifications, et cetera, et cetera. So all the
46 pre-habilitation things we just talked about, a lot of
47 other things I would do to improve health, are not

1 classified.

2
3 Now, it could be, and that's why one of my earlier
4 comments was about New South Wales, in my view, made
5 a fundamental strategic error in just going along with the
6 national model and losing the ability to have a more
7 nuanced model. So, you know, if I go back to my: if you
8 think the problem is that the system is pretty good, it
9 just needs tinkering, then you make the ABF model more
10 sophisticated.

11
12 The way I would do that is I would have a broader
13 definition of "activity". The things we've been talking
14 about, I would actually make them activities and I would
15 cost them and I would give them NWAU and all those sorts of
16 things. I would have more sophisticated measures of need
17 and more - you know, that would be my second. The third is
18 I would make it more transparent.

19
20 The fourth is that I would actually move to recognise
21 the cost structure of hospitals, which is that some costs
22 are fixed and some are variable, and we should be moving
23 much more now towards a fixed and variable funding model
24 that says, "Every emergency department in this state has
25 already got a roster for next week, and 90 per cent of
26 those costs are locked in irrespective of the volume, and
27 only 10 per cent of the emergency department costs are
28 variable, but in elective surgery it's 50 per cent", or
29 whatever, and I would move from a national average to
30 a fixed and variable funding model, which is probably going
31 to be in the vicinity, I guess, of 50 or 60 per cent of
32 hospital costs are fixed and 40 per cent are within the
33 control of the people who run the hospitals and the
34 districts.

35
36 Q. That would vary depending on the size of the hospital?

37 A. Absolutely. So the fixed - and I designed, if I just
38 use a very practical example, a couple of years ago now
39 I designed what is now called the Australian national aged
40 care classification for residential aged care. We did
41 a big costing study and we developed a fixed and variable
42 funding model which has a base care tariff, which is the
43 fixed costs of running nursing homes, and there are six
44 different tariffs depending on where you are, and the
45 more - and the three factors which drive the percentage and
46 the amount of costs that are fixed in residential aged care
47 are location, size and Indigenous status.

1
2 So on average across the state, metro nursing homes
3 are about 5 per cent cheaper than, you know, the national
4 average, and in rural and remote, they've got a cost, their
5 fixed costs are something - I haven't got the figure in
6 front of me, but it's about four times more. So in metro
7 homes, the variable component is about 50 per cent, but in
8 rural and remote, it's about 10 per cent, and that starts
9 to solve a lot of - that has solved, in residential aged
10 care, the problem we've had in New South Wales hospitals
11 for years, where we've got small rural and remote hospitals
12 which get cost based funding, that is historic funding, but
13 to move everybody to a fixed and variable model.

14
15 So they're the things I would do if I thought the
16 system was more or less all right and I just wanted to
17 tinker. But that's a pretty big tinker, but I'd still do
18 that.

19
20 Q. Coming back to the extent to which the funding model
21 is, in your view, incentivising the wrong types of care or
22 the wrong approach to the delivery of care, do I gather
23 that is because it's, in your view, incentivising the
24 delivery of activity which the Commonwealth regards as
25 activity, namely, that which is the more traditional acute
26 hospital based care?

27 A. Yes.

28
29 Q. If the model were to recognise, at least at a state
30 level, other forms of care - for example, outpatient,
31 public outpatient clinics, paediatric care delivered in
32 community settings and the like, as a species of activity
33 which --

34
35 THE COMMISSIONER: Q. Or the perioperative advice that
36 was discussed about --

37 A. Yes, perioperative. I mean, people will tell you
38 about prevention. I don't actually think prevention is the
39 problem, but I think the area where we've got huge
40 potential to improve allocative efficiency is in better
41 models for sub-acute and non-acute chronic disease
42 management, particularly in early identification and
43 intervention.

44
45 MR MUSTON: Q. Coming back to my question, if some of
46 those early identifications and interventions were
47 recognised as activity for the purpose at least of the

1 state's funding model, that would take away the problem
2 that you've identified, wouldn't it, of the funding model
3 incentivising the wrong type of care?

4 A. A couple - yeah, it solves part of the problem; it
5 doesn't solve other parts.

6
7 Q. In what way.

8 A. If I go back to the fundamental issue, I think we've
9 lost, is equity, it doesn't solve the equity problem at
10 all. Responsiveness to local need, it does not solve that.
11 Being nimble - and I think one of the things we saw, COVID
12 was the best case study we've had in the world, really, in
13 the last two decades: as soon as we had COVID, the whole
14 ABF model just came unstuck because ABF isn't nimble enough
15 to be able to gear up.

16
17 If we go back to the Central Coast, we could have an
18 activity list with 10,000 things on it, but it becomes
19 impractical, and it also - what we lose is the
20 accountabilities and responsibilities: who is responsible
21 and who is being held to account about who is achieving the
22 best outcomes for the population, rather than just
23 producing activity?

24
25 So you're right, we can make KPIs, you can classify -
26 you know, you can expand activity classifications to
27 include whatever you want and you can put in another 500
28 KPIs, but the fundamental issue - go back to what's the
29 best way to govern the New South Wales health system and
30 how do you have a funding model that reflects the
31 governance structures, the power and responsibilities and
32 accountabilities, that you want in that system? And at the
33 moment, from my perspective, those two are not in
34 alignment.

35
36 Q. But let's assume that there's an ample number of
37 categories of activity to enable someone who is a vendor,
38 a local health district, a vendor of activity, to decide
39 exactly what sort of activity they want to be delivering to
40 their community. Is the next piece your concern with the
41 fact that the volume of activity which is being purchased
42 from a local health district is something which is decided
43 by the centre?

44 A. I think - I think it's quite easy to improve - to make
45 technical changes to the ABF model that will improve the
46 system a bit. So I don't disagree with you. I think if
47 you, you know, expand the definition of "activity", bring

1 in better measures of need that are not just expressed need
2 but are also normative need, comparative need and felt
3 need, if you make the system more transparent and
4 potentially to move to fixed and variable funding, you
5 you'd actually improve the system, and that will work if
6 the conclusion is that the system's pretty good and, more
7 or less, what it needs is a bit of tinkering.

8
9 But if you think there are some more fundamental
10 issues, like we're doing too much - we've incentivised
11 hospital care at the expense of community, which I think is
12 a really big structural fundamental problem, and even
13 within hospitals, we still have concepts about a principal
14 diagnosis that puts you into a specific DRG based on your
15 principal diagnosis - the future and the biggest challenge
16 for the New South Wales health system is chronic and
17 complex health care for people who are living longer and
18 don't have a principal diagnosis but have multiple things
19 wrong with them, which, in combination, are driving their
20 need for care.

21
22 Q. Just trying to come back, though, to the problem with
23 using ABF, or the ABF model as a mechanism for funding, to
24 take another one of our favourite examples of the
25 paediatric intervention for a child who is about to start
26 school. Let it be assumed, as I think we've been told,
27 there's ample evidence out there to support the proposition
28 that an early intervention for a child with a learning
29 issue before they start school is going to produce better
30 clinical outcomes and better life outcomes than waiting
31 until they're in year 3 or 4.

32
33 So you've got a screening service which might operate,
34 the Brighter Beginnings service, that identifies need
35 within your population. The local health district is
36 probably best placed to assess that information and
37 identify the services that are required to deliver the
38 early interventions that it provokes. I gather you would
39 agree with that?

40 A. Yep.

41
42 Q. You could have a KPI - and I'm not suggesting we add
43 500 KPIs - but if it's important you could have a KPI that
44 actually identifies the amount of, number of assessments
45 which are done to determine that need, and you could have
46 a KPI which relates to the period of time that a child who
47 has been assessed as having a need waits to receive that

1 intervention.

2 A. Yes.

3

4 Q. That would at least put you on the trajectory towards
5 some form of allocative efficiency?

6 A. Activity - I mean, I was one of the first that led the
7 introduction of ABF in Australia, and to some degree,
8 I would have to say that I think activity based funding has
9 both achieved its goal and had its day.

10

11 ABF is designed to drive technical efficiency, how
12 cheaply you can produce something, rather than allocative
13 efficiency, which is whether it's worth achieving at all.
14 I do want to distinguish between allocative efficiency and
15 need, because they are not the same, and I think sometimes
16 you've heard evidence which has confused those two terms.

17

18 Most of the future gains in the health system - and
19 the New South Wales health system is technically efficient
20 by national and international, and there is not much more
21 blood in the stone to get out.

22

23 Q. To the contrary, you tell us in your submission that
24 the existing level of efficiency is, in your view, not
25 sustainable?

26 A. Yes. The current level is not sustainable, both
27 because of climate change and the amount of dirty emissions
28 that the health system produces, and also because wages
29 will need to be kept at parity with other states and
30 territories, otherwise we won't have a workforce.

31

32 So technical efficiency has been achieved. The big
33 gains of the future are not trying, against the tide, to
34 get more technical efficiency, but trying to improve the
35 allocative efficiency of the health system. So you're
36 right, you can go through this whole convoluted ABF process
37 to something that might give you a better allocative
38 outcome in the longer term, or you can redesign that
39 funding model to specifically aim to incentivise allocative
40 efficiency and then still report on technical - you've
41 still got to produce; you know, you have still got to have
42 surgery and medical admissions and all that sort of stuff,
43 but moving the focus and the KPIs and the activity targets
44 on to measures of allocative efficiency and not just
45 technical.

46

47 Q. But let me just keep exploring that example we gave

1 a bit earlier. You have your paediatric intervention
2 service?

3 A. Yes.

4

5 Q. Sorry, paediatric screening service. You identify the
6 need within the population. You identify the service that
7 you require to stand up in order to meet that need?

8 A. Yes.

9

10 Q. And when we talk about "need" there, we're not talking
11 about the worried well wanting to have an assessment; this
12 is a properly nuanced assessment made at the local health
13 district level about what actually needs to be done to
14 produce beneficial outcomes for a group of children within
15 the population. You have a KPI that measures the time it
16 takes for that intervention to be provided to the child,
17 which is, itself, informed by an evidence base as to what
18 a reasonable period of time to wait for whatever the
19 service might be, paediatric intervention of some
20 description?

21 A. Yep.

22

23 Q. You then have both the screening process and the
24 paediatric intervention recognised as activity, such that,
25 if a local health district chooses to deploy its activity
26 in that way, then it's as free to deliver that service as
27 it is to deliver a knee replacement procedure to
28 a 65-year-old?

29 A. Yes.

30

31 Q. It has to make the choice as to where it wants to
32 deploy that little piece of activity. What about that
33 deprives it of allocative efficiency?

34 A. There's no doubt you can improve allocative efficiency
35 by early identification and intervention, which is what
36 you're talking about. So if you think about the care
37 continuum, it starts off at primary prevention and then you
38 get to early identification and intervention and acute care
39 and continuing care, et cetera.

40

41 In this particular example, the other issue that that
42 raises, though, is the interface with the Commonwealth in
43 terms of the National Disability Insurance Scheme, because
44 one of the things that happened in New South Wales was that
45 there was a significant reduction of investment in
46 disability, that is, the money that was previously -
47 New South Wales previously had, early intervention programs

1 everywhere for children, all kids were screened, we had
2 early intervention programs, with the introduction of the
3 NDIS, all of that money was identified and transferred to
4 the Commonwealth as part of New South Wales's contribution
5 to the NDIS.
6

7 Q. So that, I think, consistent with what you have told
8 us earlier, is a matter for the ministry to liaise with the
9 Commonwealth about the funding stream and where the money
10 comes from and who gets it?

11 A. Absolutely. I mean, we've got an opportunity now,
12 with the new arrangements being negotiated, for early
13 identification and intervention to become a state
14 responsibility again, because it's demonstrably - the NDIS
15 has demonstrably not done well with that sort of program.
16 So that money will be returning and New South Wales is
17 going to have to rebuild the services it lost with the
18 establishment of the NDIS.
19

20 Q. But even under the existing arguments, an assessment
21 might be made within a local area of the extent to which
22 those early interventions are capable of being met by, for
23 example, the NDIS and private providers that might be
24 available in your community.

25 A. Yes.
26

27 Q. And if those providers are adequately meeting that
28 need, or to the extent that they are meeting that need,
29 that's not something that the public health system in
30 New South Wales needs to deliver. Would that be right?

31 A. Yes.
32

33 Q. Obviously, we need to keep a close eye on it because
34 these are dynamic processes. Would you agree?

35 A. Absolutely. We need models that screen newborns in
36 hospital. We have really strong evidence on the value of
37 infant home visiting. We need screening - milestone
38 screening. We need to identify those children who start
39 lagging. We need a therapeutic assessment of what's wrong
40 and we need active intervention of every single child. No
41 doubt if we did that, outcomes for those children,
42 lifelong, would be improved, and we have to think about:
43 why is it we used to provide those services and we stopped
44 doing it? One of the reasons is because of the
45 introduction of the NDIS, but the other is that we actually
46 changed the funding model to follow the national activity
47 based funding model, and when the choice you've got is,

1 "Use this \$10 you've got to deliver a unit of activity that
2 you've got an activity target for and a KPI for, or spend
3 this \$10 on an early intervention program for children that
4 we don't count, we don't value and isn't in your
5 performance statement", then human nature being what it is,
6 we incentivise the places, and what we measure matters.

7
8 Q. So coming back to the ways in which that problem might
9 be solved within the existing model, I think we've covered
10 this, but if your activity recognised that early
11 intervention is something which was capable of being sold
12 by a local health district to the ministry, whether or not
13 the ministry was able to persuade the Commonwealth to fund
14 it through the ABF model - that's a matter for the
15 ministry, not the local health district --

16 A. Yes.

17
18 Q. -- and there was a KPI introduced into the service
19 level agreement because it was, as part of a planning
20 process, perceived to be appropriate to measure the time it
21 took for that intervention to be delivered, which, of
22 course, would factor in things like the extent to which
23 that service is capable of being delivered by the NDIS
24 externally to the local health district - that would, on
25 one view, produce a system which is capable of achieving
26 both technical efficiency and allocative efficiency under
27 the existing model, wouldn't it? When I say, "the existing
28 model", I mean an ABF model as opposed to some other
29 population based funding model.

30 A. There is no doubt we can make some technical changes
31 to the ABF model that improves it. The first of those, as
32 I said, was a different set of definitions of how to count
33 activity, and that means moving away from being sold on the
34 pricing model that the authority uses to a different set of
35 activity, and the things I've just said: each of those, in
36 my view, will give you some marginal level of improvement
37 in the system.

38
39 But if all you're doing is adding those in to a system
40 that's otherwise unchanged, you will get some improvement
41 but you're not going to get any significant improvement in
42 allocative efficiency, because if you put a million dollars
43 in it out of a budget of a billion dollars, then you'll get
44 a million dollars' worth. What we don't have is the
45 systems in place and the incentives in place for districts
46 to be saying, "Which of these two investment choices gives
47 me the best bang for the buck", and the reason for that --

1
2 Q. That's what I was wanting to come to: how do we build
3 those incentives in and what is it about an alternative
4 funding model that introduces those incentives? Perhaps if
5 I could ask you to answer that question by reference to
6 a choice that might be made between deploying money to
7 provide that knee replacement for the 65-year-old or the
8 legion of 65-year-olds who need their knees replaced on the
9 one hand or providing the early intervention in the
10 paediatric space. How does a different funding model
11 change the incentive structure there?

12 A. My observation of the New South Wales health system
13 now is that districts are not responsible for the health of
14 their population or for improving that health of the
15 population. They are responsible for delivering on the
16 KPIs in an activity; you know, if you produce enough
17 widgets of activity, you've done your job. We're not
18 actually saying to them, "Where is your epidemiological
19 profile of your district? Tell us what your priorities are
20 and how you set those. Tell us how you engaged with
21 communities."

22
23 Unless we make those structural changes - you're
24 absolutely right, we can get a bit of improvement, but
25 whether that's enough, I would contend, in terms of the
26 population profile of the next decade to two, that won't be
27 enough alone.

28
29 Q. But isn't the change that's potentially needed to be
30 made to bring that about, first, a proper planning process
31 that actually clearly identifies need, identifies the
32 extent to which population has been engaged in the process
33 of deciding how to meet that need or what of that need will
34 be met within the public health system as part of the
35 allocation of resources within a limited budgetary
36 envelope; and then a discussion system-wide as to how,
37 across all of the health districts, the needs of all of
38 these populations might most efficiently be met to make the
39 best use of the money?

40
41 So that's that planning piece which, if it's done
42 properly, has the capacity to identify and have local
43 health districts properly engaged in the task of meeting
44 the health needs of their population rather than just doing
45 the same thing. That's step one.

46 A. I think --
47

1 Q. Let me go through two more steps and then I'll invite
2 you to comment, but would you agree that that first step is
3 potentially an important one?

4 A. Yes, but my proviso on that is to be clear about who's
5 responsible for meeting needs: is it the ministry who's
6 going to be held to account or is it the district?

7
8 Q. Well, let me explore that, then. As to the "held to
9 account", the holding to account occurs at the moment
10 through key performance indicators?

11 A. Yes.

12
13 Q. And if the key performance indicators, instead of
14 being just a vanilla set that gets rolled out to everyone
15 actually were more closely aligned to holding health
16 districts to the outcomes that they are hoping to achieve
17 through the services which are to be delivered as part of
18 a more structured service delivery plan, that would have
19 the districts being held to account, to the extent that the
20 budgetary envelope available enables them to do it, would
21 it not?

22 A. Yes, I think that's right. I mean, I would draw your
23 attention in my submission to the extract I included from
24 the World Health Organization on this topic, because WHO
25 I think makes a very important point.

26
27 Q. That's page 13, I think.

28 A. Page 13 - that you cannot address allocative
29 efficiency alone by just the funding model. It's all of
30 the elements of the submission, and they cite who - you
31 know, the elements they cite are human resource planning,
32 health facility planning, capital planning, case payment
33 and global budgeting - that is, what the WHO calls global
34 budgeting is population needs based funding, and I do
35 think - there's no doubt you can achieve a few, you know,
36 if you think the system is just a bit cracked and not
37 broken, then you can improve it in the ways you have been
38 describing. I think there is a judgment call about whether
39 that is sufficient.

40
41 Q. Well, the population needs based funding, there are
42 a range of ways that that can be achieved. One is by
43 making assumptions about what the population needs will be
44 across the board based on demographic information and
45 identifying a share of the budgetary envelope that's to be
46 delivered to that slice of the population based on that
47 sort of assessment?

1 A. Yes, it is. I think the element that is missing now
2 is the sort of substitution element that was in the RDF -
3 well, there are many elements but the big one is: to what
4 degree does Northern Sydney and the Eastern Suburbs of
5 Sydney, who have the highest rates of private health
6 insurance in this state, have less need for public care
7 than Far West New South Wales and South West Sydney,
8 because of the availability of private hospitals, GPs,
9 medical specialists and all the other things?

10
11 Those sorts of more nuanced and sophisticated measures
12 would have to go into the model. They're not there now.
13 I had a PhD student, a doctoral student, who did his
14 doctorate on this very topic of how you incorporate access
15 to Commonwealth funding into a needs based funding model,
16 and that's - you know, we know how to do it now. We didn't
17 know how to do it 20 years ago, we couldn't get the data,
18 but we do now. But we have to move on into those more
19 sophisticated approaches.

20
21 Q. But one way of doing that is through more
22 sophisticated service planning that identifies, by
23 reference to all of those factors, what services are
24 required to be delivered as part of the public health
25 system within a particular local health district?

26 A. Yep.

27
28 Q. And there may be ways of running a ruler over that by
29 reference to demographic assessments that can be made based
30 on population data to work out whether the total amount of
31 money which is being delivered is broadly fair and
32 equitable, but that doesn't necessarily need to be the
33 driver of the funding decision, as opposed to the services
34 which are being delivered being the driver of the funding
35 decision, does it not?

36 A. NSW Health has some quite good, quite sophisticated
37 expertise in planning, and it's not all in the ministry and
38 a lot of very good planning is done at the district level.
39 But that needs to be linked to governance: what things is
40 the district responsible for?

41
42 Go back to the example, at Central Coast, you gave of
43 neurosurgery: is it okay for the district plan to say,
44 "Well, we're not going to do neurosurgery, we're confident
45 someone else will do it", or is their job to say,
46 "Actually, this is the type of neurosurgery we think we can
47 be a purchaser of from Northern Sydney and give people

1 a better outcome and this is how we're going to do it."
2 Those things haven't been clarified. There's just an
3 automatic assumption that someone else is doing it.
4

5 Q. But why would the system work better - if decisions
6 like that, for example, will neurosurgery be delivered
7 through a Central Coast or some combination of Northern
8 Sydney and Newcastle, why is the system better if decisions
9 like that are informed by potentially ad hoc arrangements
10 between the different health districts about the purchasing
11 of activity, as opposed to a more central oversight of the
12 system and central involvement, whilst not dictating the
13 way the system is delivered, more structured central
14 involvement in deciding about where certain services are
15 going to be delivered and funding on that basis?

16 A. The centre needs to be the major driver and determiner
17 at that quaternary level.
18

19 Q. Why not at the neurosurgery level?

20 A. Because there's no practical way they're going to do
21 it. If you look at where we have big flows in really
22 low-level things, cataract surgery, hips and knees - I also
23 think we need to move away from thinking about surgery. If
24 you look now at admissions in New South Wales, only
25 15 per cent of public hospital admissions now are surgery.
26 The big challenges for the future are not designing
27 a perfect funding model for surgery; surgery is becoming,
28 and will become, even less and less. It's how do we
29 deliver medical services to people with chronic and complex
30 health care?
31

32 Q. Doesn't that reinforce the proposition, though, that
33 we should be - we shouldn't be assuming that all of these
34 different types of surgery will necessarily be delivered in
35 every local health district if a more efficient and
36 effective way of safely delivering that care is a hub and
37 spoke model where you might certainly not have all of it
38 delivered through the metro, but you might have - Dubbo
39 hospital, for example, might be a place where people go to
40 get neurosurgery, for example, but it might not be offered
41 in other --

42 A. Look, we've got a lot of good examples of where that
43 has already been - that is already what happens through the
44 Agency for Clinical Innovation, through the ministry,
45 through collaboration across districts.
46

47 Q. But does it? You say that, but does it actually get

1 done?

2 A. Well, I would argue, if I use something like cancer,
3 you know, one of the things that New South Wales has done,
4 go back to allocative efficiency, which is really world
5 leading, is in introducing multidisciplinary case
6 conferencing for cancer patients. If you come up and
7 you've got a rare cancer, there will be a case conference
8 and you will more or less get the same package of care if
9 you are on the North Coast or Far West New South Wales or
10 the Eastern Suburbs.

11
12 That has been a collaboration, not that the ministry's
13 dictating or, in fact, Cancer Institute - you know, the
14 health system has enormous power in the legs, you know,
15 it's like an octopus and the power's in the legs and those
16 legs are our clinical experts, they're the ones who drive
17 this, not a bunch of people sitting in Artarmon.

18
19 Q. But what about more run-of-the-mill procedures, like
20 the neurosurgery example that we've given: is the ACI
21 playing any role or is the ministry playing any role that
22 you are aware of in making decisions around, "Well, where
23 should we be delivering neurosurgery so that it's available
24 to everyone who needs it but perhaps not on their
25 doorstep", but adequately --

26 A. I hope they are - I hope they are planning the
27 high-level tertiary and quaternary care, I presume they are
28 but I'm not on top of the detail.

29
30 Q. You mentioned earlier joint replacements, cataract
31 surgery, those sorts of things, what role does the centre
32 have in making decisions around how and where they are
33 delivered, for example, do you think?

34 A. Yes, I will answer the question but come to say let's
35 not get too obsessed about surgery because it's actually
36 a minor part of the health system, it's only 15 per cent
37 and it's going to go down.

38
39 Q. That's why I'm asking about it because at one level,
40 coming back to something I said a moment ago, doesn't that
41 lead one to the conclusion that there should be a greater
42 role played by the centre in determining where this
43 reducing pool of work is delivered so as to make sure it's
44 delivered to everyone who needs it --

45 A. Yep.

46
47 Q. -- but most safely and efficiently, and potentially

1 not in their backyards?

2 A. Yes, activity based funding works demonstrably better
3 for surgery and procedural care, and there's a case that if
4 you had a really sophisticated model, you would limit some
5 of the activity based approaches to the things that ABF is
6 good at.

7

8 What it is not good at is fairly classifying,
9 quantifying, et cetera, people with chronic and complex
10 care and incentivising the delivery of that care in a
11 non-hospital setting. ABF incentivises people to be
12 admitted to hospital. It puts the focus - sorry,
13 I shouldn't say it "incentivises"; it puts the focus back
14 on hospitals, which is exactly the wrong incentive we want
15 to have in the system.

16

17 New South Wales has demonstrably run down community
18 health, chronic disease programs in the community,
19 prevention and early intervention, and that is the
20 inevitable, you know, outcome of an activity based funding
21 system.

22

23 There is no doubt that we need central - and it makes
24 absolutely no sense at all that every district is
25 self-sufficient in heart transplants and this and that and
26 the other thing, but that's why New South Wales has got
27 a very good guide to role delineation and every hospital
28 has a delineated role, and there should be very clear
29 statements about what should each district be
30 self-sufficient in, which is at least 90 per cent, and what
31 are the things where we think it's okay to have
32 cross-border flow for reasons of cost, quality or safety/?

33

34 Q. That won't be uniform, though, will it, across the
35 districts?

36

A. No.

37

38 Q. What, say, Dar Western New South Wales should be self
39 sufficient in might be quite different to what Southern New
40 South Wales should be --

41

A. Absolutely, and that needs to be part of their service
42 agreement, and that then --

43

44 Q. But for that to work, though, don't you need an
45 overarching approach to planning which actually identifies,
46 informed by and perhaps driven by the local health
47 districts, understanding of its --

1 A. I don't think we're disagreeing. I think we're saying
2 the same thing. New South Wales has always had central
3 planning. That's not the issue. New South Wales is
4 actually quite good at central planning and it's been that
5 way. We've always had a ministry, historically, the
6 department's always had a statewide services planning
7 branch and it did statewide services planning.

8
9 Q. Well, when you say "statewide services", we're talking
10 about heart transplants, intensive care and burns -
11 I can't, off the top of my head, remember what the other
12 statewide services are, but that planning, at least insofar
13 as the evidence gathered to date reveals, doesn't seem to
14 extend to that more nuanced service planning across all
15 other areas of the health districts' operations?

16 A. I think you've got to trade - if you go back to
17 different levels of service for different types, go back to
18 the principle of close to home. For a patient who needs
19 cataract surgery, having it as close to home as possible is
20 a really important factor, and it's the most efficient way
21 to do it, one of the most.

22
23 The only reasons we ever keep cataract surgery
24 patients overnight now is they live a really long way away.
25 We want most services for patients to be accessible and
26 close to home. We also recognise that - because we can't
27 staff them, because of safety, quality, staffing cost,
28 a whole range of services can't be - having some very
29 explicit planning about what each area should - district
30 should be able to be self sufficient in and the things
31 where the community should have an expectation of having to
32 travel.

33
34 Go back to your previous example of early intervention
35 for children, we want that to be as close to home as
36 possible. We don't want to say, "Let's set up services at
37 the two children's hospitals and all children in New South
38 Wales will travel to the two children's hospitals for early
39 intervention programs." So there has to be a reason to not
40 have it locally, and those reasons are threefold: one is
41 cost because the volumes are not there and the unit cost is
42 too expensive; the second is safety, unless you do
43 a certain amount of cardiac procedures a year, the
44 mortality rate is substantially higher, and that's linked
45 to quality; and the third is workforce, we cannot get the
46 workforce - resourcing - we cannot get the workforce or the
47 operating theatre requirements, or whatever. But there's

1 a set of pretty straightforward planning principles that
2 can be applied.

3
4 Q. Is there also a fourth, though, which is
5 prioritisation, in the sense that - let's come back to
6 those two examples we gave, you might have an early
7 intervention paediatric service which you would like to run
8 and you feel that you could get the workforce to run and
9 you feel it would produce good outcomes for your
10 community --

11 A. Yes.

12
13 Q. -- but you can't afford to do that and do it properly
14 and also provide a cataract service - that might not be
15 a fair trade-off but let's throw that into the mix. But
16 the adjacent local health district has a good cataract
17 service and it's providing it adequately and has a solid
18 workforce base and an ability to actually operate as a good
19 hub for cataract care. You could provide access to that
20 service if there was an adequate patient transport service
21 which drove your patients to the day surgery to have their
22 cataracts done and back home?

23 A. Yep.

24
25 Q. And you have to make a decision within your existing
26 funding envelope: do we try to provide both and do so
27 inadequately possibly on both fronts, or do we do one of
28 them and make a compromise? The compromise might be people
29 requiring cataract services have to go outside their local
30 area to get it done. Is that prioritisation not also a
31 fourth and important component of the planning process?

32 A. If I was asked to prioritise two things, one I have to
33 pay for and one I don't, I'm going to go for the one I
34 don't have - you know, that the priority's going to be - if
35 I can send my cataracts across the border and somebody else
36 pays, why wouldn't I choose that option? But I don't think
37 that's actually helpful from a population health
38 perspective. The question isn't: do you want to take the
39 one that's free or the one that costs you? The question
40 is: what's the best way of providing cataract surgery at
41 a system level to achieve the best patient outcome?

42
43 Q. What if the budgetary envelope that you've got, even
44 with the best funding system in the world, doesn't actually
45 enable you to provide all of those things because the
46 reality is there's not enough money in the New South Wales
47 budget to meet everyone's health needs completely? How do

1 we deal with that prioritisation piece.

2

3 THE COMMISSIONER: There may not be enough money to meet
4 everyone's health needs.

5

6 Q. This might be an impossibly general question and
7 possibly stupid, but I'll ask it anyway. You have talked
8 about in your evidence - I think because of the ABF
9 incentives, one of the things you said is New South Wales
10 has demonstrably run down community health and chronic
11 disease programs in the community. We've talked about the
12 KPIs and the service agreements, but there is an overriding
13 statutory obligation under the Health Services Act which is
14 that local health districts have got to promote, protect
15 and maintain the health of the residents in their area.

16

17 Now, precisely what that means is probably difficult
18 to define, but it's going to change over time, depending on
19 what the health needs are, and probably since not long
20 after the Second World War, we've had the shift from acute
21 illnesses killing people to chronic diseases being the big
22 problem and the big cause of healthcare costs.

23

24 If we have a funding model or models that really, in a
25 way, overly incentivise acute services, if that's at the
26 expense of services dealing with interventions,
27 preventions, addressing chronic disease, then we're running
28 the risk of potentially not fulfilling even the statutory
29 obligations, let alone what we should be doing. Is that
30 one of the problems?

31 A. That is absolutely correct. I mean, I think I would
32 add a couple of historic exercises.

33

34 Q. Yes, go ahead.

35 A. One of the things we've seen that we need to bring
36 into this conversation is what's the role of the
37 Commonwealth and what's the role of the state? Because if
38 I look at the areas, you know, as an outsider, engaged in
39 the system, there are four - the things that New South
40 Wales is solely responsible for in the main are pretty in
41 control.

42

43 There are four areas where, in my view, the system is
44 really stressed, and they are all areas that the
45 Commonwealth - where the Commonwealth interface issues are
46 absolutely fundamental. One is aged care, and that wasn't
47 an issue until the last few years, and New South Wales has

1 an attitude which is quite different to the other states on
2 aged care. The other states are saying, "Well, every
3 single failure in the aged care system ends up in our beds.
4 We might as well actually become a provider of Commonwealth
5 funded aged care beds." New South Wales has taken the view
6 of saying, "This is a Commonwealth problem, we'll keep
7 negotiating with them and telling them that they need to do
8 a better job."
9

10 MR MUSTON: Q. In fairness to New South Wales the MPS
11 services that it offers around the state probably do
12 provide a state based aged care service.

13 A. Absolutely, but I remember asking years ago whether we
14 could expand the MPS model to metropolitan Sydney and the
15 Illawarra, and at that stage it was, "No, MPSs are only
16 rural, we're not interested in expanding them and if we can
17 run them down and reduce the number we will", and
18 I actually think MPSs are absolutely fundamental to our
19 future.
20

21 So the four are aged care, NDIS - and we've got
22 a strategic opportunity with the Commonwealth transferring
23 early intervention back to the state to do the sorts of
24 things that were really good quality early intervention
25 work. I remember, going back, every district had three or
26 four developmental paediatricians. Their job was to
27 actually focus on measuring development of children and
28 organising intervention programs. We haven't had
29 a developmental paediatrician - people doing that work for
30 decades.
31

32 The third area is primary care. We've got massive
33 gaps in primary care and there's no reason that New South
34 Wales couldn't follow the Aboriginal controlled medical
35 services and start employing salaried doctors and
36 click-clacking to the Commonwealth for that.
37

38 The last is specialist medical care in the community.
39 What we've got at the moment is a whole lot of medical
40 specialists charging enormous co-payments, which make
41 access to medical specialist care in the community
42 unaffordable for the people with the biggest health risks,
43 and there is no reason, and I think you should be
44 recommending that we pull medical outpatients out of the
45 ABF model and start to say, "Whatever we provide in medical
46 outpatients in hospitals, we can bill the MBS", and
47 actually have services in hospitals, paid, whether they're

1 salaried doctors, VMOs, doesn't matter, but saying to
2 a hospital, "If you want to set up a service with
3 dermatologists and immunologists and respiratory physicians
4 and the people who manage chronic disease, whatever you set
5 up, we'll bill it to the MBS", that would be
6 a game-changer, because unless we take on and address,
7 those are the four biggest areas of stress in the health
8 system at the moment, and that all involves
9 Commonwealth-state. So in terms of what the state --

10
11 THE COMMISSIONER: Q. There is an element of "who blinks
12 first" in this?

13 A. Absolutely.

14
15 Q. About whether you say to the Commonwealth, "Give us
16 this money and we'll do this", and the Commonwealth is
17 unlikely, perhaps, to just willingly hand over buckets of
18 money, or whether you start the services and say, "This is
19 your responsibility, we're providing the service, please
20 hand over some money".

21 A. We do have - I mean if I just go through the --

22
23 Q. Is that right, though?

24 A. Absolutely. I will just go through each of them. In
25 terms of aged care, we have an opportunity next year,
26 because the Commonwealth has announced the cessation of the
27 aged care approval round. At the moment, if you want to
28 open up a new nursing home, you put in your bid and you
29 might be approved for 60 beds or whatever, that's being
30 abolished from next year and New South Wales can open up
31 whatever aged care services it wants to become a provider
32 of Commonwealth funded aged care.

33
34 In terms of NDIS, we've just talked about, but if
35 I think about allocative inefficiency, the two single most
36 inefficient things we do at the moment are have hundreds
37 and hundreds of hospital beds in this state occupied by
38 people who have been approved for aged care and who should
39 be in NDS accommodation. That's the biggest example. It's
40 not surgery, it is not whether we do this bit of surgery or
41 that bit, I'm talking about thousands of beds, probably.

42
43 The third: primary care is patchy. Some districts
44 have got enough, some don't. But instead of just saying
45 "Gee, Far West has got a problem", we should be like the
46 Northern Territory. Northern Territory has been delivering
47 salaried primary care forever, and there's no reason we

1 couldn't have that model much more extensively than we've
2 got it.

3
4 The last, for me, is really, really important, and
5 this is the one that does require a change in
6 Commonwealth-state: the Commonwealth would have to agree
7 to a proposal that New South Wales would lead, which is you
8 pull outpatients out of the ABF agreement and you fund it
9 through the Commonwealth Medicare Benefits Schedule
10 instead. And that way, you start to put some competitive
11 pressure on private doctors in their own rooms.

12
13 In my region, it's not unusual for a medical
14 specialist to charge \$300 in out-of-pocket fees for
15 a patient for a 15-minute consultation, where the patient
16 is on a disability pension, and that's because there is no
17 competition. But if that same service was provided by the
18 hospital, you would also change the incentives and the
19 behaviour of medical specialists in private practice.

20
21 Unless we actually make better use of medical
22 specialists in the community, out of hospital, we will
23 incentivise and leave no choice but for patients to be
24 admitted to hospital, because it's the only place they can
25 get affordable specialist medical care.

26
27 MR MUSTON: Q. The alternative to that is, I assume, you
28 are referring to public outpatient clinics which, however
29 they might be funded as between the state and the
30 Commonwealth, your view is that the ministry should be
31 funding local health districts, through whatever funding
32 model we might have, to deliver, as part of the suite of
33 public services, those public clinics?

34 A. I think it is a strategic planning issue. It is not
35 a funding issue. At the moment you've got an outpatient
36 clinic, and if the patient is privately referred, the named
37 doctor can bill MBS as though they are in their rooms, and
38 the doctor pays a facility fee to the hospital; and if it
39 is not privately referred, if I just book into a clinic,
40 then NSW Health pays the cost.

41
42 Not surprisingly, districts and hospitals are
43 incentivised to channel more and more referrals to be
44 privately referred, but that creates enormous inequities
45 and inefficiencies.

46
47 If you actually just said, "Any patient who presents

1 to a clinic", and it doesn't have to be - I mean, the
2 change at the Commonwealth level is that it doesn't have to
3 be to a named doctor, but if I get referred to obstetric
4 clinics, where we're also using it to train our junior
5 doctors and our midwives, et cetera, at the moment, there's
6 hardly - you know, more clinics - the quickest way for
7 a health service to solve its budget problem is to close
8 a few more outpatient clinics, and that's actually
9 allocatively really inefficient, if closing outpatient
10 clinics reduces access to care for people for early
11 identification and intervention or for chronic disease
12 management, and unless we actually incentivise setting up
13 outpatients and not paying for it out of your fixed
14 activity budget, we will always skew the system towards
15 more and more hospital based care.

16
17 Q. You indicated a bit earlier, and I think the
18 Commissioner took this up with you, that New South Wales
19 has, I think you said, run down the community based and
20 chronic disease type care. Is it that the NSW Health
21 ministry has run down a service that was once offered as
22 part of the state funded public health service, or is it
23 that that type of care, that community care, primary care,
24 specialist care, was traditionally provided by
25 a Commonwealth funded market and that market has, through
26 market forces, operated in a way which has led to the
27 diminution in the quality of the care or the availability
28 of the care in those areas, or some combination of the
29 two??

30 A. The truth is somewhere in between all those. If
31 I give a bit of history again, when community health was
32 set up in this state, and all the other states, it was
33 during the Whitlam era and it was all, in the case of
34 New South Wales, 100 per cent Commonwealth funded and
35 Whitlam said to the State of New South Wales, "You employ
36 as many people as you want and we will pay the bill." And
37 that was the halcyon days of community health. NSW dealt
38 with that by putting them on through the public service
39 because it was the quickest way to do it, and Victoria
40 responded by putting ads in the local paper and inviting
41 management committees to set up community controlled
42 community health centres, et cetera.

43
44 It then moved to a fifty-fifty cost sharing
45 arrangement - that is, it was exactly the same arrangement
46 for hospitals as it was for community health - and the
47 game-changer was the health reform agreement, because one

1 of the things that New South Wales traded off was that the
2 Commonwealth withdrew funding completely for community
3 health.
4

5 So if you were a community nurse - if you were
6 a paediatric nurse, if you were at the hospital, you could
7 be counted - your costs and activity could be counted for
8 ABF purposes, but if you were at a community health centre,
9 the state was 100 per cent responsible.

10
11 It is not surprising that the state has run down the
12 very services that it needs to take if into the future, and
13 that is, a strong and vibrant community health service
14 which does not just do prevention but also does early
15 identification and intervention and chronic and complex
16 care management, including palliative care at home, and one
17 of the major missing elements is community rehabilitation.
18

19 Q. Just picking up on the paediatric example, and this
20 may be wrong, but is the disappearance of the baby health
21 clinic that used to be an ubiquitous feature of most sort
22 of suburbs and towns - is that a symptom of that change?

23 A. Yes, absolutely. I mean, if I go right back and talk
24 about - one of my early jobs was in Fairfield community
25 health centre, and in the City of Fairfield, we had baby
26 health centres, but we also had in every public school,
27 literally every public school, a community nursing clinic,
28 and that nurse was responsible for the health of the people
29 who lived in the catchment area of the school. She used to
30 weigh the babies and she would do the school screening of
31 the kids to make sure that their, you know, hearing and
32 vision and height and all that stuff was okay, and if some
33 old person was really socially isolated, she would organise
34 some sort of support group for them, and she would run the
35 new mums' group and she would do the community nursing, the
36 home nursing, for anyone who needed care, and that included
37 a home visit to every new mother who had a baby to see what
38 they needed. That was routine, and I was assistant
39 regional director western metropolitan, in one of my
40 previous lives, responsible for that program, and we had,
41 in the 1980s over 2000 people who did that work. And all
42 the GPs knew, if the GPs were worried about a child at risk
43 or a frail older person at risk, they would ring the
44 community health centre and the community nurse was the
45 first line of call, working in partnership with the GP. It
46 was a fabulous program and it had all the things that
47 people are now writing you submissions about, that have

1 been lost.

2

3 Q. Can I come back to your submission, back to page 2.
4 Do you see, three paragraphs from the bottom, there is
5 a paragraph commencing, "When the system is decentralised,
6 the opposite occurs."

7 A. Mmm-hmm.

8

9 Q. I just want to ask you about the last sentence that
10 you have written there:

11

12 *There is no point maintaining Local Health*
13 *District boards if they do not have the*
14 *authority to make meaningful decisions.*

15

16 A. Yes.

17

18 Q. What do you mean by "meaningful decisions" when you
19 use it in that context?

20 A. The "meaningful decisions", for me, is that the
21 district has the power to make investment and disinvestment
22 decisions. I mean, we haven't been talking about
23 "disinvestment", we've only been talking about
24 "investment", but actually, there is a need to do both, and
25 for me - and I did have 10 years on the board - I saw the
26 role of the board as being the governance organisation, the
27 group that oversaw the development of a needs assessment
28 for our district, that kept it updated, that did service
29 planning and all sorts of service planning, and that set
30 priorities for investment across the care continuum, and
31 between our hospitals.

32

33 Q. So is that something that the current structure
34 facilitates or is there a problem with the current
35 structure that it prevents that system from working in the
36 way that it should?

37 A. At the moment, I think that there has been - and it
38 was when I was on the board, it started to develop - a real
39 lack of clarity about what the district is responsible for
40 and what the ministry is responsible for. Districts now
41 need to go to the ministry, cap in hand, and ask for money
42 for a range of new things, "Please increase our activity
43 target because we now want to set up a clinic for early
44 learning kids", rather than the ability to move money
45 between the ABF component, et cetera. When you talk to the
46 ministry, they say, "Oh, yes, well, we are responsible for
47 that, but when people from the districts come to ask us -

1 they have to ask for permission, and we also say 'yes'",
2 but I think that misses the point about who is accountable
3 for making sure that each district has got the right
4 balance of investment and who is accountable for those
5 decisions.
6

7 Q. But again, is it coming back to one of what seem to be
8 the core propositions: is part of the challenge with that
9 the divvying up between Commonwealth recognised activity
10 and non-Commonwealth recognised activity, as it were, such
11 that in order to get your community based clinic, even if
12 it were recognised as a species of activity that you could
13 sell to the ministry, you might still have to satisfy the
14 ministry that shifting some Commonwealth funded activity
15 into some non-Commonwealth funded activity was an
16 appropriate thing to do?

17 A. Yes, I will give you a practical example when I was on
18 the board of the Illawarra Shoalhaven - and I don't want to
19 talk too much about that because I have worked in lots of
20 other places - we wanted to change the role of one of our
21 hospitals and turn it into an MPS, a multi-purpose service,
22 and the ministry said, "No, that's not our policy, you
23 can't do it."
24

25 Q. Was it Milton or Berry?

26 A. Sorry.
27

28 Q. Was it Milton or Berry?

29 A. Berry. But also Coledale. But they were things up
30 for discussion. We didn't even have the option, we did not
31 have the authority, to do a plan for an MPS, because that's
32 a ministry decision and the ministry's view was that it was
33 trying to get itself out of, devolve itself of,
34 responsibility for anything that the Commonwealth was
35 financially responsible for, and that was a really poor -
36 I mean, it is a good example where the district was - you
37 know, Murrumbidgee has the same issue, lots and lots of
38 little hospitals. The districts, the boards, should
39 actually be able to make those sorts of decisions, meaning,
40 you know - recognising, of course, that there is
41 a political level, there is a political issue to be dealt
42 with when you want to change the role of a hospital, but
43 also who is accountable to the community for that? We
44 should have, in my view, been able to change the role of
45 one of those hospitals and account to the community for it,
46 rather than say, "Oh, it was some nameless person in
47 Artarmon who did it."

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. In terms of this, the concept of who is to be held accountable for delivering allocative efficiency, in a practical sense, how do you actually - let it be assumed that it's the LHD that is going to be accountable for allocative efficiency: how do you hold them to account for it?

A. One of the things I would do is change - I would abandon all the activity targets and I would change all the KPIs and I would put four big headings, really, and that's to ask, each year, districts to report on four things: one is what strategies they have in place to protect, promote, maintain the health of the population; the second is what strategies are they pursuing to improve the balance of investment across the care continuum; the third is what strategies are they pursuing to improve outcomes for priority populations and the most disadvantaged people; the fourth is what strategies they have in place to attract and make better use of the workforce; and the fifth is what strategies they have in place to make better use of new and emerging technologies.

Q. Coming back to the second of those five --

A. The second one - about the balance of investment across the care continuum?

Q. Yes. What do you have in mind when you refer to that?

A. For me, one of the things I'd like to see for each of the districts is to use - I'd use something like a health benefits framework which says, if you think about the population you've got, what are the points of health intervention? You've got prevention, you've got early identification and intervention, you've got acute care, you've got chronic care, you've got palliative care - that's your care continuum. I would actually really like to know what percentage of investment each district has across those and then, by major broad clinic type of problem, like mental health: "What's our investment in prevention right through to end-of-life care for mental health?" "Cancer", "Heart disease" - so I would do it under some of the big categories, and I would also do it by sub-population groups: "What percentage of our money for children is spent on prevention, early identification, et cetera?" Then I would do some benchmarking and look at the international evidence about what we know is best practice.

1 MR MUSTON: I have no further questions for this witness,
2 Commissioner.

3
4 THE COMMISSIONER: Q. By "best practice", meaning
5 looking at the evidence for both the individual or even
6 population based improvements in health outcomes?

7 A. Yep.

8
9 Q. But also economic benefits?

10 A. Absolutely. I mean, it's what I call the value
11 proposition, which is how do we - each district needs to
12 demonstrate what it's doing to maximise the allocative and
13 dynamic - we haven't talked about dynamic efficiency, but
14 the allocative and dynamic efficiency of the services they
15 are delivering or purchasing to meet the needs of the
16 population, rather than just reporting on how many widgets
17 they produced.

18
19 Q. Is there anything that you think is important from
20 your submission or evidence that you didn't think was
21 explored as fully as you would like with Mr Muston, that
22 you would like to add to your evidence?

23 A. No, I think we're fine, thank you.

24
25 MR MUSTON: Q. I will ask one more question, just given
26 you have raised the dynamic efficiency and to make sure
27 we're all on the same page. What are you alluding to when
28 you use that term?

29 A. I will use the three terms: technical efficiency is
30 how cheaply you can do things; allocative efficiency is
31 that you are using it to achieve best outcomes; and dynamic
32 efficiency is the ability of the health system to be agile
33 enough to change in response to changing needs. The most
34 obvious one I'll give you would be when we build hospitals
35 and we do cost cutting, so we reduce the size of the
36 operating theatres and a new procedure comes out, we've got
37 this brand new operating theatre, in five years' time we
38 can't do a new procedure because we can't get the machine
39 in it. That's an example of something that's technically
40 cheap to build and dynamically really inefficient.

41
42 Q. Technically cheap; maybe, at the moment that it is
43 built, allocatively efficient, in that it is a good and
44 effective operating theatre to produce outcomes based on
45 the technology then available; but a new machine comes in,
46 you want your inter-operative MRI, or whatever it might be,
47 that can produce wonderful outcomes much more cheaply than

1 ever before, but you're not able to deliver that procedure
2 because the room is too small?

3 A. Yes, so dynamic efficiency isn't just that, it is also
4 how we use our workforce, how we develop our workforce. We
5 run the risk of having such a specialised workforce that
6 people cannot adapt and change. And we saw this in COVID.
7 COVID really demonstrated that some health systems
8 internationally were much more dynamically efficient than
9 others. I sat on a WHO committee and one of the things we
10 were trying to work out at the beginning of COVID: should
11 we have some hospitals that just do COVID and business as
12 usual with others, or should we leave it that everybody
13 did. We didn't have a clue. Nobody knew how to do that.
14 But they are really important questions for the future:
15 how do we get a dynamically efficient health system that
16 adapts and changes?

17
18 And the big issues for the future are not in elective
19 surgery. They are in how to manage an absolute tsunami of
20 people going into old age.

21
22 Next year, the first of the baby boomers turn 80, and
23 we know that the average age of really getting high need
24 care is from 80 on and average life expectancy is going up
25 every year. If we do not deal with the changing
26 population, our schism between Commonwealth-state and our
27 focus on hospitals and acute care makes the system
28 structurally dynamically inefficient.

29
30 THE COMMISSIONER: Q. Well, it is a trite point, but
31 I think Mr Muston has pointed out that it's the health
32 ministry, not the "surgery ministry", and it's the Health
33 Services Act, not the "surgery services act". Actually,
34 they are not potentially as trite points as - it is
35 a health system, not an --

36 A. Absolutely.

37
38 Q. -- acute care system only?

39 A. Absolutely.

40
41 Mr Cheney, do you have any questions?

42
43 MR CHENEY: I don't, Commissioner.

44
45 THE COMMISSIONER: Or Mr Chiu, do you have any questions?

46
47 MR CHIU: No, Commissioner.

1
2 THE COMMISSIONER: Excellent. Thank you very much for
3 your time and assistance to the Inquiry. We're very
4 grateful, so thank you.

5
6 <THE WITNESS WITHDREW

7
8 THE COMMISSIONER: We'll adjourn until 2 o'clock.

9
10 LUNCHEON ADJOURNMENT

11
12 THE COMMISSIONER: Good afternoon.

13
14 MR MUSTON: Good afternoon, Commissioner.

15
16 This afternoon we have the authors of an expert report
17 entitled "Building capabilities to drive health system
18 improvements" giving evidence as a panel.

19
20 Starting with the screen, left to right,
21 Professor Luke Wolfenden and Dr Martin McNamara, and then
22 immediately in front of you, left to right, is
23 Professor Andrew Milat and Professor Don Nutbeam.

24
25 I call each of those individuals.

26
27 THE COMMISSIONER: I will start with you,
28 Professor Wolfenden. Would you like to give your evidence
29 by way of oath or affirmation?

30
31 PROFESSOR WOLFENDEN: Sorry, can you clarify that
32 question?

33
34 THE COMMISSIONER: Would you like to give your evidence by
35 way of oath or affirmation?

36
37 PROFESSOR WOLFENDEN: Affirmation.

38
39 THE COMMISSIONER: Do any of you want to take an oath or
40 would you all prefer to give an affirmation?

41
42 PROFESSOR NUTBEAM: I'm happy either way.

43
44 PROFESSOR MILAT: Affirmation.

45
46 DR McNAMARA: Affirmation is fine.

47

1 THE COMMISSIONER: If all of you are giving affirmation,
2 we can do it all at once.

3
4 <LUKE WOLFENDEN, affirmed: [2.10pm]

5
6 <MARTIN McNAMARA, affirmed:

7
8 <ANDREW MILAT affirmed:

9
10 <DON NUTBEAM, affirmed:

11
12 MR MUSTON: As a matter of logistics, I've been informed
13 that Professor Wolfenden has a commitment at 3pm which he
14 would ideally like to get to. It doesn't cause me any
15 difficulties, but on the assumption that it causes you no
16 difficulties, could we preemptively excuse him from 3pm, if
17 he drops off, so he's not doing so in contravention of his
18 summons.

19
20 THE COMMISSIONER: Mmm-hmm.

21
22 MR MUSTON: Thank you.

23
24 Perhaps could I get each of you, starting with those
25 who are here, Professor Milat first, just to identify who
26 you are and where you are from, what your role is?

27
28 PROFESSOR MILAT: Yes. Sure. So my name is
29 Professor Andrew Milat. I'm a professor of public health
30 at the University of Sydney. I'm also a senior adviser to
31 Sydney Health Partners, which is a partnership between five
32 health services and the University of Sydney, that does
33 translational research but also assists in clinical trials.
34 It does some work in building consistent capability in
35 implementation science as well. My areas of research
36 expertise are policy and practice impacts, in scale-up of
37 health system and population health interventions.

38
39 Would just like to disclose that in January I will be
40 starting a role at the Ministry of Health, just wanted to
41 let everyone know that. But at the time of the production
42 of this report, I was not part of the Ministry of Health;
43 it was done in my capacity as an academic at University of
44 Sydney.

45
46 MR MUSTON: Professor Nutbeam?

47

1 PROFESSOR NUTBEAM: I'm Don Nutbeam. I'm a professor of
2 public health at the University of Sydney, I'm the
3 executive director of Sydney Health Partners, which Andrew
4 has kindly described for you. As he has intimated, we are
5 very closely involved working with local health districts
6 in trying to improve the translation of research into
7 improved clinical practice.

8
9 MR MUSTON: Professor Wolfenden?

10
11 PROFESSOR WOLFENDEN: Hi, I'm Luke Wolfenden, professor of
12 public health at the University of Newcastle. I lead
13 a National Health and Medical Research Council funded
14 centre for research excellence and implementation science
15 called, the National Centre for Implementation Science.

16
17 I also have a fractional appointment with the Hunter
18 New England Local Health District as a health service
19 manager in a population health unit. The authorship or the
20 contribution to this report is in my role as a professor of
21 public health in the university.

22
23 MR MUSTON: Finally, Dr McNamara?

24
25 DR McNAMARA: Yes, Martin McNamara, chief executive of the
26 Sax Institute. We're interested in focusing on mobilising
27 evidence from research in policy and practice generally and
28 we've got a range of different ways we do that across
29 really all jurisdictions in the country and lots of other
30 organisations, other NGOs and other evidence users.

31
32 MR MUSTON: You have each co-authored a report headed
33 "Expert Report 3: Building capabilities to drive health
34 system improvements" dated 29 November 2024.

35
36 Commissioner, that's [SCI.0011.0605.0001].

37
38 Unless we hear anything to the contrary from any of
39 you, we will proceed on the assumption that the views
40 expressed in that report several days ago remain views that
41 each of you hold.

42
43 Do you each have a copy of the report handy?

44
45 PROFESSOR MILAT: Yes.

46
47 MR MUSTON: Could I ask you to turn to page 6,

1 paragraph 10, in which you tell us that there is an urgent
2 need for a conceptual leap in our understanding of how
3 healthcare systems respond to some challenges that you have
4 identified.

5
6 You then refer to the work of Professor Braithwaite
7 and his colleagues suggesting a need to marry ideas drawn
8 from complex science, data science and continuous
9 improvement and proposals for creating a learning health
10 system which you have described as "a dynamic learning
11 model". Conceptually, one can understand why all of that
12 sounds like it's a positive thing. What does a dynamic
13 learning model actually look like in practice? Any of you
14 can take that one up.

15
16 PROFESSOR WOLFENDEN: Commissioner, a learning health
17 system is a system where evidence is generated to guide
18 health decision-making and healthcare policy through
19 research and evidence generated from the health system
20 itself. So the idea is that rather than have a distinct
21 academic enterprise that health systems need to identify,
22 appraise and then apply if they can, we have the research -
23 or, sorry, the health system generating the research or the
24 evidence it needs for its own improvement, and if we can
25 reorientate health systems so that they are more data
26 driven, then we can accelerate the use of evidence for
27 clinical and public health practice improvement.

28
29 MR MUSTON: What might that look like in practice, perhaps
30 by reference to an example?

31
32 PROFESSOR WOLFENDEN: Certainly. So I mean, I can give -
33 one of the case studies in the report is from the Hunter
34 New England Local Health District population health unit
35 where I work. In this organisation, there is an alignment
36 or an embedding of academics or researchers within the
37 population health unit and so the unit includes the
38 necessary scientific expertise and academic infrastructure
39 to support the generation of research to improve population
40 health services.

41
42 Just to give a very kind of specific example, you
43 know, one of the responsibilities of the unit is to support
44 schools to implement healthy canteen guidelines consistent
45 with nutrition guidelines so that children are consuming
46 healthy diets consistent with dietary guidelines. The unit
47 generated evidence that it needed to dramatically improve

1 the adoption by schools of this healthy canteen guideline
2 and substantively reduce the cost of the health service in
3 achieving that outcome. That followed a series of kind of
4 sequential randomised controlled trials or studies. That
5 has kind of rapidly but iteratively improved the impact of
6 that population health service.

7
8 MR MUSTON: Just talk us through that in a little bit more
9 detail. I can understand conceptually the benefit of
10 healthy eating from a health outcomes perspective, and
11 equally can understand the benefits of having school
12 canteens delivering food which aligns with healthy eating
13 practices, but what was it that this embedded part of the
14 health service in Hunter New England did to bring about
15 results or improvements in that area?

16
17 PROFESSOR WOLFENDEN: Yes, so there's good evidence about
18 the effect of healthy canteens or healthy food environments
19 in improving student diet and, of course, the beneficial
20 effects on that in reducing chronic disease. The evidence
21 that the health service didn't have was how do we actually
22 implement successfully this policy or guideline in schools?

23
24 There wasn't a lot of evidence about how to do that
25 well, and that was the primary responsibility of the local
26 health district, so the population health unit. And so
27 this guideline or this healthy canteen policy had been
28 around for well over a decade, and compliance with the
29 guideline was about 20 per cent. So about 20 per cent of
30 New South Wales schools had implemented this mandatory
31 policy.

32
33 One of the barriers was that population health units
34 didn't know how to best support schools to implement the
35 policy. So what the unit did was implement an evaluation
36 or a research infrastructure around its usual practice, and
37 what it found was that initial efforts were largely
38 ineffective in supporting schools, and those sorts of
39 approaches were providing kind of audit and feedback, so
40 reviewing the products in the school canteen and providing
41 feedback to schools about where they were not compliant and
42 making suggestions about how they could change.

43
44 In response to that, the population health unit
45 undertook a second trial where they used research methods
46 to develop a more effective strategy and improved adoption
47 rates to about 70 per cent, which was terrific, but that

1 model of implementation support that was being provided to
2 schools was too expensive, and so then they undertook
3 a further trial where the cost of delivering that support
4 to schools was markedly reduced, such that they could
5 achieve a similar outcome at a far more efficient cost to
6 the health system.

7
8 So through that sequence of trials and kind of
9 learning from doing and contributing that back to the
10 evidence base, the efficiency and the effectiveness of the
11 service from the population health unit was dramatically
12 improved.

13
14 MR MUSTON: What was the secret source, as it were, in
15 terms of getting canteens to start selling healthy food to
16 school kids?

17
18 PROFESSOR WOLFENDEN: What we did is we kind of mapped
19 a range of barriers that were occurring at the school
20 level. So there were kind of individual barriers around,
21 you know, canteen managers not understanding the policy or
22 how they could comply; there were kind of barriers
23 associated with the broader school community and their
24 acceptability of changes to the canteen; cost
25 considerations to schools regarding the use of canteen
26 funds for a range of other school beneficial programs and
27 activities. We kind of were quite deliberate in
28 identifying and mapping strategies to address those
29 specific barriers to overcome them and ultimately improve.

30
31 But without that data, you know, the conventional
32 approach to public health, and, in fact, much of clinical
33 practice improvement, are strategies that are largely
34 educational based, that rely - that assume that if we
35 teach, then people will change, and that's often not the
36 case; you need far more nuanced and comprehensive kind of
37 multilevel strategies to achieve significant change at
38 scale across our health system.

39
40 MR MUSTON: So in that example, it was the embedding of
41 the research function within the public health unit, in
42 that case in Hunter New England, that enabled that work to
43 be done in a way which produced results, at least in Hunter
44 New England - were they then scaled to the whole of the
45 canteens across the State of New South Wales?

46
47 PROFESSOR WOLFENDEN: Yes, great question. Certainly

1 there are a number of other LHDs that were engaged in the
2 study and employed the methods, but, to my knowledge, at
3 least, while the evidence was shared, I'm unsure if the
4 strategies were replicated across the system. I suspect
5 not.

6
7 MR MUSTON: That being so, whilst at least within the
8 schools within your district, there's been some benefits
9 from a learning health system, is it really a learning
10 health system if it's not able to produce outcomes which
11 traverse a wider population than those within that slightly
12 more narrow geographic footprint in which the work is done?

13
14 PROFESSOR WOLFENDEN: Well, it's a learning health system
15 from an organisational perspective within Hunter New
16 England, but we appreciate that, you know, scale requires
17 that this activity and this evidence is kind of
18 disseminated and applied elsewhere, and we are actually
19 extending this work where we're engaging all local health
20 districts in more collaborative prevention efforts.

21
22 We've recently published a paper which kind of
23 documents the expansion of that model for health promotion
24 practice across the state for one project. So it's still,
25 I guess, emerging, and it's certainly not universal, but
26 I think we're seeing the seeds of what could be in terms of
27 system-wide improvements in prevention practice.

28
29 MR MUSTON: This might not be the best example to use
30 because there might be a debate about whether the Ministry
31 of Health or the ministry of education is best placed to
32 roll out a policy like that to bring about effectively the
33 same result, but let it be assumed for argument's sake that
34 this particular project or a project is clearly a health
35 issue - that is to say, a Ministry of Health issue - do you
36 have a view that anything needs to change about the way
37 things currently operate within NSW Health to bring about
38 that capability to scale research in a way that brings
39 about change system-wide or at least spreads the benefit of
40 that research across as large a group of the portion of the
41 population as it can reasonably be spread across?

42
43 PROFESSOR WOLFENDEN: Yes, I mean, other authors may want
44 to comment as well, but I think the substance of the report
45 that we submitted was essentially that we're looking to
46 create environments that facilitate research translation.
47 There have been a number of reviews, both here and

1 internationally, which make a number of recommendations
2 about the sorts of changes that need to happen, not just in
3 New South Wales but elsewhere. They are typically around,
4 you know, changes to research funding and research
5 prioritisation, workforce capacity building, the investment
6 in data infrastructure to enable research to take place,
7 particularly within health systems, and models of kind of
8 leadership and governance.

9
10 I would say that all of the - all of those elements
11 exist to some extent within the New South Wales health
12 system and probably the task is about how we kind of better
13 strengthen and coordinate those. But I know that - Don,
14 I'm not sure whether you want to elaborate on that?

15
16 PROFESSOR NUTBEAM: Yes, I'm certainly happy to come in.
17 I probably won't follow that example, but perhaps refer you
18 to another example that's embedded in case study, case
19 example number 4 on page 14. A very brief reference to
20 something called the "SHaPED trial". There are a lot of
21 similarities. It is a group of researchers embedded in the
22 Sydney Local Health District who have been looking to work
23 with our emergency departments to try to identify ways in
24 which we can reduce pressures there and introduce better
25 practices, particularly, in this case, in relation to the
26 management of lower back pain and, in particular, what most
27 would see as the overprescribing of opioids to manage back
28 pain in emergency departments. It's sort of established
29 practice, but, actually, it's not best practice and may
30 well be harmful to many patients.

31
32 They have undertaken a series of incremental studies,
33 proving that it's feasible to substitute opioids with other
34 forms of painkillers, demonstrating that both clinicians
35 can manage this in the emergency department and that
36 patients are very willing to accept the change, and then
37 progressively scaling it up across one emergency department
38 to three or four emergency departments, and that's a stage
39 we've reached.

40
41 The features --

42
43 THE COMMISSIONER: Can I ask, it is probably a stupid
44 question about this, but where you say - the note to myself
45 about this part of the trial is, where you say "Sydney
46 Health Partners ED trial slashed opioid prescriptions",
47 et cetera, "by implementing the ACI evidence based model of

1 care", et cetera, why wasn't the ACI evidence based model
2 of care already being used?

3

4 PROFESSOR NUTBEAM: Yes, that's a really great question,
5 to which I don't have a simple answer. I did want to just
6 pick up the themes that I think Luke alluded to. For the
7 most part, if I could simplify matters, this can be
8 explained by behaviours and by the organisations -
9 "organisational inertia", I shall call it.

10

11 With great respect to clinicians in this example,
12 working under enormous pressure, if you've always done
13 something one way, you're inclined to continue to do it in
14 that way, unless there is some active intervention that
15 might persuade you to operate otherwise. I think that's
16 what they are trying to do here, is to demonstrate that
17 a different form of intervention can produce, actually,
18 better outcomes.

19

20 THE COMMISSIONER: What's missing, though, between the
21 ACI - the ACI develops an evidence based model of care, but
22 somehow it doesn't get integrated into this hospital ED:
23 what's the missing link that has prevented that happening?
24 I hear what you say about people doing the same thing
25 they've always done.

26

27 PROFESSOR NUTBEAM: Yes, sure. I don't mean that
28 disrespectfully --

29

30 THE COMMISSIONER: No, neither do I.

31

32 PROFESSOR NUTBEAM: -- clinicians are operating under
33 pretty difficult circumstances.

34

35 THE COMMISSIONER: They are in an emergency department,
36 under pressure, so we'll take that as a given.

37

38 PROFESSOR NUTBEAM: I think, and again, I have to be very
39 careful, I don't want to be disrespectful, but honestly,
40 there are thousands of guidelines out there, like, we do
41 not lack for evidence based guidelines. We lack
42 enormously --

43

44 THE COMMISSIONER: It's translating them to --

45

46 PROFESSOR NUTBEAM: -- for an understanding of how you get
47 change implemented in a complicated healthcare system

1 operating under pressure. I think, you know, that's where
2 Luke began and that's where we'll get to eventually, and
3 why the word "dynamic" is important. It's a constantly
4 changing dynamic, especially at the point of entry in
5 emergency care for many people, and the way in which we
6 have a system that is more --

7
8 THE COMMISSIONER: But there is something missing from the
9 system --

10
11 PROFESSOR NUTBEAM: Oh, yes.

12
13 THE COMMISSIONER: -- if that doesn't get linked up, what
14 the ACI is recommending is an evidence based model of care
15 and what actually practically happens in the ED.

16
17 PROFESSOR NUTBEAM: Sure. Honestly, forgive me for
18 saying, if it was easy to fix, I'm pretty confident we'd
19 have done something about it.

20
21 THE COMMISSIONER: Yes, sure.

22
23 PROFESSOR NUTBEAM: The complexity comes from
24 understanding where the inertia sits. What is the --

25
26 THE COMMISSIONER: It won't be because clinicians are
27 wilfully making decisions like "I'm not going to act on the
28 best available evidence".

29
30 PROFESSOR NUTBEAM: Not at all, no.

31
32 THE COMMISSIONER: There is something that is just
33 preventing the link between the ACI to what we do in the
34 ED.

35
36 PROFESSOR NUTBEAM: Sure. I'm not going to put words into
37 Luke's mouth, but I think what we're collectively
38 advocating is for a much better embedding of research and
39 better access to real-time data as being significant
40 drivers of both the system and the individual clinician and
41 their behaviour. If you've got access to data in real time
42 that's prompting you and reminding you that there may be
43 alternative and better ways of managing the condition
44 that's in front of you, and if you've got a system that is
45 supporting, driving and reinforcing that, saying, "This is
46 how we want you to behave", you've a better chance,
47 I think, of getting closer alignment between what we know

1 to be the best evidence and how clinicians are handling
2 things on a day-to-day basis under pressure, basically, and
3 again, I'm going to keep emphasising, I don't want to blame
4 the victims here.

5
6 THE COMMISSIONER: No, no.

7
8 PROFESSOR NUTBEAM: You know, there is sometimes some
9 inertia amongst our clinical workforce, but basically they
10 are managing what's in front of them, using the best
11 available advice they have at that moment.

12
13 For us, it's about understanding that dynamic better
14 through research and it's also about ensuring that
15 clinicians have the evidence they need available to them at
16 the moment they need it, and that's where I think we're
17 struggling at the moment.

18
19 THE COMMISSIONER: What would be the best structure or
20 system - on this example you've given - of embedding what
21 the ACI has done in terms of coming up with an evidence
22 based model of care and getting it adopted in emergency
23 departments? It's probably not going to be the bulk of the
24 really busy clinicians in the ED who are just dealing with
25 trauma and acute illness.

26
27 PROFESSOR NUTBEAM: Sure.

28
29 THE COMMISSIONER: It probably needs to be something else.
30 What would it be?

31
32 PROFESSOR NUTBEAM: So, again, if I really knew the
33 answer, I assure you we would have done something about it.

34
35 THE COMMISSIONER: I'm not going to know if you don't
36 know, so --

37
38 PROFESSOR NUTBEAM: But I think that the conditions that
39 make that more likely, if I can put it in those terms, are
40 where people feel confident that making a change will make
41 a difference, and that - I'm going to describe a lot of the
42 research that we do in the translation and implementation
43 world is about building confidence that something is
44 practical to implement.

45
46 THE COMMISSIONER: So if you are a scientist or
47 a clinician, being confident that making a change will make

1 a difference in a positive way --

2

3 PROFESSOR NUTBEAM: Will make a difference, yes.

4

5 THE COMMISSIONER: -- would involve looking at the
6 research and the data; correct?

7

8 PROFESSOR NUTBEAM: Would involve different types of
9 research. So a lot of the evidence based guidance that you
10 refer to is classically constructed from clinical trials,
11 where the focus is on demonstrating the effectiveness of
12 something, often under optimal circumstances.

13

14 Where it may fall over is clinicians saying, "Yes, it
15 might have worked in those circumstances, but in my
16 emergency department, in my outpatient clinic, I have
17 a different population, I have a different dynamic, I'm
18 less confident" --

19

20 THE COMMISSIONER: Their pain thresholds are higher or
21 lower.

22

23 PROFESSOR NUTBEAM: Yes, and so a lot of what we do in
24 what we call translational implementation research is
25 understanding a lot better how something of proven
26 effectiveness could actually be implemented at scale in a
27 real emergency department or outpatient clinic, with real
28 clinicians and the kinds of pressures that they're
29 operating under.

30

31 So when I talk about demonstrating the feasibility in
32 real-life conditions, that's actually a research question
33 of its own type. One of the challenges I think we face
34 generally in our scientific community is the vast majority
35 of research that is done is efficacy, proving something
36 works, and far too little is done in trying to demonstrate
37 that it can be implemented in practice in a way that builds
38 confidence both in the managers, that they won't see
39 a budget blowout, and in the clinicians, who care only
40 about the best outcome for their patients.

41

42 We probably, in the end, are advocating for a shift in
43 the balance of attention, particularly, I'd have to say, by
44 the state government, because in fact, we have the NH&MRC
45 and we have the Medical Research Future Fund providing
46 enormous amounts of money that drive the improvement of
47 evidence, but we still don't have a decent system that then

1 supports the research that's required to demonstrate
2 feasibility and the ability for these things of proven
3 efficacy to be implemented in practice in ways that deliver
4 better outcomes and don't lead to cost blowouts.

5
6 For me, that's the essence of what we're advocating
7 for, is building capacity to learn more about how we
8 implement the scale in our complicated health system with
9 clinicians who are incredibly busy and under pressure. My
10 colleagues might feel free to contradict that.

11
12 THE COMMISSIONER: This is slightly off topic, and tell me
13 also if it's not your precise field of expertise, but
14 slashing opioid prescriptions by 12 per cent, I assume the
15 benefit is not that people are putting up with pain that
16 they don't need to; it's reducing the risk of some form of
17 dependence?

18
19 PROFESSOR NUTBEAM: Yes, yes. So it's a bit of both.
20 What they've been able to demonstrate is that people can
21 manage their pain perfectly well without the use of
22 opioids, which carry with them a whole range of risks and
23 potential harm; and, secondly, demonstrating that the
24 patients are actually very happy with that form of pain
25 management relative to the use of opioids. It's a bit of
26 both, but --

27
28 THE COMMISSIONER: I would be asking for the Endone, but
29 I'm probably not a good patient to - an Eastern Suburbs
30 softie.

31
32 PROFESSOR NUTBEAM: Yes, that's right. But I would have
33 to say a part of the study was nervousness on the part of
34 clinicians that if they didn't prescribe opioids, they
35 would get an annoyed patient and, therefore --

36
37 THE COMMISSIONER: There you go. Yes. There's probably
38 some truth to that.

39
40 PROFESSOR NUTBEAM: -- they don't have time to deal with
41 it, basically. So being able to demonstrate --

42
43 THE COMMISSIONER: That doesn't mean the patient is right
44 on this occasion.

45
46 PROFESSOR NUTBEAM: No, not at all, although there is
47 a view that the patient is always right, but I definitely

1 agree with you in this case.

2

3 MR MUSTON: Can I step through that to make sure I've
4 understood where the potential gap is. There has been
5 happy coincidence of some researchers and some clinicians
6 at the coalface, somewhere which has run a clinical trial
7 of some description, the outcome of which - maybe multiple
8 clinical trials across the world, possibly, the outcome of
9 which is an acceptance that there is a way of managing
10 lower back pain using other than opioid treatments which is
11 as effective, if not more effective, and doesn't carry with
12 it the risk of harm.

13

14 PROFESSOR NUTBEAM: Yes, correct.

15

16 MR MUSTON: That research has then been picked up by the
17 ACI, in part by the work that has been done locally, no
18 doubt assessed as against international work of a similar
19 character; would that be right?

20

21 PROFESSOR NUTBEAM: No, so I think the order may be the
22 other way around. The ACI has undertaken a really helpful
23 assessment of the global science around pain management,
24 lower back pain management in emergency departments. It's
25 a surprising number, by the way, of people who turn up in
26 emergency departments with acute back pain. It's, you
27 know, a serious driver of emergency department activity.
28 So they've created guidelines based on that evidence, but
29 what we're testing here is how well they can be implemented
30 in practice in a real-life emergency department.

31

32 So, in other words, the ACI's role has been to assess
33 the quality of the evidence and recommend that practice
34 changes in relation to that. We are now trying to
35 understand how to make practice change.

36

37 MR MUSTON: So in this case, neither the state nor the ACI
38 has had to actually step up and fund that underlying piece
39 of research; rather, they've looked at the world of
40 research, they've identified a body of research or an
41 evidence basis which supports the proposition that there's
42 a better way of dealing with lower back pain. They have
43 then produced a guideline.

44

45 PROFESSOR NUTBEAM: Yes.

46

47 MR MUSTON: It's been thrown into the mix with a thousand

1 or so guidelines.
2
3 PROFESSOR NUTBEAM: Yes. So this work was initially
4 funded by the partners, Sydney Health Partners, who are
5 four local health districts, and the Children's Hospital at
6 Westmead.
7
8 MR MUSTON: When you say "this work was initially funded",
9 what's that work that was funded?
10
11 PROFESSOR NUTBEAM: So the initial sort of feasibility
12 study, I think we gave something like a \$50,000 grant to
13 this research group, embedded in the local health district,
14 working with the emergency department. They've actually
15 subsequently gone on to secure something like \$6 million in
16 external funding to continue that work.
17
18 MR MUSTON: I might have missed a step, though. The
19 original piece of research that was done as, as it were,
20 almost a literature study - I know that's a terribly- that
21 downplays it, but ACI has done a piece of work --
22
23 PROFESSOR NUTBEAM: Yes.
24
25 MR MUSTON: -- which has identified the need to change
26 behaviour.
27
28 PROFESSOR NUTBEAM: Change practice, yes.
29
30 MR MUSTON: Who funded that? That was funded by the ACI?
31
32 PROFESSOR NUTBEAM: That was done by the ACI using their
33 internal resources.
34
35 MR MUSTON: That then resulted in the production of a
36 guideline of some description --
37
38 PROFESSOR NUTBEAM: A guidance, yes.
39
40 MR MUSTON: -- that was made available to all
41 practitioners across the state in whatever platform the
42 multiple guidelines can be found on?
43
44 PROFESSOR NUTBEAM: Yes.
45
46 MR MUSTON: There is then the question about the extent to
47 which that guideline is being followed or taken up in the

1 delivery of care to patients in emergency departments.

2

3 PROFESSOR NUTBEAM: So I think that's the nub of our
4 challenge.

5

6 MR MUSTON: So the piece of research you're --

7

8 PROFESSOR NUTBEAM: So we don't lack for guidance, I'm
9 going to keep emphasising that. There are a few areas,
10 relatively few areas, of clinical research where we don't
11 know what might be best or better practice.

12

13 MR MUSTON: So the \$50,000 piece of research that was
14 initially commissioned by your organisation is the work on
15 determining how to convince clinicians --

16

17 PROFESSOR NUTBEAM: How do you get this change that the
18 scientific community have identified as being advantageous?
19 How do you actually get it implemented in practice? It's
20 a straight research question, and getting answers to that
21 is what builds confidence, both in the clinician community
22 and in our health services managers, that these kinds of
23 changes - and we're focused on a very narrow example, but
24 you could find multiple examples, both in the report and
25 elsewhere, of efforts to move past guidance to how do we
26 manage change in practice and then how do we manage change
27 at scale across the system?

28

29 Those, for us, are the two really critical areas of
30 research where having research embedded in our healthcare
31 system, having clinicians and researchers working together,
32 is almost the only way you get answers to those sorts of
33 questions.

34

35 MR MUSTON: In relation to that example, that's a piece of
36 work that was done by your organisation, but is there
37 a reason why --

38

39 PROFESSOR NUTBEAM: It was funded by our organisation; it
40 was actually done by embedded clinicians working within
41 emergency departments.

42

43 MR MUSTON: Okay, so funded by your organisation.

44

45 PROFESSOR NUTBEAM: Yes.

46

47 MR MUSTON: Let's step that through. Your organisation,

1 as part of its decision-making around what to fund, decided
2 that would be a good project to pick --

3

4 PROFESSOR NUTBEAM: Yes.

5

6 MR MUSTON: -- provided the funding for that project?

7

8 PROFESSOR NUTBEAM: Yes.

9

10 MR MUSTON: Clinicians on the ground, working with
11 researchers, came up with some answers to that tricky
12 question.

13

14 PROFESSOR NUTBEAM: Yes.

15

16 MR MUSTON: Is there any reason why that sort of decision
17 making around how and where to deploy, effectively, change
18 management funding or research funding shouldn't be being
19 made by the ACI? In the sense that the ACI has its suite
20 of guidelines, it has made a decision that it's important
21 that everyone follows these guidelines, there is a reality
22 that every clinician out there is not going to have
23 a capacity to learn on the job the thousand or so
24 guidelines and maintain a knowledge of their dynamic
25 status. Isn't it the role of the ACI to be deciding how to
26 translate this research into practice?

27

28 PROFESSOR NUTBEAM: Yes - so my colleagues might - all of
29 my colleagues should feel to free jump in at any time, but
30 I - that's a difficult question to answer in that it
31 assumes that a single-point decision will lead to change in
32 a very complex organisation, if you took the New South
33 Wales system as a whole, across all of its local health
34 districts.

35

36 What I think is, it's a bit of both. So I do think,
37 when the ministry issues guidance, it's important that
38 there's some system in place that reinforces the need for
39 that guidance to be given the attention it deserves. But
40 the other part of that is the route that we're taking,
41 which is that you also need to work on the ground in local
42 health organisations with local clinicians to understand
43 their circumstances and look at what implementing something
44 like that from generic science - how it might be
45 implemented at a very local level. It's not either/or,
46 it's got to be both, in my view, and my sense is the ACI
47 has established a broad network of - they're called

1 clinical networks, I think.

2

3 PROFESSOR MILAT: Yes, they are, yes.

4

5 PROFESSOR NUTBEAM: Specifically for the purpose of trying
6 to get a much better feel for how clinicians can respond to
7 the guidance they produce, and we're working actively with
8 our local health organisations and actively in our local
9 hospitals actually to test this proposition in a more
10 systematic way than the ACI could ever do at a statewide
11 level. So it has to be a bit of both, a bit of incentive
12 from the centre, if I can put it like that, and then some
13 confidence building at a local level among both health
14 service managers and the clinicians responsible for change.

15

16 DR McNAMARA: Just to go back to the nature of the
17 question that you asked just before, I mean, I think it's
18 fair to say, in defence of ACI here, that they're not
19 releasing guidance out to the system with no thoughts
20 around implementation of that guidance. I mean, I think
21 there are genuine efforts to make sure that evidence based
22 clinical guidelines are shared appropriately with the
23 system and there's support for their implementation. But
24 as Don started to describe there, it's a challenging model
25 in the sense that it's such a large diverse system, to have
26 an implementable approach to this is a challenge.

27

28 So thinking about what might happen locally - and this
29 example that Don has been through is a really good example
30 of what could happen locally that could actually strengthen
31 the implementation of what might be developed elsewhere -
32 but I guess I think it is worth flagging that a group like
33 the ACI would definitely be thinking about implementation
34 elements of what they are doing, but there's a natural
35 limit as to how far they can take that as a centrally
36 located group.

37

38 We've got clinical networks, we've got relationships
39 out there in the clinical settings, but there need to be
40 other sorts of support around the implementation of these
41 sorts of guidelines and these evidence bases because it
42 can't all be driven from one group, despite the best
43 intentions, I think.

44

45 THE COMMISSIONER: Sorry, just while we're on this topic
46 of the case study in back pain, I was just looking, while
47 some answers were given - one of the ACI networks is in

1 relation to pain management. And then I think the model of
2 care that we're talking about is the one in relation to
3 lower back pain, which has a principle of "opiates should
4 be avoided" and emphasising "active physical therapy
5 encouraged", so for whatever reason - that, which is a 2016
6 model of care, for whatever reason, that needed this extra
7 trial and push to get it adopted in the ED.

8
9 PROFESSOR NUTBEAM: And I think that's the point I'm
10 making, really - and I agree, thank you, Martin, I'm not
11 suggesting ACI haven't thought this through; it's more that
12 there is a limit to what you can do in such a large dynamic
13 system from a central point. It's not either/or, it has to
14 be both, it seems to me, and what we've been able to do
15 here is to create more local dynamic that allows us to
16 build confidence by addressing questions of feasibility and
17 cost effectiveness that are really important at a local
18 level in the decision-making about how clinical services
19 are provided and managed.

20
21 PROFESSOR MILAT: I think one of the challenges with any
22 large scale system transformation is that you can't give
23 everything all at once. There are potentially thousands of
24 models of care that would occur across health care.
25 I think one of the challenges for the system is
26 appropriately prioritising system priorities and then
27 investing resources into that change process, because you
28 can't change everything all at once, because, you know,
29 clinicians would be unable to absorb all of that change
30 simultaneously. But it's a case of sort of going through
31 and you have to provide evidence based guidance, but then
32 you have to pick some opportunities to actually implement
33 those large-scale system transformations that have maximal
34 benefits to patients and are implementable.

35
36 That's one of the challenges I think that Don was
37 talking about. Luke and I did a study, I think it was
38 2016/17, that looked at the amount of research that's
39 produced across a whole range of different areas and we
40 found that only, you know, about a quarter of all research
41 focuses on interventions. These are things that, you know,
42 are viable solutions, whether they be a campaign, a new
43 model of care or - so the whole research enterprise is
44 primarily focused on descriptive and methodological
45 research, so this whole multi-trillion dollar enterprise
46 internationally, and of those interventions that do occur,
47 there's very few of them that focus on implementation and

1 the practical application of that research evidence.

2
3 So what you will see in clinical trials, for example,
4 is you will get high quality efficacy research, randomised
5 controlled trials, but they are often implemented with
6 a level of resourcing that really isn't possible to
7 replicate in the real world. But then you have to do the
8 next step, which is think about how you would implement
9 that high-quality evidence that shows that something works
10 under normal circumstances, in clinical contexts with
11 real-world clinicians who are trying to balance all of the
12 challenges of implementing their practice, changes, you
13 know, good days, bad days, and then having to implement
14 a model of care. So I think that's the missing bit, that
15 sort of jump from efficacy studies which are highly - well,
16 quite well funded, often with unrealistic levels of
17 resourcing, and then how you apply these things to
18 practice.

19
20 So the clinical guidelines, by their very nature, are
21 based on the best available evidence, and often that is
22 randomised controlled evidence, but that evidence doesn't
23 talk often about how you would implement things
24 practically.

25
26 I think that's one of the challenges, and for
27 a system, you know, you need to have - so up until the
28 single digital patient record, it's still an important -
29 it's a critical piece of infrastructure for the system.
30 Prior to that - and it still has a long way to go in terms
31 of its implementation and its potential as a clinical
32 practice tool but also as a tool for research, I'm not
33 saying the issue is solved, but it provides great promise
34 as one of the tools that could be used to improve practice.

35
36 Often those feedback loops to clinicians really
37 weren't there within our data and administrative systems.
38 There's often long lag times between the data that is put
39 into the system and getting it back from a clinical
40 perspective, but then also from a system management
41 perspective, so I think we're hopeful, and we do mention it
42 in the report, that that single digital patient record will
43 enable the implementation of a lot of these clinical
44 guidelines and processes with a much more timely feedback
45 loop between the collection of data and its use in
46 practice.

1 With those sorts of records as well, they can put in
2 clinical guidances, you can put in nudges within systems,
3 but unfortunately, just our IT system, though, the health
4 system, is not short of data, we have collected data for
5 many, many, many years, we're certainly not short of it,
6 but really, where we are missing the data is that sort of
7 timely data that can be used to inform clinician practice
8 in a practical way. And we're transitioning to a space
9 where we're hopeful that that, as an asset of the system,
10 could be used to really implement some of these models of
11 care, use more evidence in clinical practice, and it should
12 be a focus of our efforts, I think, moving forward.
13

14 The other thing that I think we can do as a system is
15 to build broader capability of clinicians and population
16 health practitioners in the use of evidence, the use of
17 research and data. It's not something that will come
18 naturally to a system, and there are pockets of
19 excellence - for example, Sydney Health Partners has worked
20 with its partner LHDs through its clinical academic groups
21 to do these types of trials and to implement things.
22

23 I think to do that on a system level will require
24 a focused effort from NSW Health. Certainly the report
25 outlines a whole series of things that are there, but
26 they're not connected and well funded and they don't have
27 the levels of reach through all of the clinical groups to
28 build that broader system capability.
29

30 So it does require, I think, a sustained focus and
31 investment in those areas to really provide another enabler
32 to implement those evidence based models of care, which is
33 that data, research and evidence literacy of our workforce,
34 and we need to support them, and to make that the easy
35 decision, because often, you know, for example, if people
36 want to find out the most up-to-date evidence, they have to
37 go into systems.
38

39 We have a system called SIA within New South Wales.
40 It does provide clinicians with access to the broader
41 literature but it doesn't provide - correct me if I'm
42 wrong, I went into the system and tried to have a look at
43 it, it doesn't provide all of the full text articles. It
44 provides abstracts, which are fantastic and it does provide
45 the system access --
46

47 THE COMMISSIONER: And you have to have the time to access

1 it.

2

3 PROFESSOR MILAT: And you have to have the time to do it,
4 yes. So if there are ways to sort of build that capability
5 across systems, I think we need to sort of focus on those
6 efforts. It's not going to be one thing that will change
7 that evidence practice gap.

8

9 THE COMMISSIONER: Can I just explore something? This is,
10 by the way, for any of you, and any of you can feel able to
11 add to what a colleague says, but I just wanted to go back
12 to - we were exploring this ACI evidence based model of
13 care for back pain, and that it sort of took the push of
14 this Sydney Health Partners trial to get it adopted. Then
15 Mr Muston asked, "Is there any reason why that sort of
16 decision-making about how to deploy", et cetera, "shouldn't
17 be made by the ACI? Isn't the role of the ACI to be
18 deciding how to translate this research into practice?"
19 Just on that, part of the ACI's functions, as I understand
20 it, is when there is a new model of care, to provide
21 implementation support. Is part of the problem that it
22 could be doing that role more broadly but it's just not
23 resourced to do it, or is that too simplistic, not correct,
24 or is there some other answer?

25

26 PROFESSOR NUTBEAM: I'll just jump in. I'm going to be
27 consistent: I do think it is really hard for a central
28 organisation to get involved at the level of detail that's
29 required in our large complex system and that this has to
30 be both locally driven, centrally supported, if I can put
31 it like that. I think my best answer to the perfectly
32 legitimate question is that ACI have a role in creating -
33 or the ministry - ACI/ministry has a role in creating
34 a culture that is, you know, very clearly evidence informed
35 and supports best practice, but the whole reason we have
36 localised health districts is because we understand there
37 are significant community differences in the way you might
38 go about making something that is evidence based work in
39 practice.

40

41 For me, it's not either/or --

42

43 THE COMMISSIONER: Although avoiding prescribing opioids
44 probably won't be community specific.

45

46 PROFESSOR NUTBEAM: Well, in a way that's probably an
47 unhelpful example, just in the fact that it's so obvious

1 that we really need to do all we can to minimise
2 prescribing opioids. But I think of several other examples
3 in areas where we support - we've been working with
4 colleagues out at Westmead in the development of a rapid
5 access chest pain clinic that would enable people with
6 non-life threatening chest pain to go somewhere other than
7 the emergency department. We've been looking at the
8 effectiveness of that as a mechanism for reducing pressures
9 on the emergency department and we've demonstrated that it
10 can be done safely and effectively and that patients will
11 accept it, and we are now looking at, well, how do you
12 scale that across other emergency departments with
13 different clinicians and different patient populations.
14

15 Again, I get back to the fact that we know how to
16 manage chest pain, there's good evidence based guidelines
17 on that, and the ACI has a role in saying, "You need to
18 explore, locally, how best to make this happen", and our
19 role has been, "Well, let's explore how we build confidence
20 in this among clinicians and patients that it's a service
21 that can actually reduce pressure on emergency departments,
22 deliver at least as good, if not better, outcomes and is
23 something that could be scaled up in more than one place."
24 That's the kind of learning - when Luke started us on our
25 learning health system, that's the kind of learning that
26 could come from this type of research into implementation
27 and scale-up.
28

29 MR MUSTON: Can I just come back --
30

31 PROFESSOR WOLFENDEN: Do you mind if I add to that?
32 I would like to just make two quick points. I think
33 whether it's ACI or any agency that's responsible for
34 improving health care, how best to do that is an empirical
35 question, it is a scientific question: how best do you
36 improve or change clinical practice so it is more
37 beneficial to patients?
38

39 As Andrew and others have kind of described, there is
40 very limited scientific evidence to answer that for us.
41 Two per cent of research funding, 2 to 3 per cent of
42 Australian research funding in public health is devoted to
43 that type of question, getting evidence into practice.
44

45 So while Don and others have been saying, you know,
46 a lot about what works, you know, about effective models of
47 care, we don't know how to get them in practice.

1
2 Behavioural science suggests in order for a clinician
3 to change behaviour, they need - there needs to be three
4 things in place. They have to have the opportunity to
5 undertake the behaviour; the capability to do it; and the
6 motivation.

7
8 There are a range of factors that at individual level,
9 at an organisational level and a system level, that may
10 kind of facilitate or impede that, and they differ that
11 across context - so across jurisdictions, across hospitals,
12 they often differ. So it's very complicated or difficult
13 for a central agency to have a one size fits all generic
14 approach.

15
16 I think the idea of a learning health system is that
17 we build the capacity of systems, central systems, as well
18 as local systems, to generate the evidence they need to
19 implement programs that may come centrally in a way that's
20 best for their kind of local context. I think much of the
21 recommendations in this report are around providing the
22 necessary preconditions for that localised, I guess,
23 response to healthcare improvement that is supported kind
24 of centrally. So I just wanted to make those two points.

25
26 MR MUSTON: I suppose my question about the ACI, and
27 perhaps poorly expressed, not necessarily suggesting that
28 the ACI alone should be deploying its personnel in a way
29 that undertakes this translational research into working
30 out why it's working or not working, but is there not
31 a role - to the extent that money within the public health
32 system is being deployed into research in this area, is
33 there not a role for the ACI to act, as it were, as
34 a commissioning body?

35
36 So the ACI decides, "We've issued a new guideline on
37 the use of opioid drugs in lower back pain. We can
38 probably assume, off the bat, the fact that we've issued
39 that guideline is not going to change behaviour in
40 clinicians overnight. There may be different drivers in
41 different health districts and different settings that will
42 impact on the uptake of that particular guideline. We've
43 got a whole lot of guidelines out there but we think this
44 one is the most important at the moment, so we think that
45 money should be deployed towards working out how to
46 translate that into practice." ACI then, consistent with
47 its function, can commission an organisation like yours to

1 do that research with local clinicians on the ground in a
2 way that means the ACI is still maintaining some oversight
3 or control of the way in which that overall parcel of
4 research money is spent so as to ensure that it's spent in
5 a way that best meets or is best likely to achieve the
6 objectives that the ACI, as the central body, has in
7 shaping the health system.

8
9 PROFESSOR MILAT: I'm happy to respond to that. I mean,
10 I think that the way that you've described that, I think,
11 is a very viable strategy and, you know, the opportunity,
12 particularly to leverage additional sort of external
13 resources to help those implementation efforts is an
14 opportunity, I think, for the New South Wales health
15 system.

16
17 The ACI could broker partnerships between some of the
18 advance - the translation centres, and they could be used
19 as a potential laboratory, a living lab, because they have
20 existing partnerships with the local health districts, they
21 have clinician researchers that are sort of aligned with
22 the objectives of those translation centres. For example
23 if there was a priority, you know, some money could be put
24 into that as a show of good faith, and then applications
25 for Medical Research Future Fund, or NH&MRC funding could
26 be put in, and then potentially, you know, that
27 Commonwealth funding could assist in the New South Wales
28 efforts to test these transformations of the healthcare
29 system.

30
31 That process does take a bit of time, but I think what
32 is pretty clear is that, you know, it's a very stubborn -
33 it's a very challenging thing for the health system to do
34 and having a systematic process where things are
35 prioritised and the ACI could potentially have a role in
36 sort of brokering that and bringing the partners together
37 to then focus on generating implementation research that
38 would sort of give us some really important clues on how
39 you could implement that across systems.

40
41 Certainly there are examples internationally. You
42 know, bringing things to scale across systems, believe it
43 or not, is a very challenging exercise. So the evidence -
44 there was a fantastic umbrella review conducted by
45 a colleague of mine, France Légaré, and it was done in
46 Milbank Quarterly in 2003, that showed that the best
47 examples of scale-up across systems really are in lower and

1 middle income country contexts, that in high income country
2 contexts, including Australia, there are relatively few
3 examples where things have been implemented at scale across
4 systems. It is a much more disparate picture.

5
6 What is really interesting about that picture as well
7 is there are pockets of excellence, you know, there are
8 some examples in the United States where Kaiser Permanente,
9 for example, over a decade were able to improve
10 hypertension control in their patient group, and we're
11 talking hundreds of thousands of patients in northern and
12 southern California. They implemented a series of things
13 that would be akin to a learning health system, developing
14 models of care, providing incentives for systems,
15 developing information systems that allowed clinicians to
16 see their own performance but then looking at central
17 performance, monitoring that performance over time,
18 incentivising change, training staff on a regular basis,
19 using multi-strategic strategies to bring about change, and
20 they were able to bring their blood pressure control of
21 their total patient population - so we're not talking
22 about, you know, within three of their services of, you
23 know, let's say 50, this is every single patient in their
24 patient group, they were able to bring that control up to
25 90 per cent, people on appropriate medication operating
26 within models of care.

27
28 So there are some pockets and really fantastic
29 examples, and they are great, and that's in a high income
30 country context, but there's still very little focus in the
31 system on some of those large-scale system transformations.

32
33 So the ACI having a bit more of a role and trying to
34 add to the science and then, more importantly, improving
35 clinical care and getting those models of care implemented,
36 I think that's a real opportunity for the future and there
37 is a real absence of that sort of research being funded
38 currently.

39
40 PROFESSOR NUTBEAM: Can I just come back to the question
41 you posed about ACI. I mean, I think there was an
42 assumption in there that I just wanted to test a little
43 bit, which was the ACI is able to prioritise. I think one
44 of the challenges for ACI has been that it is really trying
45 to cover an enormous spectrum, and if you can't see your
46 disease category or group in the ACI's range of activities,
47 somebody will, you know, say, "Well, why aren't you doing

1 this?" And I do think --

2

3 MR MUSTON: But could I ask rhetorically, or partly
4 rhetorically but not entirely, why doesn't that person say
5 to the ACI, "Why aren't you doing this and here is why you
6 should be doing this", and that then enables the ACI to
7 make an informed decision about whether or not it should be
8 doing it.

9

10 PROFESSOR NUTBEAM: Yes, so I think a lot of that occurs
11 and I think that the challenge ACI has had is that the
12 agenda is enormous.

13

14 I have had the luxury, in Sydney Health Partners, of
15 working with a group of chief executives who are prepared
16 to make a call on a smaller number of priorities and for us
17 to focus on trying to make a difference in a smaller number
18 of priorities.

19

20 As a statewide organisation, it is very hard to say,
21 "We're only going to do X and Y. We're not going to work
22 on Y and Z", if you get my analogy. I think there is
23 a challenge in there about prioritisation and how that
24 occurs. So that was just one piece but I think it is
25 a real challenge for statewide organisations to really say,
26 "We're only going to concentrate on this smaller number of
27 things because we feel this is where we get the best
28 outcomes for patients in the short term, and thereby, these
29 other things are less important." It sort of - it doesn't
30 feel that it works so easily like that for a statewide
31 entity.

32

33 The other thing to say is, more positively, the ACI
34 and the research translation centres like Sydney Health
35 Partners - there are three centres in New South Wales -
36 over the last 18 months have got into a much more
37 structured dialogue in order to reduce overlap and to see
38 if we can't find the right way of getting the kind of
39 system I think you alluded to, which is where the ACI
40 performs its role from the ministry's perspective, creates
41 a culture where it's encouraging change in clinical
42 practice, and we work with our local health districts to
43 actually implement - to test the implementation of change
44 in actual hospitals and clinics.

45

46 So I think there's currently soft foundations for the
47 kind of model that you've identified. Any boost that that

1 could receive I think would be welcomed by all of us as
2 a mechanism through which we get the best of a central
3 organisation with capability and local organisations with
4 capability, that's complementary.

5
6 MR MUSTON: Just looking at paragraphs, say, 24 through to
7 39 of your report, it might be a slightly unfair
8 characterisation, but there would seem to be
9 a constellation of different bodies, committees,
10 organisations who are vying for and providing funding
11 streams for pieces of research, but it doesn't really leap
12 out of the report, at least, that there's any sort of
13 systemic or structural consideration being given to how the
14 collective heft, intellectual and financial, that sits
15 behind them could be directed to produce the best outcomes
16 for the New South Wales health system. Would that be fair
17 or unfair?

18
19 PROFESSOR NUTBEAM: I'm definitely going to speak in a
20 personal capacity now. I think there are widely shared
21 frustrations that we don't, as a state, quite have our
22 act together around this, and to be fair, for the last
23 18 months the ministry has been engaged in a highly
24 consultative, highly participative process of looking at
25 a research strategy - a health research strategy for
26 New South Wales. I suspect the outcomes are known to the
27 Commission or the progress that has been made is known to
28 the Commission.

29
30 So I'm optimistic that that problem as you've
31 described it is widely recognised, better understood now,
32 I think, by the ministry who are working out what role the
33 ministry has in solving a problem that has multiple - so
34 there are a large number of independent medical research
35 institutes, over which the ministry has some limited
36 influence as a funder in many cases.

37
38 There are the universities over which the ministry has
39 some influence but, frankly, rather limited, based on my
40 experience of working in universities, and then, of course,
41 there is the health system and our local health districts
42 over which the ministry has rather more. If you look at
43 that universe it's messy and you made a fair observation,
44 it seems to me, from our report, and it feels slightly
45 messy.

46
47 The critical question for me, and this is where Martin

1 and Andrew will feel free to say, "Yes, that is very
2 interesting, Don, but I disagree": the issue for me is
3 what is the role for a state health ministry in this large
4 research ecosystem? As I mentioned very early on, we do
5 have these enormous funding agencies in the National Health
6 and Medical Research Council, Medical Research Future Fund,
7 who support a lot of discovery research, a lot of the
8 efficacy research that we've described earlier that helps
9 us build evidence of what are the best things to do,
10 creates a pipeline of discoveries that might lead to
11 improved health practice.

12
13 The question is, in that ecosystem, what role does
14 a state ministry have and can it best play? I think the
15 feedback that the ministry has received through their
16 consultation process is that it's largely at the far end of
17 the research pipeline; it's at the translation end; it's
18 how you take what we've learned from discovery science and
19 randomised trials and other forms of outstanding research -
20 how do we get that implemented in practice in ways that
21 deliver better outcomes for the community in New South
22 Wales.

23
24 If there was a single message that I saw from all of
25 the feedback received, it was we need to concentrate the
26 ministry's attention - it's not to say that's the whole
27 research universe, but the ministry's attention needs to be
28 concentrated on exactly the types of questions that we've
29 been discussing this afternoon: how do we take what we
30 know to be effective in practice and see it implemented
31 successfully at scale to deliver better patient outcomes,
32 and what research supports that process, basically, which
33 is a lot of what we've been talking about earlier. But now
34 my colleagues will come in and --

35
36 DR McNAMARA: I don't disagree what you're saying.
37 I probably would suggest we extend it in two ways. One is
38 to say that the research and other infrastructure that
39 you're referring to - I forget the paragraph numbers but
40 around the 30 to 100 part of the document - is a really
41 impressive portfolio that is quite unique in Australia,
42 what has been created in New South Wales, and I think that
43 is a great foundation to build on. I think that's one
44 point to make here.

45
46 I think the other is about how to best utilise that
47 infrastructure that has been created. Don has quite

1 rightly pointed to the translation and implementation side
2 of the role of the ministry, and I agree with what he is
3 saying there.
4

5 The other opportunity I think is to consider what are
6 the big priorities that the government sees for reforming
7 the system in the New South Wales health system that can
8 give some guidance to where the effort - in all of that
9 research infrastructure that has been created, can give
10 some guidance to where the effort should be placed within
11 that research infrastructure, both funding and otherwise.
12 Because at the moment we've got the phenomenon that we just
13 talked about in this discussion of ACI and others being
14 spread across so many different specialty areas with so
15 many different sorts of priorities and real limitations and
16 how much of that you can actually translate into the
17 system. Even if we increased the resourcing
18 substantially, it would be hard to generate change across
19 all parts of the system that we've got evidence based
20 guidelines floating around in.
21

22 So there is an opportunity to think about what are the
23 big priorities over the forward period that really warrant
24 the attention of this research infrastructure that we've
25 created. There's also an important signal to the research
26 community and to the clinical community about where extra
27 effort is going to go in things like translating and
28 implementing it at the local level.
29

30 I think that's what's implied in some of the latter
31 parts of this report, about thinking about what advice or
32 direction we can give to the system that can start to set
33 out what those priorities are for change.
34

35 PROFESSOR NUTBEAM: If it's of any help, in the
36 discussions we've had within our partnership about how you
37 do that prioritisation, we've organised our work around
38 three broad domains. One is that there are some major
39 causes of ill health that we really have to deal with,
40 because they come through the door - cardiovascular
41 disease, cancer, musculoskeletal health, diabetes, for
42 example, would fall into that category, and they're too
43 important to suggest that they are not going to be
44 priorities.
45

46 The second is looking to the future and trying to
47 shape the future, and that has to do, in particular, for

1 example, with digitally assisted health care. I hate the
2 term "virtual health care", by the way, you should never
3 use it. Nobody wants to be "virtually cared for". But
4 people are accepting of digitally assisted health care, and
5 it's an important part of the future of health care, along
6 with what we're understanding now in the possibilities of
7 genomics and precision medicine and so on. So that's a bit
8 about prioritising the future.

9
10 The third category is things that concern our chief
11 executives. To give you an example from that category, we
12 have invested a lot of attention to the care of the frail
13 elderly in hospital, because not managing that correctly
14 will often result in significant extended stays in our
15 hospital system that have all sorts of long-term effects.
16 So it's trying to get the big issues, the issues that are
17 causing practical concern in our healthcare system, and
18 a bit of investment in the future. But I only use that as
19 an illustration.

20
21 There are ways in which you can say everything's
22 important but actually, we're going to concentrate on these
23 two or three areas for these sorts of reasons. And
24 I sincerely hope that we'll move on to that in the work
25 that's going on in the ministry at the moment about its
26 prioritisation, and Andrew was quite right - sorry, Martin
27 was quite right to point out, we've actually got great
28 foundations in New South Wales, better than most other
29 states, to build something like that.

30
31 MR MUSTON: But without some sort of central oversight or
32 involvement in the way in which research funds are being
33 deployed, particularly public research funds within the
34 New South Wales system, you run the risk, don't you, that
35 the autonomous decisions being made by all of these various
36 individuals, perhaps informed by autonomous decisions being
37 made by individual clinicians, can come to shape the public
38 health system in a way which means it's sort of growing and
39 morphing organically and perhaps in a way which doesn't
40 reflect what systemically might be seen as the best way of
41 meeting the health needs of the community through the
42 public health system?

43
44 PROFESSOR NUTBEAM: I think there is an honest risk, if
45 not a risk, an actual observation, that can be made, that
46 that is a feature of a system overall. So I think your
47 observations are correct, and finding the right way of

1 prioritising is a real challenge, I think, in the ministry
2 generally.

3
4 MR MUSTON: I throw up as an example a new and innovative
5 procedure for treating drug resistant epilepsy that is
6 being delivered through Westmead kids and Westmead adult
7 hospital. It's remarkable what we are told about what it
8 can do. But putting to one side the fact that it is of
9 obvious clinical benefit and serendipitously seems to be in
10 a perfect location with that co-location of children's and
11 adult hospitals, the reason it seems to have arrived there
12 is a combination of a clinician who was interested in a new
13 technique, a Churchill fellowship that enabled that
14 clinician to go and study that new technique, which, of
15 course, was a funding decision made wholly externally to
16 the local health district; some philanthropy from local
17 residents that enabled the local health district to stand
18 up the machinery needed to perform the procedure; and then,
19 of course, an insatiable demand for the service because
20 once you stand up a service, demand will grow.

21
22 But that process - undoubtedly that happens across the
23 health system in lots of different ways every day - that
24 results in a system where the health system, in effect, and
25 the services that are offered, are being shaped by these
26 forces that are entirely external to any planning mechanism
27 that exists within the health system. I'm wondering is
28 there a way of controlling that or at least steering it,
29 which gives some level of central oversight and control,
30 perhaps through the ACI, whilst at the same time not
31 stifling the innovation and the organic way in which these
32 sorts of innovations crop up and workforce benefits of
33 keeping people interested in advancing their skills and all
34 of those sorts of things? That's probably a bit of an
35 open-ended - more of a statement than a question, but if it
36 is a comment, please comment.

37
38 PROFESSOR NUTBEAM: I suppose part of my answer to that is
39 that dialogue and alignment - so dialogue isn't someone
40 directing, it's an actual dialogue with a goal of achieving
41 a higher level of alignment, and we often talk about this
42 in the world we inhabit, which is how do you get things
43 implemented.

44
45 So we have this extraordinary research capability in
46 New South Wales. As I said, it is quite dispersed and it's
47 definitely not within the control of the ministry. But in

1 the language I use with my academic colleagues when I'm
2 feeling particularly rude, we're constantly providing
3 perfect answers to questions that no-one had asked.
4

5 For me, the issue is how do I get a dialogue going so
6 that our research capability is a bit more aligned and
7 better connected to the actual needs and priorities of our
8 health system, and a lot of the work we do is actually to
9 get that dialogue going.
10

11 The awful thing, though, is even when you get the
12 dialogue going, if the system itself isn't receptive to
13 change, then it all gets very frustrating, and so the other
14 point of alignment is how do we get our health services -
15 I tend to operate more locally so I talk about services
16 rather than the whole system - how do we get our health
17 services culturally more attuned to the idea that change is
18 constant and we have ways of gathering information that
19 both provide confidence in the evidence and confidence in
20 the potential that it can be implemented.
21

22 That's the kind of dialogue we need to try to create,
23 and again, I will say there are a lot of very practical
24 things that can be done at a ministry level, by the ACI, by
25 the Office for Health and Medical Research, which are the
26 platforms that Martin referred to that we have that are
27 unique to New South Wales, and give us a head start. There
28 are a lot of things that can be done that create a culture
29 for change within the system, and then we can foster this
30 dialogue where people are actually asking and answering
31 questions of much closer relevance to the needs of our
32 healthcare system.
33

34 MR MUSTON: So what are those things? What needs to
35 change, do you think, to foster that dialogue in a way that
36 means questions are being asked that people actually want
37 the answers to, not suggesting that the other answers are
38 not useful but --
39

40 PROFESSOR NUTBEAM: Sure. Sure. No, so I'm going to be a
41 little bit parochial. I'm not trying to promote Sydney
42 Health Partners, but we've been trying to do this for a few
43 years, and so we've created things called clinical academic
44 groups, which are groupings of clinicians and researchers,
45 around critical clinical challenges, as I mentioned -
46 cancer, cardiovascular, musculoskeletal, care of the frail
47 elderly, perioperative care, really critical things in the

1 health system - in order to get that dialogue running, and
2 we've provided modest - very modest - seed funding to
3 enable some initial questions to be asked and answered that
4 actually position these groups then to apply for much
5 larger grants, nationally competitive grants, that enable
6 them to look at this at scale in our healthcare system.

7
8 So there are these kinds of mechanisms for fostering
9 dialogue.

10
11 Andrew, very kindly, last week chaired a meeting where
12 we had a group of our chief executives in a panel
13 discussion with a group of our leading researchers on
14 exactly these questions: "What type of evidence is
15 important for me, as a chief executive, to persuade me that
16 I would need to change the way I fund a service or change
17 the way I configure a service?" And it was a very
18 enlightening discussion.

19
20 Our researchers learned that the approach that they
21 take and the kinds of questions they typically seek to
22 answer aren't providing information that's actually
23 persuasive in our clinical system, and it's that kind of
24 dialogue, I think, that gets a different culture created
25 and gets different questions being posed and answered
26 through research.

27
28 I don't know, Andrew, if you want to --

29
30 PROFESSOR MILAT: Yes, I think to add to what Don has
31 said, it requires conversations at multiple levels
32 throughout the system, because I think the challenge for
33 the system is when you've only got one voice, you know, the
34 voice of clinicians is absolutely fundamental, and, you
35 know, you can get that through various ways, through either
36 clinical academic groups or through ACI's networks; you
37 also need to talk to the chief executives who, you know,
38 oversee the health services and have sort of different
39 priorities. We also need to know what is feasible and
40 appropriate for patient groups, and I think the challenge
41 is how do you take all of those dialogues and sort of join
42 them to come up with priorities that are appropriate for
43 a system?

44
45 But once those priorities are articulated, I think, as
46 Martin and Don have said, I think we have an amazing
47 infrastructure and research ecosystem in New South Wales

1 that, with some tweaks, could focus its efforts a bit more
2 on what those system priorities are.

3
4 To give you an example, there is the Translational
5 Research Grants Scheme. Over various points of time that
6 has been thematically organised, so if we do identify five
7 system priorities. We could say that that scheme would
8 focus on answering those questions. We have an early to
9 mid career fellowship scheme. Once again, that could be
10 aligned with those system priorities once they have been
11 identified. I think the ACI has a small grants work, which
12 has been to foster innovation, that could be aligned with
13 system priorities.

14
15 I think the modest amounts of money that the New South
16 Wales health system has could be better aligned with
17 research priorities if we do have a process of clearly
18 articulating those through a series of dialogues, and
19 I don't think it's one dialogue - you know, the temptation
20 is you just talk to senior people and that's the answer
21 that you get. I think it requires multiple conversations
22 across the system.

23
24 To be fair, the research strategy would be an example
25 where the ministry has been through a process of
26 systematically talking to people about what those
27 priorities are for the system. But I think you can't have
28 a thousand bloomings and expect that that finite and
29 relatively modest amount of research funding is going to go
30 far. I think it is a case of trying to identify what the
31 priorities are in the system and then aligning and sending
32 signals to the research sector but also to clinicians, that
33 if they want to play in this space, these are the
34 priorities for this point in time.

35
36 They can shift, of course, over in time. But that's
37 the only way I can really see feasibly to have that modest
38 investment, and by virtue of investing in these areas which
39 are priorities, then people can leverage Commonwealth
40 funding in that sort of priority area, because I think my
41 observation, working in academia recently, is that once you
42 get a critical mass of expertise and focus on a particular
43 area, that does snowball and people can gain additional
44 resources to focus on that priority.

45
46 So I think, going back to your comment about the
47 system having so many priorities, so many inputs, the

1 opportunity of really motivated clinicians, I think that
2 still needs to be there, but I think it's really about
3 aligning and - aligning those efforts where we can on those
4 system priorities and allowing a lot of that innovation to
5 still occur, but then noting that these are the priorities
6 for the system that we need to push forward.

7
8 MR MUSTON: So we've used the term "dialogue", as part of
9 that critical discussion between the system and researchers
10 and clinicians, but is there something - what structure
11 needs to exist to facilitate that dialogue or make that
12 dialogue either business as usual or a gateway, as it were,
13 to research and research funding?

14
15 PROFESSOR MILAT: Yes, I think there are some obvious
16 examples where that sort of dialogue is happening
17 currently, and I'd expect that that would be great to
18 continue that, through the translation centres, because
19 they - you know, the LHDs themselves have bought into these
20 entities as a vehicle for doing research and helping them
21 to sort of get the best available evidence to implement
22 care.

23
24 I think obviously there are - where the CEs get
25 together with the ministry and pillars, that's obviously
26 a very important forum, the senior executive forum. There
27 are also similar sort of entities where patient views can
28 be brought to bear, and having conversations with various
29 peak bodies and organisations, it's critical to do that,
30 but to do that in a sort of systematic way.

31
32 Obviously consultation needs to be an ongoing
33 dialogue, these things need to continue, but then at some
34 points in time when you are developing priorities, you need
35 to have, I think, a more formal process of sort of engaging
36 with systems and then coming up with those priorities,
37 putting them up the flagpole, testing them with your
38 different constituencies and making sure that you're on
39 track to get some consensus across the system to then set
40 some of those priorities.

41
42 So I think, you know, the ministry has a guide on
43 setting research priorities, and I know that it's been done
44 in some areas across the system, but I suppose it's, you
45 know, been a challenge to do that across the whole system
46 and to get that consensus. So there's a reason why it
47 hasn't been done, because it's very challenging to get

1 consensus across such a diverse system with different
2 stakeholders at play, and balancing all of that is
3 a challenge. But I'd certainly look to the Office for
4 Health and Medical Research's recent process to give us
5 some signpost as to where we should be going through that
6 consultation process, but also those ongoing conversations
7 with some of those key organisations that I've outlined.

8
9 MR MUSTON: Are there other jurisdictions, either in
10 Australia or around the world that do this better in terms
11 of a slightly more structured approach to the deployment of
12 research within public health systems?

13
14 PROFESSOR MILAT: Yeah, I think this is a challenge
15 internationally. If you look at some systems, certainly
16 Don, I'm sure, will talk to some examples of some stuff
17 that has happened in the United Kingdom. But I think, you
18 know, often when we do look to the United States, they have
19 a very fragmented system, they almost have three health
20 systems and a lot of commercial interests drive activity in
21 that space, it's very difficult to get consensus in that
22 environment. I think if you do look to Canada and perhaps
23 the United Kingdom, there are some pockets of excellence in
24 that space.

25
26 I don't know if you wanted to talk about that example
27 that we were chatting about in the session about the
28 alignment from some of the equivalent organisations in the
29 United Kingdom around health technology and how they've
30 been through a prioritisation process and helped align with
31 the NHS's goals in that space.

32
33 PROFESSOR NUTBEAM: I mean, I have worked in the UK
34 system, both in the ministry and as an academic. What
35 I would say is it's more decisive over there, first of all.
36 They made a call, they've created a national network of
37 research translation centres. They've given them money and
38 a really clear mandate. The mandate extends a bit beyond
39 what has been the subject of much of our discussion this
40 afternoon, which is about how you take evidence of best
41 practice and see it translated at scale in our healthcare
42 system, back into the pipeline a bit - they want to see the
43 potential for economic contributions to be also supported,
44 so the example you gave in Westmead, which is phage
45 therapy, I'm guessing.

46
47 MR MUSTON: No, I don't think it's that.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

PROFESSOR NUTBEAM: It's something else but --

MR MUSTON: It is a laser that is used to ablate parts of the brain.

PROFESSOR NUTBEAM: Okay, well, there are some good examples out of Westmead, more than one, of serendipitous discovery turning into something of great practical importance in the health system.

They've just been more decisive and have not been afraid to prioritise and have dealt with the political blow-back that comes with prioritisation, and they put money into it. That is a sort of refreshing contrast to the situation I think we find in Australia generally nationally, and can observe in New South Wales as well, which feels a bit like 11,000 flowers bloom and possibly one of them might make good. We've not been so good, I think, at being decisive in identifying clear areas of need in our healthcare system and concentrating resources and trying to make that work better through research.

MR MUSTON: Within the ecosystem that is NSW Health, would the ACI be the body best placed, do you think, to make those decisive calls and seek to cordon off and direct, as best as it can, the allocation of research - state based research moneys into those areas?

PROFESSOR NUTBEAM: It's best set up to do that, no question about that. My understanding of one of the reasons why ACI was set up in the way it was, was to mobilise intelligence. So there's no question, I think, that the ACI is probably best set to do that.

You would have to want it to be in good dialogue with the Clinical Excellence Commission as well, though, who have identified some clear priorities for the healthcare system and, you know, do have need of those being intelligence driven and do need to know that, for example, if you want to reduce hospital acquired infection, which is one of the clearly identified priorities, we actually have the evidence and we have good evidence of what you need to do in practice at scale in our healthcare system.

So for me, ACI is set up to do that, but it needs to work with the other parts of government who are making

1 decisions about clinical priorities in that regard.

2

3 MR MUSTON: To the extent that they're making decisions
4 about health priorities or about research priorities which
5 are perhaps driving research priorities at the moment, it
6 is contributing to the thousand blooms, is it not? If you
7 have the CEC expressing a view about a range of different
8 things that are worth looking into and the ACI expressing
9 some views about things it thinks are worth looking into,
10 LHDs and organisations like yours looking at things that
11 might be on the ground worth looking into, that's
12 fertilising the fields, is it not?

13

14 PROFESSOR NUTBEAM: So I'm not necessarily going to agree
15 with your proposition. So I'm going to be confident that
16 the ministry knows how to create its internal dialogue to
17 minimise that. As I've said, certainly our experience of
18 working with the ACI over the last 18 months has been very
19 positive. They want to join the dots, if I can put it like
20 that. But I think, you know, any casual observer would say
21 we still suffer from fragmentation, to some extent within
22 but particularly without the health ministry, and I don't
23 think it serves New South Wales as well as we might like
24 to, as a consequence.

25

26 MR MUSTON: Professor Milat, can I come back to an issue
27 you raised a bit earlier around the single digital patient
28 record and the potential benefits that it offers, from
29 a research perspective, just to make sure I have understood
30 the gist of what you were telling us.

31

32 Coming back to the example of the opioids to treat
33 lower back pain, at the moment, you've got a range of
34 different patient record systems across the state which are
35 producing a different array of data in different formats,
36 visible, at least at a dashboard level, by a range of
37 different people in different areas, but it takes a bit of
38 work to collate all of that data and use it in a meaningful
39 way. Would that be a fair assessment of the current state
40 of affairs?

41

42 PROFESSOR MILAT: Not being an expert in that, I know that
43 there's - this is an example where that record has been
44 prioritised and, you know, the ministry has appointed
45 a fantastic senior executive to really drive this
46 initiative, to really, you know, ensure that it actually is
47 able to provide the information that it requires.

1
2 But to give you an example of what's happened in
3 Kaiser Permanente, that data became real-time data that
4 clinicians could use, entering it, and then they could also
5 look at it on the basis of, you know, hospital or a ward
6 but then also use it as part of the performance system.

7
8 I know that NSW Health has a comprehensive performance
9 system which uses a multitude of data, but I think often
10 where the missing piece currently is is to use those pieces
11 of information for informing clinical practice in real
12 time. So that's the challenge, yes.

13
14 MR MUSTON: But to step through that, you introduce a new
15 guideline that says, "You should not be prescribing opioids
16 for lower back pain other than in particular unique
17 circumstances where it's warranted." You introduce that
18 guideline perhaps with an early suite of clinician
19 education around it, but then, almost from day one, you're
20 able to utilise, once it's up and rolling, the single
21 digital patient record to actually give you a cut of people
22 presenting with back pain who are given opioid treatments
23 and you can break that down into this emergency department
24 at Concord hospital and that emergency department at Wagga
25 Base Hospital, and you can look across the system almost in
26 real time at how, if at all, this guideline is being
27 implemented and taken up by particular emergency department
28 practitioners across the state.

29
30 PROFESSOR MILAT: Yes, I think that's the Nirvana of how
31 these systems would work in the future, and I think that
32 plan, do, study, act cycle and clinical audit - I mean,
33 I think Luke would talk about that the most effective
34 strategy that's found in the implementation literature
35 again and again is the ability to do clinical audit,
36 reflecting on practice, so anything that can support that
37 plan, do, study, act cycle, and the single digital patient
38 record has great potential to do that.

39
40 In an ideal world, moving forward, we would have those
41 information systems that would enable us to know whether
42 we're hitting that model of care. I mean, there are
43 examples under the "Leading Better Value Care" initiative
44 where sort of linked datasets have brought together the
45 admitted patients data collection, births, deaths and
46 marriages - like a whole bunch of things - patient
47 experience. So there are efforts within the Ministry of

1 Health to actually try to create these linked datasets to
2 really critically assess what's happening with the
3 introduction of new models of care. But I think the
4 challenge has been in the past that, you know, we really
5 have to catch up. The technology is there to get the
6 alignments of those different data systems to enable
7 information to be extracted in a timely fashion.

8
9 I think that's something that is being worked on,
10 I believe, throughout the system. Once again, if that
11 single digital patient record can be used for research
12 purposes, once again, it's opening up a lot of that
13 clinical data for use in research, quality improvement,
14 system transformation. So I think that's what we sort of
15 need to work towards.

16
17 I don't have the answer to how to do that, and when
18 that would occur, but certainly it presents an opportunity
19 for the system, should it be implemented in the way that we
20 would hope, to achieve some of those objectives, and would
21 be, you know, removing, I think, a critical barrier in the
22 current system for how to use that information in a timely
23 way.

24
25 MR MUSTON: I think you mentioned prompts, as well. The
26 other potential benefit of something like a single digital
27 patient record across the state is if, as part of that
28 translational research, it's determined that, well, look,
29 this is not being taken up as quickly as it should, for one
30 of an array of reasons that you've identified in
31 paragraph 13 of your report, the systemic barriers, an
32 answer to that might be, "Well, we need to introduce a
33 little prompt or a dialogue box that pops up every time
34 you've clicked on the 'back pain' box and clicked on the
35 'prescribe opioid' box, and it says, 'Do you really want to
36 do this? Have you considered the guideline? There are
37 better ways potentially of dealing with this problem'", no
38 doubt in far more technical terms than that, which require
39 a clinician to then click on a button in order to progress
40 beyond the, "I'll just give them the opioid treatment",
41 which might, in and of itself, operate as a behavioural
42 change mechanism.

43
44 PROFESSOR MILAT: Yes, and I think there is strong
45 evidence that those promise and dialogues can work, but
46 I think we do need to exercise caution. Once again with
47 the sheer number of models of care, we do know that time is

1 one of the things that we've looked at in the literature
2 and certainly anecdotally here through Sydney Health
3 Partners it's the lack of time that clinicians have to do
4 a lot of these things but also the challenge of balancing
5 multiple priorities.
6

7 I think that a lot of consideration has to go into
8 sort of timing of the introduction of some of these things,
9 because people could be overloaded with just so many
10 dialogue boxes and it could slow down the process.
11

12 So really, that's a critical thing in thinking about,
13 you know, what is a reasonable load of change within
14 a system, and it obviously - but what you've described, you
15 know, that would be an ideal scenario, and once again,
16 I think that the challenge is we need to introduce these
17 things in tranches to not overwhelm systems. We do know
18 that from the broader literature, if we do introduce too
19 much change too quickly, that people just don't engage with
20 the process. That's one of the challenges with large-scale
21 system transformation, that you have to find the right
22 balance and hence the importance of things like
23 implementation science and implementation research around
24 trying to - you could even, you know - the importance of
25 quality improvement as well, so we actually are getting
26 those constant feedback loops that we're introducing change
27 as part of an organisation that is sustainable and is being
28 adopted and we're pivoting what we're doing to ensure that
29 we're not overwhelming our clinicians on the front line.
30

31 MR MUSTON: Which, in a slightly more rough and ready way,
32 means you don't want to turn your dialogue box or your, "Do
33 you really want to do this" button into a "Have you read
34 the terms and conditions" type question at the end of --
35

36 PROFESSOR NUTBEAM: I was going to offer just a note of
37 caution about - so I think all you have suggested makes
38 great sense, and Andrew's right, there's great evidence
39 that suggests prompts like that will help change behaviour.
40

41 I think the issue for me remains one of - so I'm on
42 the board of one of the local health districts. Every
43 month we meet and every month we get a report on the number
44 of hospital acquired infections, and it goes up and it goes
45 down, but honestly, you would have hoped by now we might
46 have seen a really sustained (indicates) - and that's not
47 the case.

1
2 One of the reasons for that is that we know - we know
3 we need to tackle it, we know many of the things that we
4 need to do to avoid hospital acquired infection, but the
5 feasibility of implementing in practice is not well enough
6 understood, and the reason why people continue to behave in
7 ways in which they've always behaved, that might often
8 increase the risk, is not well enough understood.
9

10 I'm almost back to where I started: we know what is
11 the right thing to do in most situations. We can apply
12 pressure to the system, and I can tell you there is real
13 pressure applied to the system on that specific indicator.
14 And yet, because we don't completely understand what
15 actually happens in practice on a day-to-day basis - with
16 our staff, working in real life, real time, we don't
17 understand that enough - we still are not making the
18 progress that we would wish to make.
19

20 I'm sort of back in the circle, that if there was one
21 thing that we could do better and need to do more of in
22 New South Wales, it's research that helps us to understand
23 how you build confidence for actual change in clinical
24 practice in our healthcare system. That, for me, is still
25 pivotal in almost every part of every discussion that we've
26 had.
27

28 MR MUSTON: You would, presumably, advocate for that to be
29 one of the ACI's priorities if it were in the decisive way
30 that you've referred to, as happening in other
31 jurisdictions, identifying those key research --
32

33 PROFESSOR NUTBEAM: I would say it was almost inescapable
34 from the 18 months of consultation that they've been
35 involved with now. The single most consistent piece of
36 feedback that they have received is, "We need to focus on
37 the point of translation." So I would be surprised if it
38 wasn't. I would, not surprisingly, perhaps, given all
39 I have said, consider that to be a really important
40 priority for a state health system, not necessarily for the
41 entire research ecosystem that we have, but for what the
42 state government can most constructively do and add most
43 value to the system - that would be the point of our
44 attention, it seems to me.
45

46 MR MUSTON: The wider research ecosystem includes
47 pharmaceutical companies, medical device companies --

1
2 PROFESSOR NUTBEAM: Yes, discovery research, people doing
3 molecular chemistry to understand the functioning of the
4 body that's a long way away from practical application in
5 humans. There's a full spectrum of research going on and
6 some really world-class research going on in New South
7 Wales, of which we should be incredibly proud.

8
9 But the point at which a state government can make
10 a difference through its health ministry to that big system
11 feels, to me, like the point of translation, where we know
12 something works and we would like to see it implemented at
13 scale to deliver patient benefit.

14
15 MR MUSTON: Can I ask you to come to case example 1 on
16 page 10 of your report. I'm just curious, in the second
17 paragraph, you refer to the initiative as having produced
18 a return on investment of \$7 for every dollar of New South
19 Wales funding. I'm just wondering, how was that
20 quantified?

21
22 PROFESSOR MILAT: What paragraph number was that?

23
24 MR MUSTON: Sorry, you see case example 1 --

25
26 PROFESSOR NUTBEAM: On page 10, case example 1.

27
28 MR MUSTON: -- immediately beneath paragraph 39.

29
30 PROFESSOR NUTBEAM: Are you able to comment on that?

31
32 MR MUSTON: It seems like a pretty good investment but --

33
34 PROFESSOR NUTBEAM: So I'm going to guess that one part of
35 the calculation was whether or not the clinician researcher
36 was able then to go on to generate external research funds.
37 So the 7:1 ratio might be around, given the amount invested
38 in their research development, did they go on to become
39 a successful researcher? I may be wrong in that.

40
41 MR MUSTON: Does anyone else want to proffer a view on
42 that one?

43
44 PROFESSOR MILAT: Yes. I think it comes from a process
45 evaluation that's published on the Ministry of Health
46 website, and so, look, I am familiar with - a lot of this
47 is around potential earnings as well, depending on how - so

1 in terms of the early to mid career researchers, they
2 essentially are - their salary is covered for a period of
3 three years, as I understand it.
4

5 In terms of the producing a greater publication yield,
6 obviously there are contributions to the research sector
7 but also their ability to attract additional funding,
8 I think that's how that calculation occurred. I think the
9 greater detail is in the report but I can take it on notice
10 and give you further answers. But I know that with other
11 research schemes, there are different ways to calculate
12 that benefit. So obviously they are: lifetime learnings
13 can be sort of thrown into a researcher, once they begin to
14 become productive, they get a fellowship, then they move on
15 to other research funding, they then leverage additional
16 research funding, so there are a number of ways that you
17 could calculate the benefit of a scheme like this,
18 depending on the methods.
19

20 MR MUSTON: But the \$7 return on every dollar spent is not
21 subject to you looking further at it and coming back to
22 correct this, but it's not suggesting that for every dollar
23 of research spend there was, in effect, a \$7 saving within
24 the health system?
25

26 PROFESSOR MILAT: No, certainly I know that that's not the
27 case in this particular analysis. It's other benefits that
28 maybe leverage funds. I can provide a definitive answer.
29 I'll go back to the report.
30

31 PROFESSOR NUTBEAM: I think the return on investment is a
32 research related return --
33

34 PROFESSOR MILAT: Return on investment, yes.
35

36 PROFESSOR NUTBEAM: -- rather than a clinical practice
37 return, if I can put it that way.
38

39 PROFESSOR MILAT: Yes. Yes, it is.
40

41 MR MUSTON: Which is excellent for the clinician or for
42 the researcher and no doubt for the organisation that they
43 might be affiliated with, but from the point of view of the
44 New South Wales Government spending \$1 on research and then
45 getting a tangible benefit in terms of costs associated
46 with the delivery of health care in New South Wales or
47 the --

1
2 PROFESSOR NUTBEAM: I'll turn it around and say New South
3 Wales probably doesn't - is not at this point competitive
4 on a population basis to Victoria and Queensland in
5 attracting national research funding. I think in terms of
6 the benefit to the state, the kind of investment that's
7 alluded to here about developing excellent clinical
8 researchers who can then go on to generate research income
9 from outside of the state has some definite benefit, it
10 seems to me. And one of the reasons for the current review
11 of research strategy in New South Wales is this fact that
12 we're probably not competing as successfully statewide as
13 we could and should in national and international grant
14 getting.

15
16 MR MUSTON: Accepting the benefit of research as a general
17 proposition, what is it that is good for the state about
18 attracting more research money?

19
20 PROFESSOR NUTBEAM: So, for example, we have - I don't
21 know, it might be 2 or 3 per cent, and I mustn't be -
22 I can't be firm about it. A very small proportion of our
23 patients are enrolled in clinical trials, and we know that
24 patients who are enrolled in clinical trials get better
25 treatment and achieve better outcomes than patients who are
26 not involved in clinical trials.

27
28 Raising the volume of clinical trial activity in
29 New South Wales and increasing the proportion of patients
30 who have access to clinical trials will improve outcomes,
31 health outcomes, for the population in New South Wales;
32 will provide access to cutting-edge treatment faster and at
33 a greater scale than is the case at the moment; and
34 depending on the nature of the trial - they'll either be
35 externally funded through a research grant giving body or
36 by a pharmaceutical or other private sector - it will
37 actually bring income into the state of New South Wales.

38
39 So increasing our research activity delivers positive
40 benefits to patients, better health outcomes and grows our
41 economy, if I can put in a little pitch like that. But
42 there is good evidence to support that position.

43
44 I don't think the two are sort of mutually exclusive.
45 There are benefits in growing research activity and
46 research competitiveness in New South Wales that are
47 directly beneficial to our healthcare system and good for

1 the economy.

2

3 MR MUSTON: Commissioner, I have no further questions for
4 these witnesses.

5

6 THE COMMISSIONER: Thank you.

7

8 Mr Cheney?

9

10 MR CHENEY: No, Commissioner.

11

12 THE COMMISSIONER: To all of you, including those that
13 have left, thank you very much for your time and for your
14 assistance. We're very grateful.

15

16 And we'll adjourn until 2 o'clock tomorrow?

17

18 MR MUSTON: Yes.

19

20 THE COMMISSIONER: All right. We'll adjourn until then,
21 thank you.

22

23 <THE WITNESSES WITHDREW

24

25 AT 4PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO
26 WEDNESDAY, 11 DECEMBER 2024 AT 2PM

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

\$	2	6840:29	6888:20, 6892:30,	6831:9, 6831:19,
\$10 [2] - 6829:1, 6829:3	2 [8] - 6802:18, 6808:44, 6813:5, 6844:3, 6849:8, 6871:41, 6894:21, 6895:16	65-year-old [2] - 6827:28, 6830:7	6892:36	6845:45, 6846:6
\$300 [1] - 6841:14	2.10pm [1] - 6850:4	65-year-olds [1] - 6830:8	abolished [1] - 6840:30	accountabilities [2] - 6824:20, 6824:32
\$50,000 [2] - 6863:12, 6864:13	20 [3] - 6832:17, 6853:29	7	Aboriginal [1] - 6839:34	accountability [2] - 6815:4, 6816:39
'	200 [1] - 6821:34	7 [3] - 6892:18, 6893:20, 6893:23	absence [1] - 6874:37	accountable [11] - 6812:10, 6814:47, 6815:31, 6818:42, 6820:9, 6820:10, 6845:2, 6845:4, 6845:43, 6846:3, 6846:5
'back [1] - 6889:34	2000 [1] - 6843:41	70 [1] - 6853:47	absolute [1] - 6848:19	accurate [1] - 6814:31
'Do [1] - 6889:35	2003 [1] - 6873:46	7:1 [1] - 6892:37	absolutely [22] - 6807:8, 6807:19, 6807:43, 6815:22, 6821:32, 6822:37, 6828:11, 6828:35, 6830:24, 6835:24, 6835:41, 6838:31, 6838:46, 6839:13, 6839:18, 6840:13, 6840:24, 6843:23, 6847:10, 6848:36, 6848:39, 6882:34	achieve [11] - 6816:14, 6818:10, 6831:16, 6831:35, 6837:41, 6847:31, 6854:5, 6854:37, 6873:5, 6889:20, 6894:25
'prescribe [1] - 6889:35	2014 [1] - 6804:32	8	absorb [1] - 6867:29	achieved [4] - 6808:37, 6826:9, 6826:32, 6831:42
'yes' [1] - 6845:1	2016 [1] - 6867:5	80 [2] - 6848:22, 6848:24	abstracts [1] - 6869:44	achieving [8] - 6810:40, 6812:10, 6815:5, 6824:21, 6826:13, 6829:25, 6853:3, 6880:40
0	2016/17 [1] - 6867:38	800 [4] - 6816:35, 6816:38, 6816:43, 6817:1	academia [1] - 6883:41	ACI [57] - 6834:20, 6856:47, 6857:1, 6857:21, 6858:14, 6858:33, 6859:21, 6862:17, 6862:22, 6862:37, 6863:21, 6863:30, 6863:32, 6865:19, 6865:25, 6865:46, 6866:10, 6866:18, 6866:33, 6866:47, 6867:11, 6870:12, 6870:17, 6870:32, 6871:17, 6871:33, 6872:26, 6872:28, 6872:33, 6872:36, 6872:46, 6873:2, 6873:6, 6873:17, 6873:35, 6874:33, 6874:41, 6874:43, 6874:44, 6875:5, 6875:6, 6875:11, 6875:33, 6875:39, 6878:13, 6880:30, 6881:24, 6883:11, 6886:25, 6886:32, 6886:34, 6886:46, 6887:8, 6887:18
0002 [1] - 6812:45	2022 [1] - 6805:2	80s [1] - 6804:13	academics [1] - 6852:36	ACI's [5] - 6862:32, 6870:19, 6874:46,
067 [1] - 6802:25	2023 [2] - 6803:30, 6812:32	9	accelerate [1] - 6852:26	
1	2024 [3] - 6802:23, 6851:34, 6895:26	90 [3] - 6822:25, 6835:30, 6874:25	accept [2] - 6856:36, 6871:11	
1 [4] - 6892:15, 6892:24, 6892:26, 6893:44	24 [1] - 6876:6	A	acceptability [1] - 6854:24	
10 [14] - 6802:23, 6804:26, 6805:2, 6808:40, 6810:21, 6810:24, 6810:45, 6811:40, 6822:27, 6823:8, 6844:25, 6852:1, 6892:16, 6892:26	29 [1] - 6851:34	abandon [1] - 6846:9	acceptance [1] - 6862:9	
10,000 [1] - 6824:18	2PM [1] - 6895:26	ABF [28] - 6804:33, 6805:22, 6807:37, 6808:8, 6810:38, 6810:44, 6816:24, 6820:28, 6820:35, 6822:9, 6824:14, 6824:45, 6825:23, 6826:7, 6826:11, 6826:36, 6829:14, 6829:28, 6829:31, 6835:5, 6835:11, 6838:8, 6839:45, 6841:8, 6843:8, 6844:45	access [12] - 6832:14, 6837:19, 6839:41, 6842:10, 6858:39, 6858:41, 6869:40, 6869:45, 6869:47, 6871:5, 6894:30, 6894:32	
10-year [1] - 6811:37	3 [5] - 6813:5, 6825:31, 6851:33, 6871:41, 6894:21	ability [8] - 6810:40, 6822:6, 6837:18, 6844:44, 6847:32, 6861:2, 6888:35, 6893:7	accessible [1] - 6836:25	
100 [3] - 6842:34, 6843:9, 6877:40	30 [2] - 6803:29, 6877:40	ablate [1] - 6886:4	accommodate [1] - 6816:7	
11 [1] - 6895:26	38 [1] - 6807:8	able [24] - 6809:23, 6810:47, 6814:46, 6819:28, 6820:3, 6824:15, 6829:13, 6836:30, 6845:39, 6845:44, 6848:1, 6855:10, 6861:20, 6861:41, 6867:14, 6870:10, 6874:9, 6874:20, 6874:24, 6874:43, 6887:47,	accommodation [1] - 6840:39	
11,000 [1] - 6886:18	39 [2] - 6876:7, 6892:28		account [11] - 6810:18, 6811:28, 6811:47, 6821:10, 6824:21, 6831:6,	
11.00am [1] - 6802:23	3pm [2] - 6850:13, 6850:16	4		
11.05am [1] - 6803:8	4 [2] - 6825:31, 6856:19	4 [2] - 6825:31, 6856:19		
12 [1] - 6861:14	40 [2] - 6813:17, 6822:32	4PM [1] - 6895:25		
121 [1] - 6802:18	5	5		
13 [3] - 6831:27, 6831:28, 6889:31	5 [1] - 6823:3	5 [1] - 6823:3		
14 [2] - 6812:37, 6856:19	50 [4] - 6822:28, 6822:31, 6823:7, 6874:23	50 [4] - 6822:28, 6822:31, 6823:7, 6874:23		
15 [4] - 6803:41, 6820:29, 6833:25, 6834:36	500 [2] - 6824:27, 6825:43	500 [2] - 6824:27, 6825:43		
15-minute [1] - 6841:15	6	6		
16 [1] - 6804:18	6 [2] - 6851:47, 6863:15	6 [2] - 6851:47, 6863:15		
18 [5] - 6804:19, 6875:36, 6876:23, 6887:18, 6891:34	60 [2] - 6822:31,	60 [2] - 6822:31,		
1980s [1] - 6843:41				
1990s [1] - 6804:12				

6882:36, 6891:29
ACI/ministry [1] - 6870:33
acquired [3] - 6886:41, 6890:44, 6891:4
act [5] - 6858:27, 6872:33, 6876:22, 6888:32, 6888:37
Act [3] - 6804:5, 6838:13, 6848:33
act" [1] - 6848:33
active [3] - 6828:40, 6857:14, 6867:4
actively [2] - 6866:7, 6866:8
activities [3] - 6822:14, 6854:27, 6874:46
activity [79] - 6804:17, 6804:19, 6804:28, 6804:33, 6804:39, 6804:44, 6805:29, 6806:20, 6806:43, 6807:14, 6808:3, 6808:18, 6808:25, 6809:7, 6810:5, 6810:6, 6810:9, 6810:12, 6810:13, 6811:17, 6812:21, 6812:29, 6817:44, 6818:44, 6818:47, 6819:1, 6819:2, 6819:21, 6820:13, 6821:38, 6821:41, 6821:42, 6823:24, 6823:25, 6823:32, 6823:47, 6824:18, 6824:23, 6824:26, 6824:37, 6824:38, 6824:39, 6824:41, 6824:47, 6826:6, 6826:8, 6826:43, 6827:24, 6827:25, 6827:32, 6828:46, 6829:1, 6829:2, 6829:10, 6829:33, 6829:35, 6830:16, 6830:17, 6833:11, 6835:2, 6835:5, 6835:20, 6842:14, 6843:7, 6844:42, 6845:9, 6845:10, 6845:12, 6845:14, 6845:15, 6846:9, 6855:17, 6862:27, 6885:20, 6894:28, 6894:39, 6894:45
activity" [1] - 6822:13
actual [6] - 6809:12, 6875:44, 6879:45, 6880:40, 6881:7, 6891:23
acute [14] - 6806:16, 6806:47, 6809:3, 6823:25, 6823:41, 6827:38, 6838:20, 6838:25, 6846:33, 6848:27, 6848:38, 6859:25, 6862:26
ad [1] - 6833:9
adapt [1] - 6848:6
adapts [1] - 6848:16
add [8] - 6825:42, 6838:32, 6847:22, 6870:11, 6871:31, 6874:34, 6882:30, 6891:42
adding [1] - 6829:39
additional [4] - 6873:12, 6883:43, 6893:7, 6893:15
address [4] - 6810:29, 6831:28, 6840:6, 6854:28
addressing [2] - 6838:27, 6867:16
adequate [2] - 6819:47, 6837:20
adequately [5] - 6816:2, 6819:45, 6828:27, 6834:25, 6837:17
adjacent [1] - 6837:16
adjourn [3] - 6849:8, 6895:16, 6895:20
adjunct [1] - 6803:13
adjuster [1] - 6810:46
adjustments [1] - 6811:9
administration [1] - 6804:11
administrative [1] - 6868:37
admission [1] - 6803:33
admissions [3] - 6826:42, 6833:24, 6833:25
admitted [3] - 6835:12, 6841:24, 6888:45
adopt [3] - 6804:42, 6805:21, 6805:32
adopted [6] - 6805:31, 6806:44, 6859:22, 6867:7, 6870:14, 6890:28
adoption [2] - 6853:1, 6853:46
ads [1] - 6842:40
adult [2] - 6880:6, 6880:11
advance [1] - 6873:18
advancing [1] - 6880:33
advantageous [1] - 6864:18
adverse [1] - 6809:33
advice [3] - 6823:35, 6859:11, 6878:31
adviser [1] - 6850:30
advisory [1] - 6803:44
advocate [1] - 6891:28
advocating [3] - 6858:38, 6860:42, 6861:6
affairs [1] - 6887:40
affiliated [1] - 6893:43
affirmation [7] - 6849:29, 6849:35, 6849:37, 6849:40, 6849:44, 6849:46, 6850:1
affirmed [5] - 6803:8, 6850:4, 6850:6, 6850:8, 6850:10
afford [2] - 6805:37, 6837:13
affordable [1] - 6841:25
afraid [1] - 6886:13
afternoon [5] - 6849:12, 6849:14, 6849:16, 6877:29, 6885:40
age [3] - 6803:30, 6848:20, 6848:23
aged [18] - 6805:6, 6805:9, 6811:32, 6822:39, 6822:40, 6822:46, 6823:9, 6838:46, 6839:2, 6839:3, 6839:5, 6839:12, 6839:21, 6840:25, 6840:27, 6840:31, 6840:32, 6840:38
agencies [4] - 6807:21, 6807:26, 6813:42, 6877:5
agency [2] - 6871:33, 6872:13
Agency [1] - 6833:44
agenda [1] - 6875:12
agile [1] - 6847:32
ago [6] - 6812:37, 6822:38, 6832:17, 6834:40, 6839:13, 6851:40
agree [9] - 6807:4, 6825:39, 6828:34, 6831:2, 6841:6, 6862:1, 6867:10, 6878:2, 6887:14
agreed [1] - 6804:39
Agreement [2] - 6804:18, 6807:27
agreement [9] - 6804:32, 6804:40, 6805:17, 6816:19, 6829:19, 6835:42, 6841:8, 6842:47
agreements [2] - 6811:16, 6838:12
ahead [2] - 6819:8, 6838:34
aim [1] - 6826:39
akin [1] - 6874:13
align [1] - 6885:30
aligned [7] - 6820:37, 6831:15, 6873:21, 6881:6, 6883:10, 6883:12, 6883:16
aligning [3] - 6883:31, 6884:3
alignment [7] - 6824:34, 6852:35, 6858:47, 6880:39, 6880:41, 6881:14, 6885:28
alignments [1] - 6889:6
aligns [1] - 6853:12
allocation [3] - 6804:4, 6830:35, 6886:27
allocations [1] - 6805:43
allocative [22] - 6810:10, 6814:4, 6823:40, 6826:5, 6826:12, 6826:14, 6826:35, 6826:37, 6826:39, 6826:44, 6827:33, 6827:34, 6829:26, 6829:42, 6831:28, 6834:4, 6840:35, 6846:3, 6846:6, 6847:12, 6847:14, 6847:30
allocatively [2] - 6842:9, 6847:43
allowed [2] - 6817:10, 6874:15
allowing [1] - 6884:4
allows [1] - 6867:15
alluded [3] - 6857:6, 6875:39, 6894:7
alluding [1] - 6847:27
almost [10] - 6803:29, 6809:20, 6863:20, 6864:32, 6885:19, 6888:19, 6888:25, 6891:10, 6891:25, 6891:33
alone [4] - 6830:27, 6831:29, 6838:29, 6872:28
alternative [4] - 6818:31, 6830:3, 6841:27, 6858:43
alternatively [1] - 6816:9
amazing [1] - 6882:46
amount [13] - 6808:8, 6808:13, 6808:17, 6808:20, 6809:34, 6822:46, 6825:44, 6826:27, 6832:30, 6836:43, 6867:38, 6883:29, 6892:37
amounts [3] - 6804:30, 6860:46, 6883:15
ample [2] - 6824:36, 6825:27
analogy [1] - 6875:22
analysis [2] - 6809:47, 6893:27
Andrew [8] - 6849:23, 6850:29, 6851:3, 6871:39, 6877:1, 6879:26, 6882:11, 6882:28
ANDREW [1] - 6850:8
Andrew's [1] - 6890:38
anecdotally [1] - 6890:2
announced [1] - 6840:26
annoyed [1] - 6861:35
annum [1] - 6806:19
answer [18] - 6810:24, 6811:19, 6811:41, 6820:8, 6830:5, 6834:34, 6857:5, 6859:33, 6865:30, 6870:24, 6870:31, 6871:40, 6880:38, 6882:22, 6883:20, 6889:17, 6889:32, 6893:28
answered [2] - 6882:3, 6882:25
answering [2] - 6881:30, 6883:8
answers [8] - 6864:20, 6864:32, 6865:11,

- 6866:47, 6881:3,
6881:37, 6893:10
anticipated [1] -
6807:12
anyway [2] - 6815:29,
6838:7
application [2] -
6868:1, 6892:4
applications [1] -
6873:24
applied [4] - 6810:17,
6837:2, 6855:18,
6891:13
apply [4] - 6852:22,
6868:17, 6882:4,
6891:11
appointed [1] -
6887:44
appointment [2] -
6821:30, 6851:17
appraise [1] - 6852:22
appreciate [1] -
6855:16
approach [12] -
6806:6, 6807:14,
6808:7, 6808:8,
6811:44, 6823:22,
6835:45, 6854:32,
6866:26, 6872:14,
6882:20, 6885:11
approaches [3] -
6832:19, 6835:5,
6853:39
appropriate [8] -
6817:2, 6818:9,
6821:23, 6829:20,
6845:16, 6874:25,
6882:40, 6882:42
appropriately [2] -
6866:22, 6867:26
approval [1] - 6840:27
approved [2] -
6840:29, 6840:38
area [18] - 6803:18,
6804:15, 6804:16,
6804:37, 6809:21,
6810:12, 6823:39,
6828:21, 6836:29,
6837:30, 6838:15,
6839:32, 6843:29,
6853:15, 6872:32,
6883:40, 6883:43
areas [21] - 6814:20,
6836:15, 6838:38,
6838:43, 6838:44,
6840:7, 6842:28,
6850:35, 6864:9,
6864:10, 6864:29,
6867:39, 6869:31,
6871:3, 6878:14,
6879:23, 6883:38,
6884:44, 6886:20,
6886:28, 6887:37
argue [2] - 6814:44,
6834:2
arguing [2] - 6808:35,
6815:8
argument [1] - 6817:8
argument's [1] -
6855:33
arguments [1] -
6828:20
arrangement [3] -
6814:30, 6842:45
arrangements [3] -
6816:29, 6828:12,
6833:9
array [2] - 6887:35,
6889:30
arrived [1] - 6880:11
Artarmon [3] -
6813:32, 6834:17,
6845:47
articles [1] - 6869:43
articulated [1] -
6882:45
articulating [1] -
6883:18
aspect [1] - 6804:9
aspects [1] - 6818:38
assess [4] - 6818:28,
6825:36, 6862:32,
6889:2
assessed [3] -
6804:30, 6825:47,
6862:18
assessment [12] -
6808:12, 6818:28,
6820:16, 6821:31,
6827:11, 6827:12,
6828:20, 6828:39,
6831:47, 6844:27,
6862:23, 6887:39
assessments [2] -
6825:44, 6832:29
asset [1] - 6869:9
assist [2] - 6812:31,
6873:27
assistance [2] -
6849:3, 6895:14
assistant [1] - 6843:38
assisted [2] - 6879:1,
6879:4
Assisting [5] -
6802:27, 6802:28,
6802:29, 6802:30,
6802:31
assists [1] - 6850:33
associated [2] -
6854:23, 6893:45
assume [5] - 6824:36,
6841:27, 6854:34,
6861:14, 6872:38
assumed [3] -
6825:26, 6846:4,
6855:33
assumes [2] -
6817:45, 6865:31
assuming [1] -
6833:33
assumption [7] -
6815:9, 6816:3,
6816:5, 6833:3,
6850:15, 6851:39,
6874:42
assumptions [1] -
6831:43
assure [1] - 6859:33
AT [2] - 6895:25,
6895:26
attention [8] -
6831:23, 6860:43,
6865:39, 6877:26,
6877:27, 6878:24,
6879:12, 6891:44
attitude [1] - 6839:1
attract [2] - 6846:18,
6893:7
attracting [2] - 6894:5,
6894:18
attuned [1] - 6881:17
audit [3] - 6853:39,
6888:32, 6888:35
Australia [6] -
6806:29, 6826:7,
6874:2, 6877:41,
6885:10, 6886:16
Australian [2] -
6822:39, 6871:42
authored [1] - 6851:32
Authority [3] -
6804:43, 6805:31,
6805:38
authority [3] -
6829:34, 6844:14,
6845:31
authors [2] - 6849:16,
6855:43
authorship [1] -
6851:19
automatic [1] - 6833:3
autonomous [2] -
6879:35, 6879:36
autonomy [1] -
6816:11
availability [5] -
6811:26, 6811:31,
6821:12, 6832:8,
6842:27
available [11] -
6815:16, 6828:24,
6831:20, 6834:23,
6847:45, 6858:28,
6859:11, 6859:15,
6863:40, 6868:21,
6884:21
average [6] - 6806:29,
6822:29, 6823:2,
6823:4, 6848:23,
6848:24
avoid [1] - 6891:4
avoided [1] - 6867:4
avoiding [1] - 6870:43
aware [2] - 6805:41,
6834:22
awful [1] - 6881:11
-
- B**
-
- babies** [1] - 6843:30
baby [4] - 6843:20,
6843:25, 6843:37,
6848:22
background [1] -
6803:17
backyards [1] -
6835:1
bad [1] - 6868:13
balance [8] - 6813:6,
6815:46, 6845:4,
6846:14, 6846:24,
6860:43, 6868:11,
6890:22
balancing [2] -
6885:2, 6890:4
bang [4] - 6812:10,
6815:5, 6818:29,
6829:47
barrier [1] - 6889:21
barriers [6] - 6853:33,
6854:19, 6854:20,
6854:22, 6854:29,
6889:31
base [7] - 6807:34,
6810:18, 6818:28,
6822:42, 6827:17,
6837:18, 6854:10
Base [1] - 6888:25
based [63] - 6804:17,
6804:19, 6804:28,
6804:33, 6804:38,
6804:44, 6805:29,
6806:43, 6807:14,
6808:12, 6808:18,
6809:46, 6810:6,
6811:17, 6812:22,
6812:29, 6815:43,
6816:15, 6816:27,
6817:44, 6818:47,
6819:21, 6820:13,
6823:12, 6823:26,
6825:14, 6826:8,
6828:47, 6829:29,
6831:34, 6831:41,
6831:44, 6831:46,
6832:15, 6832:29,
6835:2, 6835:5,
6835:20, 6839:12,
6842:15, 6842:19,
6845:11, 6847:6,
6847:44, 6854:34,
6856:47, 6857:1,
6857:21, 6857:41,
6858:14, 6859:22,
6860:9, 6862:28,
6866:21, 6867:31,
6868:21, 6869:32,
6870:12, 6870:38,
6871:16, 6876:39,
6878:19, 6886:27
bases [1] - 6866:41
basic [3] - 6809:23,
6810:22, 6815:24
basis [13] - 6806:19,
6808:25, 6808:26,
6810:1, 6814:43,
6818:44, 6833:15,
6859:2, 6862:41,
6874:18, 6888:5,
6891:15, 6894:4
bat [1] - 6872:38
bear [1] - 6884:28
Beasley [1] - 6802:14
became [2] - 6803:27,
6888:3
become [7] - 6812:22,
6828:13, 6833:28,
6839:4, 6840:31,
6892:38, 6893:14
becomes [1] - 6824:18
becoming [1] -
6833:27
beds [5] - 6839:3,
6839:5, 6840:29,
6840:37, 6840:41
began [1] - 6858:2
begin [1] - 6893:13
beginning [2] -
6803:30, 6848:10
Beginnings [1] -
6825:34
behalf [1] - 6804:25
behave [2] - 6858:46,
6891:6
behaved [1] - 6891:7
behaviour [7] -
6841:19, 6858:41,
6863:26, 6872:3,
6872:5, 6872:39,
6890:39

- behavioural** [2] - 6872:2, 6889:41
behaviours [1] - 6857:8
behind [1] - 6876:15
beliefs [1] - 6812:40
benchmarking [1] - 6846:44
beneath [1] - 6892:28
beneficial [5] - 6827:14, 6853:19, 6854:26, 6871:37, 6894:47
benefit [12] - 6853:9, 6855:39, 6861:15, 6880:9, 6889:26, 6892:13, 6893:12, 6893:17, 6893:45, 6894:6, 6894:9, 6894:16
Benefits [1] - 6841:9
benefits [10] - 6846:30, 6847:9, 6853:11, 6855:8, 6867:34, 6880:32, 6887:28, 6893:27, 6894:40, 6894:45
Berry [3] - 6845:25, 6845:28, 6845:29
best [62] - 6809:46, 6812:10, 6812:28, 6812:40, 6813:32, 6813:33, 6813:45, 6813:47, 6814:41, 6815:5, 6815:15, 6815:29, 6818:29, 6819:28, 6819:33, 6819:38, 6824:12, 6824:22, 6824:29, 6825:36, 6829:47, 6830:39, 6837:40, 6837:41, 6837:44, 6846:45, 6847:4, 6847:31, 6853:34, 6855:29, 6855:31, 6856:29, 6858:28, 6859:1, 6859:10, 6859:19, 6860:40, 6864:11, 6866:42, 6868:21, 6870:31, 6870:35, 6871:18, 6871:34, 6871:35, 6872:20, 6873:5, 6873:46, 6875:27, 6876:2, 6876:15, 6877:9, 6877:14, 6877:46, 6879:40, 6884:21, 6885:40, 6886:25, 6886:27, 6886:30, 6886:34
better [43] - 6813:26, 6818:10, 6819:9, 6823:40, 6825:1, 6825:29, 6825:30, 6826:37, 6833:1, 6833:5, 6833:8, 6835:2, 6839:8, 6841:21, 6846:19, 6846:20, 6856:12, 6856:24, 6857:18, 6858:38, 6858:39, 6858:43, 6858:46, 6859:13, 6860:25, 6861:4, 6862:42, 6864:11, 6866:6, 6871:22, 6876:31, 6877:21, 6877:31, 6879:28, 6881:7, 6883:16, 6885:10, 6886:22, 6889:37, 6891:21, 6894:24, 6894:25, 6894:40
Better [1] - 6888:43
between [20] - 6803:47, 6813:6, 6817:43, 6826:14, 6830:6, 6833:10, 6841:29, 6842:30, 6844:31, 6844:45, 6845:9, 6848:26, 6850:31, 6857:20, 6858:33, 6858:47, 6868:38, 6868:45, 6873:17, 6884:9
beyond [3] - 6807:37, 6885:38, 6889:40
bid [1] - 6840:28
big [19] - 6804:31, 6811:38, 6814:4, 6822:41, 6823:17, 6825:12, 6826:32, 6832:3, 6833:21, 6833:26, 6838:21, 6838:22, 6846:10, 6846:41, 6848:18, 6878:6, 6878:23, 6879:16, 6892:10
bigger [5] - 6809:29, 6812:18, 6814:28, 6820:31, 6820:32
biggest [5] - 6813:30, 6825:15, 6839:42, 6840:7, 6840:39
bill [4] - 6839:46, 6840:5, 6841:37, 6842:36
billion [1] - 6829:43
births [1] - 6888:45
bit [42] - 6803:17, 6806:2, 6807:33, 6812:3, 6812:5, 6814:17, 6814:30, 6818:2, 6820:26, 6821:17, 6821:34, 6824:46, 6825:7, 6827:1, 6830:24, 6831:36, 6840:40, 6840:41, 6842:17, 6842:31, 6853:8, 6861:19, 6861:25, 6865:36, 6866:11, 6868:14, 6873:31, 6874:33, 6874:43, 6879:7, 6879:18, 6880:34, 6881:6, 6881:41, 6883:1, 6885:38, 6885:42, 6886:18, 6887:27, 6887:37
blah [3] - 6813:27
blame [1] - 6859:3
blinks [1] - 6840:11
blood [2] - 6826:21, 6874:20
bloom [1] - 6886:18
bloomings [1] - 6883:28
blooms [1] - 6887:6
blow [1] - 6886:14
blow-back [1] - 6886:14
blowout [1] - 6860:39
blowouts [1] - 6861:4
board [12] - 6805:3, 6809:1, 6810:22, 6811:40, 6817:17, 6819:30, 6831:44, 6844:25, 6844:26, 6844:38, 6845:18, 6890:42
boards [2] - 6844:13, 6845:38
bodies [2] - 6876:9, 6884:29
body [6] - 6862:40, 6872:34, 6873:6, 6886:25, 6892:4, 6894:35
book [1] - 6841:39
boomers [1] - 6848:22
boost [1] - 6875:47
border [3] - 6818:40, 6835:32, 6837:35
bottom [1] - 6844:4
bought [1] - 6884:19
boundaries [1] - 6821:16
box [4] - 6889:33, 6889:34, 6889:35, 6890:32
boxes [1] - 6890:10
brain [1] - 6886:5
Braithwaite [1] - 6852:6
branch [2] - 6804:24, 6836:7
brand [1] - 6847:37
break [2] - 6811:37, 6888:23
breaker [2] - 6819:22, 6819:24
brief [1] - 6856:19
Brighter [1] - 6825:34
bring [10] - 6824:47, 6830:30, 6838:35, 6853:14, 6855:32, 6855:37, 6874:19, 6874:20, 6874:24, 6894:37
bringing [2] - 6873:36, 6873:42
brings [1] - 6855:38
broad [4] - 6804:28, 6846:37, 6865:47, 6878:38
broader [6] - 6822:12, 6854:23, 6869:15, 6869:28, 6869:40, 6890:18
broadly [2] - 6832:31, 6870:22
broken [1] - 6831:37
broker [1] - 6873:17
brokering [1] - 6873:36
brought [6] - 6803:19, 6806:26, 6808:42, 6820:3, 6884:28, 6888:44
browsed [1] - 6820:18
buck [4] - 6812:11, 6815:5, 6818:29, 6829:47
buckets [1] - 6840:17
budget [9] - 6806:23, 6808:1, 6810:14, 6821:39, 6829:43, 6837:47, 6842:7, 6842:14, 6860:39
budgetary [5] - 6819:37, 6830:35, 6831:20, 6831:45, 6837:43
budgeting [2] - 6831:33, 6831:34
build [13] - 6830:2, 6847:34, 6847:40, 6867:16, 6869:15, 6869:28, 6870:4, 6871:19, 6872:17, 6877:9, 6877:43, 6879:29, 6891:23
Building [1] - 6851:33
building [6] - 6849:17, 6850:34, 6856:5, 6859:43, 6861:7, 6866:13
builds [2] - 6860:37, 6864:21
built [1] - 6847:43
bulk [1] - 6859:23
bunch [2] - 6834:17, 6888:46
burns [1] - 6836:10
business [2] - 6848:11, 6884:12
busy [2] - 6859:24, 6861:9
button [2] - 6889:39, 6890:33
BY [1] - 6803:10
-
- C**
-
- calculate** [3] - 6807:46, 6893:11, 6893:17
calculation [2] - 6892:35, 6893:8
California [1] - 6874:12
campaign [1] - 6867:42
Canada [1] - 6885:22
cancer [6] - 6834:2, 6834:6, 6834:7, 6846:40, 6878:41, 6881:46
Cancer [1] - 6834:13
cancers [2] - 6817:17, 6817:18
cannot [4] - 6831:28, 6836:45, 6836:46, 6848:6
canteen [7] - 6852:44, 6853:1, 6853:27, 6853:40, 6854:21, 6854:24, 6854:25
canteens [4] - 6853:12, 6853:18, 6854:15, 6854:45
cap [1] - 6844:41
capabilities [2] - 6849:17, 6851:33
capability [10] - 6850:34, 6855:38, 6869:15, 6869:28, 6870:4, 6872:5, 6876:3, 6876:4, 6880:45, 6881:6

capable [4] - 6828:22, 6829:11, 6829:23, 6829:25
capacity [9] - 6808:32, 6810:29, 6830:42, 6850:43, 6856:5, 6861:7, 6865:23, 6872:17, 6876:20
capital [1] - 6831:32
cardiac [1] - 6836:43
cardiovascular [2] - 6878:40, 6881:46
care [124] - 6803:26, 6803:46, 6804:3, 6805:6, 6805:9, 6805:47, 6806:12, 6806:15, 6806:16, 6807:1, 6807:35, 6809:3, 6811:32, 6811:33, 6813:33, 6815:33, 6817:20, 6817:23, 6819:30, 6821:12, 6822:40, 6822:42, 6822:46, 6823:10, 6823:21, 6823:22, 6823:26, 6823:30, 6823:31, 6824:3, 6825:11, 6825:17, 6825:20, 6827:36, 6827:38, 6827:39, 6832:6, 6833:30, 6833:36, 6834:8, 6834:27, 6835:3, 6835:10, 6836:10, 6837:19, 6838:46, 6839:2, 6839:3, 6839:5, 6839:12, 6839:21, 6839:32, 6839:33, 6839:38, 6839:41, 6840:25, 6840:27, 6840:31, 6840:32, 6840:38, 6840:43, 6840:47, 6841:25, 6842:10, 6842:15, 6842:20, 6842:23, 6842:24, 6842:27, 6842:28, 6843:16, 6843:36, 6844:30, 6846:15, 6846:25, 6846:33, 6846:34, 6846:35, 6846:39, 6848:24, 6848:27, 6848:38, 6857:1, 6857:2, 6857:21, 6858:5, 6858:14, 6859:22, 6860:39, 6864:1, 6867:2, 6867:6, 6867:24, 6867:43, 6868:14, 6869:11, 6869:32, 6870:13, 6870:20, 6871:34, 6871:47, 6874:14, 6874:26, 6874:35, 6879:1, 6879:2, 6879:4, 6879:5, 6879:12, 6881:46, 6881:47, 6884:22, 6888:42, 6889:3, 6889:47, 6893:46
Care [1] - 6888:43
cared [1] - 6879:3
career [2] - 6883:9, 6893:1
careful [1] - 6857:39
carries [1] - 6815:8
carry [2] - 6861:22, 6862:11
carved [1] - 6808:18
case [35] - 6804:12, 6804:13, 6804:15, 6809:28, 6809:29, 6809:47, 6813:42, 6814:25, 6814:44, 6816:12, 6820:27, 6821:44, 6824:12, 6831:32, 6834:5, 6834:7, 6835:3, 6842:33, 6852:33, 6854:36, 6854:42, 6856:18, 6856:25, 6862:1, 6862:37, 6866:46, 6867:30, 6883:30, 6890:47, 6892:15, 6892:24, 6892:26, 6893:27, 6894:33
cases [1] - 6876:36
casual [1] - 6887:20
cataract [10] - 6809:24, 6833:22, 6834:30, 6836:19, 6836:23, 6837:14, 6837:16, 6837:19, 6837:29, 6837:40
cataracts [2] - 6837:22, 6837:35
catch [1] - 6889:5
catchment [1] - 6843:29
categories [2] - 6824:37, 6846:41
category [4] - 6874:46, 6878:42, 6879:10, 6879:11
causes [2] - 6850:15, 6878:39
causing [1] - 6879:17
caution [2] - 6889:46, 6890:37
caving [1] - 6807:21
CEC [2] - 6817:1, 6887:7
cent [26] - 6807:8, 6808:40, 6808:44, 6810:45, 6822:25, 6822:27, 6822:28, 6822:31, 6822:32, 6823:3, 6823:7, 6823:8, 6833:25, 6834:36, 6835:30, 6842:34, 6843:9, 6853:29, 6853:47, 6861:14, 6871:41, 6874:25, 6894:21
Central [13] - 6815:39, 6816:8, 6816:9, 6817:40, 6818:19, 6818:41, 6819:37, 6819:44, 6819:46, 6821:25, 6824:17, 6832:42, 6833:7
central [22] - 6807:21, 6807:26, 6813:6, 6813:42, 6813:44, 6814:40, 6820:5, 6833:11, 6833:12, 6833:13, 6835:23, 6836:2, 6836:4, 6867:13, 6870:27, 6872:13, 6872:17, 6873:6, 6874:16, 6876:2, 6879:31, 6880:29
centralisation [3] - 6813:9, 6813:14, 6813:22
centralise [1] - 6813:24
centralised [1] - 6812:17
centrally [4] - 6866:35, 6870:30, 6872:19, 6872:24
Centre [1] - 6851:15
centre [11] - 6804:44, 6819:32, 6824:43, 6833:16, 6834:31, 6834:42, 6843:8, 6843:25, 6843:44, 6851:14, 6866:12
centres [8] - 6842:42, 6843:26, 6873:18, 6873:22, 6875:34, 6875:35, 6884:18, 6885:37
certain [2] - 6833:14, 6836:43
certainly [15] - 6813:21, 6833:37, 6852:32, 6854:47, 6855:25, 6856:16, 6869:5, 6869:24, 6873:41, 6885:3, 6885:15, 6887:17, 6889:18, 6890:2, 6893:26
CEs [1] - 6884:24
cessation [1] - 6840:26
cetera [12] - 6821:13, 6821:45, 6827:39, 6835:9, 6842:5, 6842:42, 6844:45, 6846:44, 6856:47, 6857:1, 6870:16
chaired [1] - 6882:11
challenge [17] - 6825:15, 6845:8, 6864:4, 6866:26, 6875:11, 6875:23, 6875:25, 6880:1, 6882:32, 6882:40, 6884:45, 6885:3, 6885:14, 6888:12, 6889:4, 6890:4, 6890:16
challenges [12] - 6815:44, 6833:26, 6852:3, 6860:33, 6867:21, 6867:25, 6867:36, 6868:12, 6868:26, 6874:44, 6881:45, 6890:20
challenging [4] - 6866:24, 6873:33, 6873:43, 6884:47
chance [1] - 6858:46
change [67] - 6804:31, 6808:2, 6808:10, 6808:24, 6809:9, 6809:11, 6811:34, 6818:8, 6826:27, 6830:11, 6830:29, 6838:18, 6841:5, 6841:18, 6842:2, 6843:22, 6845:20, 6845:42, 6845:44, 6846:8, 6846:9, 6847:33, 6848:6, 6853:42, 6854:35, 6854:37, 6855:36, 6855:39, 6856:36, 6857:47, 6859:40, 6859:47, 6862:35, 6863:25, 6863:28, 6864:17, 6864:26, 6865:17, 6865:31, 6866:14, 6867:27, 6867:28, 6867:29, 6870:6, 6871:36, 6872:3, 6872:39, 6874:18, 6874:19, 6875:41, 6875:43, 6878:18, 6878:33, 6881:13, 6881:17, 6881:29, 6881:35, 6882:16, 6889:42, 6890:13, 6890:19, 6890:26, 6890:39, 6891:23
changed [3] - 6808:11, 6809:33, 6828:46
changer [2] - 6840:6, 6842:47
changes [12] - 6809:4, 6810:18, 6824:45, 6829:30, 6830:23, 6848:16, 6854:24, 6856:2, 6856:4, 6862:34, 6864:23, 6868:12
changing [3] - 6847:33, 6848:25, 6858:4
channel [2] - 6818:9, 6841:43
character [1] - 6862:19
characterisation [1] - 6876:8
charge [1] - 6841:14
charging [1] - 6839:40
chatting [1] - 6885:27
cheap [3] - 6818:16, 6847:40, 6847:42
cheaper [1] - 6823:3
cheaply [3] - 6826:12, 6847:30, 6847:47
chemistry [1] - 6892:3
Cheney [3] - 6802:36, 6848:41, 6895:8
CHENEY [2] - 6848:43, 6895:10
chest [3] - 6871:5, 6871:6, 6871:16
chief [6] - 6851:25, 6875:15, 6879:10, 6882:12, 6882:15, 6882:37
child [6] - 6825:25, 6825:28, 6825:46, 6827:16, 6828:40, 6843:42
children [10] - 6827:14, 6828:1, 6828:38, 6828:41, 6829:3, 6836:35,

6836:37, 6839:27,
6846:43, 6852:45
Children's [1] - 6863:5
children's [4] -
6806:11, 6836:37,
6836:38, 6880:10
Chiu [2] - 6802:36,
6848:45
CHIU [1] - 6848:47
choice [4] - 6827:31,
6828:47, 6830:6,
6841:23
choices [2] - 6812:4,
6829:46
choose [1] - 6837:36
chooses [1] - 6827:25
chronic [14] - 6823:41,
6825:16, 6833:29,
6835:9, 6835:18,
6838:10, 6838:21,
6838:27, 6840:4,
6842:11, 6842:20,
6843:15, 6846:34,
6853:20
Churchill [1] -
6880:13
circle [1] - 6891:20
circuit [2] - 6819:22,
6819:24
circuit-breaker [2] -
6819:22, 6819:24
circumstances [6] -
6857:33, 6860:12,
6860:15, 6865:43,
6868:10, 6888:17
cite [2] - 6831:30,
6831:31
City [1] - 6843:25
clacking [1] - 6839:36
clarified [1] - 6833:2
clarify [1] - 6849:31
clarity [1] - 6844:39
class [1] - 6892:6
classically [1] -
6860:10
classification [1] -
6822:40
classifications [2] -
6821:45, 6824:26
classified [1] - 6822:1
classify [1] - 6824:25
classifying [1] -
6835:8
clear [8] - 6810:26,
6815:34, 6831:4,
6835:28, 6873:32,
6885:38, 6886:20,
6886:38
clearly [5] - 6830:31,
6855:34, 6870:34,
6883:17, 6886:42
click [2] - 6839:36,
6889:39
click-clacking [1] -
6839:36
clicked [2] - 6889:34
climate [1] - 6826:27
clinic [17] - 6814:45,
6815:8, 6815:10,
6816:12, 6819:16,
6821:30, 6841:36,
6841:39, 6842:1,
6843:21, 6843:27,
6844:43, 6845:11,
6846:37, 6860:16,
6860:27, 6871:5,
clinical [49] - 6811:13,
6825:30, 6834:16,
6850:33, 6851:7,
6852:27, 6854:32,
6859:9, 6860:10,
6862:6, 6862:8,
6864:10, 6866:1,
6866:22, 6866:38,
6866:39, 6867:18,
6868:3, 6868:10,
6868:20, 6868:31,
6868:39, 6868:43,
6869:2, 6869:11,
6869:20, 6869:27,
6871:36, 6874:35,
6875:41, 6878:26,
6880:9, 6881:43,
6881:45, 6882:23,
6882:36, 6887:1,
6888:11, 6888:32,
6888:35, 6889:13,
6891:23, 6893:36,
6894:7, 6894:23,
6894:24, 6894:26,
6894:28, 6894:30
Clinical [2] - 6833:44,
6886:37
clinician [14] -
6803:20, 6858:40,
6859:47, 6864:21,
6865:22, 6869:7,
6872:2, 6873:21,
6880:12, 6880:14,
6888:18, 6889:39,
6892:35, 6893:41
clinicians [40] -
6819:15, 6856:34,
6857:11, 6857:32,
6858:26, 6859:1,
6859:15, 6859:24,
6860:14, 6860:28,
6860:39, 6861:9,
6861:34, 6862:5,
6864:15, 6864:31,
6864:40, 6865:10,
6865:42, 6866:6,
6866:14, 6867:29,
6868:11, 6868:36,
6869:15, 6869:40,
6871:13, 6871:20,
6872:40, 6873:1,
6874:15, 6879:37,
6881:44, 6882:34,
6883:32, 6884:1,
6884:10, 6888:4,
6890:3, 6890:29
clinics [8] - 6823:31,
6841:28, 6841:33,
6842:4, 6842:6,
6842:8, 6842:10,
6875:44
close [12] - 6809:24,
6811:24, 6817:26,
6817:27, 6817:30,
6820:4, 6828:33,
6836:18, 6836:19,
6836:26, 6836:35,
6842:7
closely [2] - 6831:15,
6851:5
closer [2] - 6858:47,
6881:31
closing [1] - 6842:9
clue [1] - 6848:13
clues [1] - 6873:38
co [3] - 6839:40,
6851:32, 6880:10
co-authored [1] -
6851:32
co-location [1] -
6880:10
co-payments [1] -
6839:40
coalface [1] - 6862:6
Coast [13] - 6815:39,
6816:10, 6817:40,
6818:19, 6818:41,
6819:37, 6819:44,
6819:47, 6821:25,
6824:17, 6832:42,
6833:7, 6834:9
coast [1] - 6813:34
Coast's [1] - 6816:8
coding [1] - 6813:5
coherently [1] -
6812:6
coincidence [1] -
6862:5
Coledale [1] - 6845:29
collaborate [1] -
6815:28
collaboration [4] -
6820:8, 6821:5,
6833:45, 6834:12
collaborative [5] -
6815:13, 6815:14,
6815:23, 6815:27,
6855:20
collate [1] - 6887:38
colleague [2] -
6870:11, 6873:45
colleagues [7] -
6852:7, 6861:10,
6865:28, 6865:29,
6871:4, 6877:34,
6881:1
collected [2] -
6807:17, 6869:4
collecting [1] -
6807:16
collection [2] -
6868:45, 6888:45
collective [1] -
6876:14
collectively [1] -
6858:37
combination [4] -
6825:19, 6833:7,
6842:28, 6880:12
comfortably [1] -
6818:36
coming [13] - 6811:37,
6815:7, 6820:39,
6823:20, 6823:45,
6829:8, 6834:40,
6845:7, 6846:23,
6859:21, 6884:36,
6887:32, 6893:21
commences [1] -
6812:45
commencing [1] -
6844:5
comment [9] -
6810:42, 6810:47,
6818:45, 6831:2,
6855:44, 6880:36,
6883:46, 6892:30
comments [1] -
6822:4
commercial [1] -
6885:20
COMMISSION [1] -
6895:25
Commission [4] -
6802:7, 6876:27,
6876:28, 6886:37
commission [4] -
6805:42, 6806:3,
6806:35, 6872:47
commissioned [1] -
6864:14
Commissioner [12] -
6802:13, 6803:3,
6812:44, 6842:18,
6847:2, 6848:43,
6848:47, 6849:14,
6851:36, 6852:16,
6895:3, 6895:10
COMMISSIONER [49]
- 6803:1, 6803:6,
6805:13, 6806:32,
6810:26, 6811:8,
6812:47, 6823:35,
6838:3, 6840:11,
6847:4, 6848:30,
6848:45, 6849:2,
6849:8, 6849:12,
6849:27, 6849:34,
6849:39, 6850:1,
6850:20, 6856:43,
6857:20, 6857:30,
6857:35, 6857:44,
6858:8, 6858:13,
6858:21, 6858:26,
6858:32, 6859:6,
6859:19, 6859:29,
6859:35, 6859:46,
6860:5, 6860:20,
6861:12, 6861:28,
6861:37, 6861:43,
6866:45, 6869:47,
6870:9, 6870:43,
6895:6, 6895:12,
6895:20
commissioning [1] -
6872:34
commitment [2] -
6809:21, 6850:13
committee [1] -
6848:9
committees [2] -
6842:41, 6876:9
common [1] - 6805:32
Commonwealth [41] -
6806:47, 6807:5,
6807:7, 6807:18,
6811:32, 6812:25,
6813:43, 6823:24,
6827:42, 6828:4,
6828:9, 6829:13,
6832:15, 6838:37,
6838:45, 6839:4,
6839:6, 6839:22,
6839:36, 6840:9,
6840:15, 6840:16,
6840:26, 6840:32,
6841:6, 6841:9,
6841:30, 6842:2,
6842:25, 6842:34,
6843:2, 6845:9,
6845:10, 6845:14,
6845:15, 6845:34,
6848:26, 6873:27,
6883:39

Commonwealth's [1] - 6805:39

Commonwealth-state [5] - 6812:25, 6813:43, 6840:9, 6841:6, 6848:26

communities [8] - 6808:29, 6809:40, 6810:33, 6810:34, 6819:27, 6819:29, 6819:31, 6830:21

community [45] - 6816:1, 6817:47, 6823:32, 6824:40, 6825:11, 6828:24, 6835:17, 6835:18, 6836:31, 6837:10, 6838:10, 6838:11, 6839:38, 6839:41, 6841:22, 6842:19, 6842:23, 6842:31, 6842:37, 6842:41, 6842:42, 6842:46, 6843:2, 6843:5, 6843:8, 6843:13, 6843:17, 6843:24, 6843:27, 6843:35, 6843:44, 6845:11, 6845:43, 6845:45, 6854:23, 6860:34, 6864:18, 6864:21, 6870:37, 6870:44, 6877:21, 6878:26, 6879:41

companies [2] - 6891:47

comparative [1] - 6825:2

compensated [3] - 6805:42, 6806:2, 6806:35

competing [1] - 6894:12

competition [1] - 6841:17

competitive [3] - 6841:10, 6882:5, 6894:3

competitiveness [1] - 6894:46

complementary [1] - 6876:4

completely [4] - 6821:37, 6837:47, 6843:2, 6891:14

complex [7] - 6825:17, 6833:29, 6835:9, 6843:15, 6852:8, 6865:32, 6870:29

complexity [2] - 6814:13, 6858:23

compliance [1] - 6853:28

compliant [1] - 6853:41

complicated [3] - 6857:47, 6861:8, 6872:12

comply [1] - 6854:22

component [3] - 6823:7, 6837:31, 6844:45

comprehensive [2] - 6854:36, 6888:8

compromise [2] - 6837:28

concentrate [3] - 6875:26, 6877:25, 6879:22

concentrated [1] - 6877:28

concentrating [1] - 6886:21

concept [5] - 6806:11, 6809:46, 6810:27, 6820:39, 6846:2

concepts [1] - 6825:13

conceptual [1] - 6852:2

conceptually [2] - 6852:11, 6853:9

concern [3] - 6824:40, 6879:10, 6879:17

concerned [1] - 6804:46

conclusion [2] - 6825:6, 6834:41

Concord [1] - 6888:24

condition [1] - 6858:43

conditions [3] - 6859:38, 6860:32, 6890:34

conducted [1] - 6873:44

conference [1] - 6834:7

conferencing [1] - 6834:6

confidence [9] - 6859:43, 6860:38, 6864:21, 6866:13, 6867:16, 6871:19, 6881:19, 6891:23

confident [6] - 6832:44, 6858:18, 6859:40, 6859:47, 6860:18, 6887:15

configure [1] - 6882:17

confused [1] - 6826:16

connected [2] - 6869:26, 6881:7

consensus [4] - 6884:39, 6884:46, 6885:1, 6885:21

consequence [1] - 6887:24

consider [2] - 6878:5, 6891:39

consideration [2] - 6876:13, 6890:7

considerations [1] - 6854:25

considered [1] - 6889:36

consistent [10] - 6806:36, 6807:40, 6820:44, 6828:7, 6850:34, 6852:44, 6852:46, 6870:27, 6872:46, 6891:35

constant [2] - 6881:18, 6890:26

constantly [2] - 6858:3, 6881:2

constellation [1] - 6876:9

constituencies [1] - 6884:38

constructed [1] - 6860:10

constructively [1] - 6891:42

consultant [1] - 6804:23

consultation [5] - 6841:15, 6877:16, 6884:32, 6885:6, 6891:34

consultative [1] - 6876:24

consumer [2] - 6813:27, 6815:21

consuming [1] - 6852:45

contend [1] - 6830:25

contents [1] - 6812:39

context [4] - 6844:19, 6872:11, 6872:20, 6874:30

contexts [3] - 6868:10, 6874:1, 6874:2

continue [6] - 6817:41, 6857:13, 6863:16, 6884:18, 6884:33, 6891:6

continued [1] - 6807:15

continuing [1] - 6827:39

continuous [1] - 6852:8

continuum [5] - 6827:37, 6844:30, 6846:15, 6846:25, 6846:35

contradict [1] - 6861:10

contrary [2] - 6826:23, 6851:38

contrast [1] - 6886:15

contravention [1] - 6850:17

contributing [2] - 6854:9, 6887:6

contribution [5] - 6806:47, 6807:5, 6807:7, 6828:4, 6851:20

contributions [2] - 6885:43, 6893:6

control [10] - 6821:36, 6821:38, 6822:33, 6838:41, 6873:3, 6874:10, 6874:20, 6874:24, 6880:29, 6880:47

controlled [5] - 6839:34, 6842:41, 6853:4, 6868:5, 6868:22

controlling [1] - 6880:28

conventional [1] - 6854:31

conversation [1] - 6838:36

conversations [5] - 6807:20, 6882:31, 6883:21, 6884:28, 6885:6

convince [1] - 6864:15

convoluted [1] - 6826:36

coordinate [1] - 6856:13

copy [1] - 6851:43

cordon [1] - 6886:26

core [1] - 6845:8

correct [9] - 6808:5, 6816:6, 6838:31, 6860:6, 6862:14, 6869:41, 6870:23, 6879:47, 6893:22

correctly [1] - 6879:13

cost [23] - 6806:9, 6806:24, 6807:47, 6811:24, 6818:12, 6818:14, 6822:15, 6822:21, 6823:4, 6823:12, 6835:32, 6836:27, 6836:41, 6841:40, 6842:44, 6847:35, 6853:2, 6854:3, 6854:5, 6854:24, 6861:4, 6867:17

costing [1] - 6822:41

costs [13] - 6805:7, 6806:22, 6822:21, 6822:26, 6822:27, 6822:32, 6822:43, 6822:46, 6823:5, 6837:39, 6838:22, 6843:7, 6893:45

Council [2] - 6851:13, 6877:6

Counsel [5] - 6802:27, 6802:28, 6802:29, 6802:30, 6802:31

count [4] - 6820:14, 6829:4, 6829:32

counted [2] - 6843:7

country [7] - 6805:33, 6806:10, 6813:18, 6851:29, 6874:1, 6874:30

couple [7] - 6806:6, 6809:41, 6817:18, 6817:24, 6822:38, 6824:4, 6838:32

coupled [1] - 6819:31

course [10] - 6806:28, 6813:2, 6820:17, 6829:22, 6845:40, 6853:19, 6876:40, 6880:15, 6880:19, 6883:36

courses [2] - 6813:47, 6817:12

cover [1] - 6874:45

covered [2] - 6829:9, 6893:2

COVID [6] - 6824:11, 6824:13, 6848:6, 6848:7, 6848:10, 6848:11

cracked [1] - 6831:36

create [10] - 6803:25, 6803:26, 6817:32, 6819:14, 6855:46, 6867:15, 6881:22, 6881:28, 6887:16, 6889:1

created [9] - 6819:3,

6862:28, 6877:42,
6877:47, 6878:9,
6878:25, 6881:43,
6882:24, 6885:36
creates [3] - 6841:44,
6875:40, 6877:10
creating [3] - 6852:9,
6870:32, 6870:33
creation [1] - 6811:12
critical [11] - 6807:9,
6864:29, 6868:29,
6876:47, 6881:45,
6881:47, 6883:42,
6884:9, 6884:29,
6889:21, 6890:12
critically [1] - 6889:2
crop [1] - 6880:32
cross [1] - 6835:32
cross-border [1] -
6835:32
cruder [1] - 6807:10
culturally [2] -
6810:33, 6881:17
culture [4] - 6870:34,
6875:41, 6881:28,
6882:24
curious [1] - 6892:16
current [8] - 6810:8,
6810:9, 6826:26,
6844:33, 6844:34,
6887:39, 6889:22,
6894:10
cut [1] - 6888:21
cutting [2] - 6847:35,
6894:32
cutting-edge [1] -
6894:32
cycle [2] - 6888:32,
6888:37
cyclic [2] - 6813:8,
6813:21

D

Daniel [1] - 6802:31
Dar [1] - 6835:38
dashboard [1] -
6887:36
data [28] - 6807:17,
6809:47, 6832:17,
6832:30, 6852:8,
6852:25, 6854:31,
6856:6, 6858:39,
6858:41, 6860:6,
6868:37, 6868:38,
6868:45, 6869:4,
6869:6, 6869:7,
6869:17, 6869:33,
6887:35, 6887:38,
6888:3, 6888:9,

6888:45, 6889:6,
6889:13
datasets [2] - 6888:44,
6889:1
date [2] - 6836:13,
6869:36
dated [2] - 6812:32,
6851:34
dates [1] - 6807:36
day-to-day [2] -
6859:2, 6891:15
days [7] - 6809:10,
6809:19, 6817:25,
6842:37, 6851:40,
6868:13
deal [4] - 6838:1,
6848:25, 6861:40,
6878:39
dealing [10] - 6814:11,
6816:8, 6816:42,
6819:24, 6819:25,
6820:40, 6838:26,
6859:24, 6862:42,
6889:37
dealt [3] - 6842:37,
6845:41, 6886:13
deaths [1] - 6888:45
debate [1] - 6855:30
decade [3] - 6830:26,
6853:28, 6874:9
decades [2] - 6824:13,
6839:30
December [1] -
6802:23
DECEMBER [1] -
6895:26
decent [1] - 6860:47
decentralisation [4] -
6812:17, 6813:9,
6813:14, 6813:22
decentralise [1] -
6813:25
decentralised [1] -
6844:5
decide [1] - 6824:38
decided [2] - 6824:42,
6865:1
decides [1] - 6872:36
deciding [4] -
6830:33, 6833:14,
6865:25, 6870:18
decision [27] -
6804:34, 6804:41,
6805:19, 6805:26,
6808:7, 6808:16,
6813:7, 6814:16,
6815:10, 6815:43,
6816:11, 6816:28,
6819:28, 6832:33,
6832:35, 6837:25,

6845:32, 6852:18,
6865:1, 6865:16,
6865:20, 6865:31,
6867:18, 6869:35,
6870:16, 6875:7,
6880:15
decision-making [6] -
6814:16, 6816:11,
6852:18, 6865:1,
6867:18, 6870:16
decisions [18] -
6811:5, 6815:30,
6819:32, 6833:5,
6833:8, 6834:22,
6834:32, 6844:14,
6844:18, 6844:20,
6844:22, 6845:5,
6845:39, 6858:27,
6879:35, 6879:36,
6887:1, 6887:3
decisive [5] - 6885:35,
6886:12, 6886:20,
6886:26, 6891:29
deeper [1] - 6814:17
defence [1] - 6866:18
define [1] - 6838:18
defines [1] - 6819:2
definite [1] - 6894:9
definitely [4] -
6861:47, 6866:33,
6876:19, 6880:47
definition [2] -
6822:13, 6824:47
definitions [1] -
6829:32
definitive [1] -
6893:28
degree [5] - 6811:26,
6811:31, 6812:16,
6826:7, 6832:4
deliberate [1] -
6854:27
delineated [1] -
6835:28
delineation [1] -
6835:27
deliver [18] - 6803:27,
6805:47, 6807:35,
6812:28, 6813:33,
6825:37, 6827:26,
6827:27, 6828:30,
6829:1, 6833:29,
6841:32, 6848:1,
6861:3, 6871:22,
6877:21, 6877:31,
6892:13
delivered [25] -
6809:12, 6809:39,
6815:11, 6815:17,
6815:45, 6821:14,

6821:15, 6821:42,
6823:31, 6829:21,
6829:23, 6831:17,
6831:46, 6832:24,
6832:31, 6832:34,
6833:6, 6833:13,
6833:15, 6833:34,
6833:38, 6834:33,
6834:43, 6834:44,
6880:6
delivering [12] -
6816:18, 6818:29,
6819:33, 6824:39,
6830:15, 6833:36,
6834:23, 6840:46,
6846:3, 6847:15,
6853:12, 6854:3
delivers [1] - 6894:39
delivery [9] - 6806:47,
6811:45, 6819:30,
6823:22, 6823:24,
6831:18, 6835:10,
6864:1, 6893:46
demand [14] - 6805:6,
6811:27, 6817:33,
6817:35, 6817:40,
6817:41, 6817:43,
6817:45, 6817:46,
6818:9, 6818:22,
6880:19, 6880:20
demanding [1] -
6818:4
demographic [2] -
6831:44, 6832:29
demonstrably [5] -
6828:14, 6828:15,
6835:2, 6835:17,
6838:10
demonstrate [6] -
6847:12, 6857:16,
6860:36, 6861:1,
6861:20, 6861:41
demonstrated [2] -
6848:7, 6871:9
demonstrating [4] -
6856:34, 6860:11,
6860:31, 6861:23
denominator [1] -
6805:32
department [20] -
6803:44, 6804:22,
6804:23, 6804:25,
6808:22, 6822:24,
6822:27, 6856:35,
6856:37, 6857:35,
6860:16, 6860:27,
6862:27, 6862:30,
6863:14, 6871:7,
6871:9, 6888:23,
6888:24, 6888:27

Department [1] -
6807:22
department's [1] -
6836:6
departments [10] -
6856:23, 6856:28,
6856:38, 6859:23,
6862:24, 6862:26,
6864:1, 6864:41,
6871:12, 6871:21
dependence [1] -
6861:17
deploy [4] - 6827:25,
6827:32, 6865:17,
6870:16
deployed [3] -
6872:32, 6872:45,
6879:33
deploying [2] -
6830:6, 6872:28
deployment [1] -
6885:11
deprives [1] - 6827:33
dermatologists [1] -
6840:3
describe [2] -
6859:41, 6866:24
described [7] -
6851:4, 6852:10,
6871:39, 6873:10,
6876:31, 6877:8,
6890:14
describing [1] -
6831:38
description [3] -
6827:20, 6862:7,
6863:36
descriptive [1] -
6867:44
deserves [1] - 6865:39
design [3] - 6803:46,
6812:3, 6820:31
designed [6] - 6804:2,
6812:6, 6812:7,
6822:37, 6822:39,
6826:11
designing [1] -
6833:26
despite [1] - 6866:42
detail [5] - 6807:33,
6834:28, 6853:9,
6870:28, 6893:9
details [1] - 6806:20
determine [2] -
6816:5, 6825:45
determined [3] -
6807:1, 6817:2,
6889:28
determiner [1] -
6833:16

determining [4] - 6811:47, 6812:13, 6834:42, 6864:15
detrimental [2] - 6807:28, 6807:29
develop [5] - 6804:16, 6813:39, 6844:38, 6848:4, 6853:46
developed [4] - 6804:42, 6805:21, 6822:41, 6866:31
developing [4] - 6874:13, 6874:15, 6884:34, 6894:7
development [4] - 6839:27, 6844:27, 6871:4, 6892:38
developmental [2] - 6839:26, 6839:29
develops [1] - 6857:21
device [1] - 6891:47
devoid [1] - 6812:7
devolve [1] - 6845:33
devolved [1] - 6813:7
devoted [1] - 6871:42
diabetes [1] - 6878:41
diagnosis [3] - 6825:14, 6825:15, 6825:18
dialogue [24] - 6875:37, 6880:39, 6880:40, 6881:5, 6881:9, 6881:12, 6881:22, 6881:30, 6881:35, 6882:1, 6882:9, 6882:24, 6883:19, 6884:8, 6884:11, 6884:12, 6884:16, 6884:33, 6886:36, 6887:16, 6889:33, 6890:10, 6890:32
dialogues [3] - 6882:41, 6883:18, 6889:45
dialysis [1] - 6806:18
dictating [2] - 6833:12, 6834:13
diet [2] - 6818:32, 6853:19
dietary [1] - 6852:46
diets [1] - 6852:46
differ [2] - 6872:10, 6872:12
difference [5] - 6859:41, 6860:1, 6860:3, 6875:17, 6892:10
differences [1] - 6870:37
different [41] - 6806:7, 6806:9, 6814:23, 6822:44, 6829:32, 6829:34, 6830:10, 6833:10, 6833:34, 6835:39, 6836:17, 6839:1, 6851:28, 6857:17, 6860:8, 6860:17, 6867:39, 6871:13, 6872:40, 6872:41, 6876:9, 6878:14, 6878:15, 6880:23, 6882:24, 6882:25, 6882:38, 6884:38, 6885:1, 6887:7, 6887:34, 6887:35, 6887:37, 6889:6, 6893:11
differential [1] - 6811:23
difficult [5] - 6838:17, 6857:33, 6865:30, 6872:12, 6885:21
difficulties [2] - 6850:15, 6850:16
digital [7] - 6868:28, 6868:42, 6887:27, 6888:21, 6888:37, 6889:11, 6889:26
digitally [2] - 6879:1, 6879:4
diminution [1] - 6842:27
direct [1] - 6886:26
directed [1] - 6876:15
directing [1] - 6880:40
direction [1] - 6878:32
directly [1] - 6894:47
director [2] - 6843:39, 6851:3
dirty [1] - 6826:27
Disability [1] - 6827:43
disability [3] - 6811:32, 6827:46, 6841:16
disadvantaged [2] - 6808:28, 6846:17
disagree [3] - 6824:46, 6877:2, 6877:36
disagreeing [1] - 6836:1
disappearance [1] - 6843:20
disclose [1] - 6850:39
discoveries [1] - 6877:10
discovery [4] - 6877:7, 6877:18, 6886:9, 6892:2
discrete [2] - 6806:20, 6814:20
discretion [1] - 6821:43
discretionary [1] - 6808:20
discussed [1] - 6823:36
discussing [1] - 6877:29
discussion [8] - 6830:36, 6845:30, 6878:13, 6882:13, 6882:18, 6884:9, 6885:39, 6891:25
discussions [1] - 6878:36
disease [11] - 6823:41, 6835:18, 6838:11, 6838:27, 6840:4, 6842:11, 6842:20, 6846:40, 6853:20, 6874:46, 6878:41
diseases [1] - 6838:21
disinvestment [2] - 6844:21, 6844:23
disparate [1] - 6874:4
dispersed [1] - 6880:46
disrespectful [1] - 6857:39
disrespectfully [1] - 6857:28
disseminated [1] - 6855:18
distant [1] - 6808:40
distinct [1] - 6852:20
distinguish [2] - 6817:43, 6826:14
distribute [2] - 6804:36, 6805:39
distributed [1] - 6803:47
distribution [3] - 6803:39, 6804:36, 6809:25
Distribution [1] - 6803:41
District [7] - 6805:1, 6805:4, 6809:13, 6844:13, 6851:18, 6852:34, 6856:22
district [50] - 6804:4, 6806:10, 6809:1, 6811:46, 6812:1, 6815:5, 6815:7, 6815:46, 6816:13, 6816:16, 6816:20, 6817:20, 6819:16, 6819:18, 6821:8, 6821:9, 6821:35, 6821:43, 6824:38, 6824:42, 6825:35, 6827:13, 6827:25, 6829:12, 6829:15, 6829:24, 6830:19, 6831:6, 6832:25, 6832:38, 6832:40, 6832:43, 6833:35, 6835:24, 6835:29, 6836:29, 6837:16, 6839:25, 6844:21, 6844:28, 6844:39, 6845:3, 6845:36, 6846:36, 6847:11, 6853:26, 6855:8, 6863:13, 6880:16, 6880:17
district's [1] - 6815:35
districts [55] - 6804:1, 6804:37, 6804:44, 6804:46, 6807:34, 6808:8, 6808:9, 6808:39, 6809:26, 6809:40, 6812:16, 6812:27, 6813:40, 6814:24, 6814:33, 6814:37, 6814:44, 6815:14, 6816:20, 6816:30, 6817:26, 6819:27, 6820:35, 6820:47, 6822:34, 6829:45, 6830:13, 6830:37, 6830:43, 6831:16, 6831:19, 6833:10, 6833:45, 6835:35, 6835:47, 6838:14, 6840:43, 6841:31, 6841:42, 6844:40, 6844:47, 6845:38, 6846:11, 6846:29, 6851:5, 6855:20, 6863:5, 6865:34, 6870:36, 6872:41, 6873:20, 6875:42, 6876:41, 6890:42
districts' [1] - 6836:15
ditch [1] - 6804:34
ditched [2] - 6806:11, 6806:12
diverse [3] - 6810:34, 6866:25, 6885:1
divide [1] - 6807:45
divvying [1] - 6845:9
doctor [3] - 6841:37, 6841:38, 6842:3
doctoral [1] - 6832:13
doctorate [1] - 6832:14
doctors [4] - 6839:35, 6840:1, 6841:11, 6842:5
document [3] - 6812:44, 6813:2, 6877:40
documents [1] - 6855:23
dollar [4] - 6867:45, 6892:18, 6893:20, 6893:22
dollars [2] - 6829:42, 6829:43
dollars' [1] - 6829:44
domains [1] - 6878:38
DON [1] - 6850:10
Don [12] - 6849:23, 6851:1, 6856:13, 6866:24, 6866:29, 6867:36, 6871:45, 6877:2, 6877:47, 6882:30, 6882:46, 6885:16
done [35] - 6813:45, 6813:47, 6817:3, 6825:45, 6827:13, 6828:15, 6830:17, 6830:41, 6832:38, 6834:1, 6834:3, 6837:22, 6837:30, 6850:43, 6854:43, 6855:12, 6857:12, 6857:25, 6858:19, 6859:21, 6859:33, 6860:35, 6860:36, 6862:17, 6863:19, 6863:21, 6863:32, 6864:36, 6864:40, 6871:10, 6873:45, 6881:24, 6881:28, 6884:43, 6884:47
door [1] - 6878:40
doorstep [1] - 6834:25
dots [1] - 6887:19
doubt [8] - 6827:34, 6828:41, 6829:30, 6831:35, 6835:23, 6862:18, 6889:38, 6893:42
down [12] - 6807:23, 6808:43, 6834:37, 6835:17, 6838:10, 6839:17, 6842:19, 6842:21, 6843:11, 6888:23, 6890:10, 6890:45
downplays [1] - 6863:21

Dr [3] - 6802:29, 6849:21, 6851:23
DR [4] - 6849:46, 6851:25, 6866:16, 6877:36
dramatically [2] - 6852:47, 6854:11
draw [1] - 6831:22
drawn [1] - 6852:7
DRG [1] - 6825:14
drive [11] - 6803:45, 6821:27, 6821:39, 6822:45, 6826:11, 6834:16, 6849:17, 6851:33, 6860:46, 6885:20, 6887:45
driven [5] - 6835:46, 6852:26, 6866:42, 6870:30, 6886:40
driver [5] - 6811:5, 6832:33, 6832:34, 6833:16, 6862:27
drivers [2] - 6858:40, 6872:40
drives [2] - 6806:22, 6821:39
driving [3] - 6825:19, 6858:45, 6887:5
drops [1] - 6850:17
drove [1] - 6837:21
drug [1] - 6880:5
drugs [1] - 6872:37
Dubbo [1] - 6833:38
Duckett [1] - 6806:37
due [1] - 6813:2
during [1] - 6842:33
dynamic [16] - 6828:34, 6847:13, 6847:14, 6847:26, 6847:31, 6848:3, 6852:10, 6852:12, 6858:3, 6858:4, 6859:13, 6860:17, 6865:24, 6867:12, 6867:15
dynamically [4] - 6847:40, 6848:8, 6848:15, 6848:28

E

Eagar [3] - 6803:4, 6803:12, 6806:34
EAGAR [1] - 6803:8
early [34] - 6804:20, 6808:34, 6809:10, 6809:19, 6820:20, 6823:42, 6823:46, 6825:28, 6825:38, 6827:35, 6827:38, 6827:47, 6828:2, 6828:12, 6828:22, 6829:3, 6829:10, 6830:9, 6835:19, 6836:34, 6836:38, 6837:6, 6839:23, 6839:24, 6842:10, 6843:14, 6843:24, 6844:43, 6846:32, 6846:43, 6877:4, 6883:8, 6888:18, 6893:1
earnings [1] - 6892:47
easily [1] - 6875:30
Eastern [3] - 6832:4, 6834:10, 6861:29
easy [4] - 6821:1, 6824:44, 6858:18, 6869:34
eating [2] - 6853:10, 6853:12
economic [2] - 6847:9, 6885:43
economics [1] - 6803:24
economy [2] - 6894:41, 6895:1
ecosystem [6] - 6877:4, 6877:13, 6882:47, 6886:24, 6891:41, 6891:46
Ed [1] - 6802:27
ED [6] - 6856:46, 6857:22, 6858:15, 6858:34, 6859:24, 6867:7
edge [1] - 6894:32
edges [1] - 6820:27
Education [1] - 6814:42
education [2] - 6855:31, 6888:19
educational [1] - 6854:34
effect [3] - 6853:18, 6880:24, 6893:23
effective [8] - 6833:36, 6847:44, 6853:46, 6862:11, 6871:46, 6877:30, 6888:33
effectively [3] - 6855:32, 6865:17, 6871:10
effectiveness [6] - 6813:26, 6854:10, 6860:11, 6860:26, 6867:17, 6871:8
effects [3] - 6807:29, 6853:20, 6879:15
efficacy [5] - 6860:35, 6861:3, 6868:4, 6868:15, 6877:8
efficiency [32] - 6807:30, 6810:10, 6813:26, 6814:4, 6823:40, 6826:5, 6826:11, 6826:13, 6826:14, 6826:24, 6826:32, 6826:34, 6826:35, 6826:40, 6826:44, 6827:33, 6827:34, 6829:26, 6829:42, 6831:29, 6834:4, 6846:3, 6846:6, 6847:13, 6847:14, 6847:26, 6847:29, 6847:30, 6847:32, 6848:3, 6854:10
efficient [12] - 6803:46, 6806:1, 6806:27, 6806:28, 6815:16, 6826:19, 6833:35, 6836:20, 6847:43, 6848:8, 6848:15, 6854:5
efficiently [4] - 6816:28, 6819:45, 6830:38, 6834:47
effort [4] - 6869:24, 6878:8, 6878:10, 6878:27
efforts [11] - 6853:37, 6855:20, 6864:25, 6866:21, 6869:12, 6870:6, 6873:13, 6873:28, 6883:1, 6884:3, 6888:47
either [10] - 6816:2, 6816:18, 6819:46, 6820:2, 6821:15, 6849:42, 6882:35, 6884:12, 6885:9, 6894:34
either/or [3] - 6865:45, 6867:13, 6870:41
elaborate [1] - 6856:14
elderly [2] - 6879:13, 6881:47
elective [6] - 6821:22, 6821:24, 6821:26, 6821:28, 6822:28, 6848:18
element [3] - 6832:1, 6832:2, 6840:11
elements [7] - 6806:6, 6831:30, 6831:31, 6832:3, 6843:17, 6856:10, 6866:34
elsewhere [4] - 6855:18, 6856:3, 6864:25, 6866:31
embedded [6] - 6853:13, 6856:18, 6856:21, 6863:13, 6864:30, 6864:40
embedding [4] - 6852:36, 6854:40, 6858:38, 6859:20
emergency [27] - 6808:22, 6822:24, 6822:27, 6856:23, 6856:28, 6856:35, 6856:37, 6856:38, 6857:35, 6858:5, 6859:22, 6860:16, 6860:27, 6862:24, 6862:26, 6862:27, 6862:30, 6863:14, 6864:1, 6864:41, 6871:7, 6871:9, 6871:12, 6871:21, 6888:23, 6888:24, 6888:27
emerging [2] - 6846:21, 6855:25
emissions [1] - 6826:27
emphasising [3] - 6859:3, 6864:9, 6867:4
empirical [1] - 6871:34
employ [1] - 6842:35
employed [1] - 6855:2
employing [1] - 6839:35
enable [10] - 6807:41, 6824:37, 6837:45, 6856:6, 6868:43, 6871:5, 6882:3, 6882:5, 6888:41, 6889:6
enabled [3] - 6854:42, 6880:13, 6880:17
enabler [1] - 6869:31
enables [2] - 6831:20, 6875:6
encouraged [1] - 6867:5
encouraging [1] - 6875:41
end [8] - 6814:12, 6820:24, 6821:38, 6846:39, 6860:42, 6877:16, 6877:17, 6890:34
end-of-life [1] - 6846:39
ended [1] - 6880:35
Endone [1] - 6861:28
ends [1] - 6839:3
engage [1] - 6890:19
engaged [6] - 6830:20, 6830:32, 6830:43, 6838:38, 6855:1, 6876:23
engagement [2] - 6813:27, 6815:21
engaging [2] - 6855:19, 6884:35
England [6] - 6851:18, 6852:34, 6853:14, 6854:42, 6854:44, 6855:16
enlightening [1] - 6882:18
enormous [8] - 6834:14, 6839:40, 6841:44, 6857:12, 6860:46, 6874:45, 6875:12, 6877:5
enormously [1] - 6857:42
enrolled [2] - 6894:23, 6894:24
ensure [4] - 6806:22, 6873:4, 6887:46, 6890:28
ensuring [1] - 6859:14
entered [1] - 6817:19
entering [3] - 6816:18, 6816:30, 6888:4
enterprise [3] - 6852:21, 6867:43, 6867:45
entire [1] - 6891:41
entirely [2] - 6875:4, 6880:26
entities [2] - 6884:20, 6884:27
entitled [1] - 6849:17
entity [1] - 6875:31
entry [1] - 6858:4
envelope [7] - 6815:47, 6819:37, 6830:36, 6831:20, 6831:45, 6837:26, 6837:43
environment [1] - 6885:22
environments [2] - 6853:18, 6855:46
epidemiological [1] - 6830:18
epilepsy [1] - 6880:5
episode [1] - 6804:24
equal [7] - 6818:12, 6818:13, 6818:14,

- 6818:15
equally [1] - 6853:11
equals [2] - 6808:1, 6817:45
equitable [1] - 6832:32
equity [9] - 6807:29, 6808:28, 6809:5, 6809:46, 6810:27, 6811:5, 6811:14, 6824:9
equivalent [1] - 6885:28
era [1] - 6842:33
error [1] - 6822:5
escapes [1] - 6806:38
especially [1] - 6858:4
essence [1] - 6861:6
essential [1] - 6810:46
essentially [3] - 6807:20, 6855:45, 6893:2
established [3] - 6804:14, 6856:28, 6865:47
establishment [1] - 6828:18
et [12] - 6821:13, 6821:45, 6827:39, 6835:9, 6842:5, 6842:42, 6844:45, 6846:44, 6856:47, 6857:1, 6870:16
evaluation [2] - 6853:35, 6892:45
eventually [1] - 6858:2
everywhere [1] - 6828:1
evidence [84] - 6806:36, 6807:33, 6812:35, 6813:19, 6813:38, 6815:39, 6816:33, 6816:35, 6819:5, 6819:18, 6820:22, 6820:45, 6825:27, 6826:16, 6827:17, 6828:36, 6836:13, 6838:8, 6846:45, 6847:5, 6847:20, 6847:22, 6849:18, 6849:28, 6849:34, 6851:27, 6851:30, 6852:17, 6852:19, 6852:24, 6852:26, 6852:47, 6853:17, 6853:20, 6853:24, 6854:10, 6855:3, 6855:17, 6856:47, 6857:1, 6857:21, 6857:41, 6858:14, 6859:1, 6859:15, 6859:21, 6860:9, 6860:47, 6862:28, 6862:33, 6862:41, 6866:21, 6866:41, 6867:31, 6868:1, 6868:9, 6868:21, 6868:22, 6869:11, 6869:16, 6869:32, 6869:33, 6869:36, 6870:7, 6870:12, 6870:34, 6870:38, 6871:16, 6871:40, 6871:43, 6872:18, 6873:43, 6877:9, 6878:19, 6881:19, 6882:14, 6884:21, 6885:40, 6886:43, 6889:45, 6890:38, 6894:42
evidence" [1] - 6858:28
evolution [1] - 6809:17
exactly [6] - 6807:18, 6824:39, 6835:14, 6842:45, 6877:28, 6882:14
example [66] - 6805:45, 6810:19, 6813:45, 6814:41, 6815:8, 6815:38, 6816:42, 6817:2, 6817:38, 6817:39, 6818:18, 6819:36, 6820:12, 6821:20, 6822:38, 6823:30, 6826:47, 6827:41, 6828:23, 6832:42, 6833:6, 6833:39, 6833:40, 6834:20, 6834:33, 6836:34, 6840:39, 6843:19, 6845:17, 6845:36, 6847:39, 6852:30, 6852:42, 6854:40, 6855:29, 6856:17, 6856:18, 6856:19, 6857:11, 6859:20, 6864:23, 6864:35, 6866:29, 6868:3, 6869:19, 6869:35, 6870:47, 6873:22, 6874:9, 6878:42, 6879:1, 6879:11, 6880:4, 6883:4, 6883:24, 6885:26, 6885:44, 6886:40, 6887:32, 6887:43, 6888:2, 6892:15, 6892:24, 6892:26, 6894:20
examples [16] - 6811:36, 6811:43, 6825:24, 6833:42, 6837:6, 6864:24, 6871:2, 6873:41, 6873:47, 6874:3, 6874:8, 6874:29, 6884:16, 6885:16, 6886:8, 6888:43
excellence [4] - 6851:14, 6869:19, 6874:7, 6885:23
Excellence [1] - 6886:37
excellent [3] - 6849:2, 6893:41, 6894:7
exclusive [1] - 6894:44
excuse [1] - 6850:16
executive [5] - 6851:3, 6851:25, 6882:15, 6884:26, 6887:45
executives [4] - 6875:15, 6879:11, 6882:12, 6882:37
exercise [2] - 6873:43, 6889:46
exercises [2] - 6816:17, 6838:32
exist [2] - 6856:11, 6884:11
existing [7] - 6826:24, 6828:20, 6829:9, 6829:27, 6837:25, 6873:20
exists [1] - 6880:27
expand [3] - 6824:26, 6824:47, 6839:14
expanding [1] - 6839:16
expansion [1] - 6855:23
expect [2] - 6883:28, 6884:17
expectancy [1] - 6848:24
expectation [1] - 6836:31
expense [2] - 6825:11, 6838:26
expensive [3] - 6806:13, 6836:42, 6854:2
experience [6] - 6803:18, 6807:40, 6807:41, 6876:40, 6887:17, 6888:47
expert [3] - 6849:16, 6851:33, 6887:42
expertise [5] - 6832:37, 6850:36, 6852:38, 6861:13, 6883:42
experts [1] - 6834:16
explained [1] - 6857:8
explicit [1] - 6836:29
explicitly [2] - 6809:26, 6816:19
explore [6] - 6807:32, 6809:9, 6831:8, 6870:9, 6871:18, 6871:19
explored [1] - 6847:21
exploring [3] - 6806:43, 6826:47, 6870:12
expressed [3] - 6825:1, 6851:40, 6872:27
expressing [2] - 6887:7, 6887:8
extend [2] - 6836:14, 6877:37
extended [1] - 6879:14
extending [1] - 6855:19
extends [1] - 6885:38
extensively [1] - 6841:1
extent [13] - 6806:46, 6807:41, 6823:20, 6828:21, 6828:28, 6829:22, 6830:32, 6831:19, 6856:11, 6863:46, 6872:31, 6887:3, 6887:21
external [5] - 6821:9, 6863:16, 6873:12, 6880:26, 6892:36
externally [4] - 6821:16, 6829:24, 6880:15, 6894:35
extra [2] - 6867:6, 6878:26
extract [1] - 6831:23
extracted [1] - 6889:7
extraordinary [1] - 6880:45
eye [1] - 6828:33
-
- F**
-
- fabulous** [1] - 6843:46
face [1] - 6860:33
facilitate [3] - 6855:46, 6872:10, 6884:11
facilitates [1] - 6844:34
facilitating [1] - 6816:21
facility [3] - 6817:3, 6831:32, 6841:38
fact [13] - 6804:13, 6815:47, 6816:8, 6818:3, 6824:41, 6834:13, 6854:32, 6860:44, 6870:47, 6871:15, 6872:38, 6880:8, 6894:11
factor [2] - 6829:22, 6836:20
factors [9] - 6803:45, 6810:44, 6811:43, 6811:46, 6815:44, 6821:11, 6822:45, 6832:23, 6872:8
factory [1] - 6818:5
failure [1] - 6839:3
fair [12] - 6803:46, 6808:36, 6808:40, 6810:23, 6832:31, 6837:15, 6866:18, 6876:16, 6876:22, 6876:43, 6883:24, 6887:39
Fairfield [2] - 6843:24, 6843:25
fairly [2] - 6820:46, 6835:8
fairness [1] - 6839:10
faith [1] - 6873:24
fall [2] - 6860:14, 6878:42
fallen [1] - 6814:31
familiar [1] - 6892:46
fantastic [4] - 6869:44, 6873:44, 6874:28, 6887:45
far [7] - 6854:5, 6854:36, 6860:36, 6866:35, 6877:16, 6883:30, 6889:38
Far [4] - 6811:24, 6832:7, 6834:9, 6840:45
fashion [2] - 6814:31, 6889:7
faster [1] - 6894:32
favourite [1] - 6825:24
feasibility [5] - 6860:31, 6861:2, 6863:11, 6867:16, 6891:5
feasible [2] - 6856:33, 6882:39
feasibly [1] - 6883:37
feature [2] - 6843:21,

- 6879:46
features [1] - 6856:41
fee [1] - 6841:38
feedback [8] -
6853:39, 6853:41,
6868:36, 6868:44,
6877:15, 6877:25,
6890:26, 6891:36
feeding [1] - 6816:33
fees [1] - 6841:14
fellowship [3] -
6880:13, 6883:9,
6893:14
felt [1] - 6825:2
fertilising [1] -
6887:12
few [9] - 6813:13,
6831:35, 6838:47,
6842:8, 6864:9,
6864:10, 6867:47,
6874:2, 6881:42
field [1] - 6861:13
fields [1] - 6887:12
fifth [1] - 6846:19
fifty [2] - 6842:44
fifty-fifty [1] - 6842:44
figure [2] - 6810:17,
6823:5
finally [1] - 6851:23
financial [1] - 6876:14
financially [1] -
6845:35
fine [2] - 6847:23,
6849:46
finite [1] - 6883:28
firm [1] - 6894:22
first [13] - 6803:3,
6809:45, 6810:14,
6813:8, 6826:6,
6829:31, 6830:30,
6831:2, 6840:12,
6843:45, 6848:22,
6850:25, 6885:35
fitness [1] - 6819:8
fits [1] - 6872:13
fitter [1] - 6819:10
five [5] - 6821:44,
6846:23, 6847:37,
6850:31, 6883:6
fix [1] - 6858:18
fixed [13] - 6808:1,
6822:22, 6822:23,
6822:30, 6822:32,
6822:37, 6822:41,
6822:43, 6822:46,
6823:5, 6823:13,
6825:4, 6842:13
flagging [1] - 6866:32
flagpole [1] - 6884:37
flippant [1] - 6810:21
floating [1] - 6878:20
flow [2] - 6809:27,
6835:32
flowers [1] - 6886:18
flows [1] - 6833:21
focus [19] - 6813:26,
6826:43, 6835:12,
6835:13, 6839:27,
6848:27, 6860:11,
6867:47, 6869:12,
6869:30, 6870:5,
6873:37, 6874:30,
6875:17, 6883:1,
6883:8, 6883:42,
6883:44, 6891:36
focused [3] - 6864:23,
6867:44, 6869:24
focuses [1] - 6867:41
focusing [1] - 6851:26
foibles [1] - 6805:41
follow [4] - 6806:32,
6828:46, 6839:34,
6856:17
followed [2] - 6853:3,
6863:47
following [2] -
6813:16, 6813:18
follows [1] - 6865:21
food [3] - 6853:12,
6853:18, 6854:15
footprint [1] - 6855:12
for [1] - 6879:3
forces [2] - 6842:26,
6880:26
forever [1] - 6840:47
forget [1] - 6877:39
forgive [1] - 6858:17
form [5] - 6804:28,
6826:5, 6857:17,
6861:16, 6861:24
formal [1] - 6884:35
formats [1] - 6887:35
forms [3] - 6823:30,
6856:34, 6877:19
formula [3] - 6803:40,
6804:36, 6809:25
Formula [1] - 6803:41
formulation [1] -
6821:10
forum [2] - 6884:26
forward [6] - 6815:7,
6817:8, 6869:12,
6878:23, 6884:6,
6888:40
foster [3] - 6881:29,
6881:35, 6883:12
fostering [1] - 6882:8
foundation [2] -
6803:27, 6877:43
foundations [2] -
6875:46, 6879:28
four [10] - 6823:6,
6838:39, 6838:43,
6839:21, 6839:26,
6840:7, 6846:10,
6846:11, 6856:38,
6863:5
fourth [4] - 6822:20,
6837:4, 6837:31,
6846:18
fractional [1] -
6851:17
fragmentation [1] -
6887:21
fragmented [1] -
6885:19
frail [3] - 6843:43,
6879:12, 6881:46
framework [5] -
6812:7, 6813:40,
6815:4, 6821:44,
6846:30
France [1] - 6873:45
frankly [1] - 6876:39
Fraser [1] - 6802:30
free [8] - 6812:4,
6815:3, 6818:40,
6827:26, 6837:39,
6861:10, 6865:29,
6877:1
free-for-all [1] -
6815:3
front [5] - 6823:6,
6849:22, 6858:44,
6859:10, 6890:29
fronts [1] - 6837:27
frustrating [1] -
6881:13
frustrations [1] -
6876:21
fulfilling [1] - 6838:28
full [3] - 6813:38,
6869:43, 6892:5
Fuller [1] - 6802:31
fully [1] - 6847:21
function [3] - 6814:21,
6854:41, 6872:47
functioning [1] -
6892:3
functions [4] -
6813:44, 6814:39,
6814:40, 6870:19
Fund [3] - 6860:45,
6873:25, 6877:6
fund [11] - 6805:40,
6806:15, 6808:24,
6810:5, 6812:21,
6818:43, 6829:13,
6841:8, 6862:38,
6865:1, 6882:16
fundamental [1] -
6811:3, 6812:14,
6820:30, 6822:5,
6824:8, 6824:28,
6825:9, 6825:12,
6838:46, 6839:18,
6882:34
funded [22] - 6811:32,
6819:20, 6839:5,
6840:32, 6841:29,
6842:22, 6842:25,
6842:34, 6845:14,
6845:15, 6851:13,
6863:4, 6863:8,
6863:9, 6863:30,
6864:39, 6864:43,
6868:16, 6869:26,
6874:37, 6894:35
funder [3] - 6814:32,
6814:36, 6876:36
Funding [1] - 6802:9
funding [99] -
6803:25, 6803:47,
6804:13, 6804:17,
6804:20, 6804:24,
6804:29, 6804:33,
6804:38, 6804:44,
6805:29, 6805:39,
6806:44, 6807:15,
6807:29, 6807:34,
6808:8, 6808:27,
6808:32, 6808:40,
6808:44, 6809:3,
6809:5, 6810:24,
6811:5, 6811:28,
6812:3, 6812:17,
6812:22, 6812:29,
6816:6, 6816:15,
6816:27, 6817:45,
6819:1, 6819:21,
6820:13, 6820:32,
6822:23, 6822:30,
6822:42, 6823:12,
6823:20, 6824:1,
6824:2, 6824:30,
6825:4, 6825:23,
6826:8, 6826:39,
6828:9, 6828:46,
6828:47, 6829:29,
6830:4, 6830:10,
6831:29, 6831:34,
6831:41, 6832:15,
6832:33, 6832:34,
6833:15, 6833:27,
6835:2, 6835:20,
6837:26, 6837:44,
6838:24, 6841:31,
6841:35, 6843:2,
6856:4, 6863:16,
6865:6, 6865:18,
6871:41, 6871:42,
6873:25, 6873:27,
6876:10, 6877:5,
6878:11, 6880:15,
6882:2, 6883:29,
6883:40, 6884:13,
6892:19, 6893:7,
6893:15, 6893:16,
6894:5
funds [5] - 6854:26,
6879:32, 6879:33,
6892:36, 6893:28
future [16] - 6814:7,
6825:15, 6826:18,
6826:33, 6833:26,
6839:19, 6843:12,
6848:14, 6848:18,
6874:36, 6878:46,
6878:47, 6879:5,
6879:8, 6879:18,
6888:31
Future [3] - 6860:45,
6873:25, 6877:6
-
- G**
-
- gain** [2] - 6804:7,
6883:43
gains [2] - 6826:18,
6826:33
game [2] - 6840:6,
6842:47
game-changer [2] -
6840:6, 6842:47
gap [3] - 6811:24,
6862:4, 6870:7
gaps [2] - 6811:38,
6839:33
gateway [1] - 6884:12
gather [5] - 6809:10,
6813:12, 6820:44,
6823:22, 6825:38
gathered [1] - 6836:13
gathering [1] -
6881:18
gear [1] - 6824:15
Gee [1] - 6815:32
gee [1] - 6840:45
general [2] - 6838:6,
6894:16
generally [5] -
6807:40, 6851:27,
6860:34, 6880:2,
6886:16
generate [5] -
6817:35, 6872:18,
6878:18, 6892:36,
6894:8
generated [3] -
6852:17, 6852:19,

6852:47
generating [2] -
6852:23, 6873:37
generation [1] -
6852:39
generic [2] - 6865:44,
6872:13
genomics [1] - 6879:7
genuine [1] - 6866:21
geographic [2] -
6810:1, 6855:12
gist [1] - 6887:30
given [13] - 6811:44,
6812:37, 6834:20,
6847:25, 6857:36,
6859:20, 6865:39,
6866:47, 6876:13,
6885:37, 6888:22,
6891:38, 6892:37
global [4] - 6804:4,
6831:33, 6862:23
Glover [1] - 6802:28
goal [5] - 6805:38,
6814:6, 6821:35,
6826:9, 6880:40
goals [1] - 6885:31
govern [1] - 6824:29
governance [5] -
6812:7, 6824:31,
6832:39, 6844:26,
6856:8
governed [1] - 6807:1
Government [1] -
6893:44
government [7] -
6813:41, 6813:43,
6860:44, 6878:6,
6886:47, 6891:42,
6892:9
governments [2] -
6807:43, 6813:24
GP [1] - 6843:45
GPs [3] - 6832:8,
6843:42
gradually [1] -
6808:42
grant [3] - 6863:12,
6894:13, 6894:35
Grants [1] - 6883:5
grants [6] - 6805:42,
6806:3, 6806:35,
6882:5, 6883:11
grateful [2] - 6849:4,
6895:14
great [13] - 6813:16,
6854:47, 6857:4,
6857:11, 6868:33,
6874:29, 6877:43,
6879:27, 6884:17,
6886:9, 6888:38,
6890:38
greater [5] - 6810:37,
6834:41, 6893:5,
6893:9, 6894:33
ground [4] - 6865:10,
6865:41, 6873:1,
6887:11
group [18] - 6806:8,
6813:32, 6827:14,
6843:34, 6843:35,
6844:27, 6855:40,
6856:21, 6863:13,
6866:32, 6866:36,
6866:42, 6874:10,
6874:24, 6874:46,
6875:15, 6882:12,
6882:13
groupings [1] -
6881:44
groups [8] - 6808:28,
6846:42, 6869:20,
6869:27, 6881:44,
6882:4, 6882:36,
6882:40
grow [1] - 6880:20
growing [3] - 6810:13,
6879:38, 6894:45
grows [1] - 6894:40
growth [3] - 6808:33,
6810:12, 6810:17
GST [1] - 6805:43
guess [6] - 6820:17,
6822:31, 6855:25,
6866:32, 6872:22,
6892:34
guessing [1] -
6885:45
guidance [12] -
6860:9, 6863:38,
6864:8, 6864:25,
6865:37, 6865:39,
6866:7, 6866:19,
6866:20, 6867:31,
6878:8, 6878:10
guidances [1] -
6869:2
guide [3] - 6835:27,
6852:17, 6884:42
guideline [14] -
6853:1, 6853:22,
6853:27, 6853:29,
6862:43, 6863:36,
6863:47, 6872:36,
6872:39, 6872:42,
6888:15, 6888:18,
6888:26, 6889:36
guidelines [19] -
6804:25, 6852:44,
6852:45, 6852:46,
6857:40, 6857:41,
6862:28, 6863:1,
6863:42, 6865:20,
6865:21, 6865:24,
6866:22, 6866:41,
6868:20, 6868:44,
6871:16, 6872:43,
6878:20
guinea [1] - 6818:19

H

habilitation [6] -
6819:5, 6819:15,
6819:19, 6819:39,
6819:40, 6821:46
halcyon [1] - 6842:37
half [1] - 6810:45
hand [4] - 6830:9,
6840:17, 6840:20,
6844:41
handling [1] - 6859:1
handy [1] - 6851:43
happy [7] - 6807:26,
6813:42, 6849:22,
6856:16, 6861:24,
6862:5, 6873:9
hard [3] - 6870:27,
6875:20, 6878:18
hardly [1] - 6842:6
harm [2] - 6861:23,
6862:12
harmful [1] - 6856:30
harnessing [1] -
6807:4
hate [1] - 6879:1
head [2] - 6836:11,
6881:27
headed [1] - 6851:32
heading [1] - 6813:6
headings [1] -
6846:10
headmaster [1] -
6817:13
headmistress [1] -
6817:13
Health [43] - 6802:36,
6803:40, 6804:5,
6804:18, 6805:1,
6805:4, 6807:27,
6809:13, 6814:41,
6831:24, 6832:36,
6838:13, 6841:40,
6842:20, 6844:12,
6848:32, 6850:31,
6850:40, 6850:42,
6851:3, 6851:13,
6851:18, 6852:34,
6855:31, 6855:35,
6855:37, 6856:22,
6856:46, 6863:4,
6869:19, 6869:24,
6870:14, 6875:14,
6875:34, 6877:5,
6881:25, 6881:42,
6885:4, 6886:24,
6888:8, 6889:1,
6890:2, 6892:45
health [239] - 6803:13,
6803:18, 6803:21,
6803:24, 6803:28,
6803:34, 6804:1,
6804:5, 6804:6,
6804:11, 6804:16,
6804:31, 6804:35,
6804:37, 6804:38,
6804:40, 6805:5,
6805:16, 6807:7,
6807:34, 6807:45,
6807:47, 6808:9,
6808:21, 6808:27,
6809:2, 6809:6,
6809:40, 6810:31,
6810:36, 6811:23,
6811:27, 6811:34,
6811:45, 6812:1,
6812:21, 6813:15,
6813:30, 6814:34,
6814:40, 6815:14,
6815:33, 6815:45,
6816:13, 6817:31,
6819:27, 6820:47,
6821:8, 6821:9,
6821:14, 6821:43,
6821:47, 6824:29,
6824:38, 6824:42,
6825:16, 6825:17,
6825:35, 6826:18,
6826:19, 6826:28,
6826:35, 6827:12,
6827:25, 6828:29,
6829:12, 6829:15,
6829:24, 6830:12,
6830:13, 6830:14,
6830:34, 6830:37,
6830:43, 6830:44,
6831:15, 6831:32,
6832:5, 6832:24,
6832:25, 6833:10,
6833:30, 6833:35,
6834:14, 6834:36,
6835:18, 6835:46,
6836:15, 6837:16,
6837:37, 6837:47,
6838:4, 6838:10,
6838:14, 6838:15,
6838:19, 6839:42,
6840:7, 6841:31,
6842:7, 6842:22,
6842:31, 6842:37,
6842:42, 6842:46,
6842:47, 6843:3,
6843:8, 6843:13,
6843:20, 6843:25,
6843:26, 6843:28,
6843:44, 6846:13,
6846:29, 6846:31,
6846:38, 6846:40,
6847:6, 6847:32,
6848:7, 6848:15,
6848:31, 6848:35,
6849:17, 6850:29,
6850:32, 6850:37,
6851:2, 6851:5,
6851:12, 6851:18,
6851:19, 6851:21,
6851:33, 6852:9,
6852:16, 6852:18,
6852:19, 6852:21,
6852:23, 6852:25,
6852:27, 6852:34,
6852:37, 6852:40,
6853:2, 6853:6,
6853:10, 6853:14,
6853:21, 6853:26,
6853:33, 6853:44,
6854:6, 6854:11,
6854:32, 6854:38,
6854:41, 6855:9,
6855:10, 6855:14,
6855:19, 6855:23,
6855:34, 6856:7,
6856:11, 6861:8,
6863:5, 6863:13,
6864:22, 6865:33,
6865:42, 6866:8,
6866:13, 6867:24,
6869:3, 6869:16,
6870:36, 6871:25,
6871:34, 6871:42,
6872:16, 6872:31,
6872:41, 6873:7,
6873:14, 6873:20,
6873:33, 6874:13,
6875:42, 6876:16,
6876:25, 6876:41,
6877:3, 6877:11,
6878:7, 6878:39,
6878:41, 6879:1,
6879:2, 6879:4,
6879:5, 6879:38,
6879:41, 6879:42,
6880:16, 6880:17,
6880:23, 6880:24,
6880:27, 6881:8,
6881:14, 6881:16,
6882:1, 6882:38,
6883:16, 6885:12,
6885:19, 6885:29,
6886:10, 6887:4,
6887:22, 6890:42,
6891:40, 6892:10,
6893:24, 6893:46,

6894:31, 6894:40
healthcare [16] - 6838:22, 6852:3, 6852:18, 6857:47, 6864:30, 6872:23, 6873:28, 6879:17, 6881:32, 6882:6, 6885:41, 6886:21, 6886:38, 6886:44, 6891:24, 6894:47
Healthcare [1] - 6802:9
healthy [9] - 6852:44, 6852:46, 6853:1, 6853:10, 6853:12, 6853:18, 6853:27, 6854:15
hear [2] - 6851:38, 6857:24
heard [2] - 6820:45, 6826:16
hearing [1] - 6843:31
heart [5] - 6814:13, 6817:35, 6817:36, 6835:25, 6836:10
Heart [1] - 6846:40
heart-lung [1] - 6814:13
heft [1] - 6876:14
height [1] - 6843:32
held [9] - 6803:32, 6804:10, 6804:47, 6818:41, 6824:21, 6831:6, 6831:8, 6831:19, 6846:2
help [4] - 6816:13, 6873:13, 6878:35, 6890:39
helped [2] - 6819:7, 6885:30
helpful [2] - 6837:37, 6862:22
helping [1] - 6884:20
helps [2] - 6877:8, 6891:22
hence [1] - 6890:22
HETI [1] - 6814:41
hi [1] - 6851:11
high [8] - 6809:22, 6814:13, 6834:27, 6848:23, 6868:4, 6868:9, 6874:1, 6874:29
high-complexity [1] - 6814:13
high-level [2] - 6809:22, 6834:27
high-quality [1] - 6868:9
higher [3] - 6836:44, 6860:20, 6880:41
highest [1] - 6832:5
highly [3] - 6868:15, 6876:23, 6876:24
Hilbert [1] - 6802:36
hip [2] - 6809:23, 6819:19
hips [1] - 6833:22
historic [2] - 6823:12, 6838:32
historical [1] - 6807:35
historically [1] - 6836:5
history [1] - 6842:31
hitting [1] - 6888:42
hmm [7] - 6807:38, 6809:36, 6815:41, 6816:46, 6820:42, 6844:7, 6850:20
hoc [1] - 6833:9
hold [4] - 6803:12, 6812:41, 6846:6, 6851:41
holding [2] - 6831:9, 6831:15
home [13] - 6809:24, 6817:27, 6820:4, 6828:37, 6836:18, 6836:19, 6836:26, 6836:35, 6837:22, 6840:28, 6843:16, 6843:36, 6843:37
homeless [1] - 6808:30
homes [3] - 6822:43, 6823:2, 6823:7
honest [1] - 6879:44
honestly [3] - 6857:39, 6858:17, 6890:45
hope [4] - 6834:26, 6879:24, 6889:20
hoped [1] - 6890:45
hopeful [2] - 6868:41, 6869:9
hoping [1] - 6831:16
horses [1] - 6813:47
Hospital [5] - 6804:43, 6805:31, 6805:38, 6863:5, 6888:25
hospital [31] - 6806:11, 6806:14, 6820:4, 6822:32, 6822:36, 6823:26, 6825:11, 6828:36, 6833:25, 6833:39, 6835:11, 6835:12, 6835:27, 6840:2, 6840:37, 6841:18, 6841:22, 6841:24, 6841:38, 6842:15, 6843:6, 6845:42, 6857:22, 6879:13, 6879:15, 6880:7, 6886:41, 6888:5, 6888:24, 6890:44, 6891:4
hospitals [33] - 6804:38, 6805:40, 6806:8, 6806:9, 6806:10, 6806:23, 6811:26, 6814:34, 6822:21, 6822:33, 6823:10, 6823:11, 6825:13, 6832:8, 6835:14, 6836:37, 6836:38, 6839:46, 6839:47, 6841:42, 6842:46, 6844:31, 6845:21, 6845:38, 6845:45, 6847:34, 6848:11, 6848:27, 6866:9, 6872:11, 6875:44, 6880:11
hub [2] - 6833:36, 6837:19
huge [2] - 6805:8, 6823:39
human [2] - 6829:5, 6831:31
humans [1] - 6892:5
hundreds [3] - 6840:36, 6840:37, 6874:11
Hunter [8] - 6816:2, 6819:46, 6851:17, 6852:33, 6853:14, 6854:42, 6854:43, 6855:15
hypertension [1] - 6874:10
hypothetical [1] - 6816:43
hypothetically [1] - 6816:43

lan [1] - 6802:30
idea [8] - 6806:12, 6808:23, 6810:20, 6810:47, 6814:3, 6852:20, 6872:16, 6881:17
ideal [2] - 6888:40, 6890:15
ideally [1] - 6850:14
ideas [3] - 6820:21, 6820:28, 6852:7
identical [1] - 6813:24
identification [8] - 6823:42, 6827:35, 6827:38, 6828:13, 6842:11, 6843:15, 6846:33, 6846:43
identifications [1] - 6823:46
identified [13] - 6821:11, 6821:17, 6824:2, 6828:3, 6852:4, 6862:40, 6863:25, 6864:18, 6875:47, 6883:11, 6886:38, 6886:42, 6889:30
identifies [7] - 6821:7, 6825:34, 6825:44, 6830:31, 6832:22, 6835:45
identify [12] - 6807:17, 6812:27, 6825:37, 6827:5, 6827:6, 6828:38, 6830:42, 6850:25, 6852:21, 6856:23, 6883:6, 6883:30
identifying [6] - 6803:45, 6806:22, 6831:45, 6854:28, 6886:20, 6891:31
IHACPA [3] - 6805:22, 6806:44, 6807:14
IHPA [2] - 6805:37, 6806:26
ill [1] - 6878:39
Illawarra [11] - 6803:22, 6804:47, 6805:3, 6808:34, 6809:13, 6809:28, 6810:23, 6817:17, 6817:21, 6839:15, 6845:18
illness [1] - 6859:25
illnesses [1] - 6838:21
illustration [1] - 6879:19
immeasurable [1] - 6821:18
immediately [3] - 6809:21, 6849:22, 6892:28
immunologists [1] - 6840:3
impact [3] - 6810:44, 6853:5, 6872:42
impacts [1] - 6850:36
impede [1] - 6872:10
implement [17] - 6852:44, 6853:22, 6853:34, 6853:35, 6859:44, 6861:8, 6867:32, 6868:8, 6868:13, 6868:23, 6869:10, 6869:21, 6869:32, 6872:19, 6873:39, 6875:43, 6884:21
implementable [2] - 6866:26, 6867:34
implementation [22] - 6850:35, 6851:14, 6854:1, 6859:42, 6860:24, 6866:20, 6866:23, 6866:31, 6866:33, 6866:40, 6867:47, 6868:31, 6868:43, 6870:21, 6871:26, 6873:13, 6873:37, 6875:43, 6878:1, 6888:34, 6890:23
Implementation [1] - 6851:15
implemented [20] - 6804:19, 6853:30, 6857:47, 6860:26, 6860:37, 6861:3, 6862:29, 6864:19, 6865:45, 6868:5, 6874:3, 6874:12, 6874:35, 6877:20, 6877:30, 6880:43, 6881:20, 6888:27, 6889:19, 6892:12
implementing [5] - 6856:47, 6865:43, 6868:12, 6878:28, 6891:5
implications [1] - 6805:8
implicit [1] - 6815:9
implied [1] - 6878:30
importance [3] - 6886:10, 6890:22, 6890:24
important [31] - 6806:13, 6809:6, 6811:19, 6811:25, 6812:12, 6816:31, 6817:27, 6821:42, 6825:43, 6831:3, 6831:25, 6836:20, 6837:31, 6841:4, 6847:19, 6848:14, 6858:3, 6865:20, 6865:37, 6867:17, 6868:28, 6872:44, 6873:38, 6875:29, 6878:25, 6878:43,

6879:5, 6879:22,
6882:15, 6884:26,
6891:39
importantly [2] -
6804:2, 6874:34
impossibly [1] -
6838:6
impractical [1] -
6824:19
impressive [1] -
6877:41
improve [22] -
6810:10, 6814:3,
6819:8, 6820:29,
6821:47, 6823:40,
6824:44, 6824:45,
6825:5, 6826:34,
6827:34, 6831:37,
6846:14, 6846:16,
6851:6, 6852:39,
6852:47, 6854:29,
6868:34, 6871:36,
6874:9, 6894:30
improved [6] -
6828:42, 6851:7,
6853:5, 6853:46,
6854:12, 6877:11
improvement [12] -
6829:36, 6829:40,
6829:41, 6830:24,
6852:9, 6852:24,
6852:27, 6854:33,
6860:46, 6872:23,
6889:13, 6890:25
improvements [5] -
6847:6, 6849:18,
6851:34, 6853:15,
6855:27
improves [1] -
6829:31
improving [4] -
6830:14, 6853:19,
6871:34, 6874:34
inadequately [1] -
6837:27
incentive [3] -
6830:11, 6835:14,
6866:11
incentives [9] -
6803:26, 6811:12,
6811:16, 6829:45,
6830:3, 6830:4,
6838:9, 6841:18,
6874:14
incentivise [7] -
6804:3, 6820:14,
6826:39, 6829:6,
6838:25, 6841:23,
6842:12
incentivised [3] -
6809:7, 6825:10,
6841:43
incentivises [3] -
6819:14, 6835:11,
6835:13
incentivising [5] -
6823:21, 6823:23,
6824:3, 6835:10,
6874:18
inclined [1] - 6857:13
include [2] - 6808:38,
6824:27
included [3] -
6809:46, 6831:23,
6843:36
includes [2] -
6852:37, 6891:46
including [4] -
6815:44, 6843:16,
6874:2, 6895:12
income [5] - 6874:1,
6874:29, 6894:8,
6894:37
incorporate [1] -
6832:14
increase [3] - 6816:6,
6844:42, 6891:8
increased [1] -
6878:17
increasing [2] -
6894:29, 6894:39
incredibly [3] -
6806:13, 6861:9,
6892:7
incremental [1] -
6856:32
Independent [3] -
6804:43, 6805:30,
6805:37
independent [1] -
6876:34
indicated [2] -
6806:46, 6842:17
indicates [1] -
6890:46
indicator [1] - 6891:13
indicators [4] -
6820:41, 6820:46,
6831:10, 6831:13
Indigenous [3] -
6808:30, 6810:33,
6822:47
individual [6] -
6805:40, 6847:5,
6854:20, 6858:40,
6872:8, 6879:37
individuals [2] -
6849:25, 6879:36
ineffective [1] -
6853:38
inefficiencies [1] -
6841:45
inefficiency [1] -
6840:35
inefficient [4] -
6840:36, 6842:9,
6847:40, 6848:28
inequality [1] -
6810:29
inequitable [1] -
6810:1
inequities [1] -
6841:44
inertia [3] - 6857:9,
6858:24, 6859:9
inescapable [1] -
6891:33
inevitable [1] -
6835:20
infant [1] - 6828:37
infection [2] -
6886:41, 6891:4
infections [1] -
6890:44
influence [2] -
6876:36, 6876:39
inform [1] - 6869:7
information [10] -
6825:36, 6831:44,
6874:15, 6881:18,
6882:22, 6887:47,
6888:11, 6888:41,
6889:7, 6889:22
informed [8] -
6819:28, 6827:17,
6833:9, 6835:46,
6850:12, 6870:34,
6875:7, 6879:36
informing [1] -
6888:11
infrastructure [10] -
6852:38, 6853:36,
6856:6, 6868:29,
6877:38, 6877:47,
6878:9, 6878:11,
6878:24, 6882:47
inhabit [1] - 6880:42
initial [3] - 6853:37,
6863:11, 6882:3
initiative [3] -
6887:46, 6888:43,
6892:17
Innovation [1] -
6833:44
innovation [3] -
6880:31, 6883:12,
6884:4
innovations [1] -
6880:32
innovative [1] -
6880:4
6880:4
input [1] - 6819:31
inputs [1] - 6883:47
INQUIRY [1] - 6895:25
Inquiry [5] - 6802:7,
6812:31, 6820:18,
6820:25, 6849:3
inquiry [1] - 6815:27
insatiable [1] -
6880:19
insofar [2] - 6804:46,
6836:12
instance [1] - 6821:26
instead [4] - 6808:18,
6831:13, 6840:44,
6841:10
Institute [3] - 6814:42,
6834:13, 6851:26
institutes [1] -
6876:35
Insurance [1] -
6827:43
insurance [2] -
6811:27, 6832:6
integrated [1] -
6857:22
intellectual [1] -
6876:14
intelligence [2] -
6886:33, 6886:40
intensive [3] -
6806:12, 6806:15,
6836:10
intentions [1] -
6866:43
inter [1] - 6847:46
inter-operative [1] -
6847:46
interest [1] - 6813:17
interested [8] -
6803:25, 6804:12,
6811:14, 6811:15,
6839:16, 6851:26,
6880:12, 6880:33
interesting [3] -
6813:22, 6874:6,
6877:2
interests [1] - 6885:20
interface [2] -
6827:42, 6838:45
intergovernmental [1]
- 6812:25
internal [2] - 6863:33,
6887:16
international [6] -
6813:19, 6813:37,
6826:20, 6846:45,
6862:18, 6894:13
internationally [6] -
6813:18, 6848:8,
6856:1, 6867:46,
6873:41, 6885:15
intervention [33] -
6818:31, 6820:21,
6823:43, 6825:25,
6825:28, 6826:1,
6827:1, 6827:16,
6827:19, 6827:24,
6827:35, 6827:38,
6827:47, 6828:2,
6828:13, 6828:40,
6829:3, 6829:11,
6829:21, 6830:9,
6835:19, 6836:34,
6836:39, 6837:7,
6839:23, 6839:24,
6839:28, 6842:11,
6843:15, 6846:32,
6846:33, 6857:14,
6857:17
interventions [7] -
6823:46, 6825:38,
6828:22, 6838:26,
6850:37, 6867:41,
6867:46
intimated [1] - 6851:4
introduce [7] -
6819:47, 6856:24,
6888:14, 6888:17,
6889:32, 6890:16,
6890:18
introduced [1] -
6829:18
introduces [1] -
6830:4
introducing [2] -
6834:5, 6890:26
introduction [10] -
6804:31, 6804:40,
6805:16, 6807:14,
6807:37, 6826:7,
6828:2, 6828:45,
6889:3, 6890:8
invest [1] - 6820:20
invested [2] - 6879:12,
6892:37
investing [2] -
6867:27, 6883:38
investment [19] -
6827:45, 6829:46,
6844:21, 6844:24,
6844:30, 6845:4,
6846:15, 6846:24,
6846:36, 6846:38,
6856:5, 6869:31,
6879:18, 6883:38,
6892:18, 6892:32,
6893:31, 6893:34,
6894:6
invite [1] - 6831:1

inviting [1] - 6842:40	6819:4, 6819:41,	knowing [1] - 6810:45	6856:8	6842:2, 6845:41,
involve [3] - 6803:43,	6819:43, 6834:30	knowledge [4] -	Leading [1] - 6888:43	6854:20, 6865:45,
6860:5, 6860:8	joints [1] - 6818:6	6812:40, 6815:29,	leading [2] - 6834:5,	6866:11, 6866:13,
involved [7] - 6803:33,	judgment [1] -	6855:2, 6865:24	6882:13	6867:18, 6868:6,
6804:10, 6814:15,	6831:38	known [2] - 6876:26,	leap [2] - 6852:2,	6869:23, 6870:28,
6851:5, 6870:28,	jump [3] - 6865:29,	6876:27	6876:11	6872:8, 6872:9,
6891:35, 6894:26	6868:15, 6870:26	knows [1] - 6887:16	learn [2] - 6861:7,	6878:28, 6880:29,
involvement [6] -	junior [1] - 6842:4	KPI [8] - 6821:25,	6865:23	6880:41, 6881:24,
6820:5, 6820:7,	jurisdictions [4] -	6821:35, 6825:42,	learned [2] - 6877:18,	6887:36
6821:5, 6833:12,	6851:29, 6872:11,	6825:43, 6825:46,	6882:20	levels [5] - 6815:19,
6833:14, 6879:32	6885:9, 6891:31	6827:15, 6829:2,	learning [15] -	6836:17, 6868:16,
involves [2] - 6819:26,	justify [1] - 6808:13	6829:18	6825:28, 6844:44,	6869:27, 6882:31
6840:8		KPIs [11] - 6821:16,	6852:9, 6852:10,	leverage [4] - 6873:12,
irrespective [1] -	K	6821:22, 6821:33,	6852:13, 6852:16,	6883:39, 6893:15,
6822:26		6821:34, 6824:25,	6854:9, 6855:9,	6893:28
isolated [1] - 6843:33	Kaiser [2] - 6874:8,	6824:28, 6825:43,	6855:14, 6871:24,	LHD [3] - 6815:39,
issue [27] - 6810:42,	6888:3	6826:43, 6830:16,	6871:25, 6872:16,	6821:16, 6846:5
6811:14, 6811:15,	Kathy [1] - 6803:4	6838:12, 6846:10	6874:13	LHDs [4] - 6855:1,
6811:31, 6812:9,	KATHY [1] - 6803:8		learnings [1] -	6869:20, 6884:19,
6813:16, 6815:23,	keep [9] - 6807:26,	L	6893:12	6887:10
6815:29, 6818:47,	6813:41, 6819:19,	lab [1] - 6873:19	least [21] - 6807:5,	liaise [1] - 6828:8
6820:9, 6824:8,	6826:47, 6828:33,	laboratory [1] -	6808:10, 6809:10,	life [10] - 6803:20,
6824:28, 6825:29,	6836:23, 6839:6,	6873:19	6809:19, 6809:33,	6811:13, 6821:35,
6827:41, 6836:3,	6859:3, 6864:9	lack [11] - 6811:2,	6811:4, 6819:11,	6825:30, 6846:39,
6838:47, 6841:34,	keeping [1] - 6880:33	6811:4, 6811:8,	6811:10, 6811:11,	6848:24, 6860:32,
6841:35, 6845:37,	kept [2] - 6826:29,	6811:10, 6811:11,	6844:39, 6857:41,	6862:30, 6871:6,
6845:41, 6855:35,	6844:28	6844:39, 6857:41,	6864:8, 6890:3	6891:16
6868:33, 6877:2,	key [7] - 6803:39,	6864:8, 6890:3	lacked [1] - 6805:33	lifelong [1] - 6828:42
6881:5, 6887:26,	6820:40, 6820:45,	lagged [1] - 6805:33	lag [1] - 6868:38	lifetime [1] - 6893:12
6890:41	6831:10, 6831:13,	lagging [1] - 6828:39	language [2] -	likely [3] - 6817:40,
issued [2] - 6872:36,	6885:7, 6891:31	language [2] -	6814:30, 6881:1	6859:39, 6873:5
6872:38	kids [5] - 6828:1,	6854:30, 6881:1	large [11] - 6809:34,	limit [3] - 6835:4,
issues [11] - 6805:8,	6843:31, 6844:44,	6854:40, 6866:25,	6867:12, 6867:22,	6866:35, 6867:12
6812:14, 6814:22,	6854:16, 6880:6	6867:12, 6867:22,	6867:33, 6870:29,	limitations [1] -
6815:20, 6825:10,	killing [1] - 6838:21	6867:33, 6870:29,	6874:31, 6876:34,	6878:15
6838:45, 6848:18,	kind [25] - 6852:42,	6877:3, 6890:20	6877:3, 6890:20	limited [7] - 6808:21,
6865:37, 6879:16	6853:3, 6853:5,	large-scale [3] -	leave [2] - 6841:23,	6815:47, 6819:37,
IT [1] - 6869:3	6853:39, 6854:8,	6867:33, 6874:31,	6848:12	6830:35, 6871:40,
iteratively [1] - 6853:5	6854:18, 6854:20,	6890:20	led [2] - 6826:6,	6876:35, 6876:39
itself [7] - 6814:36,	6854:22, 6854:27,	largely [3] - 6853:37,	6842:26	line [2] - 6843:45,
6827:17, 6845:33,	6854:36, 6855:17,	6854:33, 6877:16	left [3] - 6849:20,	6890:29
6852:20, 6881:12,	6855:22, 6856:7,	larger [1] - 6882:5	6849:22, 6895:13	linguistically [1] -
6889:41	6856:12, 6871:24,	laser [1] - 6886:4	legion [1] - 6830:8	6810:33
J	6871:25, 6871:39,	last [11] - 6805:2,	legitimate [1] -	link [2] - 6857:23,
	6872:10, 6872:20,	6821:33, 6824:13,	6870:32	6858:33
January [1] - 6850:39	6872:23, 6875:38,	6838:47, 6839:38,	legs [3] - 6834:14,	linked [6] - 6815:25,
job [7] - 6813:39,	6875:47, 6881:22,	6841:4, 6844:9,	6834:15, 6834:16	6832:39, 6836:44,
6815:3, 6830:17,	6882:23, 6894:6	6875:36, 6876:22,	Leonards [1] - 6820:2	6858:13, 6888:44,
6832:45, 6839:8,	kindly [2] - 6851:4,	6882:11, 6887:18	less [13] - 6806:44,	6889:1
6839:26, 6865:23	6882:11	latter [1] - 6878:30	6816:38, 6817:9,	list [4] - 6819:6,
jobs [1] - 6843:24	kinds [4] - 6860:28,	lead [6] - 6834:41,	6817:10, 6823:16,	6819:12, 6821:34,
John [2] - 6816:2,	6864:22, 6882:8,	6841:7, 6851:12,	6825:7, 6832:6,	6824:18
6819:46	6882:21	6861:4, 6865:31,	6833:28, 6834:8,	literacy [1] - 6869:33
join [2] - 6882:41,	Kingdom [3] -	6877:10	6860:18, 6875:29	literally [2] - 6817:23,
6887:19	6885:17, 6885:23,	leadership [1] -	Level [1] - 6802:18	6843:27
joint [11] - 6818:4,	6885:29		level [37] - 6809:22,	literature [5] -
6818:18, 6818:23,	knee [3] - 6821:20,	6841:7, 6851:12,	6812:29, 6814:46,	6863:20, 6869:41,
6818:29, 6818:36,	6827:27, 6830:7	6861:4, 6865:31,	6815:19, 6815:20,	6888:34, 6890:1,
6818:39, 6818:42,	knees [2] - 6830:8,	6877:10	6817:46, 6823:30,	6890:18
	6833:22		6826:24, 6826:26,	live [3] - 6813:34,
			6827:13, 6829:19,	
			6829:36, 6832:38,	
			6833:17, 6833:19,	
			6833:22, 6834:27,	
			6834:39, 6837:41,	

- 6815:33, 6836:24
lived [1] - 6843:29
lives [1] - 6843:40
living [2] - 6825:17, 6873:19
load [1] - 6890:13
loading [1] - 6810:38
local [57] - 6804:1, 6807:34, 6808:9, 6809:40, 6811:45, 6812:1, 6812:27, 6815:14, 6815:45, 6816:12, 6819:27, 6821:43, 6824:10, 6824:38, 6824:42, 6825:35, 6827:12, 6827:25, 6828:21, 6829:12, 6829:15, 6829:24, 6830:42, 6832:25, 6833:35, 6835:46, 6837:16, 6837:29, 6838:14, 6841:31, 6842:40, 6851:5, 6853:25, 6855:19, 6863:5, 6863:13, 6865:33, 6865:41, 6865:42, 6865:45, 6866:8, 6866:13, 6867:15, 6867:17, 6872:18, 6872:20, 6873:1, 6873:20, 6875:42, 6876:3, 6876:41, 6878:28, 6880:16, 6880:17, 6890:42
Local [7] - 6805:1, 6805:3, 6809:13, 6844:12, 6851:18, 6852:34, 6856:22
localised [2] - 6870:36, 6872:22
locally [11] - 6813:7, 6813:47, 6814:47, 6816:18, 6836:40, 6862:17, 6866:28, 6866:30, 6870:30, 6871:18, 6881:15
located [1] - 6866:36
location [6] - 6810:8, 6812:1, 6814:14, 6822:47, 6880:10
locked [1] - 6822:26
logical [2] - 6813:44, 6814:15
logicality [1] - 6814:11
logistics [1] - 6850:12
long-term [1] - 6879:15
look [22] - 6813:42, 6815:18, 6820:7, 6833:21, 6833:24, 6833:42, 6838:38, 6846:44, 6852:13, 6852:29, 6865:43, 6869:42, 6876:42, 6882:6, 6885:3, 6885:15, 6885:18, 6885:22, 6888:5, 6888:25, 6889:28, 6892:46
looked [3] - 6862:39, 6867:38, 6890:1
looking [19] - 6810:10, 6816:10, 6820:29, 6847:5, 6855:45, 6856:22, 6860:5, 6866:46, 6871:7, 6871:11, 6874:16, 6876:6, 6876:24, 6878:46, 6887:8, 6887:9, 6887:10, 6887:11, 6893:21
loop [1] - 6868:45
loops [2] - 6868:36, 6890:26
lose [5] - 6810:38, 6810:39, 6819:7, 6824:19
losing [2] - 6811:4, 6822:6
lost [16] - 6806:7, 6808:25, 6808:27, 6808:29, 6808:32, 6808:46, 6809:20, 6809:41, 6809:45, 6810:27, 6810:28, 6817:25, 6824:9, 6828:17, 6844:1
low [2] - 6814:12, 6833:22
low-level [1] - 6833:22
low-turnover [1] - 6814:12
lower [10] - 6856:26, 6860:21, 6862:10, 6862:24, 6862:42, 6867:3, 6872:37, 6873:47, 6887:33, 6888:16
lowest [1] - 6805:32
Luke [7] - 6849:21, 6851:11, 6857:6, 6858:2, 6867:37, 6871:24, 6888:33
LUKE [1] - 6850:4
Luke's [1] - 6858:37
lung [1] - 6814:13
luxury [1] - 6875:14
Légaré [1] - 6873:45
- M**
- machine** [2] - 6847:38, 6847:45
machinery [1] - 6880:18
Macquarie [1] - 6802:18
main [2] - 6815:3, 6838:40
maintain [3] - 6838:15, 6846:13, 6865:24
maintained [1] - 6806:5
maintaining [2] - 6844:12, 6873:2
major [5] - 6806:8, 6833:16, 6843:17, 6846:37, 6878:38
majority [1] - 6860:34
manage [8] - 6840:4, 6848:19, 6856:27, 6856:35, 6861:21, 6864:26, 6871:16
managed [1] - 6867:19
management [14] - 6803:22, 6803:38, 6818:32, 6823:42, 6842:12, 6842:41, 6843:16, 6856:26, 6861:25, 6862:23, 6862:24, 6865:18, 6867:1, 6868:40
manager [1] - 6851:19
managers [4] - 6854:21, 6860:38, 6864:22, 6866:14
managing [5] - 6809:16, 6858:43, 6859:10, 6862:9, 6879:13
mandate [2] - 6885:38
mandatory [1] - 6853:30
map [1] - 6807:19
mapped [1] - 6854:18
mapping [1] - 6854:28
maps [1] - 6807:9
marginal [1] - 6829:36
markedly [1] - 6854:4
market [3] - 6842:25, 6842:26
marriages [1] - 6888:46
marry [1] - 6852:7
Martin [7] - 6849:21, 6851:25, 6867:10, 6876:47, 6879:26, 6881:26, 6882:46
MARTIN [1] - 6850:6
mass [1] - 6883:42
massive [1] - 6839:32
material [1] - 6810:43
materiality [1] - 6810:46
maternity [1] - 6813:46
matter [6] - 6806:1, 6821:6, 6828:8, 6829:14, 6840:1, 6850:12
matters [4] - 6811:18, 6820:13, 6829:6, 6857:7
maximal [1] - 6867:33
maximise [2] - 6804:6, 6847:12
MBS [3] - 6839:46, 6840:5, 6841:37
McNamara [8] - 6849:21, 6849:46, 6850:6, 6851:23, 6851:25, 6866:16, 6877:36
mean [41] - 6805:26, 6805:27, 6805:28, 6808:6, 6810:20, 6810:27, 6810:28, 6811:36, 6815:27, 6817:34, 6818:1, 6818:3, 6818:11, 6819:1, 6821:32, 6823:37, 6826:6, 6828:11, 6829:28, 6831:22, 6838:31, 6840:21, 6842:1, 6843:23, 6844:18, 6844:22, 6845:36, 6847:10, 6852:32, 6855:43, 6857:27, 6861:43, 6866:17, 6866:20, 6873:9, 6874:41, 6885:33, 6888:32, 6888:42
meaning [2] - 6845:39, 6847:4
meaningful [4] - 6844:14, 6844:18, 6844:20, 6887:38
means [6] - 6829:33, 6838:17, 6873:2, 6879:38, 6881:36, 6890:32
measure [9] - 6811:17, 6816:44, 6820:13, 6821:1, 6821:17, 6821:22, 6821:29, 6829:6, 6829:20
measures [7] - 6810:37, 6821:25, 6822:16, 6825:1, 6826:44, 6827:15, 6832:11
measuring [4] - 6811:18, 6820:47, 6821:2, 6839:27
mechanism [8] - 6806:45, 6807:6, 6819:16, 6825:23, 6871:8, 6876:2, 6880:26, 6889:42
mechanisms [1] - 6882:8
Medical [7] - 6851:13, 6860:45, 6873:25, 6877:6, 6881:25, 6885:4
medical [16] - 6811:33, 6826:42, 6832:9, 6833:29, 6839:34, 6839:38, 6839:39, 6839:41, 6839:44, 6839:45, 6841:13, 6841:19, 6841:21, 6841:25, 6876:34, 6891:47
Medicare [1] - 6841:9
medication [1] - 6874:25
medicine [1] - 6879:7
meet [9] - 6813:33, 6813:41, 6817:41, 6827:7, 6830:33, 6837:47, 6838:3, 6847:15, 6890:43
meeting [8] - 6816:16, 6818:42, 6828:27, 6828:28, 6830:43, 6831:5, 6879:41, 6882:11
meets [1] - 6873:5
member [2] - 6803:40, 6805:3
memory [1] - 6815:39
mental [3] - 6809:2, 6846:38, 6846:39
mention [1] - 6868:41
mentioned [4] - 6834:30, 6877:4, 6881:45, 6889:25
message [1] - 6877:24
messy [2] - 6876:43, 6876:45
met [3] - 6828:22, 6830:34, 6830:38
methodological [1] - 6867:44

methods [3] - 6829:44, 6863:15
 6853:45, 6855:2, 6893:18
metro [3] - 6823:2, 6823:6, 6833:38
metropolitan [2] - 6839:14, 6843:39
mid [2] - 6883:9, 6893:1
middle [2] - 6817:12, 6874:1
midwives [1] - 6842:5
might [59] - 6804:9, 6805:11, 6807:32, 6809:31, 6810:20, 6813:2, 6813:4, 6818:22, 6818:35, 6821:26, 6821:27, 6825:33, 6826:37, 6827:19, 6828:21, 6828:23, 6829:8, 6830:6, 6830:38, 6833:37, 6833:38, 6833:39, 6833:40, 6835:39, 6837:6, 6837:14, 6837:28, 6838:6, 6839:4, 6840:29, 6841:29, 6841:32, 6845:13, 6852:29, 6855:29, 6855:30, 6857:15, 6860:15, 6861:10, 6863:18, 6864:11, 6865:28, 6865:44, 6866:28, 6866:31, 6870:37, 6876:7, 6877:10, 6879:40, 6886:19, 6887:11, 6887:23, 6889:32, 6889:41, 6890:45, 6891:7, 6892:37, 6893:43, 6894:21
Milat [4] - 6849:23, 6850:25, 6850:29, 6887:26
MILAT [19] - 6849:44, 6850:8, 6850:28, 6851:45, 6866:3, 6867:21, 6870:3, 6873:9, 6882:30, 6884:15, 6885:14, 6887:42, 6888:30, 6889:44, 6892:22, 6892:44, 6893:26, 6893:34, 6893:39
Milbank [1] - 6873:46
milestone [1] - 6828:37
mill [1] - 6834:19
million [3] - 6829:42, 6829:44, 6863:15
Milton [2] - 6845:25, 6845:28
mind [2] - 6846:27, 6871:31
mine [1] - 6873:45
minimise [2] - 6871:1, 6887:17
minister [1] - 6812:26
Ministry [6] - 6850:40, 6850:42, 6855:30, 6855:35, 6888:47, 6892:45
ministry [68] - 6807:21, 6807:26, 6811:39, 6812:12, 6812:15, 6812:20, 6813:37, 6813:38, 6814:3, 6814:6, 6814:8, 6814:11, 6814:15, 6814:17, 6814:19, 6814:32, 6814:35, 6814:43, 6815:9, 6815:12, 6816:4, 6816:21, 6816:40, 6828:8, 6829:12, 6829:13, 6829:15, 6831:5, 6832:37, 6833:44, 6834:21, 6836:5, 6841:30, 6842:21, 6844:40, 6844:41, 6844:46, 6845:13, 6845:14, 6845:22, 6845:32, 6848:32, 6855:31, 6865:37, 6870:33, 6876:23, 6876:32, 6876:33, 6876:35, 6876:38, 6876:42, 6877:3, 6877:14, 6877:15, 6878:2, 6879:25, 6880:1, 6880:47, 6881:24, 6883:25, 6884:25, 6884:42, 6885:34, 6887:16, 6887:22, 6887:44, 6892:10
ministry's [10] - 6812:24, 6815:3, 6815:35, 6816:30, 6821:34, 6834:12, 6845:32, 6875:40, 6877:26, 6877:27
minor [1] - 6834:36
minus [2] - 6808:39, 6808:44
missed [1] - 6863:18
misses [1] - 6845:2
missing [8] - 6832:1, 6843:17, 6857:20, 6857:23, 6858:8, 6868:14, 6869:6, 6888:10
mix [7] - 6804:13, 6804:15, 6811:47, 6821:44, 6837:15, 6862:47
mmm-hmm [7] - 6807:38, 6809:36, 6815:41, 6816:46, 6820:42, 6844:7, 6850:20
mobilise [1] - 6886:33
mobilising [1] - 6851:26
model [92] - 6803:47, 6804:17, 6804:33, 6804:34, 6804:42, 6805:21, 6805:29, 6805:30, 6805:32, 6805:42, 6806:18, 6806:27, 6806:44, 6806:45, 6807:9, 6807:10, 6807:13, 6807:16, 6807:22, 6807:37, 6808:29, 6809:4, 6809:10, 6809:32, 6810:7, 6810:38, 6811:29, 6812:17, 6816:15, 6816:27, 6817:45, 6819:2, 6819:14, 6819:21, 6820:28, 6820:32, 6822:6, 6822:7, 6822:9, 6822:23, 6822:30, 6822:42, 6823:13, 6823:20, 6823:29, 6824:1, 6824:2, 6824:14, 6824:30, 6824:45, 6825:23, 6826:39, 6828:46, 6828:47, 6829:9, 6829:14, 6829:27, 6829:28, 6829:29, 6829:31, 6829:34, 6830:4, 6830:10, 6831:29, 6832:12, 6832:15, 6833:27, 6833:37, 6835:4, 6838:24, 6839:14, 6839:45, 6841:1, 6841:32, 6852:13, 6854:1, 6855:23, 6856:47, 6857:1, 6857:21, 6858:14, 6859:22, 6866:24, 6867:1, 6867:6, 6867:43, 6868:14, 6870:12, 6870:20, 6875:47, 6888:42
model" [1] - 6852:11
models [13] - 6823:41, 6828:35, 6838:24, 6856:7, 6867:24, 6869:10, 6869:32, 6871:46, 6874:14, 6874:26, 6874:35, 6889:3, 6889:47
modest [5] - 6882:2, 6883:15, 6883:29, 6883:37
molecular [1] - 6892:3
moment [26] - 6805:4, 6805:11, 6814:35, 6815:31, 6819:17, 6820:46, 6824:33, 6831:9, 6834:40, 6839:39, 6840:8, 6840:27, 6840:36, 6841:35, 6842:5, 6844:37, 6847:42, 6859:11, 6859:16, 6859:17, 6872:44, 6878:12, 6879:25, 6887:5, 6887:33, 6894:33
money [43] - 6803:47, 6804:6, 6804:36, 6806:2, 6807:44, 6808:9, 6808:13, 6808:17, 6809:2, 6809:12, 6809:16, 6809:27, 6809:34, 6810:45, 6814:47, 6815:16, 6815:47, 6818:11, 6819:38, 6819:39, 6827:46, 6828:3, 6828:9, 6828:16, 6830:6, 6830:39, 6832:31, 6837:46, 6838:3, 6840:16, 6840:18, 6844:41, 6844:44, 6846:42, 6860:46, 6872:31, 6872:45, 6873:4, 6873:23, 6883:15, 6885:37, 6886:15, 6894:18
money" [1] - 6840:20
moneys [1] - 6886:28
monitoring [1] - 6874:17
month [2] - 6890:43
months [5] - 6812:37, 6875:36, 6876:23, 6887:18, 6891:34
morning [2] - 6803:1, 6803:6
morphing [1] - 6879:39
mortality [1] - 6836:44
most [25] - 6812:12, 6815:15, 6817:36, 6818:13, 6819:28, 6826:18, 6830:38, 6834:47, 6836:20, 6836:21, 6836:25, 6840:35, 6843:21, 6846:17, 6847:33, 6856:26, 6857:7, 6869:36, 6872:44, 6879:28, 6888:33, 6891:11, 6891:35, 6891:42
mother [1] - 6843:37
motivated [1] - 6884:1
motivation [1] - 6872:6
mouth [1] - 6858:37
move [11] - 6808:32, 6822:20, 6822:29, 6823:13, 6825:4, 6832:18, 6833:23, 6844:44, 6864:25, 6879:24, 6893:14
moved [3] - 6803:21, 6808:26, 6842:44
moving [5] - 6822:22, 6826:43, 6829:33, 6869:12, 6888:40
MPS [4] - 6839:10, 6839:14, 6845:21, 6845:31
MPSs [2] - 6839:15, 6839:18
MRI [1] - 6847:46
multi [3] - 6845:21, 6867:45, 6874:19
multi-purpose [1] - 6845:21
multi-strategic [1] - 6874:19
multi-trillion [1] - 6867:45
multidisciplinary [1] - 6834:5
multilevel [1] - 6854:37
multiple [8] - 6825:18, 6862:7, 6863:42, 6864:24, 6876:33, 6882:31, 6883:21, 6890:5
multiplier [1] - 6808:19
multitude [1] - 6888:9
mums' [1] - 6843:35
Murrumbidgee [2] -

6813:34, 6845:37
musculoskeletal [2] -
 6878:41, 6881:46
mustn't [1] - 6894:21
Muston [4] - 6802:27,
 6847:21, 6848:31,
 6870:15
MUSTON [75] -
 6803:3, 6803:10,
 6803:12, 6806:41,
 6811:2, 6811:22,
 6812:44, 6813:2,
 6823:45, 6839:10,
 6841:27, 6847:1,
 6847:25, 6849:14,
 6850:12, 6850:22,
 6850:46, 6851:9,
 6851:23, 6851:32,
 6851:47, 6852:29,
 6853:8, 6854:14,
 6854:40, 6855:7,
 6855:29, 6862:3,
 6862:16, 6862:37,
 6862:47, 6863:8,
 6863:18, 6863:25,
 6863:30, 6863:35,
 6863:40, 6863:46,
 6864:6, 6864:13,
 6864:35, 6864:43,
 6864:47, 6865:6,
 6865:10, 6865:16,
 6871:29, 6872:26,
 6875:3, 6876:6,
 6879:31, 6880:4,
 6881:34, 6884:8,
 6885:9, 6885:47,
 6886:4, 6886:24,
 6887:3, 6887:26,
 6888:14, 6889:25,
 6890:31, 6891:28,
 6891:46, 6892:15,
 6892:24, 6892:28,
 6892:32, 6892:41,
 6893:20, 6893:41,
 6894:16, 6895:3,
 6895:18
mutually [1] - 6894:44

N

name [2] - 6806:37,
 6850:28
named [2] - 6841:36,
 6842:3
nameless [1] -
 6845:46
namely [1] - 6823:25
narrow [3] - 6819:3,
 6855:12, 6864:23
narrowly [1] - 6819:2

national [16] -
 6804:33, 6804:42,
 6805:21, 6805:30,
 6805:47, 6819:2,
 6821:44, 6822:6,
 6822:29, 6822:39,
 6823:3, 6826:20,
 6828:46, 6885:36,
 6894:5, 6894:13
National [6] - 6804:18,
 6807:27, 6827:43,
 6851:13, 6851:15,
 6877:5
nationally [4] -
 6806:27, 6806:28,
 6882:5, 6886:17
natural [1] - 6866:34
naturally [1] - 6869:18
nature [5] - 6818:8,
 6829:5, 6866:16,
 6868:20, 6894:34
NDIS [9] - 6828:3,
 6828:5, 6828:14,
 6828:18, 6828:23,
 6828:45, 6829:23,
 6839:21, 6840:34
NDS [1] - 6840:39
nearly [1] - 6804:26
necessarily [7] -
 6805:31, 6806:26,
 6832:32, 6833:34,
 6872:27, 6887:14,
 6891:40
necessary [2] -
 6852:38, 6872:22
need [116] - 6803:46,
 6804:2, 6804:41,
 6805:9, 6805:20,
 6805:27, 6808:25,
 6808:26, 6810:37,
 6811:34, 6812:28,
 6814:23, 6814:45,
 6815:18, 6815:21,
 6815:23, 6815:24,
 6815:27, 6816:35,
 6816:37, 6817:7,
 6817:8, 6817:43,
 6817:45, 6817:46,
 6818:23, 6818:27,
 6818:44, 6819:14,
 6819:15, 6819:21,
 6819:29, 6820:20,
 6820:26, 6820:31,
 6820:36, 6821:11,
 6821:29, 6822:16,
 6824:10, 6825:1,
 6825:2, 6825:3,
 6825:20, 6825:34,
 6825:45, 6825:47,
 6826:15, 6826:29,

6827:6, 6827:7,
 6827:10, 6828:28,
 6828:33, 6828:35,
 6828:37, 6828:38,
 6828:39, 6828:40,
 6830:8, 6830:31,
 6830:33, 6832:6,
 6832:32, 6833:23,
 6835:23, 6835:44,
 6838:35, 6839:7,
 6844:24, 6844:41,
 6848:23, 6852:2,
 6852:7, 6852:21,
 6854:36, 6856:2,
 6859:15, 6859:16,
 6861:16, 6863:25,
 6865:38, 6865:41,
 6866:39, 6868:27,
 6869:34, 6870:5,
 6871:1, 6871:17,
 6872:3, 6872:18,
 6877:25, 6881:22,
 6882:16, 6882:37,
 6882:39, 6884:6,
 6884:33, 6884:34,
 6886:21, 6886:39,
 6886:40, 6886:43,
 6889:15, 6889:32,
 6889:46, 6890:16,
 6891:3, 6891:4,
 6891:21, 6891:36
needed [8] - 6805:32,
 6807:17, 6830:29,
 6843:36, 6843:38,
 6852:47, 6867:6,
 6880:18
needing [1] - 6818:36
needs [48] - 6808:29,
 6813:33, 6813:41,
 6814:21, 6816:15,
 6816:17, 6816:26,
 6816:27, 6818:42,
 6821:13, 6822:9,
 6825:7, 6827:13,
 6828:30, 6830:37,
 6830:44, 6831:5,
 6831:34, 6831:41,
 6831:43, 6832:15,
 6832:39, 6833:16,
 6834:24, 6834:44,
 6835:41, 6836:18,
 6837:47, 6838:4,
 6838:19, 6843:12,
 6844:27, 6847:11,
 6847:15, 6847:33,
 6852:24, 6855:36,
 6859:29, 6872:3,
 6877:27, 6879:41,
 6881:7, 6881:31,
 6881:34, 6884:2,
 6884:11, 6884:32,

6886:46
negotiated [1] -
 6828:12
negotiating [1] -
 6839:7
nervousness [1] -
 6861:33
network [3] - 6804:15,
 6865:47, 6885:36
networks [5] -
 6816:21, 6866:1,
 6866:38, 6866:47,
 6882:36
neurosurgery [15] -
 6815:40, 6815:45,
 6816:9, 6816:12,
 6817:38, 6817:39,
 6818:2, 6832:43,
 6832:44, 6832:46,
 6833:6, 6833:19,
 6833:40, 6834:20,
 6834:23
neurosurgical [2] -
 6816:16, 6816:26
never [2] - 6810:24,
 6879:2
New [98] - 6802:19,
 6803:14, 6803:20,
 6803:34, 6804:15,
 6804:17, 6804:20,
 6804:25, 6804:34,
 6804:40, 6805:19,
 6805:28, 6805:35,
 6805:46, 6806:5,
 6807:8, 6807:30,
 6808:6, 6811:24,
 6813:21, 6813:29,
 6813:42, 6814:4,
 6814:22, 6822:4,
 6823:10, 6824:29,
 6825:16, 6826:19,
 6827:44, 6827:47,
 6828:4, 6828:16,
 6828:30, 6830:12,
 6832:7, 6833:24,
 6834:3, 6834:9,
 6835:17, 6835:26,
 6835:38, 6835:39,
 6836:2, 6836:3,
 6836:37, 6837:46,
 6838:9, 6838:39,
 6838:47, 6839:5,
 6839:10, 6839:33,
 6840:30, 6841:7,
 6842:18, 6842:34,
 6842:35, 6843:1,
 6851:18, 6852:34,
 6853:14, 6853:30,
 6854:42, 6854:44,
 6854:45, 6855:15,

6856:3, 6856:11,
 6865:32, 6869:39,
 6873:14, 6873:27,
 6875:35, 6876:16,
 6876:26, 6877:21,
 6877:42, 6878:7,
 6879:28, 6879:34,
 6880:46, 6881:27,
 6882:47, 6883:15,
 6886:17, 6887:23,
 6891:22, 6892:6,
 6892:18, 6893:44,
 6893:46, 6894:2,
 6894:11, 6894:29,
 6894:31, 6894:37,
 6894:46
new [22] - 6814:45,
 6817:35, 6817:36,
 6817:47, 6828:12,
 6840:28, 6843:35,
 6843:37, 6844:42,
 6846:20, 6847:36,
 6847:37, 6847:38,
 6847:45, 6867:42,
 6870:20, 6872:36,
 6880:4, 6880:12,
 6880:14, 6888:14,
 6889:3
newborns [1] -
 6828:35
Newcastle [6] -
 6816:3, 6816:7,
 6820:2, 6821:21,
 6833:8, 6851:12
next [10] - 6807:12,
 6810:14, 6813:13,
 6822:25, 6824:40,
 6830:26, 6840:25,
 6840:30, 6848:22,
 6868:8
NGOs [1] - 6851:30
NH&MRC [2] -
 6828:4, 6828:16
NHS's [1] - 6885:31
night [1] - 6847:46
nimble [2] - 6824:11,
 6824:14
Nirvana [1] - 6888:30
no-one [2] - 6807:36,
 6881:3
nobody [3] - 6811:41,
 6848:13, 6879:3
non [5] - 6823:41,
 6835:11, 6845:10,
 6845:15, 6871:6
non-acute [1] -
 6823:41
non-Commonwealth
 [2] - 6845:10,
 6845:15

- non-hospital** [1] - 6835:11
- non-life** [1] - 6871:6
- normal** [1] - 6868:10
- normative** [1] - 6825:2
- north** [1] - 6813:34
- North** [1] - 6834:9
- Northern** [13] - 6805:46, 6805:47, 6806:34, 6816:2, 6816:7, 6819:46, 6820:15, 6821:21, 6832:4, 6832:47, 6833:7, 6840:46
- northern** [1] - 6874:11
- note** [2] - 6856:44, 6890:36
- nothing** [1] - 6809:42
- notice** [1] - 6893:9
- noting** [1] - 6884:5
- notion** [1] - 6815:7
- November** [1] - 6851:34
- NSW** [10] - 6802:36, 6803:40, 6832:36, 6841:40, 6842:20, 6842:37, 6855:37, 6869:24, 6886:24, 6888:8
- nuance** [3] - 6805:34, 6810:39, 6817:25
- nuanced** [9] - 6806:44, 6807:9, 6807:13, 6821:6, 6822:7, 6827:12, 6832:11, 6836:14, 6854:36
- nub** [1] - 6864:3
- nudges** [1] - 6869:2
- number** [20] - 6814:19, 6816:43, 6817:2, 6819:41, 6824:36, 6825:44, 6839:17, 6855:1, 6855:47, 6856:1, 6856:19, 6862:25, 6875:16, 6875:17, 6875:26, 6876:34, 6889:47, 6890:43, 6892:22, 6893:16
- numbers** [2] - 6816:10, 6877:39
- nurse** [4] - 6843:5, 6843:6, 6843:28, 6843:44
- nursing** [6] - 6822:43, 6823:2, 6840:28, 6843:27, 6843:35, 6843:36
- Nutbeam** [3] - 6849:23, 6850:46, 6851:1
- NUTBEAM** [70] - 6849:42, 6850:10, 6851:1, 6856:16, 6857:4, 6857:27, 6857:32, 6857:38, 6857:46, 6858:11, 6858:17, 6858:23, 6858:30, 6858:36, 6859:8, 6859:27, 6859:32, 6859:38, 6860:3, 6860:8, 6860:23, 6861:19, 6861:32, 6861:40, 6861:46, 6862:14, 6862:21, 6862:45, 6863:3, 6863:11, 6863:23, 6863:28, 6863:32, 6863:38, 6863:44, 6864:3, 6864:8, 6864:17, 6864:39, 6864:45, 6865:4, 6865:8, 6865:14, 6865:28, 6866:5, 6867:9, 6870:26, 6870:46, 6874:40, 6875:10, 6876:19, 6878:35, 6879:44, 6880:38, 6881:40, 6885:33, 6886:2, 6886:7, 6886:30, 6887:14, 6890:36, 6891:33, 6892:2, 6892:26, 6892:30, 6892:34, 6893:31, 6893:36, 6894:2, 6894:20
- nutrition** [1] - 6852:45
- NWAW** [1] - 6822:15
-
- O**
-
- o'clock** [2] - 6849:8, 6895:16
- oath** [3] - 6849:29, 6849:35, 6849:39
- objectives** [4] - 6820:32, 6873:6, 6873:22, 6889:20
- obligation** [1] - 6838:13
- obligations** [1] - 6838:29
- observation** [6] - 6813:23, 6813:29, 6830:12, 6876:43, 6879:45, 6883:41
- observations** [1] - 6879:47
- observe** [1] - 6886:17
- observer** [1] - 6887:20
- obsessed** [1] - 6834:35
- obstetric** [1] - 6842:3
- obvious** [6] - 6805:45, 6820:8, 6847:34, 6870:47, 6880:9, 6884:15
- obviously** [7] - 6828:33, 6884:24, 6884:25, 6884:32, 6890:14, 6893:6, 6893:12
- occ** [1] - 6814:40
- occasion** [1] - 6861:44
- occupied** [1] - 6840:37
- occur** [4] - 6867:24, 6867:46, 6884:5, 6889:18
- occurred** [1] - 6893:8
- occurring** [1] - 6854:19
- occurs** [5] - 6809:18, 6831:9, 6844:6, 6875:10, 6875:24
- October** [1] - 6812:32
- octopus** [1] - 6834:15
- OF** [1] - 6895:25
- offer** [2] - 6815:39, 6890:36
- offered** [3] - 6833:40, 6842:21, 6880:25
- offering** [1] - 6817:9
- offers** [3] - 6817:10, 6839:11, 6887:28
- Office** [2] - 6881:25, 6885:3
- often** [15] - 6854:35, 6860:12, 6868:5, 6868:16, 6868:21, 6868:23, 6868:36, 6868:38, 6869:35, 6872:12, 6879:14, 6880:41, 6885:18, 6888:9, 6891:7
- old** [2] - 6843:33, 6848:20
- older** [2] - 6810:32, 6843:43
- once** [15] - 6842:21, 6850:2, 6867:23, 6867:28, 6880:20, 6882:45, 6883:9, 6883:10, 6883:41, 6888:20, 6889:10, 6889:12, 6889:46, 6890:15, 6893:13
- one** [112] - 6804:14, 6805:45, 6806:7, 6806:15, 6806:26, 6806:27, 6807:5, 6807:36, 6808:9, 6808:13, 6808:36, 6809:20, 6810:14, 6812:11, 6813:30, 6814:14, 6814:20, 6817:44, 6818:13, 6818:16, 6818:38, 6819:24, 6820:39, 6822:3, 6824:11, 6825:24, 6826:6, 6827:44, 6828:44, 6829:25, 6830:9, 6830:45, 6831:3, 6831:42, 6832:3, 6832:21, 6834:3, 6834:39, 6834:41, 6836:21, 6836:40, 6837:27, 6837:32, 6837:33, 6837:39, 6838:9, 6838:30, 6838:35, 6838:46, 6841:5, 6842:47, 6843:16, 6843:24, 6843:39, 6845:7, 6845:20, 6845:45, 6846:8, 6846:11, 6846:24, 6846:28, 6847:25, 6847:34, 6848:9, 6852:11, 6852:14, 6852:33, 6852:43, 6853:33, 6855:24, 6856:37, 6857:13, 6860:33, 6866:42, 6866:47, 6867:2, 6867:21, 6867:25, 6867:36, 6868:26, 6868:34, 6870:6, 6871:23, 6872:13, 6872:44, 6874:43, 6875:24, 6877:37, 6877:43, 6878:38, 6880:8, 6881:3, 6882:33, 6883:19, 6886:8, 6886:19, 6886:31, 6886:42, 6888:19, 6889:29, 6890:1, 6890:20, 6890:41, 6890:42, 6891:2, 6891:20, 6891:29, 6892:34, 6892:42, 6894:10
- ones** [1] - 6834:16
- ongoing** [2] - 6884:32, 6885:6
- open** [4] - 6817:47, 6840:28, 6840:30, 6880:35
- open-ended** [1] - 6880:35
- opening** [1] - 6889:12
- operate** [7] - 6804:29, 6825:33, 6837:18, 6855:37, 6857:15, 6881:15, 6889:41
- operated** [1] - 6842:26
- operating** [10] - 6807:13, 6817:4, 6836:47, 6847:36, 6847:37, 6847:44, 6857:32, 6858:1, 6860:29, 6874:25
- operation** [1] - 6820:2
- operations** [2] - 6812:20, 6836:15
- operative** [1] - 6847:46
- opiates** [1] - 6867:3
- opioid** [6] - 6856:46, 6861:14, 6862:10, 6872:37, 6888:22, 6889:40
- opioid'** [1] - 6889:35
- opioids** [9] - 6856:27, 6856:33, 6861:22, 6861:25, 6861:34, 6870:43, 6871:2, 6887:32, 6888:15
- opportunities** [1] - 6867:32
- opportunity** [12] - 6812:36, 6828:11, 6839:22, 6840:25, 6872:4, 6873:11, 6873:14, 6874:36, 6878:5, 6878:22, 6884:1, 6889:18
- opposed** [4] - 6818:30, 6829:28, 6832:33, 6833:11
- opposite** [1] - 6844:6
- optimal** [1] - 6860:12
- optimistic** [2] - 6814:5, 6876:30
- option** [2] - 6837:36, 6845:30
- orchestrated** [1] - 6815:22
- order** [10] - 6806:22, 6807:17, 6817:3, 6827:7, 6845:11, 6862:21, 6872:2, 6875:37, 6882:1, 6889:39
- organic** [1] - 6880:31
- organically** [1] - 6879:39

organisation ^[15] - 6823:30, 6823:31, 6841:28, 6841:35, 6842:8, 6842:9, 6860:16, 6860:27
organisations ^[11] - 6851:30, 6857:8, 6865:42, 6866:8, 6875:25, 6876:3, 6876:10, 6884:29, 6885:7, 6885:28, 6887:10
organisational ^[3] - 6855:15, 6857:9, 6872:9
organise ^[1] - 6843:33
organised ^[2] - 6878:37, 6883:6
organising ^[1] - 6839:28
Organization ^[1] - 6831:24
origin ^[1] - 6807:36
original ^[1] - 6863:19
otherwise ^[4] - 6826:30, 6829:40, 6857:15, 6878:11
out-of-pocket ^[1] - 6841:14
outcome ^[12] - 6805:7, 6807:29, 6820:33, 6826:38, 6833:1, 6835:20, 6837:41, 6853:3, 6854:5, 6860:40, 6862:7, 6862:8
outcomes ^[33] - 6809:5, 6810:11, 6810:36, 6812:10, 6816:29, 6816:36, 6824:22, 6825:30, 6827:14, 6828:41, 6831:16, 6837:9, 6846:16, 6847:6, 6847:31, 6847:44, 6847:47, 6853:10, 6855:10, 6857:18, 6861:4, 6871:22, 6875:28, 6876:15, 6876:26, 6877:21, 6877:31, 6894:25, 6894:30, 6894:31, 6894:40
outlined ^[1] - 6885:7
outlines ^[1] - 6869:25
outpatient ^[8] - 6823:30, 6823:31, 6841:28, 6841:35, 6842:8, 6842:9, 6860:16, 6860:27
outpatients ^[4] - 6839:44, 6839:46, 6841:8, 6842:13
outside ^[3] - 6821:37, 6837:29, 6894:9
outsider ^[1] - 6838:38
outstanding ^[1] - 6877:19
overall ^[2] - 6873:3, 6879:46
overarching ^[1] - 6835:45
overcome ^[1] - 6854:29
overlap ^[1] - 6875:37
overloaded ^[1] - 6890:9
overly ^[1] - 6838:25
overnight ^[4] - 6809:38, 6809:42, 6836:24, 6872:40
overprescribing ^[1] - 6856:27
overriding ^[1] - 6838:12
oversaw ^[1] - 6844:27
oversee ^[1] - 6882:38
oversight ^[5] - 6813:7, 6833:11, 6873:2, 6879:31, 6880:29
overweight ^[1] - 6819:6
overwhelm ^[1] - 6890:17
overwhelming ^[1] - 6890:29
own ^[4] - 6841:11, 6852:24, 6860:33, 6874:16

P

package ^[1] - 6834:8
paediatric ^[10] - 6823:31, 6825:25, 6827:1, 6827:5, 6827:19, 6827:24, 6830:10, 6837:7, 6843:6, 6843:19
paediatrician ^[1] - 6839:29
paediatricians ^[1] - 6839:26
page ^[10] - 6813:5, 6831:27, 6831:28, 6844:3, 6847:27, 6851:47, 6856:19, 6892:16, 6892:26
paid ^[2] - 6806:18, 6839:47
pain ^[22] - 6856:26, 6856:28, 6860:20, 6861:15, 6861:21, 6861:24, 6862:10, 6862:23, 6862:24, 6862:26, 6862:42, 6866:46, 6867:1, 6867:3, 6870:13, 6871:5, 6871:6, 6871:16, 6872:37, 6887:33, 6888:16, 6888:22
pain¹ ^[1] - 6889:34
painkillers ^[1] - 6856:34
palliative ^[2] - 6843:16, 6846:34
panel ^[2] - 6849:18, 6882:12
paper ^[3] - 6806:37, 6842:40, 6855:22
paragraph ^[8] - 6813:8, 6844:5, 6852:1, 6877:39, 6889:31, 6892:17, 6892:22, 6892:28
paragraphs ^[3] - 6813:13, 6844:4, 6876:6
parcel ^[1] - 6873:3
parity ^[1] - 6826:29
parochial ^[1] - 6881:41
part ^[35] - 6808:43, 6809:25, 6811:44, 6816:39, 6824:4, 6828:4, 6829:19, 6830:34, 6831:17, 6832:24, 6834:36, 6835:41, 6841:32, 6842:22, 6845:8, 6850:42, 6853:13, 6856:45, 6857:7, 6861:33, 6862:17, 6865:1, 6865:40, 6870:19, 6870:21, 6877:40, 6879:5, 6880:38, 6884:8, 6888:6, 6889:27, 6890:27, 6891:25, 6892:34
participating ^[1] - 6815:13
participative ^[1] - 6876:24
particular ^[16] - 6804:3, 6810:32, 6812:1, 6816:34, 6817:32, 6821:24, 6827:41, 6832:25, 6855:34, 6856:26, 6872:42, 6878:47, 6883:42, 6888:16, 6888:27, 6893:27
particularly ^[10] - 6821:23, 6821:27, 6823:42, 6856:7, 6856:25, 6860:43, 6873:12, 6879:33, 6881:2, 6887:22
partly ^[1] - 6875:3
partner ^[1] - 6869:20
partnering ^[1] - 6805:5
partners ^[2] - 6863:4, 6873:36
Partners ^[10] - 6850:31, 6851:3, 6856:46, 6863:4, 6869:19, 6870:14, 6875:14, 6875:35, 6881:42, 6890:3
partnership ^[4] - 6817:19, 6843:45, 6850:31, 6878:36
partnerships ^[2] - 6873:17, 6873:20
parts ^[7] - 6810:30, 6810:31, 6824:5, 6878:19, 6878:31, 6886:4, 6886:47
past ^[2] - 6864:25, 6889:4
patchy ^[1] - 6840:43
patient ^[33] - 6805:7, 6806:19, 6818:28, 6819:47, 6836:18, 6837:20, 6837:41, 6841:15, 6841:36, 6841:47, 6861:29, 6861:35, 6861:43, 6861:47, 6868:28, 6868:42, 6871:13, 6874:10, 6874:21, 6874:23, 6874:24, 6877:31, 6882:40, 6884:27, 6887:27, 6887:34, 6888:21, 6888:37, 6888:46, 6889:11, 6889:27, 6892:13
patients ^[26] - 6816:9, 6817:20, 6817:23, 6819:41, 6834:6, 6836:24, 6836:25, 6837:21, 6841:23, 6856:30, 6856:36, 6860:40, 6861:24, 6864:1, 6867:34, 6871:10, 6871:20, 6871:37, 6874:11, 6875:28, 6888:45, 6894:23, 6894:24, 6894:25, 6894:29, 6894:40
pay ^[4] - 6806:7, 6819:16, 6837:33, 6842:36
payable ^[1] - 6804:30
paying ^[2] - 6807:18, 6842:13
payment ^[1] - 6831:32
payments ^[1] - 6839:40
pays ^[3] - 6837:36, 6841:38, 6841:40
peak ^[1] - 6884:29
peer ^[1] - 6806:7
pension ^[1] - 6841:16
people ^[73] - 6804:14, 6808:23, 6808:30, 6809:16, 6809:17, 6809:34, 6810:11, 6812:27, 6813:32, 6813:33, 6813:39, 6814:6, 6815:28, 6815:32, 6817:47, 6818:3, 6818:22, 6818:30, 6818:35, 6818:40, 6819:5, 6819:11, 6820:19, 6821:27, 6822:33, 6823:37, 6825:17, 6832:47, 6833:29, 6833:39, 6834:17, 6835:9, 6835:11, 6837:28, 6838:21, 6839:29, 6839:42, 6840:4, 6840:38, 6842:10, 6842:36, 6843:28, 6843:41, 6843:47, 6844:47, 6846:17, 6848:6, 6848:20, 6854:35, 6857:24, 6858:5, 6859:40, 6861:15, 6861:20, 6862:25, 6869:35, 6871:5, 6874:25, 6879:4, 6880:33, 6881:30, 6881:36, 6883:20, 6883:26, 6883:39, 6883:43, 6887:37, 6888:21, 6890:9, 6890:19, 6891:6, 6892:2

per [28] - 6806:19, 6807:8, 6808:40, 6808:44, 6810:45, 6822:25, 6822:27, 6822:28, 6822:31, 6822:32, 6823:3, 6823:7, 6823:8, 6833:25, 6834:36, 6835:30, 6842:34, 6843:9, 6853:29, 6853:47, 6861:14, 6871:41, 6874:25, 6894:21
perceive [2] - 6815:44, 6816:1
perceived [1] - 6829:20
percentage [3] - 6822:45, 6846:36, 6846:42
perception [2] - 6818:23, 6819:3
perfect [3] - 6833:27, 6880:10, 6881:3
perfectly [3] - 6812:23, 6861:21, 6870:31
perform [1] - 6880:18
performance [11] - 6811:16, 6820:41, 6820:45, 6829:5, 6831:10, 6831:13, 6874:16, 6874:17, 6888:6, 6888:8
performs [1] - 6875:40
perhaps [20] - 6816:6, 6818:22, 6819:45, 6821:1, 6821:23, 6830:4, 6834:24, 6835:46, 6840:17, 6850:24, 6852:29, 6856:17, 6872:27, 6879:36, 6879:39, 6880:30, 6885:22, 6887:5, 6888:18, 6891:38
period [5] - 6807:20, 6825:46, 6827:18, 6878:23, 6893:2
perioperative [3] - 6823:35, 6823:37, 6881:47
Permanent [2] - 6874:8, 6888:3
permission [1] - 6845:1
person [5] - 6820:1, 6843:33, 6843:43, 6845:46, 6875:4
personal [1] - 6876:20
personnel [1] - 6872:28
perspective [9] - 6816:37, 6824:33, 6837:38, 6853:10, 6855:15, 6868:40, 6868:41, 6875:40, 6887:29
persuade [3] - 6829:13, 6857:15, 6882:15
persuasive [1] - 6882:23
phage [1] - 6885:44
pharmaceutical [2] - 6891:47, 6894:36
PhD [2] - 6803:23, 6832:13
phenomenon [1] - 6878:12
philanthropy [1] - 6880:16
physical [1] - 6867:4
physicians [1] - 6840:3
physio [1] - 6821:30
physiotherapy [1] - 6818:31
pick [3] - 6857:6, 6865:2, 6867:32
picked [1] - 6862:16
picking [1] - 6843:19
picture [2] - 6874:4, 6874:6
piece [14] - 6824:40, 6827:32, 6830:41, 6838:1, 6862:38, 6863:19, 6863:21, 6864:6, 6864:13, 6864:35, 6868:29, 6875:24, 6888:10, 6891:35
pieces [2] - 6876:11, 6888:10
pig [1] - 6818:19
pillars [1] - 6884:25
pipeline [3] - 6877:10, 6877:17, 6885:42
pitch [1] - 6894:41
pivotal [1] - 6891:25
pivoting [1] - 6890:28
place [13] - 6805:34, 6816:22, 6829:45, 6833:39, 6841:24, 6846:12, 6846:18, 6846:20, 6856:6, 6865:38, 6871:23, 6872:4
placed [4] - 6825:36, 6855:31, 6878:10, 6886:25
places [2] - 6829:6, 6845:20
plan [6] - 6814:46, 6831:18, 6832:43, 6845:31, 6888:32, 6888:37
planning [39] - 6811:44, 6813:45, 6814:1, 6814:10, 6814:17, 6814:20, 6814:22, 6815:15, 6816:4, 6816:14, 6819:26, 6819:31, 6820:6, 6821:4, 6821:7, 6829:19, 6830:30, 6830:41, 6831:31, 6831:32, 6832:22, 6832:37, 6832:38, 6834:26, 6835:45, 6836:3, 6836:4, 6836:6, 6836:7, 6836:12, 6836:14, 6836:29, 6837:1, 6837:31, 6841:34, 6844:29, 6880:26
plans [1] - 6820:19
platform [1] - 6863:41
platforms [1] - 6881:26
play [3] - 6877:14, 6883:33, 6885:2
played [1] - 6834:42
playing [2] - 6834:21
plus [2] - 6808:39, 6808:43
pocket [1] - 6841:14
pockets [4] - 6869:18, 6874:7, 6874:28, 6885:23
point [24] - 6808:6, 6808:10, 6809:28, 6809:29, 6809:32, 6811:37, 6831:25, 6844:12, 6845:2, 6848:30, 6858:4, 6865:31, 6867:9, 6867:13, 6877:44, 6879:27, 6881:14, 6883:34, 6891:37, 6891:43, 6892:9, 6892:11, 6893:43, 6894:3
pointed [2] - 6848:31, 6878:1
points [6] - 6846:31, 6848:34, 6871:32, 6872:24, 6883:5, 6884:34
pointy [1] - 6814:12
pointy-end [1] - 6814:12
policy [14] - 6803:19, 6812:24, 6813:39, 6813:40, 6845:22, 6850:36, 6851:27, 6852:18, 6853:22, 6853:27, 6853:31, 6853:35, 6854:21, 6855:32
political [3] - 6845:41, 6886:13
pool [1] - 6834:43
poor [1] - 6845:35
poorer [1] - 6810:31
poorly [1] - 6872:27
pops [1] - 6889:33
population [53] - 6804:1, 6804:7, 6808:12, 6808:18, 6808:24, 6808:26, 6808:33, 6810:13, 6810:19, 6816:15, 6816:17, 6816:26, 6821:13, 6824:22, 6825:35, 6827:6, 6827:15, 6829:29, 6830:14, 6830:15, 6830:26, 6830:32, 6830:44, 6831:34, 6831:41, 6831:43, 6831:46, 6832:30, 6837:37, 6846:13, 6846:31, 6846:42, 6847:6, 6847:16, 6848:26, 6850:37, 6851:19, 6852:34, 6852:37, 6852:39, 6853:6, 6853:26, 6853:33, 6853:44, 6854:11, 6855:11, 6855:41, 6860:17, 6869:15, 6874:21, 6894:4, 6894:31
populations [4] - 6803:45, 6830:38, 6846:17, 6871:13
portfolio [1] - 6877:41
portion [1] - 6855:40
posed [2] - 6874:41, 6882:25
position [3] - 6803:29, 6882:4, 6894:42
positions [1] - 6803:38
positive [4] - 6852:12, 6860:1, 6887:19, 6894:39
positively [1] - 6875:33
possibilities [1] - 6879:6
possible [5] - 6807:15, 6807:19, 6836:19, 6836:36, 6868:6
possibly [4] - 6837:27, 6838:7, 6862:8, 6886:18
postoperative [1] - 6819:10
pot [1] - 6809:12
potential [12] - 6818:28, 6823:40, 6861:23, 6862:4, 6868:31, 6873:19, 6881:20, 6885:43, 6887:28, 6888:38, 6889:26, 6892:47
potentially [12] - 6811:4, 6825:4, 6830:29, 6831:3, 6833:9, 6834:47, 6838:28, 6848:34, 6867:23, 6873:26, 6873:35, 6889:37
power [4] - 6815:24, 6824:31, 6834:14, 6844:21
power's [1] - 6834:15
practical [11] - 6822:38, 6833:20, 6845:17, 6846:4, 6859:44, 6868:1, 6869:8, 6879:17, 6881:23, 6886:9, 6892:4
practically [2] - 6858:15, 6868:24
practice [54] - 6808:20, 6810:8, 6841:19, 6846:46, 6847:4, 6850:36, 6851:7, 6851:27, 6852:13, 6852:27, 6852:29, 6853:36, 6854:33, 6855:24, 6855:27, 6856:29, 6860:37, 6861:3, 6862:30, 6862:33, 6862:35, 6863:28, 6864:11, 6864:19, 6864:26, 6865:26, 6868:12, 6868:18, 6868:32, 6868:34, 6868:46, 6869:7, 6869:11, 6870:7, 6870:18, 6870:35, 6870:39, 6871:36,

6871:43, 6871:47,
6872:46, 6875:42,
6877:11, 6877:20,
6877:30, 6885:41,
6886:44, 6888:11,
6888:36, 6891:5,
6891:15, 6891:24,
6893:36
practices [2] -
6853:13, 6856:25
practitioners [3] -
6863:41, 6869:16,
6888:28
pre [8] - 6805:29,
6817:23, 6819:5,
6819:15, 6819:19,
6819:39, 6819:40,
6821:46
pre-habilitation [6] -
6819:5, 6819:15,
6819:19, 6819:39,
6819:40, 6821:46
pre-surgical [1] -
6817:23
precise [1] - 6861:13
precisely [2] -
6806:22, 6838:17
precision [3] - 6811:8,
6811:11, 6879:7
preconditions [1] -
6872:22
predated [1] - 6804:18
predicting [1] -
6809:26
preemptively [1] -
6850:16
prefer [1] - 6849:40
preferred [1] -
6813:14
Premier's [1] -
6807:22
prepared [3] -
6806:37, 6812:31,
6875:15
prescribe [1] -
6861:34
prescribing [3] -
6870:43, 6871:2,
6888:15
prescriptions [2] -
6856:46, 6861:14
present [1] - 6802:34
presenting [1] -
6888:22
presents [2] -
6841:47, 6889:18
pressure [11] -
6807:25, 6841:11,
6857:12, 6857:36,
6858:1, 6859:2,
6861:9, 6871:21,
6874:20, 6891:12,
6891:13
pressures [3] -
6856:24, 6860:28,
6871:8
presumably [3] -
6809:38, 6816:44,
6891:28
presume [1] - 6834:27
presuming [1] -
6810:15
pretty [13] - 6808:23,
6817:8, 6820:22,
6820:26, 6822:8,
6823:17, 6825:6,
6837:1, 6838:40,
6857:33, 6858:18,
6873:32, 6892:32
prevented [1] -
6857:23
preventing [1] -
6858:33
prevention [11] -
6820:20, 6823:38,
6827:37, 6835:19,
6843:14, 6846:32,
6846:39, 6846:43,
6855:20, 6855:27
preventions [1] -
6838:27
prevents [1] - 6844:35
previous [2] -
6836:34, 6843:40
previously [2] -
6827:46, 6827:47
price [9] - 6806:1,
6806:7, 6806:27,
6806:28, 6806:30,
6807:46, 6807:47,
6808:1, 6808:2
Pricing [3] - 6804:43,
6805:31, 6805:38
pricing [1] - 6829:34
primarily [2] -
6812:24, 6867:44
primary [8] - 6811:33,
6827:37, 6839:32,
6839:33, 6840:43,
6840:47, 6842:23,
6853:25
Prince [1] - 6817:23
principal [3] -
6825:13, 6825:15,
6825:18
principle [6] -
6808:27, 6809:5,
6815:24, 6817:26,
6836:18, 6867:3
principles [2] -
6814:28, 6837:1
priorities [38] -
6830:19, 6844:30,
6867:26, 6875:16,
6875:18, 6878:6,
6878:15, 6878:23,
6878:33, 6878:44,
6881:7, 6882:39,
6882:42, 6882:45,
6883:2, 6883:7,
6883:10, 6883:13,
6883:17, 6883:27,
6883:31, 6883:34,
6883:39, 6883:47,
6884:4, 6884:5,
6884:34, 6884:36,
6884:40, 6884:43,
6886:38, 6886:42,
6887:1, 6887:4,
6887:5, 6890:5,
6891:29
prioritisation [10] -
6815:46, 6837:5,
6837:30, 6838:1,
6856:5, 6875:23,
6878:37, 6879:26,
6885:30, 6886:14
prioritise [3] -
6837:32, 6874:43,
6886:13
prioritised [2] -
6873:35, 6887:44
prioritising [3] -
6867:26, 6879:8,
6880:1
priority [5] - 6846:17,
6873:23, 6883:40,
6883:44, 6891:40
priority's [1] - 6837:34
private [9] - 6811:26,
6811:27, 6821:12,
6828:23, 6832:5,
6832:8, 6841:11,
6841:19, 6894:36
privately [3] -
6841:36, 6841:39,
6841:44
problem [21] - 6810:9,
6815:35, 6815:36,
6822:8, 6823:10,
6823:39, 6824:1,
6824:4, 6824:9,
6825:12, 6825:22,
6829:8, 6838:22,
6839:6, 6840:45,
6842:7, 6844:34,
6846:38, 6870:21,
6876:30, 6876:33
problem' [1] - 6889:37
problems [2] -
6820:31, 6838:30
procedural [1] -
6835:3
procedure [10] -
6816:34, 6816:45,
6818:24, 6820:3,
6827:27, 6847:36,
6847:38, 6848:1,
6880:5, 6880:18
procedures [4] -
6814:13, 6817:3,
6834:19, 6836:43
proceed [1] - 6851:39
process [28] -
6808:47, 6809:17,
6816:5, 6816:14,
6819:26, 6821:6,
6826:36, 6827:23,
6829:20, 6830:30,
6830:32, 6837:31,
6867:27, 6873:31,
6873:34, 6876:24,
6877:16, 6877:32,
6880:22, 6883:17,
6883:25, 6884:35,
6885:4, 6885:6,
6885:30, 6890:10,
6890:20, 6892:44
processes [2] -
6828:34, 6868:44
produce [14] - 6809:7,
6825:29, 6826:12,
6826:41, 6827:14,
6829:25, 6830:16,
6837:9, 6847:44,
6847:47, 6855:10,
6857:17, 6866:7,
6876:15
produced [6] -
6812:14, 6847:17,
6854:43, 6862:43,
6867:39, 6892:17
produces [1] -
6826:28
producing [4] -
6819:19, 6824:23,
6887:35, 6893:5
production [2] -
6850:41, 6863:35
productive [1] -
6893:14
products [1] - 6853:40
Professor [16] -
6803:4, 6803:12,
6806:34, 6806:37,
6813:4, 6849:21,
6849:23, 6849:28,
6850:13, 6850:25,
6850:29, 6850:46,
6851:9, 6852:6,
6887:26
PROFESSOR [98] -
6849:31, 6849:37,
6849:42, 6849:44,
6850:28, 6851:1,
6851:11, 6851:45,
6852:16, 6852:32,
6853:17, 6854:18,
6854:47, 6855:14,
6855:43, 6856:16,
6857:4, 6857:27,
6857:32, 6857:38,
6857:46, 6858:11,
6858:17, 6858:23,
6858:30, 6858:36,
6859:8, 6859:27,
6859:32, 6859:38,
6860:3, 6860:8,
6860:23, 6861:19,
6861:32, 6861:40,
6861:46, 6862:14,
6862:21, 6862:45,
6863:3, 6863:11,
6863:23, 6863:28,
6863:32, 6863:38,
6863:44, 6864:3,
6864:8, 6864:17,
6864:39, 6864:45,
6865:4, 6865:8,
6865:14, 6865:28,
6866:3, 6866:5,
6867:9, 6867:21,
6870:3, 6870:26,
6870:46, 6871:31,
6873:9, 6874:40,
6875:10, 6876:19,
6878:35, 6879:44,
6880:38, 6881:40,
6882:30, 6884:15,
6885:14, 6885:33,
6886:2, 6886:7,
6886:30, 6887:14,
6887:42, 6888:30,
6889:44, 6890:36,
6891:33, 6892:2,
6892:22, 6892:26,
6892:30, 6892:34,
6892:44, 6893:26,
6893:31, 6893:34,
6893:36, 6893:39,
6894:2, 6894:20
professor [6] -
6803:13, 6803:27,
6850:29, 6851:1,
6851:11, 6851:20
proffer [2] - 6815:38,
6892:41
profile [2] - 6830:19,
6830:26
program [4] - 6828:15,

- 6829:3, 6843:40,
6843:46
- programs** [8] -
6827:47, 6828:2,
6835:18, 6836:39,
6838:11, 6839:28,
6854:26, 6872:19
- progress** [3] -
6876:27, 6889:39,
6891:18
- progressively** [1] -
6856:37
- project** [6] - 6805:5,
6855:24, 6855:34,
6865:2, 6865:6
- promise** [2] - 6868:33,
6889:45
- promote** [3] - 6838:14,
6846:12, 6881:41
- promotion** [1] -
6855:23
- prompt** [1] - 6889:33
- prompting** [1] -
6858:42
- prompts** [2] - 6889:25,
6890:39
- pronged** [1] - 6804:35
- proper** [2] - 6819:31,
6830:30
- properly** [5] - 6812:45,
6827:12, 6830:42,
6830:43, 6837:13
- proportion** [3] -
6804:1, 6894:22,
6894:29
- proposal** [1] - 6841:7
- proposals** [1] - 6852:9
- proposition** [9] -
6808:5, 6817:31,
6825:27, 6833:32,
6847:11, 6862:41,
6866:9, 6887:15,
6894:17
- propositions** [1] -
6845:8
- protect** [2] - 6838:14,
6846:12
- proud** [1] - 6892:7
- proven** [2] - 6860:25,
6861:2
- provide** [22] - 6816:20,
6816:28, 6818:39,
6828:43, 6830:7,
6837:14, 6837:19,
6837:26, 6837:45,
6839:12, 6839:45,
6867:31, 6869:31,
6869:40, 6869:41,
6869:43, 6869:44,
6870:20, 6881:19,
6887:47, 6893:28,
6894:32
- provided** [19] -
6808:13, 6808:17,
6810:9, 6814:14,
6816:1, 6817:22,
6819:34, 6819:43,
6819:44, 6819:45,
6821:8, 6821:9,
6827:16, 6841:17,
6842:24, 6854:1,
6865:6, 6867:19,
6882:2
- provider** [5] - 6814:34,
6815:19, 6815:21,
6839:4, 6840:31
- providers** [3] -
6814:37, 6828:23,
6828:27
- provides** [2] -
6868:33, 6869:44
- providing** [13] -
6809:26, 6830:9,
6837:17, 6837:40,
6840:19, 6853:39,
6853:40, 6860:45,
6872:21, 6874:14,
6876:10, 6881:2,
6882:22
- proving** [2] - 6856:33,
6860:35
- proviso** [1] - 6831:4
- provokes** [1] -
6825:38
- public** [35] - 6803:23,
6803:33, 6804:4,
6804:11, 6811:27,
6811:34, 6813:30,
6821:14, 6821:30,
6823:31, 6828:29,
6830:34, 6832:6,
6832:24, 6833:25,
6841:28, 6841:33,
6842:22, 6842:38,
6843:26, 6843:27,
6850:29, 6851:2,
6851:12, 6851:21,
6852:27, 6854:32,
6854:41, 6871:42,
6872:31, 6879:33,
6879:37, 6879:42,
6885:12
- publication** [1] -
6893:5
- published** [2] -
6855:22, 6892:45
- pull** [2] - 6839:44,
6841:8
- purchased** [1] -
6824:41
- purchaser** [4] -
6812:22, 6814:33,
6814:36, 6832:47
- purchasing** [2] -
6833:10, 6847:15
- purpose** [5] - 6806:21,
6812:18, 6823:47,
6845:21, 6866:5
- purposes** [3] -
6806:33, 6843:8,
6889:12
- pursuing** [2] -
6846:14, 6846:16
- push** [3] - 6867:7,
6870:13, 6884:6
- put** [23] - 6813:46,
6817:8, 6819:39,
6820:19, 6824:27,
6826:4, 6829:42,
6840:28, 6841:10,
6846:10, 6858:36,
6859:39, 6866:12,
6868:38, 6869:1,
6869:2, 6870:30,
6873:23, 6873:26,
6886:14, 6887:19,
6893:37, 6894:41
- puts** [3] - 6825:14,
6835:12, 6835:13
- putting** [6] - 6810:44,
6842:38, 6842:40,
6861:15, 6880:8,
6884:37
-
- Q**
-
- quality** [12] - 6816:38,
6816:44, 6835:32,
6836:27, 6836:45,
6839:24, 6842:27,
6862:33, 6868:4,
6868:9, 6889:13,
6890:25
- quantified** [1] -
6892:20
- quantifying** [1] -
6835:9
- quantum** [1] - 6804:39
- quarter** [1] - 6867:40
- Quarterly** [1] -
6873:46
- quaternary** [5] -
6809:22, 6813:45,
6814:12, 6833:17,
6834:27
- Queensland** [1] -
6894:4
- questions** [17] -
6811:20, 6847:1,
6848:14, 6848:41,
6848:45, 6864:33,
6867:16, 6877:28,
6881:3, 6881:31,
6881:36, 6882:3,
6882:14, 6882:21,
6882:25, 6883:8,
6895:3
- quick** [1] - 6871:32
- quicker** [1] - 6819:9
- quickest** [2] - 6842:6,
6842:39
- quickly** [2] - 6889:29,
6890:19
- quite** [19] - 6807:28,
6807:29, 6808:21,
6814:23, 6814:31,
6824:44, 6832:36,
6835:39, 6836:4,
6839:1, 6854:27,
6868:16, 6876:21,
6877:41, 6877:47,
6879:26, 6879:27,
6880:46
-
- R**
-
- radical** [1] - 6809:38
- radically** [1] - 6808:10
- raised** [2] - 6847:26,
6887:27
- raises** [2] - 6812:14,
6827:42
- raising** [1] - 6894:28
- randomised** [4] -
6853:4, 6868:4,
6868:22, 6877:19
- range** [17] - 6803:21,
6804:39, 6815:43,
6818:35, 6831:42,
6836:28, 6844:42,
6851:28, 6854:19,
6854:26, 6861:22,
6867:39, 6872:8,
6874:46, 6887:7,
6887:33, 6887:36
- rapid** [1] - 6871:4
- rapidly** [1] - 6853:5
- rare** [4] - 6806:12,
6817:16, 6817:18,
6834:7
- rate** [1] - 6836:44
- rates** [2] - 6832:5,
6853:47
- rather** [17] - 6805:40,
6806:14, 6806:19,
6808:11, 6818:44,
6824:22, 6826:12,
6830:44, 6844:44,
6845:46, 6847:16,
6852:20, 6862:39,
6876:39, 6876:42,
6881:16, 6893:36
- ratio** [1] - 6892:37
- RDF** [3] - 6808:7,
6808:37, 6832:2
- re** [1] - 6812:37
- re-read** [1] - 6812:37
- reach** [1] - 6869:27
- reached** [1] - 6856:39
- read** [2] - 6812:37,
6890:33
- ready** [1] - 6890:31
- real** [20] - 6844:38,
6858:39, 6858:41,
6860:27, 6860:32,
6862:30, 6868:7,
6868:11, 6874:36,
6874:37, 6875:25,
6878:15, 6880:1,
6888:3, 6888:11,
6888:26, 6891:12,
6891:16
- real-life** [2] - 6860:32,
6862:30
- real-time** [2] -
6858:39, 6888:3
- real-world** [1] -
6868:11
- reality** [3] - 6807:43,
6837:46, 6865:21
- really** [80] - 6807:36,
6808:28, 6809:5,
6809:6, 6810:9,
6811:19, 6811:25,
6812:14, 6814:3,
6814:36, 6815:21,
6817:18, 6817:27,
6820:33, 6821:28,
6821:41, 6824:12,
6825:12, 6828:36,
6833:21, 6834:4,
6835:4, 6836:20,
6836:24, 6838:24,
6838:44, 6839:24,
6841:4, 6842:9,
6843:33, 6845:35,
6846:10, 6846:35,
6847:40, 6848:7,
6848:14, 6848:23,
6851:29, 6855:9,
6857:4, 6859:24,
6859:32, 6862:22,
6864:29, 6866:29,
6867:10, 6867:17,
6868:6, 6868:36,
6869:6, 6869:10,
6869:31, 6870:27,
6871:1, 6873:38,
6873:47, 6874:6,
6874:28, 6874:44,

6875:25, 6876:11, 6877:40, 6878:23, 6878:39, 6881:47, 6883:37, 6884:1, 6884:2, 6885:38, 6887:45, 6887:46, 6889:2, 6889:4, 6889:35, 6890:12, 6890:33, 6890:46, 6891:39, 6892:6

reason [15] - 6817:34, 6829:47, 6836:39, 6839:33, 6839:43, 6840:47, 6864:37, 6865:16, 6867:5, 6867:6, 6870:15, 6870:35, 6880:11, 6884:46, 6891:6

reasonable [3] - 6808:42, 6827:18, 6890:13

reasonably [1] - 6855:41

reasons [12] - 6813:23, 6813:25, 6817:33, 6828:44, 6835:32, 6836:23, 6836:40, 6879:23, 6886:32, 6889:30, 6891:2, 6894:10

rebuild [1] - 6828:17

receive [4] - 6807:35, 6821:31, 6825:47, 6876:1

received [5] - 6807:33, 6808:10, 6877:15, 6877:25, 6891:36

recent [2] - 6812:36, 6885:4

recently [3] - 6804:47, 6855:22, 6883:41

receptive [1] - 6881:12

recognise [3] - 6822:20, 6823:29, 6836:26

recognised [8] - 6808:38, 6823:47, 6827:24, 6829:10, 6845:9, 6845:10, 6845:12, 6876:31

recognising [1] - 6845:40

recommend [1] - 6862:33

recommendations [3] - 6820:34, 6856:1, 6872:21

recommending [2] - 6839:44, 6858:14

reconfiguration [1] - 6809:39

record [9] - 6868:28, 6868:42, 6887:28, 6887:34, 6887:43, 6888:21, 6888:38, 6889:11, 6889:27

recording [1] - 6806:33

records [1] - 6869:1

recover [1] - 6820:4

recovery [1] - 6819:10

redesign [1] - 6826:38

reduce [8] - 6811:33, 6839:17, 6847:35, 6853:2, 6856:24, 6871:21, 6875:37, 6886:41

reduced [2] - 6811:27, 6854:4

reduces [1] - 6842:10

reducing [4] - 6834:43, 6853:20, 6861:16, 6871:8

reduction [1] - 6827:45

refer [5] - 6846:27, 6852:6, 6856:17, 6860:10, 6892:17

reference [5] - 6830:5, 6832:23, 6832:29, 6852:30, 6856:19

referrals [1] - 6841:43

referred [7] - 6806:45, 6841:36, 6841:39, 6841:44, 6842:3, 6881:26, 6891:30

referring [2] - 6841:28, 6877:39

reflect [3] - 6806:30, 6812:18, 6879:40

reflected [1] - 6806:24

reflecting [2] - 6812:40, 6888:36

reflects [1] - 6824:30

Reform [2] - 6804:18, 6807:27

reform [5] - 6804:32, 6804:40, 6805:17, 6820:30, 6842:47

reforming [1] - 6878:6

refreshing [1] - 6886:15

regard [1] - 6887:1

regarding [1] - 6854:25

regards [1] - 6823:24

region [3] - 6805:6, 6815:33, 6841:13

regional [1] - 6843:39

regular [1] - 6874:18

rehabilitation [2] - 6820:16, 6843:17

reinforce [1] - 6833:32

reinforces [3] - 6810:7, 6810:8, 6865:38

reinforcing [1] - 6858:45

related [1] - 6893:32

relates [1] - 6825:46

relation [6] - 6814:10, 6856:25, 6862:34, 6864:35, 6867:1, 6867:2

relations [4] - 6812:25, 6812:26, 6813:43, 6813:44

relationships [1] - 6866:38

relative [1] - 6861:25

relatively [3] - 6864:10, 6874:2, 6883:29

releasing [1] - 6866:19

relevance [1] - 6881:31

rely [1] - 6854:34

remain [1] - 6851:40

remains [2] - 6821:43, 6890:41

remarkable [1] - 6880:7

remember [3] - 6836:11, 6839:13, 6839:25

reminding [1] - 6858:42

remote [3] - 6823:4, 6823:8, 6823:11

removing [1] - 6889:21

renal [2] - 6806:18, 6817:22

reorientate [1] - 6852:25

replaced [1] - 6830:8

replacement [13] - 6809:24, 6818:4, 6818:18, 6818:23, 6818:30, 6818:37, 6818:39, 6819:4, 6819:41, 6819:43, 6821:20, 6827:27, 6830:7

replacements [3] - 6818:42, 6819:20, 6834:30

replicate [1] - 6868:7

replicated [1] - 6855:4

Report [1] - 6851:33

report [23] - 6826:40, 6846:11, 6849:16, 6850:42, 6851:20, 6851:32, 6851:40, 6851:43, 6852:33, 6855:44, 6864:24, 6868:42, 6869:24, 6872:21, 6876:7, 6876:12, 6876:44, 6878:31, 6889:31, 6890:43, 6892:16, 6893:9, 6893:29

reporting [1] - 6847:16

require [7] - 6814:44, 6819:41, 6827:7, 6841:5, 6869:23, 6869:30, 6889:38

required [7] - 6804:5, 6818:41, 6819:30, 6825:37, 6832:24, 6861:1, 6870:29

requirements [1] - 6836:47

requires [6] - 6820:5, 6820:30, 6855:16, 6882:31, 6883:21, 6887:47

requiring [1] - 6837:29

Research [7] - 6851:13, 6860:45, 6873:25, 6877:6, 6881:25, 6883:5

research [131] - 6803:13, 6803:18, 6803:28, 6850:33, 6850:35, 6851:6, 6851:14, 6851:27, 6852:19, 6852:22, 6852:23, 6852:39, 6853:36, 6853:45, 6854:41, 6855:38, 6855:40, 6855:46, 6856:4, 6856:6, 6858:38, 6859:14, 6859:42, 6860:6, 6860:9, 6860:24, 6860:32, 6860:35, 6861:1, 6862:16, 6862:39, 6862:40, 6863:13, 6863:19, 6864:6, 6864:10, 6864:13, 6864:20, 6864:30, 6865:18, 6865:26, 6867:38, 6867:40, 6867:43, 6867:45, 6868:1, 6868:4, 6868:32, 6869:17, 6869:33, 6870:18, 6871:26, 6871:41, 6871:42, 6872:29, 6872:32, 6873:1, 6873:4, 6873:37, 6874:37, 6875:34, 6876:11, 6876:25, 6876:34, 6877:4, 6877:7, 6877:8, 6877:17, 6877:19, 6877:27, 6877:32, 6877:38, 6878:9, 6878:11, 6878:24, 6878:25, 6879:32, 6879:33, 6880:45, 6881:6, 6882:26, 6882:47, 6883:17, 6883:24, 6883:29, 6883:32, 6884:13, 6884:20, 6884:43, 6885:12, 6885:37, 6886:22, 6886:27, 6886:28, 6887:4, 6887:5, 6887:29, 6889:11, 6889:13, 6889:28, 6890:23, 6891:22, 6891:31, 6891:41, 6891:46, 6892:2, 6892:5, 6892:6, 6892:36, 6892:38, 6893:6, 6893:11, 6893:15, 6893:16, 6893:23, 6893:32, 6893:44, 6894:5, 6894:8, 6894:11, 6894:16, 6894:18, 6894:35, 6894:39, 6894:45, 6894:46

Research's [1] - 6885:4

researcher [4] - 6892:35, 6892:39, 6893:13, 6893:42

researchers [12] - 6852:36, 6856:21, 6862:5, 6864:31, 6865:11, 6873:21, 6881:44, 6882:13, 6882:20, 6884:9, 6893:1, 6894:8

residential [3] - 6822:40, 6822:46, 6823:9

residents [3] - 6818:43, 6838:15, 6880:17

residual [1] - 6819:40

resistant [1] - 6880:5

- resource** [6] - 6803:39, 6804:35, 6806:13, 6806:14, 6809:25, 6831:31
Resource [1] - 6803:41
resourced [1] - 6870:23
resources [6] - 6830:35, 6863:33, 6867:27, 6873:13, 6883:44, 6886:21
resourcing [4] - 6836:46, 6868:6, 6868:17, 6878:17
respect [1] - 6857:11
respiratory [1] - 6840:3
respond [3] - 6852:3, 6866:6, 6873:9
responded [1] - 6842:40
response [4] - 6808:33, 6847:33, 6853:44, 6872:23
responses [1] - 6818:10
responsibilities [3] - 6824:20, 6824:31, 6852:43
responsibility [10] - 6814:1, 6815:24, 6816:18, 6816:25, 6820:39, 6820:40, 6828:14, 6840:19, 6845:34, 6853:25
responsible [19] - 6815:30, 6815:34, 6816:16, 6820:9, 6824:20, 6830:13, 6830:15, 6831:5, 6832:40, 6838:40, 6843:9, 6843:28, 6843:40, 6844:39, 6844:40, 6844:46, 6845:35, 6866:14, 6871:33
responsiveness [1] - 6824:10
rest [2] - 6806:16, 6813:18
result [3] - 6809:11, 6855:33, 6879:14
resulted [1] - 6863:35
results [3] - 6853:15, 6854:43, 6880:24
retirement [1] - 6803:30
retrofit [1] - 6807:46
retrograde [1] - 6810:7
retrospective [1] - 6810:7
return [6] - 6892:18, 6893:20, 6893:31, 6893:32, 6893:34, 6893:37
returning [1] - 6828:16
reveals [1] - 6836:13
reversal [1] - 6809:27
reverse [1] - 6807:10
revert [1] - 6809:27
review [3] - 6812:36, 6873:44, 6894:10
reviewing [1] - 6853:40
reviews [1] - 6855:47
rewards [1] - 6810:11
rhetorically [2] - 6875:3, 6875:4
Richard [2] - 6802:14, 6802:36
ridiculous [1] - 6813:31
rightly [1] - 6878:1
ring [1] - 6843:43
risk [10] - 6838:28, 6843:42, 6843:43, 6848:5, 6861:16, 6862:12, 6879:34, 6879:44, 6879:45, 6891:8
risks [2] - 6839:42, 6861:22
role [55] - 6803:13, 6803:19, 6803:43, 6803:44, 6804:22, 6804:47, 6812:13, 6812:15, 6812:24, 6812:27, 6814:7, 6814:16, 6814:19, 6814:26, 6814:32, 6814:33, 6814:43, 6815:12, 6816:4, 6816:21, 6816:31, 6834:21, 6834:31, 6834:42, 6835:27, 6835:28, 6838:36, 6838:37, 6844:26, 6845:20, 6845:42, 6845:44, 6850:26, 6850:40, 6851:20, 6862:32, 6865:25, 6870:17, 6870:22, 6870:32, 6870:33, 6871:17, 6871:19, 6872:31, 6872:33, 6873:35, 6874:33, 6875:40, 6876:32, 6877:3, 6877:13, 6878:2
roles [5] - 6803:22, 6803:32, 6803:37, 6803:39, 6804:10
roll [2] - 6807:23, 6855:32
rolled [1] - 6831:14
rolling [1] - 6888:20
room [1] - 6848:2
rooms [3] - 6811:33, 6841:11, 6841:37
Ross [1] - 6802:28
roster [1] - 6822:25
rough [1] - 6890:31
roughly [1] - 6808:19
round [1] - 6840:27
route [1] - 6865:40
routine [1] - 6843:38
rude [1] - 6881:2
ruler [1] - 6832:28
run [16] - 6814:42, 6816:37, 6822:33, 6834:19, 6835:17, 6837:7, 6837:8, 6838:10, 6839:17, 6842:19, 6842:21, 6843:11, 6843:34, 6848:5, 6862:6, 6879:34
run-of-the-mill [1] - 6834:19
running [7] - 6809:34, 6812:20, 6813:15, 6822:43, 6832:28, 6838:27, 6882:1
rural [6] - 6814:22, 6814:23, 6823:4, 6823:8, 6823:11, 6839:16
-
- S**
-
- safe** [3] - 6817:2, 6817:28, 6817:30
safely [4] - 6817:4, 6833:36, 6834:47, 6871:10
safety [5] - 6814:40, 6816:44, 6835:32, 6836:27, 6836:42
sake [1] - 6855:33
salaried [3] - 6839:35, 6840:1, 6840:47
salary [1] - 6893:2
sat [2] - 6803:40, 6848:9
satisfied [2] - 6812:39, 6815:4
satisfy [1] - 6845:13
sausage [1] - 6818:5
saving [1] - 6893:23
saw [5] - 6821:34, 6824:11, 6844:25, 6848:6, 6877:24
Sax [1] - 6851:26
SC [4] - 6802:14, 6802:27, 6802:36
scale [22] - 6850:36, 6854:38, 6855:16, 6855:38, 6860:26, 6861:8, 6864:27, 6867:22, 6867:33, 6871:12, 6871:27, 6873:42, 6873:47, 6874:3, 6874:31, 6877:31, 6882:6, 6885:41, 6886:44, 6890:20, 6892:13, 6894:33
scale-up [3] - 6850:36, 6871:27, 6873:47
scaled [2] - 6854:44, 6871:23
scaling [1] - 6856:37
scenario [1] - 6890:15
Schedule [1] - 6841:9
scheme [3] - 6883:7, 6883:9, 6893:17
Scheme [2] - 6827:43, 6883:5
schemes [1] - 6893:11
schism [1] - 6848:26
school [12] - 6825:26, 6825:29, 6843:26, 6843:27, 6843:29, 6843:30, 6853:11, 6853:40, 6854:16, 6854:19, 6854:23, 6854:26
schools [11] - 6852:44, 6853:1, 6853:22, 6853:30, 6853:34, 6853:38, 6853:41, 6854:2, 6854:4, 6854:25, 6855:8
SCI.0011.0605.0001 [1] - 6851:36
SCI.0011.0718.0001 [1] - 6812:45
science [10] - 6850:35, 6851:14, 6852:8, 6862:23, 6865:44, 6872:2, 6874:34, 6877:18, 6890:23
Science [1] - 6851:15
scientific [5] - 6852:38, 6860:34, 6864:18, 6871:35, 6871:40
scientist [1] - 6859:46
screen [2] - 6828:35, 6849:20
screened [1] - 6828:1
screening [6] - 6825:33, 6827:5, 6827:23, 6828:37, 6828:38, 6843:30
second [10] - 6814:29, 6818:47, 6822:17, 6836:42, 6846:13, 6846:23, 6846:24, 6853:45, 6878:46, 6892:16
Second [1] - 6838:20
secondly [1] - 6861:23
secret [1] - 6854:14
sector [3] - 6883:32, 6893:6, 6894:36
secure [1] - 6863:15
see [18] - 6812:23, 6813:5, 6815:32, 6843:37, 6844:4, 6846:28, 6856:27, 6860:38, 6868:3, 6874:16, 6874:45, 6875:37, 6877:30, 6883:37, 6885:41, 6885:42, 6892:12, 6892:24
seed [1] - 6882:2
seeds [1] - 6855:26
seeing [3] - 6806:12, 6814:35, 6855:26
seek [2] - 6882:21, 6886:26
seem [3] - 6836:13, 6845:7, 6876:8
sees [2] - 6814:36, 6878:6
selective [1] - 6821:33
self [5] - 6809:21, 6835:25, 6835:30, 6835:38, 6836:30
self-sufficiency [1] - 6809:21
self-sufficient [2] - 6835:25, 6835:30
sell [1] - 6845:13
selling [1] - 6854:15
send [2] - 6820:15, 6837:35
sending [1] - 6883:31
Senior [1] - 6802:27
senior [4] - 6850:30, 6883:20, 6884:26, 6887:45

sense [11] - 6813:36, 6814:29, 6814:41, 6821:41, 6835:24, 6837:5, 6846:4, 6865:19, 6865:46, 6866:25, 6890:38
sensible [2] - 6812:23, 6814:29
sentence [1] - 6844:9
separate [1] - 6806:15
sequence [1] - 6854:8
sequential [1] - 6853:4
serendipitous [1] - 6886:8
serendipitously [1] - 6880:9
series [5] - 6853:3, 6856:32, 6869:25, 6874:12, 6883:18
serious [1] - 6862:27
serves [1] - 6887:23
service [63] - 6805:5, 6807:47, 6811:47, 6816:19, 6816:29, 6817:10, 6817:31, 6817:32, 6817:33, 6817:35, 6817:39, 6817:41, 6817:42, 6817:47, 6818:4, 6818:10, 6819:26, 6821:4, 6821:7, 6825:33, 6825:34, 6827:2, 6827:5, 6827:6, 6827:19, 6827:26, 6829:18, 6829:23, 6831:18, 6832:22, 6835:41, 6836:14, 6836:17, 6837:7, 6837:14, 6837:17, 6837:20, 6838:12, 6839:12, 6840:2, 6840:19, 6841:17, 6842:7, 6842:21, 6842:22, 6842:38, 6843:13, 6844:28, 6844:29, 6845:21, 6851:18, 6853:2, 6853:6, 6853:14, 6853:21, 6854:11, 6866:14, 6871:20, 6880:19, 6880:20, 6882:16, 6882:17
services [64] - 6803:13, 6803:28, 6804:16, 6804:37, 6804:38, 6809:22, 6809:23, 6809:39, 6811:32, 6811:45, 6813:45, 6813:46, 6814:12, 6814:34, 6814:47, 6816:1, 6817:36, 6818:11, 6818:12, 6818:14, 6818:15, 6818:39, 6819:29, 6819:34, 6821:7, 6821:8, 6825:37, 6828:17, 6828:43, 6831:17, 6832:23, 6832:33, 6833:14, 6833:29, 6836:6, 6836:7, 6836:9, 6836:12, 6836:25, 6836:28, 6836:36, 6837:29, 6838:25, 6838:26, 6839:11, 6839:35, 6839:47, 6840:18, 6840:31, 6841:33, 6843:12, 6847:14, 6848:33, 6850:32, 6852:40, 6864:22, 6867:18, 6874:22, 6880:25, 6881:14, 6881:15, 6881:17, 6882:38
Services [3] - 6804:5, 6838:13, 6848:33
servicing [1] - 6812:26
session [1] - 6885:27
set [27] - 6812:4, 6814:45, 6815:3, 6817:34, 6817:39, 6818:5, 6819:15, 6820:34, 6821:16, 6829:32, 6829:34, 6830:20, 6831:14, 6836:36, 6837:1, 6840:2, 6840:4, 6842:32, 6842:41, 6844:29, 6844:43, 6878:32, 6884:39, 6886:30, 6886:32, 6886:34, 6886:46
setting [4] - 6816:12, 6835:11, 6842:12, 6884:43
settings [3] - 6823:32, 6866:39, 6872:41
several [2] - 6851:40, 6871:2
shall [1] - 6857:9
shape [4] - 6820:25, 6820:26, 6878:47, 6879:37
SHAPEd [1] - 6856:20
shaped [1] - 6880:25
shaping [1] - 6873:7
share [9] - 6805:39, 6808:36, 6808:40, 6808:44, 6809:2, 6810:23, 6814:8, 6817:20, 6831:45
shared [6] - 6814:1, 6814:21, 6814:26, 6855:3, 6866:22, 6876:20
sharing [1] - 6842:44
sharpest [1] - 6813:39
sheer [1] - 6889:47
shift [5] - 6808:7, 6810:44, 6838:20, 6860:42, 6883:36
shifting [1] - 6845:14
Shoalhaven [5] - 6805:1, 6805:3, 6809:13, 6810:23, 6845:18
short [3] - 6869:4, 6869:5, 6875:28
shortage [2] - 6820:19, 6820:21
show [2] - 6816:37, 6873:24
showed [1] - 6873:46
shows [1] - 6868:9
SIA [1] - 6869:39
side [3] - 6814:10, 6878:1, 6880:8
signal [1] - 6878:25
signals [1] - 6883:32
significant [6] - 6827:45, 6829:41, 6854:37, 6858:39, 6870:37, 6879:14
significantly [1] - 6810:1
signpost [1] - 6885:5
similar [3] - 6854:5, 6862:18, 6884:27
similarities [1] - 6856:21
simple [1] - 6857:5
simplify [1] - 6857:7
simplistic [1] - 6870:23
simply [2] - 6804:42, 6805:21
simultaneously [1] - 6867:30
sincerely [1] - 6879:24
single [14] - 6828:40, 6839:3, 6840:35, 6865:31, 6868:28, 6868:42, 6874:23, 6877:24, 6887:27, 6888:20, 6888:37, 6889:11, 6889:26, 6891:35
single-point [1] - 6865:31
sits [2] - 6858:24, 6876:14
sitting [3] - 6813:32, 6819:6, 6834:17
situation [1] - 6886:16
situations [1] - 6891:11
six [1] - 6822:43
size [6] - 6804:2, 6810:19, 6822:36, 6822:47, 6847:35, 6872:13
skew [1] - 6842:14
skills [1] - 6880:33
slashed [1] - 6856:46
slashing [1] - 6861:14
slice [1] - 6831:46
sliced [1] - 6808:11
slightly [7] - 6821:6, 6855:11, 6861:12, 6876:7, 6876:44, 6885:11, 6890:31
slow [1] - 6890:10
small [4] - 6823:11, 6848:2, 6883:11, 6894:22
smaller [3] - 6875:16, 6875:17, 6875:26
smorgasbord [1] - 6812:4
snowball [1] - 6883:43
socially [1] - 6843:33
soft [1] - 6875:46
softie [1] - 6861:30
sold [2] - 6829:11, 6829:33
solely [1] - 6838:40
solid [1] - 6837:17
solutions [1] - 6867:42
solve [5] - 6823:9, 6824:5, 6824:9, 6824:10, 6842:7
solved [3] - 6823:9, 6829:9, 6868:33
solves [1] - 6824:4
solving [1] - 6876:33
someone [4] - 6824:37, 6832:45, 6833:3, 6880:39
sometimes [2] - 6826:15, 6859:8
somewhat [1] - 6819:25
somewhere [3] - 6842:30, 6862:6, 6871:6
soon [1] - 6824:13
sophisticated [10] - 6805:30, 6806:6, 6819:26, 6822:10, 6822:16, 6832:11, 6832:19, 6832:22, 6832:36, 6835:4
sophistication [2] - 6805:34, 6810:39
Sorry [1] - 6845:26
sorry [7] - 6827:5, 6835:12, 6849:31, 6852:23, 6866:45, 6879:26, 6892:24
sort [46] - 6803:26, 6807:12, 6808:17, 6811:15, 6814:12, 6824:39, 6826:42, 6828:15, 6831:47, 6832:2, 6843:21, 6843:34, 6856:28, 6863:11, 6865:16, 6867:30, 6868:15, 6869:6, 6870:4, 6870:5, 6870:13, 6870:15, 6873:12, 6873:21, 6873:36, 6873:38, 6874:37, 6875:29, 6876:12, 6879:31, 6879:38, 6882:38, 6882:41, 6883:40, 6884:16, 6884:21, 6884:27, 6884:30, 6884:35, 6886:15, 6888:44, 6889:14, 6890:8, 6891:20, 6893:13, 6894:44
sorts [18] - 6811:38, 6822:15, 6832:11, 6834:31, 6839:23, 6844:29, 6845:39, 6853:38, 6856:2, 6864:32, 6866:40, 6866:41, 6869:1, 6878:15, 6879:15, 6879:23, 6880:32, 6880:34
sound [1] - 6817:8
sounds [1] - 6852:12
source [1] - 6854:14
South [95] - 6802:19, 6803:14, 6803:21, 6803:34, 6804:15, 6804:17, 6804:20, 6804:25, 6804:34, 6804:40, 6805:19, 6805:28, 6805:35, 6805:46, 6806:5, 6807:8, 6807:30,

6808:6, 6808:35,
6811:24, 6813:21,
6813:29, 6813:42,
6814:4, 6814:22,
6817:19, 6822:4,
6823:10, 6824:29,
6825:16, 6826:19,
6827:44, 6827:47,
6828:4, 6828:16,
6828:30, 6830:12,
6832:7, 6833:24,
6834:3, 6834:9,
6835:17, 6835:26,
6835:38, 6835:40,
6836:2, 6836:3,
6836:37, 6837:46,
6838:9, 6838:39,
6838:47, 6839:5,
6839:10, 6839:33,
6840:30, 6841:7,
6842:18, 6842:34,
6842:35, 6843:1,
6853:30, 6854:45,
6856:3, 6856:11,
6865:32, 6869:39,
6873:14, 6873:27,
6875:35, 6876:16,
6876:26, 6877:21,
6877:42, 6878:7,
6879:28, 6879:34,
6880:46, 6881:27,
6882:47, 6883:15,
6886:17, 6887:23,
6891:22, 6892:6,
6892:18, 6893:44,
6893:46, 6894:2,
6894:11, 6894:29,
6894:31, 6894:37,
6894:46
southern [1] - 6874:12
Southern [1] -
6835:39
space [6] - 6830:10,
6869:8, 6883:33,
6885:21, 6885:24,
6885:31
Special [1] - 6802:7
SPECIAL [1] - 6895:25
specialised [1] -
6848:5
specialist [5] -
6839:38, 6839:41,
6841:14, 6841:25,
6842:24
specialists [5] -
6811:33, 6832:9,
6839:40, 6841:19,
6841:22
specialty [1] - 6878:14
species [2] - 6823:32,
6845:12
specific [5] - 6825:14,
6852:42, 6854:29,
6870:44, 6891:13
specifically [2] -
6826:39, 6866:5
spectrum [2] -
6874:45, 6892:5
spend [6] - 6804:6,
6815:46, 6818:29,
6819:38, 6829:2,
6893:23
spending [1] -
6893:44
spent [5] - 6810:21,
6846:43, 6873:4,
6893:20
spread [2] - 6855:41,
6878:14
spreads [1] - 6855:39
St [1] - 6820:2
staff [3] - 6836:27,
6874:18, 6891:16
staffing [1] - 6836:27
stage [3] - 6803:24,
6839:15, 6856:38
stakeholders [1] -
6885:2
stand [5] - 6817:10,
6817:32, 6827:7,
6880:17, 6880:20
start [11] - 6825:25,
6825:29, 6828:38,
6839:35, 6839:45,
6840:18, 6841:10,
6849:27, 6854:15,
6878:32, 6881:27
started [6] - 6803:20,
6811:13, 6844:38,
6866:24, 6871:24,
6891:10
starting [3] - 6849:20,
6850:24, 6850:40
starts [2] - 6823:8,
6827:37
state [45] - 6807:1,
6807:44, 6808:43,
6810:30, 6812:25,
6813:17, 6813:43,
6822:24, 6823:2,
6823:29, 6828:13,
6832:6, 6838:37,
6839:11, 6839:12,
6839:23, 6840:9,
6840:37, 6841:6,
6841:29, 6842:22,
6842:32, 6843:9,
6843:11, 6848:26,
6855:24, 6860:44,
6862:37, 6863:41,
6876:21, 6877:3,
6877:14, 6886:27,
6887:34, 6887:39,
6888:28, 6889:27,
6891:40, 6891:42,
6892:9, 6894:6,
6894:9, 6894:17,
6894:37
State [2] - 6842:35,
6854:45
state's [1] - 6824:1
statement [2] -
6829:5, 6880:35
statements [1] -
6835:29
states [6] - 6805:39,
6826:29, 6839:1,
6839:2, 6842:32,
6879:29
States [2] - 6874:8,
6885:18
statewide [1] -
6813:46, 6814:42,
6836:6, 6836:7,
6836:9, 6836:12,
6866:10, 6875:20,
6875:25, 6875:30,
6894:12
status [3] - 6810:31,
6822:47, 6865:25
statutory [2] -
6838:13, 6838:28
stays [1] - 6879:14
steering [1] - 6880:28
step [10] - 6812:3,
6815:11, 6830:45,
6831:2, 6862:3,
6862:38, 6863:18,
6864:47, 6868:8,
6888:14
steps [1] - 6831:1
stick [1] - 6817:38
stifling [1] - 6880:31
still [22] - 6803:12,
6811:38, 6812:39,
6814:31, 6816:16,
6823:17, 6825:13,
6826:40, 6826:41,
6845:13, 6855:24,
6860:47, 6868:28,
6868:30, 6873:2,
6874:30, 6884:2,
6884:5, 6887:21,
6891:17, 6891:24
stone [1] - 6826:21
stood [1] - 6808:45
stopped [2] - 6811:18,
6828:43
straight [1] - 6864:20
straightforward [3] -
6818:2, 6820:33,
6837:1
strategic [4] - 6822:5,
6839:22, 6841:34,
6874:19
strategies [10] -
6846:12, 6846:14,
6846:16, 6846:18,
6846:20, 6854:28,
6854:33, 6854:37,
6855:4, 6874:19
strategy [8] - 6814:24,
6853:46, 6873:11,
6876:25, 6883:24,
6888:34, 6894:11
stream [1] - 6828:9
streams [1] - 6876:11
Street [1] - 6802:18
strengthen [2] -
6856:13, 6866:30
stress [1] - 6840:7
stressed [1] - 6838:44
strong [3] - 6828:36,
6843:13, 6889:44
structural [3] -
6825:12, 6830:23,
6876:13
structurally [1] -
6848:28
structure [8] - 6806:9,
6806:24, 6822:21,
6830:11, 6844:33,
6844:35, 6859:19,
6884:10
structured [4] -
6831:18, 6833:13,
6875:37, 6885:11
structures [1] -
6824:31
struggling [1] -
6859:17
stubborn [1] -
6873:32
student [3] - 6832:13,
6853:19
studies [4] - 6852:33,
6853:4, 6856:32,
6868:15
study [12] - 6822:41,
6824:12, 6855:2,
6856:18, 6861:33,
6863:12, 6863:20,
6866:46, 6867:37,
6880:14, 6888:32,
6888:37
stuff [3] - 6826:42,
6843:32, 6885:16
stupid [2] - 6838:7,
6856:43
sub [2] - 6823:41,
6846:42
sub-acute [1] -
6823:41
sub-population [1] -
6846:42
subject [3] - 6809:17,
6885:39, 6893:21
submission [9] -
6808:39, 6812:31,
6812:36, 6820:44,
6826:23, 6831:23,
6831:30, 6844:3,
6847:20
submissions [2] -
6820:18, 6843:47
submitted [1] -
6855:45
subsequently [1] -
6863:15
substance [1] -
6855:44
substantial [1] -
6809:11
substantially [2] -
6836:44, 6878:18
substantively [1] -
6853:2
substitute [1] -
6856:33
substitution [1] -
6832:2
suburbs [1] - 6843:22
Suburbs [3] - 6832:4,
6834:10, 6861:29
successful [1] -
6892:39
successfully [3] -
6853:22, 6877:31,
6894:12
suffer [1] - 6887:21
sufficiency [1] -
6809:21
sufficient [5] -
6831:39, 6835:25,
6835:30, 6835:39,
6836:30
sufficiently [1] -
6808:38
suggest [2] - 6877:37,
6878:43
suggested [1] -
6890:37
suggesting [7] -
6815:2, 6825:42,
6852:7, 6867:11,
6872:27, 6881:37,
6893:22
suggestions [1] -
6853:42
suggests [3] -

- 6807:34, 6872:2, 6890:39
suite [4] - 6819:29, 6841:32, 6865:19, 6888:18
summons [1] - 6850:18
support [15] - 6825:27, 6843:34, 6852:39, 6852:43, 6853:34, 6854:1, 6854:3, 6866:23, 6866:40, 6869:34, 6870:21, 6871:3, 6877:7, 6888:36, 6894:42
supported [3] - 6870:30, 6872:23, 6885:43
supporting [2] - 6853:38, 6858:45
supports [4] - 6861:1, 6862:41, 6870:35, 6877:32
suppose [3] - 6872:26, 6880:38, 6884:44
surgery [29] - 6817:24, 6818:30, 6818:37, 6819:9, 6821:21, 6821:22, 6821:24, 6821:26, 6821:28, 6822:28, 6826:42, 6833:22, 6833:23, 6833:25, 6833:27, 6833:34, 6834:31, 6834:35, 6835:3, 6836:19, 6836:23, 6837:21, 6837:40, 6840:40, 6848:19, 6848:32, 6848:33
surgical [1] - 6817:23
surprised [1] - 6891:37
surprising [2] - 6843:11, 6862:25
surprisingly [2] - 6841:42, 6891:38
suspect [2] - 6855:4, 6876:26
sustainable [3] - 6826:25, 6826:26, 6890:27
sustained [2] - 6869:30, 6890:46
Sydney [34] - 6802:19, 6803:22, 6808:34, 6808:35, 6808:36, 6809:28, 6814:23, 6816:2, 6816:7, 6817:20, 6819:46, 6820:15, 6821:21, 6832:4, 6832:5, 6832:7, 6832:47, 6833:8, 6839:14, 6850:30, 6850:31, 6850:32, 6850:44, 6851:2, 6851:3, 6856:22, 6856:45, 6863:4, 6869:19, 6870:14, 6875:14, 6875:34, 6881:41, 6890:2
symptom [1] - 6843:22
system [20] - 6803:21, 6803:34, 6804:29, 6804:35, 6808:27, 6809:6, 6809:35, 6809:47, 6810:29, 6811:28, 6811:34, 6812:3, 6812:6, 6812:21, 6813:15, 6813:30, 6814:4, 6814:17, 6815:13, 6815:14, 6815:20, 6819:33, 6820:5, 6820:25, 6821:12, 6821:14, 6822:8, 6823:16, 6824:29, 6824:32, 6824:46, 6825:3, 6825:5, 6825:16, 6826:18, 6826:19, 6826:28, 6826:35, 6828:29, 6829:25, 6829:37, 6829:39, 6830:12, 6830:34, 6830:36, 6831:36, 6832:25, 6833:5, 6833:8, 6833:12, 6833:13, 6834:14, 6834:36, 6835:15, 6835:21, 6837:41, 6837:44, 6838:39, 6838:43, 6839:3, 6840:8, 6842:14, 6844:5, 6844:35, 6847:32, 6848:15, 6848:27, 6848:35, 6848:38, 6849:17, 6850:37, 6851:34, 6852:10, 6852:17, 6852:19, 6852:23, 6854:6, 6854:38, 6855:4, 6855:9, 6855:10, 6855:14, 6855:27, 6855:39, 6856:12, 6857:47, 6858:6, 6858:9, 6858:40, 6858:44, 6859:20, 6860:47, 6861:8, 6864:27, 6864:31, 6865:33, 6865:38, 6866:19, 6866:23, 6866:25, 6867:13, 6867:22, 6867:25, 6867:26, 6867:33, 6868:27, 6868:29, 6868:39, 6868:40, 6869:3, 6869:4, 6869:9, 6869:14, 6869:18, 6869:23, 6869:28, 6869:39, 6869:42, 6869:45, 6870:29, 6871:25, 6872:9, 6872:16, 6872:32, 6873:7, 6873:15, 6873:29, 6873:33, 6874:13, 6874:31, 6875:39, 6876:16, 6876:41, 6878:7, 6878:17, 6878:19, 6878:32, 6879:15, 6879:17, 6879:34, 6879:38, 6879:42, 6879:46, 6880:23, 6880:24, 6880:27, 6881:8, 6881:12, 6881:16, 6881:29, 6881:32, 6882:1, 6882:6, 6882:23, 6882:32, 6882:33, 6882:43, 6883:2, 6883:7, 6883:10, 6883:13, 6883:16, 6883:22, 6883:27, 6883:31, 6883:47, 6884:4, 6884:6, 6884:9, 6884:39, 6884:44, 6884:45, 6885:1, 6885:19, 6885:34, 6885:42, 6886:10, 6886:21, 6886:39, 6886:44, 6888:6, 6888:9, 6888:25, 6889:10, 6889:14, 6889:19, 6889:22, 6890:14, 6890:21, 6891:12, 6891:13, 6891:24, 6891:40, 6891:43, 6892:10, 6893:24, 6894:47
system's [1] - 6825:6
system-wide [6] - 6815:13, 6815:14, 6819:33, 6830:36, 6855:27, 6855:39
systematic [3] - 6866:10, 6873:34, 6884:30
systematically [1] - 6883:26
systemic [2] - 6876:13, 6889:31
systemically [1] - 6879:40
systems [30] - 6803:26, 6813:31, 6829:45, 6848:7, 6852:3, 6852:21, 6852:25, 6856:7, 6868:37, 6869:2, 6869:37, 6870:5, 6872:17, 6872:18, 6873:39, 6873:42, 6873:47, 6874:4, 6874:14, 6874:15, 6884:36, 6885:12, 6885:15, 6885:20, 6887:34, 6888:31, 6888:41, 6889:6, 6890:17
-
- T**
-
- tackle** [1] - 6891:3
Tamsin [1] - 6802:29
tangible [1] - 6893:45
target [3] - 6808:3, 6829:2, 6844:43
targeted [1] - 6821:24
targets [4] - 6811:17, 6821:38, 6826:43, 6846:9
tariff [1] - 6822:42
tariffs [1] - 6822:44
task [2] - 6830:43, 6856:12
teach [1] - 6854:35
teaching [1] - 6806:8
technical [10] - 6824:45, 6826:11, 6826:32, 6826:34, 6826:40, 6826:45, 6829:26, 6829:30, 6847:29, 6889:38
technically [3] - 6826:19, 6847:39, 6847:42
technique [2] - 6880:13, 6880:14
technologies [1] - 6846:21
technology [3] - 6847:45, 6885:29, 6889:5
temptation [1] - 6883:19
ten [1] - 6809:3
- tend** [1] - 6881:15
tender [1] - 6813:2
term [7] - 6820:47, 6826:38, 6847:28, 6875:28, 6879:2, 6879:15, 6884:8
terms [26] - 6804:28, 6805:43, 6806:43, 6813:15, 6816:36, 6817:22, 6826:16, 6827:43, 6830:25, 6840:9, 6840:25, 6840:34, 6846:2, 6847:29, 6854:15, 6855:26, 6859:21, 6859:39, 6886:30, 6885:10, 6889:38, 6890:34, 6893:1, 6893:5, 6893:45, 6894:5
terribly [1] - 6863:20
terrific [1] - 6853:47
territories [2] - 6805:40, 6826:30
territory [1] - 6807:44
Territory [5] - 6805:46, 6805:47, 6806:35, 6840:46
tertiary [1] - 6834:27
test [5] - 6817:31, 6866:9, 6873:28, 6874:42, 6875:43
testing [2] - 6862:29, 6884:37
text [1] - 6869:43
theatre [3] - 6836:47, 6847:37, 6847:44
theatres [1] - 6847:36
thematically [1] - 6883:6
themes [1] - 6857:6
themselves [1] - 6884:19
therapeutic [1] - 6828:39
therapy [2] - 6867:4, 6885:45
thereabouts [1] - 6808:17
thereby [1] - 6875:28
therefore [2] - 6816:36, 6861:35
they have [16] - 6815:43, 6816:3, 6845:1, 6846:12, 6846:18, 6846:20, 6856:32, 6859:11, 6862:42, 6869:36, 6872:4, 6873:19, 6873:20, 6883:10,

6885:18, 6891:36
they've [15] - 6807:44,
6819:19, 6823:4,
6857:25, 6861:20,
6862:28, 6862:39,
6862:40, 6863:14,
6885:29, 6885:36,
6885:37, 6886:12,
6891:7, 6891:34
things [1] - 6820:36
thinking [5] - 6833:23,
6866:28, 6866:33,
6878:31, 6890:12
thinks [1] - 6887:9
third [8] - 6811:31,
6815:19, 6822:17,
6836:45, 6839:32,
6840:43, 6846:15,
6879:10
thoughts [1] - 6866:19
thousand [4] -
6862:47, 6865:23,
6883:28, 6887:6
thousands [4] -
6840:41, 6857:40,
6867:23, 6874:11
threatening [1] -
6871:6
three [12] - 6822:45,
6839:25, 6844:4,
6847:29, 6856:38,
6872:3, 6874:22,
6875:35, 6878:38,
6879:23, 6885:19,
6893:3
threefold [1] - 6836:40
thresholds [1] -
6860:20
throughout [2] -
6882:32, 6889:10
throw [2] - 6837:15,
6880:4
thrown [2] - 6862:47,
6893:13
tide [1] - 6826:33
timely [4] - 6868:44,
6869:7, 6889:7,
6889:22
timing [1] - 6890:8
tinker [4] - 6820:27,
6820:35, 6823:17
tinkering [3] -
6820:27, 6822:9,
6825:7
TO [1] - 6895:25
today [2] - 6803:3,
6812:35
together [8] - 6804:16,
6814:25, 6815:25,
6864:31, 6873:36,
6876:22, 6884:25,
6888:44
tomorrow [1] -
6895:16
tonight [1] - 6808:22
took [7] - 6803:23,
6804:22, 6812:13,
6829:21, 6842:18,
6865:32, 6870:13
tool [2] - 6868:32
tools [1] - 6868:34
top [2] - 6834:28,
6836:11
topic [4] - 6831:24,
6832:14, 6861:12,
6866:45
total [4] - 6807:47,
6832:30, 6874:21
towards [6] - 6804:32,
6822:23, 6826:4,
6842:14, 6872:45,
6889:15
towns [1] - 6843:22
track [2] - 6810:40,
6884:39
trade [2] - 6836:16,
6837:15
trade-off [1] - 6837:15
traded [1] - 6843:1
traditional [1] -
6823:25
traditionally [1] -
6842:24
train [1] - 6842:4
training [1] - 6874:18
Training [1] - 6814:42
trajectory [1] - 6826:4
tranches [1] - 6890:17
transcript [1] -
6806:33
transferred [1] -
6828:3
transferring [1] -
6839:22
transformation [3] -
6867:22, 6889:14,
6890:21
transformations [3] -
6867:33, 6873:28,
6874:31
transitioning [1] -
6869:8
translate [4] -
6865:26, 6870:18,
6872:46, 6878:16
translated [1] -
6885:41
translating [2] -
6857:44, 6878:27
translation [12] -
6851:6, 6855:46,
6859:42, 6873:18,
6873:22, 6875:34,
6877:17, 6878:1,
6884:18, 6885:37,
6891:37, 6892:11
Translational [1] -
6883:4
translational [4] -
6850:33, 6860:24,
6872:29, 6889:28
transparency [2] -
6811:2, 6811:11
transparent [4] -
6806:23, 6808:46,
6822:18, 6825:3
transplant [1] -
6817:35
transplants [4] -
6814:13, 6817:22,
6835:25, 6836:10
transport [3] -
6819:47, 6820:15,
6837:20
trauma [1] - 6859:25
travel [2] - 6836:32,
6836:38
traverse [1] - 6855:11
treasury [1] - 6807:22
treat [2] - 6810:38,
6887:32
treating [1] - 6880:5
treatment [5] -
6819:42, 6819:43,
6889:40, 6894:25,
6894:32
treatments [3] -
6817:16, 6862:10,
6888:22
trial [9] - 6853:45,
6854:3, 6856:45,
6856:46, 6862:6,
6867:7, 6870:14,
6894:28, 6894:34
trial [1] - 6856:20
trials [13] - 6850:33,
6853:4, 6854:8,
6860:10, 6862:8,
6868:3, 6868:5,
6869:21, 6877:19,
6894:23, 6894:24,
6894:26, 6894:30
tricky [1] - 6865:11
tried [1] - 6869:42
trillion [1] - 6867:45
trite [2] - 6848:30,
6848:34
truth [2] - 6842:30,
6861:38
try [6] - 6815:28,
6816:13, 6837:26,
6856:23, 6881:22,
6889:1
trying [25] - 6805:6,
6806:21, 6809:9,
6809:31, 6825:22,
6826:33, 6826:34,
6845:33, 6848:10,
6851:6, 6857:16,
6860:36, 6862:34,
6866:5, 6868:11,
6874:33, 6874:44,
6875:17, 6878:46,
6879:16, 6881:41,
6881:42, 6883:30,
6886:22, 6890:24
tsunami [1] - 6848:19
Tuesday [1] - 6802:23
turn [7] - 6808:23,
6845:21, 6848:22,
6851:47, 6862:25,
6890:32, 6894:2
turning [1] - 6886:9
turnover [1] - 6814:12
tweaks [1] - 6883:1
two [28] - 6804:14,
6804:35, 6808:9,
6808:16, 6815:18,
6818:15, 6818:38,
6820:36, 6824:13,
6824:33, 6826:16,
6829:46, 6830:26,
6831:1, 6836:37,
6836:38, 6837:6,
6837:32, 6840:35,
6842:29, 6864:29,
6871:32, 6871:41,
6872:24, 6877:37,
6879:23, 6894:44
two-pronged [1] -
6804:35
type [11] - 6821:24,
6824:3, 6832:46,
6842:20, 6842:23,
6846:37, 6860:33,
6871:26, 6871:43,
6882:14, 6890:34
types [7] - 6804:3,
6823:21, 6833:34,
6836:17, 6860:8,
6869:21, 6877:28
typically [2] - 6856:3,
6882:21

U

ubiquitous [1] -
6843:21
UK [1] - 6885:33
ultimate [1] - 6815:10
ultimately [1] -
6854:29
umbrella [1] - 6873:44
unable [1] - 6867:29
unaffordable [1] -
6839:42
unchanged [1] -
6829:40
under [18] - 6804:4,
6813:6, 6816:24,
6819:20, 6828:20,
6829:26, 6838:13,
6846:41, 6857:12,
6857:32, 6857:36,
6858:1, 6859:2,
6860:12, 6860:29,
6861:9, 6868:10,
6888:43
underlying [1] -
6862:38
understood [5] -
6862:4, 6876:31,
6887:29, 6891:6,
6891:8
undertake [1] - 6872:5
undertaken [2] -
6856:32, 6862:22
undertakes [1] -
6872:29
undertook [2] -
6853:45, 6854:2
undoubtedly [1] -
6880:22
unfair [2] - 6876:7,
6876:17
unfortunately [1] -
6869:3
unhelpful [1] -
6870:47
uniform [2] - 6820:46,
6835:34
unique [3] - 6877:41,
6881:27, 6888:16
unit [17] - 6807:45,
6808:1, 6808:2,
6816:38, 6829:1,
6836:41, 6851:19,
6852:34, 6852:37,
6852:43, 6852:46,
6853:26, 6853:35,
6853:44, 6854:11,
6854:41
United [5] - 6874:8,
6885:17, 6885:18,
6885:23, 6885:29
units [4] - 6808:18,
6816:43, 6817:1,
6853:33
universal [1] -
6855:25

universe [2] - 6876:43, 6877:27
universities [2] - 6876:38, 6876:40
University [7] - 6803:14, 6803:28, 6850:30, 6850:32, 6850:43, 6851:2, 6851:12
university [1] - 6851:21
unless [7] - 6830:23, 6836:42, 6840:6, 6841:21, 6842:12, 6851:38, 6857:14
unlikely [1] - 6840:17
unmet [1] - 6805:9
unrealistic [1] - 6868:16
unresolved [1] - 6805:8
unstuck [2] - 6807:28, 6824:14
unsure [1] - 6855:3
unusual [1] - 6841:13
up [69] - 6805:2, 6806:32, 6808:11, 6808:18, 6808:23, 6814:45, 6816:12, 6817:10, 6817:32, 6817:34, 6817:39, 6817:47, 6818:5, 6819:15, 6819:36, 6820:34, 6824:15, 6827:7, 6834:6, 6836:36, 6839:3, 6840:2, 6840:5, 6840:28, 6840:30, 6842:12, 6842:18, 6842:32, 6842:41, 6843:19, 6844:43, 6845:9, 6845:29, 6848:24, 6850:36, 6852:14, 6856:37, 6857:6, 6858:13, 6859:21, 6861:15, 6862:16, 6862:25, 6862:38, 6863:47, 6865:11, 6868:27, 6869:36, 6871:23, 6871:27, 6873:47, 6874:24, 6880:4, 6880:18, 6880:20, 6880:32, 6882:42, 6884:36, 6884:37, 6886:30, 6886:32, 6886:46, 6888:20, 6888:27, 6889:5, 6889:12, 6889:29, 6889:33, 6890:44

up-to-date [1] - 6869:36
updated [1] - 6844:28
uptake [1] - 6872:42
urgent [1] - 6852:1
useful [2] - 6821:27, 6881:38
users [1] - 6851:30
uses [2] - 6829:34, 6888:9
usual [4] - 6809:17, 6848:12, 6853:36, 6884:12
utilise [2] - 6877:46, 6888:20

V

valuable [2] - 6807:6, 6818:13
Value [1] - 6888:43
value [8] - 6818:10, 6818:12, 6818:14, 6818:15, 6828:36, 6829:4, 6847:10, 6891:43
vanilla [1] - 6831:14
variable [8] - 6822:22, 6822:23, 6822:28, 6822:30, 6822:41, 6823:7, 6823:13, 6825:4
various [4] - 6879:35, 6882:35, 6883:5, 6884:28
vary [1] - 6822:36
vast [1] - 6860:34
vehicle [1] - 6884:20
vendor [2] - 6824:37, 6824:38
venture [1] - 6807:41
via [2] - 6805:42, 6806:3
viable [2] - 6867:42, 6873:11
vibrant [1] - 6843:13
vicinity [1] - 6822:31
victims [1] - 6859:4
Victoria [2] - 6842:39, 6894:4
view [27] - 6807:28, 6807:42, 6809:32, 6809:33, 6811:3, 6811:37, 6813:13, 6814:8, 6814:18, 6819:38, 6822:4, 6823:21, 6823:23, 6826:24, 6829:25, 6829:36, 6838:43, 6839:5, 6841:30,

6845:32, 6845:44, 6855:36, 6861:47, 6865:46, 6887:7, 6892:41, 6893:43
views [4] - 6851:39, 6851:40, 6884:27, 6887:9
virtual [1] - 6879:2
virtually [1] - 6879:3
virtue [1] - 6883:38
visible [1] - 6887:36
vision [1] - 6843:32
visit [1] - 6843:37
visiting [1] - 6828:37
VMOs [1] - 6840:1
voice [2] - 6882:33, 6882:34
volume [7] - 6807:46, 6808:1, 6812:13, 6817:19, 6822:26, 6824:41, 6894:28
volumes [1] - 6836:41
voluntary [5] - 6804:41, 6805:19, 6805:26, 6808:7, 6808:16
vying [1] - 6876:10

W

wages [1] - 6826:28
Wagga [1] - 6888:24
wait [4] - 6819:6, 6821:29, 6821:30, 6827:18
waiting [4] - 6819:12, 6821:22, 6821:25, 6825:30
waits [1] - 6825:47
Wales [92] - 6802:19, 6803:14, 6803:21, 6803:34, 6804:15, 6804:17, 6804:20, 6804:25, 6804:34, 6804:41, 6805:19, 6805:28, 6805:35, 6805:46, 6806:5, 6807:8, 6807:30, 6808:6, 6811:24, 6813:21, 6813:30, 6813:42, 6814:4, 6814:22, 6817:24, 6822:4, 6823:10, 6824:29, 6825:16, 6826:19, 6827:44, 6827:47, 6828:16, 6828:30, 6830:12, 6832:7, 6833:24, 6834:3, 6834:9, 6835:17, 6835:26,

6835:38, 6835:40, 6836:2, 6836:3, 6836:38, 6837:46, 6838:9, 6838:40, 6838:47, 6839:5, 6839:10, 6839:34, 6840:30, 6841:7, 6842:18, 6842:34, 6842:35, 6843:1, 6853:30, 6854:45, 6856:3, 6856:11, 6865:33, 6869:39, 6873:14, 6873:27, 6875:35, 6876:16, 6876:26, 6877:22, 6877:42, 6878:7, 6879:28, 6879:34, 6880:46, 6881:27, 6882:47, 6883:16, 6886:17, 6887:23, 6891:22, 6892:7, 6892:19, 6893:44, 6893:46, 6894:3, 6894:11, 6894:29, 6894:31, 6894:37, 6894:46
Wales's [1] - 6828:4
walk [1] - 6815:11
walking [1] - 6818:36
wants [3] - 6827:31, 6840:31, 6879:3
War [1] - 6838:20
ward [1] - 6888:5
warrant [1] - 6878:23
warranted [1] - 6888:17
watching [1] - 6820:17
Waterhouse [1] - 6802:29
waves [2] - 6813:8, 6813:21
ways [19] - 6829:8, 6831:37, 6831:42, 6832:28, 6851:28, 6856:23, 6858:43, 6861:3, 6870:4, 6877:20, 6877:37, 6879:21, 6880:23, 6881:18, 6882:35, 6889:37, 6891:7, 6893:11, 6893:16
weaknesses [1] - 6817:44
website [1] - 6892:46
WEDNESDAY [1] - 6895:26
week [2] - 6822:25, 6882:11
weigh [1] - 6843:30

weight [1] - 6819:7
welcomed [1] - 6876:1
West [7] - 6808:35, 6811:24, 6817:20, 6832:7, 6834:9, 6840:45
western [1] - 6843:39
Western [4] - 6808:34, 6808:35, 6809:28, 6835:38
Westmead [6] - 6863:6, 6871:4, 6880:6, 6885:44, 6886:8
whereas [3] - 6807:10, 6814:34, 6821:25
whereby [1] - 6819:32
whilst [5] - 6807:16, 6816:10, 6833:12, 6855:7, 6880:30
Whitlam [2] - 6842:33, 6842:35
WHO [3] - 6831:24, 6831:33, 6848:9
whole [21] - 6805:33, 6806:29, 6811:14, 6812:6, 6824:13, 6826:36, 6836:28, 6839:39, 6854:44, 6861:22, 6865:33, 6867:39, 6867:43, 6867:45, 6869:25, 6870:35, 6872:43, 6877:26, 6881:16, 6884:45, 6888:46
wholly [1] - 6880:15
wide [6] - 6815:13, 6815:14, 6819:33, 6830:36, 6855:27, 6855:39
widely [2] - 6876:20, 6876:31
wider [2] - 6855:11, 6891:46
widgets [3] - 6812:13, 6830:17, 6847:16
wilfully [1] - 6858:27
willing [1] - 6856:36
willingly [1] - 6840:17
wish [1] - 6891:18
WITHDREW [2] - 6849:6, 6895:23
withdrew [1] - 6843:2
witness [2] - 6803:3, 6847:1
WITNESS [1] - 6849:6
witnesses [1] - 6895:4
WITNESSES [1] - 6895:23
Wolfenden [5] -

6849:21, 6849:28,
6850:13, 6851:9,
6851:11

WOLFENDEN [12] -
6849:31, 6849:37,
6850:4, 6851:11,
6852:16, 6852:32,
6853:17, 6854:18,
6854:47, 6855:14,
6855:43, 6871:31

Wollongong [1] -
6803:28

women's [1] - 6806:10

wonderful [1] -
6847:47

wondering [2] -
6880:27, 6892:19

word [1] - 6858:3

words [3] - 6820:7,
6858:36, 6862:32

workforce [21] -
6814:20, 6814:21,
6814:22, 6814:24,
6814:25, 6814:39,
6816:14, 6826:30,
6836:45, 6836:46,
6837:8, 6837:18,
6846:19, 6848:4,
6848:5, 6856:5,
6859:9, 6869:33,
6880:32

works [6] - 6835:2,
6860:36, 6868:9,
6871:46, 6875:30,
6892:12

world [13] - 6813:31,
6824:12, 6834:4,
6837:44, 6859:43,
6862:8, 6862:39,
6868:7, 6868:11,
6880:42, 6885:10,
6888:40, 6892:6

World [2] - 6831:24,
6838:20

world-class [1] -
6892:6

worried [2] - 6827:11,
6843:42

worse [1] - 6810:36

worst [1] - 6820:33

worth [8] - 6806:33,
6819:4, 6826:13,
6829:44, 6866:32,
6887:8, 6887:9,
6887:11

writes [1] - 6819:18

writing [1] - 6843:47

written [1] - 6844:10

wrote [1] - 6804:24

Y

year [15] - 6810:6,
6810:14, 6810:15,
6810:18, 6810:22,
6811:41, 6816:35,
6817:3, 6825:31,
6836:43, 6840:25,
6840:30, 6846:11,
6848:22, 6848:25

years [20] - 6803:29,
6803:41, 6804:19,
6804:26, 6805:2,
6809:3, 6810:22,
6810:24, 6811:40,
6813:17, 6820:29,
6822:38, 6823:11,
6832:17, 6838:47,
6839:13, 6844:25,
6869:5, 6881:43,
6893:3

years' [1] - 6847:37

yield [1] - 6893:5