

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Wednesday, 26 February 2025 at 9.30am

(Day 070)

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: Good morning, Commissioner.

4

5 This morning we have the last public hearings of the
6 Inquiry commencing. It will involve a shortish passage of
7 evidence from the three individuals who are sitting in
8 front of you, followed, I think, by providing you,
9 Commissioner, with an opportunity to address any questions
10 that you might have arising out of the written submissions
11 that have been prepared by the parties.

12

13 THE COMMISSIONER: Yes.

14

15 MR MUSTON: The submissions, as you will have seen, are
16 reasonably comprehensive and we've come to the view that
17 there is probably little to be gained in either reading
18 them out or providing you with a highlights package.

19

20 THE COMMISSIONER: I think the way we should proceed with
21 the submissions is take them as having been read, and
22 I might just have some questions for Mr Cheney, it looks
23 like, in terms of clarification and the like in relation to
24 NSW Health's submissions, and then, to the extent that you
25 need to, some time for you to reply.

26

27 MR MUSTON: Thank you. The three witnesses we have today
28 are Mr Minns, Mr D'Amato and the health secretary.

29

30 THE COMMISSIONER: Welcome.

31

32 MR MUSTON: I wonder whether we want --

33

34 THE COMMISSIONER: All right, okay. Do we know whether
35 oaths or affirmations?

36

37 MR MUSTON: I did not make that inquiry, I'm sorry.

38

39 <SUSAN LEE PEARCE, sworn: [9.32am]

40

41 <ALFAISTER DAVIS D'AMATO, sworn:

42

43 <PHILIP GREGORY MINNS, sworn:

44

45 MR MUSTON: I probably should have indicated,
46 Commissioner, from a timing point of view, the witnesses
47 ideally - they are obviously at your disposal - would like

1 to be able to get to a commitment --
2
3 THE COMMISSIONER: I'm aware of the commitment and I'm
4 sure that won't be - well, it won't be a problem.
5
6 MR MUSTON: Thank you. I think my expectation is we will
7 be completed the oral evidence, or the oral evidence will
8 have concluded by lunchtime.
9
10 THE COMMISSIONER: Yes. If, for some unforeseen reason,
11 you haven't finished, against your expectation, we will
12 find another time, another day.
13
14 MR MUSTON: Can I indicate I've also factored in to that
15 expectation a short break of some description during the
16 morning for the stenographers.
17
18 THE COMMISSIONER: Yes, we will have to give people
19 a break, so at 11 I will take, in your hands, a shorter
20 than usual break but still 10 to 15.
21
22 MR MUSTON: That should be fine. I have every expectation
23 that we will move quite quickly through this evidence.
24
25 THE COMMISSIONER: Okay.
26
27 MR MUSTON: Thank you. Could I ask each of you, starting
28 with you, Ms Pearce - actually, I should take it back one
29 step. Could you each give us your full name for the
30 record.
31
32 MS PEARCE: Susan Lee Pearce.
33
34 MR MUSTON: You are currently the health secretary.
35
36 MS PEARCE: Health secretary.
37
38 MR MUSTON: Mr D'Amato.
39
40 MR D'AMATO: Alfaister Davis D'Amato, deputy secretary
41 financial services and CFO.
42
43 MR MUSTON: And Mr Minns?
44
45 MR MINNS: Phillip Gregory Minns, deputy secretary for
46 people, culture and governance.
47

1 MR MUSTON: Have each of you had an opportunity to review
2 the submissions made to the Inquiry by NSW Health?
3
4 MS PEARCE: Yes.
5
6 MR D'AMATO: Yes.
7
8 MR MINNS: Yes.
9
10 MR MUSTON: Do you have a copy of those submissions with
11 you, if required?
12
13 MS PEARCE: Yes.
14
15 MR D'AMATO: Yes.
16
17 MR MINNS: Yes.
18
19 MR MUSTON: I want to start by asking some questions about
20 prevention. Your submissions engage, or health's
21 submissions engage with some recommendations made by
22 counsel assisting in relation to prevention and the role
23 that prevention might potentially play within the public
24 health system going forward, but can I start by just asking
25 you to give me your broad definition of prevention, so
26 we're sure we're all talking about the same thing.
27
28 MS PEARCE: Well, thank you for the question. From my
29 perspective, prevention is relatively clear and that is
30 that it's measures designed to prevent people from becoming
31 unwell, to prolong life in the fittest and most, you know,
32 healthy possible way, and I guess, broadly speaking, that's
33 how I would define it.
34
35 THE COMMISSIONER: The World Health Organization has
36 a definition of prevention. Is that in line with how
37 NSW Health sees things?
38
39 MS PEARCE: I'd have to get you to provide it to me,
40 Commissioner.
41
42 THE COMMISSIONER: I can read it out to you, if I can find
43 it.
44
45 MS PEARCE: Thanks. I don't have that at hand.
46
47 THE COMMISSIONER: Just bear with me a second:

1
2 *Approaches and activities aimed at reducing*
3 *the likelihood that a disease or disorder*
4 *will affect an individual, interrupting or*
5 *slowing the progress of the disorder, or*
6 *reducing disability.*

7
8 That sounds --

9
10 MS PEARCE: I think it is said more eloquently than what
11 I just said but essentially that is how I see it, yes.

12
13 THE COMMISSIONER: I mean, there are all those
14 subdefinitions, primordial, primary, secondary, tertiary,
15 but that sort of covers it, I think.

16
17 MS PEARCE: Yes.

18
19 MR MUSTON: I probably should ask do either Mr D'Amato or
20 Mr Minns want to add anything in relation to the broad
21 definition of prevention as a public health concept?

22
23 MR MINNS: No, thank you.

24
25 MR D'AMATO: No.

26
27 MR MUSTON: Starting with you then --

28
29 THE COMMISSIONER: Can I just ask another question. I was
30 going to ask Mr Cheney, but given that we've got some live
31 witnesses I will ask them. In your "Future Health"
32 document, "Guiding the next decade of care 2022-2032",
33 which I think, in a really comprehensive way, at least sets
34 out a very strong framework for NSW Health over the next
35 10 years. It's said that prevention and promotion
36 currently account for 10 per cent of NSW Health
37 expenditure. Just pausing there, are you able to tell me
38 how much of that percentage is claimed as prevention and
39 how much is promotion?

40
41 MS PEARCE: I might ask Mr D'Amato if he has that
42 information, if that's okay, Commissioner.

43
44 MR D'AMATO: So these figures, Commissioner, are normally
45 published in our financial statements and they include
46 a section where we effectively report on different areas of
47 spend and one of that is related to the population health

1 services so the population health services covers exactly
2 that, as a combined figure.

3
4 Now, we tend to have all this information at the cost
5 centre levels. I can't tell you the precise split between
6 the prevention and the promotion, if you want, and I also
7 need to note --

8
9 THE COMMISSIONER: Just pausing there, what should I take
10 to be the meaning of "promotion" versus "prevention"? Is
11 "promotion" something like advice given, like, "Don't
12 vape"? Could that be promotion, as distinct from some sort
13 of preventative service which might be addressing a chronic
14 disease?

15
16 MS PEARCE: I think it covers a range of areas,
17 Commissioner.

18
19 THE COMMISSIONER: Please tell me.

20
21 MS PEARCE: If you have a coronary event it might be
22 cardiac rehab after that event to promote your health
23 following a health event. So I think it covers all ends of
24 the spectrum. Obviously promotion, as you've outlined,
25 which is preventative as well, issues around vaping,
26 smoking, which the state, and indeed the country, has been
27 incredibly successful with over the years - you know,
28 promoting health but preventing illness, I think sometimes
29 merge together, which is why it's difficult to split --

30
31 THE COMMISSIONER: Just the cardiac example you gave,
32 I can see that as how that might fall within both camps.

33
34 MS PEARCE: Exactly. I think there are other examples in
35 terms of stroke, for example, where somebody suffers
36 a stroke, clearly we want to promote that person's health
37 beyond that event, and that might include a range of
38 activities to assist with that. Healthy eating, lifestyle
39 factors, exercise - there are a range of things that fall
40 into that category.

41
42 THE COMMISSIONER: Can you help me with this, and this is
43 not a criticism, it's just so that I can understand it
44 better, in the national health prevention strategy, I think
45 it might be 2021 to 2031, again, without criticism, nothing
46 much seems to have been done in relation to that strategy,
47 but it recommends that Australia, as a whole, increase

1 spending on what it calls prevention to 5 per cent. I've
2 got a figure for prevention and promotion here in "Future
3 Health" of 10 per cent. Is it likely that - and there are
4 some other publications or reports I've seen where it's
5 said that the amount of dollars per person in each state,
6 there's not much difference. Is all the slight variations
7 in this likely to come down to how prevention is being
8 defined?
9

10 MS PEARCE: Look, I think the definition is one thing.
11 I think that the other override - what can be perceived at
12 times of other priorities in the health system are at play
13 here, and I don't think any of us would disagree that more
14 focus needs to be placed on health promotion and
15 prevention.
16

17 THE COMMISSIONER: "Future Health" says that.
18

19 MS PEARCE: As an individual health practitioner, I fully
20 support that. It is indeed, in my view, the case that over
21 many years in health systems, that, if I could use this
22 term, the squeaky wheel gets the oil, and by that I mean
23 that things that are very strongly in the public eye,
24 elective surgery wait lists, emergency department waiting
25 times, draw a lot of attention and focus, and acute
26 services in hospitals. Our objective I think going forward
27 in respect to how we provide health care has to change, and
28 I'm sure we'll talk about --
29

30 THE COMMISSIONER: This is the whole notion of becoming
31 a proactive service as distinct from a reactive service
32 that I find in many reports?
33

34 MS PEARCE: Well, I think we will always need to have
35 a reactive service.
36

37 THE COMMISSIONER: Of course.
38

39 MS PEARCE: There is no question of that. The issue
40 from --
41

42 THE COMMISSIONER: But extending beyond acute services to
43 other services that might stop the need for some acute
44 services?
45

46 MS PEARCE: Indeed. And I think that, you know, look,
47 I've been working in health for a very long time, I've seen

1 lots of changes over all those many years. One of the
2 things that I'm acutely aware of, and I expect we may
3 discuss this today in terms of our planning for capital and
4 clinical services, is that we really need to contend that
5 the health system of the future will certainly always have
6 strong similarities to what we have now, but it does need
7 to morph and change and to have the capacity to be able to
8 do that, and in order to do that, we have to be able to
9 talk to our communities about - you know, I won't continue
10 on and on about this, but it's a complex area that requires
11 a lot more attention and we fully support that view.

12
13 MR MUSTON: Could I just take up quickly the squeaky wheel
14 analogy that you drew. The squeaky wheels, I think you
15 alluded to explicitly, were emergency department waiting
16 times and elective surgery waiting times as the issues
17 which funding is deployed to meet because the public talks
18 about them. To what extent are those wheels squeaky, to
19 use that term, because they happen to be things which are
20 being reported on publicly by BHI and therefore seem to
21 find their way into the press?

22
23 MS PEARCE: I might just re-clarify my intent in that
24 comment. By it I mean that there is a lot of focus on
25 those things and that it is almost as though that is all we
26 do in hospitals and that there are strong community views
27 and perceptions around those things, and they have every
28 right to be, you know, I'm not discounting the interest in
29 those areas of the health system. They are very important
30 parts of the work that we do to support our community. But
31 our health system is much broader than that.

32
33 Yes, we do publicly report on them, obviously, and
34 have done for many years now, in a very open and
35 transparent way. There are a range of other public
36 reporting measures around the health or otherwise of
37 communities in Australia.

38
39 Where the challenges lie from my perspective - and
40 I think it is an area we certainly can explore around
41 reporting - but where difficulties lie for us often is that
42 if a Commonwealth report comes out talking about health of
43 a particular community or communities in New South Wales,
44 there's an automatic assumption that the public health
45 system is solely responsible for that, and very often we
46 are not. We are a part of it, certainly, but in terms of,
47 you know, people's health generally, there are a lot of

1 determinants that are associated with that that don't
2 solely rest with NSW Health. So I think we've got to get
3 to a place where, rather than arguing about, you know,
4 apples and oranges in reports, we have a unified set of
5 agreed measures across the country, really, that, you know,
6 we are in partnership in delivering.

7
8 MR MUSTON: We'll come back to that in a moment, but just
9 in relation to this reporting, do you think, if there was
10 wider reporting of other areas in which the health service
11 could potentially be improving or other areas where funding
12 could and probably should be deployed and maybe those
13 inside think should really be the squeaky wheels - if there
14 was reporting about those problems, do you think that would
15 enhance the ability to spread that funding in a way which
16 actually better met what those within health perceive to be
17 the best - the greatest need?

18
19 MS PEARCE: Look, in part. I don't think it's the sole
20 answer. I think that the - I mean, we report obviously,
21 you know, smoking rates in pregnancy, vaccination rates,
22 various other things that are focused upon, and there is
23 strong endeavour around those things.

24
25 I don't think there is one silver bullet for this
26 issue, I suppose is what I'm saying. It does require
27 a collective effort, and indeed, from our perspective - and
28 you will have noted from our submission - that whole of
29 government approach to these issues is important. I think
30 "The First 2000 Days" is a very good example of that, where
31 there is energy and endeavour from different government
32 departments to come together around that, because it is
33 rarely the case, although health may be slightly different
34 to that, that one single government agency is solely
35 responsible for something. But you can't boil the ocean
36 with these things and you have to have clear priorities,
37 and I think that is a good example of a very clear
38 priority.

39
40 So I think it's multifaceted. Reporting is one
41 element but the commitment is the other element to it and
42 by that I mean it has to have broader commitment than just
43 within one single agency.

44
45 THE COMMISSIONER: Can I ask you a question about that.
46 Again, in "Future Health", which I have taken to be like
47 a foundational document for you for the next 10 years,

1 there's a passage in relation to the section or the
2 priority you set for people being healthy and well which -
3 I will just read it to you and then ask a question about
4 it. It's from page 31. Sorry, I can give the document,
5 maybe it can be put up on the screen [SCI.0001.0010.0001],
6 and if we can go to the page 0031. The last page on that
7 paragraph says:

8
9 *There is widespread evidence of a strong*
10 *relationship between health and social*
11 *determinants of health. Social*
12 *determinants of health such as income,*
13 *education and housing can strengthen or*
14 *undermine someone's health trajectory and*
15 *outcomes. Therefore, NSW Health's efforts*
16 *to support people to be healthy and well*
17 *and to address social determinants of*
18 *health cannot be achieved in isolation and*
19 *requires us to work collaboratively across*
20 *health disciplines and with partner*
21 *agencies and organisations.*

22
23 Accepting all of that, I take that to mean that there is
24 a need to be working with other parts of government in
25 relation to this - do you agree with that?

26
27 MS PEARCE: Yes, I do.

28
29 THE COMMISSIONER: Can I ask, in paragraph 5.5 of the
30 submission on page 6, the submission tells me that
31 considerable work will be required to facilitate
32 implementation of a whole of government priority for
33 preventative health which would ordinarily be a matter for
34 consideration for the cabinet office, which has a lead role
35 in coordinating whole of government policy reform.

36
37 Accepting that also, but based on what I've just read
38 from "Future Health", I would have thought work's already
39 happening in this space?

40
41 MS PEARCE: It is. I think, though, in terms of the
42 recommendations, Commissioner, around, I guess, the role of
43 prevention across the state, we're probably looking at that
44 more broadly. So certainly there is endeavour already
45 around "The First 2000 Days" across government agencies
46 with various ministers involved in that, including, of
47 course, our minister.

1
2 I think the broader issue of how - and, you know,
3 clearly the government, in reviewing your final report,
4 will turn its mind to how it wishes to approach any such
5 recommendation.
6

7 THE COMMISSIONER: Right. It's just that what I take from
8 5.5, which might be a misconstruction, and perhaps either
9 you or Mr Cheney will eventually tell me that, but it looks
10 like a slight push-back to what counsel assisting is
11 recommending, whereas my take on what counsel assisting is
12 recommending, in terms of prevention, is that it's entirely
13 consistent with what is in "Future Health" and the idea
14 that at least part of the approach to prevention requires
15 whole of government --
16

17 MS PEARCE: I don't see it as a push-back --
18

19 THE COMMISSIONER: Okay.
20

21 MS PEARCE: -- at all.
22

23 THE COMMISSIONER: In which case, given you are the
24 secretary, I won't take it that way.
25

26 MS PEARCE: Thank you. It is responding, I think, to
27 recommendation 1, which essentially talks about, in counsel
28 assisting's submissions, you know, preventative health
29 should be identified as a standing whole of government
30 priority against which new policy proposals are brought
31 forward by all, all we're saying is that, at the end of the
32 day, NSW Health in and of itself can't make that
33 recommendation happen. It would require, obviously, the
34 view of government and the role of the cabinet office in
35 bringing --
36

37 THE COMMISSIONER: It's NSW Health's view that this is
38 important but because we think it's important doesn't mean
39 that we've got everyone on board.
40

41 MS PEARCE: I think, you know, obviously I can't speak for
42 the government in that regard. I think the signals from
43 our minister are very clear, that he is very interested in
44 this space. There are a range of examples where government
45 agencies come together. For example, there is a task force
46 on domestic and family violence, of which I'm a member.
47 That is led by the cabinet office, so it's another example.

1 It has education, it has health, it has police, it has DCJ,
2 and I think, if I may, one of the, you know, very strong
3 lessons that we learnt during the pandemic, which is still
4 a bit difficult to talk about in some respects for us, is
5 that coming together with other government agencies, the
6 private sector, community-led organisations, NGOs, the
7 community, was a very strong lesson for us.

8
9 It's not to say that it didn't happen before the
10 pandemic, but that strengthened our relationships in a way
11 that I think was - they were deepened to an extent that one
12 of the things that I personally as an individual who was
13 part of that from day one wanted to leave, I guess, behind
14 as a legacy of that time, was that we would continue in
15 those endeavours together around the very difficult
16 problems that governments face, and that one single
17 organisation cannot possibly, on its own, deal with.

18
19 THE COMMISSIONER: Sure.

20
21 MR MUSTON: Can I come back very briefly to this topic of
22 reporting. I think you've told us it's one piece but
23 obviously not the entire ball game in terms of the planning
24 and delivery of an effective and accessible healthcare
25 system. In relation to that one piece, in accepting that
26 that's all it is, can I ask you this: do you think that
27 wider reporting of areas in which the system is working
28 well, areas in which the system could improve might be
29 a useful tool in assisting with both the public dialogue
30 about the way in which health, health planning and spending
31 is done in this state, but also internally, do you think it
32 might assist with funding distribution and planning
33 decisions in a way that perhaps take the focus off those
34 two issues that you raised earlier, namely, elective
35 surgery wait times and emergency department wait times?

36
37 MS PEARCE: We're still talking about health promotion and
38 prevention specifically?

39
40 MR MUSTON: Talking more about reporting generally, just
41 picking up on your earlier answer about squeaky wheels.
42 Let me take it back and make the question a lot shorter.
43 You've given some evidence about the squeaky wheel getting
44 the oil. The two squeaky wheels that you've identified as
45 getting a lot of oil at the moment and over the recent
46 years are elective surgery wait times and emergency
47 department wait times. Is that right?

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MS PEARCE: Again, I'd just slightly rephrase how I've characterised that.

MR MUSTON: No, please do.

MS PEARCE: My point was that they draw a lot - it's not just about funding, I don't think it's - I'm not saying that all of our funding goes to those areas, if that's the inference you take, and I'd like to correct that. What I'm saying is that there are areas of the health system that get a lot of attention and focus, including from the community, because it's almost like a perception that that is, you know, not a singular purpose of the New South Wales health system, but, you know, a very significant part of its role and function, and so I think that it's not just about funding of those. I'm not suggesting that all of the money gets directed to those things in the absence of other things.

MR MUSTON: No. What impact, though, does that public attention on those two things have on decision-making around funding and the prioritisation of funding within the wider planning of the health system?

MS PEARCE: Look, again, a very complex area, and we have, you know, at any one time 85 to 90,000 people scheduled for surgery. I will take the opportunity to say that those people are scheduled for surgery not overdue for their surgery, and we work very hard to deliver to our community getting that surgery done on time. It's clear that that is important to the public.

It's clear that it's important to the public that if they enter an emergency department, they are seen in a timely fashion. Fundamentally, these issues come back to patient safety and the quality of care that we provide. So it's not one element of the system that we think about when we're thinking about those things, but I think it's fair to say that the strong reporting around those obviously does draw attention and focus to them. Look, I mean we have no end of data and reports in the health system. We are overflowing with that information, and I think we've got to be very clear about, you know - which is why "Future Health" obviously goes to some broad but key priorities for the health system - we have to think about how we prioritise the reporting and what - you know, what we focus

1 on. Some of our colleagues would argue that if you
2 strongly focus on one area, then, you know, the other will
3 slip, and so it's managing all of those things in a way
4 that gives them equal weight in the attention and focus.
5

6 If I may, the New South Wales health system I think,
7 in terms of - again, I'm sorry to keep referring to the
8 pandemic but I think it's relevant. The chief health
9 officer, Dr Kerry Chant, well known by everyone by now, and
10 our public health system in terms of its public health, as
11 opposed to the public health system, had a very strong
12 footprint across New South Wales ahead of the pandemic. It
13 set us up in a way to deal with that very long incident
14 that we were in better shape to begin with, frankly, in my
15 view - of course, you would expect me to say that, but
16 I believe that to be true. You know, we have, as a state,
17 placed a lot of investment in health promotion, health
18 prevention and the setting up of public health, you know,
19 doctors and units right across New South Wales.
20

21 I think that the pandemic really did shine a light on
22 that part of the health system in a way that probably
23 hadn't before. So there is an opportunity for us to think
24 about what are the key messages that we want for society to
25 take note of, noting that people will only hear so many
26 messages from a state health system. So, you know, as
27 I say, there are key priorities around vaccination, there
28 are key priorities around smoking in pregnancy, that go
29 squarely to those issues of what then happens to someone
30 during the course of their life.
31

32 If really what you're asking me is if we could do more
33 reporting on that, look, we certainly would not object
34 necessarily to that notion, but we need to be mindful of
35 what we're reporting, how much we're reporting and what its
36 objective is so that it actually makes a difference.
37

38 MR MUSTON: Can I give perhaps an example to test that.
39 We've heard lots of evidence about wait times for
40 paediatric referrals. It's not because all other
41 specialists are not important but because it has been
42 a useful example to use through the Inquiry. Do you think
43 if there was reporting on the wait times for paediatric
44 referrals, referable to some evidence-based guidelines
45 around when those referrals should ideally occur, that that
46 might make it easier for the ministry to deploy funds into
47 areas like paediatric care which would result in bringing

1 those referral times as best as possible within guidelines?

2

3 THE COMMISSIONER: By "guidelines", do you mean clinically
4 appropriate?

5

6 MR MUSTON: Clinically appropriate. Evidence-based
7 guidelines.

8

9 MS PEARCE: I think the issue of referral to specialist
10 services in the public health system broadly is an
11 interesting and very challenging area. We have, you know,
12 somewhere between 15 and 20 million occasions of service
13 a year in our outpatients clinics.

14

15 Part of the work that we've done over the years, and
16 I think this preceded the pandemic - and I raise that
17 because obviously it intercepted a number of things that
18 were under way - was to look at the referral process and
19 the appropriateness of referrals to those clinics, because
20 that is another factor.

21

22 It's quite easy to talk about a list in terms of
23 people who are referred and waiting for an appointment,
24 it's actually what's sitting in there that is really also
25 important. So it's not a straightforward matter.

26

27 One of the other things - and I know that this
28 obviously does happen but perhaps not as systemically as we
29 can think about - is what our outreach looks like in terms
30 of specialist service outreach to GPs and to others to
31 provide advice and guidance to assist them in their
32 decision-making about what care a patient needs.

33

34 We will always internally have a view, I guess, where
35 there is pressure in our system in respect to referrals,
36 wait lists, surgeries, and I guess that's the other thing
37 I will say: the management of our specialist services and
38 how that then translates to procedural services is another
39 finely balanced part of the health system that is not
40 straightforward.

41

42 THE COMMISSIONER: Can I just ask, so that I understand
43 what you just said properly, when you said:

44

45 *Part of the work that we've done over the*
46 *years, and I think this preceded the*
47 *pandemic - and I raise that because*

1 *obviously it intercepted a number of things*
2 *that were under way - was to look at the*
3 *referral process and the appropriateness of*
4 *referrals to those clinics ...*

5

6 What should I take that to mean, that there's issues about
7 whether the recommendation by the clinician for a referral
8 to a clinic is appropriate, or --

9

10 MS PEARCE: In some cases, yes.

11

12 THE COMMISSIONER: Can I explore that with you, then.
13 Both, I think, within public hearing evidence but certainly
14 time and time again at meetings and roundtables, people
15 within the paediatric workforce of NSW Health were telling
16 me, time and time again, and some, clearly with passion and
17 frustration, that there are wait lists for people that need
18 to see a clinician for a paediatric issue - might be
19 developmental, whatever, but a paediatric health issue -
20 and the wait lists are between two years to five years,
21 which they told me in all those instances is beyond the
22 clinically appropriate time.

23

24 There's been no suggestion to me at this stage that
25 those people were wrong. You're not --

26

27 MS PEARCE: I'm talking about - sorry, Commissioner, to be
28 clear, I'm talking about our outpatient clinics broadly.
29 So prior to the pandemic - so paediatrics is a part of that
30 and paediatric services. Prior to the pandemic, we had
31 commenced a piece of work in regard to referral processes
32 so that we could ensure that those people who were on the
33 wait list absolutely need to be there: is there another
34 opportunity for them?

35

36 The paediatric issue, absolutely acknowledge, is very
37 challenging. I think that there has been a lot of
38 frustration around that particular area. We understand
39 that. We understand the fact that the public health system
40 plays a very important role in providing specialist
41 services to families, particularly if they can't afford
42 out-of-pocket costs. I don't step away from that at all.

43

44 We have got a piece of work under way with regard to
45 the provision of paediatric services across the state. We
46 know that there is variability in terms of where
47 paediatricians are located around the state. That, of

1 course, drives inequities in terms of access and the
2 ability for people to access those services. So, no, that
3 comment was not intended to dispute the challenge that we
4 have in that area.

5
6 THE COMMISSIONER: I suppose to Mr Muston's question,
7 though, there is no reason why that sort of data about wait
8 lists, for example, for paediatric intervention, is more or
9 less important than what the wait list is for elective
10 surgery, is there?

11
12 MS PEARCE: No, look, I mean I think that, in the end, it
13 is incumbent on us to treat that every bit as seriously as
14 we do any other list that we have for people who are
15 scheduled for a procedure or an appointment.

16
17 THE COMMISSIONER: Okay. Can I ask you still on
18 prevention, rather than published data, but can I ask you
19 a more general question about prevention. It's one of the
20 long-term priorities in the NHRA, one of the long-term
21 reforms, but as you point out in health's submissions, in
22 the NHRA, that reform - in fact, all the reforms - came
23 without any dedicated funding.

24
25 When Rosemary Huxtable did her mid-term review - she's
26 obviously a distinguished former public servant so she's
27 a lot more polite than I would be - what I took from her
28 report was that in terms of achievements of technical
29 efficiency, the NHRA has had some success in terms of
30 activity based funding, but otherwise, I didn't find any
31 pats on the back from any other aspect of the NHRA in terms
32 of implementation from her in her report.

33
34 But in relation to prevention in particular - and
35 I think this applies to all the long-term health reforms
36 that are in the NHRA - she said, "Look, there needs to be
37 some funding because there's been no progress. There needs
38 to be some dedicated funding and setting up an innovation
39 agency."

40
41 I take it that in the general sense, without getting
42 into specifics and without asking you to agree with whether
43 reform without funding makes any sense at all - I take it
44 NSW Health's position would be with general agreement with
45 Ms Huxtable about the need for some further funding in this
46 space?
47

1 MS PEARCE: I don't think we would argue with that, no.
2
3 THE COMMISSIONER: And by "further funding", I don't just
4 mean from the states.
5
6 MS PEARCE: No, neither do I.
7
8 THE COMMISSIONER: Obviously the Commonwealth --
9
10 MS PEARCE: Very much would be welcoming any funding from
11 the Commonwealth for that endeavour.
12
13 THE COMMISSIONER: Yes.
14
15 MR MUSTON: Sticking with prevention now, I think you have
16 told us that an important piece in the prevention puzzle is
17 addressing the social determinants of health.
18
19 MS PEARCE: Yes.
20
21 MR MUSTON: And many of those, or the levers that --
22
23 THE COMMISSIONER: Sorry, can I just interrupt? I think
24 some representatives of the AMA came in. Am I right?
25
26 MR CHAPMAN: Yes, Commissioner, thank you,
27
28 THE COMMISSIONER: You seek leave to appear?
29
30 MR CHAPMAN: We do. Scott Chapman.
31
32 THE COMMISSIONER: Thank you. Leave is granted.
33
34 Go ahead, sorry.
35
36 MR MUSTON: I think you have already intimated that many
37 of the levers that can be pulled to influence the social
38 determinants of health lie outside the control of the
39 Ministry of Health.
40
41 MS PEARCE: Yes.
42
43 MR MUSTON: Truly, for there to be effective prevention,
44 requires a whole of government approach to the issue.
45
46 MS PEARCE: We believe so, yes.
47

1 MR MUSTON: Just so we understand, in broad terms, what
2 a term like "whole of government approach" means, when
3 I use that term and you agree, what do you have in mind?
4

5 MS PEARCE: Look, I think I've given an example or
6 a number of examples already in regard to that. And again,
7 I'd just like to be clear: we don't shy away from our
8 responsibilities in health prevention, promotion, at all.
9 I think it's something that the health system has advocated
10 for, taken very seriously over a very long period of time.
11

12 What we mean by that is it's not every single element
13 of the government that needs to be involved in it, but the
14 examples we've given are fairly clear as to how you can see
15 the obvious benefits if government agencies come together,
16 domestic and family violence being an example of that. The
17 health system obviously plays a role in screening,
18 supporting, treating people who are victims, victim
19 survivors. The Department of Communities and Justice has
20 a role in its care of families, children in out of home
21 care. The police obviously have a role in their response
22 to it. Education has a role also in screening and
23 observing and, you know, reporting issues as they arise.
24 So where you can bring government agencies together around
25 those issues, in our view, it's fairly straightforward in a
26 way, even though nothing about it is straightforward, that
27 you can do a better job.
28

29 MR MUSTON: You mentioned corrective services and one of
30 the aspects of that whole of government approach to
31 prevention which corrective services has some influence
32 over is the food that is given to prisoners.
33

34 MS PEARCE: Mmm-hmm.
35

36 MR MUSTON: Would you agree with that?
37

38 MS PEARCE: Food? Yes.
39

40 MR MUSTON: The particular diet which is made available to
41 those who are in custody is but one of no doubt a wide
42 array of things that Department of Communities and Justice
43 and in particular corrective services might contribute to
44 overall prevention?
45

46 MS PEARCE: Look, absolutely. I mean, we know also about
47 people who engage with our health system in the corrective

1 environment that sometimes it's the first contact they've
2 had with a health care provider, and so, you know, clearly
3 for those people, we play a very significant role in their
4 health whilst in custody and we know that once outside of
5 that custodial environment, you know, there's a path that
6 needs to be joined up to ensure that some of those
7 processes that are put in place continue.

8
9 THE COMMISSIONER: When we did our visit at Malabar, one
10 of the things we discussed was this topic and, without
11 verballing anyone, it was either expressly made it clear,
12 or by implication, that the diet of prisoners isn't great.
13 We certainly saw piles of white bread being handed to the
14 prisoners before they were sent back to their cells in the
15 afternoon. Would there be anything wrong in me making
16 a recommendation that Justice Health at least set the
17 nutrition standards for prisoners?

18
19 MS PEARCE: I wouldn't presume to say whether you made
20 a recommendation was wrong, Commissioner, but I don't see
21 necessarily an issue with that. I think that they do have
22 a strong --

23
24 THE COMMISSIONER: Are they better placed, do you think,
25 than corrections to do that as health experts?

26
27 MS PEARCE: Maybe. It may be broader than Justice Health,
28 you know, and NSW Health more broadly has a role to play in
29 that.

30
31 THE COMMISSIONER: But Justice Health would have the
32 expertise in relation to what diets are likely not to lead
33 to metabolic disease and obesity or diabetes. It's not in
34 the community's interests that prisoners develop those
35 conditions or exacerbate them.

36
37 MS PEARCE: The health system does obviously rely on
38 dietitians in regard to those endeavours, so even with
39 respect to the food that is provided in hospital --

40
41 THE COMMISSIONER: Without agreeing with me, there are no
42 alarm bells going off, are there, that if Justice Health
43 played either the sole role or a greater role --

44
45 MS PEARCE: So long as Justice Health is adequately
46 equipped to do that, yes.

47

1 MR MUSTON: So that I can understand that last answer, is
2 your point that whether it was Justice Health who was
3 responsible for, for example, making recommendations which
4 had to be adopted about the diet of prisoners or whether it
5 was, say, some appropriately qualified people within
6 Dr Chant's team is not really to the point, the issue is so
7 long as an appropriately qualified group of people --

8

9 MS PEARCE: Yes.

10

11 MR MUSTON: -- likely residing within the Ministry of
12 Health, make recommendations, they, in the ideal world,
13 ought be followed.

14

15 MS PEARCE: Yes.

16

17 MR MUSTON: Do you broadly accept that, in terms of the
18 whole of government response to prevention, there is more
19 that needs to be done?

20

21 MS PEARCE: Look, I think that there is the need to do
22 more, and in a constructive way. I guess that's why we do
23 point to that whole of government approach. It's not the
24 sole answer for everything. We will continue as a health
25 system to do our part in that, regardless, but it would be
26 nice to see, in the coming years, I think, a focus on the
27 broader aspects of the health system rather than - and I'm
28 not saying that this is, you know, an issue with this
29 government or the previous government or any government, it
30 goes back to my comments before, however described, there
31 are parts of the health system that get a lot of attention
32 and focus from the community, from media, from others, but
33 there are other big swathes of work that we do that don't
34 necessarily get recognised.

35

36 We do a lot of work in this area. I think it's fair
37 to say that. And we are not alone in doing it. The strong
38 partnership with health and with our primary health
39 networks and others, with Aboriginal community controlled
40 health organisations and so on, is all a component part of
41 this. But it would be nice to think about health - and
42 I think, look, the NHRA, taking the Commissioner's comments
43 and Rosemary Huxtable's views in the mid-term review, very
44 challenging, obviously, and again I'm not using this as
45 a shield, the pandemic obviously impacted the ability for
46 the government to roll out the 2020 version of that, but
47 there is an opportunity --

1
2 THE COMMISSIONER: Can I just challenge you on that.

3
4 MS PEARCE: Yes, sure.

5
6 THE COMMISSIONER: I don't disagree with you about the
7 pandemic being a priority at the time of what I'll call its
8 acute phase - you know what I mean, when there were
9 lockdowns, et cetera, great uncertainty - but the topic
10 we're talking about, whether it's prevention to stop people
11 taking up a risky behaviour or whether it's prevention in
12 the sense of some form of primary care to intervene early
13 in a chronic disease to stop it progressing, and the
14 impacts that those measures might have that are either
15 about population health or the economy or potential saving
16 or avoidance of healthcare costs, have been topics that
17 have been covered in the literature for - not since 2020
18 but for decades.

19
20 The NHRA, in my view, also has to be looked at in the
21 context of the National Health and Hospitals Reform
22 Commission report, which is 16 years ago, which talks about
23 all these issues. The report at one stage - well, it did
24 recommend the Commonwealth taking over of the entire
25 funding of all healthcare costs. That report, which itself
26 is based on decades-before literature, itself has
27 prevention of chronic disease as a priority. I think it
28 recommended the establishment of a prevention agency by the
29 Commonwealth Government and certainly recommended embedding
30 prevention in all aspects of the health system.

31
32 So whilst I would accept that the pandemic has played
33 a role from March 2020, without blaming any person or any
34 individual government, we have known for a long time that
35 chronic disease is costly in many ways, it needs to be
36 addressed, and, on top of that, we've got an ageing
37 population, including all the boomers that are about to
38 turn 80 either this year or next year, and we know what
39 that's going to potentially do to the need for more
40 services and hence more costs. So my only point is - and
41 I'm sure you agree - the world, in terms of this thinking,
42 didn't start in 2020 with the NHRA. There's been lots of
43 literature before that.

44
45 MS PEARCE: Completely agree with you, and I guess -
46 I don't want to keep using my earlier phrase, or just
47 drawing that direct, you know, point, but I have sat in

1 many, many, many hearings and given evidence many times on
2 the New South Wales health system. Very rarely am
3 I asked --

4
5 THE COMMISSIONER: Not as friendly as this one, surely.

6
7 MS PEARCE: No, certainly not, which is a great relief to
8 me, thank you.

9
10 THE COMMISSIONER: Wait until Mr Cheney gets his go. It
11 will get less friendly.

12
13 MS PEARCE: I'm ready. It's okay. The point I'm making
14 is that very rarely am I asked about prevention and health
15 promotion in those hearings. What I'm asked about is how
16 many beds do we have in a hospital, what does the hospital
17 do? Very focused on bricks and mortar. And it is, to my
18 earlier point --

19
20 THE COMMISSIONER: That's the past.

21
22 MS PEARCE: -- if we continue to solely focus on bricks
23 and mortar as a proxy for health service delivery, we're
24 not going to progress beyond that. It is important to us
25 that we are able to focus on the broad suite of health
26 care, including health promotion and prevention. Even
27 when, in late 2022, the government at the time, the premier
28 at the time, announced urgent care - you know, the
29 partnership with the Victorian government - and wanted to
30 talk about urgent care clinics, we proactively dissuaded
31 the government at that time from talking about "clinics",
32 because people see bricks and mortar. What we successfully
33 convinced the government to focus upon was urgent care
34 services, and I know we're still talking about urgent care,
35 but the point is the way service delivery occurs doesn't
36 all mean it's within the four walls of a hospital.

37
38 I see this in the same way. There is a definite need
39 for us to consider this, and I completely agree with you.
40 If you go back into the sands of time, people will have
41 been talking about this forever. So there is an
42 opportunity for health systems broadly. There's an
43 opportunity for the NHRA. I think that the signals in
44 respect of the discussions that had been occurring are very
45 clearly pointed to the fact - and I think Rosemary
46 Huxtable's work did an excellent job in highlighting this -
47 the NHRA cannot just be about hospital services.

1
2 MR MUSTON: Mr Minns?
3
4 MR MINNS: Just to amplify that point, Commissioner, the
5 entire reason, if we go back to the very first workshop we
6 had about "Future Health", that document that you referred
7 to --
8
9 THE COMMISSIONER: Gosh, how long ago was that now?
10
11 MR MINNS: It was 2018, I think. Somewhere in 2018, yes.
12 That was our attempt to try and change the narrative about
13 the health system.
14
15 THE COMMISSIONER: From just build bricks and mortar.
16
17 MR MINNS: Yes.
18
19 THE COMMISSIONER: I remember you saying that to me. Yes,
20 please go ahead, though.
21
22 MR MINNS: Just to amplify what the secretary has
23 presented, if we can't engage the community and thereby
24 politicians in a broader conversation about what good looks
25 like for the healthcare system, we'll always be led to the
26 squeaky part, you know? And the fact that we try to make
27 "Future Health" the central guiding document for all of the
28 planning work that we then do, the further workforce plan,
29 services plans, whatever, is we're trying to get to that
30 broader place of a total health system.
31
32 THE COMMISSIONER: Sure, yes, understood.
33
34 MR MUSTON: What do you think needs to be done or what
35 impediments are there that need to be cleared away to
36 improve that dialogue with the community about what the
37 health system is and should be delivering for them so as to
38 shift that focus from the old fashioned it's all about
39 bricks and mortar view which, as you indicate, still seems
40 to predominate?
41
42 MS PEARCE: I think, first of all - and I'm very happy to
43 share some of the commentary with my colleagues - you have
44 to be able to create the vision and a tangible picture of
45 what it means and what it looks like, and I think that's
46 where we've historically struggled a little with this.
47

1 So the real-life examples: what does this mean for
2 you? I think it's very easy to see a hospital building
3 with all of the things inside it and assume that, oh,
4 great, we've got one of them, one of them, one of them,
5 because you can see it, and I think the parts of our system
6 that struggle the most in this area, frankly, are the parts
7 that are the unseen work, and finding a way, as Mr Minns
8 has said, to help our community to better understand our
9 role in that, to see the partnerships, to experience
10 occasions of care that have a better continuum rather than
11 fragmented, as we all know and experience, would be the
12 objective.

13
14 MR MUSTON: Coming back to my questions earlier about
15 reporting, would reporting which had the effective
16 highlighting the unmet need within the community make it
17 easier to communicate to that audience why decisions were
18 being made to prioritise spending in areas that were
19 intended to address that unmet need, even though they might
20 not be, say, bricks and mortar?

21
22 MS PEARCE: Look, again, I see that in the broader context
23 of clinical service planning for the needs of a population.
24 If you're going to report, you need accountability, because
25 fundamentally I think one of the challenges that we
26 experience - and you may consider this a self-serving
27 comment - is that we become responsible for everything
28 when, in many cases, we are not. And I'm not trying to
29 shield us or to pretend that we don't have a very broad
30 role across the health of this state, but if you're going
31 to report - it's not about creating an opportunity to say,
32 "Well, it's their fault, it's their fault", I don't mean
33 that. But you need to have some cogent way of explaining
34 to the community where the responsibility lies, so that you
35 can then properly address those issues as they come to
36 hand. So I think it's difficult to just say, "Well, if you
37 report on it, it will happen organically." You need to
38 have the underpinnings of what that reporting actually
39 means.

40
41 THE COMMISSIONER: Can you give me a concrete example of
42 what you're talking about when you say that?

43
44 MS PEARCE: So the AIHW reports - and we have, you know,
45 the reports on government services, Productivity Commission
46 reports about - and I just can't remember the exact title,
47 Commissioner, I'm so sorry, in terms of the name of the

1 report, but let's just say broadly about the health of
2 a population, you know, population groups across the state.
3
4 THE COMMISSIONER: Yes, okay.
5
6 MS PEARCE: When those reports come out, it will say
7 fundamentally, the further west you go, generally speaking,
8 across the state, often the poorer the health of the
9 community.
10
11 THE COMMISSIONER: Yes.
12
13 MS PEARCE: I guess the point I'm making is that there are
14 a lot of elements to why that is the case.
15
16 THE COMMISSIONER: All right. Let me help you, then.
17 It's not NSW Health's fault that there's a lot of
18 advertising for fast food near schools, as an example.
19 Agree with that?
20
21 MS PEARCE: Yes.
22
23 THE COMMISSIONER: It's not NSW Health's fault that there
24 is not a tax on sugary drinks. Agree with that? It's not
25 your fault. I'm not asking you to agree that I should
26 impose a sugar tax --
27
28 MS PEARCE: Yes. I'm not --
29
30 THE COMMISSIONER: -- which I might --
31
32 MS PEARCE: I'm not seeking to apportion fault.
33
34 THE COMMISSIONER: But they're examples of where
35 NSW Health's not in control.
36
37 MS PEARCE: Broadly, yes, that's fair.
38
39 MR MUSTON: Stable housing is a clearer, less
40 controversial example, maybe.
41
42 THE COMMISSIONER: I haven't drafted my housing
43 recommendations yet, I've only got to sugar tax.
44
45 MR MUSTON: But isn't reporting on those sorts of issues
46 and bringing the public into the tent on those issues an
47 important part of that dialogue that you say needs to

1 happen to enable the public to understand the public health
2 system and what it is that it's trying to achieve?

3

4 MS PEARCE: Potentially. Potentially. I mean, I think
5 that the - if you look at reporting as it exists now on,
6 you know, as I said, we've got reports on all manner of
7 things, the extent to which they are properly understood is
8 questionable. I can give you some concrete examples of
9 that.

10

11 MR MUSTON: Pausing there, and I'm happy to take some
12 concrete examples, but part of the mandate of the BHI is to
13 deliver that information in a way which is capable of being
14 understood by those who read it.

15

16 MS PEARCE: Mmm.

17

18 MR MUSTON: You would agree with that?

19

20 MS PEARCE: Yes.

21

22 MR MUSTON: So coming back to your examples of the reports
23 that are misunderstood.

24

25 MS PEARCE: So you will have a report about the length of
26 time somebody spends in an emergency department. I have,
27 on countless occasions, had to correct the perception that
28 continues to be promulgated that that means they are
29 waiting for treatment, when, in actual fact, the treatment
30 has started and there may be very good reasons why those
31 people need to still be in the emergency department for
32 five hours or longer. Sometimes there aren't good reasons,
33 I accept that.

34

35 THE COMMISSIONER: Good reasons would be what, to be
36 monitored or --

37

38 MS PEARCE: Yes, you know, there are many patient
39 conditions. There are very good reasons why you --

40

41 THE COMMISSIONER: Or a different clinician needs to be
42 found?

43

44 MS PEARCE: Possibly or that the patient is so critically
45 unwell that moving them would present a risk to them. It
46 may be a drug overdose where they need to be monitored for
47 a while. It could be an allergic reaction where they need

1 to be monitored and then they can actually go home, they
2 don't need to be admitted. There are many different
3 scenarios.

4
5 THE COMMISSIONER: So the bare statistic doesn't tell you
6 everything?

7
8 MS PEARCE: The statistic doesn't tell you everything.

9
10 The elective surgery "wait list", which is one of my
11 greatest bugbears in, you know - probably not, but you know
12 what I mean. It is people - that's why I carefully said
13 earlier, it's about people who are scheduled for surgery.
14 They are scheduled by clinicians. So of the 85 or 90
15 thousand, the way that is reported and the way that is
16 continued to be promulgated is that we have 90,000 people
17 who are overdue for their surgery, and that is simply not
18 the case.

19
20 So my point is, we are not afraid of reporting. We
21 have lots of reports. We are open, transparent. We don't
22 seek to hide. And I think our evidence before this Inquiry
23 has been consistent with what I'm saying to you. We've
24 been very open and transparent. My point is that if you're
25 going to report, there needs to be as much clarity around
26 what that report means as possible - what is the purpose of
27 it, who is responsible for it - so that you can actually
28 make use of it, because otherwise, all you end up with is
29 a headline every quarter or whenever the report comes out
30 that is of no value to anyone.

31
32 THE COMMISSIONER: Sorry, a headline not in the report but
33 somewhere else?

34
35 MS PEARCE: No, in a media publication.

36
37 THE COMMISSIONER: I suppose on that, though, as a general
38 proposition, in any democracy, the fact that data can be
39 misrepresented isn't a reason for secrecy.

40
41 MS PEARCE: No, no, and I'm not suggesting that, not at
42 all. I mean, I think, you know, New South Wales has had
43 one of the most transparent public reporting regimes in
44 place for many years now. Obviously with the inception of
45 the BHI, that has continued to evolve over those many
46 years. I think we were the first state to have patient
47 reported outcome measures, the experiences of our patients,

1 the surveys of patients. You know, we are very open about
2 this. I really wish to make that point very clear. I'm
3 not arguing that we shouldn't have reporting on this topic.
4 I'm arguing the point, I suppose, that if you're going to
5 have it, it needs to be meaningful and prioritised in a way
6 that addresses the most significant needs. Because if all
7 you have is just dataset after dataset, it ends up getting
8 lost.

9
10 MR MUSTON: But that careful reporting of a wider range of
11 information potentially gives healthy opportunity to
12 contextualise those pieces of information that are focused
13 on, doesn't it, in the sense that you might say, "Yes, at
14 this particular facility, the waiting times for elective
15 surgery are longer than at other facilities, but that's
16 because we have reduced the waiting times for, say,
17 paediatric appointments by diverting funds into that area
18 and we have a limited budgetary envelope, and that's why
19 we've made this decision and here's - yes, that's the
20 downside of the decision but here's the upside of it.
21 That's the decision we've made." Isn't that the sort of
22 conversation that would enhance the public's understanding
23 of what it is the ministry's trying to do?

24
25 MS PEARCE: In theory, yes.

26
27 MR MUSTON: In theory? Why in theory?

28
29 MS PEARCE: I guess for the reasons, without belabouring
30 it, of the points that I made before, that the public - the
31 public reporting is one thing. How it's interpreted is
32 another. It is very challenging. So I will give - you
33 know, this is a long time ago, we had the best - I was in
34 the deputy secretary role still. We had the best BHI
35 quarterly report that we'd had sort of ever, very excited
36 about the fact that it was a really good report.

37
38 Unfortunately, one of the major media outlets
39 misinterpreted 90th percentile as 90 per cent, which meant
40 that the headline that day was that 90 per cent of our
41 patients were waiting more than 354 days, or something, for
42 their orthopaedic surgery.

43
44 THE COMMISSIONER: It would be really hard for me to craft
45 a recommendation in relation to this topic. I'd really
46 like to.

47

1 MS PEARCE: I know, Commissioner, I'm sorry, but I'm just
2 sharing my post traumatic stress about some of this
3 reporting, but it just destroyed the rest of the report.
4 My point is that it got no more attention. So, you know,
5 if there were to be recommendations around a regime of
6 reporting, I think they just need to be carefully
7 considered about what their objective is.

8
9 MR MUSTON; Mr Minns?

10
11 MR MINNS: The proposition you put to the secretary
12 really, you know - you were talking about the idea of
13 rationing, that the decision-making that the ministry has
14 to take and that LHDs have to take from time to time is
15 a rationing decision to say, "I can't do it all in every
16 aspect, in every theatre or field, so I'm going to make
17 these evidence-based choices about priority."

18
19 Now, it would be tremendous if the need for that
20 rationing could be appreciated and understood in a whole
21 range of areas. But it is consistently of no interest in
22 the media debate about health funding. It's just never
23 conceded as a - now, to some degree you can say, "Well,
24 that's just life in a big city. You can't do anything
25 about it. If you're going to work in government, you're
26 going to face that dilemma."

27
28 The issue, though, is that a huge distraction of
29 resource occurs when one of those sort of exemplar stories
30 that is, you know, not accurate, a misrepresentation of the
31 data - it just becomes a huge diversionary event for people
32 in the ministry, for people in LHDs. So when you go to the
33 fact of what's our progress been on some of the reform
34 measures under NHRA or under "Future Health" strategy,
35 we're often derailed in the effort because of the sort of
36 tumult of debate that starts to occur that, in some cases,
37 doesn't have an evidence base behind it.

38
39 So, you know, to some degree we're just saying there's
40 a consequence to that treatment of health data which we
41 will always have to manage and we don't shy away from
42 having clear data and from publishing it, but it will have
43 an unintended consequence at times where the system gets
44 heavily diverted into a blind alley. But I mean, that's
45 always going to happen to us.

46
47 MR MUSTON: Is that contributed to in at least a small

1 part by the fact that there might not be the clearest
2 articulation of the decision-making around that rationing,
3 to use your term?
4

5 MR MINNS: Well, to some degree, but also, you know, the
6 capacity for public servants to offer that articulation is
7 at times not our decision.
8

9 MR MUSTON: Why is that?
10

11 MR MINNS: Because we're servants of the government of the
12 day and they will have a particular approach for how they
13 want to handle an issue like that, and we have to conform
14 to that.
15

16 MR MUSTON: Would the system not be improved if it
17 required, as part of business as usual, a clear
18 articulation of the plan or the rationing that is embodied
19 within the plan for each local health district to deliver
20 care to its communities in the areas that it, as part of
21 that exercise, considers to be most in need of
22 prioritising?
23

24 MR MINNS: Well, I think you can have an attempt at it but
25 there's always going to be a debate.
26

27 MR MUSTON: Accepting that there will always be a debate,
28 but those who are charged with the responsibility of making
29 those decisions shouldn't shy away from that debate, should
30 they?
31

32 MR MINNS: Well, no, but I can't speak for a government.
33

34 MR MUSTON: Isn't there a risk that if you don't provide
35 the information about those decisions which might provoke
36 a debate that you are left with a community that doesn't
37 really know quite what it is that the health system is
38 trying to achieve?
39

40 MR MINNS: That is a risk. But at the same time, the
41 abiding risk is that the community or members of the
42 community will not be happy with the outcome of the
43 rationing decision, because, you know, if we go back to the
44 bricks and mortar idea, a town 50 kilometres away has
45 a configuration and we don't have it, and - you know, so
46 there's always that level of irreconcilable --
47

1 THE COMMISSIONER: That's the word, isn't it? You used
2 the word "rationing", but if we talk about changing where
3 a service is delivered and taking it from one geographical
4 area to another, it's incredibly important that before the
5 decision is made there's really meaningful consultation -
6 agree --
7
8 MR MINNS: Yes --
9
10 THE COMMISSIONER: -- with the community?
11
12 MR MINNS: -- but the consultation --
13
14 THE COMMISSIONER: But even if you had perfect
15 consultation, you might still be left with a community
16 which has one or more members or groups still very angry.
17
18 MR MINNS: Yes, Commissioner.
19
20 THE COMMISSIONER: And that is the irreconcilable - well,
21 there's nothing you can do about that.
22
23 MR MINNS: Yes.
24
25 MR MUSTON: But, having gone through that public
26 consultation process and made the decision about the way in
27 which the spending is to be prioritised, accepting that
28 there will be someone out there in the community who will
29 not be happy with it, is it not in the interests of the
30 health system that there be a public or a transparent
31 exposure of that reasoning process and why the decision has
32 been made that some people will be happy with and others
33 will be unhappy with?
34
35 MR MINNS: So in theory, yes.
36
37 THE COMMISSIONER: Why do you say "in theory", though?
38
39 MR MINNS: Because depending on the level of the matter
40 and the amount of community interest and/or concern the --
41
42 THE COMMISSIONER: Do you just mean that politics might
43 intervene at some stage?
44
45 MR MINNS: Yes. Yes, I do, Commissioner.
46
47 THE COMMISSIONER: Well, that's just the reality of the

1 world.

2

3 MR MINNS: It is.

4

5 MS PEARCE: I think also, if I may, the other element of
6 it - I don't think you can put one broad brush over that
7 issue, because it depends on what you're talking about. It
8 may be, for example, we've had some examples of this in
9 parts of the state where staffing has been in issue in very
10 small communities that have a 24/7 emergency department,
11 a decision has been taken to alter those services until
12 staffing can be addressed. That is an information
13 provision to the community, not a consultation. We can't
14 consult about every decision we make in the interests of
15 any given community. So service planning --

16

17 THE COMMISSIONER: Sorry, what do you see as the
18 difference between information and consultation?

19

20 MS PEARCE: Well, consultation to me means that you're -
21 to me, that word, in its ordinary sense, means that you're
22 consulting them about what their views are and taking those
23 into account for that decision.

24

25 THE COMMISSIONER: Yes. I agree with that.

26

27 MS PEARCE: In the example I gave, where a district or
28 a service finds itself with no choice, thinking about the
29 safety of the staff and the community, this is the best way
30 they have to arrange their services, you know, for
31 a temporary period usually, then what is very important in
32 that case is that you provide the community up-front with
33 that information before the change occurs.

34

35 THE COMMISSIONER: So that example is one, though, where
36 a change is occurring that's really time sensitive, like,
37 it has to --

38

39 MS PEARCE: Yes.

40

41 THE COMMISSIONER: There's not time for what I would call
42 meaningful consultation.

43

44 MS PEARCE: Yes, or indeed, consultation necessarily won't
45 alter the outcome because we have to be able to arrange our
46 services.

47

1 MR MUSTON: But that's not a rationing decision or
2 a planning decision so much as this is a circumstance which
3 has presented which leads to only one conclusion, namely,
4 we can only provide services at this location in this way,
5 safely for our staff and for the community, within
6 a certain time period.

7
8 MS PEARCE: Yes. I'm just drawing the point that it's
9 a broad suite of things in terms of the way we engage with
10 communities. Forward planning, different thing. Time
11 sensitive issues, another example. You know? So there are
12 degrees of how that works, I think.

13
14 MR MUSTON: In terms of the forward planning, though, if
15 you have a clear articulation provided to the community as
16 to what the health system is hoping to achieve and what
17 rationing decisions have needed to be made through that
18 process, to the extent that there are some who might be
19 unhappy with those decisions, is the natural or available
20 riposte not, "Well, if we get more funding, next budget,
21 we'll be able to provide both, but at the moment we can't"?
22 Doesn't that shift accountability for some of these
23 rationing decisions to those ultimately responsible for
24 making decisions about how much money the ministry has?

25
26 MS PEARCE: In some cases that might be right. In other
27 cases, no.

28
29 MR MUSTON: Why not?

30
31 MS PEARCE: I will give you an example. I'm a resident of
32 this part of Sydney so I speak as a community member as
33 well, but when we made changes to the services at Manly and
34 Mona Vale with the building of a new hospital on the
35 Northern Beaches, there was great unhappiness about the
36 role of Mona Vale Hospital in particular. There was a lot
37 of consultation and discussion at the time. There are
38 still many people in the community who want that hospital
39 back. So people feel passionately about health. I mean,
40 we love that people care about what we do, as much as we
41 do, and we respect the fact that people really care about
42 this stuff. But it's not always --

43
44 THE COMMISSIONER: But this is the intractable problem,
45 though, that Mr Minns identified.

46
47 MS PEARCE: Yes.

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THE COMMISSIONER: You mentioned health being important to people. I suspect that health and public education are the two most important things to the community as a whole. I could be wrong, it's a guess, but I'm probably right, I think, about that.

MS PEARCE: I think so.

THE COMMISSIONER: So when you make big decisions about health, including closing a service somewhere because it doesn't make sense or it's not safe or whatever the proper reason is, you will probably never not have some people that are unhappy, regardless of how good either your information process is or, if there was a consultation process, how good your consultation process.

I will give you another example. Murray-Darling Basin taking water off irrigators for the environment. The consultation process was hopeless, but even if it had been world standard, there will always be people that literally want to kill you if you think about taking water, even in voluntary sales, from people who are irrigators, including big irrigators, and giving it to the environment.

Health, it's the same category of importance to people. So I think you plan as best you can and you have the services where they should be, but if that means a diversion, then sometimes people are just always going to be unhappy.

MS PEARCE: Look, I think being up-front and transparent with the community is really important and we don't shy away from that. I'm just drawing a distinction that not everything is equal.

MR MUSTON: From an accountability point of view, you mentioned the need for there to be accountability attaching to reporting. Is there not potentially also a need for accountability to attach to planning, in the sense that if you do articulate to the community what it is you are hoping to achieve through the rationing decisions you make, then there should be some level of accountability in terms of the extent to which you have succeeded in those endeavours?

MS PEARCE: Yes.

1
2 MR MUSTON: Could I quickly just ask a couple of
3 questions, hopefully to round us out in relation to
4 prevention. To the extent that it is a whole of government
5 issue, I think you have accepted or broadly accepted in
6 your submissions that any mechanism which potentially
7 results in funds being directed towards preventative
8 measures across whole of government could only be a good
9 thing.

10
11 To the extent that some mechanism was in place that
12 had that effect, do you perceive there to be any real
13 benefit in someone, probably the Ministry of Health, taking
14 a coordinating role in relation to decisions around those
15 funds or at least providing advice and recommendations in
16 relation to decisions around those funds so as to ensure,
17 as best as possible, that the moneys that are being spent
18 on prevention or deployed towards prevention are deployed
19 in a way that gives best bang for buck?

20
21 MS PEARCE: Look, I guess again it would be important if
22 the government, you know, was minded in that way, that
23 there was a role, presumably, for the TCO - and I think
24 health has a strong role in this, I completely agree with
25 that.

26
27 Is it up to health to make decisions for other
28 government agencies in terms of their expenditure?
29 I suspect not. So it would be - the process and the
30 structure around that would need to be carefully considered
31 in order for it to work.

32
33 I mean, we all have component parts of funding for
34 other programs, so this is not something that is completely
35 absent from the world we live in, but, you know, I think
36 that it's fair to say as a secretary responsible for an
37 agency that I would find it difficult if another secretary
38 said, "Now you've got to spend X amount on this because
39 I say so". You need a proper construct around that to make
40 it work.

41
42 MR MUSTON: Perhaps I wasn't clear. It's not quite what
43 I had in mind.

44
45 MS PEARCE: Okay.

46
47 MR MUSTON: You will have seen the proposed recommendation

1 around prevention being identified as a whole of government
2 priority.
3
4 MS PEARCE: Yes.
5
6 MR MUSTON: Against which, say, new policy proposals might
7 be assessed.
8
9 MS PEARCE: Yes.
10
11 THE COMMISSIONER: It's on page 5 of your submission, that
12 the recommendations are set out.
13
14 MS PEARCE: Yes.
15
16 MR MUSTON: To the extent that presumably there are more
17 new policy proposals put forward in any given year than
18 there are new policy proposals accepted and funded,
19 a decision needs to be made about which of them should be
20 funded and which shouldn't.
21
22 MS PEARCE: Yes.
23
24 MR MUSTON: You rightly tell us that that's ultimately
25 a decision for government and not for any particular
26 department. But do you think there's a role for the
27 Ministry of Health, as part of that process, to look at
28 all - let it be assumed that there was such a priority in
29 place - for health to look at all new policy proposals put
30 forward which are said to be supported by this prevention
31 priority and provide advice to government about the way in
32 which - or which of them could, in a coordinated way,
33 produce the best outcome from a prevention point of view.
34
35 MS PEARCE: Yes, I think it's reasonable for health to
36 provide advice, yes.
37
38 MR MUSTON: For example, health knows a whole lot about
39 population health and dynamics which other departments
40 might not know about, and the government might not, without
41 the assistance of health, have an understanding of.
42
43 MS PEARCE: Sure, yes.
44
45 MR D'AMATO: Sorry to interrupt, I just want to add an
46 extra option, perhaps, and this is something that the
47 treasury has already put in place in regards to carbon

1 emission, for instance. Rather than, if you want,
2 identifying an agency responsible for reviewing, that
3 becomes part of the process in describing the policy
4 proposal, for then government to make the decision rather
5 than have that delegated, if you want, to an agency, and
6 I wonder whether an opportunity could be created where this
7 step could be introduced into the preparation of policy
8 proposals.

9
10 They are doing something similar with respect to
11 Aboriginal health and Aboriginal affairs more broadly. So
12 again, I don't want to take health out of the review
13 process, but I do think that there are alternative options
14 to consider.

15
16 MR MUSTON: You were taken to paragraph 5.5 of health's
17 submissions. I don't know whether you have that readily at
18 hand, but it opens with a suggestion that considerable work
19 would be required to do the things that are referred to in
20 the balance of that paragraph. Just in broad terms, what
21 did you have in mind when you referred to the need for
22 considerable work?

23
24 MS PEARCE: Well, I think again it goes back to that
25 recommendation around a preventative health focus for whole
26 of government. I really think that it doesn't imply
27 anything more than it does - it would require work of
28 government to establish such a structure. Certainly not
29 impossible.

30
31 THE COMMISSIONER: And building on work currently under
32 way.

33
34 MS PEARCE: Yes, that's right, Commissioner. You know,
35 there is work that we do in this way already. But if it
36 was to be, you know, if something was to be formally
37 established, the process Alfa has outlined is an
38 alternative, it just requires some work to pull that
39 together. It's not an overnight proposition,
40 notwithstanding the work that we already do together.
41 That's all.

42
43 MR MUSTON: There is no reason why, though, a body of that
44 type couldn't be established with a view to it evolving and
45 developing as time goes on to best produce outcomes that
46 are sought to be achieved through its implementation? We
47 wouldn't need to wait until you had the perfect

1 construction of a body like that before you've put it in
2 place?
3
4 MS PEARCE: No. I mean, obviously it is a matter for the
5 government to determine whether that's the road they want
6 to go down. But certainly, I - no, it doesn't need - you
7 know, we don't need to let perfect get in the way of
8 progress.
9
10 MR MUSTON: The good.
11
12 MS PEARCE: Yes.
13
14 MR MUSTON: Can I ask you to turn to page 11 of your
15 submission, section 6, "Funding health services". Do you
16 see set out there in the second paragraph under the
17 heading, "Counsel assisting's recommendation 4" - there is
18 an articulation, at least in my copy, in blue text of
19 recommendation --
20
21 MS PEARCE: Which paragraph?
22
23 MR MUSTON: Perhaps can we get --
24
25 THE COMMISSIONER: It is section 6 on page 11.
26
27 MR MUSTON: Could we get the NSW Health submission up on
28 the screen, it is [MOH.0010.0758.0001], at page 11.
29
30 MS PEARCE: Okay, sorry, yes, got it.
31
32 MR MUSTON: I might just give you a moment very quickly to
33 read that second paragraph from the top under the heading
34 "Counsel assisting's recommendation 4". Just so we're all
35 on the same page, that's a recommendation which is made in
36 counsel assisting's submissions to which you then respond.
37
38 MS PEARCE: Yes.
39
40 MR MUSTON: I just want to raise one small issue. Concern
41 has been raised by health in its submissions in relation to
42 the use of the word "ensure".
43
44 MS PEARCE: Mmm.
45
46 MR MUSTON: Can I just understand what the concern with
47 that word is?

1
2 MS PEARCE: Did you want to talk about that, Alfa?

3
4 MR D'AMATO: Yes, sure. I think we need to be mindful
5 that ultimately we have a finite budget and to ensure that
6 this is accommodating for the needs of every community is
7 very difficult, and we need to, as we were saying before,
8 make some decisions and use some rational approaches to
9 decide where the priority goes.

10
11 So "ensuring", in my opinion, doesn't take into
12 account that we also need to make sure that these services
13 are provided in an efficient way, because otherwise, it's
14 simply providing funding to meet the costs of delivering
15 and the costs of delivering doesn't imply there is
16 efficient costs of delivering.

17
18 THE COMMISSIONER: I don't take where you've used -
19 sorry, this is addressed to Mr Muston. Where you've used
20 the word "ensure" in your submission, I have not taken it
21 to mean some form of guarantee but, rather, best endeavours
22 to ensure.

23
24 MR MUSTON: Quite.

25
26 THE COMMISSIONER: The word "ensure" appears all the time
27 in the NHRA about ensuring primary care is available to all
28 Australians. I think it is probably meant the same way
29 there, too.

30
31 MS PEARCE: We would prefer "best endeavours", if that's
32 an option.

33
34 MR MUSTON: There would be no dispute with the proposition
35 that the approach to funding should at least have, as its
36 objective --

37
38 MS PEARCE: Yes.

39
40 MR MUSTON: -- the delivery of the health services that
41 the ministry aspires to provide to the people of New South
42 Wales through its planning processes?

43
44 MS PEARCE: We are very firm in our commitment to
45 absolutely doing our best to ensure that the districts and
46 networks within our system have the funding available to
47 them that they need to deliver a service. But I think our

1 submission makes the point that there is a lot of change,
2 there are a lot of variables. Sometimes there are
3 unexpected things. So I think we've reacted to it in the
4 way that, you know, it's not a - it's not perfect and we
5 don't say that it is perfect. Our intent and our
6 endeavour, though, is to do our very best to use the money
7 that we have available to us to ensure that our districts
8 and networks have, you know, the best possible opportunity,
9 is probably the way I would look at it, to deliver the care
10 that they need to for the community.

11
12 THE COMMISSIONER: Can I ask you a question related to
13 that, then. Would I be right, then, in making the
14 assumption that the goal of NSW Health is, within what its
15 responsibilities are in relation to the provision of
16 healthcare service, to provide a system that equates to
17 universal healthcare coverage?

18
19 MS PEARCE: Yes, I mean, look, our objectives, I think,
20 are fairly clear in the provision of services across the
21 community. I mean, they're well spelled out in service
22 agreements and so on every year. But we do our part in the
23 provision of universal health care in the state. Certainly
24 we do.

25
26 THE COMMISSIONER: Having got agreement to that, I will
27 put the question in a slightly expansive form. It seems to
28 me that a combination of the Health Services Act, the NHRA,
29 Medicare, which is obviously the Commonwealth, and the way
30 the New South Wales health system is set up, that the
31 entirety of that is aimed at universal healthcare
32 coverage - do you agree with that?

33
34 MS PEARCE: Yes. Yes. You know, obviously people can
35 enter our system under those principles and get the care
36 that they need.

37
38 MR D'AMATO: Can I just add, in terms of the "ensure",
39 I think that perhaps it is the connection to "sufficiently
40 resourced" that creates a bit of a concern, in that
41 "sufficiently" implies there is no measure to determine
42 efficiency. So in that, I presume that using an approach
43 where we have a state efficient price, we could argue they
44 are sufficiently funded if we used that as a measure.

45
46 THE COMMISSIONER: Are you at 6.3 of your submission?
47

1 MR D'AMATO: I'm just referring to the statement in -
2 sorry, in the --

3
4 MS PEARCE: It's counsel assisting's recommendation 4,
5 Commissioner.

6
7 THE COMMISSIONER: It's just that in 6.3 the submission is
8 made:

9
10 *... no funding model can ever "ensure"*
11 *adequate resourcing for [LHDs] ...*

12
13 I thought that might have been the point you were --

14
15 MR D'AMATO: And I guess I want to connect the comment we
16 make is referring to the fact that "ensure sufficient
17 funding", so I guess the point is going back to the
18 efficiency element that we use a state efficient price. So
19 if we use that, you will see there will be variability
20 across the state, as you would expect, but it doesn't mean
21 that they are not sufficiently funded.

22
23 THE COMMISSIONER: No, but the funding model may not be
24 able to ensure adequate resourcing, but if you had a proper
25 planning process, including a proper planning process or
26 a comprehensive planning process for workforce as well,
27 then through that process you could ensure there's adequate
28 resourcing.

29
30 MR D'AMATO: And I agree with you, and in fact I think
31 that we probably need to explain that when we talk about
32 the funding model, we need to recognise the funding model
33 is a framework. It's just an enabler. It's not the
34 aim to - the aim, obviously, is to support the goal or the
35 strategy, the strategic intention, but that's the purpose
36 of the funding model. So I agree with you in that the
37 planning side is the part that really drives a decision and
38 the funding model just enables those decisions.

39
40 THE COMMISSIONER: In corroboration of what you have just
41 said, other witnesses have said the same thing to us.
42 I think Professor Wilson, in his evidence, said something
43 like - which may appear in counsel assisting's submission -
44 that funding shouldn't be wagging the dog or services; you
45 need to work out what the services are that are needed
46 first and also then have the comprehensive workforce
47 planning, and workforce shouldn't drive the services

1 either, and that what are the best funding models are after
2 that process.

3

4 MS PEARCE: We completely agree with that view,
5 Commissioner. I think the one thing I would add to that,
6 though, is that they should also have the capacity to
7 articulate what is not required, and that is where we are
8 very challenged at times, because divestment as opposed to
9 investment --

10

11 THE COMMISSIONER: That gets back to the political problem
12 we were talking about before.

13

14 MS PEARCE: There is a circular issue there.

15

16 MR MUSTON: I will come back to that very shortly but do
17 I understand the point that you're essentially seeking to
18 make or one of the points you're seeking to make around the
19 use of the word "ensure", that health service and the
20 delivery of health care is in and of itself a dynamic
21 process?

22

23 MS PEARCE: Yes.

24

25 MR D'AMATO: Yes.

26

27 MR MUSTON: As a result of which whatever funding models
28 or collection of funding approaches are adopted, they need
29 to be constantly monitored?

30

31 MR D'AMATO: Correct.

32

33 MR MUSTON: And they, too, need to be dynamic, such that
34 they are able to be adjusted as required when circumstances
35 change, which render them inappropriate?

36

37 MR D'AMATO: Yes.

38

39 MS PEARCE: Well, Mr D'Amato will have a more precise view
40 of this. There needs to be flexibility. I think that's
41 clear. But I think the other thing that is very clear to
42 us is that you also can't be in a position where you are
43 chopping and changing your funding model on a whim, when
44 you have a finite budget, as we do, if you do that - and
45 we've done these exercises before - there are big winners
46 and there are big losers in terms of how those
47 methodologies play out, and that is where things become

1 incredibly difficult.

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So, for example, when ABF was introduced into the state - as I'm sure you have heard - transition grants were put in place to keep the system safe and operating, because some districts did less well out of that funding methodology than others, and what was, I think, intended to be a temporary arrangement lasted for a long time while that washed through.

THE COMMISSIONER: I said I would give people a break at 11. It's 7 past. First of all, how are you going for time? Do you think you are on track?

MR MUSTON: I think we are. I can probably move on --

THE COMMISSIONER: Do you want to finish a point?

MR MUSTON: Just a couple of questions, before we --

THE COMMISSIONER: Yes, go ahead.

MR MUSTON: Could I ask you to go to paragraph 6.5 of your submissions, which I think is serendipitously up on the screen. I want to ask you, Mr D'Amato quickly, in relation to 6.5(a), these, as I understand it, are some of the issues which change and are dynamic in a way that might make it difficult to ensure in the sense of guarantee that services will be funded, but can I ask you in relation to 6.5(a), my understanding of the evidence that you gave at an earlier time was that the base figure of the health budget is adjusted before growth so as to take into account things like increased payments required under changes to awards and the like. Have I misunderstood that evidence?

MR D'AMATO: No, that is correct. It is still the case, and noting that that probably was a bit challenging during the COVID period, we are entering now this new process with treasury and that is the case.

The wages increases agreed by government are funded through government, yes.

MR MUSTON: So to the extent that that's a change that might result in an increase in the cost of delivering health care, that will come logically with an increase in the base?

1
2 MR D'AMATO: Yes, to the degree that there is enough base.
3 So when, at times, we need to access workforce outside, if
4 you want, the standard approach, and that will be premium
5 labour, agency, locum costs, they will not be accommodated,
6 because it's subject to first the market forces, so the
7 price will be determined by the demand and supply; and,
8 second, might not follow the same regime that increases
9 have been agreed with the government.

10
11 MR MUSTON: Mr Minns?

12
13 MR MINNS: Certainly during COVID, agency costs did
14 spiral. We've done some work in the last 18 months
15 particularly with the nursing agency framework to try and
16 get those costs back to a reasonable position, but I think
17 what (a) is referring to is that there were some factors
18 that were seeing price escalation that weren't actually
19 funded through treasury.

20
21 MR D'AMATO: That's right.

22
23 MR MINNS: But it essentially related to premium or
24 contingent labour.

25
26 THE COMMISSIONER: Can I just ask a question about the
27 paragraph before - that is, paragraph 6.4 - where the point
28 is made that even if you do service planning, at
29 a particular date or point in time, in a system as large
30 and complex as the New South Wales public health system,
31 these variables will constantly change. Do you see that?

32
33 MS PEARCE: Mmm-hmm.

34
35 THE COMMISSIONER: I'm not suggesting this is the case
36 here. Sometimes there's a disconnect between how the
37 lawyers draft a submission and what the client actually
38 truly thinks. I'm just wondering if that's not potentially
39 overstating what the constant change might be in terms of
40 planning. The reason being is that I think, on the
41 evidence we've received, it's fairly well established and
42 constant that there are populations with high rates of
43 chronic disease, high rates of obesity; we have an ageing
44 problem - sorry, an ageing population and all of our
45 populations need access to adequate and timely primary care
46 and aged care.

47

1 Those things aren't in constant change; they're
2 problems that are going to need to be addressed not just
3 today but in five years and probably 10 years.
4

5 To the extent that this says there's constant change,
6 that doesn't change the fact that those problems I just
7 mentioned are ones that you're going to be grappling with
8 not just today but for the foreseeable future and probably
9 the long term, do you agree with that?
10

11 MS PEARCE: Yes, I do agree with that.
12

13 MR MUSTON: I note the time.
14

15 THE COMMISSIONER: All right. Is 15 minutes okay? We'll
16 come back at 11.27.
17

18 **SHORT ADJOURNMENT.**
19

20 THE COMMISSIONER: Yes, when you are ready.
21

22 MR MUSTON: While we are on paragraph 6.5 of the health
23 submissions, we note those two items at 6.57(b) and (c)
24 which essentially raise issues that we've already discussed
25 this morning, but I will ask, just in case you are able to
26 come up with an answer, is there anything you think could
27 be done to overcome some of those challenges systemically?
28 Maybe take it in two steps: (b) and (c) I presume to
29 implicitly refer to decisions which are required to be made
30 which do not necessarily reflect the decisions which would
31 be made by the ministry in terms of disinvestment in
32 services or the delivery of new infrastructure.
33

34 THE COMMISSIONER: (c), the government can do what it
35 wants, I think, is the --
36

37 MR MUSTON: Of course. Of course. But is the point that
38 there are decisions often made, occasionally, made by
39 government which do not necessarily align with the
40 decisions which the ministry, in its informed way, would
41 have made?
42

43 MR MINNS: Given we're not the decision-maker, that
44 dilemma doesn't arise. We offer the advice that is sought
45 and then government will make the policy decision.
46

47 To your point is there anything systemically possible,

1 when I was working in defence there was a reference to the
2 inability to be able to close bases, some of which were
3 costing way more than they were producing value, because of
4 asbestos management, et cetera. Now, that invariably ran
5 up against an electorate kind of issue, and there was
6 a reference made to the fact that the US had some kind of
7 I think it was a senate committee, the point of which was
8 to try to find a way to get these decisions made about
9 defence locations in a public, objective, transparent way
10 that then didn't just become hostage to local politics.

11

12 I don't know how successful that arrangement is in the
13 USA. I just know that it was offered as a suggestion and
14 wasn't taken up in the 2009 White Paper by the then
15 government.

16

17 MR MUSTON: So translating that into the health space, if
18 there was a way of, in the ideal world, bringing about
19 a bipartisan consensus on issues like disinvestment in
20 services or infrastructure projects, new builds, that would
21 presumably reduce some of the challenges that are
22 identified in paragraphs 6.5(b) and (c)?

23

24 MR MINNS: In theory, possibly. I don't hold a lot of
25 hope in practice.

26

27 THE COMMISSIONER: Moruya Hospital.

28

29 MR MUSTON: I'll move on. The ministry and local health
30 districts are currently conducting health service planning,
31 I presume.

32

33 MS PEARCE: Yes.

34

35 MR D'AMATO: Yes.

36

37 MR MUSTON: And that planning is in, at least some ways,
38 currently informed by what are perceived to be the
39 population health needs.

40

41 MS PEARCE: They are informed by that, yes.

42

43 MR MUSTON: Communities.

44

45 MS PEARCE: Yes.

46

47 MR MUSTON: Always more work to be done in that area in

1 terms of identifying what those community health needs are,
2 but to the extent they have been identified, planning is
3 seeking to take them into account.

4
5 MS PEARCE: Yes.

6
7 MR MUSTON: Are decisions on resource allocation being
8 guided by that existing planning process?

9
10 MS PEARCE: Resource allocation in the form of?

11
12 MR MUSTON: Distribution of resources to local health
13 districts and within local health districts to different
14 facilities and services? I'm assuming that they would be,
15 but --

16
17 MS PEARCE: I think - I mean, look, Alfa would be able to
18 provide more specific comments here but there is clearly an
19 interplay in terms of the planning assumptions based - you
20 know, the demographics of any given community, the health
21 needs of that community, there is an interplay between
22 those things and the current funding model, including, of
23 course, population growth. But, Alfa, would you like to --

24
25 MR D'AMATO: Yes, sure. In terms of the role of planning
26 in the current, or what has been over the last probably
27 10 years, funding regime has been more in regards to new
28 facilities, because it has been used to address and
29 identify the future pipeline, or new builds, and where the
30 demand was already coming in or projected, and that's how
31 it has been incorporated into our funding model.

32
33 Definitely there is more that we need to do in terms
34 of utilising that information to start thinking, projecting
35 again over the forwards, and the reason why I'm saying that
36 is that obviously during COVID, that wasn't really
37 a priority, in that we really focused on addressing and
38 responding to the COVID realities. But since then, as we
39 discussed, we are working with treasury in regards to
40 making sure the forwards are accurate and reflect the
41 demand pressure, and also internally that we are
42 rebalancing, with a blended approach, that funding model.

43
44 MR MUSTON: Is the distribution of growth funding
45 currently informed by population health considerations?

46
47 MR D'AMATO: Indeed. It's predominantly determined by

1 population growth, if you want, unlike taking into account
2 actual activity.

3
4 One of the reasons why we've done that is because we
5 wanted to remove, if you want, the risk of, or mitigate the
6 risk of, an unintended consequence of ABF, in that do more
7 to get more. Instead, with purchasing, our purchasing
8 approach has always been weighted more in regards to where
9 the population growth is effectively happening, and has
10 also been weighted for ageing sake, so we take into account
11 also population changes.

12
13 MR MUSTON: Could I ask you to go to paragraph 6.8 of the
14 health submissions on page 13. Do you see set out there in
15 6.8 and continuing over the page is a proposed
16 reformulation or rewording of recommendation 4 in
17 particular?

18
19 MR D'AMATO: Yes.

20
21 MR MUSTON: In light of the matters that we've just run
22 through, could you assist us to understand how the proposed
23 reworded version of recommendation 4 amounts to any change?

24
25 MR D'AMATO: Yes. So in terms of the role of the health
26 service planning, informed by population health needs, to
27 guide the discussion on resource allocation, I feel that in
28 the past, the planning has informed the resource allocation
29 from the new builds only, versus us taking a good look at
30 the projection over multiple years, because this is the
31 challenge we have had: in terms of the purchasing, it is
32 a 12-month cycle, and what I'm advocating for is that we
33 need to take a longer term - a longer horizon in regards to
34 the population growth that can kind of allow us then to
35 better plan, and so it's a bit of a dynamic process between
36 the planning and the purchasing and the forward resource
37 allocation to inform, then, the distribution of growth.

38
39 I think to that extent, if I can add, in terms of the
40 preventative activities, that's where we also need to
41 create a better feedback into - the population growth
42 should not be taken into as a linear, but we should take
43 into account if there are investments in prevention
44 activities, how this could actually moderate or mitigate
45 some of the spikes in the demand growth and therefore see
46 where there is a better balance of distributing resources.

47

1 I acknowledge that in theory it makes sense, but I do
2 think that perhaps if we apply this over a medium term
3 horizon, say a four-year period, it could actually give us
4 more funding certainty and again, you know, give us an
5 opportunity to focus on outcomes, not only outputs.
6

7 THE COMMISSIONER: Can I ask you, I think it's related to
8 this, but in 6.7, the submission says:

9
10 *Although NSW Health would aspire to*
11 *undertake the ... planning ... as quickly*
12 *as reasonably possible, the practical*
13 *reality may be that even a carefully*
14 *reformulated funding model devised to*
15 *resource delivery of that system at that*
16 *point in time rapidly faces resource*
17 *constraints.*

18
19 What should I understand by "rapidly faces resource
20 constraints" to mean?

21
22 MR D'AMATO: I feel that it is fair to say we are stepping
23 out of COVID in that, you know, we're still - and as
24 I mentioned before in my previous statements - we are still
25 identifying what the new base is. What we know is there is
26 still a fair bit of pressure in the system, and what I mean
27 by that is budget pressure at the district level.
28

29 THE COMMISSIONER: This is the constrained financial
30 environment point, is it, or is it more than that?
31

32 MR D'AMATO: No, I think that - look, I'm trying to be
33 positive in that we see some of the numbers, if you want,
34 in the cost of goods and services coming down, so I feel
35 that we are over the peak, so that means before we step in
36 and say, "Okay, this is the base", or "This is where we
37 think the starting point should be", we need to make sure
38 that we are carefully reformulating the funding formula to
39 make sure that we know where we start so that we can
40 then --
41

42 THE COMMISSIONER: So the "rapidly faces resource
43 constraints" might mean that costs just keep going up, is
44 it, or more than that?
45

46 MR D'AMATO: Yes, but I also need to state that in certain
47 items, yes, but other items, actually, it is coming down.

1 So again, it's a bit of a balancing. Looking at the
2 financial statement from last year, our goods and services
3 spend compared to the year before is 100 million less.

4
5 MR MUSTON: Can I just move quickly to another topic,
6 patient transport.

7
8 THE COMMISSIONER: Just before you do that, can I ask
9 a question about the budgets.

10
11 MR MUSTON: Please do.

12
13 THE COMMISSIONER: Can we get - it is the joint statement
14 of Mr Daly, Mr Portelli and Ms Smith, [MOH.0011.0089.0001].
15 If we can go to page 0003, the heading "Service agreement
16 activity projections and assessment". I'll ask you this,
17 Mr D'Amato, but please, Ms Pearce or Mr Minns, feel free to
18 say anything if you like as well.

19
20 This part of the statement I don't fully understand,
21 and it comes up in this context: counsel assisting have
22 made a submission that what is called the equity adjuster
23 is a bit opaque, and there has been some criticism about
24 the use of that word.

25
26 The reason this came up is that more than one chief
27 executive and LHD and more than one board member - and by
28 "board member" I mean an intelligent, engaged member of LHD
29 boards - expressed the opinion to me that they didn't
30 really understand how the budgets are set.

31
32 Can I just ask you some questions, if you can answer
33 them, about paragraph 13, and help me understand parts of
34 it. About halfway down paragraph 13, it says:

35
36 *Where a population is consuming fewer*
37 *health resources than the average,*
38 *additional activity based funding is*
39 *normally allocated to the relevant LHD.*

40
41 Can you tell me why, for populations consuming fewer health
42 resources, that additional activity is allocated? Why is
43 that?

44
45 MR D'AMATO: So, first of all, I just wanted to mention
46 that the health needs index is, effectively - this formula
47 around the equity is effectively - is the last element or

1 RDF that is contained into our purchasing. The formula
2 basically identifies where some population groups are not
3 accessing the health services, and therefore to create an
4 incentive for the health service to provide more services
5 above the estimated trend, and again above what the
6 population growth and the ageing is taking into account, we
7 actually increase the targets, therefore providing more
8 resources. So this tends to equate to amounts between,
9 say, 5 to 10 million, in certain cases, and also depending
10 on the size of the envelope available.

11
12 So, for instance, before COVID, I recall that certain
13 in budget cycles there were around 13 million added to what
14 otherwise would have been the growth that we were
15 purchasing from a district, specifically to provide
16 additional resources to address these gaps.

17
18 THE COMMISSIONER: All right. Can I ask you, the word
19 "normally" appears. Does that mean additional activity
20 based funding isn't always allocated if a population is
21 consuming fewer resources? It's not inevitable, there's
22 some sort of decision-making process, is there?

23
24 MR D'AMATO: This is effectively - and I think there is
25 a formula on the same statement, further down on 24. So
26 what this suggests is that if we - there you go, that's it.
27 The diagram shows how the formula works. This is applied
28 not to the budget, but to the NWAUs. So assume
29 a particular district is delivering 1 million NWAU, being
30 the base, then on top of that we add what we expect to see
31 in the ageing population growth - so again, taking into
32 account ABS statistics and determining that in a particular
33 catchment area, the population is growing 2 per cent, we
34 would assume that therefore the NWAU activity should grow
35 by 2 per cent.

36
37 Then on that there is an adjustment, and as you can
38 see, it's plus or minus, depending on the values. So, for
39 instance, for unplanned readmissions there is an assumption
40 that the demand should come down, therefore, they should
41 target the unplanned readmissions, because there are NWAUs
42 values attached to it. Same with potential preventable
43 hospitalisation, and this is targeted via a group of DRGs.
44 Then you can see towards the end it illustrates the
45 telehealth use is where we say we want to encourage this,
46 therefore, we would allow more growth, even though it is
47 not captured into historical trends and is not related to

1 population and ageing, so it's a specific adjustment, and
2 finally is the mental health.

3
4 Other factors to consider are then including
5 commissioning on new hospitals and the like.

6
7 So effectively, the equity adjustment is a boost, if
8 you want, to the NWAU, so that determines additional
9 activity that we should purchase from certain areas.

10
11 THE COMMISSIONER: What do I take, then, paragraph 14 to
12 mean, when it tells me that the equity adjuster aims to
13 estimate whether residents of some LHDs are consuming less
14 than other LHDs when taking into account their demographics
15 but it is not designed to suggest an ideal level of
16 consumption. What should I take that to mean?

17
18 MR D'AMATO: That's a good question. I think what we're
19 trying to explain in here is there is an estimate, in that
20 there's not a precise science, because obviously we're
21 taking into account the socioeconomic factors, we're taking
22 into account all other indicators included into this
23 formula to determine that the utilisation, compared to
24 other areas, is lower.

25
26 So the idea there is to provide additional funding for
27 the districts to then deploy towards either increased
28 services, targeting this population, or to determine
29 whether there could be prevention activities they could do.

30
31 Admittedly, this has been done through NWAUs,
32 therefore I feel that the comments that have been made
33 throughout the Inquiry reflect more the complexity of where
34 this is applied rather than the reality or whether it is
35 sufficient or not.

36
37 MR MUSTON: Can I ask a question about that.

38
39 THE COMMISSIONER: You can.

40
41 MR MUSTON: Just so I understand it, the way in which this
42 adjuster operates is to make an assessment based on some
43 population information about the anticipated use of the
44 hospital services; to the extent that the current use does
45 not align with that estimate, an additional amount of
46 activity is included in a local health district's budget.

- 1 MR D'AMATO: That's correct.
2
- 3 MR MUSTON: The local health district needs to deliver
4 that activity as part of its service level agreement.
5
- 6 MR D'AMATO: Yes, that's correct.
7
- 8 MR MUSTON: And if it delivers that activity, or it sells
9 to the ministry that activity and the ministry purchases
10 it, the additional funding flows in that way.
11
- 12 MR D'AMATO: Yes. Fundamentally, that's correct.
13
- 14 MR MUSTON: Does that take into account in any way the
15 proposition that, for some population segments, delivering
16 activity is more expensive - for example, to deliver
17 activity to a member of the community who does not speak
18 English can take longer and cost more than delivering the
19 same item of activity to a member of the community who is
20 health literate and has English as their first language?
21
- 22 MR D'AMATO: Look, it takes into account the typical
23 average complexity or the activity delivered from the
24 particular district, because ultimately when we apply these
25 increases on an average NWAU, if you want, so if the
26 particular district includes some specialist services and
27 therefore their weighting, if you want, is higher than
28 other services, we will add 2 per cent more, and therefore
29 there is a degree of complexity captured into that.
30
- 31 MR MUSTON: But if the particular community served by
32 a local health district has a much higher proportion of its
33 population which fits into that category of people for whom
34 it is more expensive to deliver care, increasing the amount
35 of care that is delivered doesn't take that into account,
36 does it?
37
- 38 MR D'AMATO: But you could argue that way. I would also
39 argue that, at times when we purchase additional activity
40 in settings that are more mature, if you want, where the
41 incremental cost might not actually consume the full extra
42 state price that we pay, the activity, it could be the
43 other way. So I think we also need to contemplate the fact
44 that an ABF environment is, you know, on an average
45 environment.
46
- 47 MR MUSTON: But that depends very much on the population

1 in question. If they are lucky enough to have a lot of
2 their population that sit on the right side of the average,
3 and a small proportion that sit on the wrong side of the
4 average, then they will be well funded to deliver the
5 activity which is being purchased in the ideal world.
6

7 MR D'AMATO: That's exactly right. That's the theory
8 part. Then there is the practicality and the reality and
9 the reality is that we don't fund the districts at an
10 average price, either, in that there will - as you would
11 expect, there would be variability at the district level
12 and that's where we introduce transition grants, or what we
13 call now cost price adjustments, to acknowledge that it's
14 unlikely that everyone is going to operate at the price in
15 the base, and where we actually use the state efficient
16 price is to provide funding for new activity, and therefore
17 I would argue that there is a bit of a swings and
18 roundabouts in regards to whether we are purchasing
19 everything at one price or that we're purchasing some
20 services at the marginal rate and others probably actually
21 are more expensive than the state efficient price.
22

23 MR MUSTON: To the extent that the adjustments are being
24 made in that way through transition grants and did you say
25 cost price adjustment?
26

27 MR D'AMATO: Yes, that's correct.
28

29 MR MUSTON: Is there any articulation of that as
30 a formula or a particular approach that, for example,
31 members of - or chief executives, board members, members of
32 the community can actually look at and understand how those
33 adjustments are being quantified?
34

35 MR D'AMATO: So there are a number of public documents,
36 and we adopted the national consistent and standard
37 activity based funding approach, so that is all documented
38 on the IHACPA website. Internally, we also have additional
39 resources, one in particular is what we call the ABM
40 compendium that goes through the details in regards to what
41 is the construct of these adjustments, the construct of the
42 state efficient price and how we then use that to set the
43 budgets.
44

45 But I acknowledge that, and as I mentioned previously,
46 the formula effectively has grown a little bit out of, you
47 know - over the recent years and it is complex, and I would

1 argue the RDF had the same situation, in that it grew from
2 something that was simple to understand, and CEs, boards
3 were able to understand what was included, and as we keep
4 adjusting around the edges, it becomes a little bit too
5 complex.
6

7 I feel that one part that I would advocate for, and
8 what we did also with the National Health Reform Agreement,
9 is there have to be regular reviews, regular intervals, say
10 a five-year, four-year period, where these funding models
11 need to be reassessed so that we don't just keep adding.
12

13 THE COMMISSIONER: Can I just ask one final point of
14 clarification. What should I understand to be - in
15 paragraph 15(c), so if we drop down on page 4, it says:
16

17 *Reallocation of base funding based on*
18 *population need does not factor in*
19 *geography and how people live their lives.*
20

21 What is the full scope of what I should understand by "how
22 people live their lives"?

23
24 MR D'AMATO: Hang on a second. Which is this?
25

26 THE COMMISSIONER: 15(c), on page 4 of the statement. Do
27 you see it starts with "Reallocation of base funding"?
28

29 MR D'AMATO: Yes.
30

31 THE COMMISSIONER: What should I understand to be the
32 meaning of "how people live their lives"? What's included
33 in that?
34

35 MR D'AMATO: Okay, so there are a couple of things there.
36 One part is in relation to the ABF being a provider base,
37 in that we fund where the services are provided, unlike
38 a population base approach where we pay where the
39 population lives, and that also leads to complexity where
40 we need to take into account more beds at the end of the
41 year, where certain patients, say they are from Dubbo and
42 they get treated at RPA, at the end of the year, when we
43 used to have an RDF environment we had to have to move
44 money around, and that creates complexity that could be
45 avoided through an ABF approach, where we pay services at
46 the RPA independently of whether these services are
47 provided for someone from other areas.

1
2 In regards to, then, whether there is - "the transfer
3 of patients" - so that's the inter-hospital transfers, yes,
4 that is an area that we need to unpack. And we started,
5 actually, that process already with the small hospitals,
6 because that also affects small facilities, and that is an
7 area that we also advocated for at the national level
8 through our submissions in response to the national
9 efficient price determination.

10
11 It is not an easy area to address, but I do think that
12 there's more that we can do. One of the reasons why it's
13 difficult to address is because at times, it's difficult to
14 predict the amount, you know, because ultimately we have
15 ambulances that can provide these services, patient
16 transport services, which tend to be less costly than the
17 ambulance, and then there is fixed wings. So taking all
18 this into consideration, for us to provide budget to
19 a hospital, because we know they may do fixed-wing transfer
20 based on historical trends, leaves us then with no
21 opportunity to move the budget around if, for instance,
22 that particular hospital didn't have to have transport that
23 year.

24
25 So normally the LHDs, what they do, they keep the
26 budget centrally and deploy where it is then consumed, and
27 therefore from the ministry's point of view it is more
28 a concept of how do we ensure there is sufficient
29 flexibility, if you want, in the price, in the base
30 allocation, to accommodate for some of these extra costs?
31 And the other part to consider is often, when they exceed,
32 if you want, the historical cost in transportation, they do
33 approach us and we try to address whether we can support
34 them or not, if that makes sense.

35
36 MS PEARCE: I think if I could just add one further
37 comment, I guess, to the theme of this, I do think there is
38 an opportunity for us to create environments for better
39 understanding of the health funding model, whatever it is -
40 you know, whatever it is. I do think that our funding
41 model is - and indeed the allocation of budgets are -
42 poorly understood by many people across the health system,
43 and so that's a responsibility that we will take on in
44 respect of how we can improve on that.

45
46 I know some of our chief executives are already
47 running sessions for clinicians and others to give them

1 a better insight. There's a lot of historical thinking
2 in health in regard to the way things were 20 years ago,
3 25 years ago, that people assume are still the case now,
4 and I visit the districts quite a lot and I will have it
5 put to me, you know, "Why haven't we had any budget
6 growth?" Well, those questions are quite easy to answer,
7 to be honest.

8
9 THE COMMISSIONER: So what I'll take from what you just
10 said is that, obviously, if people either don't care or
11 aren't engaged, if they don't understand the budget, that's
12 one thing, but the evidence that I've taken is that the
13 chief executives, the board members we've spoken, the
14 clinicians we've spoken to are engaged and do want to know,
15 and the best practice would be that they have a really good
16 understanding of how the budgets are put together.

17
18 MS PEARCE: Yes, and look, I think that there are degrees
19 of that as well. I mean, there is a huge amount of
20 technical detail --

21
22 THE COMMISSIONER: Of course.

23
24 MS PEARCE: -- you know, that Alfa and his team are
25 engaged in all of the time. But I think fundamentally -
26 and we've had representations in the past for our
27 colleagues in Western Sydney, for example, around health
28 needs, literacy and non-English speaking backgrounds and
29 the like. We understand those issues. But I do think that
30 there is an opportunity for us, for people who are actively
31 engaged, to do a better job of explaining how these things
32 are put together.

33
34 THE COMMISSIONER: Sure.

35
36 MR MUSTON: In the context of a devolved system it's
37 critically important, isn't it, that the people who are out
38 there in the network or at the coalface have an
39 understanding of the funding model and what it's seeking to
40 achieve so that they can provide feedback as to whether or
41 not it's actually working?

42
43 MS PEARCE: Yes, and I think whilst, you know, I've been
44 clear about what I see as our responsibility, I think that,
45 you know, people also have a responsibility to keep
46 themselves abreast of those things.

47

1 People will have different views about how it should
2 be. We accept that. None of us would sit here and say
3 that our arrangements are perfect at all. But there is an
4 opportunity, and I think, look, the population growth
5 element of our funding model is substantial in respect of
6 growth, and I think that that even - even that element is
7 often quite poorly understood. It's some things that are
8 relatively straightforward.

9
10 So, you know, we've had representations in the past
11 from members of various districts that will take a view
12 that they have been historically - you know, not had the
13 funding that they would have liked to have seen. We then
14 can produce information to say, "Look, you've had
15 substantial budget growth in that period". So it's not
16 just incumbent upon the ministry, I think it's incumbent
17 upon the system right the way through to be able to explain
18 this with some clarity without getting, you know, sort of
19 bogged down in the technical aspects of the information.
20 So there is a balance to be had there.

21
22 MR MUSTON: A key part of that balance is through the
23 system an understanding of how it works and what it is
24 intending to achieve so that it can be constantly monitored
25 and assessed as to whether or not it is achieving those
26 objectives.

27
28 MR D'AMATO: I think that's part of the work that we are
29 really starting in regards to our service agreements for
30 next year and we're starting the consultation process with
31 CEs and relevant stakeholders.

32
33 MR MUSTON: I want to come briefly to the issue of patient
34 transport, if we can move on. In a state as large as
35 New South Wales and with the hospital system that it has,
36 it's inevitable that there will be a wide range of clinics,
37 procedures and other services which are only able to be
38 delivered at larger facilities, whether that be larger
39 facilities in the regional areas or, in some cases, only in
40 metropolitan areas - that's the reality, isn't it?

41
42 MS PEARCE: Yes.

43
44 MR D'AMATO: Yes.

45
46 MR MUSTON: Part of the rationing decisions that we've
47 talked about already involve difficult decisions which need

1 to be made by the health system as to where certain
2 procedures and clinics are to be made available and where
3 they can't, in a sensible or economically viable way, be
4 made available. Would that be right?

5
6 MS PEARCE: Yes, and also relying on, obviously there's,
7 you know, the workforce elements, but patient safety is
8 a prevailing consideration in those decisions as well.

9
10 MR MUSTON: It's an important part of the evolving nature
11 of health care in Australia and around the world that where
12 once you could get all manner of procedures done in your
13 small cottage hospital in a rural and regional area,
14 nowadays that's just not, in many cases, a practical
15 reality, having regard to the need to ensure patient safety
16 and deal with the workforce challenges that exist?

17
18 MS PEARCE: Look, I think we've done a lot of work over
19 time with respect to low-volume procedures that were being
20 performed sporadically. There is a patient safety element
21 to that. What I would say to you is that I started working
22 in Broken Hill as a registered nurse in 1991, it has always
23 been the case, in my experience in health, that it was
24 required of us to transfer patients to larger centres for
25 care. This is not a new concept. And in that case - and
26 I was there for 10 years - it was to Adelaide in most
27 circumstances for high level treatment and care. We had
28 visiting medical officers from Adelaide who would come to
29 Broken Hill to provide clinics and care to our patients.

30
31 What we've gotten better at in the 30-plus years since
32 that time is our virtual modalities, our ability to connect
33 our health system in a way that wasn't available to us
34 before. So there are elements of that that need to be
35 factored in to this thinking, because it's not all just
36 about moving patients from point A to point B.

37
38 A very good example of that - and I think you may have
39 seen this at some point - was the vRGS in Dubbo, you know,
40 what that has enabled for Western New South Wales - and we
41 hope beyond - is for some patients, staying where they are
42 and being cared for via that medium is every bit as
43 sensible, safe and effective, less disruptive for the
44 patient and their family, and, you know, obviously as
45 a lower level consideration I would say to you more cost
46 effective for the health system.

1 So I think there are things that exist now that
2 certainly didn't exist when I was a girl, and I'm happy to
3 say that, you know, we have come a long way. We need to
4 continue to strive for improvement in this regard, but,
5 yes, it's a very different system to what it was.
6

7 MR MUSTON: Accepting that improvements of that type have
8 been made and no doubt will continue to be made, there
9 remains a need to move patients physically around the state
10 from time to time --
11

12 MS PEARCE: Yes.
13

14 MR MUSTON: -- to enable them to access care in the
15 centres where that care is provided.
16

17 MS PEARCE: Yes.
18

19 MR MUSTON: I think there's a range - we've heard evidence
20 of a wide range of different patient transport options that
21 exist across the state, something of a patchwork of patient
22 transport options. Would that be a --
23

24 MS PEARCE: There are a number of transport options.
25

26 MR MUSTON: Within the metro areas you have HealthShare's
27 patient transport service, and in outer metropolitan areas,
28 and then out in the regions, LHDs run their own patient
29 transport services; is that correct?
30

31 MS PEARCE: In many cases. I mean, I think HealthShare's
32 services are expanding.
33

34 MR D'AMATO: That's right.
35

36 MS PEARCE: But it's been a - it's certainly been a work
37 in progress.
38

39 MR MUSTON: To some extent patient transport is conducted
40 by ambulance in some regional areas.
41

42 MR D'AMATO: In some, yes.
43

44 MS PEARCE: In some, yes.
45

46 MR MUSTON: And then there is the isolated patients travel
47 and accommodation assistance scheme, about which we've

1 heard a lot of evidence.

2

3 MS PEARCE: Yes.

4

5 MR MUSTON: Just dealing with that last item, whilst that
6 provides some reimbursement for travel and accommodation
7 costs associated with receiving health care at locations
8 remote from your home, the evidence seems to suggest that
9 it doesn't adequately cover the costs to the extent that
10 there is a shortfall, ordinarily, between your IPTAAS
11 payment and the cost that is actually incurred by a patient
12 in travelling to and, if necessary, accommodating
13 themselves at a remote location to receive care. Would
14 that generally be consistent with your understanding of the
15 way that system works?

16

17 MR D'AMATO: Well, the system works on certain rates that
18 have been adjusted not long ago. Obviously that doesn't
19 take into account that there's core CPI changes that may
20 impact, for instance, the petrol, you know, and the
21 distance and the like. I do think that we also need to
22 acknowledge at the moment that system is not means tested,
23 either, so it's available to everyone.

24

25 But in saying that, I think we have had a significant
26 boost into the funding for that program, and obviously that
27 is subject to also budget deliberations that we are
28 currently talking to treasury about.

29

30 MR MUSTON: In relation to that scheme, am I right in my
31 understanding that it's also a reimbursement scheme - that
32 is to say, you arrange your travel and accommodation and
33 then, after the event, you are entitled to be reimbursed
34 whatever funds the scheme provides for the cost that you
35 have actually already incurred in connection with that
36 travel and accommodation?

37

38 MR D'AMATO: That's my understanding, that it is
39 coordinated centrally so that we try to streamline the
40 process as well.

41

42 MS PEARCE: A lot of work went into streamlining it and
43 improving access to it and awareness of it with the
44 additional funding that we received for IPTAAS, yes.

45

46 MR MUSTON: We've received evidence that suggests
47 notwithstanding the existence of all of those different

1 options there remain significant accessibility issues for
2 at least a cohort of patients in rural and remote areas.
3 Do you accept that that's - at the moment at least, that
4 remains the reality?

5
6 MS PEARCE: I think access to care for people in rural and
7 remote locations is a key area of focus for us. You know,
8 you've no doubt heard from us and from others that we've
9 substantially strengthened our role with the creation of
10 the regional health division, which, amongst other things,
11 is very focused on what those connections to care look like
12 and, you know, it's been pleasing from my perspective over
13 these last few years, at least, that our focus in that
14 area - it's always been there, but we're very - it has
15 definitely strengthened. So, you know, there is always
16 more to do.

17
18 I think the other key component which comes through in
19 our submissions is the need for the continuing
20 partnerships, you know, with other providers of health
21 care, and certainly that's something we continue to strive
22 for improvement in, but there are strong partnerships that
23 exist as well to try to, you know, make sure we get people
24 to the care that they need.

25
26 MR MUSTON: In the context of patient transport issues,
27 what do you have in mind when you refer to the
28 strengthening of partnerships with other organisations?

29
30 MS PEARCE: Well, look, I mean, I think that there are
31 some examples in local communities where it may be the case
32 that a staff member, for example, of another government
33 agency, is travelling from point A to point B, and could
34 actually assist with bringing a patient back or - if it's
35 non-urgent and they don't need healthcare professionals
36 with them. There are always opportunities like that that
37 can exist. Obviously with our partners in the Aboriginal
38 community controlled health organisations space, you know,
39 we continue to look for opportunities there to work
40 together.

41
42 The issue of patient transport in rural communities
43 is - you know, this issue is not lost on us as to the
44 challenges. Obviously the use of what we would have
45 called, you know, historically the red fleet or the
46 ambulance fleet for inter-hospital transfers in rural
47 communities has been a challenging issue, to some extent

1 improved by the enhancements to our rural ambulance
2 services that have strengthened rosters, made them 24/7 and
3 so on, so that's certainly helped that situation.
4

5 The challenge for us again, in weighing up where we
6 can invest money, is that you don't want to create
7 a situation where you've got non-emergency patient
8 transport staff sitting and waiting, you know, in a quite
9 rural or remote community and, you know, sort of have
10 a wasted resource sitting there. So it's this constant
11 tension of weighing up those issues that we work through
12 all the time. But our non-emergency patient transport
13 offerings I think have certainly strengthened, at least
14 over the last, is it 10 years? It feels like about
15 10 years, but it's - I don't know, but over the last
16 several years.
17

18 MR D'AMATO: I think probably it is fair to say in the
19 last probably two years we enhanced even further by
20 connecting the non-emergency patient transport to our
21 internal systems. There is, for instance, a process we
22 rolled out in Hunter New England whereby - we call it
23 "Reservation" - there is even further streamline in
24 booking the patient transport services and we are now
25 currently rolling that out statewide. It provides better,
26 you know, experience for patients and reduced duplication
27 and waste, if you want, because then we can integrate the
28 whole process inside our hospitals to then the discharge.
29 So I think that's effectively what we are trying to do and
30 we have good evidence that it works.
31

32 MS PEARCE: Yes. We have created a great - and I've been
33 up to the hub up in Newcastle and seen this first-hand -
34 we've created a greater level of visibility about the
35 utilisation of the non-emergency patient transport fleet.
36 So in the same way that we focus our attention on ambulance
37 vehicles, you know, delayed at hospital, we have also now
38 placed focus on non-emergency patient transport staff. You
39 know, we don't want them sitting around waiting. So that
40 real-time booking and joining those things up is part of
41 that objective that Alfa's just mentioned.
42

43 MR MUSTON: So to the extent that gaps in accessibility
44 issues are either preventing patients from accessing care
45 that they need or causing them to forgo that care, they are
46 issues which, in the context of the universal health
47 system, should - presumably will need to be addressed?

1
2 MS PEARCE: I think it's fair to say that we continue to
3 address those, you know, through the actions that we take
4 each and every year, that there is - a key area of focus
5 for us is to continue to provide access to care. I mean,
6 we have now got cancer centres through New South Wales in
7 rural communities that never existed in the past. There
8 are many examples, I think, of where we have strengthened
9 our footprint to provide care to people closer to home.

10
11 The utilisation of small rural hospitals, for example,
12 for other procedural works - so, you know, in the Mid North
13 Coast they have used some of their smaller facilities to be
14 able to do their eye lists and make use of those capital
15 resources in a way that perhaps wasn't previously done, to
16 keep - so our objective, I think, has always got to be to
17 keep people as close to home as possible, to get the care
18 that they need, noting that it is not possible to provide
19 all manner of care to every community and working through
20 that in a sensible way.

21
22 But we have major centres across New South Wales which
23 we're fortunate to have, in large rural communities, so not
24 everyone is coming in to metropolitan Sydney for, you know,
25 high level care that they need. We are networked. So,
26 yes, look, I am very confident that our system is
27 adequately focused on this. I'm not saying it's perfect,
28 but we are genuine in our endeavour.

29
30 MR MUSTON: We heard evidence throughout the course of the
31 Inquiry from Aboriginal community controlled health
32 organisations to the effect that the burden of transporting
33 patients to care, First Nations patients to care often
34 rests upon them, and that they are not funded to provide
35 that service to their communities. Can I ask first, in
36 relation to that, is it possible that that is, in some
37 instances, happening out there in the system - accepting
38 that no system can be perfect, but --

39
40 MS PEARCE: Look, I think, and again, I think our
41 submissions have pointed to this, we see greater
42 opportunity to continue to partner, noting obviously the
43 Commonwealth has a substantial role in this also in respect
44 of funding.

45
46 I think you know, we've learnt a lot of lessons over
47 the years with regard to working with Aboriginal

1 communities and Aboriginal medical services, and I think
2 that we have - and certainly during my tenure as the
3 secretary, have substantially strengthened our endeavours
4 with regard to Aboriginal health. It is a key priority of
5 mine personally. I think all of our chief executives are
6 very clear about this priority, and what we have to
7 recognise is that we need to listen more and partner better
8 to achieve those outcomes. We've learnt some of those
9 lessons the hard way, I'm afraid, but it's something that
10 we have a lot of energy and endeavour around and there is
11 a lot of room for improvement.

12
13 MR MUSTON: Just on the topic of patient transport,
14 though, to round it out, if it's the case in some instances
15 that First Nations patients are being referred to
16 Aboriginal community controlled health organisations by
17 parts of the public health service to arrange their
18 transport to care, and the community controlled health
19 organisations are not being funded to provide that
20 transport, that would not be an appropriate feature of a
21 universal healthcare system, would it?

22
23 MS PEARCE: We would always be very happy to look at those
24 circumstances.

25
26 MR MUSTON: Can I come now to the topic of primary care.

27
28 THE COMMISSIONER: Just before you do, can I just ask you,
29 Ms Pearce, about counsel assisting's recommendation 7,
30 which I find on page 19 of your submission - maybe if we
31 can get the document back on the screen - I don't have the
32 document number.

33
34 MS PEARCE: Is this "The planning process must"?

35
36 THE COMMISSIONER: Yes, that recommendation. There are
37 suggestions in your submission that if this were to be
38 done, it couldn't be done in a day, and I accept that, but
39 have you given any thought as to if this planning process
40 was undertaken, how long it might take?

41
42 MS PEARCE: I don't think I have a time frame in mind,
43 Commissioner. I mean, I think that the issue generally --

44
45 THE COMMISSIONER: If it was taken up, though, it would be
46 obviously, as a matter of obviousness, treated very
47 seriously and properly resourced so that it was done with

1 as much expedition as possible?

2

3 MS PEARCE: Absolutely, and, look, you're aware also, I'm
4 sure, of the changes we've made recently within the
5 ministry to bring some things together to give greater
6 cohesion to how our planning exercises work. I've not --

7

8 THE COMMISSIONER: Yes. Including workforce planning.

9

10 MS PEARCE: Indeed. I think that, you know, I don't want
11 to bore you with the history of NSW Health, but it's fair
12 to say that in 2011, with the governance review at the
13 time, there was substantial change made to the role of the
14 ministry in respect to some of these endeavours, and
15 really, I think it's fair to say the pendulum swung too far
16 away from - so, you know, we're not suggesting that it all
17 sits in the centre by any stretch, I want to be clear about
18 that, but there is an opportunity, I think, to rebalance
19 that to give us a more strengthened role in this space, in
20 partnership with our system and partners, and that's what
21 we're trying to do. But yes, we're placing a great level
22 of seriousness --

23

24 THE COMMISSIONER: With proper resourcing, assuming it was
25 done, would 12 months be a reasonable time frame for this
26 sort of planning?

27

28 MS PEARCE: It depends to what extent - it depends on
29 what - you know, if you are doing a statewide clinical
30 services plan and looking at that, I think it would take
31 probably longer than 12 months, to be honest. I think you
32 would be looking probably at a couple of years,
33 potentially.

34

35 I don't want to sound overly bureaucratic about that,
36 but the level of consultation that would be required to
37 deliver something like that - I don't think I would like to
38 put us in a position where we were trying to expedite
39 something in a way that then left people feeling like they
40 hadn't been heard. So it is something that I do believe
41 would take time, in addition to the fact that each and
42 every day, you know, there are planning exercises going on.

43

44 THE COMMISSIONER: Of course, I understand you are still
45 running the system, yes.

46

47 MS PEARCE: It would be, in my view, in the time I have in

1 this role as the secretary, you know, a great achievement
2 for the health system, I think, would be to have
3 a statewide clinical services plan that could assist future
4 executives such as ourselves, could assist future
5 governments, if there could be a level of support around
6 that, it would be ideal.

7
8 THE COMMISSIONER: Mr Muston, you wanted to move to
9 primary care.

10
11 MR MUSTON: Move to primary care. Again, just to make
12 sure we're all talking about the same thing, could you,
13 when I use the term "primary care" or when you use the term
14 "primary care", could you give us just a snapshot of what
15 you are intending to refer to?

16
17 MS PEARCE: I think, you know, fundamentally primary care
18 is obviously provided to people. It is - gee, how would
19 you describe it? I mean, it's just - it's the basic level
20 of health care that people access to be able to, you know,
21 live free of disease and ill health. Yeah, I - and I see
22 that, you know, largely obviously provided out of an acute
23 care setting like a hospital, that it is ingrained in
24 people's day-to-day lives in the access of health care from
25 different providers.

26
27 MR MUSTON: It includes as an important component general
28 practice.

29
30 MS PEARCE: Yes.

31
32 MR MUSTON: But extends into necessary referral pathways
33 for specialist care.

34
35 MS PEARCE: Yes.

36
37 MR MUSTON: Allied health care.

38
39 MS PEARCE: Yes.

40
41 MR MUSTON: Et cetera. Are you able to identify what you
42 understand to be the importance of good and accessible
43 primary care, say first from the perspective of the
44 community?

45
46 MS PEARCE: Well, I mean, I think that for the community,
47 having access to primary care providers is a key issue. We

1 know that there are issues with that, and then there are
2 variabilities in respect of how people access primary
3 health care. That's not just confined, I might say, to
4 rural communities. It also is a feature of metropolitan
5 areas in terms of how people access their primary health
6 care --

7
8 THE COMMISSIONER: Can I ask you this: would you agree
9 with the proposition that the access to adequate and timely
10 primary care, including care provided by general
11 practitioners, is foundational to good population health
12 outcomes?

13
14 MS PEARCE: I think that it - yes, I do agree with that.

15
16 MR MUSTON: Would it also be true that effective and
17 accessible primary care is critical to the promotion,
18 protection and maintenance of community health?

19
20 MS PEARCE: Yes.

21
22 MR MUSTON: In terms of the importance of primary care
23 when viewed from the perspective of the acute care system,
24 what's your understanding of the relationship between the
25 two?

26
27 MS PEARCE: Well, at its most basic level, I think if the
28 community isn't accessing care in the community, primary
29 care, to keep themselves well, then, you know, that
30 potentially leads to chronic disease and other forms of
31 disease that become far more acute. I'm sure that you've
32 heard about our Lumos program along the way, the data
33 linkage set that we built between general practice and the
34 New South Wales health system, that clearly demonstrates
35 things that you would expect it to, and that is, people who
36 access care with their GP are less likely to - say, post
37 discharge, for example, from hospital, if they do have an
38 acute episode, we know that when people access their GP
39 after those episodes, they are less likely to return to
40 hospital. It's commonsense, but our data now bears that
41 out.

42
43 MR MUSTON: The evidence that we've gathered suggests that
44 the primary care system across New South Wales is under
45 severe strain. Would you agree with that characterisation
46 in general terms?
47

1 MS PEARCE: Not everywhere, but again, there is
2 variability in respect to this, yes.

3

4 MR MUSTON: It is particularly acute but not exclusively
5 a feature of health care in rural and regional and remote
6 communities?

7

8 MS PEARCE: Yes, look, I made the point at the start that
9 it is a factor in rural communities and remote communities,
10 of course, primary care takes on many different forms, as
11 we've talked about, Aboriginal community controlled health
12 organisations, AMSs, pharmacists and other forms of care -
13 Royal Flying Doctor Service clinics, the list goes on.

14

15 The reason I made the point that it's not confined to
16 rural and remote New South Wales, again using an example
17 from the pandemic, was when I established the mass
18 vaccination centre at Homebush, that wasn't a, you know,
19 throwing a dart onto a dartboard objective. We knew from
20 our data that the access to GPs in the radius surrounding
21 Sydney Olympic Park warranted us putting a mass vaccination
22 centre there at the time. So I think that there again, it
23 is not entirely uniform across the state as to how these
24 issues play out.

25

26 MR MUSTON: In fact, it's very much a place by place,
27 community by community proposition, would that be right?

28

29 MS PEARCE: Yes.

30

31 MR MUSTON: Some communities are adequately served in
32 terms of primary care by the existing market based
33 providers of primary care that exist in those communities?

34

35 MS PEARCE: Yes.

36

37 MR MUSTON: And there are others where the market based
38 provider of primary care is under severe strain or duress
39 in a way that means that, in order to continue, will
40 potentially require some further level of support from
41 somewhere?

42

43 MS PEARCE: Yes. Look, I think this is something that's
44 recognised pretty universally, or very - entirely
45 universally across the country. The federal government
46 obviously has just announced, you know, several billion
47 dollars with respect to bulk-billing. I think that goes to

1 the issue that there is a recognition of some of the
2 challenges in primary care across the country.

3
4 I'm also the chair of the Health Workforce Taskforce
5 that reports to health ministers across the country and one
6 of the pieces of work that the task force has been charged
7 with is implementing the recommendations from Robin Kruk,
8 who conducted a review on behalf of the Commonwealth with
9 regard to the challenges around the health workforce, and
10 in particular the challenges of people coming into the
11 country to provide health care.

12
13 When we canvassed all of the states and territories
14 about the first group of health professionals that we
15 wanted to create an expedited pathway into the country for,
16 the number one - one of the number one priorities in that
17 was primary health care and, indeed, they were the very
18 first - that was the very first expedited pathway that was
19 created, I think in October of last year. So I guess what
20 I'm saying is that there are many signals out there that it
21 is recognised that primary care does require some
22 improvement across the country, not just in New South
23 Wales.

24
25 MR MUSTON: In New South Wales, though, there are an
26 increasing number of communities who do not have access to
27 primary care at the moment; is that correct?

28
29 MS PEARCE: I can't confirm that.

30
31 MR MUSTON: The evidence we have received in Western NSW
32 LHD referred to some research which had been conducted by
33 a PHN which covered that area to the effect that there
34 were - I think it was projected that by 2025 - someone will
35 correct me if that's wrong - 2025, 2026?

36
37 THE COMMISSIONER: Near future.

38
39 MR MUSTON: There would be 41 towns within Western NSW LHD
40 that would be without primary care. Do you have any reason
41 to think that that research was wrong?

42
43 MS PEARCE: No, I think you're asking me globally. I mean,
44 again, there will be other communities where it's
45 increasing. I think --

46
47 THE COMMISSIONER: But where NSW Health itself has been

1 forced to step into the primary care space, whether it's
2 single employer model, the 4Ts, Bowraville is an example -
3 they're all places where the primary care has failed, the
4 market has failed; correct?

5
6 MS PEARCE: Yes.

7
8 THE COMMISSIONER: And without in any way wishing to be
9 pedantic, which is not me, to the extent that your - the
10 submission seems to suggest that these are just isolated
11 examples - that's the word used. Would you agree with me
12 that rather than that being the best expression of things,
13 they're examples of where NSW Health has had to step up
14 because, without allocating blame as to why this happened,
15 primary care in a particular area of the state has failed
16 and so the option for NSW Health is just leave it and
17 no-one gets access or to step up, provide that access and
18 obviously work with the Commonwealth to get a funding
19 stream from it, and that that is obviously viewed as part
20 of NSW Health's responsibilities to that extent where
21 there's been that failure?

22
23 MS PEARCE: Yes, look, I think we accept and acknowledge
24 that we often become a provider of last resort, if I can
25 put it in those terms, and I don't mean that in an
26 unpleasant way, but the simple reality is when all else
27 fails, often we are still there. And so, yes, we do take
28 those responsibilities seriously.

29
30 THE COMMISSIONER: Would you agree with me, though, that
31 we don't - and when I say "we" I'm not talking only
32 NSW Health, but as an entire health system - ideally we
33 would have better planning, that we don't leave it until
34 NSW Health has to step in as last resort, in the sense that
35 we plan such that we see where primary health care is
36 failing and will fail or is likely to fail, and have plans
37 in place, though, that there is a continuity of care in
38 terms of primary care?

39
40 MS PEARCE: Yes, look, I think there are - you know, the
41 provider of last resort example is one end of the spectrum.
42 Obviously you don't want to leave it to a situation --

43
44 THE COMMISSIONER: In terms of an emergency department,
45 you are always a provider of last resort.

46
47 MS PEARCE: This is my point. I'm not suggesting that we

1 leave it until everything collapses and then we step in.
2 Yes, I do agree that planning together with the
3 Commonwealth in particular around these issues is
4 important. Alfa might like to talk about 19(2) exemptions
5 which no doubt you have heard about. You know, clearly it
6 would be preferable from our perspective if you could
7 negotiate, you know, when you can see the obvious freight
8 train coming around these issues, that you are able to get
9 in front of that and work together on a solution. I think
10 that would be our preferred setting. Yes.

11
12 THE COMMISSIONER: Could I take you up on something about
13 what you just said about the importance of planning with
14 the Commonwealth, which I completely agree with. Just two
15 things about that. There's a suggestion, which to some
16 degree is true in the submission, that in terms of the
17 state involving itself in primary care provision, you've
18 got to be careful that you don't actually interfere with
19 a viable primary care market.

20
21 MS PEARCE: Yes.

22
23 THE COMMISSIONER: The AMA has also made that point.

24
25 MS PEARCE: Yes.

26
27 THE COMMISSIONER: I don't read anything in counsel
28 assisting's submissions as suggesting that the state should
29 be interfering with, competing with, or I think the word is
30 "cannibalising" viable local markets. I think to the
31 extent that there is a fear of that, it is misplaced. But
32 at a fundamental level - and please don't take this as
33 a personal criticism, it's not - the vibe of your
34 submission in relation to primary care I have read as being
35 too alarmist, which hasn't helped me, and in my opinion -
36 and this is what I really need your view on - in my view,
37 it misstates what the NHRA is. There is a lot, in the
38 health submission, about the NHRA setting out what you call
39 a "planning regime", that counsel assisting's
40 recommendations, I think you use the words "trample over".

41
42 I don't view the NHRA as a planning document. The way
43 I view it is that it's an aspirational document. It
44 certainly outlines who's got funding responsibility, but in
45 my view, properly analysed, it's a document with
46 aspirations for a cohesive national health system, but
47 rather than being a planning document, it's a document that

1 tells the various entities - ie, the Commonwealth and the
2 states and the local hospital networks and the PHNs - that
3 you've all got together and make plans that will give us
4 this unified national health system.

5
6 Do you have a different view than mine, that it's not
7 really a planning document, it's more the way I described
8 it?

9
10 MS PEARCE: I think it does outline a set of aspirations
11 about what the health system ought look like.

12
13 THE COMMISSIONER: Yes.

14
15 MS PEARCE: We talked a lot before about reporting, if you
16 like.

17
18 THE COMMISSIONER: Yes.

19
20 MS PEARCE: And measurement of things, and I suppose one
21 thing I would say is if you cast your eye around what is
22 measured, and you will see the health data that is
23 reported, most often relates to hospitals.

24
25 THE COMMISSIONER: Yes.

26
27 MS PEARCE: The challenge that we, I think, have had is
28 how do we bring together these systems so that reporting
29 around the provision of those types of services that we're
30 discussing now have got any reporting mechanisms around
31 them to assist us collectively to come together around
32 things. I think that, from my own personal perspective, is
33 a gap.

34
35 THE COMMISSIONER: Okay, coming back to my question,
36 though, do you see the NHRA the way I do - we both agree
37 that it is aspirational, but that it's more designed as
38 a document that outlines that the responsible entities in
39 terms of healthcare provision, including primary care, have
40 to get together to make detailed plans?

41
42 MS PEARCE: Yes, I think it does go to that and I think
43 it's increasingly going to that place. I think it's moved
44 with time to that view. I just don't see - and we don't
45 wish to be alarmist, Commissioner.

46
47 THE COMMISSIONER: The reason I use that word is the

1 feeling I got from reading the submission was that it was
2 almost as though counsel assisting had recommended that
3 New South Wales take over the provision of primary health
4 care across all of New South Wales, including the Sydney
5 basin, and it certainly doesn't say that. That's not the
6 recommendation. The recommendations talk about market
7 failure. That's the reason why I used that word. That
8 general gist of the "please don't trample over the planning
9 regime in the NHRA", I personally think is misplaced, which
10 is why I just wanted to explore with you your take on what
11 the NHRA really is.

12
13 MS PEARCE: I think that perhaps our response to it is
14 based in a concern that we ought step into the primary care
15 space where there is no funding identified.

16
17 THE COMMISSIONER: Okay. Okay. The submissions certainly
18 make the point about levels of risk of doing that.

19
20 MS PEARCE: Yes.

21
22 THE COMMISSIONER: How great, really, is that risk,
23 though? Has the Commonwealth ever, in circumstances where
24 New South Wales has stepped in as a provider of primary
25 health care because of a failing market or a failed
26 market - has the Commonwealth ever said no?

27
28 MR D'AMATO: Well, the Commonwealth there's a capped
29 funding environment. So at the moment, there's no option
30 for us - if we were to use an ABF environment under the
31 NHRA. So that's a challenge. I think probably our
32 submission also reflects the experience that we have had
33 over a number of years in negotiating with the Commonwealth
34 on a bilateral way, and I reflect on what we managed after
35 a number of years to agree in respect to services like the
36 RPA Virtual. It's --

37
38 THE COMMISSIONER: Don't get me wrong. In exploring this,
39 don't think I don't think that the Commonwealth ought to be
40 more proactive in this space, because I do. And often it's
41 NSW Health that has to be proactive, otherwise people are
42 left without primary care. It's just that I don't see the
43 risk as being as great as what is put in your submission,
44 or the way - I will just call it pitched in your
45 submission.

46
47 MS PEARCE: I think the example I gave earlier of urgent

1 care services, you know, we pursued that with a government
2 commitment. The funding around those was substantial,
3 134 million. So I guess these are not frivolous endeavours
4 in terms from a funding perspective.

5
6 THE COMMISSIONER: No, and it's also, I should say, not
7 lost on me that in examples like Bowraville, even though
8 you've been able to tap into the MBS, it's still at a cost
9 to NSW Health. There is additional cost. I understand
10 that, and the Commonwealth should probably be paying for
11 that as well, but that's a separate issue. So I understand
12 that as well.

13
14 MS PEARCE: So in a circumstance where any government of
15 the day decided that they wanted to embark on an endeavour
16 around primary care, based on advice and information, you
17 know, we obviously would then enact that. Our nervousness
18 around, I guess, the way we've read it, is that regardless
19 of whether there is, you know, that agreement in place or,
20 indeed, if there is Commonwealth money available, we should
21 just do it anyway. I guess what we're saying is we're
22 given a budget, we're expected to deliver upon that budget.
23 It is not at our behest that we can just say, "Oh, well,
24 okay, now we're going to spend millions of dollars over
25 here", without the express approval of government.

26
27 MR MINNS: Commissioner, if I may, I think there is just
28 another angle around the issue that goes to what is causing
29 the market failures. So for perhaps a decade, maybe
30 longer, we've seen a drift away from general practice, you
31 know, training and participation.

32
33 THE COMMISSIONER: Yes.

34
35 MR MINNS: That has become fairly significant. Now, we've
36 relied on international medical graduates for quite some
37 time to provide services in primary care in remote and
38 rural environments.

39
40 THE COMMISSIONER: Which itself is probably evidence of
41 a failure. Yes.

42
43 MR MINNS: Yes. I mean, that's not new. That's possibly
44 20 years in its formation.

45
46 THE COMMISSIONER: Yes.

1 MR MINNS: But when you look at, you know, who is the
2 accountable government that determines how many doctors get
3 trained in Australia and how many of them are available or
4 required to work in non-metropolitan areas, that's not
5 something that NSW Health can influence at all.

6
7 THE COMMISSIONER: Both Professor Duckett and
8 Professor Braithwaite gave evidence to this Inquiry that
9 there has been, I think in Professor Duckett's words, a big
10 failure in workforce planning in health for a long time,
11 including in relation to GPs and nurses.

12
13 MR MINNS: Yes. And you know, the GP workforce is
14 a workforce employed through the Commonwealth's role in the
15 system.

16
17 THE COMMISSIONER: Yes.

18
19 MR MINNS: So it's just to make that point that we can't
20 control - we don't have levers to deal with that issue.

21
22 THE COMMISSIONER: Yes.

23
24 MR MINNS: But we then face the consequence of it.

25
26 THE COMMISSIONER: I understand that, thank you.

27
28 MS PEARCE: I think the super specialisation within
29 medicine as well, over time, has contributed to this. GPs
30 are specialists and they need to be viewed in that way.
31 I think that is part of the challenge that they face.

32
33 THE COMMISSIONER: There might be a range of problems
34 including, despite what is being bid in the precursor of
35 the federal election about longstanding MBS rates, about
36 whether either the rates or the funding models are adequate
37 for dealing with chronic disease and the kind of integrated
38 care that's needed to manage those, whether you can even -
39 how viable it is to be a GP anymore. A whole range of
40 things that we are - we have evidence on and we haven't
41 forgotten.

42
43 MS PEARCE: There are generational factors. There's a lot
44 of things.

45
46 MR MUSTON: Can I come back to the Commissioner's earlier
47 question, though. Are you aware of any instances in

1 New South Wales where NSW Health has identified an
2 unfillable hole in the primary health market - that is to
3 say, a town or community where the market is never going to
4 be able to provide primary care, and in which New South
5 Wales has put forward a proposal along the lines of what is
6 being done in Bowraville, only to have the Commonwealth
7 say, "We are not going to give you a 19(2) exemption?" Has
8 this ever happened?

9
10 MS PEARCE: I think there have been challenges with 19(2)
11 exemptions, yes.

12
13 MR MUSTON: In respect of arrangements like that?

14
15 MS PEARCE: They are not easily negotiated.

16
17 THE COMMISSIONER: I think for a 19(2) exemption you need
18 to ensure that you're not going to interfere with a market
19 and that has to be established, there has to be
20 consultation with local businesses, et cetera. Is that the
21 sort of - it's not an automatic box tick.

22
23 MS PEARCE: It is not automatic. No, it is not.

24
25 THE COMMISSIONER: We understand that.

26
27 MR MUSTON: But for example, in communities which have
28 been identified as not having any primary care because
29 there is not a market provider within that community and
30 the practical and commercial reality is, having regard to
31 MBS rates and the like, there will never be a market
32 provider of primary care, or at least not in the immediate
33 or foreseeable future, have any such locations been
34 identified by NSW Health as part of its planning and had
35 a structured solution to the problem identified in the form
36 of NSW Health delivering primary care through a salaried
37 employee, only to have the Commonwealth say, "That
38 community's access to their MBS entitlements will not be
39 coming through you"?

40
41 MS PEARCE: I think the challenge we're experiencing with
42 responding to that, Mr Muston, is that there are degrees of
43 this. Again, there are, you know, any number of different
44 formulations of how this can occur. So in many
45 circumstances, the health system, if it can manage it
46 within the available resources, will take on things in the
47 interests of the community, without going to the

1 Commonwealth, if we can manage it and if it makes the best
2 sense.

3
4 Alfa made the point before about the cap on health
5 funding that exists. That is a real thing. There is no
6 unlimited flow of money to us from the Commonwealth,
7 because it's capped. The other issue, as I've raised, is
8 that 19(2) exemptions, in particular for staff like nurse
9 practitioners and others, are not a simple or
10 straightforward exercise to get agreement to.

11
12 MR MUSTON: I understand that. Does the cap include MBS
13 moneys paid through 19(2) exemptions?

14
15 MR D'AMATO: No, it does not. I think we also need to
16 acknowledge that when we do actually pick up this work
17 through, say, emergency departments, it does include it.
18 Obviously with the exception, where these activities are
19 conducted from smaller hospitals, they are subject to
20 a different regime through the ABF and the NHRA, if you
21 want.

22
23 MR MUSTON: Accepting the additional challenges that might
24 arise in the context of seeking to access MBS moneys
25 through nurse practitioners, allied health practitioners
26 and the like, if we just stick for present purposes with
27 a more straightforward scenario of patients or community
28 members who would have entitlement to MBS funding for care
29 provided to them by a GP in the community, were there one
30 there, are you aware of any circumstance in which
31 NSW Health has said, "We will provide through a salaried
32 employee of NSW Health primary care as a substitute for the
33 GP that is not there, will you give us a 19(2) exemption to
34 enable those members of the community to access through us
35 their MBS entitlements", only to have the Commonwealth say
36 "No"?

37
38 MS PEARCE: It's difficult for us to - I know you want us
39 to give you a straight answer to the question, but it's
40 difficult for us to respond to because there are too many
41 variables in what you are asking us. It is not that
42 straightforward.

43
44 MR MUSTON: I'm mindful of the fact that --

45
46 MS PEARCE: And the reason for that, sorry, is because of
47 what I said before, that in many cases, we wouldn't

1 necessarily go to the Commonwealth and ask them for that
2 because, you know, you would be fairly confident about what
3 the answer would be.

4
5 MR MUSTON: Why --

6
7 THE COMMISSIONER: Mr Muston's question was "only to have
8 the Commonwealth say" - there is no example of
9 a categorical no; is that right?

10
11 MS PEARCE: There may be. I don't have them available to
12 me. But I don't think we can categorically say that that
13 has never happened.

14
15 MR MINNS: Commissioner - correct me if I'm wrong on this,
16 please - my recollection when I was at one of the national
17 ministerial meetings was, it was only last year in the
18 current NHRA negotiations, or the currently stalled
19 negotiations, that the Commonwealth conceded that where
20 there was a market failure, and we were stepping in, that
21 they needed to give us money for that. That was
22 a break-through, wasn't it, last year?

23
24 MR D'AMATO: It was, particularly because the NHRA
25 specifically calls out that they will not pay any services
26 that are paid under an ABF arrangement, except for when
27 there is a 19(2).

28
29 MR MUSTON: But the 4Ts program predates last year.

30
31 MS PEARCE: Yeah, it does.

32
33 MR MUSTON: Bowraville clinic pre-dates last year.

34
35 MS PEARCE: There are certainly examples of where the
36 Commonwealth has stepped up. We're not disputing that.
37 What we're saying is that there are --

38
39 THE COMMISSIONER: You mean a universal recognition that
40 they need to? Okay.

41
42 MS PEARCE: Yes. The objective that we would like to
43 see - you know, what we would love to see - is exactly what
44 Mr Minns has just outlined, that there is an agreed
45 arrangement between the state and the Commonwealth that
46 where there is market failure and the state has to step in
47 to that, that the Commonwealth recognises that and that

1 there isn't a tussle over funding. Obviously there would
2 need to be a discussion about that, but I think, you know,
3 that would be the gold standard from our perspective, if
4 that could be achieved.

5
6 MR MUSTON: Do you need that gold standard standing
7 arrangement before plans are made for the delivery of
8 services like the ones that are being provided in
9 Bowraville and other communities which might have similar
10 needs?

11
12 MS PEARCE: Often those types of services are part of
13 state government election commitments, for example, where
14 they will recognise those issues. That has certainly
15 happened in the past. But I think we can demonstrate
16 fairly clearly that we do a lot of work in the primary
17 sector. We talked about prevention and promotion earlier
18 in today's discussion. We've talked about vaccinations.
19 There are many things that we do in that space already
20 without waiting for the Commonwealth. So we don't resile
21 from that. I suppose when we --

22
23 THE COMMISSIONER: That's because you are better placed to
24 tell the Commonwealth what the problems are, aren't you?

25
26 MS PEARCE: Indeed.

27
28 THE COMMISSIONER: Local knowledge from the LHDs,
29 et cetera.

30
31 MS PEARCE: Absolutely. It is a commitment we take
32 seriously. We don't step away from that. When we think
33 about it on the broad scale, though, we also need to be
34 cognisant of when you do something in one place, there's an
35 expectation that you do it in another, and there is
36 a potential snowball effect for that. So balancing that is
37 required of us. We don't have an unlimited budget to fund
38 this part of the health system.

39
40 MR MUSTON: But just to pick up on that, let's say there
41 are five communities that have that need and as part of
42 a planning, informed planning process, the local health
43 districts are of the view that ideally, that need should be
44 met, potentially in priority to other needs, the fact that
45 you can't fund all five surely would not be a good reason
46 not to do one or two or as many as you are actually able to
47 fund?

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MS PEARCE: No. Look, as I said before, wherever we've been able to manage our resources to deliver those types of services, we will, without necessarily waiting for the Commonwealth. But it obviously needs to be weighed up and considered in regard to the budget available to that area.

MR MINNS: I think the final point I'd make on it is that, you know, it's a potential moral hazard zone because the community rarely fires up at the federal government when they've got no GP in town, right? The community and the local MPs go straight to the place of last resort and so the campaign is on, "Well, what is the Minister for Health going to do about that?"

Now, to some degree, the Commonwealth over a decade or more has kind of just let that situation prevail. Yesterday's announcement is a suggestion that prioritising primary health care is significantly back on the agenda of the current federal government. \$8.5 billion is a lot of money. But that hasn't been there for a decade.

THE COMMISSIONER: Weren't they outbid by the opposition?

MR MINNS: I think possibly, yes. But apparently, they were going to get rid of more public servants.

THE COMMISSIONER: We've got to make sure we're not biased here.

MS PEARCE: No, no.

MR MINNS: So, you know, in that context, if the state steps in, then the Commonwealth, in the past, has been happy to stay silent, and so the expectation that we'll always step in becomes prevalent. So in that process, we have actually committed the New South Wales Government to a level and scale of expenditure that we don't have any authority to commit them to, and nor does our minister without going to the expenditure and review committee. So that's the kind of context that makes it difficult for us to just wade in to this pond and sort it out later. Very, very challenging.

MR MUSTON: But can I just test this issue around the provider of last resort. I think, Ms Pearce, you indicated that when you were referring to the provider of last resort

1 you were referring particularly to the fact that patients
2 who don't receive or have access to good primary care will
3 ultimately present at an emergency department potentially
4 in a more unwell state than they would have if they had
5 received the care that could and should ideally have been
6 provided in a primary care setting.

7
8 MS PEARCE: Yes.

9
10 MR MUSTON: That is, particularly for what are really
11 primary care type concerns, a far more expensive setting in
12 which to deliver the care to those patients - that is to
13 say, emergency departments are a far more expensive setting
14 to deliver primary care than a general practice type
15 clinic, and the care, from the patient's point of view,
16 that's able to be provided in that urgent and episodic way
17 is, long term, probably inferior to what they would get and
18 need to deal with the chronic illness or their long-term
19 health concerns. Would that be right?

20
21 MS PEARCE: Yes.

22
23 MR MUSTON: And it may well be that there are cases in
24 which, as the provider of last resort, the state or the
25 Ministry of Health looks at the situation, informed by the
26 planning process it undertakes, and concludes that it
27 would, in some communities, be better - a better use of
28 resources to be providing that primary care rather than
29 maintaining a potentially small emergency department. In
30 those circumstances, would the fact that the state has not
31 historically been involved in the delivery of primary care
32 mean that delivering the care in the setting and in the way
33 that is deemed to be most appropriate would still be a hard
34 no?

35
36 MS PEARCE: No, I don't think we're saying that. I think
37 what we're saying is if the government of the day supports
38 and endorses that approach, we would deliver it, and that
39 it cannot solely rest with the state government to consider
40 those things, and that if we had an environment where the
41 Commonwealth had - if there was an agreement with the
42 Commonwealth to recognise, when we do need to step in in
43 that way, that would create a much better environment for
44 us all to work within.

45
46 I will give you one other example which is also
47 related to the urgent care services. When we were

1 constructing that program of work, one of the things that
2 we were acutely aware of is that you run the risk of market
3 distortion even further by the state government stepping in
4 and paying, for example, occasions of service with GPs to
5 see patients, you know, and making a payment to them for
6 doing so, if you've got a GP down the road that's already
7 bulk-billing, they might think well, "Why am I bothering
8 with this when 100 metres down the road now the state
9 government is funding someone to do what I'm already
10 doing?" There is always a cause and effect with those
11 types of decisions that we need to be aware of.

12
13 So the need for it to be a joint planning exercise is
14 paramount. The funding is part of that.

15
16 THE COMMISSIONER: I agree with everything you have said
17 but I don't read as what counsel assisting is recommending
18 to me as interfering with --

19

20 MS PEARCE: No, I'm just making the point that there are
21 a lot of things for us to consider when we step into that
22 space, that's all.

23

24 THE COMMISSIONER: Yes.

25

26 MR MUSTON: I note the time, Commissioner, and I know the
27 time commitments that others have. If we could sit on
28 potentially for 15 minutes --

29

30 THE COMMISSIONER: Sure, was it 1.30 you have to leave?

31

32 MS PEARCE: Yes, that's fine, thank you, Commissioner.

33

34 MR MUSTON: I will endeavour to be as quick as I can.

35

36 Can I ask you to turn to paragraph 9.2 of your - that
37 is health's - submissions on page 42. Do you see there
38 there is a reformulated version of recommendation 12? Can
39 I just ask a few short questions in relation to that.

40

41 As to the first component of it - that is, the
42 undertaking a system-wide clinical service planning which
43 involves the primary health networks, et cetera, is that
44 not already buying done? Read that first sentence up to
45 "in appropriate case". Pause as "in appropriate cases".

46

47 MS PEARCE: It is being done but I think how it is being

1 done is the point we're trying to make. We want something
2 that's more comprehensive.

3
4 MR MUSTON: As to that next sentence:

5
6 *In appropriate cases, this may include an*
7 *assessment of the feasibility and cost of*
8 *NSW Health delivering some of that care.*

9
10 Is that being done?

11
12 MS PEARCE: I think it does happen but it's been in
13 perhaps - I don't want to be unfair and say ad hoc, but
14 there is an element of that to this. What we're
15 foreshadowing in this is that we would like, as we touched
16 on earlier, something that was more robust, that was, you
17 know, future looking as well, that looks across the system
18 more holistically. Obviously it would require government
19 support.

20
21 MR MUSTON: Yes.

22
23 MR D'AMATO: Sorry, just to add, I think that kind of
24 integrated approach will give us a better opportunity to
25 interface with the Commonwealth, because at the moment we
26 do ad hoc and we do it when there is close to a crisis,
27 versus doing with a horizon, if you want, over multiple
28 years, where we know at times we can predict when, if you
29 want, a market failure will occur or is likely to occur.
30 That's probably what we're trying to achieve with this.

31
32 MR MUSTON: For example, to the extent that the PHN in
33 Western New South Wales LHD had identified five years ago
34 the 41 towns across that horizon would be without primary
35 care, was there any assessment being made in collaboration
36 with the PHN of the feasibility and cost of NSW Health
37 delivering primary care to those communities?

38
39 MR D'AMATO: Not that I was involved in, and that's
40 probably one of the reasons why I would like to see these
41 kind of recommendations, so these can be integrated in our
42 broader planning strategy that allows us to prioritise
43 across the state what is the available envelope and/or
44 approach the government through the normal processes to put
45 forward options.

46
47 MR MUSTON: Could I come down to the end of that

1 recommendation. Do you see in the penultimate line where
2 there is a reference to "Commonwealth funding streams
3 sufficient to fund the delivery of the care"? Can I just
4 ask you what at least you understood the word "sufficient"
5 to mean in that context?
6

7 MS PEARCE: I don't think it's any broader than what its
8 plain meaning is, that if we're delivering the care, that
9 the funding attached to it should be sufficient to enable
10 us to carry that out.
11

12 THE COMMISSIONER: Cover the cost?
13

14 MS PEARCE: Yes.
15

16 MR D'AMATO: And if I may, it's likely that, at face
17 value, the Commonwealth will turn around and simply say it
18 is the MBS rate and we know that that is not covering the
19 cost, so that's what we're trying to achieve with this.
20

21 MR MUSTON: Isn't that part of the problem, though, in
22 communities where the nature of the primary care demand is
23 such that the MBS money is not going cover the cost, that
24 that's the very situation in which the market is never
25 going to provide that care?
26

27 MR D'AMATO: That's right. That's why I think it is
28 important we establish that upfront, as a way to engage
29 with the Commonwealth, should we be in that situation.
30 Because otherwise, it feels to me that they're simply
31 cost-shifting back to us. The fact that they are not able
32 to attract and retain resources to deliver the primary
33 care, and simply ask us to step in, means we have to cover
34 the gap.
35

36 MR MUSTON: There may be circumstances, though, in which
37 the ministry, having regard to its wider operations within
38 an area, is able to find efficiencies in the delivery of
39 that primary care that, say, a private general practice
40 would not be able to.
41

42 MR D'AMATO: I don't disagree with that. Probably more
43 likely than not we may have infrastructure in place
44 already. On the other hand, I think we have to consider
45 the efficiencies that the Commonwealth would gain as us
46 stepping in too.
47

1 MR MUSTON: There is also potentially a wider array of
2 services that are being delivered by NSW Health in an area
3 which back in the day would have been provided largely by
4 GP VMOs who are also no longer there, such that there is
5 potential for there to be synergies in the operations
6 across the acute and primary care setting, to the extent
7 that NSW Health were stepping in and providing that primary
8 care. Would that be right?
9

10 MS PEARCE: I think that's fair.
11

12 MR D'AMATO: I think that is fair.
13

14 MR MUSTON: Could I quickly turn to paragraph 9.35.
15 Sorry, that was on page 54. Do you see in the second
16 sentence there, there's the reference, to pick up on
17 something you said a moment ago, Mr D'Amato, about the
18 potential for capital works, including repurposing of
19 existing and developing new infrastructure, workforce,
20 et cetera. Accepting the possibility that capital works
21 might be required in some locations, it would be right,
22 wouldn't it, that in other locations they would not be
23 required; it all depends very much on what's present in the
24 particular town or community that is in need of a primary
25 care service?
26

27 MR D'AMATO: I tend to agree with you. I think that the
28 note in regards to the capital works is more in respect to
29 the aged care services, that they will require significant
30 reconfigurations of the existing assets. I think that if
31 we assume that the primary health - the services that we
32 contemplate in this kind of scenario being a GP clinic or
33 something like that, it might not be, you know, as
34 significant. But if you think about reconfiguring wards so
35 that they can accommodate aged care services, I think they
36 could be material.
37

38 MR MUSTON: Okay. So to the extent that we're talking
39 about, at least at this moment, primary care, the
40 infrastructure and facilities that NSW Health already has
41 in many communities in the form of older smaller hospitals
42 often would be capable of being repurposed or utilised in a
43 way that could provide primary care either as a complement
44 to or perhaps even a substitute to the emergency type
45 facility that's provided there, assuming, as part of
46 a wider planning operation, appointments were left open for
47 emergency walk -ins and those sorts of --

1
2 MS PEARCE: I think that's fair, yes.
3
4 MR MUSTON: Could I then turn to aged care. Evidence
5 received by the Inquiry suggests that a failing in the aged
6 care market is also having very significant and detrimental
7 impacts on the acute care services, particularly in some
8 local health districts. I think Shoalhaven Illawarra, or
9 Illawarra Shoalhaven - that one I should have got right -
10 is a feature of the health landscape at the moment. Would
11 that be right?
12
13 MS PEARCE: Most certainly that has been an issue, yes.
14
15 MR MUSTON: And without wanting to oversimplify it, the
16 key problem is an inability to have older patients who have
17 been admitted for an episode of acute care then discharged
18 into an aged care facility, which would be more appropriate
19 for their care at a time when they have had the acute
20 episode resolved, they no longer need acute care in a
21 hospital, but they are not able to go back to live
22 independently, and there is no aged care place currently
23 for many of them.
24
25 MS PEARCE: That's right.
26
27 MR MUSTON: Such that they are spending often very long
28 periods of time --
29
30 MR D'AMATO: Very long, yes.
31
32 MR MUSTON: -- in medical wards.
33
34 MR D'AMATO: Very long time.
35
36 MR MUSTON: The consequence for the patient is it's
37 somewhat counter intuitively often the worst place for an
38 elderly patient to be in terms of the health outcomes.
39
40 MS PEARCE: Yes.
41
42 MR MUSTON: And that's no criticism of the care that is
43 being provided in those hospitals --
44
45 MS PEARCE: No, no, we agree.
46
47 MR MUSTON: -- it is just the nature of their needs. And

1 it also has massive consequences in terms of the ability of
2 the acute healthcare system to deal with its own needs and
3 patient flows to accommodate things like emergency
4 department presentations, the squeaky wheels that we talked
5 about earlier, and no doubt many things. Would that be
6 right?

7
8 MR D'AMATO: I would add that it will have a consequence
9 on the workforce as well and also on other patients. At
10 times, some of these patients might be dementia patients
11 that require specialist care and are being accommodated in
12 acute settings, and sometimes these can also be for a year
13 and a half. So I was just recently visiting a district and
14 there was a particular case where they couldn't discharge
15 this patient to a specialist unit and as a result he was
16 still admitted, and that obviously creates --

17
18 THE COMMISSIONER: There are real impacts on your
19 workforce that work in the public hospitals if they have to
20 deal with aged care patients with, for example, problematic
21 dementia.

22
23 MS PEARCE: Yes.

24
25 MR D'AMATO: It goes back to the concept, as well, that
26 they are acute wards, they are not set up for aged care
27 patients.

28
29 MR MUSTON: The problem is not showing any signs of
30 resolving itself, is it - that is to say, there is no
31 indication that the aged care market is at any point in the
32 near future going to step in and take these patients?

33
34 MR D'AMATO: I can't see that being resolved in the short
35 term.

36
37 MR MUSTON: In amending the proposed recommendation, the
38 health submissions at paragraph 9.49 propose the complete
39 removal of aged care on the basis that aged care is and
40 should always remain a Commonwealth responsibility. To the
41 extent that the Commonwealth doesn't do anything about it,
42 what, if anything, is it suggested that the Ministry of
43 Health should do to deal with the situation?

44
45 MS PEARCE: Well, I mean, I think it's pretty clear that
46 we have, for many months, been having this conversation
47 with the Commonwealth, and I do believe that the

1 Commonwealth has genuine endeavour around addressing some
2 of the challenges. It's not always about beds available in
3 aged care settings, it's about the workforce to support
4 those beds, which is in issue here. So it's not a simple
5 matter of, you know, there's a bed available. So I think
6 that the Commonwealth absolutely does have a role in that,
7 as do the aged care employers. I guess what I would say is
8 that this is a significant issue for these elderly people,
9 spending the last days of their life in an acute ward in
10 hospital is far from what you would want for anyone.

11
12 In the grand scale of aged care beds across the state
13 in New South Wales, I think we've got - there's more than
14 70,000 aged care beds in New South Wales across 800 nursing
15 homes and so on. It's a very large system. To the extent
16 that we can assist, we do. But I guess the point we're
17 making in our submission is that this one - primary care,
18 you know, obviously has many different permutations. Aged
19 care in this regard, when someone is medically cleared for
20 discharge, I will say, is squarely with the Commonwealth,
21 and whilst we have to do what we need to do to support the
22 residential aged care sector, it is difficult for us to
23 say, "Well, you know, we will create an environment where
24 we then open up services that are akin to the residential
25 aged care sector."

26
27 The reason I say it - and look, the government, any
28 government of the day at a state level may change its
29 mind --

30
31 MR MUSTON: The Victorian government, for example, does
32 participate in the aged care market.

33
34 MS PEARCE: They do. They do, in a far more substantial
35 way than we do here in New South Wales. But, you know, we
36 have had, in New South Wales now over many years, with
37 government decisions along the way, the decision to alter
38 the way those services were provided by the state. That
39 has been enacted by the health system over, you know,
40 probably 20 years, since those decisions were taken. You
41 know, for example, at Wallsend in Newcastle, with the
42 cooperation and assistance of families and carers, we
43 recently relocated the residents who were remaining there.

44
45 There is an argument on the other side of this that
46 the public health system is not the best provider for these
47 types of services and that aged care specialist providers

1 indeed can provide much better options where they exist.
2 So again, we don't resile from our responsibility to
3 elderly people in this state, whether they're in a
4 residential aged care facility or not, but the Commonwealth
5 has very clear responsibilities, legislatively, in regard
6 to this issue.

7
8 MR MUSTON: New South Wales and the ministry also
9 participate to a reasonable degree in the aged care market
10 through the MPS facilities in rural and regional areas.

11
12 MS PEARCE: Yes. But I mean again, those services are
13 a recognition essentially of areas where the market wasn't
14 going to meet demand, I think it's fair to say, and that
15 using the capital asset of the state health system in that
16 way has been a sensible approach.

17
18 MR MUSTON: Again, in a way --

19
20 THE COMMISSIONER: Probably an essential approach.

21
22 MS PEARCE: Yes, yes.

23
24 MR MUSTON: I'll move on very quickly to one last topic
25 that I wanted to raise with you, and that's the affiliated
26 health organisations.

27
28 I understand that there is a distinction drawn in the
29 submissions, the health submissions, between what are said
30 to be the services provided by affiliated health
31 organisations in their capacity as affiliated health
32 organisations and other services provided by those
33 entities. Could I ask you to just explain where the line
34 is drawn and how that distinction is to be drawn?

35
36 MS PEARCE: I think that affiliated health organisations,
37 as we have pointed out - they're a very important part of
38 the public health system, I'll say that, and I think that
39 they are long term partners with us, we value them, and
40 I think it's important for me to say that on the record for
41 the avoidance of any doubt about how we feel about those
42 organisations.

43
44 By their very nature, they are entities in and of
45 their own right that have the ability to commence services
46 under their own corporate regimes and objectives that may
47 not be things that the state wishes to purchase. So

1 I think that our distinction is drawn to just simply
2 clarify that the state seeks to purchase activity from
3 those entities in a fairly - you know, I mean, I think
4 there's a great degree of consistency about how that goes
5 from year to year. There will be other desires and
6 objectives of those organisations that may not be something
7 that the state wishes to entertain.

8
9 MR MUSTON: So that is to say if there is a service being
10 offered by an AHO, for example, Karitane, which has
11 historically been provided as part of the public health
12 system, if that entity decides it wants to operate another
13 facility in a different geographical location to provide
14 care of the type that it provides to a cohort of patients
15 which is not something that the public health system itself
16 wants to provide, then that obviously doesn't form part of
17 the services that are being offered by the affiliated
18 health organisation in that capacity?

19
20 MS PEARCE: Look, I think generally speaking, what has
21 happened over time is that through various government
22 commitments, expansion of services in the AHOs has
23 certainly occurred. It's not to say that it's a set and
24 forget arrangement and that it never changes, that's
25 certainly not the case. But I suppose, you know, from an
26 administrative perspective for us, you can understand I'm
27 sure that we can't have a situation where an organisation
28 is at large to just decide it's going to do something and
29 then assume automatically that the state will pay for that.

30
31 MR MUSTON: Of course. But is there any reason why
32 services which the state is requiring an organisation to
33 perform pursuant to service level agreements ought not be
34 delivered in that organisation's capacity as an affiliated
35 health organisation?

36
37 MS PEARCE: No.

38
39 MR MUSTON: That is to say, enter into a service level
40 agreement with an AHO, to the extent that services are
41 required by that agreement, presumably all of those
42 services must be being delivered in that organisation's
43 capacity as an AHO?

44
45 MS PEARCE: Yes.

46
47 MR MUSTON: And to the extent that services are required

1 to be delivered in that way and through that means, is
2 there any reason why schedule 3 to the Act ought not
3 reflect that fact?
4

5 MS PEARCE: No, but I still come back to the point.
6 I mean, it's not a - it is a negotiated situation, as you
7 would with any - even with a local health district that
8 might decide that it wants to start offering robotic
9 surgery in a hospital, for which there is no funding, or
10 indeed, if we come back to the clinical services plan,
11 which we would love to see in place, that there is actually
12 no need for that - that is an example that I would give
13 you. I don't see a huge distinction between how we would
14 deal with entities within the health system in that regard
15 and how we would deal with the affiliated health
16 organisations.
17

18 MR D'AMATO: If anything, the only thing I wanted to add
19 is that it is important we reflect on the fact that the
20 affiliated health organisations fit inside the network,
21 inside the districts, and that is important that they are
22 managed at that level, because effectively from the
23 ministry it is very difficult for us to determine what
24 a district may require and give the flexibility locally to
25 determine whether some services could be, you know,
26 provided by affiliated health organisations.
27

28 MR MUSTON: Could I just take you up on that? It may be
29 accepted that decisions around which services might be
30 required to be provided by an affiliated health
31 organisation are best informed by an overarching planning
32 process which, in itself, is driven in large part by
33 information coming out of the local health districts.
34

35 MR D'AMATO: Yes.
36

37 MR MUSTON: So decisions about what service should be
38 provided, I understand you to be saying, is something that
39 local health districts should have a lot of input in
40 relation to.
41

42 MR D'AMATO: Absolutely, because I think it's important
43 that the districts have the autonomy to determine where the
44 services can be delivered in respect of the footprint of
45 their catchment area.
46

47 When I was at Southeastern Illawarra many years ago,

1 for instance, we used to have St Vincent's as part of our
2 catchment area, Calvary, War Memorial, and that was
3 integral in determining the service plan and configuration
4 of the services.

5
6 MR MUSTON: Having decided, as part of that planning
7 process, which I think ideally we're moving towards being
8 a collaborative process between local health districts and
9 ministry and probably the affiliated health organisations
10 themselves, but once you have reached a point where you
11 have an understanding about what services should be
12 provided, is there any reason why the ministry could not be
13 the entity responsible for dealing with the commercials -
14 that is to say, the paying part?

15
16 MR D'AMATO: So my experience is that our role could be in
17 setting some frameworks in the way the funding is allocated
18 to individual AHOs. Us being involved in the agreement, it
19 removes, to a degree, the flexibility at the local level to
20 determine whether they might want to shift services within
21 a financial year. So that's why I think I'm a little bit
22 concerned about the ministry being involved. I appreciate
23 St Vincent's Health Network is different, but other
24 facilities are well embedded in the operational needs of
25 the local health districts and they are best at managing
26 that interface on a day-to-day, including the contract.

27
28 At times, and we've done this this year, for instance,
29 in Hunter New England, where we supported the district to
30 make sure that there was a standard approach in
31 establishing the funding model for the particular hospital,
32 and that's where I think there is a role for the ministry,
33 to establish there is a consistent and standard approach
34 for funding those organisations.

35
36 MR MUSTON: But the organisations require, or presumably
37 would require, some certainty around the commercial
38 arrangements, at least for the duration of the service
39 level agreement.

40
41 MR D'AMATO: Yes.

42
43 MR MUSTON: So when you refer to a shifting around of the
44 priorities and the like during the terms of the service
45 agreement, I assume you're not contemplating the deal
46 changing after the agreement has been signed?

47

1 MS PEARCE: No, no.

2

3 MR D'AMATO: No, no. Say, for instance, many of these
4 organisations provide sub-acute care, and say that at
5 a point in time, you know, there is more pressure on the
6 acute sector and therefore they will probably approach the
7 local operator to determine whether there is extra capacity
8 for them to do some work on behalf of the district. That's
9 the kind of arrangement, operational arrangement.

10

11 MR MUSTON: But is there any reason why the ministry - if
12 the ministry had responsibility for maintaining the service
13 level agreements, why a three-way collaboration, overseen
14 by the ministry in relation to these issues, could not
15 still occur?

16

17 MR D'AMATO: I feel that if there is a three-way
18 collaboration, it means that it will eventually delay all
19 opportunities that might be identified by the local health
20 districts. Again, as far as I can see in my experience
21 with working in collaboration with the affiliated health
22 organisations, it is that their management of the contract
23 has to be done at the local level. Then the ministry can
24 ensure that there is a consistent approach in the way the
25 funding is allocated, indexation is provided for and
26 additional funding for extra services are allocated to the
27 district to then pass on, pass through to the AHOs.

28

29 MS PEARCE: I think it's fair to say, though, that there
30 has been frustration with the AHOs over time with differing
31 arrangements, district to district. We accept that.
32 I think that the ministry has become far more involved over
33 recent years with regard to setting a framework.
34 I personally meet regularly with the AHOs and their
35 representative organisation. We can do better in regard to
36 ensuring that consistency for them that doesn't necessarily
37 mean the service level agreement being struck with the
38 ministry.

39

40 I think, to add to the point that Alfa made, we don't
41 dictate to the districts how they necessarily apportion
42 activity to hospitals within the LHD. That is the
43 responsibility of the chief executive to determine. So
44 even for their own hospitals, they have that discretion
45 about how they move activity around, for want of a better
46 expression. I'm not saying that it's substantially - you
47 know, swings and roundabouts like that, but there is

1 a discretion there.

2

3 MR MUSTON: But having exercised that discretion and made
4 a decision, presumably prior to entering into a service
5 level agreement, with the AHO that they want a particular
6 amount of activity, potentially to be going through the
7 AHO's facility, is there any reason why that couldn't be
8 communicated to the ministry, "This is what we want to
9 purchase from this AHO", and the ministry could then go
10 forth and purchase that activity from the AHO under
11 a service level agreement with it?

12

13 MR D'AMATO: I think it is going to be adding additional
14 admin, unnecessary admin processes in then - and
15 potentially delaying all aspects about the operational
16 opportunities the district may have with this extra
17 capacity.

18

19 I will give you an example, one of these AHOs
20 obviously asked some help in regards to managing the
21 conversation with the district and the reality is the
22 district was - what can I say, the needs of the district
23 were different to the expectation of the AHOs. So where is
24 the ministry in that? Ultimately, this needs to
25 accommodate for the needs of the district, the local
26 community. So that's why I struggle to see how the
27 ministry could add any value in the relationship.

28

29 MR MUSTON: Can I quickly come to - I'm just mindful of
30 the time - one last point, which is the suggestion that
31 there be some independent structured process aimed at
32 resolving disputes around the size of the grant which is
33 proffered for services required to be delivered or sought
34 to be delivered under service level agreements. What - can
35 I invite any of you to say - is the challenge with that
36 proposal?

37

38 MS PEARCE: I'm happy to start. I think the role of the
39 ministry is substantial in playing that role, actually,
40 between a district and an AHO, and we often have done that.
41 I think that's where we're seeking to get greater clarity
42 for the AHOs with regard to how this process establishes.
43 I know that there's nervousness amongst them around their
44 ongoing funding. There's no evidence of - because they
45 have raised it with me in the past, you know, they want
46 five-year agreements and so on to give certainty. There is
47 no evidence of us ever, you know, pulling the rug out from

1 under an AHO in that regard.

2
3 I guess my point is if we went to having an
4 independent arbiter over these types of matters, first of
5 all, I'm not sure - that person or entity doesn't need to
6 have regard for the apportionment of the health budget that
7 we do. It's very difficult for me to see how that could,
8 in practice, operate in a way that didn't then result in a
9 situation where you were constantly having, you know - or
10 at issue in terms of the amount of funding that is
11 provided.

12
13 The other thing I will say is that the board chairs of
14 affiliated health organisations often, and do, raise issues
15 if they have them around the funding that's being made
16 available to them, with the minister or with me, and we
17 work through those issues with them. That's our
18 responsibility as the people responsible for administering
19 the funds that government give us.

20
21 MR MUSTON: But can I ask this: when you used the term
22 a moment ago, the issues arising in relation to the
23 distribution of the health budget, obviously issues arise
24 in terms of what proportion of budgets are to be delivered
25 to local health districts to do their best with, to deliver
26 the care that they need to deliver, and they might go over
27 budget, in which case, there are consequences in terms of
28 their KPIs and the like, but the extent to which they are
29 over budget is ultimately a matter which is dealt with.
30 For an affiliated health organisation, why should they be
31 exposed to a situation in which they are being - the amount
32 of money being proffered for the services sought of them is
33 less than what it actually costs to deliver those services,
34 whether we exist in a constrained budgetary environment or
35 not?

36
37 THE COMMISSIONER: That should be the fundamental
38 principle, shouldn't it, that in terms of the services that
39 AHOs are required to deliver under the service agreement,
40 they should be provided with funding that covers the
41 reasonable cost of delivering the services they have to?
42 Do you agree?

43
44 MS PEARCE: Yes. We agree with that principle,
45 Commissioner, so long as the costs of delivering those
46 services are transparent and available to all parties.

47

1 THE COMMISSIONER: There might be disagreement as to what
2 the reasonable cost of delivering the services is, which
3 brings in the dispute mechanism as to when that --
4

5 MR MINNS: Which, you know - and there could be
6 a situation where an AHO has elected to reach an enterprise
7 agreement outcome with a relevant union that is different
8 to the arrangement that operates in the state, and so then
9 they would just arrive saying, "I'd like that money,
10 please."
11

12 MR MUSTON: They might, but assume against - as at least
13 a hypothetical possibility - that in order for them to
14 function as an operation, they needed to do that. The
15 issue arises, I understand, that there may be a debate
16 about what the reasonable cost is, but what's proposed is
17 that in circumstances where a debate of that type arises,
18 the ministry might say, "No, no, you can do it more
19 efficiently", or "The cost that you are putting forward is
20 actually also cross-subsidising other non-AHO work that you
21 are doing", or "You've got an agreement with your employees
22 which is not consistent with the agreement we have with
23 ours", and no doubt a range of other factors. To the
24 extent that the AHO disagrees with any of those
25 propositions, you can't have a situation, can you, where
26 you just continue to stand off over potentially years?
27

28 MR D'AMATO: But I wonder whether this is more the symptom
29 of what we experienced over the last four years throughout
30 COVID, where the AHOs, you know, say the large ones, were
31 subject to the same regime where we actually worked with
32 the districts, in that there were adjustments to the
33 funding as a result of extra costs incurred throughout
34 COVID, and now we just need to move back into normal
35 scenarios. And taking into account the normal scenarios,
36 I think that the larger AHOs, who deliver acute, sub-acute
37 care, they tend to provide the data, we can see their
38 costs, and the cost is effectively not too dissimilar to
39 the cost of other services, therefore using a state
40 efficient price seems to me appropriate. So take this one
41 aside
42

43 Then the other ones that provide unique services that
44 are not well captured by the ABF, the reality is, apart
45 from the services we added throughout COVID, the base
46 funding remains the same, it just gets annexed. So again
47 to me this is a period of adjustment, the symptoms that we

1 are trying to address here are likely as a consequence of
2 decisions throughout COVID.

3
4 MR MUSTON: Well, in the case of Royal Rehab, the evidence
5 suggested they hadn't entered into a service level
6 agreement with Northern Sydney LHD for 12 years, which well
7 and truly pre-dates COVID. In that situation, would it not
8 have been preferable for ministry to take, or in that case,
9 Northern Sydney LHD to take its view as to what the
10 reasonable cost of delivering the care through Royal
11 Rehab's facility would be, Royal Rehab to take its view, to
12 the extent that they did not align, some appropriately
13 competent independent party could make an assessment of
14 available efficiencies, reasonable ways of doing business,
15 risk of cross-subsidisation, whatever else, and say, "The
16 services you require under the service level agreement cost
17 X. Now, you don't have to take those services for X. And
18 Royal Rehab, you don't have to provide those services for X
19 if you don't want to", but to the extent that there is any
20 debate about what a fair cost for the services being
21 required, that debate has been resolved independently and
22 in a way which enables both parties to make a decision
23 about whether they want to take them, provide them and move
24 on.

25
26 MR D'AMATO: My only observation in that is that the AHOs
27 can submit the data and are submitting the data to us. So,
28 for instance, we know the unit cost of delivering care for
29 St Vincent's. Royal Rehab has the same opportunity to send
30 it to us so that we can then take into account that, and
31 that's where I see the opportunity for the ministry is to
32 step in and provide a framework which is consistent. What
33 I mean by that is the transition arrangements, cost price
34 adjustments and things that can be then taken into account,
35 and again with the view of being consistent.

36
37 MR MUSTON: But how, then, do we deal with the situation
38 where, having provided the data to the ministry and the
39 ministry's looked carefully at that data and formed its own
40 independent view or objective view that they think that the
41 amount that is being put forward as the cost of delivering
42 the services is in excess of the actual cost; the AHO
43 disagrees, it says, "No, no, no, you've got it wrong." How
44 do you resolve that in a way other than forcing a service
45 level agreement on an AHO with a price that it says is
46 insufficient for it to deliver the services that are
47 required of them?

1
2 MR D'AMATO: Again, if you take into account Royal Rehab,
3 I don't have the full details. I'm talking more about
4 other areas where I'm more aware of the arrangements. Say
5 they provide the cost information, which is standard across
6 all other hospitals, it gives us also an opportunity at the
7 district level to determine whether they want to access
8 more services or not. So I do think that the framework
9 that we mention could actually resolve this and remove the
10 need to have a third party intervening into a dispute
11 resolution.

12
13 THE COMMISSIONER: I think, though, that the evidence
14 before me, which I have to go on, is a series of these
15 AHOs, including St Vincent's, all at a level of - at a very
16 generalised level have said, "We are not given sufficient
17 money to cover the costs of the services we deliver," which
18 leads to either not signing a service agreement or, in the
19 case of St Vincent's, saying they wouldn't until there was
20 some additional money provided that has to be paid back.

21
22 In circumstances where there is that level of
23 agreement for these organisations, I'm not sure, in the
24 end, I understand the objection to, if there's an impasse,
25 an independent person or entity providing an opinion as to
26 where the truth lies, which the minister ultimately could
27 ignore or not ignore.

28
29 MR D'AMATO: So perhaps, if we have two more minutes,
30 sorry. We need to consider the difference between
31 liquidity challenges and costs and technical efficiencies.
32 So when we're talking about the price --

33
34 THE COMMISSIONER: Yes, but the dispute person can worry
35 about all that.

36
37 MR D'AMATO: Well, look, I tend to think that the
38 liquidity challenges are different and again, they are more
39 the symptom of the fact that we are stepping out of COVID
40 and there are some --

41
42 THE COMMISSIONER: They might be, but that might be your
43 argument to the --

44
45 MS PEARCE: I think the point fundamentally is that there
46 needs to be a greater degree, on both sides, of information
47 sharing with respect to these issues and I think we can do

1 a better job of that.

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We can go back many years when affiliated health organisations were offered the opportunity for their staff to become Crown employees, when WorkChoices legislation was afoot. They declined that. They have made various decisions over the years with respect to their businesses that cannot all sheet home to the New South Wales health system. But we are partners and in that partnership, we need to work through these issues together.

It was put to me recently that they want an automatic mirroring of whatever rates of pay are given to X number - X staff, you know, craft group. My response to that was traditionally we have passed on the escalations around staffing to the AHOs, but how am I to know that they haven't paid their staff a smaller amount than what the state government has agreed under an EBA?

THE COMMISSIONER: But I'm not going to be making a finding as to whether any AHO is or isn't funded to the amount it should be.

MS PEARCE: Yes.

THE COMMISSIONER: What counsel's submissions are directed to really is only if there seems to be an impasse that can't be resolved, that a mechanism for doing that might be helpful.

MS PEARCE: Look, I think our submission lays out our view and our concerns with that suggestion. I mean, I think in any dispute settling arrangement there needs to be a series of events that occur before any such thing could be considered. We think we can manage that without an independent arbiter. We're nervous about someone, without having to take into account all of the things we have to consider in the apportionment of our budget, making those decisions.

MR MUSTON: I note the time, Commissioner. I'm grateful to everyone for staying longer than --

THE COMMISSIONER: Mr Chapman, do you have - no?

MR CHAPMAN: No

1 THE COMMISSIONER: Mr Cheney, do you want --

2

3 MR CHENEY: No, Commissioner.

4

5 THE COMMISSIONER: Without wishing to hold you up, but
6 given you're here, obviously I will be saying more about
7 this at another time, but can I thank NSW Health for the
8 cooperative way it has approached this Special Commission.
9 That is appreciated.

10

11 That thanks extends to your legal advisers and, within
12 reason, to your representatives, and that is in relation to
13 production of documents, assistance with witnesses,
14 assistance with statements and site visits, and also thanks
15 to your staff who have participated - too many doctors,
16 nurses, et cetera, to name - but also to management,
17 thanks, including executives within the ministry, so
18 thank you for that.

19

20 MS PEARCE: Thank you, Commissioner. I'm very grateful to
21 receive that, thank you.

22

23 THE COMMISSIONER: Sorry, I should just say are there any
24 final comments the three of you wish to make? Is there any
25 final comment you want to leave us with?

26

27 MS PEARCE: I think on reflection of what you have said,
28 we have approached this in a very open way. We accept that
29 there is always room for improvement. We are grateful for
30 the acknowledgment that you've given to our staff and to
31 our executive team and also to the quality of the New South
32 Wales health system broadly. We thank you for that and for
33 your approach and that of your counsel assisting to this
34 process. Thank you.

35

36 THE COMMISSIONER: Anything to add?

37

38 MR D'AMATO: No.

39

40 MR MINNS: No.

41

42 THE COMMISSIONER: Thank you very much. You are excused.

43

44 We'll start at an appropriate time later this
45 afternoon?

46

47 MR MUSTON: Yes.

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THE COMMISSIONER: Shall we take an hour? 2.30?

MR MUSTON: 2.30.

THE COMMISSIONER: We will adjourn until 2.30.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Right, are we all set?

MR MUSTON: Yes.

THE COMMISSIONER: Mr Cheney, thank you for your submissions. Can I just ask a few questions.

MR CHENEY: Yes.

THE COMMISSIONER: Can I start with the response to counsel assisting's recommendation 3, 4 and 5, which are on page 11 of your submission. That's just to orientate you. If we can then go to starting at paragraph 6.16, page 15:

The special Commission might sympathise with patients, clinicians and the wider community ...

Just pausing there, there's been a suggestion that "might" should be replaced with "do". Moving forward, though:

But the practical reality is that, for so long as this fragmented health system exists ... No amount of collaborative planning and reformulation of planning funding approaches can be a complete panacea.

That was taken up in the evidence earlier today. Then you go on to say in 6.17:

Nor, with respect, is there anything "surprising" about the fact that repeated commitment by ... governments ... have not eliminated the challenges posed ...

et cetera. Can I just ask your response to this: I am surprised, and I will tell you why. I actually find it

1 astonishing that we still haven't eliminated the challenges
2 that you speak of.

3
4 The reason I say that is that in the course of doing
5 this Inquiry we have all read countless reports -
6 Productivity Commission reports till the Productivity
7 Commission would be blue in the face; report of the
8 National Health and Hospitals Reform Commission; but
9 countless other reports that recommend there needs to be
10 a change into the way services are provided and funded.
11 There have been recommendations that have been made for
12 somewhere between 40 years plus. So why do you say that
13 it's not surprising?

14
15 MR CHENEY: Well - and I don't mean this to sound glib,
16 Commissioner - for so long as we are bedevilled by this
17 federal system, the challenges that we are referring to in
18 6.16 and 6.17 require a whole of government approach, state
19 and federal, and it's that problem --

20
21 THE COMMISSIONER: For want of a better expression, hasn't
22 government been telling government to do certain things for
23 the amount of time I just indicated?

24
25 MR CHENEY: There is no doubt, Commissioner, that the
26 governments generally recognise the problem and the need
27 for a solution. What we suggest is not surprising is that
28 given that we are bedevilled by this federal system, it's
29 not surprising that the solution hasn't been found.

30
31 THE COMMISSIONER: But my point is that the federal system
32 has been telling itself to make changes for a lot of years.
33 To me, it is surprising that we are still where we are.

34
35 MR CHENEY: Perhaps we approached it with too much
36 cynicism, Commissioner, but if the proposition is that we
37 should be able to fix it, then we can readily agree with
38 it, yes, Commissioner.

39
40 THE COMMISSIONER: Yes. Can I then take you to the
41 submission you make about there being a planning regime in
42 the NHRA that - you've mentioned this earlier in your
43 submission, and when we get to your submissions in relation
44 to primary care, which start on page 41, if you go to
45 page 43 at 9.5, you have referred to counsel assisting's
46 submission regarding one of the matters mentioned in the
47 NHRA - that is, the Commonwealth Government is responsible

1 for system management, support, policy and funding of
2 primary care.

3
4 MR CHENEY: Yes.

5
6 THE COMMISSIONER: And you complain that that somewhat
7 simplifies the regime, or what you call the "planning
8 regime". You have then addressed individual
9 responsibilities in paragraph 9.9, and in 9.9(b) you are
10 obviously keen for me to note that PHNs are referred to,
11 given the bold print, and again in 9.10, you are mentioning
12 the roles that PHNs have, and again in 9.14(a), you've
13 mentioned, again in bold print, so I don't miss it, the
14 role of primary health networks.

15
16 Can we get up the NHRA, please, it's document
17 [SCI.0001.0024.001]. Thanks. And if we could go to
18 clause - well, page 7 of the document, that's it. So these
19 are the objectives. Let's just work through this together
20 to see if we can reach agreement. Objective 7:

21
22 *The Commonwealth and the States will work*
23 *in partnership to implement arrangements*
24 *for a nationally unified and locally*
25 *controlled health system ...*

26
27 So, just pausing there, I don't think there is any doubt
28 that it's the state and the Commonwealth have a role in
29 creating this Nirvana of a locally controlled health
30 system; correct?

31
32 MR CHENEY: I accept that, yes.

33
34 THE COMMISSIONER: If we go to (b), the Commonwealth and
35 the states will work in partnership to:

36
37 *Improve the provision of GP and primary*
38 *healthcare services ...*

39
40 So just pausing there, at least some role for the state in
41 improving the provision of GP and primary healthcare
42 services. You accept that?

43
44 MR CHENEY: Accept that, Commissioner.

45
46 THE COMMISSIONER: (c):

47

1 *Improve care coordination for people with*
2 *chronic and complex needs ...*

3

4 And, of course, those people need, amongst other sorts of
5 services, primary healthcare services. Agreed?

6

7 MR CHENEY: Agreed.

8

9 THE COMMISSIONER: So a role for the state in relation to
10 that?

11

12 MR CHENEY: Yes.

13

14 THE COMMISSIONER: Same in relation to working effectively
15 together with aged care and disability support systems - do
16 you see that, subparagraph (h)?

17

18 MR CHENEY: Yes.

19

20 THE COMMISSIONER: So a joint role there for the state as
21 well as the Commonwealth?

22

23 MR CHENEY: In working effectively to implement that
24 system, yes.

25

26 THE COMMISSIONER: Okay. Then if we move to schedule C,
27 where there is a little bit more detail in relation to the
28 long-term health reform principle, so that's on page 56 of
29 the document, so C1 sets out - you see the words in C1
30 begin with "Shared action", all of those things? So the
31 action in relation to the long-term health reform
32 principles, which in relation to C include prevention and
33 wellbeing and presumably then that aspect of prevention
34 required from primary care, that is to be shared action;
35 you agree with that?

36

37 MR CHENEY: Yes, Commissioner.

38

39 THE COMMISSIONER: C2:

40

41 *The Parties acknowledge that a genuine*
42 *commitment to shared action on long term*
43 *health system reform ...*

44

45 et cetera

46

47 MR CHENEY: Yes, Commissioner.

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THE COMMISSIONER: C3:

*Facilitation of innovative approaches will
be critical. The Parties agree funding
pools and models ...*

et cetera. Do you see that? That's an agreement between
not just the Commonwealth but with the states? Do you see
that

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: C4:

*The Parties agree to jointly develop
detailed implementation plans ...*

Now, just pausing there, I mean, the text is obvious,
that the parties are agreeing to develop plans. I'm going
to keep going through this with you, but do you still
maintain that this is a planning regime? Because the way
I read this document is that, as I mentioned to the health
secretary - and I think she agreed - it's a document that
outlines aspirations and objectives, to the extent they are
different; it is a document that allocates funding
responsibility and absolutely the Commonwealth is on the
hook for the funding of primary care and aged care; and
it's a document that otherwise says the parties have all
got to work together to develop plans, including plans for
shared action in relation to all of these priorities,
including these long-term health reforms, that relate to,
amongst other things, prevention and primary care, but it's
not the plan itself. Do you accept that?

MR CHENEY: I accept that nothing in the NHRA addendum
constitutes a plan for long-term health care, if that's
what --

THE COMMISSIONER: Why did you call it a planning regime
in your submissions?

MR CHENEY: Because it contemplates a regime of planning
in those provisions that the Commissioner has just taken me
to. We didn't intend to --

THE COMMISSIONER: Contemplating a regime of planning is

1 different from a planning regime, isn't it? I don't think
2 that's a semantic difference; that's a real difference,
3 isn't it? See, the thrust of your submission is counsel
4 assisting's submissions in relation to primary care
5 shouldn't be accepted because it trampled all over this
6 planning regime.

7
8 My response to that is I don't even - I don't accept
9 the premise of the submission because I don't accept that
10 there's a planning regime here, other than you've got to
11 work together, including on primary health care. The
12 Commonwealth will have to fund it, no doubt about that.

13
14 MR CHENEY: Yes.

15
16 THE COMMISSIONER: But the state, the local hospital
17 networks, the PHNs, everyone involved has to work together.

18
19 MR CHENEY: Yes.

20
21 THE COMMISSIONER: You agree with that?

22
23 MR CHENEY: Commissioner, but that proposition sits in the
24 context that the agreement provides, in clause 11, that the
25 Commonwealth will be responsible for, among other things,
26 system management and support policy and funding,
27 et cetera.

28
29 THE COMMISSIONER: Absolutely. But that is fleshed out by
30 what is in the rest of it.

31
32 MR CHENEY: Yes.

33
34 THE COMMISSIONER: No-one's suggesting that the
35 Commonwealth isn't responsible for what it says it's
36 responsible for in the NHRA, including funding. But in
37 terms of the action to address prevention and primary
38 health care, it's as clear as day that it's to be shared
39 action.

40
41 MR CHENEY: Yes, although that's a somewhat loaded term,
42 if by that term it's taken that responsibility will be
43 shared, or that the --

44
45 THE COMMISSIONER: Well, having responsibility for the
46 shared action

47

1 MR CHENEY: Yes, but I'm speaking of the ultimate
2 responsibility the subject of clause 11.

3
4 THE COMMISSIONER: Well, you see, I don't know that that's
5 right. Otherwise, it would say that. I mean, I don't want
6 to labour the point, but if we go back to C1 "Shared
7 action":

8
9 *Prioritising prevention and helping people*
10 *to manage their health across their*
11 *lifetime through:*

12
13 *(ii) prevention and wellbeing.*

14
15 It doesn't allocate that the Commonwealth will be
16 responsible for 99 per cent of the shared action and the
17 state for 1 per cent, it contemplates what it says, that
18 there will be a complete universal sharing between the
19 Commonwealth, the states, the LHDs, the local hospitals,
20 the PHNs to fulfil the objectives of the NHRA, with - in
21 terms of aged care, primary care, the Commonwealth provides
22 the dough

23
24 MR CHENEY: I accept that.

25
26 THE COMMISSIONER: If we move on, don't worry about paying
27 for value - I'm going to some of the clauses that you have
28 mentioned in your submission, but if we go to C23 on
29 page 60, "Joint planning and funding at a local level", C23
30 concedes the point that you have already made, and you make
31 in your submission, about fragmentation.

32
33 MR CHENEY: And perhaps it is the genesis of our point.

34
35 THE COMMISSIONER: Yes. Regardless of whether we've got
36 a fragmented system - and we do - that is what it is at the
37 moment, C25:

38
39 *The Parties recognise that they need to*
40 *work together to better plan ...*

41
42 Again, that indicates to me this isn't a planning regime.
43 It might be a plan to make a plan, but it's not the
44 planning regime the way I saw you pitching it in your
45 submission; it's telling - it's the parties telling
46 themselves they need to work together to make these plans.
47 Do you accept that?

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MR CHENEY: I do, Commissioner. And nothing - it may not read this way, but nothing we put in that submission was intended to in some way abrogate our role in that process.

THE COMMISSIONER: Well, when you use the words that "counsel assisting is trampling over the planning regime", is there another way I should have taken that other than that being a fairly severe criticism of the way counsel assisting has made recommendations to me concerning what recommendations I should make? It's fairly strong to say they are trampling over something that we're now agreeing may not be the planning regime you have set out in your submission.

MR CHENEY: Well, perhaps we could have said "treading lightly upon", Commissioner.

THE COMMISSIONER: If you had said that, we may not have gotten to where we are. I have to say this, and it is never me to be unduly critical unless I'm watching television, but there is a lot of, "This NHRA is a big impediment to what counsel assisting is recommending". Now, there might be matters of debate, but I don't see this document, or what it sets out, as being the impediment that you have submitted, and I don't see counsel assisting, in terms of what they are submitting to me, as being something that, in terms of their submission, can be fairly construed as trampling over, stepping on, ignoring, what is in the NHRA.

I view it, frankly, as entirely consistent with what is in the NHRA, because it contemplates something that, more or less, is implementing at least the objectives of the NHRA, bearing in mind also that whilst - I don't ignore and won't ignore what is in this agreement concerning the role that PHNs have played, but I can't ignore what Rosemary Huxtable has said in her mid-term review about PHNs, which is they are not given sufficient guidance, nor are they given funding to do much good, and they haven't achieved much.

I don't think she's been critical of individuals, she's being critical of the way the NHRA has been set up and funded in the sense that, because there's a gap in terms of how the PHNs have been either empowered or probably resourced and funded, there is a very big role for

1 LHDs in relation to this shared action. And I think they
2 fulfil it, to be honest.

3
4 MR CHENEY: We accept that, Commissioner, yes.

5
6 THE COMMISSIONER: Okay. I mean, again, I'm starting to
7 labour the point, but if you look at page 62, you've
8 referred to some of these clauses in your submission, but
9 C38:

10
11 *The Parties acknowledge that all*
12 *governments currently invest in primary*
13 *prevention ...*

14
15 So there is even a recognition within the document itself,
16 that whilst the Commonwealth is the funding entity
17 responsible, everyone is chipping in because they have
18 to --

19
20 MR CHENEY: Yes, Commissioner.

21
22 THE COMMISSIONER: -- in relation to prevention, which
23 would include primary healthcare services. That's why -
24 I mean, 9.12 of your submission on page 46, again, you say
25 that the states have a supporting role in planning.
26 I don't see - they're not co-stars in this agreement; the
27 state is front and centre with the Commonwealth in terms of
28 achieving the objectives of the NHRA. I'm not sensing you
29 disagreeing with that anymore

30
31 MR CHENEY: I'm not, and in my submission, what we say in
32 the next sentence embraces that point, because we quote the
33 fact that we're to work together.

34
35 THE COMMISSIONER: Yes, yes, shared action. Shared
36 action.

37
38 MR CHENEY: Yes.

39
40 THE COMMISSIONER: Absolutely agree with that. I mean, if
41 it's not shared action, what happens is, which hasn't been
42 what's happening, is the LHDs recognise a problem, they
43 probably - some of them discuss it with PHNs, some of the
44 PHNs are more active than others, but if the Commonwealth
45 is there it's got no idea, and then you get the problem
46 that is discussed about getting the money out of the
47 Commonwealth when there is primary healthcare failure and

1 the resistance to that. That's why it's got to be shared
2 action.

3
4 And credit where credit's due, NSW Health at least on
5 the evidence I've seen, I would describe as the proactive
6 party when these problems emerge or have emerged, and are
7 continuing to emerge, and the Commonwealth being reactive.
8 That's going to need to change. Obviously I can't
9 control - well, I can't control what the state does let
10 alone the Commonwealth, but I'm acutely aware this is
11 a state based Special Commission. But unless the
12 Commonwealth's there - but the State of New South Wales is
13 the educator here. It's got the local management, it's got
14 the skilled and invested local commissions, particularly in
15 regional areas, but in the city as well. No-one should
16 interpret that for me to mean that the Commonwealth or the
17 relevant Commonwealth department doesn't care but it's just
18 not on the ground to the same extent. Do you agree with
19 that?

20
21 MR CHENEY: I do. But Commissioner, the point we were
22 trying to press in 9.12 is that the agreement contemplates
23 that we have a role in the planning of primary care by
24 working together with the Commonwealth, and we were trying
25 to push back on the proposition - to the extent that we've
26 said that counsel assisting's recommendations involve
27 trampling on the planning regime, that was a reference to
28 the aspect of the recommendation that would have us move
29 into where there's been a failed primary care market, solve
30 the problem and chase the money later from the
31 Commonwealth.

32
33 THE COMMISSIONER: But what is wrong with that? What is
34 wrong with that?

35
36 MR CHENEY: Well, apart from the funding implications,
37 that --

38
39 THE COMMISSIONER: What are the funding implications?

40
41 MR CHENEY: As we put in our submission, were we to do
42 that, it follows inevitably that existing services that we
43 supply would have to suffer to --

44
45 THE COMMISSIONER: Why, why? You are doing this already.
46 You are doing this in - god, I could list Murrumbidgee
47 single employer model, the 4Ts, Bowraville. I could go on

1 and on. You're doing this already. Does that make you
2 sacrifice services you could otherwise deliver?

3
4 MR CHENEY: To the extent there is a limited pie,
5 Commissioner, every cent we spend on that --

6
7 THE COMMISSIONER: But hasn't the Commonwealth come along
8 in every one of those instances and funded - provided
9 a funding stream?

10
11 MR CHENEY: But the point we were pushing back on was the
12 notion that where we could not get up-front agreement from
13 the Commonwealth about this, we should, nevertheless,
14 plough on and --

15
16 THE COMMISSIONER: But does that mean the citizens of
17 New South Wales should just have to wait until the
18 Commonwealth decides, "Oh, we'll provide a funding stream",
19 if their GPs disappear in a town?

20
21 MR CHENEY: There is no easy solution to any of this,
22 Commissioner, but the solution that was put forward in
23 counsel assisting's submissions would have the state
24 bearing the --

25
26 THE COMMISSIONER: But you mention risk. Where is the
27 risk? What's the risk? What's the funding risk?

28
29 MR CHENEY: I'm not sure I used the term "risk", but I --

30
31 THE COMMISSIONER: No, you have. You have. You have
32 talked about risk in your submissions about becoming
33 a provider of primary care or aged care in the
34 circumstances of market failure. You do talk about risk.
35 I'm curious as to what the risk is when I haven't been
36 given evidence of any scenario where there has been
37 a market failure of aged care and the state has had to do
38 something, and the Commonwealth has said, "No, we're not
39 going to fund it."

40
41 MR CHENEY: Can I call Mr Chiu in on that, Commissioner?
42 He's had something --

43
44 THE COMMISSIONER: I'm perfectly content to hear from
45 either of you.

46
47 MR CHIU: Commissioner, perhaps I could try to --

1
2 THE COMMISSIONER: Sorry I don't mean to interrupt, but
3 9.34, page 53, where one of the things said against this
4 is:

5
6 *... whether New South Wales is to bear the*
7 *significant financial risk from increased*
8 *NSW Health involvement in primary care and*
9 *aged care ... it cannot speak for*
10 *Government's willingness to bear the risk.*

11
12 My question is: where do I find the risk?

13
14 MR CHIU: If I could try to distil the entire position in
15 a more basic way without the emotion, perhaps, the first --

16
17 THE COMMISSIONER: Hang on, there's no emotion from me.
18 The emotion's in "trampling over" in your submission.

19
20 MR CHIU: And that point is taken.

21
22 The first proposition is that where NSW Health has
23 been able to provide primary care in situations of market
24 failure within its existing budget envelope - so within an
25 envelope of a particular local health district - it has
26 done so and it's sought funding.

27
28 THE COMMISSIONER: Yes.

29
30 MR CHIU: And that will presumably continue to happen as
31 a matter of reality.

32
33 THE COMMISSIONER: Well, if it didn't, the Commonwealth
34 would be in breach of the agreement.

35
36 MR CHIU: Indeed. The second proposition, and I think the
37 secretary made this point today that is, health's
38 nervousness is that a commitment to doing that at scale,
39 wherever there is market failure, is likely to go beyond
40 its existing budget envelope.

41
42 THE COMMISSIONER: What does "at scale" mean in that
43 submission?

44
45 MR CHIU: It's a little bit unclear, because the proposal,
46 the recommendation is "wherever there is market failure".
47 So I don't know whether that means five local health

1 districts, 50 communities, 500 communities, and part of our
2 proposal is you've got to do the statewide services
3 planning to work out what sort of scale you're talking
4 about, how much it's going to cost.

5
6 THE COMMISSIONER: Yes. Yes.

7
8 MR CHIU: So the nervousness --

9
10 THE COMMISSIONER: Well, I partially agree with what you
11 just said. I agree that the planning is really important,
12 including at the level of detail that are in proposed
13 recommendation 7.

14
15 MR CHIU: Yes.

16
17 THE COMMISSIONER: But whether or not you're doing that
18 planning - and let's assume you do - in the process of
19 doing that planning, these crises of primary care
20 disappearing can happen at any time.

21
22 MR CHIU: And as I said in my first proposition, where we
23 can, within the existing envelope, do what we can, we will.

24
25 The nervousness, the third proposition, if I might
26 suggest, is that if health were to commit, within its
27 existing envelope, without the commitment of the New South
28 Wales Government, to do that at some scale, whatever that
29 scale may be, it will then have to reallocate its existing
30 resources for that. Now, that may be a good thing,
31 Commissioner - it could be that system-wide services
32 planning says, "It's better use of your money to do this
33 instead of that."

34
35 THE COMMISSIONER: Okay, can I just, then, check whether
36 I'm understanding you. Leaving aside an issue as to
37 whether there is a risk that the Commonwealth doesn't come
38 in and provide funding as it's meant to, as it has agreed
39 to --

40
41 MR CHIU: Yes.

42
43 THE COMMISSIONER: -- there is a separate risk that
44 health, as distinct from the New South Wales Government, is
45 identifying as a risk to itself if the government
46 weren't to come on - the New South Wales Government
47 wasn't --

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MR CHIU: Correct. I can never speak for the New South Wales Government. I can only speak from the perspective of NSW Health, so that's the risk.

THE COMMISSIONER: I understand the submission. Sorry, go ahead.

MR CHIU: If I could just - the fourth proposition arising from that is - sorry, before I go on to the fourth, as part of that nervousness, you heard the secretary say, if the New South Wales Government as a matter of policy says, "Yes, we're going to do this", in response to your recommendation, your proposed recommendation, then the evidence of NSW Health is we will do it, if that's - yes.

THE COMMISSIONER: Okay. And just to follow on to make sure I understand you, when you're talking about thinning resources, it's not with an eye to whether the Commonwealth comes in, it's more that if we, NSW Health, do this in terms of primary care provision, but our budgetary envelope stays exactly the same --

MR CHIU: Yes.

THE COMMISSIONER: -- there is an inevitable consequence concerning that.

MR CHIU: The thinning of services.

THE COMMISSIONER: I've got it. Okay. I understand what you are putting to me.

MR CHIU: That's the proposition.

THE COMMISSIONER: In terms of risk, there's another aspect of risk, isn't there, you would agree, that if - forget whose fault this is, forget even - well, we'll never forget who the funder is, but if access to reasonable and timely primary care is allowed to dwindle and dissipate or disappear altogether, there is another risk to New South Wales as a whole - that is, worse population health outcomes; agree with that?

MR CHIU: Yes.

THE COMMISSIONER: And probably more healthcare costs in

1 the long run because those people deprived of primary
2 healthcare services will almost inevitably end up in ED or
3 probably as acute care patients in a hospital. Do you
4 agree with that?

5
6 MR CHIU: Indeed and that risk, if I might suggest, arises
7 on both NSW Health level and the New South Wales Government
8 level, because within the health - within any local health
9 district, it has to weigh up the cost of stepping in at
10 a primary care level versus the offset cost of the acute
11 services but, more importantly, at a government level it
12 has to decide as a matter of policy which way it wants to
13 go.

14
15 THE COMMISSIONER: Yes. Okay.

16
17 MR CHIU: Now, the fourth proposition, Commissioner, is
18 that - although I can't speak for the New South Wales
19 Government - one would expect that in considering what it
20 should do as a matter of policy in response to your
21 proposed recommendation, it needs to take into account in
22 some way the NHRA. We can debate how much or whether it's
23 an aspirational document only --

24
25 THE COMMISSIONER: I imagine the main thing it will take
26 into account is, "You, the Commonwealth, say you are going
27 to pay for this".

28
29 MR CHIU: That's an intergovernmental discussion that I'm
30 not privy to. There is very little evidence as to what's
31 happening on that front.

32
33 THE COMMISSIONER: No, but we can read the text.

34
35 MR CHIU: We can read the text. I think there is some
36 evidence that they are in negotiations, and I heard the
37 word "stalled" used this morning.

38
39 THE COMMISSIONER: I took Mr Minns to mean that, given
40 what is looming at some stage, including up to and
41 including May, ie, a federal election, that that's the
42 cause of a stalling.

43
44 MR CHIU: Indeed.

45
46 THE COMMISSIONER: I might be wrong about that, but that's
47 what I --

1
2 MR CHIU: But my point there is simply that what account
3 the New South Wales Government, in deciding policy, takes
4 of the NHRA, is really a matter for the government and its
5 understanding of the NHRA, not so much a legal assessment
6 of what it means.

7
8 They were the only points I wanted to raise on that.

9
10 THE COMMISSIONER: All right. Because this is the same
11 topic, I don't know whether you want to stay on your feet,
12 but we'll just see. Can I take you to 9.30 and just get
13 your view on this, this is at page 52 of your submission -
14 I think we're done with the NHRA - well, not done with it
15 but for the purposes of these discussions we are. If we
16 could go to 9.30 on page 52.

17
18 MR CHIU: Yes.

19
20 THE COMMISSIONER: Do you think the submission is a bit of
21 a stretch when it says that the occasions where New South
22 Wales has had to provide or support primary care services
23 are "isolated instances"? Is that - the way I read -
24 I take that as being some hyperbole in that submission,
25 because when the gaps have emerged and the crises have
26 occurred, New South Wales has stepped in. It's not once or
27 twice, it's more than that. But the expression "isolated
28 instances" runs the risk of resigning it to something like,
29 "Oh, well, this happened once or twice, but it's not -
30 that's all it is and there's no prospect of it happening
31 again".

32
33 MR CHIU: It's not really the intent --

34
35 THE COMMISSIONER: I think we know that primary care is
36 really struggling, particularly in the regions and in areas
37 of socioeconomic disadvantage.

38
39 MR CHIU: Commissioner, it's not really the intent of that
40 submission, it's unfortunate, perhaps, that use of the
41 word, because the point there is really the evidence
42 identified multiple examples of where this occurred, but
43 the evidence, I don't suggest, got to the point where one
44 could conclude wherever it occurred, as a systematic
45 process, the local health district has stepped in.

46
47 THE COMMISSIONER: Well, if I was a betting man, and I am,

1 I would think something - if a town loses any reasonable
2 access to primary care services, my bet is on NSW Health
3 taking some action.
4

5 MR CHIU: Has taken some action, I suppose, but the
6 evidence didn't really explore to what extent and what kind
7 of action.
8

9 THE COMMISSIONER: Well, I don't know that I would agree
10 with that. I mean, we went - we heard significant evidence
11 on the single employer model. We had significant evidence
12 on the 4Ts. We had significant evidence in relation to
13 Bowraville, where we went to, and I think we had a really
14 good, broad range of evidence when we went on our regional
15 travels from management of LHDs and the clinicians there
16 about the stresses on them because of the stresses on
17 primary care. So I don't know that I agree entirely.
18

19 MR CHIU: Commissioner, if I could make this submission:
20 the evidence, in my submission, rises to the level that, in
21 many instances, NSW Health stepping in has occurred. In
22 many instances, that has been a good thing. What I do have
23 difficulty --
24

25 THE COMMISSIONER: Are there instances where it hasn't?
26

27 MR CHIU: That's the difficulty. There has been evidence
28 as to concerns raised by I think GPs in particular, as to
29 whether it's always the right solution in every instance --
30

31 THE COMMISSIONER: It may not be, if there's a market. If
32 there is a viable market for GPs there wouldn't
33 necessarily.
34

35 MR CHIU: The difficulty is there may not be a viable
36 market there now, why is there not a viable market, perhaps
37 the solution is NSW Health stepping in, perhaps it is not
38 if there is an alternative.
39

40 THE COMMISSIONER: There are no doubt various levels of
41 complexity.
42

43 MR CHIU: That's all that submission goes to and it links
44 back to our other submission that you've got to do that
45 detailed robust planning to work out is it viable, and how
46 much it's going to cost, is there a cheaper way of doing
47 it.

1
2 THE COMMISSIONER: Save that it's a relatively robust
3 process to get a 19(2) exemption, isn't it?
4
5 MR CHIU: It is. It is, yes.
6
7 THE COMMISSIONER: Yes. Thank you. That's --
8
9 MR CHIU: I may sit down.
10
11 THE COMMISSIONER: Yes, thank you. Either of you can feel
12 free to address this, but have we reached the stage in our
13 discussion where you would feel comfortable in conceding,
14 if we can go to 9.37 at page 55 of your submission - you
15 see, you're telling me there, recommendations 11, 12 and 14
16 would require reform of the NHRA. I really don't think
17 that's right. These things, in terms of New South Wales
18 stepping in when it's had to, in terms of failing markets
19 for primary care, are happening now without reform of the
20 NHRA. The NHRA contemplates, as we've gone over enough,
21 I think, shared action
22
23 MR CHENEY: Yes.
24
25 THE COMMISSIONER: I don't see how 11, 12 and 14 would
26 either require reform of the NHRA - I don't see why it
27 would require creation of a new mechanism for funding of
28 the states, given that the Commonwealth has agreed that
29 it's the funder of primary care services. I also don't
30 agree, in 9.40, that it would be a significant piece of
31 national healthcare reform. I think that's really very
32 much at the - well, I think there is a fair amount of
33 hyperbole in that submission too. Do you agree? Based on
34 the discussion we've just had, do you agree? I know you
35 want to say, "You've got to be really cautious in terms of
36 these recommendations because we mightn't get the money
37 from the state government, and whilst the Commonwealth has
38 to pay, they might agree late" - I get all that. But
39 I don't see any of that requiring, frankly, anything other
40 than implementation of the agreement, not reform of it.
41
42 MR CHENEY: Well, it's a matter, I suppose, Commissioner,
43 whether one sees merit in there being concordance between
44 the wording of the National Health Reform Agreement and
45 what is happening in practice.
46
47 THE COMMISSIONER: Well, is there anything in the NHRA

1 that forbids the state providing primary care?

2

3 MR CHENEY: No, there is no - nothing in the agreement
4 purports to.

5

6 THE COMMISSIONER: So are recommendations 11, 12 and 14
7 really a significant piece of national healthcare reform?
8 Is that a stretch? I mean, this is being done now. There
9 are aged care patients in New South Wales hospitals ward
10 after ward that could be in an aged care facility if there
11 was a bed or a workforce available. There is primary care
12 being provided now by the state under exemptions and other
13 arrangements. Do, really 11, 12 and 14 go so far as
14 a "significant piece of national healthcare reform"?

15

16 I mean, the National Health and Hospitals Reform
17 Commission in 2009 which suggested the Commonwealth take
18 over the funding of basically everything - that would have
19 been. And Mr Rudd had a slightly watered-down version of
20 that. I agree that would be a significant piece of
21 national healthcare reform. Recommendations 11, 12 and 14,
22 in my view, are a commonsense approach to a really
23 important problem about primary care and aged care.

24

25 MR CHENEY: And, Commissioner, perhaps at the risk of
26 agreeing --

27

28 THE COMMISSIONER: Well, do you agree with me or not? Do
29 you agree that you are stretching it with "significant
30 piece of national healthcare reform"?

31

32 MR CHENEY: Yes, if one accepts this proposition, that
33 nothing about the National Health Reform Agreement is in
34 any way justiciable. There is no way of enforcing the
35 obligations that lie or that are set out in that agreement,
36 and so in that respect, one could say on any suggestion to
37 a change in the way the system is implemented, it's
38 unnecessary to have that change reflected in the agreement,
39 because ultimately, to what end, if it can't be enforced.
40 So if I could perhaps express my agreement with that
41 qualification, Commissioner.

42

43 THE COMMISSIONER: Okay. I think we've sufficiently
44 covered 9.45 and "trampling over", but on that page at
45 page 58, you make a submission in 9.47 about - I just don't
46 understand this about aged care, the last sentence:

47

1 *Although health services are often provided*
2 *to the aged in a care setting --*

3
4 that is, by NSW Health --

5
6 *aged care is not synonymous with health*
7 *services, but encompasses a much broader*
8 *range of services not within the usual*
9 *business of a public health system.*

10
11 What are you telling me there?

12
13 MR CHENEY: Primarily, Commissioner, the residential
14 accommodation that is such a significant feature of aged
15 care. That concept --

16
17 THE COMMISSIONER: Well, counsel assisting are not
18 necessarily talking about retirement living, I don't think,
19 in their submission. Don't the MPSs, though - they have
20 communal rooms, they have rooms with windows that wards
21 don't have necessarily in public hospitals. It is just -
22 it seems as though this is suggesting that counsel
23 assisting is recommending the setting up of, like,
24 retirement villages, which is not the way I'm interpreting
25 what they're suggesting that I should do.

26
27 MR CHENEY: Commissioner, what is said in 9.47 provides
28 some examples of what would be caught by a recommendation
29 in the form pressed, that we would be assuming
30 responsibility for, among other things, accommodation,
31 supervision and transportation of the elderly, with all the
32 associated demands around capital infrastructure and
33 workforce.

34
35 THE COMMISSIONER: Can I ask you a few questions about -
36 going back to statewide services, and the recommendation is
37 recommendation 9 and it's on page 31 of your submission,
38 just to orientate you.

39
40 MR CHENEY: Yes.

41
42 THE COMMISSIONER: So that's the proposed recommendation
43 from counsel assisting.

44
45 MR CHENEY: Yes.

46
47 THE COMMISSIONER: Then your first challenge to it is at

1 page 34, at paragraph 8.11, where you say:

2
3 *A challenge that the proposed*
4 *recommendation must confront is the need to*
5 *ensure that centralisation of governance at*
6 *Ministry level does not diminish the*
7 *capacity of the supra-LHD services to*
8 *harness local expertise.*

9
10 Why would it? Why would it diminish the capacity? Why do
11 you say it would diminish the capacity?

12
13 MR CHENEY: Commissioner, you did hear evidence,
14 particularly in the regions, of the advantages of localised
15 management as it applies to any given health facility in
16 the region. So it's a similar theme - that is, to the
17 extent that those witnesses who spruiked the advantages of
18 localised --

19
20 THE COMMISSIONER: But the recommendation and the
21 submission don't suggest you ignore that local knowledge,
22 do they?

23
24 MR CHENEY: No, and 8.11 doesn't suggest otherwise. All
25 it is saying is that a challenge that the recommendation
26 has to confront is that if this role is centralised, as the
27 recommendation contemplates, there may be that risk.

28
29 THE COMMISSIONER: Okay. Still in this section but at
30 page 38, 8.22:

31
32 *CA Submissions [505] submit that there are*
33 *insufficient specialist rehabilitation beds*
34 *at Royal Rehab and Prince of Wales Hospital*
35 *to enable patient flow.*

36
37 Just pausing there, I'm not sure that it's correct to
38 characterise that as a submission. The evidence that
39 I heard was that there aren't enough specialist
40 rehabilitation beds for either people suffering from spinal
41 injuries or traumatic brain injuries, and there was no
42 challenge that I remember to that evidence. Do you accept
43 that there are not enough specialist rehabilitation beds?
44 Do you accept that as a matter of fact?

45
46 MR CHENEY: Yes, I do, Commissioner, and as I recall it,
47 there was some support for that proposition in the

1 evidence.

2

3 THE COMMISSIONER: Okay. It is just that the word
4 "submission" threw me, because I didn't take it as
5 a submission, I took it as counsel assisting reminding me
6 what the evidence actually was.

7

8 MR CHENEY: Oh, I see the point.

9

10 THE COMMISSIONER: All right. Workforce. So the
11 workforce proposed recommendation 15 is at page 62. That's
12 15. Then there's a further recommendation, to orientate
13 you - I can't find 16 at the moment. Yes, 16 is at page 68
14 about expanding HETI's role. Not really what I wanted.
15 I wanted to get to 17, I'm sorry, page 74. So this is
16 counsel assisting's submissions and proposed recommendation
17 in relation to award reform. I'm just struggling to
18 understand exactly what you mean by, at page 77 in 10.52:

19

20 *Further, were legislative amendments*
21 *enacted to give effect to this*
22 *recommendation, the award review process*
23 *proposed would likely be lengthy and*
24 *involve significant input from*
25 *stakeholders, principally NSW Health and*
26 *industrial organisations.*

27

28 Firstly, just as a matter of principle, is there something
29 wrong with NSW Health and the unions having significant
30 input into this process?

31

32 MR CHENEY: No.

33

34 THE COMMISSIONER: What do you mean? What's the problem
35 that you're identifying?

36

37 MR CHENEY: I'm not sure that 10.52 necessarily identifies
38 a problem so much as reflects the reality that
39 implementation of the recommendation would carry.

40

41 THE COMMISSIONER: Well, it does say:

42

43 *Further, were this to happen --*

44

45 ie, counsel assisting's recommendation, "the process would
46 likely be lengthy and involve significant input",
47 et cetera. I have taken that as a submission of some form

1 of obstacle to what counsel assisting are recommending.
2 I'm just trying to work out - I mean, I would have thought
3 it was a matter of obviousness, it can't be an obstacle
4 that the unions and NSW Health have a say.

5

6 MR CHENEY: No.

7

8 THE COMMISSIONER: Why does it have to be lengthy? Why
9 would it have to be lengthy or why is it likely lengthy?
10 Isn't that up to - I mean, partly it might be the IRC, but
11 that's in the hands of the parties, isn't it?

12

13 MR CHENEY: Yes, although the one example we've given in
14 10.52 is of what was a lengthy process, being the example
15 that is cited in counsel assisting's submissions.

16

17 THE COMMISSIONER: Okay. Recommendation 20, at page 86:

18

19 *Consideration should be given to the*
20 *routine collection ...*

21

22 of data of the kind - so this relates to Dr Richards' role
23 as the chief wellness officer at the Sydney LHD, and she
24 gave evidence about, amongst other things, what she
25 described as - be careful how I phrase this - concerning
26 levels of burnout, burnout being more than fatigue

27

28 MR CHENEY: Yes.

29

30 THE COMMISSIONER: And collecting information about that
31 and its causes, no doubt as a helpful means of management,
32 plus maybe ultimately ministry working out what might be
33 ways we can mollify that, to the extent that it's possible.

34

35 MR CHENEY: Yes.

36

37 THE COMMISSIONER: What makes you think, as you say, if
38 you go to 10.87, in relation to what is proposed in
39 recommendation 20, that on this topic, there is likely to
40 be resistance at local level?

41

42 MR CHENEY: Only that what is contemplated by
43 recommendation 20, Commissioner, is the routine collection
44 and collation of data from the workforce.

45

46 THE COMMISSIONER: Why would the workforce have
47 resistance - what makes you make this submission or what do

1 you base this submission on that a workforce, that I think
2 everyone accepts - I mean, it's a health workforce, so it's
3 working hard and probably under stress at the best of
4 times, it's coming out of the pandemic - what makes you
5 think there would be local resistance to some kind of
6 process whereby, in a way that appropriately might protect
7 any confidentiality or privacy involved, involves
8 collecting data about how people are feeling? Why would
9 the workforce resist that?

10
11 MR CHENEY: Commissioner, I'm not sure that 10.87 is
12 necessarily pointing to a problem with the workforce's
13 response to such --

14
15 THE COMMISSIONER: It talks about "including the data
16 collected about workforce wellbeing", what am
17 I misinterpreting?

18
19 MR CHENEY: It's a reference to the top-down directive -
20 that is, that ministry direct each LHD chief executive, one
21 assumes, to implement the same system as Dr Richards
22 describes.

23
24 THE COMMISSIONER: There would be a way of managing that,
25 wouldn't there, that still accommodates the main thrust of
26 recommendation 20? Do you agree with that?

27
28 MR CHENEY: I do, Commissioner, and I'd emphasise that
29 what is described in 10.87 is described as a potential
30 challenge, not put forward any higher.

31
32 THE COMMISSIONER: Okay. Can I just then move to some
33 concerns about sharing of other workforce data, I think,
34 including vacancies, et cetera. You address this at 10.97
35 on page 91:

36
37 *The concerns raised by NSW Health's*
38 *witnesses regarding the sharing of*
39 *workforce data are more appropriately*
40 *described as concerns that data may be*
41 *misinterpreted, misrepresented or misused*
42 *by stakeholders or the public ...*

43
44 Should I interpret that to mean that it's not really meant
45 to be suggested that the public would go out of its way to
46 misrepresent any data, but it's, what, some sort of concern
47 about the press, is it?

1
2 MR CHENEY: Yes, Commissioner. I think there was some
3 evidence in the example we cite in 10.97 in respect of
4 vacancy data, for example.

5
6 THE COMMISSIONER: Okay. Staying with the same topic but
7 10.99 on page 92:

8
9 *Separately, many of the requests for data*
10 *that are made are for datasets that cannot*
11 *be produced automatically from NSW Health's*
12 *systems or are for data not routinely*
13 *collected ... and which would create*
14 *a significant workload ...*

15
16 Accepting that at face value, do you accept that that's the
17 system that health's created?

18
19 MR CHENEY: Yes, Commissioner. I mean, it's our system.

20
21 THE COMMISSIONER: In other words, the fact that datasets
22 can't be produced automatically from NSW Health's systems
23 is alone not a reason for not producing it. The difficulty
24 is the way you have set yourselves up?

25
26 MR CHENEY: Well, not necessarily with any fault on our
27 part, Commissioner. For example, there was --

28
29 THE COMMISSIONER: Well, just take the word "fault" to not
30 mean I'm pointing the finger at anyone in particular,
31 but --

32
33 MR CHENEY: But the example I recall from the evidence
34 about the vacancy data was a concern that, for example, it
35 would be necessary for the administration at Broken Hill
36 Hospital, for example, to dig in and produce the data
37 that's then relayed centrally to ministry.

38
39 THE COMMISSIONER: But, if someone, including me, were to
40 take the view that that sort of data is data that the
41 public's entitled to know --

42
43 MR CHENEY: Yes.

44
45 THE COMMISSIONER: -- then that's not a reason - the
46 difficulty in producing it isn't a reason for secrecy or
47 not producing it. Do you agree with that?

1
2 MR CHENEY: No, and it's not put forward that way,
3 Commissioner; it was just to acknowledge the workload.
4

5 THE COMMISSIONER: I won't take it that way. In 10.102,
6 going through to the next page and 10.106, you make some
7 submissions about what I'll just call the Concord hospital
8 dispute. Do you see those?
9

10 MR CHENEY: Yes, 106.
11

12 THE COMMISSIONER: In particular, 10.105, you talk about
13 the submission that counsel assisting has made that it
14 should have been obvious that the letter that Dr Cheung
15 received would likely have been viewed by him as suggesting
16 that disciplinary procedures would be weaponised against
17 him, and you tell me that that submission should be
18 rejected because Dr Cheung never gave this evidence.
19

20 Just pausing there, my current but not final position,
21 but my current state of mind, is that it's not necessary
22 for me to make findings about who specifically was at fault
23 in relation to what happened at Concord hospital.
24

25 Putting that aside for a second, though, the
26 observations that I would make are - I would push back at
27 what you've got at 10.104. In my view, the ministry
28 probably should have been involved earlier. This
29 hospital - the medical staff council was in revolt, and
30 I think there could have been some earlier action.
31

32 In relation to Dr Cheung specifically, though, whether
33 or not Dr Cheung gave any specific evidence, I don't intend
34 to read the letters or letter out to you, but I think an
35 objective, reasonable reader would have taken it as
36 a threat. If it was me - and I may not be reasonable -
37 I would have taken it as a threat. It's a letter that's
38 heavily slanted towards, "You'd better be careful, mate,
39 and pull your head in, otherwise you're in a lot of trouble
40 and here is why." Now, that's a paraphrase, I accept that.
41 So whether or not Dr Cheung said that, whether or not
42 I make findings of blame here - which I think is very
43 unlikely - I certainly think that, and you can tell me if
44 you want to push back on this, that letter could have been
45 better drafted and a different approach could have been
46 taken to the whole Concord hospital issue that might have
47 been better and resulted in a swifter conclusion and it

1 might be another example of why management and clinicians
2 have really got to communicate closely together to make
3 sure these sorts of things don't get out of hand.

4
5 MR CHENEY: I think all three propositions were conceded
6 by the relevant witnesses, Commissioner.

7
8 But can I just make the point that what we were
9 pushing back on in 10.105 was the suggestion that you
10 should find that the action would have been viewed by
11 Dr Cheung as suggesting that disciplinary procedures would
12 be weaponised against him, when it is, after all, the fact
13 that Dr Cheung was no shrinking violet. He gave evidence
14 and he didn't say anything to that effect and he wasn't
15 asked that. It's just unfair to make a finding against my
16 client in that circumstance, when it's got some serious --

17
18 THE COMMISSIONER: You might be right in terms of
19 Dr Cheung's individual reaction about it, but it's open to
20 me to say something about the letter, from an objective
21 point of view

22
23 MR CHENEY: Yes, Commissioner.

24
25 THE COMMISSIONER: All right. AHOs. I mean, there's not
26 a lot for us to discuss because there was a discussion
27 between Mr Muston and the secretary, but can I just try and
28 understand a couple of your submissions. Sorry, this
29 commences at page 95 at 11.3. You're introducing the
30 notion of the difference between services listed in
31 schedule 3 of the Act and the services that might be listed
32 to be provided under a service agreement.

33
34 MR CHENEY: Yes.

35
36 THE COMMISSIONER: You make the submission in 11.3, about
37 six lines from the bottom:

38
39 *The reality is that for so long as*
40 *a service is included in Schedule 3, the*
41 *public can reasonably expect such a service*
42 *to be funded from year to year, and that*
43 *expectation informs NSW Health's approach*
44 *to funding Schedule 3 services and*
45 *establishments.*

46
47 Can I just pose an alternative to that: why isn't what the

1 public can reasonably expect to be the services provided
2 those ones that are outlined in a service agreement? Why
3 wouldn't the public have its expectation based on a service
4 agreement rather than just schedule 3?

5
6 MR CHENEY: We weren't suggesting that the schedule 3
7 entries were the sole source of the public's expectation,
8 Commissioner, and we take your point.

9
10 THE COMMISSIONER: There's a lot of effort gone into
11 saying that counsel assisting may have conflated schedule 3
12 with service agreements, but that's not your intent?

13
14 MR CHENEY: No, Commissioner.

15
16 THE COMMISSIONER: All right. And there are services
17 listed in schedule 3 that are services that are not
18 provided - correct?

19
20 MR CHENEY: Yes, Commissioner.

21
22 THE COMMISSIONER: And what's the problem with the
23 proposed recommendation that schedule 3 be reviewed
24 annually?

25
26 MR CHENEY: We attempted to deal with that in our written
27 submissions, Commissioner, I think at 11 --

28
29 THE COMMISSIONER: The recommendation I have in mind is at
30 page 106 of your submission, okay? So let me just
31 orientate you. If you go to page 106 --

32
33 MR CHENEY: Yes.

34
35 THE COMMISSIONER: -- down the bottom of that page, you
36 will see this, counsel assisting "On an annual basis, and
37 in conjunction with the planning", et cetera:

38
39 *... Schedule 3 to the [HSA] should be*
40 *reviewed to ensure that it accurately*
41 *records the recognised services and*
42 *establishments of each of them and amended*
43 *to the extent necessary to reflect those*
44 *services.*

45
46 Your push-back to that, as I read it, which commences at
47 11.30 on the next page, you say:

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A periodic review of Schedule 3 may ensure accuracy --

which I assume no-one thinks is a bad thing --

but the creation of an annual review could create an expectation of annual addition of services provided by [AHOs]. This may include an expectation on the part of [AHOs] that new services will be added to Schedule 3 ...

I don't understand what the basis of that submission is. The way I would see it is the AHOs would have an expectation of providing the services that are being set out in their service agreements. Why would some kind of periodic or annual review of schedule 3 to ensure accuracy create the expectation you're fearful of in 11.30?

MR CHENEY: The submission is no more sophisticated than acknowledging that an annual review, if it's implemented, would create, in those who are interested, an expectation that the schedule may change from year to year.

THE COMMISSIONER: So that's a guess?

MR CHENEY: Well, we are dealing with --

THE COMMISSIONER: It is not based on evidence

MR CHENEY: No, we are dealing with - Commissioner, this is put forward by way of a comment as to some of the recommendations of the recommendation. We weren't pushing back on it and we did supply the historical context to the evolution of the schedule 3 entries.

THE COMMISSIONER: Then, recommendation 24 regarding the dispute mechanism concerning the funding of the AHOs - just to orientate you, that's at the bottom of page 108:

A structured process ...

Et cetera. Your concern, or your first concern about that, is the next page, at 11.34

MR CHENEY: Yes.

1
2 THE COMMISSIONER: Where you say it's consistent with the
3 legislative framework. What's being proposed by counsel
4 assisting, as I understand it, is first of all, it should
5 be fundamental that AHOs get funded to the extent of the
6 reasonable costs of the services they're required to
7 deliver. Then, built on that, if there is a fundamental,
8 irreconcilable impasse between St Vincent's and NSW Health
9 or Tresillian and NSW Health, where NSW Health says, for
10 multiple reasons, "We have given you every cent you need to
11 deliver the services you are required to", and St Vincent's
12 says, or Tresillian or some other AHO says, "You are
13 underfunding us and that is making us tap into other
14 sources of funding or it threatens our actual survival",
15 why would an independent arbiter be a problem, if the
16 independent arbiter is no more than to express an opinion
17 as to what their independent view is in a manner that, of
18 course, can't trump the minister's power in the HSA?

19
20 MR CHENEY: That would be fine, Commissioner, but that's
21 not how the recommendation reads.

22
23 THE COMMISSIONER: I don't take it to mean that the
24 minister's now lost --

25
26 MR CHENEY: It uses the language of "resolving the
27 dispute", suggesting he's going to determine it, not an
28 independent, non-binding opinion.

29
30 THE COMMISSIONER: Yes, but I wouldn't leap to that
31 submission is consistent with the repeal of a provision in
32 the HSA. Anyway, let's forget that. Do I take it, then,
33 that the resistance to the mechanism is lessened if it's
34 a mechanism by which an arbiter says, "In my independent
35 view, the answer is X", but the minister can always say,
36 "Well, I've seen what the independent arbiter says, I still
37 think it's Y, and that's what I'm sticking with"?

38
39 MR CHENEY: Yes, and that's the thrust of 11.34.

40
41 THE COMMISSIONER: All right. Got it. Thanks.

42
43 First Nations. This commences at 141 of your
44 submission, again, just to orientate ourselves. So the
45 first recommendation is a coordinated whole of government
46 approach. That's not very controversial.

47

1 MR CHENEY: No.

2

3 THE COMMISSIONER: The next recommendation is 30, on 143.
4 "Meaningful collaboration", "joint planning", I'm not sure
5 that that's particularly controversial either.

6

7 And then we have, I think, the subject of more
8 submissions from you, recommendation 31 at page 148. Just
9 pause there. Can I just ask you this: I understand what
10 you've said in your submission, and I'll certainly take it
11 into account, but at a high level of generality, looking at
12 recommendation 31(a), is there any disagreement that in
13 general, yearly or short-term funding cycles aren't
14 particularly helpful, or that they have disadvantages,
15 particularly in relation to recruitment and retention? Is
16 that accepted?

17

18 MR CHENEY: Yes, and that might be inferred from what we
19 say in 14.26, by way of work under way.

20

21 THE COMMISSIONER: Sure. And in relation to (c) - and
22 please, in relation to (c), don't think I don't think there
23 needs to be, whenever money is handed over to anyone, some
24 form of analysis of how it's being spent and an analysis of
25 what the outcomes were, but as a general proposition, do
26 you agree that ACCHOs are best placed to determine what the
27 health services that their communities need are?

28

29 MR CHENEY: I don't think anyone on behalf of my client
30 would suggest otherwise, Commissioner.

31

32 THE COMMISSIONER: Yes. Okay.

33

34 MR CHENEY: You will see from 14.29 that we have
35 acknowledged the need to adopt a less rigid approach.

36

37 THE COMMISSIONER: Yes. And I should say, in complete
38 fairness, when we're talking about yearly or short-term
39 funding cycles, by far and away, the problem is with
40 Commonwealth grants not --

41

42 MR CHENEY: Yes.

43

44 THE COMMISSIONER: I'm completely aware of that. You have
45 probably made that point too.

46

47 Can I ask you something, and I apologise for this,

1 I meant to ask the three witnesses, but with the single
2 digital patient record that will be relatively soon started
3 to be rolled out, and I think the plan is for it to be
4 fully rolled out by 2029, or 2028/29, but at this stage,
5 it's not proposed to extend it to general practitioners.
6 I can see a lot of advantages in - and no doubt NSW Health
7 could - if it was rolled out to general practitioners. Has
8 there been any form of costing done as to what it might
9 cost to roll it out to general practitioners?

10
11 MR CHENEY: Commissioner, I might have to take that
12 question on notice, if I may.

13
14 THE COMMISSIONER: You can, and take this one on notice,
15 too, but I imagine you'll embrace the proposition, that if
16 we consider - well, there's no doubt general practitioners
17 are involved in primary healthcare services, it would
18 certainly be a pretty strong case that rolling out the SDPR
19 to general practitioners would be an aspect of primary
20 health care for which the Commonwealth should make a final
21 contribution at least. Would you agree with that?

22
23 MR CHENEY: Perhaps they should fund it entirely,
24 Commissioner, yes.

25
26 THE COMMISSIONER: They were the questions I had in
27 relation to your submission. You are absolutely free to
28 say anything further you want to submit, before I hear from
29 Mr Muston, which might be tomorrow, probably. Unless you
30 have nothing you want to say in reply?

31
32 MR CHENEY: Commissioner, may I --

33
34 THE COMMISSIONER: Do you want to think about it?

35
36 MR CHENEY: Commissioner, this request might in part
37 address the last question you put to Mr Muston about
38 whether he wishes to be heard now. I've spoken to him
39 about our request for some time to respond to the written
40 submissions received from the other interested parties.

41
42 THE COMMISSIONER: Oh, yes.

43
44 MR CHENEY: We're not anticipating that anything we say
45 will be lengthy, and indeed, we're content to submit to
46 a page limit, if that be required, but may we have until
47 next Wednesday, 5 March, to provide a written reply to

1 anything that's in the submissions of the other parties?
2
3 THE COMMISSIONER: Is there anything - is that a problem?
4 You've raised an eyebrow, so there's a slight problem.
5
6 MR MUSTON: I was mindful of the timeline --
7
8 THE COMMISSIONER: I know there is a massive problem.
9
10 MR MUSTON: -- for you having to deal with whatever it is
11 and --
12
13 THE COMMISSIONER: If we set a page limit, that might
14 accommodate it.
15
16 MR MUSTON: Five pages in total by way of response to all
17 of the third party submissions.
18
19 THE COMMISSIONER: I think I will give health 10 pages, if
20 it is dealing with all of the submissions. Ten pages in
21 total. You can live with that?
22
23 MR CHENEY: I thought I might also deal with the two
24 questions on notice, Commissioner, in that same --
25
26 THE COMMISSIONER: I've even forgotten what they are. One
27 was the costing of the SDPR for general practice. What was
28 the other one?
29
30 MR CHENEY: It was what the position was as to who should
31 fund --
32
33 THE COMMISSIONER: All right. Okay. I thought you agreed
34 with it being the Commonwealth. All right. Is there
35 anything further you want to address me on, though?
36
37 MR CHENEY: No, Commissioner.
38
39 THE COMMISSIONER: All right. Thank you. And thank you
40 for your assistance and the submissions. Thank you both,
41 or thank you to the team.
42
43 Mr Muston, do you want to say anything in reply? Do
44 you feel you need to? Do you want to do it in writing, do
45 you want to come back tomorrow morning and do it?
46
47 MR MUSTON: Look, I can - there are a few issues that

1 I might --

2

3 THE COMMISSIONER: 10.30 tomorrow?

4

5 MR MUSTON: Yes.

6

7 THE COMMISSIONER: I've got to go to a swearing in
8 tomorrow, so, actually, is it okay - I mean, we've listed
9 it for three days. Why don't we come back at 11 o'clock
10 tomorrow for you to do whatever you want to do in reply.

11

12 MR MUSTON: I will be very brief. That sounds fine to me.
13 I wouldn't mind going to the same swearing in, actually.

14

15 THE COMMISSIONER: I still would prefer to give you the
16 time to think about anything that was said either by the
17 witnesses today or any exchanges I had with Mr Cheney. If
18 you are going to be short - I mean, I don't care - we could
19 make it 11.30 or 12, what suits you?

20

21 MR MUSTON: Well, 11.30 will give you and possibly --

22

23 THE COMMISSIONER: Why don't we adjourn to 11.30 for
24 Mr Muston to make any submissions in reply that he wishes.
25 Otherwise, that's all today, and I'll thank a few other
26 people tomorrow.

27

28 All right. We'll adjourn until 11.30 tomorrow.
29 Thank you all for your assistance.

30

31 **AT 3.49PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
32 **TO THURSDAY, 27 FEBRUARY 2025 AT 11.30AM**

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