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

THE COMMISSIONER: Good morning.

MR MUSTON: Good morning, Commissioner.

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Welcome.

MR MUSTON: I wonder whether we want --

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

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

<SUSAN LEE PEARCE, sworn: [9.32am]

<ALFAISTER DAVIS D'AMATO,sworn:

<PHILIP GREGORY MINNS, sworn:

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

to be able to get to a commitment --

THE COMMISSIONER: I'm aware of the commitment and I'm sure that won't be - well, it won't be a problem.

MR MUSTON: Thank you. I think my expectation is we will be completed the oral evidence, or the oral evidence will have concluded by lunchtime.

THE COMMISSIONER: Yes. If, for some unforeseen reason, you haven't finished, against your expectation, we will find another time, another day.

MR MUSTON: Can I indicate I've also factored in to that expectation a short break of some description during the morning for the stenographers.

THE COMMISSIONER: Yes, we will have to give people a break, so at 11 I will take, in your hands, a shorter than usual break but still 10 to 15.

MR MUSTON: That should be fine. I have every expectation that we will move quite quickly through this evidence.

THE COMMISSIONER: Okay.

MR MUSTON: Thank you. Could I ask each of you, starting with you, Ms Pearce - actually, I should take it back one step. Could you each give us your full name for the record.

MS PEARCE: Susan Lee Pearce.

MR MUSTON: You are currently the health secretary.

MS PEARCE: Health secretary.

MR MUSTON: Mr D'Amato.

MR D'AMATO: Alfaister Davis D'Amato, deputy secretary financial services and CFO.

MR MUSTON: And Mr Minns?

MR MINNS: Phillip Gregory Minns, deputy secretary for people, culture and governance.

MR MUSTON: Have each of you had an opportunity to review the submissions made to the Inquiry by NSW Health?

MS PEARCE: Yes.

MR D'AMATO: Yes.

MR MINNS: Yes.

MR MUSTON: Do you have a copy of those submissions with you, if required?

MS PEARCE: Yes.

MR D'AMATO: Yes.

MR MINNS: Yes.

MR MUSTON: I want to start by asking some questions about prevention. Your submissions engage, or health's submissions engage with some recommendations made by counsel assisting in relation to prevention and the role that prevention might potentially play within the public health system going forward, but can I start by just asking you to give me your broad definition of prevention, so we're sure we're all talking about the same thing.

MS PEARCE: Well, thank you for the question. From my perspective, prevention is relatively clear and that is that it's measures designed to prevent people from becoming unwell, to prolong life in the fittest and most, you know, healthy possible way, and I guess, broadly speaking, that's how I would define it.

THE COMMISSIONER: The World Health Organization has a definition of prevention. Is that in line with how NSW Health sees things?

MS PEARCE: I'd have to get you to provide it to me, Commissioner.

THE COMMISSIONER: I can read it out to you, if I can find it.

MS PEARCE: Thanks. I don't have that at hand.

THE COMMISSIONER: Just bear with me a second:

Approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder, or reducing disability.

That sounds --

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

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

MS PEARCE: Yes.

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

MR MINNS: No, thank you.

MR D'AMATO: No.

MR MUSTON: Starting with you then --

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

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

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

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

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

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

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

THE COMMISSIONER: Please tell me.

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

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

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

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

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

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

THE COMMISSIONER: "Future Health" says that.

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

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

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

THE COMMISSIONER: Of course.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> *There is widespread evidence of a strong relationship between health and social determinants of health. Social determinants of health such as income, education and housing can strengthen or undermine someone's health trajectory and outcomes. Therefore, NSW Health's efforts to support people to be healthy and well and to address social determinants of health cannot be achieved in isolation and requires us to work collaboratively across health disciplines and with partner agencies and organisations.*

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

MS PEARCE: Yes, I do.

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

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

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

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

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

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

THE COMMISSIONER: Okay.

MS PEARCE: -- at all.

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

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

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

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

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

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

THE COMMISSIONER: Sure.

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

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

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

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

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

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

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

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

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

those referral times as best as possible within guidelines?

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

MR MUSTON: Clinically appropriate. Evidence-based guidelines.

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

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

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

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

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

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

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

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

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

MS PEARCE: In some cases, yes.

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

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

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

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

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

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

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

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

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

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

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

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

MS PEARCE: I don't think we would argue with that, no.

THE COMMISSIONER: And by "further funding", I don't just mean from the states.

MS PEARCE: No, neither do I.

THE COMMISSIONER: Obviously the Commonwealth --

MS PEARCE: Very much would be welcoming any funding from the Commonwealth for that endeavour.

THE COMMISSIONER: Yes.

MR MUSTON: Sticking with prevention now, I think you have told us that an important piece in the prevention puzzle is addressing the social determinants of health.

MS PEARCE: Yes.

MR MUSTON: And many of those, or the levers that --

THE COMMISSIONER: Sorry, can I just interrupt? I think some representatives of the AMA came in. Am I right?

MR CHAPMAN: Yes, Commissioner, thank you,

THE COMMISSIONER: You seek leave to appear?

MR CHAPMAN: We do. Scott Chapman.

THE COMMISSIONER: Thank you. Leave is granted.

Go ahead, sorry.

MR MUSTON: I think you have already intimated that many of the levers that can be pulled to influence the social determinants of health lie outside the control of the Ministry of Health.

MS PEARCE: Yes.

MR MUSTON: Truly, for there to be effective prevention, requires a whole of government approach to the issue.

MS PEARCE: We believe so, yes.

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

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

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

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

MS PEARCE: Mmm-hmm.

MR MUSTON: Would you agree with that?

MS PEARCE: Food? Yes.

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

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

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

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

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

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

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

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

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

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

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

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

MS PEARCE: Yes.

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

MS PEARCE: Yes.

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

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

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

THE COMMISSIONER: Can I just challenge you on that.

MS PEARCE: Yes, sure.

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: That's the past.

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

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

MR MUSTON: Mr Minns?

MR MINNS: Just to amplify that point, Commissioner, the entire reason, if we go back to the very first workshop we had about "Future Health", that document that you referred to --

THE COMMISSIONER: Gosh, how long ago was that now?

MR MINNS: It was 2018, I think. Somewhere in 2018, yes. That was our attempt to try and change the narrative about the health system.

THE COMMISSIONER: From just build bricks and mortar.

MR MINNS: Yes.

THE COMMISSIONER: I remember you saying that to me. Yes, please go ahead, though.

MR MINNS: Just to amplify what the secretary has presented, if we can't engage the community and thereby politicians in a broader conversation about what good looks like for the healthcare system, we'll always be led to the squeaky part, you know? And the fact that we try to make "Future Health" the central guiding document for all of the planning work that we then do, the further workforce plan, services plans, whatever, is we're trying to get to that broader place of a total health system.

THE COMMISSIONER: Sure, yes, understood.

MR MUSTON: What do you think needs to be done or what impediments are there that need to be cleared away to improve that dialogue with the community about what the health system is and should be delivering for them so as to shift that focus from the old fashioned it's all about bricks and mortar view which, as you indicate, still seems to predominate?

MS PEARCE: I think, first of all - and I'm very happy to share some of the commentary with my colleagues - you have to be able to create the vision and a tangible picture of what it means and what it looks like, and I think that's where we've historically struggled a little with this.

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

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

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

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

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

report, but let's just say broadly about the health of a population, you know, population groups across the state.

THE COMMISSIONER: Yes, okay.

MS PEARCE: When those reports come out, it will say fundamentally, the further west you go, generally speaking, across the state, often the poorer the health of the community.

THE COMMISSIONER: Yes.

MS PEARCE: I guess the point I'm making is that there are a lot of elements to why that is the case.

THE COMMISSIONER: All right. Let me help you, then. It's not NSW Health's fault that there's a lot of advertising for fast food near schools, as an example. Agree with that?

MS PEARCE: Yes.

THE COMMISSIONER: It's not NSW Health's fault that there is not a tax on sugary drinks. Agree with that? It's not your fault. I'm not asking you to agree that I should impose a sugar tax --

MS PEARCE: Yes. I'm not --

THE COMMISSIONER: -- which I might --

MS PEARCE: I'm not seeking to apportion fault.

THE COMMISSIONER: But they're examples of where NSW Health's not in control.

MS PEARCE: Broadly, yes, that's fair.

MR MUSTON: Stable housing is a clearer, less controversial example, maybe.

THE COMMISSIONER: I haven't drafted my housing recommendations yet, I've only got to sugar tax.

MR MUSTON: But isn't reporting on those sorts of issues and bringing the public into the tent on those issues an important part of that dialogue that you say needs to

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

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

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

MS PEARCE: Mmm.

MR MUSTON: You would agree with that?

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

MS PEARCE: No, in a media publication.

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

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

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

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

MS PEARCE: In theory, yes.

MR MUSTON: In theory? Why in theory?

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

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

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

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

MR MUSTON; Mr Minns?

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

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

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

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

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

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

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

MR MUSTON: Why is that?

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

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

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

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

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

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

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

THE COMMISSIONER: That's the word, isn't it? You used the word "rationing", but if we talk about changing where a service is delivered and taking it from one geographical area to another, it's incredibly important that before the decision is made there's really meaningful consultation - agree --

MR MINNS: Yes --

THE COMMISSIONER: -- with the community?

MR MINNS: -- but the consultation --

THE COMMISSIONER: But even if you had perfect consultation, you might still be left with a community which has one or more members or groups still very angry.

MR MINNS: Yes, Commissioner.

THE COMMISSIONER: And that is the irreconcilable - well, there's nothing you can do about that.

MR MINNS: Yes.

MR MUSTON: But, having gone through that public consultation process and made the decision about the way in which the spending is to be prioritised, accepting that there will be someone out there in the community who will not be happy with it, is it not in the interests of the health system that there be a public or a transparent exposure of that reasoning process and why the decision has been made that some people will be happy with and others will be unhappy with?

MR MINNS: So in theory, yes.

THE COMMISSIONER: Why do you say "in theory", though?

MR MINNS: Because depending on the level of the matter and the amount of community interest and/or concern the --

THE COMMISSIONER: Do you just mean that politics might intervene at some stage?

MR MINNS: Yes. Yes, I do, Commissioner.

THE COMMISSIONER: Well, that's just the reality of the

world.

MR MINNS: It is.

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

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

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

THE COMMISSIONER: Yes. I agree with that.

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

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

MS PEARCE: Yes.

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

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

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

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

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

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

MR MUSTON: Why not?

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

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

MS PEARCE: Yes.

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.

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

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

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

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

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

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

MS PEARCE: Okay.

MR MUSTON: You will have seen the proposed recommendation

around prevention being identified as a whole of government priority.

MS PEARCE: Yes.

MR MUSTON: Against which, say, new policy proposals might be assessed.

MS PEARCE: Yes.

THE COMMISSIONER: It's on page 5 of your submission, that the recommendations are set out.

MS PEARCE: Yes.

MR MUSTON: To the extent that presumably there are more new policy proposals put forward in any given year than there are new policy proposals accepted and funded, a decision needs to be made about which of them should be funded and which shouldn't.

MS PEARCE: Yes.

MR MUSTON: You rightly tell us that that's ultimately a decision for government and not for any particular department. But do you think there's a role for the Ministry of Health, as part of that process, to look at all - let it be assumed that there was such a priority in place - for health to look at all new policy proposals put forward which are said to be supported by this prevention priority and provide advice to government about the way in which - or which of them could, in a coordinated way, produce the best outcome from a prevention point of view.

MS PEARCE: Yes, I think it's reasonable for health to provide advice, yes.

MR MUSTON: For example, health knows a whole lot about population health and dynamics which other departments might not know about, and the government might not, without the assistance of health, have an understanding of.

MS PEARCE: Sure, yes.

MR D'AMATO: Sorry to interrupt, I just want to add an extra option, perhaps, and this is something that the treasury has already put in place in regards to carbon

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

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

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

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

THE COMMISSIONER: And building on work currently under way.

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

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

construction of a body like that before you've put it in place?

MS PEARCE: No. I mean, obviously it is a matter for the government to determine whether that's the road they want to go down. But certainly, I - no, it doesn't need - you know, we don't need to let perfect get in the way of progress.

MR MUSTON: The good.

MS PEARCE: Yes.

MR MUSTON: Can I ask you to turn to page 11 of your submission, section 6, "Funding health services". Do you see set out there in the second paragraph under the heading, "Counsel assisting's recommendation 4" - there is an articulation, at least in my copy, in blue text of recommendation --

MS PEARCE: Which paragraph?

MR MUSTON: Perhaps can we get --

THE COMMISSIONER: It is section 6 on page 11.

MR MUSTON: Could we get the NSW Health submission up on the screen, it is [MOH.0010.0758.0001], at page 11.

MS PEARCE: Okay, sorry, yes, got it.

MR MUSTON: I might just give you a moment very quickly to read that second paragraph from the top under the heading "Counsel assisting's recommendation 4". Just so we're all on the same page, that's a recommendation which is made in counsel assisting's submissions to which you then respond.

MS PEARCE: Yes.

MR MUSTON: I just want to raise one small issue. Concern has been raised by health in its submissions in relation to the use of the word "ensure".

MS PEARCE: Mmm.

MR MUSTON: Can I just understand what the concern with that word is?

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

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

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

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

MR MUSTON: Quite.

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

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

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

THE COMMISSIONER: Are you at 6.3 of your submission?

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

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

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

> *... no funding model can ever "ensure" adequate resourcing for [LHDs] ...*

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

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

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

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

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

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

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

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

MS PEARCE: There is a circular issue there.

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

MS PEARCE: Yes.

MR D'AMATO: Yes.

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

MR D'AMATO: Correct.

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

MR D'AMATO: Yes.

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

incredibly difficult.

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?

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

MR MUSTON: Mr Minns?

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

MR D'AMATO: That's right.

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

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

MS PEARCE: Mmm-hmm.

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

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

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

MS PEARCE: Yes, I do agree with that.

MR MUSTON: I note the time.

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

SHORT ADJOURNMENT.

THE COMMISSIONER: Yes, when you are ready.

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

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

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

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

To your point is there anything systemically possible,

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

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

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

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

THE COMMISSIONER: Moruya Hospital.

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

MS PEARCE: Yes.

MR D'AMATO: Yes.

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

MS PEARCE: They are informed by that, yes.

MR MUSTON: Communities.

MS PEARCE: Yes.

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

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

MS PEARCE: Yes.

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

MS PEARCE: Resource allocation in the form of?

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

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

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

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

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

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

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

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

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

MR D'AMATO: Yes.

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

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

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

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

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

> *Although NSW Health would aspire to undertake the ... planning ... as quickly as reasonably possible, the practical reality may be that even a carefully reformulated funding model devised to resource delivery of that system at that point in time rapidly faces resource constraints.*

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

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

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

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

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

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

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

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

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

MR MUSTON: Please do.

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

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

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

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

Where a population is consuming fewer health resources than the average, additional activity based funding is normally allocated to the relevant LHD.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: Can I ask a question about that.

THE COMMISSIONER: You can.

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

MR D'AMATO: That's correct.

MR MUSTON: The local health district needs to deliver that activity as part of its service level agreement.

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

MR MUSTON: And if it delivers that activity, or it sells to the ministry that activity and the ministry purchases it, the additional funding flows in that way.

MR D'AMATO: Yes. Fundamentally, that's correct.

MR MUSTON: Does that take into account in any way the proposition that, for some population segments, delivering activity is more expensive - for example, to deliver activity to a member of the community who does not speak English can take longer and cost more than delivering the same item of activity to a member of the community who is health literate and has English as their first language?

MR D'AMATO: Look, it takes into account the typical average complexity or the activity delivered from the particular district, because ultimately when we apply these increases on an average NWAU, if you want, so if the particular district includes some specialist services and therefore their weighting, if you want, is higher than other services, we will add 2 per cent more, and therefore there is a degree of complexity captured into that.

MR MUSTON: But if the particular community served by a local health district has a much higher proportion of its population which fits into that category of people for whom it is more expensive to deliver care, increasing the amount of care that is delivered doesn't take that into account, does it?

MR D'AMATO: But you could argue that way. I would also argue that, at times when we purchase additional activity in settings that are more mature, if you want, where the incremental cost might not actually consume the full extra state price that we pay, the activity, it could be the other way. So I think we also need to contemplate the fact that an ABF environment is, you know, on an average environment.

MR MUSTON: But that depends very much on the population

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR D'AMATO: Yes.

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Of course.

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

THE COMMISSIONER: Sure.

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

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

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

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

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

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

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

MS PEARCE: Yes.

MR D'AMATO: Yes.

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

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

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

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

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

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

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

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

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

MS PEARCE: Yes.

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

MS PEARCE: Yes.

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

MS PEARCE: There are a number of transport options.

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

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

MR D'AMATO: That's right.

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

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

MR D'AMATO: In some, yes.

MS PEARCE: In some, yes.

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

heard a lot of evidence.

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

as much expedition as possible?

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

THE COMMISSIONER: Yes. Including workforce planning.

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

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

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

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

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

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

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

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

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

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

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

MS PEARCE: Yes.

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

MS PEARCE: Yes.

MR MUSTON: Allied health care.

MS PEARCE: Yes.

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

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

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

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

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

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

MS PEARCE: Yes.

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

MS PEARCE: Yes.

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

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

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

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

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

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

MS PEARCE: I can't confirm that.

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

THE COMMISSIONER: Near future.

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

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

THE COMMISSIONER: But where NSW Health itself has been

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

MS PEARCE: Yes.

THE COMMISSIONER: The AMA has also made that point.

MS PEARCE: Yes.

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

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

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: The reason I use that word is the

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

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

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: I understand that, thank you.

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

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

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

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

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

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

MR MUSTON: In respect of arrangements like that?

MS PEARCE: They are not easily negotiated.

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

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

THE COMMISSIONER: We understand that.

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: Why --

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

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

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

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

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

MS PEARCE: Yeah, it does.

MR MUSTON: Bowraville clinic pre-dates last year.

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

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

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

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

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

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

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

MS PEARCE: Indeed.

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

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

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

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

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

MS PEARCE: Yes.

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

MR MUSTON: As to that next sentence:

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

Is that being done?

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

MR MUSTON: Yes.

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

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

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

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

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

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

THE COMMISSIONER: Cover the cost?

MS PEARCE: Yes.

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

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

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

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

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

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

MS PEARCE: I think that's fair.

MR D'AMATO: I think that is fair.

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

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

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

MS PEARCE: I think that's fair, yes.

MR MUSTON: Could I then turn to aged care. Evidence received by the Inquiry suggests that a failing in the aged care market is also having very significant and detrimental impacts on the acute care services, particularly in some local health districts. I think Shoalhaven Illawarra, or Illawarra Shoalhaven - that one I should have got right - is a feature of the health landscape at the moment. Would that be right?

MS PEARCE: Most certainly that has been an issue, yes.

MR MUSTON: And without wanting to oversimplify it, the key problem is an inability to have older patients who have been admitted for an episode of acute care then discharged into an aged care facility, which would be more appropriate for their care at a time when they have had the acute episode resolved, they no longer need acute care in a hospital, but they are not able to go back to live independently, and there is no aged care place currently for many of them.

MS PEARCE: That's right.

MR MUSTON: Such that they are spending often very long periods of time --

MR D'AMATO: Very long, yes.

MR MUSTON: -- in medical wards.

MR D'AMATO: Very long time.

MR MUSTON: The consequence for the patient is it's somewhat counter intuitively often the worst place for an elderly patient to be in terms of the health outcomes.

MS PEARCE: Yes.

MR MUSTON: And that's no criticism of the care that is being provided in those hospitals --

MS PEARCE: No, no, we agree.

MR MUSTON: -- it is just the nature of their needs. And

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

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

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

MS PEARCE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: Again, in a way --

THE COMMISSIONER: Probably an essential approach.

MS PEARCE: Yes, yes.

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

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

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

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

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

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

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

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

MS PEARCE: No.

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

MS PEARCE: Yes.

MR MUSTON: And to the extent that services are required

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

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

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

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

MR D'AMATO: Yes.

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

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

When I was at Southeastern Illawarra many years ago,

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

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

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

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

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

MR D'AMATO: Yes.

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

MS PEARCE: No, no.

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

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

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

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

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

a discretion there.

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

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

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

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

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

under an AHO in that regard.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a better job of that.

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

THE COMMISSIONER: Mr Cheney, do you want --

MR CHENEY: No, Commissioner.

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

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

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

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

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

THE COMMISSIONER: Anything to add?

MR D'AMATO: No.

MR MINNS: No.

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

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

MR MUSTON: Yes.

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

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

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

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

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

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

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

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

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

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

MR CHENEY: Yes.

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

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

> *The Commonwealth and the States will work in partnership to implement arrangements for a nationally unified and locally controlled health system ...*

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

MR CHENEY: I accept that, yes.

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

> *Improve the provision of GP and primary healthcare services ...*

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

MR CHENEY: Accept that, Commissioner.

THE COMMISSIONER: (c):

Improve care coordination for people with chronic and complex needs ...

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

MR CHENEY: Agreed.

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

MR CHENEY: Yes.

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

MR CHENEY: Yes.

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

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

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

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: C2:

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

et cetera

MR CHENEY: Yes, Commissioner.

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

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

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

MR CHENEY: Yes.

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

MR CHENEY: Yes.

THE COMMISSIONER: You agree with that?

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

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

MR CHENEY: Yes.

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

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

THE COMMISSIONER: Well, having responsibility for the shared action

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

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

> *Prioritising prevention and helping people to manage their health across their lifetime through:*
>
> *(ii) prevention and wellbeing.*

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

MR CHENEY: I accept that.

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

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

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

> *The Parties recognise that they need to work together to better plan ...*

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

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

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

MR CHENEY: We accept that, Commissioner, yes.

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

> *The Parties acknowledge that all governments currently invest in primary prevention ...*

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

MR CHENEY: Yes, Commissioner.

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

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

THE COMMISSIONER: Yes, yes, shared action. Shared action.

MR CHENEY: Yes.

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

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

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

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

THE COMMISSIONER: But what is wrong with that? What is wrong with that?

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

THE COMMISSIONER: What are the funding implications?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My question is: where do I find the risk?

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

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

MR CHIU: And that point is taken.

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

THE COMMISSIONER: Yes. Yes.

MR CHIU: So the nervousness --

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

MR CHIU: Yes.

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

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

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

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

MR CHIU: Yes.

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

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

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

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

THE COMMISSIONER: Yes. Okay.

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

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

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

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

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

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

MR CHIU: Indeed.

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

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

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

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

MR CHIU: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Save that it's a relatively robust process to get a 19(2) exemption, isn't it?

MR CHIU: It is. It is, yes.

THE COMMISSIONER: Yes. Thank you. That's --

MR CHIU: I may sit down.

THE COMMISSIONER: Yes, thank you. Either of you can feel free to address this, but have we reached the stage in our discussion where you would feel comfortable in conceding, if we can go to 9.37 at page 55 of your submission - you see, you're telling me there, recommendations 11, 12 and 14 would require reform of the NHRA. I really don't think that's right. These things, in terms of New South Wales stepping in when it's had to, in terms of failing markets for primary care, are happening now without reform of the NHRA. The NHRA contemplates, as we've gone over enough, I think, shared action

MR CHENEY: Yes.

THE COMMISSIONER: I don't see how 11, 12 and 14 would either require reform of the NHRA - I don't see why it would require creation of a new mechanism for funding of the states, given that the Commonwealth has agreed that it's the funder of primary care services. I also don't agree, in 9.40, that it would be a significant piece of national healthcare reform. I think that's really very much at the - well, I think there is a fair amount of hyperbole in that submission too. Do you agree? Based on the discussion we've just had, do you agree? I know you want to say, "You've got to be really cautious in terms of these recommendations because we mightn't get the money from the state government, and whilst the Commonwealth has to pay, they might agree late" - I get all that. But I don't see any of that requiring, frankly, anything other than implementation of the agreement, not reform of it.

MR CHENEY: Well, it's a matter, I suppose, Commissioner, whether one sees merit in there being concordance between the wording of the National Health Reform Agreement and what is happening in practice.

THE COMMISSIONER: Well, is there anything in the NHRA

that forbids the state providing primary care?

MR CHENEY: No, there is no - nothing in the agreement purports to.

THE COMMISSIONER: So are recommendations 11, 12 and 14 really a significant piece of national healthcare reform? Is that a stretch? I mean, this is being done now. There are aged care patients in New South Wales hospitals ward after ward that could be in an aged care facility if there was a bed or a workforce available. There is primary care being provided now by the state under exemptions and other arrangements. Do, really 11, 12 and 14 go so far as a "significant piece of national healthcare reform"?

I mean, the National Health and Hospitals Reform Commission in 2009 which suggested the Commonwealth take over the funding of basically everything - that would have been. And Mr Rudd had a slightly watered-down version of that. I agree that would be a significant piece of national healthcare reform. Recommendations 11, 12 and 14, in my view, are a commonsense approach to a really important problem about primary care and aged care.

MR CHENEY: And, Commissioner, perhaps at the risk of agreeing --

THE COMMISSIONER: Well, do you agree with me or not? Do you agree that you are stretching it with "significant piece of national healthcare reform"?

MR CHENEY: Yes, if one accepts this proposition, that nothing about the National Health Reform Agreement is in any way justiciable. There is no way of enforcing the obligations that lie or that are set out in that agreement, and so in that respect, one could say on any suggestion to a change in the way the system is implemented, it's unnecessary to have that change reflected in the agreement, because ultimately, to what end, if it can't be enforced. So if I could perhaps express my agreement with that qualification, Commissioner.

THE COMMISSIONER: Okay. I think we've sufficiently covered 9.45 and "trampling over", but on that page at page 58, you make a submission in 9.47 about - I just don't understand this about aged care, the last sentence:

Although health services are often provided to the aged in a care setting --

that is, by NSW Health --

aged care is not synonymous with health services, but encompasses a much broader range of services not within the usual business of a public health system.

What are you telling me there?

MR CHENEY: Primarily, Commissioner, the residential accommodation that is such a significant feature of aged care. That concept --

THE COMMISSIONER: Well, counsel assisting are not necessarily talking about retirement living, I don't think, in their submission. Don't the MPSs, though - they have communal rooms, they have rooms with windows that wards don't have necessarily in public hospitals. It is just - it seems as though this is suggesting that counsel assisting is recommending the setting up of, like, retirement villages, which is not the way I'm interpreting what they're suggesting that I should do.

MR CHENEY: Commissioner, what is said in 9.47 provides some examples of what would be caught by a recommendation in the form pressed, that we would be assuming responsibility for, among other things, accommodation, supervision and transportation of the elderly, with all the associated demands around capital infrastructure and workforce.

THE COMMISSIONER: Can I ask you a few questions about - going back to statewide services, and the recommendation is recommendation 9 and it's on page 31 of your submission, just to orientate you.

MR CHENEY: Yes.

THE COMMISSIONER: So that's the proposed recommendation from counsel assisting.

MR CHENEY: Yes.

THE COMMISSIONER: Then your first challenge to it is at

page 34, at paragraph 8.11, where you say:

> *A challenge that the proposed recommendation must confront is the need to ensure that centralisation of governance at Ministry level does not diminish the capacity of the supra-LHD services to harness local expertise.*

Why would it? Why would it diminish the capacity? Why do you say it would diminish the capacity?

MR CHENEY: Commissioner, you did hear evidence, particularly in the regions, of the advantages of localised management as it applies to any given health facility in the region. So it's a similar theme - that is, to the extent that those witnesses who spruiked the advantages of localised --

THE COMMISSIONER: But the recommendation and the submission don't suggest you ignore that local knowledge, do they?

MR CHENEY: No, and 8.11 doesn't suggest otherwise. All it is saying is that a challenge that the recommendation has to confront is that if this role is centralised, as the recommendation contemplates, there may be that risk.

THE COMMISSIONER: Okay. Still in this section but at page 38, 8.22:

> *CA Submissions [505] submit that there are insufficient specialist rehabilitation beds at Royal Rehab and Prince of Wales Hospital to enable patient flow.*

Just pausing there, I'm not sure that it's correct to characterise that as a submission. The evidence that I heard was that there aren't enough specialist rehabilitation beds for either people suffering from spinal injuries or traumatic brain injuries, and there was no challenge that I remember to that evidence. Do you accept that there are not enough specialist rehabilitation beds? Do you accept that as a matter of fact?

MR CHENEY: Yes, I do, Commissioner, and as I recall it, there was some support for that proposition in the

evidence.

THE COMMISSIONER: Okay. It is just that the word "submission" threw me, because I didn't take it as a submission, I took it as counsel assisting reminding me what the evidence actually was.

MR CHENEY: Oh, I see the point.

THE COMMISSIONER: All right. Workforce. So the workforce proposed recommendation 15 is at page 62. That's 15. Then there's a further recommendation, to orientate you - I can't find 16 at the moment. Yes, 16 is at page 68 about expanding HETI's role. Not really what I wanted. I wanted to get to 17, I'm sorry, page 74. So this is counsel assisting's submissions and proposed recommendation in relation to award reform. I'm just struggling to understand exactly what you mean by, at page 77 in 10.52:

> *Further, were legislative amendments enacted to give effect to this recommendation, the award review process proposed would likely be lengthy and involve significant input from stakeholders, principally NSW Health and industrial organisations.*

Firstly, just as a matter of principle, is there something wrong with NSW Health and the unions having significant input into this process?

MR CHENEY: No.

THE COMMISSIONER: What do you mean? What's the problem that you're identifying?

MR CHENEY: I'm not sure that 10.52 necessarily identifies a problem so much as reflects the reality that implementation of the recommendation would carry.

THE COMMISSIONER: Well, it does say:

> *Further, were this to happen --*

ie, counsel assisting's recommendation, "the process would likely be lengthy and involve significant input", et cetera. I have taken that as a submission of some form

of obstacle to what counsel assisting are recommending. I'm just trying to work out - I mean, I would have thought it was a matter of obviousness, it can't be an obstacle that the unions and NSW Health have a say.

MR CHENEY: No.

THE COMMISSIONER: Why does it have to be lengthy? Why would it have to be lengthy or why is it likely lengthy? Isn't that up to - I mean, partly it might be the IRC, but that's in the hands of the parties, isn't it?

MR CHENEY: Yes, although the one example we've given in 10.52 is of what was a lengthy process, being the example that is cited in counsel assisting's submissions.

THE COMMISSIONER: Okay. Recommendation 20, at page 86:

> *Consideration should be given to the routine collection ...*

of data of the kind - so this relates to Dr Richards' role as the chief wellness officer at the Sydney LHD, and she gave evidence about, amongst other things, what she described as - be careful how I phrase this - concerning levels of burnout, burnout being more than fatigue

MR CHENEY: Yes.

THE COMMISSIONER: And collecting information about that and its causes, no doubt as a helpful means of management, plus maybe ultimately ministry working out what might be ways we can mollify that, to the extent that it's possible.

MR CHENEY: Yes.

THE COMMISSIONER: What makes you think, as you say, if you go to 10.87, in relation to what is proposed in recommendation 20, that on this topic, there is likely to be resistance at local level?

MR CHENEY: Only that what is contemplated by recommendation 20, Commissioner, is the routine collection and collation of data from the workforce.

THE COMMISSIONER: Why would the workforce have resistance - what makes you make this submission or what do

you base this submission on that a workforce, that I think everyone accepts - I mean, it's a health workforce, so it's working hard and probably under stress at the best of times, it's coming out of the pandemic - what makes you think there would be local resistance to some kind of process whereby, in a way that appropriately might protect any confidentiality or privacy involved, involves collecting data about how people are feeling? Why would the workforce resist that?

MR CHENEY: Commissioner, I'm not sure that 10.87 is necessarily pointing to a problem with the workforce's response to such --

THE COMMISSIONER: It talks about "including the data collected about workforce wellbeing", what am I misinterpreting?

MR CHENEY: It's a reference to the top-down directive - that is, that ministry direct each LHD chief executive, one assumes, to implement the same system as Dr Richards describes.

THE COMMISSIONER: There would be a way of managing that, wouldn't there, that still accommodates the main thrust of recommendation 20? Do you agree with that?

MR CHENEY: I do, Commissioner, and I'd emphasise that what is described in 10.87 is described as a potential challenge, not put forward any higher.

THE COMMISSIONER: Okay. Can I just then move to some concerns about sharing of other workforce data, I think, including vacancies, et cetera. You address this at 10.97 on page 91:

> *The concerns raised by NSW Health's witnesses regarding the sharing of workforce data are more appropriately described as concerns that data may be misinterpreted, misrepresented or misused by stakeholders or the public ...*

Should I interpret that to mean that it's not really meant to be suggested that the public would go out of its way to misrepresent any data, but it's, what, some sort of concern about the press, is it?

MR CHENEY: Yes, Commissioner. I think there was some evidence in the example we cite in 10.97 in respect of vacancy data, for example.

THE COMMISSIONER: Okay. Staying with the same topic but 10.99 on page 92:

> *Separately, many of the requests for data that are made are for datasets that cannot be produced automatically from NSW Health's systems or are for data not routinely collected ... and which would create a significant workload ...*

Accepting that at face value, do you accept that that's the system that health's created?

MR CHENEY: Yes, Commissioner. I mean, it's our system.

THE COMMISSIONER: In other words, the fact that datasets can't be produced automatically from NSW Health's systems is alone not a reason for not producing it. The difficulty is the way you have set yourselves up?

MR CHENEY: Well, not necessarily with any fault on our part, Commissioner. For example, there was --

THE COMMISSIONER: Well, just take the word "fault" to not mean I'm pointing the finger at anyone in particular, but --

MR CHENEY: But the example I recall from the evidence about the vacancy data was a concern that, for example, it would be necessary for the administration at Broken Hill Hospital, for example, to dig in and produce the data that's then relayed centrally to ministry.

THE COMMISSIONER: But, if someone, including me, were to take the view that that sort of data is data that the public's entitled to know --

MR CHENEY: Yes.

THE COMMISSIONER: -- then that's not a reason - the difficulty in producing it isn't a reason for secrecy or not producing it. Do you agree with that?

MR CHENEY: No, and it's not put forward that way, Commissioner; it was just to acknowledge the workload.

THE COMMISSIONER: I won't take it that way. In 10.102, going through to the next page and 10.106, you make some submissions about what I'll just call the Concord hospital dispute. Do you see those?

MR CHENEY: Yes, 106.

THE COMMISSIONER: In particular, 10.105, you talk about the submission that counsel assisting has made that it should have been obvious that the letter that Dr Cheung received would likely have been viewed by him as suggesting that disciplinary procedures would be weaponised against him, and you tell me that that submission should be rejected because Dr Cheung never gave this evidence.

Just pausing there, my current but not final position, but my current state of mind, is that it's not necessary for me to make findings about who specifically was at fault in relation to what happened at Concord hospital.

Putting that aside for a second, though, the observations that I would make are - I would push back at what you've got at 10.104. In my view, the ministry probably should have been involved earlier. This hospital - the medical staff council was in revolt, and I think there could have been some earlier action.

In relation to Dr Cheung specifically, though, whether or not Dr Cheung gave any specific evidence, I don't intend to read the letters or letter out to you, but I think an objective, reasonable reader would have taken it as a threat. If it was me - and I may not be reasonable - I would have taken it as a threat. It's a letter that's heavily slanted towards, "You'd better be careful, mate, and pull your head in, otherwise you're in a lot of trouble and here is why." Now, that's a paraphrase, I accept that. So whether or not Dr Cheung said that, whether or not I make findings of blame here - which I think is very unlikely - I certainly think that, and you can tell me if you want to push back on this, that letter could have been better drafted and a different approach could have been taken to the whole Concord hospital issue that might have been better and resulted in a swifter conclusion and it

might be another example of why management and clinicians have really got to communicate closely together to make sure these sorts of things don't get out of hand.

MR CHENEY: I think all three propositions were conceded by the relevant witnesses, Commissioner.

But can I just make the point that what we were pushing back on in 10.105 was the suggestion that you should find that the action would have been viewed by Dr Cheung as suggesting that disciplinary procedures would be weaponised against him, when it is, after all, the fact that Dr Cheung was no shrinking violet. He gave evidence and he didn't say anything to that effect and he wasn't asked that. It's just unfair to make a finding against my client in that circumstance, when it's got some serious --

THE COMMISSIONER: You might be right in terms of Dr Cheung's individual reaction about it, but it's open to me to say something about the letter, from an objective point of view

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: All right. AHOs. I mean, there's not a lot for us to discuss because there was a discussion between Mr Muston and the secretary, but can I just try and understand a couple of your submissions. Sorry, this commences at page 95 at 11.3. You're introducing the notion of the difference between services listed in schedule 3 of the Act and the services that might be listed to be provided under a service agreement.

MR CHENEY: Yes.

THE COMMISSIONER: You make the submission in 11.3, about six lines from the bottom:

> *The reality is that for so long as a service is included in Schedule 3, the public can reasonably expect such a service to be funded from year to year, and that expectation informs NSW Health's approach to funding Schedule 3 services and establishments.*

Can I just pose an alternative to that: why isn't what the

public can reasonably expect to be the services provided those ones that are outlined in a service agreement? Why wouldn't the public have its expectation based on a service agreement rather than just schedule 3?

MR CHENEY: We weren't suggesting that the schedule 3 entries were the sole source of the public's expectation, Commissioner, and we take your point.

THE COMMISSIONER: There's a lot of effort gone into saying that counsel assisting may have conflated schedule 3 with service agreements, but that's not your intent?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: All right. And there are services listed in schedule 3 that are services that are not provided - correct?

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: And what's the problem with the proposed recommendation that schedule 3 be reviewed annually?

MR CHENEY: We attempted to deal with that in our written submissions, Commissioner, I think at 11 --

THE COMMISSIONER: The recommendation I have in mind is at page 106 of your submission, okay? So let me just orientate you. If you go to page 106 --

MR CHENEY: Yes.

THE COMMISSIONER: -- down the bottom of that page, you will see this, counsel assisting "On an annual basis, and in conjunction with the planning", et cetera:

> *... Schedule 3 to the [HSA] should be reviewed to ensure that it accurately records the recognised services and establishments of each of them and amended to the extent necessary to reflect those services.*

Your push-back to that, as I read it, which commences at 11.30 on the next page, you say:

> *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.

THE COMMISSIONER: Where you say it's consistent with the legislative framework. What's being proposed by counsel assisting, as I understand it, is first of all, it should be fundamental that AHOs get funded to the extent of the reasonable costs of the services they're required to deliver. Then, built on that, if there is a fundamental, irreconcilable impasse between St Vincent's and NSW Health or Tresillian and NSW Health, where NSW Health says, for multiple reasons, "We have given you every cent you need to deliver the services you are required to", and St Vincent's says, or Tresillian or some other AHO says, "You are underfunding us and that is making us tap into other sources of funding or it threatens our actual survival", why would an independent arbiter be a problem, if the independent arbiter is no more than to express an opinion as to what their independent view is in a manner that, of course, can't trump the minister's power in the HSA?

MR CHENEY: That would be fine, Commissioner, but that's not how the recommendation reads.

THE COMMISSIONER: I don't take it to mean that the minister's now lost --

MR CHENEY: It uses the language of "resolving the dispute", suggesting he's going to determine it, not an independent, non-binding opinion.

THE COMMISSIONER: Yes, but I wouldn't leap to that submission is consistent with the repeal of a provision in the HSA. Anyway, let's forget that. Do I take it, then, that the resistance to the mechanism is lessened if it's a mechanism by which an arbiter says, "In my independent view, the answer is X", but the minister can always say, "Well, I've seen what the independent arbiter says, I still think it's Y, and that's what I'm sticking with"?

MR CHENEY: Yes, and that's the thrust of 11.34.

THE COMMISSIONER: All right. Got it. Thanks.

First Nations. This commences at 141 of your submission, again, just to orientate ourselves. So the first recommendation is a coordinated whole of government approach. That's not very controversial.

MR CHENEY: No.

THE COMMISSIONER: The next recommendation is 30, on 143. "Meaningful collaboration", "joint planning", I'm not sure that that's particularly controversial either.

And then we have, I think, the subject of more submissions from you, recommendation 31 at page 148. Just pause there. Can I just ask you this: I understand what you've said in your submission, and I'll certainly take it into account, but at a high level of generality, looking at recommendation 31(a), is there any disagreement that in general, yearly or short-term funding cycles aren't particularly helpful, or that they have disadvantages, particularly in relation to recruitment and retention? Is that accepted?

MR CHENEY: Yes, and that might be inferred from what we say in 14.26, by way of work under way.

THE COMMISSIONER: Sure. And in relation to (c) - and please, in relation to (c), don't think I don't think there needs to be, whenever money is handed over to anyone, some form of analysis of how it's being spent and an analysis of what the outcomes were, but as a general proposition, do you agree that ACCHOs are best placed to determine what the health services that their communities need are?

MR CHENEY: I don't think anyone on behalf of my client would suggest otherwise, Commissioner.

THE COMMISSIONER: Yes. Okay.

MR CHENEY: You will see from 14.29 that we have acknowledged the need to adopt a less rigid approach.

THE COMMISSIONER: Yes. And I should say, in complete fairness, when we're talking about yearly or short-term funding cycles, by far and away, the problem is with Commonwealth grants not --

MR CHENEY: Yes.

THE COMMISSIONER: I'm completely aware of that. You have probably made that point too.

Can I ask you something, and I apologise for this,

I meant to ask the three witnesses, but with the single digital patient record that will be relatively soon started to be rolled out, and I think the plan is for it to be fully rolled out by 2029, or 2028/29, but at this stage, it's not proposed to extend it to general practitioners. I can see a lot of advantages in - and no doubt NSW Health could - if it was rolled out to general practitioners. Has there been any form of costing done as to what it might cost to roll it out to general practitioners?

MR CHENEY: Commissioner, I might have to take that question on notice, if I may.

THE COMMISSIONER: You can, and take this one on notice, too, but I imagine you'll embrace the proposition, that if we consider - well, there's no doubt general practitioners are involved in primary healthcare services, it would certainly be a pretty strong case that rolling out the SDPR to general practitioners would be an aspect of primary health care for which the Commonwealth should make a final contribution at least. Would you agree with that?

MR CHENEY: Perhaps they should fund it entirely, Commissioner, yes.

THE COMMISSIONER: They were the questions I had in relation to your submission. You are absolutely free to say anything further you want to submit, before I hear from Mr Muston, which might be tomorrow, probably. Unless you have nothing you want to say in reply?

MR CHENEY: Commissioner, may I --

THE COMMISSIONER: Do you want to think about it?

MR CHENEY: Commissioner, this request might in part address the last question you put to Mr Muston about whether he wishes to be heard now. I've spoken to him about our request for some time to respond to the written submissions received from the other interested parties.

THE COMMISSIONER: Oh, yes.

MR CHENEY: We're not anticipating that anything we say will be lengthy, and indeed, we're content to submit to a page limit, if that be required, but may we have until next Wednesday, 5 March, to provide a written reply to

anything that's in the submissions of the other parties?

THE COMMISSIONER: Is there anything - is that a problem? You've raised an eyebrow, so there's a slight problem.

MR MUSTON: I was mindful of the timeline --

THE COMMISSIONER: I know there is a massive problem.

MR MUSTON: -- for you having to deal with whatever it is and --

THE COMMISSIONER: If we set a page limit, that might accommodate it.

MR MUSTON: Five pages in total by way of response to all of the third party submissions.

THE COMMISSIONER: I think I will give health 10 pages, if it is dealing with all of the submissions. Ten pages in total. You can live with that?

MR CHENEY: I thought I might also deal with the two questions on notice, Commissioner, in that same --

THE COMMISSIONER: I've even forgotten what they are. One was the costing of the SDPR for general practice. What was the other one?

MR CHENEY: It was what the position was as to who should fund --

THE COMMISSIONER: All right. Okay. I thought you agreed with it being the Commonwealth. All right. Is there anything further you want to address me on, though?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: All right. Thank you. And thank you for your assistance and the submissions. Thank you both, or thank you to the team.

Mr Muston, do you want to say anything in reply? Do you feel you need to? Do you want to do it in writing, do you want to come back tomorrow morning and do it?

MR MUSTON: Look, I can - there are a few issues that

I might --

THE COMMISSIONER: 10.30 tomorrow?

MR MUSTON: Yes.

THE COMMISSIONER: I've got to go to a swearing in tomorrow, so, actually, is it okay - I mean, we've listed it for three days. Why don't we come back at 11 o'clock tomorrow for you to do whatever you want to do in reply.

MR MUSTON: I will be very brief. That sounds fine to me. I wouldn't mind going to the same swearing in, actually.

THE COMMISSIONER: I still would prefer to give you the time to think about anything that was said either by the witnesses today or any exchanges I had with Mr Cheney. If you are going to be short - I mean, I don't care - we could make it 11.30 or 12, what suits you?

MR MUSTON: Well, 11.30 will give you and possibly --

THE COMMISSIONER: Why don't we adjourn to 11.30 for Mr Muston to make any submissions in reply that he wishes. Otherwise, that's all today, and I'll thank a few other people tomorrow.

All right. We'll adjourn until 11.30 tomorrow. Thank you all for your assistance.

AT 3.49PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 27 FEBRUARY 2025 AT 11.30AM

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