

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Thursday, 27 February 2025 at 11.30am

(Day 071)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)
Mr Daniel Fuller	(Counsel Assisting)

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu SC for NSW Health

1 THE COMMISSIONER: Good morning.

2

3 Just before I invite you to say anything you want to
4 say in reply, Mr Muston, there's just a matter that partly
5 came out of looking at the transcript yesterday that I'd
6 just like to take up briefly with Mr Cheney.

7

8 At the risk of asking you the longest question in
9 history, which I'm happy to do, and go on the record as the
10 longest question in this Special Commission, there is a bit
11 of material I need to walk you through to get to the point
12 where I want to know what your view is, so just bear with
13 me.

14

15 It starts at the part of your submission that
16 addresses the proposed funding recommendations of counsel
17 assisting. So to orientate you, you have set out counsel
18 assisting's recommendations 3, 4 and 5 on page 11 of your
19 submission.

20

21 MR CHENEY: Yes.

22

23 THE COMMISSIONER: They are the three recommendations you
24 then address in this next section of your submission.

25

26 You make a number of points, I think six - no, there
27 are seven - seven points you have put in your submissions
28 concerning those proposed recommendations. Can I take you
29 to the fourth and the sixth. The fourth is at 6.18 and
30 6.19, where you make a submission that what is at 296 of
31 counsel assisting's submissions is an oversimplification of
32 the budget process and you set out why in 6.19.

33

34 Just so we know exactly what we're talking about, if
35 you go to 296 of counsel assisting's submissions, that's
36 where counsel have submitted that, at a general level, the
37 health budget is determined by reference to a base, the
38 historical origins aren't really known, and then they say:

39

40 *As a matter of practical reality --*

41

42 god, that term's used by you, too --

43

44 *the adjusted base figure cannot be seen as*
45 *any sort of attempt to deliver to the*
46 *ministry the funds required to deliver any*
47 *particular health service, but, rather,*

1 *reflects the somewhat arbitrary portion of*
2 *the annual budget that is devoted to the*
3 *health system, perhaps informed by an*
4 *understanding of what it would cost for the*
5 *health system to continue for another year*
6 *in its existing form.*

7
8 I can understand some sensitivity around the word
9 "arbitrary"

10
11 MR CHENEY: Yes.

12
13 THE COMMISSIONER: The way I read it is, first of all,
14 it's a submission that suggests it's somewhat arbitrary -
15 and I will come back to that. Of course, it can't be
16 entirely arbitrary, because it's based on the previous
17 year's budget with growth, so that means it's not entirely
18 arbitrary, and I would accept that.

19
20 MR CHENEY: Yes.

21
22 THE COMMISSIONER: If we then look at the submission
23 you've made in 6.22, there's a submission made by you
24 concerning what counsel assisting submits are the opaque
25 character of the equity adjusters. Now, those equity
26 adjusters we did discuss yesterday, and in particular -
27 I don't think we need to go - well, it might assist if we
28 just quickly go back to the statement of Mr Daly,
29 Mr Portelli and Ms Smith, which is [MOH.0011.0089.0001],
30 if we could bring that up. Thank you.

31
32 If we could go to paragraph 10 on 0003 and following,
33 there were some questions yesterday, I think by both
34 Mr Muston and myself, concerning paragraphs 10 and onwards,
35 through to and including 15, I think, that Mr D'Amato
36 mainly answered with some contribution by the secretary.

37
38 As things stand, the totality of that evidence,
39 whether the word "opaque" is quite right, there's -
40 I think, a submission that it's not as transparent as it
41 could be is a reasonable submission, and I think that one
42 of the bases for considering that a reasonable submission
43 is what the secretary said yesterday.

44
45 MR CHENEY: Yes.

46
47 THE COMMISSIONER: And it is at 7082 and 7083 of the

1 transcript, where - I won't call it a concession, but where
2 she recognised, prompted by a question from Mr Muston, that
3 there are people in the health system that ought to have
4 a really full understanding of how the budget is put
5 together and don't.

6
7 MR CHENEY: Yes.

8
9 THE COMMISSIONER: In credit to her, she suggested that
10 health should do some work on that to change that.

11
12 MR CHENEY: Yes.

13
14 THE COMMISSIONER: At least in relation to the "opaque"
15 submission and how this equity adjuster works, I think it's
16 a fair submission that, whilst I certainly don't regard it
17 as, as you say in your submission - I'm not going to make
18 a finding that the equity adjuster is in some way utterly
19 secret, nor would I make a finding that it is irrational.

20
21 MR CHENEY: Yes.

22
23 THE COMMISSIONER: So, if that's the concern, that's not
24 going to be the finding, but I think we could probably
25 agree, you tell me if you disagree, it is at least not as
26 transparent as it could be, and, as the secretary said
27 yesterday, there's work to be done so that people
28 understand it better that ought to understand it. Do you
29 agree with that?

30
31 MR CHENEY: I do, Commissioner.

32
33 THE COMMISSIONER: Thank you.

34
35 MR CHENEY: I think there was some evidence from at least
36 one representative in Tamworth to that effect, that they
37 found --

38
39 THE COMMISSIONER: There may well have been. I've lost
40 track of everyone that either spoke to me or said something
41 in a public hearing, but definitely there was more than one
42 board member, who I regard as experienced people, including
43 someone with a long career in finance, that said, "I don't
44 understand it", and he was trying.

45
46 Anyway, putting that aside, going back to the
47 submission at 296 and the submission about "somewhat

1 arbitrary", in relation to that, what I'd take you to and
2 get your views on is, first of all, I think where the basis
3 of that submission comes from is the treasury submission,
4 which we'll need to go to, which is [TRY.0001.0001.0001],
5 if we could get that up on the screen. That's the
6 document, thanks, and if we could just go to page 0003,
7 which is page 2 of the actual document.

8
9 Under the heading "Response to the Issues Paper", what
10 I'm told is:

11
12 *The budget baseline is established through*
13 *a combination of individual policy*
14 *decisions and the application of an annual*
15 *escalation rate.*

16
17 Just pausing there, I won't go through all the bits of
18 transcript, but I think there was a recognition by the
19 relevant witnesses that they don't have any real knowledge
20 about where the health budget was originally set, either at
21 the commencement of the time we had districts or before
22 that when there were area health services - it's back in
23 the past, and what has clearly happened is there has been
24 growth applied to those budgets and, no doubt, money for
25 what is described as "individual policy decision", but the
26 original position is in the dim, dark past, I think that
27 was what the evidence is.

28
29 Then treasury tells me in 2.3 that there is an initial
30 escalation of 4 per cent:

31
32 *This includes 2.5 per cent for cost growth*
33 *and 1.5 per cent for service growth. The*
34 *2.5 per cent ... reflects the mid-point of*
35 *the Reserve Bank of Australia's inflation*
36 *target range the 1.5 per cent service*
37 *growth assumption is unique to Health.*

38
39 That's said to be based on issues - well, sorry, impacts of
40 population growth, ageing, system efficiency and fiscal
41 affordability. So on the face of this submission, the
42 1.5 per cent, you wouldn't describe as entirely arbitrary,
43 and it looks as though it does give, on the basis of this
44 submission, at least some consideration, albeit we're not
45 quite sure how, to things that might relate to the need for
46 health services, okay? So I accept that.

1 MR CHENEY: Yes.

2

3 THE COMMISSIONER: If we can move on to page 0007, at
4 paragraph 2.30 - just pausing there, part of this
5 submission tells me:

6

7 *Health's financial and operational*
8 *performance suggests that the current level*
9 *of funding is adequate.*

10

11 Again, I won't take you to all the transcript - and you can
12 just look at that paragraph alone - of course, that
13 statement is in isolation from a consideration of health
14 outcomes or things like ambitions to reduce the rates of
15 chronic disease, et cetera, or even what might be unmet
16 demand. That's the way I take that submission, unless you
17 consider there's something more to it than that.

18

19 MR CHENEY: Arguably within the term "operational
20 performance" is contemplated a consideration of how the
21 system is coping.

22

23 THE COMMISSIONER: All right. Then if we go to the
24 evidence that was given by the treasury officials when they
25 gave their sworn evidence, which was on 18 November. We
26 need to go to - starting at transcript page - and if we
27 could get the transcript up, please - 6245.

28

29 If we go to 6245, it's just to remind everyone who the
30 witnesses were. So it's 18 November. If I've said a
31 different date, I apologise. It's 18 November commencing
32 at 6425. The witnesses were Mr Kastoun, who is the
33 executive director of the health and stronger communities
34 division. At 6246 there was Mr Cornelius, who is the
35 director of the health team in the policy and budget group,
36 and Mr D'Amato joined them.

37

38 If we then look at page 6250, please, so Mr Cornelius
39 told us:

40

41 *Effectively the base is the full recurrent*
42 *budget for health, which is ... around*
43 *33 billion ...*

44

45 In about the middle of the page, at line 24, Mr Muston
46 asked:

47

1 *So let's stick with the operational*
2 *component ... How is the operational base*
3 *calculated?*

4
5 Answer:

6
7 *Well, I think that just reflects the*
8 *history of incremental budgeting over time.*

9
10 Mr Muston:

11
12 *You might not know, it might be such*
13 *a piece of ancient history, but do any of*
14 *you have any understanding of where, in*
15 *history or how historically the figure was*
16 *originally arrived at?*

17
18 Mr Cornelius, "I don't", Mr Kastoun, "Before my time as
19 well". That's the point about really no-one seems to know
20 the origins of the base.

21
22 Then if we go to 6255, Mr Kastoun is telling us about,
23 commencing at about line 4, the cap and, I take from this,
24 the difficult financial or constrained financial
25 environment that we're in now in relation to budget
26 deficits and what the forecasting is, and reminding me, as
27 is perfectly appropriate, at line 32, that there's
28 competing priorities for money that New South Wales has to
29 spend, which can't just all be on health.

30
31 MR CHENEY: Yes.

32
33 THE COMMISSIONER: Again, as Mr Muston joins in on that,
34 at 6256, commencing at about line 12. Then if we go to
35 6257 at about line 22, Mr Muston comes back to the base,
36 and he asks:

37
38 *... this question of what is to be*
39 *delivered as part of the public health*
40 *system, we've got the urgent care that*
41 *someone might need, if they've had an*
42 *accident ... If you walk into a hospital*
43 *and you need to have something done*
44 *urgently ...*

45
46 et cetera. Mr Kastoun, "Hope so". Mr Muston:

47

1 *That's those core urgent or acute aspects*
2 *of it, but then as to what sits around that*
3 *in terms of those non-urgent acute forms of*
4 *care, as part of treasury's function, does*
5 *it have visibility of what's on the table*
6 *and what's off the table at any given year*
7 *as part of the public health system, and in*
8 *determining whether or not the base is*
9 *adequate?*

10
11 Mr Cornelius:

12
13 *I think it's fair to say we don't have the*
14 *same level of visibility around community*
15 *care as we do for what's in scope for*
16 *activity based funding.*

17
18 Now, unless you tell me otherwise, what I take from
19 that is that treasury has a good idea of what funding might
20 be necessary based on ABF from the public hospitals which
21 is, as we know, largely about the acute care services, but
22 just to quote their words, doesn't have "the same level of
23 visibility around community care", which I extrapolate to
24 doesn't have the same level of visibility about services
25 that might be required outside the public hospital system -
26 do you accept that?

27
28 MR CHENEY: I accept that's the effect of Mr Cornelius's
29 answer, yes, Commissioner.

30
31 THE COMMISSIONER: Then if we go to 6267, and again,
32 Mr Cornelius is telling us about the budgetary process, he
33 says:

34
35 *So over the forward estimates, we have*
36 *visibility of health's budget for 10 years*
37 *... that tenth year is escalated at*
38 *4 per cent to create a new year in forward*
39 *estimates ...*

40
41 et cetera. Then at the top of 6268, Mr Cornelius explains:

42
43 *So in the budget papers you'll see*
44 *a headline growth, which is just literally*
45 *the movement between the current year*
46 *projection and the new budget year. Then*
47 *we have an underlying growth rate, which*

1 *reflects the movement in ongoing services.*

2

3 Which again I take to be an indication about ABF.
4 Mr Muston then says at line 20:

5

6 *So that adjusts the base. But then is*
7 *there an additional growth factor which is*
8 *applied to that which is this figure that*
9 *includes things like the, as you have told*
10 *us about in the submission, cost of*
11 *operating refurbished or new hospitals ...*

12

13 And then there is an exchange about that. Then Mr Muston
14 says:

15

16 *You tell us in the submission that health*
17 *gets the benefit of an additional*
18 *1.5 per cent service growth assumption.*
19 *Could you just explain what that is and how*
20 *it's been arrived at?*

21

22 Mr Cornelius tells me:

23

24 *So that was a decision of government back*
25 *in 2019 where the growth rate over the full*
26 *10-year planning horizon was set at*
27 *4 per cent. The 1.5 per cent was - it's*
28 *a fairly notional concept. It's slightly*
29 *higher than population growth. Health*
30 *would argue that it's not enough to cover*
31 *the impact of population ageing as well as*
32 *population growth. It was determined with*
33 *reference to fiscal capacity at the time.*

34

35 If you flip over to 6269, at line 20, Mr Muston asks:

36

37 *Can I come back to just those broad*
38 *concepts of change - population changes and*
39 *the like. To what extent or in what way is*
40 *the growth factor that is applied to the*
41 *base arrived at by reference to, say,*
42 *increased burden - an identified increased*
43 *burden of disease within the community, if*
44 *at all?*

45

46 Mr Cornelius:

47

1 As I mentioned, that 1.5 per cent was set
2 back in 2019, and it wasn't overly
3 scientific. It was with reference
4 broadly - it had the concept of the
5 population growth and a bit of a concept
6 around demand; certainly we had
7 a conversation with health at the time
8 around what some of those impacts would be,
9 but ultimately it was considered in the
10 context of what was fiscally affordable at
11 the time.

12
13 Now, what I take from all of that, and what I want to
14 know is, whether you accept that, is that when the
15 submission is made at 296 by counsel assisting that this
16 growth factor from an unknown base is somewhat arbitrary,
17 whilst I wouldn't accept that it's fully arbitrary, it is
18 by no means a growth factor that is applied after a careful
19 analysis of population health needs within the populations
20 of the districts, let alone the burden of disease in those
21 districts. Do you accept that on the basis of that
22 evidence?

23
24 MR CHENEY: On the basis of Mr Cornelius's answers, yes,
25 Commissioner. I think we were resisting - and I'm not
26 suggesting that this is what was being put, but the word
27 "arbitrary" can be a bit loaded.

28
29 THE COMMISSIONER: It can. I mean, there is a word before
30 it that says "somewhat", which qualifies it. If it just
31 said "entirely arbitrary", I would reject it, and I do
32 reject it.

33
34 MR CHENEY: Yes.

35
36 THE COMMISSIONER: And whether or not the word "arbitrary"
37 is or isn't appropriate, even in the context of "somewhat
38 arbitrary" --

39
40 MR CHENEY: Yes.

41
42 THE COMMISSIONER: -- although I think that's probably
43 fair enough, the real point is that on the basis of that
44 evidence, the growth factor seems to be more aligned with
45 what is "fiscally affordable at the time", rather than
46 "health needs".

47

1 MR CHENEY: If that's so, Commissioner, it doesn't follow
2 that that approach is to be criticised, in my submission.
3 One does need to have a means for awarding growth in a
4 budget.

5
6 THE COMMISSIONER: I'm not sure that I would consider it,
7 though, on the basis of all the evidence I've heard, the
8 best way of a budget for health services in New South Wales
9 to be set, if the aim is not just to deal with the
10 day-to-day complexity of dealing with acute illness and
11 acute disease, but if the aim is to address some of these
12 matters that we've explored again and again and again and
13 that the literature is full of - that is, dealing with the
14 burden of disease, preventing, early intervention in
15 chronic disease, dealing with the ageing population, which
16 itself comes with chronic disease and the diseases of
17 ageing, and trying to, through that, get some economic
18 benefits including benefits in relation to resourcing for
19 health services and the cost of health services. Do you
20 accept that?

21
22 MR CHENEY: I do, Commissioner. I mean, I'm conscious
23 that I don't appear to --

24
25 THE COMMISSIONER: Don't get me wrong. Overlaid in all of
26 this is what funding is provided by the Commonwealth.

27
28 MR CHENEY: Yes. I did want to make - the only other
29 point, Commissioner, is I'm not here in the interests of or
30 appearing for treasury. It may be that if there were
31 somebody here on behalf of treasury, they could speak more
32 fully to --

33
34 THE COMMISSIONER: They can certainly, if it's needed -
35 I mean, I'm not going to tell anyone what to do. Your
36 side, if you feel so inclined, could provide them with
37 a reminder of the evidence they gave on the past occasion
38 and also the transcript of today. I certainly have,
39 I thought, been careful to read out word for word what they
40 said.

41
42 MR CHENEY: Yes.

43
44 THE COMMISSIONER: Perhaps I'll just leave it at that.
45 Yes, I'll leave it at that. I was very, very conscious of
46 not putting my own - their words into my own words, but,
47 rather, using their words to draw my conclusions.

1
2 MR CHENEY: Yes. I suppose the only point I would make,
3 Commissioner, is that it's not a matter for my client to
4 dictate to treasury how it deals --
5
6 THE COMMISSIONER: I completely accept that. Completely
7 accept that. I mean, your client gets an opportunity to
8 make submissions to treasury in the normal course of
9 events --
10
11 MR CHENEY: Yes.
12
13 THE COMMISSIONER: -- which is how I understand the
14 process works. But I would accept that ultimately, the
15 amount of money that NSW Health is provided with doesn't
16 happen because they say, "Give us X", or they put their
17 hands on the cash. All right? Thank you
18
19 MR CHENEY: Thank you.
20
21 THE COMMISSIONER: That was the further bit I wanted to
22 explore but --
23
24 MR CHENEY: I think Mr Chiu wanted to explore one topic.
25
26 THE COMMISSIONER: -- I think Mr Chiu is keen to say
27 something.
28
29 MR CHIU: Commissioner, with some trepidation, returning
30 to the topic of primary care and section 9, just, on
31 reviewing of the transcript from yesterday, I do have a
32 little bit of a concern we may be at cross-purposes on one
33 minor issue.
34
35 THE COMMISSIONER: Okay, yes.
36
37 MR CHIU: If you would just bear with me.
38
39 THE COMMISSIONER: Just let me get into the system again.
40 Yes, what page?
41
42 MR CHIU: If I could take you to the health submission at
43 page 43, paragraph 9.5, you'll see there, this is a section
44 of some 24 paragraphs under the heading "The National
45 Health Reform Agreement" --
46
47 THE COMMISSIONER: Yes.

1
2 MR CHIU: -- "2020-2025". You will see there in the first
3 sentence of 9.5 that what this section seeks to do is to
4 address two particular paragraphs arising from counsel
5 assisting's submissions, that's 567 and 568. If I could
6 take you briefly to 567 and 568.

7
8 THE COMMISSIONER: Yes, I have that.

9
10 MR CHIU: You will see at 567 counsel assisting's
11 submissions refer to a particular part of what I will call
12 "the NHRA", and there is a section bolded there, and then
13 at 568, first sentence:

14
15 *As is clear from that passage, the*
16 *responsibility of the Commonwealth*
17 *Government is in system management,*
18 *support, policy and funding.*

19
20 No-one could disagree with that because that's in the NHRA.
21 It is really the next few sentences:

22
23 *However, the Commonwealth Government is not*
24 *engaged in service delivery.*

25
26 And then a reference, a couple of lines below, to,
27 "Mr Spittal's observation, 'It bears no responsibility for
28 delivering these services and thus lacks a clear obligation
29 to rectify market failures' is apt." Can I just make it
30 clear, Commissioner, that the section in the next 24
31 paragraphs in our submissions only seeks to make the point
32 that you made yesterday, that it is a joint process.

33
34 THE COMMISSIONER: I see, all right.

35
36 MR CHIU: It's not intended to suggest that the
37 Commonwealth has sole responsibility.

38
39 THE COMMISSIONER: I didn't take your submission to be
40 entirely disregarding that; it just lent that way a few
41 times.

42
43 MR CHIU: No. The only other matter for clarification is
44 that you referred to the expression "planning regime" --

45
46 THE COMMISSIONER: Yes, just so you are aware, it just
47 reminds me, seeing Mr Spittal's name there, there is a bit

1 of the transcript I saw the other day where - I don't need
2 you to respond to that, it just reminded me - he described
3 the idea that LHDs don't provide primary care as a myth.
4 Anyway. You wanted to say something else?

5
6 MR CHIU: We don't disagree with that, as our submission
7 quite clearly states.

8
9 The only other point is you referred yesterday to the
10 expression "planning regime". That expression isn't
11 actually used anywhere within section 9. The word "regime"
12 is used - "regime" may not be the best word.

13
14 THE COMMISSIONER: I understand that. There is
15 a reference to a "planning regime" earlier on in this
16 submission.

17
18 MR CHIU: It's a cross-reference.

19
20 THE COMMISSIONER: It then used the word "regime" in 9.5.

21
22 MR CHIU: Yes. If I could take you to 7.10, the only
23 place where that expression is used.

24
25 THE COMMISSIONER: 7.10?

26
27 MR CHIU: Yes, so it's page 24. We're quite content for
28 the first sentence of that paragraph to read:

29
30 *The interplay between recommendation 7 and*
31 *the addendum to the National Health Reform*
32 *Agreement.*

33
34 The words "and the planning regime provided for" are really
35 otiose and, as you pointed, out perhaps not the best
36 characterisation of the document.

37
38 THE COMMISSIONER: No. I no, think that's right.

39
40 MR CHIU: They are the only two points.

41
42 THE COMMISSIONER: That's right. Thank you for that.

43
44 Yes, Mr Muston.

45
46 MR MUSTON: I can be quite brief. I might just quickly
47 take up one issue, or draw one issue to your attention,

1 arising out of the exchange that you've just had with
2 Mr Cheney around the treasury evidence.

3
4 I just want to remind you, Commissioner, of
5 section 127 of the Health Services Act.

6
7 THE COMMISSIONER: Yes.

8
9 MR MUSTON: That sets out the mandatory considerations, as
10 it were, when making decisions around how much funding
11 ought or ought not be provided to the health service. Now,
12 we --

13
14 THE COMMISSIONER: That Act's in my room, so is there
15 a particular --

16
17 MR MUSTON: I can tell you what it says, but before I do,
18 we embrace the reality that there is always going to be
19 a limited budgetary envelope for the delivery of health
20 care and the healthcare service.

21
22 THE COMMISSIONER: Yes, and I think you have said that in
23 your submission --

24
25 MR MUSTON: Repeatedly.

26
27 THE COMMISSIONER: -- more than once.

28
29 MR MUSTON: As we acknowledged in the passage of evidence
30 that you took my learned friend to with the treasury,
31 health, education - all of these things have to compete for
32 a limited parcel of money, and in the perfect world, they
33 wouldn't, and in the perfect world, all of those services
34 would be absolutely rolled gold and provide everything
35 because there was unlimited funding, but that's not real.

36
37 However, section 127 does make clear that the
38 mandatory consideration in deciding how much money to
39 provide to the health service is the size and health needs
40 of the population resident within the area of the local
41 health district. So that's the division of money into
42 local health districts, which we say must necessarily mean
43 that, in making decisions around how you go about that
44 rationing at every level, whether it's at the LHD level
45 making decisions about which service is to be offered,
46 whether it's at the ministry to LHD level in deciding how
47 to distribute moneys to LHDs from within ministry's portion

1 of the budget, or whether it's at that level where
2 decisions are being made about how much of the budget ought
3 reasonably be delivered as part of a rationing exercise to
4 education, health and various other things, you have to
5 have some regard to, or at least have to understand, what
6 the health needs of the community are and what the health
7 service that you're intending to provide is seeking to
8 meet, not perfectly, because that's never going to be
9 possible, but you can't make those sorts of decisions
10 without some understanding of the system that you're trying
11 to create or the needs that you're trying to meet.

12
13 THE COMMISSIONER: Sure.

14
15 MR MUSTON: The other thing that emerged from that
16 evidence about treasury, to the extent that there was an
17 exchange about the adequacy of the budget having regard to
18 its operational performance, my memory of that evidence -
19 and I don't have the transcript --

20
21 THE COMMISSIONER: It was largely, well, they generally
22 keep to their budgets so that means it's adequately funded.
23 I don't accept that that's actually the right criteria for
24 deciding whether a health service is adequately funded or
25 not.

26
27 MR MUSTON: No. My memory of the evidence was also that
28 to the extent that there was an assumption made that it was
29 performing operationally, that was informed by some of the
30 reporting, which brings us to a topic that we touched on
31 yesterday.

32
33 To the extent that reporting about emergency
34 department waiting times and elective surgery wait times
35 were features of that reporting, that from memory, and
36 I might stand corrected - I'm told the treasury submission
37 explicitly alluded to it. But to the extent that those two
38 things are identified as being indicative of operational
39 performance in a way that could enable one to readily infer
40 that the funding of the wider health service was adequate,
41 we say that's problematic.

42
43 But it probably raises another issue, which brings us
44 into the planning side of the submissions we've made. This
45 really emerges from some evidence that was given yesterday
46 around, again, the reality that with reporting and the
47 reporting of areas in which the health service is

1 succeeding and reporting in areas in which the health
2 service might not be achieving its objectives, comes
3 a risk, we're told, of that information being misused as
4 a result of which, there is, one might think, an
5 understandable reluctance to report on areas where the
6 health service is not necessarily performing.

7
8 We, in a way, see that as, in part, creating or
9 contributing to the problem, because if the public is not
10 given a full and transparent understanding of the planning
11 process, the rationing decisions that have to be made,
12 those rationing decisions which will affect some people
13 favourably and affect some people, at least to their view,
14 unfavourably, if they don't understand those decisions, and
15 they don't - well, as a starting proposition, if they don't
16 understand those decisions and they're not brought into
17 discussions around them in a way which enables them to
18 understand them, then there can't really be any proper
19 consultation and dialogue with a community about what the
20 health service is and should look like.

21
22 If they don't understand them, then one can readily
23 see why, when they see a reference to a waiting time in
24 emergency or a waiting time for elective surgery, they
25 might also misunderstand exactly what they mean in the
26 context of the overall functioning of the health system.

27
28 The planning regime that we've suggested might commend
29 itself to you by way of recommendations would see a far
30 more transparent articulation of these rationing decisions.
31 True it is, a decision is made that a particular service is
32 going to be provided from within a limited budgetary
33 envelope and another one is not, and there will be people
34 who will be unhappy about that, but that's the reality of
35 the health system. We shouldn't proceed --

36
37 THE COMMISSIONER: I accept what you're saying to me.
38 I also accept - and this isn't a reason for not accepting
39 your proposed recommendations, but I do accept - the
40 evidence yesterday, which I won't go to word for word,
41 I will just paraphrase, from the witnesses yesterday: the
42 concern that some published data or information can be
43 either inappropriately or mistakenly weaponised against
44 health, thereby leading to, as Mr Minns said, diversion of
45 resources to deal with that weaponisation.

46
47 That's not lost on me and I am entirely sympathetic to

1 that point of view, but it doesn't by any means mean that
2 the data or information that should be publicly available
3 shouldn't be publicly available.
4

5 MR MUSTON: But it's not just the reporting of the data;
6 it starts with a clearer and more transparent articulation
7 of the planning process --
8

9 THE COMMISSIONER: Yes.
10

11 MR MUSTON: -- which, in part, requires proper engagement
12 with the community around it to work out what the community
13 really needs.
14

15 THE COMMISSIONER: Agree, yes.
16

17 MR MUSTON: There might be a difference between what they
18 really need and what they really want, and that's
19 a discussion that has to be had with the community and they
20 need to be educated as to why maybe what they want is not
21 what they need.
22

23 THE COMMISSIONER: In some places, that will be
24 inevitable.
25

26 MR MUSTON: I'm not for one moment suggesting that the
27 public should be invited into every facet of health
28 planning but there needs to be a far greater level of
29 transparency around these rationing decisions, because once
30 those rationing decisions are clearly laid out and made,
31 then to the extent that the outcomes of those rationing
32 decisions result in an inability to access a service in a
33 particular location or the like, it's not seen as - or it
34 is not quite so easily characterised as a failing of the
35 health system; it's a consequence of a limited budget and
36 rationing decisions that need to be made within a limited
37 budget.
38

39 If people are unhappy about that, it is better that
40 they understand that that is the product of a rationing
41 decision as opposed to that is the product of a failure on
42 the part of this, "We provide everything everywhere health
43 system" that members of the community might be led to
44 believe they have, which is not in any way a reality.
45

46 But that has to come with some accountability. Now,
47 the health secretary yesterday gave some evidence around

1 the need for accountability with reporting. I think the
2 particular example that she gave was to the extent that
3 there is reporting around poor health outcomes in
4 communities, that people other than just the NSW Ministry
5 of Health need to be held accountable for those poor health
6 outcomes, because everyone contributes, and we'll come to
7 primary care in a moment.

8
9 But accountability also should attach to this planning
10 process, in the sense that, having made the rationing
11 decisions you need to make, having articulated clearly why
12 you've made them, you put yourself in a position where
13 you're able to deal with, in a logical way, criticism that
14 might be levelled at you for the rationing decisions, "I'm
15 not providing this emergency department in this country
16 town because we've made a decision that the resources
17 required to meet the health needs of this particular
18 community are better deployed in a different way."

19
20 You have that conversation, but then there has to be
21 an identification of the outcomes that you're hoping to
22 achieve through those rationing decisions as part of your
23 planning, and there needs to be some accountability for the
24 extent to which those outcomes are achieved.

25
26 So again, whilst at one level that might be something
27 which might be the cause for some alarm, because it might
28 reveal particular - I won't use the word "failures", but it
29 might reveal particular challenges in some areas, but if
30 you are able to then revert back to your planning process
31 and say, "Well, we know that those challenges were going to
32 be faced. They were always going to be faced because that
33 was the inevitable consequence of the rationing decision
34 that we made, but here's the other thing we're reporting on
35 that the public can see and this is where we've, for
36 example, closed waiting times or delays in accessing the
37 much spoken of paediatric referral services" - a rationing
38 decision is made, clearly articulated, we're going to focus
39 on this because within this community, paediatric
40 services - just to use that example again - ought be
41 prioritised over an emergency department in a particular
42 small country town.

43
44 You are able to say, "The pluses and minuses of the
45 rationing decision that we've made were intended to be
46 reducing the gap on the paediatric times, potentially
47 increasing waits for emergency departments in surrounding

1 emergency rooms or departments, yes, that's happened, but
2 so, too, have we secured a benefit here."
3

4 If there is more reporting on that and a clearer
5 articulation of it, over time, it increases the capacity of
6 the health system to defend itself in the context of those
7 pieces of misused information.
8

9 Here is exactly what has been said. It's been misused
10 in a way. Yes, it's going to take some resources to do it,
11 but if you've actually got your planning system laid out
12 and there's been good public engagement in relation to it,
13 your capacity to actually get in and say, "Here is how we
14 contextualised that figure and here is why you should
15 actually not be so disappointed with the health system that
16 we're providing in your town", or, possibly, "We
17 acknowledge that's a failure because we had intended
18 through our planning process to achieve a better outcome
19 than we have and we haven't and so we need to do something
20 about it", but as a public health system, we need to,
21 I think, be able to embrace that.
22

23 Interestingly, our issue with primary care, and I'll
24 come in a little bit of detail to it, the approach which we
25 think has come through the evidence to primary care is, as
26 Mr Chiu said a moment ago, it is, in a way, in various
27 ways, happening out in LHDs - gaps in primary care are
28 being patched, and, in some cases, described as "isolated
29 cases" - we might take issue with the term "isolated", but
30 in some cases - there has been a complete stepping into the
31 primary care space; in other areas there has been
32 a patching up or a supporting, and, of course, we've heard
33 evidence of the ultimate consequence of the absence of
34 primary care, which is NSW Health becoming the provider of
35 last resort, delivering, in effect, primary care services
36 or delivering healthcare services to those who are in need
37 of primary care services through emergency departments in a
38 way which seems universally to be recognised to be both
39 more expensive and inferior, in terms of health outcomes,
40 to a properly functioning and accessible primary care
41 service, in the context of that primary care. Obviously
42 very different, if you have an urgent emergency, emergency
43 departments are the place for you to go.
44

45 THE COMMISSIONER: Of course, yes.

46
47 MR MUSTON: But in making these rationing decisions, the

1 one thing that, at least as we see it, seems to be largely
2 off the table at the moment, is primary care. I'll come
3 back to why we say that is right, but just to put it in its
4 context. We've heard evidence about the fear of there
5 being no Commonwealth funding for the delivery of primary
6 care by local health districts in areas of need. Whilst we
7 understand that, and I will just develop that shortly, what
8 that really means is, in making rationing decisions, will
9 we provide an ear, nose and throat service, will we provide
10 a paediatric service, will we provide an emergency
11 department in this hospital? These difficult decisions are
12 being made, under the planning approach we suggest there
13 should be perhaps a slightly more focused examination of
14 how system-wide those decisions all work together.

15
16 As a consequence of the rationing decisions that are
17 being made at the moment, you might get your ear, nose and
18 throat service, you might get a paediatric service, you
19 might get both, but the one issue that's not clearly on the
20 table, unless there's a guarantee of Commonwealth funding,
21 is primary care.

22
23 We say that because there is the reluctance to step in
24 and provide - or a stated reluctance to step in and provide
25 it if there is no Commonwealth funding, what that
26 essentially means is, if, as part of the planning process
27 that's happening at the moment, an assessment is made of
28 the healthcare needs of the community, an assessment is
29 made of the extent to which they are being met by other
30 external providers of health care, at the end of that
31 process, one looks at it and says, "Well, in this
32 particular community, there is no primary care," even if
33 the view were taken that, in the rationing decisions that
34 need to be made, funding primary care in that community
35 would be a better use of the money than, say, some other
36 form of care provided by the ministry, then at the moment,
37 it would seem that the approach is, "Unless the
38 Commonwealth is paying, we will still not provide that
39 primary care". That, we say, is, in essence, the
40 fundamental shift that is required.

41
42 Now, we point in our submissions to, and touched on
43 yesterday, the reality that whenever the state has stepped
44 in to provide primary care, it would seem, unsurprisingly
45 having regard to the terms of the NHRA, the Commonwealth
46 has agreed to provide a 19(2) exemption and deliver MBS
47 funding to the people of the communities who have the same

1 entitlement to that MBS funding as people who live in
2 communities with a functioning general practice market,
3 albeit delivered, in those cases, by the state.
4

5 That, in essence, is where we see the problem with the
6 current approach to primary care lying.
7

8 Now, I just want to address some concerns that were
9 raised by Mr Chiu in his submissions yesterday. If we
10 could get yesterday's transcript up at page 7139. Do you,
11 Commissioner, have access to your transcript while it's
12 coming up?
13

14 THE COMMISSIONER: Just going to 7139, did you say?
15

16 MR MUSTON: Yes, 7139 at line 45, right at the bottom.
17

18 THE COMMISSIONER: "It's a little bit unclear"?
19

20 MR MUSTON: "It's a little bit unclear". What that
21 follows from is an exchange you had with Mr Chiu about the
22 concerns around the risk and, in particular, the risks
23 associated with needing to address primary care, and it's
24 in quotes here, "at scale". What is said is:
25

26 *It's a little bit unclear, because the*
27 *proposal, the recommendation is "wherever*
28 *there is market failure". So I don't know*
29 *whether that means five local health*
30 *districts, 50 communities, 500*
31 *communities ...*
32

33 Et cetera. The starting proposition is we don't see any
34 reason why, if, as part of the planning that's undertaken,
35 a community is identified which lacks primary care and
36 a decision were made that the best way of providing that
37 primary care was via a Ministry of Health in some way,
38 shape or form, that there is any reason at all why you
39 would not take steps to do that or, more to the point, why
40 you would have to wait until you'd made an assessment of
41 the total need across the state before you decided whether
42 to step in and deal with that first one you found, which,
43 may not have been what was intended, but at one level what
44 one might infer from that submission is we need to work out
45 the total cost of delivering primary care to all the
46 communities across the entire state which are in need of
47 it, and in circumstances where it can only be, or should

1 really only be, provided by the state, and once we know the
2 total amount of money we're dealing with across all of
3 those different communities, at that point we can make
4 a decision about whether or not we want to do it.

5
6 Of course, the fundamental problem with that is by the
7 time you get to the end of your assessment exercise, things
8 will have changed. There might be more communities that
9 need it, there might be less. It's a dynamic process.

10
11 But in any event, a point we make is we don't see why
12 you need to make an assessment of the at scale cost of
13 delivering that care before, as part of your planning
14 process in each of the communities, that each LHD is
15 dealing with, it would not, in appropriate circumstances -
16 which again, I'll come to - step in to provide that primary
17 care.

18
19 Just to sort of round that out, if we go back to 7138,
20 at line 11, we get another facet of this, which is - you
21 see Mr Cheney has identified there, the point that they
22 were pushing back on was the notion that where they could
23 not get an up-front agreement from the Commonwealth about
24 this, they should, nevertheless, plough on.

25
26 Now, again, what an "up-front agreement" means is a
27 little bit unclear. At one level it might mean, "We've
28 actually looked at this particular community, in
29 appropriate collaboration with the PHN, we've come to the
30 view, and as part of our wider collaborative planning
31 process, we've come to the view that the only way in which
32 this community is going to receive primary care is if it is
33 delivered by the state. Here's the way in which we're
34 going to provide it, through a clinic co-located at a small
35 country hospital, for example, and a salaried employee
36 delivering the primary care, that's the way we're going to
37 do it, can we get a 19(2) exemption?"

38
39 If that's what's being suggested as part of the
40 up-front agreement on the part of the Commonwealth, we
41 would still say, even if the Commonwealth says, "No", if,
42 as part of sensible health planning and rationing, that's
43 the best use of the money, it should be spent in that way,
44 unlikely though it is, we would take it one step further
45 and say even if the state did not agree to contribute
46 further money to the ministry for the purpose of delivering
47 that service in that town, then there's no reason why, as

1 part of the difficult rationing decisions that need to be
2 made, primary care should be off the table. Both of those
3 things seem most unlikely outcome, though, because the
4 reality is, to the extent it's borne out --

5
6 THE COMMISSIONER: They do, but what you're putting to me,
7 as I understand it, is even if, in the unlikely scenario of
8 the Commonwealth saying "No", and then the more unlikely
9 scenario of the state saying "No", as an aspect of proper
10 planning, it might be that the consensus expert view of
11 that planning is, "We are better off putting our funding
12 and resources into primary care in this area than other
13 particular services."

14
15 MR MUSTON: Exactly. We're certainly not suggesting that
16 if part of that informed planning process said, "What we
17 really need in this community is a dialysis chair, and
18 I don't think we can surrender a dialysis chair for primary
19 care", well, that's an easy decision. But, of course, if
20 you then get a 19(2) exemption, maybe you can have both.

21
22 THE COMMISSIONER: Of course.

23
24 MR MUSTON: But the suggestion that unless there's
25 Commonwealth funding you would never provide primary care,
26 if as part of that planning process it actually flipped the
27 way and those on the ground --

28
29 THE COMMISSIONER: Primary care might be the best form of
30 care for certain parts of the state.

31
32 MR MUSTON: Exactly.

33
34 THE COMMISSIONER: Yes.

35
36 MR MUSTON: And if it is, the notion that primary care is
37 a Commonwealth responsibility ought not stand in the way of
38 delivering the care that is actually deemed to be the best
39 spend of the existing budgetary envelope.

40
41 THE COMMISSIONER: Yes.

42
43 MR MUSTON: Of course, what we know is, whenever it's been
44 done, the Commonwealth has stepped in with a section 19(2)
45 exemption and enabled the MBS funds to flow through to the
46 state. Whilst there was - I think we can't rule out
47 conclusively, I think was the evidence, the possibility

1 that they've never said no, no-one has been able to
2 identify for us an instance in which a properly thought
3 through primary care service operated by the state has been
4 knocked back by the Commonwealth insofar as a 19(2)
5 exemption is concerned. Which means, chances are, if you
6 actually plan it, and it's the right place to be putting it
7 or an appropriate place to be putting it, having regard to
8 the rationing and planning task that you have to engage in,
9 then the Commonwealth will step in and it's very
10 difficult to see how --

11

12 THE COMMISSIONER: Well, the chances are, in those
13 circumstances, it will honour the funding responsibilities
14 it has under the National Health Reform Agreement.

15

16 MR MUSTON: Yes. As I said a moment ago, we shouldn't
17 lose sight of the fact that the Medicare money, this is -
18 whilst it is characterised as an intergovernmental issue,
19 which of course it is, the Medicare money, or the rights to
20 the Medicare money, are actually rights which are enjoyed
21 by the population, and so if there is a functioning market,
22 you can go to your GP, maybe pay a gap, maybe get
23 bulk-billed, either way you get access to your Medicare
24 money. If there's no functioning market, you have no
25 ability to tap into that money, the 19(2) exemption --

26

27 THE COMMISSIONER: Even if you need primary care.

28

29 MR MUSTON: Even if you need primary care. The 19(2)
30 exemption is a means by which those people who exist in
31 communities that don't have access to a primary care market
32 can get access to their MBS entitlements. That,
33 presumably, is the way the state characterises it in its
34 discussions with the Commonwealth around 19(2) exemptions
35 in those instances where it's been done - for example,
36 Bowraville, the 4Ts.

37

38 Just to round that out, the last piece of transcript
39 that is perhaps worth looking at in terms of the up-front
40 agreement is 7105, at line 42.

41

42 THE COMMISSIONER: 7105, at line?

43

44 MR MUSTON: At line 42. Again, I'm not suggesting that
45 the up-front agreement referred to by Mr Cheney necessarily
46 encapsulated what the health secretary referred to there as
47 the gold standard, but to the extent that it might be

1 suggested that before the ministry were to step in and
2 deliver primary care there would need to be some
3 overarching agreement by the Commonwealth to provide
4 funding in every instance of market failure in the sense
5 contemplated in that passage, we would say that is neither
6 necessary nor realistic. I mean, that's, in essence,
7 delivering to the Commonwealth the very same problem as it
8 has been suggested we're delivering to the state - an
9 invitation to write a blank cheque, and that's unlikely to
10 happen.

11
12 But what is likely to happen is, instead of a general,
13 "Will you fund everything within these sort of very loose
14 parameters", if, instead of that, you've got, "Will you
15 fund this one because, in collaboration with the PHN as
16 part of the planning process required by the NHRA, we've
17 identified a hole in the market which is capable and best
18 filled by the state, and this is the way we intend to fill
19 it, can you give us a 19(2) exemption", the PHN ticks it
20 off. Obviously the ministry thinks it is a good idea to do
21 it because it's doing it. It's very difficult to see the
22 Commonwealth resisting it. But if it did, and as I said
23 part of a rationing decision saw the need to deliver that
24 primary care anyway, then it ought not - the fact that the
25 Commonwealth is not coming to the party should not be
26 a basis for denying the community the care which it's been
27 determined is best suited to their needs.

28
29 What we do know, coming back to Mr Chiu's concerns
30 about it all being a little bit open-ended and we're not
31 really quite sure what's contemplated, is, lest there be
32 any doubt about it, we are not suggesting that you
33 recommend any sort of broad-scale takeover of primary care
34 in New South Wales.

35
36 If you have a look at paragraphs 585 and following of
37 our submissions, you see what we are proposing is very much
38 a place-based approach to the issue. I think the concept
39 of the place-based approach to the issue had its genesis in
40 some evidence that, at least for our purposes, was some
41 evidence given by Mr Spittal in Dubbo, and then embraced by
42 many, many people along the way.

43
44 THE COMMISSIONER: Others, yes.

45
46 MR MUSTON: But the idea that what we're recommending is
47 anything like any sort of broad-scale takeover, we say sits

1 most uncomfortably with what we're actually suggesting in
2 those paragraphs. What we're suggesting is, in a
3 place-based way, you have to have a look at the needs of
4 the community, you have to have a look at the extent to
5 which those health needs are being met by services external
6 to the local health district, including, in the case of
7 primary care, Aboriginal community controlled health
8 organisations, active GP market; you then ask yourself the
9 next question, is that enough, are they met? If the answer
10 is yes, you don't spend a dollar worth of the limited
11 health budget on primary care in that town.

12
13 THE COMMISSIONER: Yes.

14
15 MR MUSTON: If the answer is "Yes, but it's under severe
16 duress and in three to five years time it's not going to be
17 there because that GP who has been provided a great service
18 to that town is going to retire and there is no real
19 prospect of" --

20
21 THE COMMISSIONER: He says, "I've got no real prospect of
22 selling my business ."

23
24 MR MUSTON: Or if there is a chance of maintaining
25 a private market or enabling, for example, the Aboriginal
26 community controlled health organisation, to take up more
27 of a role in the delivery of primary care to the wider
28 community in a town, step two is you look at what do we
29 need to do, or what could we do to support and sustain an
30 existing primary care market? That might not be much, and
31 it might be temporary, or it might be quite a lot. It will
32 vary from place to place, but what we do know from the
33 evidence is - and this is drawing on something Mr Chiu
34 acknowledged a moment ago - it's happening everywhere and
35 it's happening in a way which is often quite effective.

36
37 For example, the much spoken of single employer model,
38 it's not a takeover of primary care; it's a means or
39 a mechanism by which the state, in collaboration with the
40 Commonwealth, have provided training pathways to try and
41 revive and sustain an existing primary care market. It
42 might not be needed forever, if the market actually gets to
43 the point where it's up and rolling. But in the meantime,
44 it is.

45
46 The virtual rural generalist program, which has been
47 set up through Western NSW LHD - great service - one of the

1 key features of it, as we were told by Mr Spittal, was it
2 enables GPs in small country towns who have a pretty
3 stressful job to take time off.

4
5 THE COMMISSIONER: Get some respite, yes.

6
7 MR MUSTON: It is a virtual locum service that is provided
8 for them so that when they want to --

9
10 THE COMMISSIONER: Was it Dr Hua?

11
12 MR MUSTON: Martin Hua, his name was. He gave us some
13 evidence about the real benefits of that service, which
14 meant, overnight, he could actually sleep without thinking
15 he was going to get called out to deal with an emergency,
16 or if he wanted to take his family on holidays, he could go
17 away without having to pay more for a locum than he was
18 going to make out of the two weeks' worth of care that he
19 felt he was obliged to deliver to his population.

20
21 He was a good example, because there was another
22 situation in which some further support for the viability
23 of a small rural general practice was required. He,
24 I think the evidence was, was employed in a role within the
25 LHD where he was providing care and services across the
26 LHD's operations but also through his general practice,
27 which I think his evidence was he operated with his wife.
28 But again, by providing that employment opportunity,
29 a small step which enabled an existing GP market, at least
30 in his case, until his children finish primary school,
31 I think was his evidence, to sustain.

32
33 So again, not a takeover of those general practice
34 services, quite the contrary, to the extent that they
35 exist, consideration should be given to what, if anything,
36 needs to be done to support them.

37
38 THE COMMISSIONER: Yes.

39
40 MR MUSTON: But you then get to the end of the road and
41 there are communities which don't have a GP service and,
42 under current arrangements, having regard to the MBS, the
43 number of GPs coming out of the training pipeline, where
44 they want to live, et cetera, a constellation of factors
45 combine to mean that there are communities that do not
46 have, shortly will not have, and once they're gone may
47 never have, a viable GP market.

1
2 In those instances, we say the state should, as part
3 of its planning process, be giving active consideration to
4 delivering that primary care, if, as most of the evidence
5 suggests fairly persuasively, the delivery of those primary
6 care services are critical to the maintenance of the health
7 and wellbeing of the populations in those communities.

8
9 THE COMMISSIONER: Yes.

10
11 MR MUSTON: So that's what is proposed by the
12 recommendation, not a broad-scale takeover, not we need to
13 work out every town, place by place, it's a dynamic
14 process, it might change. The planning process that we
15 suggest needs to be happening constantly. We need to
16 identify that town that's maybe going to lose its general
17 practice and work out proactively whether there's something
18 we can do to support it. Once it's gone, we need to step
19 in and provide that primary care, if it's an appropriate
20 use of funds, in an unfunded way, but most likely having
21 secured funding from the Commonwealth to do it.

22
23 THE COMMISSIONER: Sure.

24
25 MR MUSTON: To the extent that we're suggesting the state
26 should be doing it before it has received funding from the
27 Commonwealth, what we're essentially saying is that the
28 planning and arrangements for the delivery of that care in
29 towns where it's required should not await an agreement
30 between the state and the Commonwealth about the provision
31 of those funds, and to the extent it's deemed to be the
32 best use of health funds, even if that agreement is never
33 forthcoming, it should be provided.

34
35 Could I quickly just address a couple of issues
36 arising out of health submissions. Could I take you to
37 paragraph 9.40.

38
39 THE COMMISSIONER: Page 55?

40
41 MR MUSTON: At page 55. There was some engagement between
42 you and my learned friend Mr Cheney yesterday around
43 whether or not the healthcare reform was something that, in
44 fact, would amount to a major adjustment to the NHRA.

45
46 THE COMMISSIONER: Yes.

1 MR MUSTON: And I think Mr Cheney's response was, in
2 effect, to say, well, whilst it might not be directly
3 inconsistent with the NHRA, it's not - I think he indicated
4 the document wasn't justiciable and what was important was
5 the way people thought about it and approached it.

6
7 THE COMMISSIONER: Yes.

8
9 MR MUSTON: May I say this in response to at least the
10 implicit notion that the way people think about and
11 approach the NHRA is consistent with the suggestion that
12 the state really ought have no role in either primary care
13 or aged care, in the sense suggested by the submissions
14 prepared by the ministry: that can't be the national view
15 of the NHRA, when one has regard to these two factors:
16 first, the evidence given most recently by the secretary
17 yesterday and touched on by others, that in Victoria,
18 a government decision was made not to move out of aged
19 care, and so Victoria remains a provider, large provider,
20 of aged care services, albeit funded through the
21 Commonwealth in the same way as other providers of aged
22 care.

23
24 That did not involve any sort of major reform, it
25 didn't even require a change. The only thing that has
26 changed is the way we've chosen to approach aged care.

27
28 THE COMMISSIONER: Yes.

29
30 MR MUSTON: True it is that that's a government decision.
31 As you will see from the recommendations that we make,
32 government, we think, ought review that decision - perhaps
33 not on a broad scale but certainly to whatever scale is
34 needed to overcome what is a fundamental problem within the
35 health service created by the absence of sufficient aged
36 care beds. I'm not just talking about the counting of the
37 beds, I'm talking about beds that will willingly
38 accommodate the patients who are not being accommodated at
39 the moment in anywhere but acute wards of hospitals, where
40 they plainly should not be.

41
42 THE COMMISSIONER: Yes.

43
44 MR MUSTON: Second point, in terms of primary care, is
45 evidence which has been given to the Inquiry to the effect
46 that Queensland has made a government decision to provide,
47 through the auspices of the state, a very substantial

1 amount of primary care. Again, the precise arrangements
2 that they have there we don't say need to be replicated
3 here, but I raise it because no substantial reform of the
4 NHRA was required, it certainly didn't trample over the
5 principles of that agreement, and it didn't even amount to
6 any significant change to what's happening in any other
7 state, including this one.

8
9 THE COMMISSIONER: Yes.

10
11 MR MUSTON: Could I just touch very quickly on paragraphs
12 8.11 and 8.22 of the ministry's submissions insofar as they
13 deal with specialist networks.

14
15 THE COMMISSIONER: Yes.

16
17 MR MUSTON: Again, there can be no doubt about it, we are
18 certainly not suggesting, through the recommendations that
19 we propose in respect of a more centralised, greater
20 centralised oversight of some of these specialist networks,
21 that the capacity - or that the ability to harness local
22 expertise is cut away; very much to the contrary. The
23 system depends upon that local expertise to function. But
24 what we're suggesting is it actually should be, to use the
25 term used in 11, put in harness so it can all be driven in
26 the same direction.

27
28 The example of the spinal service is a good one, which
29 I think is touched on in 8.22. It's a passage that was
30 touched on yesterday about whether or not there are
31 sufficient beds. What is said there is, "Well, it is
32 always open to local health districts and specialty
33 networks to submit funding requests for new services or an
34 expansion", but the problem with that conceptually is if
35 you don't have central control and oversight over the
36 service - and you will recall the evidence given about the
37 spinal service, and the particular concern that was raised,
38 was a lack of central awareness, knowledge and control over
39 the movement of patients through that system.

40
41 If you do have your patient who has suffered a spinal
42 injury, they have been taken to, say, North Shore, they've
43 been treated acutely care in the immediate aftermath of
44 their injury, they've then been moved to Royal Rehab,
45 what's then missing is that networked approach to, "Okay,
46 I've got another patient sitting in North Shore who needs
47 to come into a Royal Rehab bed. I need to move this

1 patient out" - this patient actually came from Griffith, to
2 pick a random town - "Do I have a bed in Griffith which is
3 capable of dealing with this patient at this next phase of
4 their rehabilitation", because that would be perfect, and
5 that would enable me to free up a bed at Royal Rehab which
6 would enable me to get this spinal patient out. That sort
7 of central oversight which requires not LHDs, who have no
8 idea who is sitting in North Shore or Royal Rehab, to ask
9 for an expansion of their existing services, is never going
10 to work. What is going to work is if the service itself is
11 the one which is controlling what it has and it is the one
12 that's making a request, saying, "We need a little bit more
13 funding to fund a bed in Griffith for the next six to
14 12 months", because I have a patient who really should be
15 close to her or his home, and if I can get that funding
16 there, then I can do that, and if they're driving the
17 system, then all of that local expertise, to use the term
18 again, is harnessed and is driven in the direction which
19 best meets the needs of patients who are making their way
20 through the system.

21
22 THE COMMISSIONER: Yes.

23
24 MR MUSTON: AHOs is the last thing I want to raise.
25 Concern has been expressed about, in the evidence
26 yesterday, and also to a lesser extent in a submission made
27 on behalf of the AHOs, the risks of severing relationships
28 between AHOs and LHDs in which they provide services.

29
30 Again, so there can be no doubt about it, we are
31 certainly not suggesting that the LHDs - that those
32 relationships be severed or that they cease in any way.
33 Those relationships are obviously fundamental to planning
34 around what services are going to be required and in an
35 operational sense, critically important in terms of the
36 delivery of those services.

37
38 But what we are suggesting is that the commercial
39 arrangements - there is no reason why the commercial
40 arrangement, for the reasons we have given in our
41 submissions, would not more sensibly be managed through the
42 ministry. There are a few reasons for that.

43
44 The first is it immunises or at least gives the AHOs
45 some protection from constrained budgetary environments
46 that exist within local health districts. If a decision is
47 made that services are required, as part of a sensible

1 planning exercise, it's determined that the best way to
2 provide those services in an LHD or multiple LHDs is
3 through an AHO, then the AHO shouldn't be having
4 a negotiation with an LHD or multiple LHDs, each of which
5 have had their own limited budgetary environment to contend
6 with, making it very difficult for them to engage with the
7 AHO around what might be a fair and reasonable amount of
8 money to pay for the services that are required. And if
9 a problem arises in relation to it, let it be assumed that
10 there is some sort of a dispute or unhappiness around the
11 money --

12
13 THE COMMISSIONER: Well, you don't have to assume. There
14 is.

15
16 MR MUSTON: -- it is far better that that be dealt with
17 centrally and by the ministry and in a way which is removed
18 from the important relationships that need to continue to
19 function to enable the planning and the delivery of
20 services to happen.

21
22 THE COMMISSIONER: Yes.

23
24 MR MUSTON: It was suggested, I think by Mr D'Amato
25 yesterday, that adding the ministry to that equation would
26 result in the process being significantly delayed because
27 it's another set of hands, and accepting that with more
28 people involved in the process there is some risk of the
29 process being delayed --

30
31 THE COMMISSIONER: There is a fair delay with Royal
32 Rehab's service agreement, isn't there?

33
34 MR MUSTON: That's the point I was going to make. In
35 circumstances where Royal Rehab is 12 years out of signing
36 a service level agreement, it's difficult to see how
37 dealing directly with the ministry in relation to that
38 issue could have produced greater delays than those which
39 they have experienced in their dealings with the local
40 health district.

41
42 THE COMMISSIONER: Yes.

43
44 MR MUSTON: But also it ties in nicely with the planning
45 which we suggest needs to be happening across the system.
46 Local health districts are on the ground, identifying the
47 health needs of their populations, making difficult

1 decisions about the best way to meet those health needs.
2 That's informed by involvement, we suggest, or should be
3 informed by involvement at ministry level, about how that
4 looks as a system, and to the extent that a piece of that
5 delivery is to happen through an AHO, the local health
6 district says to the ministry, "We would like to purchase
7 the following service from this AHO. Please go and acquire
8 it for us", you can deal with it in a budgetary sense as
9 between the ministry and the local health district in
10 whatever way they feel is appropriate, but in terms of the
11 payment of the AHO and the engagement of them, it's done in
12 a way which is simple and through a single contracting
13 entity, not multiple entities, particularly in the case of
14 those who deal with multiple LHDs and the services that
15 they provide.

16
17 But there is another reason why it is important and
18 that is bringing us back to this issue around schedule 3 to
19 the Health Services Act.

20
21 THE COMMISSIONER: Yes.

22
23 MR MUSTON: It's not entirely clear what is contemplated
24 by the submissions made in relation to the divvying up of
25 services that are AHO services and those that are not AHO
26 services.

27
28 I rather gathered that the evidence given by the
29 secretary yesterday accepted as a core proposition that
30 services provided under service level agreements by AHOs
31 should be captured as services that they are providing in
32 that capacity, and therefore should be in schedule 3, and
33 it's really difficult to see how there could be any
34 argument with that proposition.

35
36 If you are under a service level agreement providing
37 services as an AHO, then there is a range of benefits that
38 you get, as is pointed out, under your status as an AHO,
39 including indemnity insurance, should something go wrong,
40 and the carving out of some services within a service level
41 agreement from that regime, we suggest, makes no sense at
42 all.

43
44 But that's not to say that it would not, of course, be
45 open to an AHO or to the ministry or an LHD, as part of
46 ordinary procurement arrangements, to say, "We've got
47 a one-off program that we want to run over here. We've got

1 a short-term funding stream or grant to provide
2 a particular service. We're going to go to a competitive
3 tender. AHOs are free to tender for it, they might get
4 it." We're certainly not suggesting that anything that an
5 AHO might do that involves health should be a part of
6 schedule 3, and we're definitely not suggesting that
7 anything the AHO might do of its own accord, providing its
8 own good works to other people within the community that
9 might be health related, necessarily have to come within
10 schedule 3. I don't think that's ever been suggested.

11
12 THE COMMISSIONER: Yes.

13
14 MR MUSTON: But to the extent that a decision is made that
15 services are to be provided by the AHO through its service
16 level agreement to different LHDs or to one LHD, those
17 services should all be in schedule 3.

18
19 There are two things I want to say about that. The
20 first is, the proposition that by including a service in
21 schedule 3 you, in some way, create an expectation that it
22 would be provided for evermore, we say just doesn't
23 withstand the slightest degree of scrutiny.

24
25 We say what flows from that is the proposition
26 contained in health's submissions to the effect that as
27 a result of which amendments to schedule 3 should only ever
28 be reductive - that is to say, "We'll take things off but
29 we won't put things in" - we say that just makes no sense
30 at all. That entirely defeats the purpose of having
31 a schedule to the Act of the type that's there.

32
33 That sort of gets me I think to my last point, which
34 is the last issue raised in relation to schedule 3, you
35 will find it at 11.30 --

36
37 THE COMMISSIONER: Of health's submissions?

38
39 MR MUSTON: Of health's submissions. So the starting
40 proposition is: they suggest services provided by AHOs
41 should only remain on schedule 3 to the extent that they
42 are things that historically were on schedule 3, and we can
43 continue to whittle it down. We say that makes no logical
44 sense: schedule 3 should contain whatever is contemplated
45 by a service level agreement.

46
47 Pausing there, the evidence is that, at the moment,

1 the concerns that have been raised which have given rise to
2 these recommendations include a range of services provided
3 by AHOs under their service level agreements which are not
4 in schedule 3.

5
6 THE COMMISSIONER: Yes.

7
8 MR MUSTON: So we're not talking about a complaint by an
9 AHO that they are providing - Karitane, for example, a good
10 example, provides a range of services under its service
11 level agreement, it also runs a facility I think in
12 Shellharbour was the evidence. The ministry didn't want to
13 be providing services in Shellharbour through Illawarra
14 Shoalhaven LHD. Totally fine. Karitane is doing that off
15 its own bat. No suggestion at all that the Shellharbour
16 facility should be rolled into schedule 3, unless and until
17 a decision is made as part of a planning process, that
18 maybe the people of Shellharbour require that service and
19 it should be part of the offering of the public health
20 system down there, at which time, if it ever came, that
21 should obviously be included in schedule 3, we would say.

22
23 Another reason that all of this should be run - that
24 is, the service level agreements should be run - through
25 the ministry, is because the ministry needs to know what is
26 in the service level agreements and have control over it
27 across all of the LHDs in order to inform what it is doing
28 year on year with schedule 3.

29
30 We then come to the concerns expressed in 11.30
31 and following about the proposal that schedule 3 be
32 changed, and it's suggested in 11.31 that there might be
33 an inaccurate understanding on the part of counsel
34 assisting about what is involved in the process of amending
35 schedule 3.

36
37 The first issue is, part of that inaccurate
38 understanding is said to overlook the fact that services
39 included ought be funded on an ongoing basis. You'll see
40 that there.

41
42 THE COMMISSIONER: Yes.

43
44 MR MUSTON: We say we certainly do not have any view that
45 services included under schedule 3 need to be funded on an
46 ongoing basis, but we don't think that's inaccurate, we
47 think that's a fair understanding of the way the schedule

1 works.

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The next is, if we then go over to 11.32, it seems to be suggested that the process of changing schedule 3 involves substantial legislative amendment of the type that one might imagine was required in order to change a section of the Act, an amending Act or something along those lines, but if you look at section 62, which you don't have with you but I'll just park it in your mind, section 62(2) of the Health Services Act expressly provides that:

The Governor may, by order published on the NSW legislation website:

...

amend column 2 of Schedule 3 by inserting a description of any hospital, health institution, health service or health support service ...

THE COMMISSIONER: It's pretty minor stuff.

MR MUSTON: It's very minor. So if the ministry comes to the view that a certain range of services ought be included in service level agreements with AHOs, those services, we say, must, therefore, be services they're providing in that capacity, that bundle of services, no doubt, would form the basis of a recommendation made by the minister to the governor about what's in the best interest of delivering health care to the people of New South Wales for a given period, and schedule 3 could be amended literally at the stroke of a pen.

THE COMMISSIONER: Yes.

MR MUSTON: I don't think I need to address any further the proposal that there be some independent process to resolve differences of opinion between --

THE COMMISSIONER: I think that went away on the basis that the minister is not impinged upon his authority or power in the Act.

MR MUSTON: No. As we sought to make clear in the submissions, it's important that that cuts both ways.

THE COMMISSIONER: Yes.

1 MR MUSTON: The disputes which have emerged, for example,
2 the dispute with Royal Rehab, and similarly disputes which
3 have emerged although ultimately been resolved, supposedly
4 what's said to have been reluctantly, by AHOs signing
5 service level agreements that they did not feel provided
6 adequate funding to deliver the care, but to the extent
7 that those disputes emerge, it's clear that both sides of
8 the bargain have a different view about what the fair and
9 reasonable cost of delivering the services are.

10
11 Views might differ about whether - I think Mr Minns
12 gave some evidence yesterday about, or touched on, the
13 possibility that they might have different employment
14 arrangements within their organisations. Maybe that's
15 appropriate, maybe it's not.

16
17 Issues have been raised along the way with - I think
18 the Royal Rehab evidence touched on the suggestion that
19 there were inefficiencies within the way in which they were
20 operating and that efficiencies should be found. Maybe
21 that's right, maybe it's wrong, but I think it's artificial
22 to think that continuing to enable one part of the bargain
23 to make a decision about what the fair and reasonable cost
24 of the services are is ever going to actually overcome
25 those problems.

26
27 What we're suggesting, though, is that to the extent
28 that an impasse is reached, and it won't be in every case
29 but it will be in some, but where that impasse is reached,
30 instead of waiting 12 years to sign a service level
31 agreement because you can't agree on it, that there should
32 be some process whereby an independent person - it might be
33 a consultant, you know, there are very capable people out
34 there who have the required skill sets - can look at it and
35 say, almost in the nature of an independent expert's
36 assessment, "These are the services that you are requiring.
37 This is the reasonable cost of providing those services in
38 this setting".

39
40 Neither health nor the minister can be bound by that,
41 in the sense that they can't be compelled to pay that, and
42 shouldn't be. As a result of that exercise, they might
43 say, "We don't want to take those services", or "We will
44 take less." Similarly, the AHO can't be bound to provide
45 them.

46
47 So let it be assumed that the Gordian knot is cut in

1 favour of the ministry, but those who are running the AHO,
2 with their own independent obligations as directors, say,
3 "Well, that might be what the ministry says and that might
4 be what the independent expert says, but we don't think we
5 can provide those services for that cost, and to do so and
6 to enter into an agreement requiring us to do so, would
7 expose us to the risk of insolvent trading proceedings."
8

9 THE COMMISSIONER: Yes. Yes.

10
11 MR MUSTON: If that's right, they, of course, also have to
12 be at liberty to say, "Rightio, if that's what it is, we
13 won't take it", or "we won't give it."
14

15 But there needs to be some process which is
16 sufficiently binding on the parties, such that, if the
17 services are required and there remains a desire to take
18 those services, and they're able to be provided and
19 willingly provided, then some independent assessment of
20 what the costs of providing those services are, we think,
21 is only reasonable and appropriate.
22

23 Now, that would provide a level of transparency around
24 it. It would expose, I have to accept, ministry to the
25 risk that these assessments might happen and the
26 independent assessor might review it and say, "Actually,
27 what you're paying for those services is less than what
28 they're worth".
29

30 But equally, it might be go the other way. There
31 might be a conclusion that, "You, AHO, are
32 cross-subsidising other aspects of your operation through
33 this". The fact that those risks exist, we say, shouldn't
34 stand in the way of introducing a system to resolve those
35 disputes and, if anything, the concerns around the
36 potential consequences of the resolution of those disputes
37 can serve only to make the parties more keenly aware of the
38 desirability of resolving these matters commercially in the
39 ordinary way.
40

41 Unless there's anything further I can assist you with,
42 Commissioner --
43

44 THE COMMISSIONER: No, thank you for that.
45

46 Did anything emerge out of any of that? You're
47 welcome to take the opportunity.

1
2 MR CHIU: Commissioner, a very brief point. It's again in
3 relation to counsel assisting's submissions on the primary
4 care recommendations.

5
6 THE COMMISSIONER: Yes.

7
8 MR CHIU: There were at times - I don't mean this
9 critically at all - references to NSW Health and to the New
10 South Wales Government, and to New South Wales in counsel
11 assisting's oral submissions in relation to those
12 recommendations. Related to the issue I pointed out
13 yesterday around transcript 7140.25, in my submission,
14 there are two slightly different questions you might
15 consider in preparing your report.

16
17 The first question is: should NSW Health, within its
18 existing budgetary envelope, provide primary care wherever
19 there is a market failure --

20
21 THE COMMISSIONER: Yes.

22
23 MR CHIU: -- before securing funding from the
24 Commonwealth?

25
26 THE COMMISSIONER: Well, not even where there's a market
27 failure, there might be circumstances where, through its
28 planning analysis that --

29
30 MR CHIU: Indeed. However one --

31
32 THE COMMISSIONER: I mean, it wouldn't be appropriate if
33 it was, to use your words, "cannibalising an existing
34 market".

35
36 MR CHIU: Well, "cannibalising" in our - we were using
37 that only by reference to workforce, not to the market

38
39 THE COMMISSIONER: All right. Yes.

40
41 MR CHIU: But that's one question: however one defines
42 the limits of the expansion, whether NSW Health, within its
43 existing budgetary envelope, should do so before securing
44 funding from the Commonwealth, and for the reasons we've
45 already detailed, we say the answer to that should be "No".

46
47 But there's a second question which is: should the

1 New South Wales Government fund NSW Health to do those
2 things, however one defines it, before securing funding
3 from the Commonwealth? Now, that's a question I cannot
4 answer, because I don't speak for the New South Wales
5 Government. That's the only point I wished to make.
6

7 THE COMMISSIONER: Okay. We had that discussion
8 yesterday --
9

10 MR CHIU: Yes, we did.
11

12 THE COMMISSIONER: -- so that just clarifies it again.
13 All right.
14

15 Nothing further?
16

17 MR MUSTON: No.
18

19 THE COMMISSIONER: Yesterday, I expressed my gratitude to
20 NSW Health and its staff, its management and even its legal
21 advisers.
22

23 Can I extend my thanks, though, to the following, who
24 have assisted this Special Commission: the first is, there
25 has been a number of unions - the Health Services Union,
26 ASMOF, Nurses and Midwives, and their leadership, together
27 with the leadership of representative bodies such as the
28 AMA, that have assisted the Special Commission. Many other
29 entities involved in the provision of health care made
30 thoughtful and helpful written submissions, including
31 universities, and I think almost all of the medical
32 colleges assisted with submissions and also with witnesses
33 and evidence.
34

35 The Sax Institute and a large number of experts
36 engaged by Sax and another expert panel gave great
37 assistance to the Commission, including in the provision of
38 written reports, as well as in meetings and oral evidence.
39

40 Thank you also to icourts for the assistance they have
41 given with document management, including management in the
42 hearings and, of course, with transcript. The work of
43 those involved from icourts has been flawless.
44

45 Finally, thank you to all of those who have provided
46 their services to the Special Commission. That includes
47 administrative and clerical assistance, those who have

1 provided a more managerial role, as well as, of course, to
2 all the solicitors and the counsel team, of which it would
3 be impossible to say more without gushing.
4

5 So, thank you all, and we will adjourn.
6

7 **AT 1.05PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
8 **ACCORDINGLY**
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