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

THE COMMISSIONER: Good morning.

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

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

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

MR CHENEY: Yes.

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

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

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

As a matter of practical reality --

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

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

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

I can understand some sensitivity around the word "arbitrary"

MR CHENEY: Yes.

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

MR CHENEY: Yes.

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

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

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

MR CHENEY: Yes.

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

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

MR CHENEY: Yes.

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

MR CHENEY: Yes.

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

MR CHENEY: Yes.

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

MR CHENEY: I do, Commissioner.

THE COMMISSIONER: Thank you.

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

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

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

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

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

> *The budget baseline is established through a combination of individual policy decisions and the application of an annual escalation rate.*

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

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

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

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

MR CHENEY: Yes.

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

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

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

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

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

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

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

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

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

So let's stick with the operational component ... How is the operational base calculated?

Answer:

Well, I think that just reflects the history of incremental budgeting over time.

Mr Muston:

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

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

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

MR CHENEY: Yes.

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

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

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

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

Mr Cornelius:

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

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

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

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

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

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

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

reflects the movement in ongoing services.

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

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

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

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

Mr Cornelius tells me:

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

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

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

Mr Cornelius:

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

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

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

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

MR CHENEY: Yes.

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

MR CHENEY: Yes.

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

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

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

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

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

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

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

MR CHENEY: Yes.

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

MR CHENEY: Yes. I suppose the only point I would make, Commissioner, is that it's not a matter for my client to dictate to treasury how it deals --

THE COMMISSIONER: I completely accept that. Completely accept that. I mean, your client gets an opportunity to make submissions to treasury in the normal course of events --

MR CHENEY: Yes.

THE COMMISSIONER: -- which is how I understand the process works. But I would accept that ultimately, the amount of money that NSW Health is provided with doesn't happen because they say, "Give us X", or they put their hands on the cash. All right? Thank you

MR CHENEY: Thank you.

THE COMMISSIONER: That was the further bit I wanted to explore but --

MR CHENEY: I think Mr Chiu wanted to explore one topic.

THE COMMISSIONER: -- I think Mr Chiu is keen to say something.

MR CHIU: Commissioner, with some trepidation, returning to the topic of primary care and section 9, just, on reviewing of the transcript from yesterday, I do have a little bit of a concern we may be at cross-purposes on one minor issue.

THE COMMISSIONER: Okay, yes.

MR CHIU: If you would just bear with me.

THE COMMISSIONER: Just let me get into the system again. Yes, what page?

MR CHIU: If I could take you to the health submission at page 43, paragraph 9.5, you'll see there, this is a section of some 24 paragraphs under the heading "The National Health Reform Agreement" --

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes, I have that.

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

> *As is clear from that passage, the responsibility of the Commonwealth Government is in system management, support, policy and funding.*

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

> *However, the Commonwealth Government is not engaged in service delivery.*

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

THE COMMISSIONER: I see, all right.

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

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

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

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

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

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

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

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

MR CHIU: It's a cross-reference.

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

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

THE COMMISSIONER: 7.10?

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

> *The interplay between recommendation 7 and the addendum to the National Health Reform Agreement.*

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

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

MR CHIU: They are the only two points.

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

Yes, Mr Muston.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

MR MUSTON: Repeatedly.

THE COMMISSIONER: -- more than once.

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

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

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

THE COMMISSIONER: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Agree, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Of course, yes.

MR MUSTON: But in making these rationing decisions, the

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

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

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

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

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

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

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

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

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

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

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

> *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 ...*

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Of course.

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

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

MR MUSTON: Exactly.

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

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

THE COMMISSIONER: Even if you need primary care.

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

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

THE COMMISSIONER: 7105, at line?

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

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

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

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

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

THE COMMISSIONER: Others, yes.

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

THE COMMISSIONER: Get some respite, yes.

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

THE COMMISSIONER: Was it Dr Hua?

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

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

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

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Sure.

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

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

THE COMMISSIONER: Page 55?

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

THE COMMISSIONER: Of health's submissions?

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

THE COMMISSIONER: Yes.

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

works.

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.

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

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

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

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

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

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

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

THE COMMISSIONER: Yes. Yes.

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

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

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

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

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

THE COMMISSIONER: No, thank you for that.

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

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

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Yes.

MR CHIU: -- before securing funding from the Commonwealth?

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

MR CHIU: Indeed. However one --

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

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

THE COMMISSIONER: All right. Yes.

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

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

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

THE COMMISSIONER: Okay. We had that discussion yesterday --

MR CHIU: Yes, we did.

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

Nothing further?

MR MUSTON: No.

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

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

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

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

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

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

So, thank you all, and we will adjourn.

AT 1.05PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED ACCORDINGLY

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