



Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley



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New South Wales

Special Commission of Inquiry into Healthcare Funding

Her Excellency the Honourable Margaret Beazley AC KC
Governor of New South Wales
Office of the Governor
Macquarie Street
Sydney NSW 2000

Your Excellency,

Special Commission of Inquiry into Healthcare Funding

I was appointed by Letters Patent dated 23 August 2023, issued pursuant to the *Special Commissions of Inquiry Act 1983 (SCOI Act)*, to conduct a Special Commission of Inquiry into Healthcare Funding.

In accordance with the amendments to those Letters Patent made on 21 February 2024 and 13 November 2024, I now present to you the Report of the Special Commission, comprising four volumes.

Pursuant to s 10(3) of the SCOI Act, I respectfully recommend that the whole of the Report be made public.

Yours faithfully,

A handwritten signature in blue ink, appearing to read 'Richard Beasley'.

The Honourable Justice Richard Beasley
Commissioner

The Special Commission of Inquiry into Healthcare Funding acknowledges the Traditional Owners and Custodians of Country throughout New South Wales.

We pay our respects to Elders past and present.

We acknowledge the Gadigal people, the Traditional Owners and Custodians of the land on which the Special Commission's office was located, as well as the Traditional Custodians of the lands on which we travelled and worked during the course of the Special Commission.

We recognise Aboriginal and Torres Strait Islander people as the First Peoples of Australia and celebrate their continuing connection to the land, sea, and community.

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Chapter 1:

Overview

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Introduction

- 1.1. Whatever the merits or otherwise of the Report that follows, this Special Commission of Inquiry should at least be welcomed as a refreshing change to other Commissions conducted in Australia and NSW in recent years. Rather than being an inquiry into the failure of government and its agencies, or into their poor conduct, misconduct or unlawful conduct, it has been an inquiry into how a government service might be improved: in this case, the organisation and funding of the NSW public health system.
- 1.2. Rather than being hindered (or delayed) by government agencies, the government agency primarily the subject of this Special Commission, NSW Health, has offered its cooperation. In addition to the timely provision of summonsed documents, that cooperation extended to facilitating evidence from witnesses, who on many occasions expressed a form of disagreement or criticism about how things were done, or offered a different viewpoint to that of the NSW Ministry of Health (the Ministry of Health) or management. In this respect, I am particularly grateful to the Chief Executives of each of the Local Health Districts (LHDs) and Specialty Health Networks (SHNs) who, with the cooperation of their staff and clinicians, facilitated a genuine exchange of ideas about ways in which the delivery of healthcare across NSW could be improved. This Special Commission was aided by that cooperation and this Report, and its findings and recommendations, have benefited from it.
- 1.3. Nationally and internationally, over a long time, there have been many reports, inquiries, and reviews into health systems. Notably, in NSW there was the 2008 Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling Inquiry) conducted by Commissioner Peter Garling SC (as his Honour then was). It still makes for interesting reading, not only in respect of the recommendations made, but for observations that remain germane 17 years later. Not the least significant is this:¹

It is clear to me that the level of funding presently provided to NSW public hospitals is inadequate to deliver the service that the public of NSW expect without significant changes to the way in which services are provided.

- 1.4. The words “the service the public of NSW expect” are an important qualifier in the quote above. This brings in the notion discussed later in this Overview, as to what a universal healthcare system should be. And while this Special Commission has also examined the funding available for public hospitals, its remit through the Terms of Reference (TORs) was far wider than that of the Garling Inquiry. This Special Commission has been required to examine funding available for health services

¹ Exhibit N.4.5, Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (27 November 2008) Volume 3 [25.45] [SCI.0011.0762.0001 at 0020].

outside of the NSW public hospital system, including community care, primary care, and other services.

- 1.5. Considerations about the vital nature of primary care (including preventive services), and what the reasonable boundaries of a universal public health system could or should be, date back more than a century. In 1920, Lord Dawson² emphasised (perhaps for the first time in a major government inquiry) the fundamental importance of primary care and the role of the general practitioner.³ A fantastic number of inquiries, reports, and papers since Lord Dawson's interim report have emphasised the importance of preventive medicine, particularly since the shift of the burden of disease to chronic conditions from at least the 1980s.⁴ Emphasis on preventive measures has not been just for their health benefits, but for the potential economic benefits and healthcare cost avoidance or savings that result from (or may result from) such measures.
- 1.6. Having mentioned a report from the earlier part of the 20th century (but not without relevance still today), it is worth mentioning a fundamental assumption upon which this Report is based. At its core (and while not forgetting its TORs are broad and far reaching) this was an inquiry into how health services are funded by the State of NSW.⁵ The fundamental assumption is that it is desirable for the State of NSW to have and fund a universal healthcare system.⁶
- 1.7. Before briefly discussing what underlies this assumption, it is perhaps best to define what a universal healthcare system is. According to the World Health Organization (WHO), universal health coverage:⁷

means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care

² Lord Dawson was commissioned by the Ministry of Health in the United Kingdom to chair the Consultative Council on Medical and Allied services: Exhibit N.3.1, *Interim Report on The Future Provision of Medical and Allied Services 1920* (May 1920) [SCI.0011.0606.0001 at 0001-0002]. Although no final report was produced, Lord Dawson's interim report was influential in the creation of the National Health Service in 1948.

³ Exhibit N.3.1, *Interim Report on The Future Provision of Medical and Allied Services 1920* (May 1920) [SCI.0011.0606.0001].

⁴ See, for example, Exhibit O.3, JF Fries, 'The Compression of Morbidity' (1983) 61(3) *The Milbank Memorial Fund Quarterly. Health and Society, Special Issue: Aging: Demographic, Health and Social Prospects* 397 [SCI.0011.0811.0001 at 0001]; Exhibit E.87, National Health and Hospitals Commission, *A healthier future for all Australians – final report* (30 June 2009) [SCI.0009.0108.0001 at 0005]; Exhibit H2.16, NSW Legislative Assembly Public Accounts Committee, *Inquiry into the Management of Health Care Delivery in NSW* (Report, 18 September 2018) pp 7-8 [SCI.0011.0213.0001 at 0015-0016]; Exhibit H2.10, Productivity Commission, *Shifting the Dial: Supporting Paper No. 4 – Why a better health system matters* (Report, 3 August 2017) pp 2, 12-19 [SCI.0011.0151.0001 at 0005, 0015-0022]; Exhibit N.4.12, *Rapid Literature Review prepared by Professor Braithwaite and Colleague at Macquarie University* (29 November 2024) [SCI.0011.0754.0001 at 0001]; Exhibit N.3.29.3, *Annexure C - The Value of Prevention Report, The Australian Partnership Centre* (February 2021) p 5 [MOH.0010.0748.0001 at 0006].

⁵ Noting that no such inquiry can be had without considering Commonwealth funding streams.

⁶ See, for example, Transcript of the Commission, 26 February 2025, T7066.12-36 (Pearce).

⁷ Exhibit O.26, World Health Organisation, *Universal health coverage Factsheet* (5 October 2023) [SCI.0011.0843.0001 at 0002].

- 1.8. This seems to be no more than a slight expansion on Lord Beveridge's⁸ statement that the "[r]estoration of a sick person to health is a duty of the State",⁹ or another way of saying that a comprehensive health service:¹⁰

will ensure that for every citizen there is available whatever medical treatment [they require], in whatever form [they require] it, domiciliary or institutional, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents.

- 1.9. To this point in time, it seems a safe assumption that universal healthcare coverage is considered a good thing in this country. Even before the introduction of Medibank in 1975, most of the population probably already held the view that the Crown is "ultimately to be responsible for the provision, either directly or indirectly, of an adequate and acceptable level of health services of all types to the whole community."¹¹
- 1.10. While in 1981 Australia suffered what, when viewed with the benefit of hindsight, might be seen as the embarrassment of abolishing an established system of universal healthcare, the restoration of a similar system through Medicare in 1984 has meant (albeit with increasing and significant gaps) that Australia has generally had a universal healthcare system since.
- 1.11. As with public education, it would be unorthodox (and perhaps asinine) to take the view that government funds expended to maintain a universal healthcare system are not funds well spent. Of course, there are no doubt people with a different view. The introduction of Medibank was, to say the least, vigorously opposed (inside and outside the Commonwealth Parliament), as was its reintroduction as Medicare, although perhaps to a lesser extent. Exploring those views or any similar views that remain was not thought to be of any use to this Special Commission. Medicare remains a national universal health insurance scheme,¹² and universal healthcare coverage remains supported by the Addendum to the National Health Reform Agreement 2020–2025 (the *Addendum to the NHRA*),¹³ as well as by provisions within the *Health Services Act 1997* (NSW). Universal healthcare coverage is now firmly part of the social contract between Australians and their governments.

⁸ Sir William Beveridge was appointed by the chairman of the Committee on Reconstruction Problems in the United Kingdom, the Right Honourable Arthur Greenwood MP, to chair an interdepartmental committee which would conduct a comprehensive survey of existing schemes of social insurance and allied services: Exhibit O.1, Sir William Beveridge, *Social Insurance and Allied Services Report* (November 1942) [SCI.0011.0844.0001 at 0002].

⁹ Exhibit O.1, Sir William Beveridge, *Social Insurance and Allied Services Report* (November 1942) [427] [SCI.0011.0844.0001 at 0159].

¹⁰ Exhibit O.1, Sir William Beveridge, *Social Insurance and Allied Services Report* (November 1942) [427] [SCI.0011.0844.0001 at 0158].

¹¹ Exhibit O.2, Parliament of NSW, *Report of the Committee on Community Health Services No 91 1969* (November 1969) [3.12] [SCI.0011.0815.0001 at 0013].

¹² Albeit now with significant gaps and out of pocket expenses discussed in this Report, as well as only limited oral health/dental services.

¹³ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) [SCI.0001.0024.0001].

- 1.12. Having established that assumption, some of my key findings and recommendations, outlined in substantial detail in this Report, can be mentioned. The first, and broadest, is that if universal healthcare is the aim of the NSW public health system, at least parts of that system are underfunded. They have been for some time.
- 1.13. I appreciate that such a finding requires detailed explanation. I believe that it is provided in this Report. It also begs an important question – underfunded to do what? The statement that the health system is underfunded as a whole or as to specific services cannot be made good without identification of what services should or need to be delivered, and where and when they need to be delivered. While the provision of health services for acute injury and disease may not be controversial, beyond these, the health services that **should** be delivered by the NSW public health system, requires a mix of value judgements and expert opinions. Within those expert opinions and value judgements will be a range of differences as to what health services should be provided in a generally free and universal system, and at what level of availability. This requires detailed knowledge of population health issues, workforce availability, and socio-economic demographics (at least). It requires consideration and determination of what we want to achieve from public health services, which in turn raises issues that are, at the pointy end, both moral and ethical. That said, the system is, in several specific respects, underfunded.
- 1.14. I should say now that this is not a view I hold only (or even primarily) because there are LHDs that are currently over budget, or that several Affiliated Health Organisations (AHOs) contend that they are inadequately funded. That could be explained by a number of factors, although a deficit in funding to meet the reasonable cost of delivering those services that are contemplated by their service agreements (and for which there might be even more unmet demand) is one rational explanation. In any event, it is beyond sensible argument, in my view, that there is under resourcing or underfunding in aspects of the wider healthcare system, such as:
- a. primary care (including general practitioner services and allied health);
 - b. mental health services;
 - c. community health services;
 - d. aged care;
 - e. dental services;
 - f. paediatric services;
 - g. preventive health services; and
 - h. health services for First Nations people.

- 1.15. This Report is replete with evidence establishing gaps in service provision and in underfunding related to these crucial aspects of a health system. At least some aspect of underfunding is readily acknowledged by government.¹⁴ The fact that parts of the NSW public health system are underfunded should not lead anyone to the conclusion that this is necessarily a form of stinging criticism of any NSW Government in recent memory. There is evidence that, prior to the COVID-19 pandemic, wages (particularly agency fees) were more stable, as were the costs of all the goods, equipment, materials, and disposables used in the health system.¹⁵ Further, public health services in NSW are funded by both the State and the Commonwealth Governments. It should not be lost on anyone, and is no doubt not lost on anyone within NSW Health or NSW Treasury, that the Commonwealth Government has taken responsibility for the funding of primary care and aged care under the *Addendum to the NHRA*.
- 1.16. The NHRA brings me to what is a fundamental problem with the provision of health services in NSW – the fragmented funding arrangements that exist between the states and the Commonwealth. In Australia’s federation, the Commonwealth Government has by far the most revenue raising power, including the personal and income tax power. Absent an increase in grant funds from the Commonwealth (whether because of a shift in priorities, taxation reform, or economic growth), or an increase in funding through the NHRA (which does not produce a reduction in grant funding due to the fiscal equalisation process carried out by the Grants Commission¹⁶), the system is likely to remain – for some important services – underfunded and stretched. An attempt was made in 2010 (or at least advocated for) to address this funding divide. In their final report, *A Healthier Future for All Australians*,¹⁷ the Commissioners of the National Health and Hospitals Reform Commission recommended (in summary and *inter alia*) that the Commonwealth Government:
- a. take full funding responsibility for primary care, basic dental care (“Denticare”) and aged care, as well as for First Nations peoples’ healthcare;
 - b. fund 100 per cent of the efficient cost of public hospital outpatient services; and
 - c. fund 40 per cent of the efficient cost of every public patient admitted to a hospital (or subacute mental health facility), but moving “over time to 100 per cent”, and every attendance at a public Emergency Department.

¹⁴ As to “underfunding” or “chronic underfunding” of both community and mental health services, see, for example, Exhibit O.30, New South Wales, *Budget estimates 2024-2025 Portfolio Committee No 2 – Health*, Legislative Council, 9 September 2024, pp 3-4 (Rose Jackson, Minister for Water, Minister for Housing, Minister for Homelessness, Minister for Mental Health, Minister for Youth and Minister for the North Coast) [SCI.0011.0849.0001 at 0004-0005]; Exhibit O.28, New South Wales, *Hansard*, Legislative Council, 8 May 2024, pp 70-71 (Jeremy Buckingham, Member of the Legislative Council) [SCI.0011.0850.0001 at 0070-0071].

¹⁵ Transcript of the Commission, 21 November 2024, T6524.5-35 (D’Amato).

¹⁶ Exhibit M.20, Report by Stephen Duckett, *Report on Commonwealth-State financial arrangements in health care* (13 September 2023) [23]-[24], [46]-[49], [76]-[77] [SCI.0011.0500.0001 at 0005, 0008, 0012]; Transcript of the Commission, 20 November 2024, T6492.32-6495.17 (Duckett).

¹⁷ Exhibit E.87, National Health and Hospitals Commission, *A healthier future for all Australians- Final Report* (30 June 2009) [SCI.0009.0108.0001].

- 1.17. In essence, the report recommended a “single payer model” for health services under what was to be called “Medicare Select”, with the Commonwealth Government to be the sole funder, and the states to provide the services. The then Rudd Government proposed legislating and implementing many of these recommendations (but to a limit of 60 per cent funding for public hospital admissions),¹⁸ with the Commonwealth to “claw back” a third of Goods and Services Tax (GST) revenue then passed on to the states. Whether this proposed reform would have ended “the blame game” between the Commonwealth and the states over healthcare funding, as both the Commissioners and Prime Minister Rudd hoped, no one knows for sure. If history is a guide, though, it may have resulted in the Commonwealth claiming that it funds all healthcare, and the states claiming that it underfunds all of healthcare. In any event, for reasons that do not matter for the purposes of this Report, these proposed changes were abandoned, and we have been left with the NHRA.
- 1.18. Under the *Addendum to the NHRA*, the NSW Government receives funding from the Commonwealth for about 40 per cent of the cost of activity in public hospitals.¹⁹ That may or may not be appropriate, but funding for acute services provided in public hospitals will not do much to address the demand for health services that are needed to effectively address the impacts of chronic disease – for example, cardiovascular disease, chronic obstructive pulmonary disease, obesity (and disease related to it like diabetes), mental health conditions, arthritic conditions – and an ageing population. There are a series of “long term reforms” in the *Addendum to the NHRA* (which include “joint planning and funding at a local level”, preventive health and wellbeing measures, and “enhanced health data”).²⁰ Although those “long term” reforms are clearly identified, there does not appear to have been significant progress towards achieving them, or creating a funding model that would support them. Meanwhile, as discussed later in this Overview and Report, it is beyond doubt that there has been a substantial decline in Medicare services – a Commonwealth responsibility – both in terms of access to them or even as to any availability in many parts of NSW. The *Addendum to the NHRA* will not achieve its aims unless the states and the Commonwealth can sit down and agree on a funding envelope that is sufficient to enable the states, including NSW, to provide health services when and where they are needed, including those that are aimed at reducing rates of chronic disease (including early intervention) and having people “age well”.
- 1.19. It is often said that government, and NSW Health, exist in a “constrained financial environment”. This or similar phrases have been repeated to me so many times over the last year and a half that it is tempting to add “CFE” to the thousands of acronyms used in health and medicine.

¹⁸ Exhibit O.9, Transcript of National Press Club Q&A Canberra, Health and Hospital Reform (3 March 2010) [SCI.0011.0836.0001].

¹⁹ Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, Deb Willcox AM (17 November 2023) [8] [MOH.9999.0001.0001 at 0002].

²⁰ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) sch C pp 56-64 [SCI.0001.0024.0001 at 0056-0064].

- 1.20. It is also frequently said, correctly, that the State Government has other important things beyond health that it needs to fund. It is true that money is required for education and for transport, including infrastructure. The Police must be funded. So, too, the judicial and correctional system, as well as other things that are the funding responsibility of the State Government. There is, no doubt, a limit as to what proportion of the State budget can be allocated to health services – the cost of which is growing at a faster rate than any other NSW Government service.²¹ Spending on health services, perhaps more than any other government service, has the potential to fully consume the limited financial resources that NSW or any other State has, and that spending (in the most beneficial way to health outcomes) does have to reflect what is “fiscally affordable to government”.²² Further, universal healthcare does not require that every community’s health needs be met within a relatively short distance from their homes. The State does not have the financial resources for a system like that. It has been stated, many times, that “[e]fficiencies and rationalisations must occur.”²³
- 1.21. There is truth in all this, but it requires context. That context includes the fact that a great deal of technical efficiency has been achieved over the last few decades, and there are limits as to how much more can reasonably be harnessed. The population is also ageing. Chronic disease is widespread and has rising rates (particularly in areas of socio-economic disadvantage), and these matters, along with ever newer and more expensive treatments and models of care, place a continual and growing financial burden on the system. There is also this context to consider – along with expenditure on public education – does government spend any more important or worthwhile dollars than it does on health services? Probably not. With an ageing population and high rates of chronic disease, if we are to continue to provide healthcare to citizens that is (generally but not exclusively) free at the point of delivery, more money for public health services will need to be found. If not, governments will soon have to admit that they are no longer able to provide a system that can accurately be described as universal healthcare.

Prevention

- 1.22. It is uncontroversial that the NSW population is ageing, and the burden of disease has shifted over the last few decades towards chronic disease. The people of NSW and Australia live longer, on average, than they did 50 years ago, but we live an increasingly long time with illnesses. This imposes a great financial burden on the health system.

²¹ Exhibit A.20, *NSW Intergenerational Report 2021-2022* (June 2021) pp 14-15 [SCI.0001.0016.0001 at 0014-0015].

²² Transcript of the Commission, 18 November 2024, T6292.18-20 (Kastoun).

²³ Exhibit N.4.5, Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (27 November 2008) Volume 3 [25.60] [SCI.0011.0762.0001 at 0023].

- 1.23. Newer, more expensive (but some perhaps “game changing”) technologies, treatments, and drugs²⁴ are continually being developed, including with the aid of artificial intelligence. Artificial intelligence is also considered to have huge potential in clinical settings, including for the speed and accuracy of diagnostic processes (such as analysing images and scans) and therapeutic decision making.²⁵ It might soon play a greater role in the monitoring and self-management of some chronic diseases (and in, but not limited to, primary care generally), and in predicting both disease progression and treatment success.²⁶ Precisely how these still (rapidly) developing advancements might ultimately impact the health system from both a health outcomes and cost perspective is not yet fully known, and is highly uncertain. Those matters are beyond the scope of this Report. What is clear, is that, as things currently stand, a large proportion of public health funds are spent on the last years of people’s lives, even the last months.
- 1.24. The theory that compressing the period of morbidity experienced by the average person may have healthcare cost and other economic benefits is not new. A vast amount of research and academic work has been undertaken suggesting that health services, programs, and policies aimed at disease prevention or early intervention have economic benefits.²⁷ A useful starting point for this could be the work of Professor James Fries in 1980,²⁸ of which there are many successors, including NSW Treasury.²⁹ The Productivity Commission has produced reports in this field, describing preventive health strategies as “fundamental to Australia’s productivity and future prosperity”, and noting that “weak” “incentives [to avoid] hospitalisation”, and high rates of chronic disease, result in “lower labour force participation”.³⁰ Further, Intergenerational Reports of both the Commonwealth and State

²⁴ For example, new drugs such as Ozempic® (semaglutide) that are directed to addressing the risk factor of obesity: Exhibit N1.2, Sax Institute, *Expert Report 2-Strengthening the focus on prevention of chronic disease through applying evidence-based insights* (November 2024) [24] [SCI.0011.0608.0001 at 0007-0008]; Car T Cell and other immune-effector cell therapies to treat cancer: Transcript of the Commission, 26 February 2024, T1089.20-1090.36 (Levesque); Exhibit B.3, Statement of Adjunct Professor Jean-Frederic Levesque (30 January 2024) [69f] [MOH.0001.0435.0001 at 0023]; Gene therapies to treat genetic conditions: Exhibit N3.10, Statement of Dr Olivia Hibbitt (18 June 2024) [13]–[15], [35]–[36], [50]–[51] [MOH.0006.0008.0001 at 0003, 0009, 0013].

²⁵ Panel for the Future of Science and Technology, European Parliamentary Research Service, *Artificial Intelligence in healthcare: Applications, risks, and ethical and societal impacts* (June 2022) p 5 <[http://www.europarl.europa.eu/RegData/etudes/STUD/2022/729512/EPRS_STU\(2022\)729512_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2022/729512/EPRS_STU(2022)729512_EN.pdf)>; John Moore, *AI in health care: the risks and benefits* (Medical Economics Webpage, 15 March 2023) <<https://www.medicaleconomics.com/view/ai-in-health-care-the-risks-and-benefits>>.

²⁶ Critical Intelligence Unit, ACI, NSW Health *Clinical applications of artificial intelligence: living evidence* (Webpage, 3 December 2024) <<https://aci.health.nsw.gov.au/statewide-programs/critical-intelligence-unit/artificial/clinical-applications>>; H Salehinejad et al, ‘Novel Machine Learning model to improve performance of an early warning system in hospitalized patients: a retrospective multisite cross-validation study’, (December 2023) 66 *The Lancet* 102312 <<https://www.thelancet.com/action/showPdf?pii=S2589-5370%2823%2900489-3>>.

²⁷ Exhibit O.25, G Hampson et al, *Reimagining Prevention for a healthier, more prosperous society* (Whitepaper, October 2023) pp 25-26 [SCI.0011.0832.0001 at 0026-0027]; Exhibit N.3.29.3, Annexure C - *The Value of Prevention An evidence Check rapid review* (February 2021) p 16 [MOH.0010.0748.0001 at 0017]; Exhibit N.4.12, *Rapid Literature Review prepared by Professor Braithwaite and Colleague at Macquarie University* (29 November 2024) [SCI.0011.0754.0001 at 0001].

²⁸ Exhibit O.3, JF Fries, ‘The Compression of Morbidity’ (1983) 61(3) *The Milbank Memorial Fund Quarterly. Health and Society, Special Issue: Aging: Demographic, Health and Social Prospects* 397 [SCI.0011.0811.0001 at 0001].

²⁹ Exhibit A.20, *NSW Intergenerational Report 2021-2022* (June 2021) pp 7, 74-75 [SCI.0001.0016.0001 at 0007, 0074-0075].

³⁰ Exhibit O.24, *Reaping broader economic benefits from an effective healthcare system: A visual lens* (24 July 2019) pp 1, 3, 5 [SCI.0011.0882.0001 at 0001, 0003, 0005].

Governments stress the need to reduce rates of chronic disease as a means of reducing the growth in healthcare costs.³¹

- 1.25. This shift in disease burden from acute illness to chronic conditions, leading to a greater need for health services and a huge increase to health system costs,³² prompted the National Health and Hospitals Reform Commission to recommend in 2009 that Australia should “embed prevention and early intervention into every aspect of our health system and our lives”, to be aided by the establishment of an “independent National Health Promotion and Prevention Agency”.³³ This did not happen. Then in 2017, Australia’s various Ministers for Health told us of the great healthcare costs created by chronic disease through their Council of Australian Governments “National Strategic Framework for Chronic Conditions” which had three (as yet) unmet objectives of a “focus on prevention”, “provide efficient, effective and appropriate care to support people with chronic conditions”, and the targeting of “priority populations”.³⁴
- 1.26. If these concepts are so well accepted by experts (including health economists), and government itself, the lack of funding or action to adequately prevent (or intervene early in) chronic disease³⁵ is a curiosity. It should be a top priority. And not only for the potential economic and cost saving benefits, but for population health reasons.³⁶ Nothing much yet can be done to prevent ageing, and it is an ageing population that will almost, as a matter of certainty, be one of the main contributors to the growth in demand for health services, and the growth in costs to the system. If NSW Health remains funded and resourced, in the main, as a reactive system that treats acutely unwell people in public hospitals, there is a substantial risk that it will soon be overwhelmed by what looms as a huge increase in healthcare demands by an ageing population with high expectations.³⁷

³¹ Exhibit A.20, *NSW Intergenerational Report 2021-2022* (June 2021) pp 43, 75 [SCI.0001.0016.0001 at 0043, 0075]; Exhibit M.6.4, NSW Government, NSW Budget 2016-2017, Budget Paper No. 5 Intergenerational Report (Report, 2016) pp 86, 89 [SCI.0011.0572.0001 at 0088, 0091]; Exhibit A.22, Australian Government, *Intergenerational Report 2021: Australia over the next 40 years* (June 2021) pp 99 [SCI.0001.0018.0001 at 0117].

³² Exhibit O.3, JF Fries, ‘The Compression of Morbidity’ (1983) 61(3) *The Milbank Memorial Fund Quarterly. Health and Society, Special Issue: Aging: Demographic, Health and Social Prospects* 397 [SCI.0011.0811.0001 at 0001]; Exhibit O.14, P Crosland et al, ‘The Economic Cost of preventable disease in Australia: a systematic review of estimates and methods’ (2019) 43(5) *Australian and New Zealand Journal of Public Health* 484 [SCI.0011.0860.0001].

³³ Exhibit E.87, National Health and Hospitals Reform Commission, *A healthier future for all Australians – Final Report* (30 June 2009) [SCI.0009.0108.0001 at 0005].

³⁴ Exhibit O.12, Australian Health Ministers’ Advisory Council, *National Strategic Framework for Chronic Conditions* (Framework, 2017) p 15 [SCI.0011.0852.0001 at 0017].

³⁵ Exhibit O.22, G Sacks, D Mann, *Policies for tackling obesity and creating healthier food environments: Scorecard and recommended actions for the Australian Federal Government* (Report, October 2022) p 5 [SCI.0011.0834.0001 at 0005].

³⁶ Exhibit N.3.29.3, Annexure C - *The Value of Prevention An evidence Check rapid review* (February 2021) p 16 [MOH.0010.0748.0001 at 0017].

³⁷ Exhibit O.8, Lord Darzi of Denham, *High Quality Care for All: NHS Next Stage Review Final Report* (June 2008) p 27 [10] [SCI.0011.0857.0001 at 0033]; Transcript of the Commission, 17 May 2024, T3083.18-24 (Williams); Transcript of the Commission, 10 December 2024, T6848.18-28 (Eagar).

- 1.27. As was observed by Lord Dawson 105 years ago, “prevention and curative medicine cannot be separated on any sound principle”.³⁸ It seems that concept found its way into the NHRA. It has not inspired much action, however, despite evidence that investing in preventive care can be (by multiples) more cost effective than investing in treatment.³⁹ The preference, it seems, is greater investment in reactive services, like urgent care clinics and services. Whatever the evidence for the benefits of such clinics in reducing pressure on hospital Emergency Departments, their function and purpose is not to provide the kind of continuous and longitudinal primary care required for effective treatment of chronic disease, nor do they have the objective of providing preventive health services, except (perhaps) incidentally. As I was told on many occasions, they are not a substitute for primary care.
- 1.28. True it is that “prevention and wellbeing” was identified as one of the “four strategic priorities [to] guide further reform of [the] health system between 2020 and 2025” and as one of the “long term health reform principles” under the Addendum to the *Addendum to the NHRA*.⁴⁰ On the evidence available to this Special Commission, the emphasis seems to be more on “long term” than “priorit[y]”. It would not be unfair to observe that the evidence demonstrates a greater desire for ephemeral aspiration than actually funding something that is aimed at “prevention and wellbeing”, ensuring it is done, and analysing the outcomes. Of course, additional funding for that work is not currently on the agenda. The *Addendum to the NHRA*’s “long-term health reform principles” expressly come with the agreement of the Commonwealth and the states that any “activities” forming part of Schedule C – in this case, relevantly, “[s]hared action on ... prioritising prevention and helping people manage their health across their lifetime” – are to “be delivered within existing resources and programs, unless specific budgetary authority or agreement ... has been sought and granted.”⁴¹
- 1.29. Reform without funding seems wildly optimistic (at best) as a plan for “prioritising prevention”. The result seems to be that the Commonwealth does not fund the states, including NSW, to do much more than provide acute care services. Partly (but not solely) because of this, prevention is inadequately prioritised and financed in the NSW Health system. This would also appear to be the case across the country, which may explain why Rosemary Huxtable AO PSM in her final report of the *Mid-Term Review of the Addendum to the National Health Reform Agreement 2020–2025* (the Mid-Term Review of the *Addendum to the NHRA*) recommended a “renewed focus on prevention activities”, found that a lack of dedicated reform funding was a “key constraint” on implementing the long term reform agenda, and recommended a

³⁸ Exhibit N.3.1, Lord Dawson of Penn, *Interim Report on The Future Provision of Medical and Allied Services* (Interim Report, May 1920) [5] [SCI.0011.0606.0001 at 0004].

³⁹ Exhibit O.25, G Hampson et al, *Reimagining Prevention for a healthier, more prosperous society* (Whitepaper, October 2023) pp vi-vii [SCI.0011.0832.0001 at 0007-0008].

⁴⁰ See Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 2(c)(ii) p 6 [SCI.0001.0024.0001 at 0006].

⁴¹ See Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) sch C cl C1(c)(ii), C5 p 56 [SCI.0001.0024.0001 at 0056].

dedicated funding stream for reform activity.⁴² This echoed, in part, what was recommended by the National Health and Hospitals Reform Commission back in 2009. Quite how an absence of adequate funding for reform was not seen as a problem when the *Addendum to the NHRA* was agreed to is hard to understand, but not thought worthy of exploration. Regrettably, despite being aware for decades of the need to assist health departments and agencies to shift out of a “reactive mode” and embed prevention firmly in the health system, governments both State and Commonwealth have largely prioritised shorter term markers (for example, elective surgery “wait lists”) over more comprehensive and forward looking policies, programs, and services aimed at better long term population health and wellbeing.⁴³ This is an impediment to realising the potential long term population health and economic benefits of a more preventive approach. On the basis of an overwhelming amount of expert evidence and research of various kinds, that must change.

- 1.30. That change is required is not something of which NSW Health would appear to need to be convinced. In its strategy document *Future Health: Guiding the Next Decade of Care in NSW 2022–2032*, it says:⁴⁴

Based on these projections, activity across the health system in NSW will nearly double by 2031 if today's trends in disease and demand continue. This is due to:

- *rising demand, at rates beyond that attributed to population growth, especially in mental health, diabetes and communicable diseases;*
- *changing demographics, with the population of people over 65 likely to account for 45% of health activity if current models and settings of care remain as they are today; and*
- *growing complexity, with one in four people anticipated to have two or more chronic conditions by 2031.*

According to the Australian Burden of Disease Study (2015), over one-third of the current disease burden is likely preventable and due to modifiable risk factors.

Furthermore, while NSW Health presently sees 85% of its spend concentrated in hospital settings, known patient needs, and their experience and outcomes already suggest a need to change current

⁴² See Recommendations 33 and 34 in Exhibit N.3.17, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report* (Rosemary Huxtable AO PSM) (24 October 2023) [5.5.2]-[5.5.4] [SCI.0011.0585.0001 at 0105-0106].

⁴³ On this topic generally, including the “bounded rationality” of the political approach to health service delivery, see: Exhibit O.34, Demos and The Health Foundation, *The Preventative Shift: How can we embed prevention or achieve long term missions* (Discussion Paper, February 2025) [SCI.0011.0809.0001].

⁴⁴ Exhibit A.14, NSW Health, *Future Health: Guiding the next decade of care in NSW 2022-2032* (Report, May 2022) p 7 [SCI.0001.0010.0001 at 0007].

models of care. Patients will increasingly want their care provided within and beyond the hospital setting in ways that are integrated across healthcare providers. For example, it is recognised that today:

- *two-thirds of the disease burden in NSW is due to conditions that could largely be managed outside the hospital setting (for example, patients with chronic disease, who currently access high rates of care in all settings) and hospitalisation can exacerbate a condition that could have been preventable via community-based*
- *specific groups in the community experience poorer health outcomes and access to care (for example, people over age 75 and from lower socio-economic backgrounds), which is exacerbated by poor linkages in today's care model provided across the health system in NSW*
- *the COVID pandemic accelerated the adoption and acceptance of virtual healthcare models to deal with specific types of health concerns.*

1.31. If one seeks to understand how much NSW Health spends on “prevention”, it is not easy to find a definitive answer. The claim is 10 per cent of NSW Health’s expenditure, but this is in respect to “prevention and promotion”.⁴⁵ How much is claimed for “promotion” as distinct from “prevention” is not specified, and does not yield an easy answer.⁴⁶ Other data (although itself not perfect) indicates that the State spends about the same on prevention per head of population as other states.⁴⁷ That amount is said, in turn, to amount to no more than 2 per cent of the health budget. The *National Preventive Health Strategy* (2021) recommends increasing national health expenditure for public and preventive health activities to 5 per cent by 2030⁴⁸ (the NHRA being one “platform” of achieving this goal, as noted by Ms Huxtable in her final report of the *Mid-Term Review of the Addendum to the NHRA*⁴⁹).

1.32. This discrepancy might be explained by how “prevention” is defined.⁵⁰ This is an important starting point. A lack of clarity concerning what is “prevention” can act as a barrier to shifting the health system to being a more preventive one,⁵¹ and can also

⁴⁵ Exhibit A.14, *Future Health: Guiding the next decade of care in NSW 2022-2032* (Report, May 2022) p 9 [SCI.0001.0010.0001 at 0009].

⁴⁶ Transcript of the Commission, 26 February 2025, T7030.29-7031.40 (Pearce/D’Amato).

⁴⁷ Exhibit M.17, A Shiell et al, ‘How Do We Fund Public Health in Australia? How Should We?’ (2024) 48(5) *Australian and New Zealand Journal of Public Health* 100187 [SCI.0011.0495.0001 at 0003].

⁴⁸ Exhibit A.31, *National Preventive Health Strategy 2021-2030* (2021) p 9 [SCI.0001.0027.0001 at 0009].

⁴⁹ Exhibit N.3.17, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report* (Rosemary Huxtable AO PSM) 24 October 2023) [5.5.2] [SCI.0011.0585.0001 at 0105].

⁵⁰ Transcript of the Commission, 26 February 2025, T7029.19-7030.11 (Pearce), 7030.19-23 (Minns), 7030.19-25 (D’Amato).

⁵¹ Exhibit O.32, P Cairney et al, *Unlocking prevention in integrated care systems, NHS Confederation*, (Report, October 2024) pp 14, 17 [SCI.0011.0840.0001 at 0014, 0017].

lead to an undesirable opaqueness about claims made concerning expenditure on prevention. It seems that a decision first needs to be made as to whether “disease prevention” is being addressed (typically a matter for health systems), or “health promotion” (which might be multisectorial). Primordial prevention, primary prevention, secondary prevention, and tertiary prevention all have broadly accepted definitions.⁵² The Australian Institute of Health and Welfare (AIHW) defines “health prevention” as “an action to keep people healthy and well, and to prevent or avoid the risk of poor health, illness, injury and death”.⁵³ With respect, this seems a touch broad, and read literally could include treatment for acute illness or injury. The Australian Prevention Partnership Centre adopts the WHO definition of “prevention”, which is:⁵⁴

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

- 1.33. In any event, what is used by NSW Health for the 10 per cent funding claim is not clear.⁵⁵ It should be. Like the total health budget, or the budget for all the LHDs, SHNs and other public health organisations, the amount of money expended on prevention (and as a separate matter health “promotion”) is part of the information that the public is entitled to be properly informed of. We should also know what is considered to be “prevention” with specificity, not generality. A health service that can be said to be preventive should at least either decrease the risk of a particular disease occurring; prevent the progression of such disease; or reduce the morbid states from diseases that have already occurred (i.e., primary, secondary and tertiary prevention).
- 1.34. Many preventive health policies have had success internationally and in Australia. The compulsory use of seatbelts is an obvious example, as are campaigns to reduce smoking rates (including health literacy about the disease risks of smoking) is another. Efforts to reduce obesity however have not been wildly successful. Obesity remains one of the highest contributors to chronic disease and years of ill health, and hence to healthcare costs, while having the vice of also being a cause of premature death.⁵⁶

⁵² Exhibit H.1.35, Impact Economics and Policy and HSU, Reform Critical – A Fragmented Health System at Breaking Point (Report, February 2023) p 50 [SCI.0011.0162.0001 at 0050]; Exhibit N.3.29.3, Annexure C - *The Value of Prevention An evidence check rapid review* (February 2021) p 7 [MOH.0010.0748.0001 at 0008].

⁵³ Exhibit O.29, Australian Institute of Health and Welfare, “*What are the determinants of health?*” (Web article, 2 July 2024) [SCI.0011.0841.0001 at 0005].

⁵⁴ Exhibit O.6, World Health Organisation, *Global Forum IV on Chronic Disease Prevention and Control* (Final Report, 2005) p 44 [SCI.0011.0845.0001 at 0050].

⁵⁵ It seems it is coincidentally unclear what definition the NHS in the UK uses – see House of Commons, Committee of Public Accounts, Fifth Report of session 2024-25, NHS Financial Sustainability HC350 (Web Report, 29 January 2025) <<https://committees.parliament.uk/publications/46303/documents/233234/default/>> pp 5-6 [5], p 15 [22] [SCI.0011.0847.0001 at 0009-0010, 0019].

⁵⁶ Exhibit N.3.29.3, Annexure C - *The Value of Prevention An evidence check rapid review* (February 2021) p 4 [MOH.0010.0748.0001 at 0005].

- 1.35. Given the grim rates of obesity in Australia and NSW (amongst the highest when compared to other OECD countries,⁵⁷ with 66 per cent of adults being overweight or obese and 26 per cent of children as at 2022⁵⁸), I cannot resist the temptation while on the topic of preventive health of noting that no government in Australia has yet imposed a sugar tax, or tax on drinks with high levels of sugar. In view of the weight of evidence of the multiple benefits of such a tax when one has been imposed in other countries,⁵⁹ this can only be described as a monumental failure. Those opposed to a sugar tax raise a number of objections, none of which carry enough substance or logic to justify their repetition in this Report. True it is that the *National Obesity Strategy 2022–32* gently recommends that government should “consider policy approaches that use price to reduce the consumption of sugar-sweetened beverages”.⁶⁰ I guess we can “consider” anything as a health policy or service. Sadly, the *National Obesity Strategy*, and the *National Preventive Health Strategy 2021–30* are documents more read by Commissioners of health system inquiries than acted upon. Neither has led to the introduction of a sugar tax of some kind – a tax that a vast array of evidence and literature suggests should have been imposed long ago.
- 1.36. I have no doubt that executives within the Ministry of Health, management across the NSW public health system at all levels, and almost all of the medical and clinical workforces within NSW Health are aware of the need to, as far as possible, ensure adequate services are provided (including preventive health measures and community and home based care) to limit the number of people who must be treated in our public hospitals. As for NSW Health, that conclusion can be drawn from the emphasis on prevention, healthy ageing, and management of diseases “at home” in its *Future Health Report*.⁶¹ Collectively, they have the expertise and skills to stand up a more proactive, prevention based health system. They cannot succeed as they might in that endeavour without the funding to do so.
- 1.37. Nobody with relevant expertise seems to think that, without effective preventive services, including those aimed at “ageing well”, NSW will be able to fund the extent of health services that will be needed in the near future.⁶² Preventive services must be more firmly brought within the field of other services provided by NSW Health. It is nothing less than basic economics and logic that, if government aspires to provide (and

⁵⁷ Exhibit A.31, *National Preventative Health Strategy 2021-2030 (2021)* p 53 [SCI.0001.0027.0001 at 0053]; Exhibit O.13, J Ananthapavan et al, *Assessing Cost-Effectiveness of Obesity Prevention Report, The Australian Prevention Partnership* (2018) p 10 [SCI.0011.0851.0001 at 0010].

⁵⁸ Exhibit N.3.20, Australian Institute of Health and Welfare, *Overweight and Obesity* (Web Report, 17 June 2024) [SCI.0011.0711.0001].

⁵⁹ Exhibit O.15, Andrea M Teng et al, ‘Impact of sugar-sweetened beverage taxes on purchase and dietary intake: Systematic review and meta-analysis’ (2019) 20(9) *Obesity Reviews* 1187 [SCI.0011.0837.0001]; Exhibit O.21, T Dry and P Baker, ‘Why Doesn’t Australia Have a Sugar-Sweetened Beverage Tax?’, *Austaxpolicy: Tax and Transfer Policy Blog* (Blog Post, 11 March 2022) [SCI.0011.0842.0001]; Exhibit O.27, P Beadon and J Geraghty, *Sickly Sweet: It’s time for a sugary drinks tax* (May 2024) [SCI.0011.0807.0001].

⁶⁰ Exhibit O.20, *National Obesity Strategy 2022-32: Enabling Australian to eat well and be active* (4 March 2022) p 35 [SCI.0011.0812.0001 at 0035].

⁶¹ Exhibit A.14, *Future Health: Guiding the next decade of care in NSW 2022-2032* (Report, May 2022) [SCI.0001.0010.0001].

⁶² Transcript of the Commission, 20 November 2024, T6431.11-23, 6448.10-23 (Braithwaite).

fund and resource) what can properly be described as a universal healthcare system for its citizens, that healthcare system should seek to keep to a reasonable minimum the number of people who need costly acute care by providing services that significantly contribute to keeping people healthy.

- 1.38. Moreover, in my view, the issue of “prevention” of disease (or early intervention) is of such importance that preventive health should be expressly identified as a whole of government priority against which any new government incentives or policy proposals brought forward by all branches of government should be assessed. Prevention and early intervention must be firmly embedded into the way the NSW government functions, including in the NSW public health system. This will almost certainly require greater investment by the Commonwealth and the State of NSW in preventive services and health promotion, as well as some different prioritisation (something the King’s Fund has observed recently about the National Health Service⁶³). Only one thing is clear – what we are currently doing in the area of prevention is nowhere near enough.
- 1.39. Accordingly, preventive care must be a whole of government priority against which all new initiatives and policy proposals are to be assessed. This priority should be informed and coordinated by a multiagency, multidisciplinary body led by NSW Health – ideally under the oversight of the Chief Health Officer.

Primary care

- 1.40. Clause 7 of the NHRA states that the:⁶⁴

Commonwealth and the States will work in partnership to implement arrangements for a nationally unified and locally controlled health system which will:

...

b. improve the provision of GP and primary health care services, including Aboriginal and Torres Strait Islander community controlled health organisations, and the effective integration of health services at a local and national level (Schedule C);

and

c. improve care coordination for people with chronic and complex needs, ...

⁶³ Siva Anandaciva, “When it comes to prevention spending in the NHS, “some number is not a number, soon is not a time”, *The King’s Fund* (Blog Post, 6 February 2025) < <https://www.kingsfund.org.uk/insight-and-analysis/blogs/some-is-not-a-number-soon-is-not-a-time>> [SCI.0011.0838.0001].

⁶⁴ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cls 7b- 7c p 7 [SCI.0001.0024.0001 at 0007].

- 1.41. These objectives are expanded upon in more detail in Schedule C of the *Addendum to the NHRA* (which outlines the “long-term health reform principles”),⁶⁵ but the evidence before this Special Commission indicates that they are not being met (or even close to being met) in many places. This is consistent with the observations and findings made in the *Mid-Term Review of the Addendum to the NHRA* conducted by Ms Huxtable.⁶⁶
- 1.42. This Special Commission visited every LHD in NSW. The evidence gathered establishes beyond doubt that the primary care system in NSW is under severe pressure. Comprehensive primary care – by which I mean general practice and the range of specialist and allied health referral pathways required to promote and maintain community health – is not available as it should be in parts of the metropolitan area of Sydney, or in the regions. In some rural and remote areas, there has been market failure, and additional market failure in those areas looms on the horizon. There are access and affordability problems everywhere. At the time of writing this Report, various bulk billing commitments or promises are being made and exchanged during a federal election campaign. Market failure or “thinness” are a different issue, as is the payment model in any event. As explored in Professor Mark Cormack’s *Scope of Practice Review*,⁶⁷ and as recommended in the *Strengthening Medicare Taskforce Report*,⁶⁸ primary care – particularly for the treatment and management of complex chronic disease – requires a funding rethink, which is likely to involve the implementation of blended and bundled funding to incentivise the integrated and clinical team services needed.
- 1.43. The causes of the strain on the primary care system are multifactorial. NSW (like all of Australia) has an ageing population, where the burden of disease has shifted in the lifetime of Medicare. Far more longitudinal care is required now to address chronic conditions (including mental health) that require more complex integrated care.⁶⁹ There are not enough general practitioners in regional and rural areas, or in metropolitan areas of socio-economic disadvantage.⁷⁰ That an insufficient number of

⁶⁵ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) sch C pp 56-64 [SCI.0001.0024.0001 at 0056-0064].

⁶⁶ Exhibit N.3.17, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report* (Rosemary Huxtable AO PSM) 24 October 2023) [5.5.1] [SCI.0011.0585.0001 at 0103].

⁶⁷ Exhibit O.31, Professor Mark Cormack, *Unleashing the Potential of our Health Workforce: Scope of Practice Review* (Final Report, October 2024) Recommendation 10 pp 36-37 [SCI.0011.0839.0001 at 0036-0037].

⁶⁸ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 5 [SCI.0001.0053.0001 at 0005].

⁶⁹ Exhibit O.16, The Medicare Benefits Review Taskforce Final Report to the Ministry for Health, *An MBS for the 21st Century, Recommendations, Learnings and Ideas for the Future* (Final Report, December 2020) p 17 [SCI.0011.0810.0001 at 0023].

⁷⁰ See, for example, Exhibit L.3.4, PHN Cooperative, *Response to Consultation on Thin Markets in Regional and Remote Australia* (20 October 2023) p 3 [MOH.0010.0689.0001 at 0004]; Exhibit E.86, Outline of Evidence of Dr Robin Williams (16 May 2024) [14], [16], [20] [SCI.0009.0106.0001 at 0003, 0005]; Exhibit F.18, Western NSW PHN, *Securing the future of Primary Health Care in small towns in Western NSW* (March 2019) pp 1-3 [SCI.0009.0111.0001 at 0001-0003]; Exhibit F.19, Statement of Melissa Welsh (22 May 2024) [26] [MOH.9999.1285.0001 at 0007]; Exhibit F.27, Far West LHD, *Service Development Priority Focus Areas* (March 2024) p 5 [MOH.9999.1283.0001 at 0005]; Exhibit F.31, Outline of Evidence of Greg Sam and Associate Professor Shannon Nott (21 May 2024) [35]-[37] [SCI.0009.0110.0001 at 0008]; Exhibit E.35, RFDS, *Best for the Bush: Rural and Remote Health Baseline 2023* (27 March 2024) pp 58, 60-61 [SCI.0009.0025.0001 at 0058, 0060-0061]; Exhibit E.25, Nous Group, *Evidence base for additional investment in rural health Australia - National Rural Health Alliance* (Report, 23 June 2023) pp 24-25, 36-37 [SCI.0009.0016.0001 at

medical students desire to be general practitioners is well known. The excessive workload on general practitioners (particularly in regional and rural areas) was described in startling detail in the evidence.⁷¹ There is a strong perception that Medicare Benefits Schedule (MBS) rates are inadequate (and likely have been for many years). This is particularly so for general practitioners who treat, or want to effectively treat, patients with chronic disease. The treatment of chronic disease is not suited to “15-minute medicine”. It is true that MBS rates have been increased and items reformed and added since 1999 that seek to address and provide payment for the management of specific chronic diseases, including care planning, case management and medication reviews.⁷² But there is evidence that those changes are insufficient, and probably substantially so.⁷³ Moreover, the MBS itself is not enough to ensure availability of the kind of integrated care that might be needed. This is deeply unfortunate given the importance of primary care to better population health outcomes, and to the prevention of chronic conditions, as well as to earlier intervention into, and proper management of, people experiencing such diseases.

- 1.44. Beyond these matters, this Special Commission (and as noted in a considerable volume of health research and other literature) received evidence of the unaffordability of primary care services to parts of the population (or significant delays in availability of such services), as well as substantial affordability issues in relation to the provision of specialist care services where MBS rates may bear little relationship to fees charged, and for which little has been done to address this problem.⁷⁴ It is well established that out-of-pocket expenses – which are high for non-bulk billed services like those of specialists – are an impediment to access to healthcare in Australia, particularly in remote or socio-economically disadvantaged areas.⁷⁵

0026-0027, 0038-0039]; Exhibit I.42, Statement of Prudence Buist (14 August 2024) [10]-[13] [SCI.0011.0351.0001 at 0002-0003]; Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [17] [MOH.0011.0041.0001 at 0004].

⁷¹ Exhibit M.13, Royal College of General Practitioners, *General Practice Health of the Nation 2024* (October 2024) pp 16, 25, 28-30 [SCI.0011.0506.0001 at 0030, 0039, 0042-0044]; Exhibit K.112, Hunter New England and Central Coast PHN, *General Practice Viability Insights* (Report, July 2024) p 12 [SCI.0011.0444.0001 at 0012]; Exhibit I.42, Statement of Prudence Buist (14 August 2024) [14] [SCI.0011.0351.0001 at 0003].

⁷² Exhibit O.18, Productivity Commission, *Innovations in Care for Chronic Health Conditions*, Productivity Reform Case Study (March 2021) pp 149-150 [SCI.0011.0816.0001 at 0157-0158]; Exhibit O.16, The Medicare Benefits Review Taskforce Final Report to the Ministry for Health, *An MBS for the 21st Century, Recommendations, Learnings and Ideas for the Future* (December 2020) pp 3, 37 [SCI.0011.0810.0001 at 0009, 0043].

⁷³ Exhibit M.13, Royal College of General Practitioners, *General Practice Health of the Nation 2024* (October 2024) pp vii, 8-9, 34-35 [SCI.0011.0506.0001 at 0011, 0022-0023, 0048-0049]; Exhibit I.42, Statement of Prudence Buist (14 August 2024) [15] [SCI.0011.0351.0001 at 0003].

⁷⁴ Exhibit O.23, M R Angeles et al, ‘Challenges for Medicare and universal health care in Australia since 2000’ (2023) 218 (7) *Medical Journal of Australia* 322, p 324-326 [SCI.0011.0805.0001 at 003-0005]; Transcript of the Commission, 10 December 2024, T6839.38-6840.9 (Eagar); Exhibit M.13, Royal College of General Practitioners, *General Practice Health of the Nation 2024* (October 2024) pp iii, vii, 2, 5-12, 22, 34-35 [SCI.0011.0506.0001 at 0007, 0011, 0016, 0019-0026, 0036, 0048-0049].

⁷⁵ Exhibit O.33, K Saxby and Y Zhang, ‘Bulk-billing rates and out-of-pocket costs for general practitioner services in Australia, 2022, by SA3 region: analysis of Medicare claims data’ (2025) 222(3) *Medical Journal of Australia* 144, p 144 and 147 [SCI.0011.0835.0001 at 0001, 0004]; Exhibit M.3, Royal College of General Practitioners, *General Practice Health of the Nation 2024* (October 2024) p10 [SCI.0011.0506.0001 at 0024].

- 1.45. The Commonwealth Government has agreed it is responsible for “system management and support, policy and funding for GP and primary health care services”.⁷⁶ Based on the evidence adduced and available to this Special Commission, the Commonwealth is not entirely meeting its obligations and responsibilities for primary care under the *Addendum to the NHRA*. In at least parts of Sydney and NSW, the accuracy of the Commonwealth’s claim that Medicare is “Australia’s universal health insurance scheme”⁷⁷ is debatable. Warnings have been issued by Primary Health Networks (PHNs), the Rural Doctors’ Association NSW, the Royal Australian College of General Practitioners (RACGP), and the Royal Flying Doctor Service concerning the primary care system.⁷⁸ And while this Special Commission is aware of examples of excellent collaboration between some LHDs and PHNs,⁷⁹ for many reasons (including a lack of policy direction and funding from the Commonwealth) PHNs do not seem in general to have been as effective in addressing gaps in primary care as they might have been.⁸⁰
- 1.46. For a health system to function as we would want it to, primary care cannot be allowed to wither. If that happens, we will pay for it in worse health outcomes and poorer population health. We will pay for it in additional need for secondary, tertiary and quaternary care. There is an overwhelming amount of evidence concerning the importance of primary care, and the health outcomes and economic importance of prevention (which in part is driven by access to affordable and timely primary care).⁸¹

⁷⁶ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 13(b) p 10 [SCI.0001.0024.0001 at 0010].

⁷⁷ See, for example, Australian Government Department of Health and Age Care, About Medicare (Webpage, 20 December 2022) <<https://www.health.gov.au/topics/medicare/about>> [SCI.0011.0802.0001].

⁷⁸ See, for example, Western PHN identified in 2019 that within the next decade that 41 towns within their PHN would to be without a general practice: Exhibit F.18, Western NSW Primary Health Network, *Securing the future of Primary Health Care in small towns in Western NSW* (Report, March 2019) p 1 [SCI.0009.0111.0001 at 0001]. See also Exhibit F.31, Outline of evidence of Greg Sam and Associate Professor Shannon Nott (21 May 2024) [36] [SCI.0009.0110.0001 at 0008]; Exhibit M.13, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2024*, (Report, 2024) p iii [SCI.0011.0506.0001 at 0007]; Transcript of the Commission, 18 March 2024, T1155.26-33 (Christmas); Transcript of the Commission, 22 May 2024, T3120.7-3121.17 (Nott); Transcript of the Commission, 16 October 2024, T5818.18-22, 5824.21-34, 5859.23-27, 5862.3-16 (Hoffman), T5820.37-5821.2 (Van de Water).

⁷⁹ See, for example, Murrumbidgee LHD and Murrumbidgee PHN: Exhibit C33.1 Statement of Jill Ludford (12 March 2024) [90a], [91]-[94], [154] [MLH.0001.0016.0001 at 0016, 0019-0020, 0031]; Transcript of the Commission, 21 March 2024, T1587.39-1590.33 (Yoosuff); see also South Eastern PHN, Illawarra Shoalhaven LHD and Southern NSW LHD: Exhibit I.42, Statement of Prudence Buist (14 August 2024) [37], [44]-[49], [56] [SCI.0011.0351.0001 at 0007, 0009, 0011]; Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [84] [MOH.0011.0041.0001 at 0019]; see also Healthy North Coast PHN and Mid North Coast LHD and Northern NSW LHD: Exhibit K.70, Memorandum of Understanding between Healthy North Coast and MNCLHD and NNSWLHD (6 February 2024) [MOH.0010.0585.0001].

⁸⁰ Exhibit A.45, *Australian health services: too complex to navigate*, Policy Issues Paper No. 1 -2019 (28 February 2019) p 28 [SCI.0001.0041.0001 at 0037]; Exhibit O.23, M R Angeles P Crosland, M Heshner, ‘Challenges for Medicare and universal health care in Australia since 2000’ (2023) 218 (7) *Medical Journal of Australia* 322, p 323 [SCI.0011.0805.0001 at 0002].

⁸¹ See, for example, Exhibit A.22, Australian Government, *Intergenerational Report 2021: Australia over the next 40 years* (June 2021) pp 99 [SCI.0001.0018.0001 at 0117]; Exhibit E.87, National Health and Hospitals Reform Commission, *A healthier future for all Australians – Final Report* (June 2009) [SCI.0009.0108.0001 at 0043]; Exhibit N.3.17, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Rosemary Huxtable AO PSM) (24 October 2023) p 48 [SCI.0011.0585.0001 at 0053]; Exhibit H1.94, Marie Bonal et al, ‘A French classification to describe medical deserts: a multi-professional approach based on the first contact with the healthcare system’ (2024) 23(5) *International Journal of Health Geographics* 1, p 11 [MOH.0010.0346.0001 at 0011]; Exhibit H2.11, Productivity Commission, *Shifting the Dial: Supporting Paper No. 5 – Integrated care* (Paper, August 2017) p 106 [SCI.0011.0152.0001 at 0108]; Exhibit E.47, Statement of Mark Spittal (30 April 2024) [19] [MOH.9999.1202.0001 at 0005]; Transcript of the Commission, 29 November 2023, T193.12-17, 217.9-12 (Chant); Transcript of the Commission, 23 April 2024, T2375.39-43 (Rutledge).

- 1.47. Through its staff, NSW Health said on many occasions during this Special Commission that the Commonwealth has responsibility for primary care **not** NSW. This claim was (rightly) walked back in other evidence, and in submissions. It was never correct for the following reasons.
- 1.48. First, the idea that the State of NSW has no responsibility for primary care is inconsistent with the legislative provisions in the *Health Services Act* concerning the purposes and functions of LHDs, which firmly encompass primary healthcare concepts and services.⁸²
- 1.49. Secondly, it is not consistent with the *Addendum to the NHRA*, in which “contributions of the states” towards primary care are noted.⁸³ While it is clear that the Commonwealth has ultimate funding responsibility for general practice and primary care services, as well as for system management and policy, the States and the Commonwealth must:⁸⁴

work in partnership to implement arrangements for a nationally unified and locally controlled health system which will:

- (a) *improve patient outcomes, patient experience and access to services, including by focusing on what matters most to patients, supporting innovative models of care and trialling new funding arrangements (Schedule C);*
- (b) *improve the provision of GP and primary health care services, including Aboriginal and Torres Strait Islander community controlled health organisations, and the effective integration of health services at a local and national level (Schedule C);*

- 1.50. Thirdly, it is not consistent with what actually happens. While NSW Health readily acknowledges that it is a primary caregiver of “last resort”, mainly through public hospital Emergency Department services, it actually does much more than that. There are now a number of examples of the State providing primary care services – usually because of a failure of the primary care market entirely, or inadequate coverage – particularly in regional and rural areas.⁸⁵ When it has done so, it has done

⁸² *Health Services Act 1997* (NSW) ss 9, 10.

⁸³ *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 13(b) p 10 [SCI.0001.0024.0001 at 0010].

⁸⁴ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cls 7(a)- 7(b) p 10 [SCI.0001.0024.0001 at 0010].

⁸⁵ See for example, primary care delivered through the Western NSW Integrated Care Strategy and HealthOne NSW model (whether co-location, hub and spoke or virtual integration models): Exhibit E.27, Western NSW Primary Health Network and Australian Healthcare and Hospitals Association, *Sustainability of Primary Care in Small Towns and Communities Initiative* (Report, 23 January 2020), pp 29-34 [SCI.0009.0042.0001 at 0029-0034]; Exhibit K.53B, Statement of Stewart Dowrick (12 September 2024) [67]-[68] [MOH.0011.0069.0001 at 0017]; Transcript of the Commission, 16 October 2024, T5834.10-5836.30, 5861.25-31 (Sloane); Single Employer Model and multidisciplinary integrated community models of care: Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [96], [147]-[150] [MLH.0001.0016.0001 at 0020, 0030]; Transcript of the Commission 20 March 2024, T1459.2-1460.40 (MacKenzie); Transcript of the Commission, 19 September 2024 T5477.15-5479.37 (Koschel); Transcript of the Commission, 16 May 2024, T2958.21-2961.1 (Spittal); Rapid Access Clinics or Urgent Care Clinics, including primary care: Exhibit K.53B, Statement of Stewart Dowrick (12 September 2024) [11avii], [32], [40], [67], [80] [MOH.0011.0069.0001 at 0003, 0009, 0011, 0016-0017, 0020]; Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [104] [MLH.0001.0016.0001 at 0021-0022]; Transcript of the Commission, 22 March 2024, T1659.8-30, 1663.18-42 (Bruce); Transcript of the Commission, 23 April 2024, T2352.29-2353.25 (MacLellan); Transcript of the

it well; resulting in significant benefit to those communities and to the wider system. Ultimately, the Commonwealth contributes to the funding of these services, although not always covering the full cost.⁸⁶

- 1.51. There are even instances of local councils having to step in to provide primary care to their communities.⁸⁷
- 1.52. One thing is very clear to me: in circumstances where a failure of primary care has been addressed in parts of this State (either entirely or significantly), it has been NSW Health, through the LHDs, that has been the proactive party, as opposed to the Commonwealth (even if the Commonwealth has ultimately provided funding when required); but this may reflect the fact that these entities are better placed than the Commonwealth to both deliver those services (noting that the Commonwealth is not a primary healthcare service provider) and implement the structures required to draw upon the funding promised by the Commonwealth to all Australians through the MBS.
- 1.53. I was also told, through the final written submissions made by NSW Health to this Special Commission, that to the extent there is evidence of NSW LHDs providing or supporting primary care services, these were “isolated instances”.⁸⁸ That submission was somewhat disavowed (as it should have been) in oral submissions.⁸⁹ Apart from numerous instances of LHDs/NSW Health providing primary care services when they have been needed, the true position was well summarised by Mark Spittal, Chief Executive, Western NSW LHD, who gave evidence that:⁹⁰

there is a bit of a myth in Australia that local health districts – or local health networks if we're in other states - don't step in to providing general practice services. In fact, there are many examples...[t]he Four Ts was our version of that.

- 1.54. I was also warned that care needed to be taken so that any provision of primary health services by LHDs did not risk “cannibalising’ the primary care workforce including in

Commission, 29 April 2024, T2485.44-2486.6, 2500.31-2503.24 (Daly); Transcript of the Commission, 30 July 2024, T4222.20-35 (Fieldings); Community health centres with s 19(2) exemption: Transcript of the Commission, 17 September 2024, T5200.10-22 (Slaven); The 4Ts Model: Transcript of the Commission, 16 May 2024, T2943.42- 2946.27 (Spittal); Primary health services and GP VMO models provided through Multipurpose Services: Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [68]-[85], [90a], [123] [MLH.0001.0016.0001 at 0012-0014, 0016, 0025]; Transcript of the Commission 16 October 2024, T5834.10-T5836.30 (Sloane).

⁸⁶ See, for example, Bowraville HealthOne: Transcript of the Commission, 18 September 2024, T5309.4-5312.6 (Wong).

⁸⁷ See, for example, the Bogan Medical Centre operated by Bogan Shire Council: Exhibit E.68, Outline of Evidence of Derek Francis (10 May 2024) [SCI.0009.0079.0001]; Exhibit E.69, Outline of Evidence of Debb Wood (10 May 2024) [SCI.0009.0078.0001]; Lachlan Shire Council contracting the Royal Flying Doctors Service to provide primary health care services at a general practice in Condobolin: Exhibit E.71, Outline of Evidence of Greg Tory (13 May 2024) [13]-[19] [SCI.0009.0089.0001 at 0002-0004]; Cobar Medical Centre which Cobar Shire Council leases at below commercial rent together with free accommodation for the medical staff of the medical centre: Exhibit F.32, Statement of Jarrod Marsden (21 May 2024) [22]-[25] [SCI.0009.0113.0001 at 0004-0005]; Transcript of the Commission, 22 May 2024, T3226.11-46 (Marsden/Smith).

⁸⁸ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [9.30] [MOH.0010.0758.0001 at 0052]

⁸⁹ Transcript of the Commission, 26 February 2025, T7097.8-28 (Pearce); T7143.20-7145.5 (Chiu SC).

⁹⁰ Transcript of the Commission, 16 May 2024, T2944.11-23 (Spittal).

fragile private markets”.⁹¹ That is not a risk that arises from the recommendation made in relation to primary care. It does not contemplate NSW Health becoming a competitor service where other adequate primary health services exist. To obtain, for example, an exemption pursuant to s 19(2) of *Health Insurance Act 1973* (Cth) that would enable the State to receive MBS funding, the local market (if one even exists) for primary care services must be consulted and explored. That is part of the “checks and balances” involved. Further, the planning process recommended as part of Recommendations 21 to 26 will enable NSW Health and its LHDs and SHNs to ascertain where primary care services are needed.

- 1.55. If (and this is unlikely) the Commonwealth were for some reason to walk away from its funding responsibilities under the *Addendum to the NHRA*, there would be some clear options for NSW Health. One is that a decision might need to be made whether, faced with no extra funding, primary care services should be provided in lieu of some other currently provided service in a particular location. The other is that NSW Health receives additional funding to provide such a service as a decision of the NSW Government.
- 1.56. NSW Health asserted in its final written submissions that any recommendation concerning it providing primary care services in the face of market failure would “trample over”⁹² what it calls a planning and responsibility allocation “regime” in parts of the *Addendum to the NHRA*.⁹³ Much of that submission was ultimately not pressed in oral submissions.⁹⁴ That was appropriate because, while the NHRA is full of aspirations, and sets out which polity has funding responsibilities, it does not contain a “planning regime” for primary care in Australia. As stated in cl 7 of the Objectives of the *Addendum to the NHRA*, the Commonwealth and the states must “work in partnership” to “improve the provision of GP and primary healthcare services”. In short, there remains a lot of work for the Commonwealth to do with the states to plan for primary health services, especially where the access to timely and adequate primary care is (or is becoming) problematic. I have no doubt, as an aspect of that work, that the management and clinicians of NSW LHDs and SHNs are very well placed (whether working closely with PHNs or not) to understand and identify areas of primary care failure or stress in their various populations. That is, in part, why s 19(2) exemptions and models such as the 4Ts in Western NSW LHD, Bowraville HealthOne in Mid North Coast LHD and the Single Employer model that was piloted in Murrumbidgee LHD, and later significantly expanded, exist.

⁹¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [9.31] [MOH.0010.0758.0001 at 0053].

⁹² Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [9.45] [MOH.0010.0758.0001 at 0058].

⁹³ See e.g. Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020), sch C cl C23 - C28; C35 - C40, sch E cl E25 - E40 pp 60-61, 62-63, 72-75 [SCI.0001.0024.0001 at 0060-0061, 0062-0063, 0072-0075].

⁹⁴ Transcript of the Commission, 26 February 2024, T7098.12-7099.45 (Pearce); Transcript of the Commission, 27 February 2025, 7173.29-7175.40, 7201.2- 7202.17 (Chiu SC).

- 1.57. Given the importance of primary care, it would be unproductive and undesirable for there to be any kind of stand off between the State of NSW and the Commonwealth over the funding of primary care services where they are needed. They must cooperate entirely. The evidence suggests that they usually do, at least after gaps emerge, with the State delivering the service, and the Commonwealth providing a funding stream. Ministerial Directions for s 19(2) exemptions have been issued to enable the Commonwealth to fund primary care services provided by the State. As noted, however, in both the *Strengthening Medicare Taskforce Report*⁹⁵ and in the *Scope of Practice Review*⁹⁶ (and other reports and reviews), other funding models (particularly for the primary care treatment of chronic diseases) such as blended and bundled funding integrated with fee-for-service need to be trialled. Where there are failures or gaps in primary care, NSW Health must provide those services, and to an adequate level so that all populations have timely and affordable access to primary care. The provision of those services should not wait for the flow of Commonwealth funds.
- 1.58. NSW Health should put to the Commonwealth the specific primary care (or, in a context addressed later in this Overview and Report, aged care services) that its planning process and analysis has identified as needing to be provided. NSW Health is more than capable of demonstrating such service needs (and has in the past, when seeking Commonwealth funding). The data and evidence that could be presented to the Commonwealth would include (but is not limited to) MBS and Pharmaceutical Benefits Scheme (PBS) expenditure rates in areas where there is a lack of or dwindling primary care (although access difficulties to primary care even where it exists is an important issue and impediment to adequate coverage). The Commonwealth would be obliged to provide that funding, and should be pursued for it at all necessary levels of government.⁹⁷
- 1.59. Moreover, the Commonwealth and State should act as though the long term health reforms of the *Addendum to the NHRA* and the words “joint planning and funding at local level”⁹⁸ mean something. They need to coordinate and collaborate more closely to jointly plan and pool funds to ensure that adequate, affordable and timely primary care services are available to populations where primary care is diminishing or where market failure has happened or is approaching. It is not good enough for the Commonwealth and the states to merely “encourage local health organisations, such as Primary Health Networks, [LHDs] ... primary and community health services, to collaborate when planning health services and making investment decisions”.⁹⁹ The

⁹⁵ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (Report, December 2022) pp 2, 5 [SCI.0001.0053.0001 at 0002, 0005].

⁹⁶ Exhibit O.31, Professor Mark Cormack, *Unleashing the Potential of our Health Workforce: Scope of Practice Review* (Report, October 2024) pp 36-37, 69, 75 [SCI.0011.0839.0001 at 0036-0037, 0069, 0075].

⁹⁷ Exhibit O.16, The Medicare Benefits Review Taskforce Final Report to the Ministry for Health, *An MBS for the 21st Century, Recommendations, Learnings and Ideas for the Future* (December 2020) p 17 [SCI.0011.0810.0001 at 0023].

⁹⁸ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020-2025* (2020), sch C, cl C1(b)(iii) p 56 [SCI.0001.0024.0001 at 0056].

⁹⁹ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020-2025* (2020), sch C, cl C26(a) p 60 [SCI.0001.0024.0001 at 0060].

time to “encourage” things (and for using language like that) is over. It is now time for the Commonwealth and State (through NSW Health and its relevant agencies) to act so that primary health services do not continue to diminish.

Aged care

- 1.60. Aged care is also identified as a Commonwealth responsibility in the *Addendum to the NHRA*, which provides that “the Commonwealth will be responsible for ... planning, funding, policy, management, and delivery of the national aged care system”.¹⁰⁰
- 1.61. What, then, to make of the Commonwealth’s commitment to honouring this responsibility when on this Special Commission’s site visits I was shown numerous wards in public hospitals full of people who could and should otherwise be in an aged care facility if there was a bed available? What should I make also of the fact that some of these wards are crowded, lack natural light, and offer no communal spaces? The Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) lamented that the flaws of the current system arise to a significant extent from the decisions by successive governments to consider aged care as a form of welfare for the very needy, to be provided to the barest extent required.¹⁰¹ Making the assumption that attitudes have changed since the Aged Care Royal Commission, market failure and unavailability of beds in aged care facilities remains. The financial and other burdens of this currently fall on NSW Health. They should not, but those in need of aged care that are currently caught in the middle should also certainly not bear the brunt of this funding gap.
- 1.62. It probably need not be said, but will be, that public hospital wards are not a substitute for aged care facilities. There are many compelling reasons why elderly patients who are clinically suitable and ready to be in an aged care facility should not be in a public hospital ward. Although somewhat counterintuitive, the evidence before this Special Commission overwhelmingly supports the conclusion that a hospital ward is not the best place for these patients to be, in so far as their health and welfare are concerned.
- 1.63. Further, staff in public hospitals rightly expect that their employment will involve providing healthcare to people who are so acutely unwell that they require admission to a public hospital. They did not sign up to provide aged care services to elderly people who, but for bed unavailability, should be in an aged care facility. This includes those aged care patients with what is described as “problematic” dementia: that is, they are prone to outbursts of violence and aggression because of that progressive disease.
- 1.64. Accepting, as I must, that the Commonwealth is supposed to manage and fund the national aged care system, it is frequently left to NSW Health to pick up the pieces when the system fails in the many instances it does. While such failure should not

¹⁰⁰ Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 13(f) [SCI.0001.0024.0001 at 0010].

¹⁰¹ Exhibit O.17, *Final Report of the Royal Commission into Aged Care and Quality Safety* (1 March 2021) vol 1, p 12 [SCI.0011.0774.0001 at 0022].

happen, where it does, NSW Health, via the LHDs, should conduct an assessment of the aged care needs in those communities and coordinate to support or deliver the required aged care services in a more appropriate setting than a public hospital. This will need to be done in consultation with its expert medical and other clinical workforce, as well as local communities.

- 1.65. In many instances, NSW Health has done and is doing this through numerous multipurpose services (MPS) (many of which this Special Commission visited while on its travels) located in rural and remote areas of the State. Commonwealth funding streams for delivery of aged care by NSW Health should be pursued by the NSW Government (and should be provided by the Commonwealth), but the provision of aged care to the extent that is required to relieve the existing and unsustainable burden on NSW public hospitals (and the workforce) should not await the outcome of those intergovernmental discussions. It is entirely unrealistic to think that a private market will re-emerge to meet that demand. Through its facilities, NSW Health is already filling some of the gap in the availability of aged care services out of necessity. It should continue to do this in a more systematic way.
- 1.66. However, it is appropriate that I record my view that the Commonwealth has lagged on this issue. It has known, or should have known, that a problem of market and other failure was emerging in aged care for well over a decade. I say “other failure”, as it should also have known that those persons needing a bed in an aged care facility now in general have far higher needs than they did in decades past. This is because, in part, people are ageing at home for longer because of aged care home packages. When they do need an aged care facility, however, their nursing needs are frequently acute, including needs associated with dementia, not just other chronic diseases or other travails of ageing. The Commonwealth should have known years ago that many aged care providers were not in a position to provide high level care. The NSW Government should pursue all avenues to obtain the assistance and cooperation of the Commonwealth to address this significant problem.

First Nations healthcare

- 1.67. This Special Commission made site visits to Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs) in the majority of LHDs. Roundtable discussions were also held, including with representatives of many ACCHOs and AMSs both remotely from the Commission offices, and at the National Centre of Indigenous Excellence in Redfern (Redfern Roundtable).
- 1.68. The evidence given can be summarised by these five main observations and findings set out in the following paragraphs.
- 1.69. First, ACCHOs and AMSs are vital to the communities they serve. They are an indispensable, central hub of those communities.

- 1.70. Secondly, the perception of management and clinicians who work in Aboriginal health is that their organisations are underfunded. Based on the evidence of the level of demand they have, this perception is reasonably held.
- 1.71. Thirdly, ACCHOs and AMSs have little autonomy as to how they can spend funds they receive, particularly from the Commonwealth. At this point it can be noted that under the *Addendum to the NHRA* it is the Commonwealth that has assumed “lead responsibility” for the “system management and support, policy and funding” of ACCHOs and AMSs.¹⁰² Whether this lack of autonomy is based on some kind of fear as to how efficiently those funds might be used, or because of some other factor, does not matter for the purposes of the recommendations in this Report. Those delivering care at ACCHOs and AMSs hold the view they could use funds more effectively to deliver better health outcomes for those in their care if they were allowed to make the decisions about where to and to what extent they should allocate those funds based on the needs of their communities. Undoubtedly, they are best placed to make those decisions. This is a matter not seemingly reflected in Commonwealth thinking, but is in NSW Health’s *Aboriginal Health Plan 2024–2034*.¹⁰³
- 1.72. Fourthly, funding is also often short term. Whether again this is due to a lack of trust or something else is not known. It should be blindingly obvious, though, (as Commissioner Garling observed)¹⁰⁴ that short term funding in healthcare is almost always undesirable. It makes the establishment and maintenance of health services and programs attached to that funding difficult to the point that the funding can sometimes even become counterproductive. Workforce planning based on short term funding is stressful for everyone involved and burdened by obvious disincentives relating to both recruitment and retention.
- 1.73. Fifthly, reporting requirements in relation to funding are considered burdensome. There is evidence that supports this view. Our democracy would no doubt be better served if all agencies of Australian governments were required to be as transparent as ACCHOs or AMSs. That is not to suggest there should not be proper accountability for the use of public funds, including as to the outcomes achieved from funding particular projects or services. The preponderance of evidence, however, is that the administrative burdens on those organisations relating to funds they receive from government (Commonwealth and State) is excessively onerous and a financial drain on them. The introduction of a modest amount of common sense by intelligent people should be able to reduce this burden.

¹⁰² Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 13(b) p 10 [SCI.0001.0024.0001 at 0010].

¹⁰³ Exhibit N.3.31, NSW Health, *NSW Aboriginal Health Plan 2024-2034: Sharing Power in System Reform* (October 2024) p 7 [SCI.0011.0744.0001 at 0011].

¹⁰⁴ Exhibit N.4.5, Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (27 November 2008) Volume 3 [25.176]-[25.183] [SCI.0011.0762.0001 at 0044-0045].

- 1.74. Of equal significance, however, to these more negative matters was a positive discussion at the Redfern Roundtable about how gaps and duplications in Aboriginal health services might be avoided. The First Nations participants at that and other roundtables and meetings held with this Special Commission could have understandably, as an aspect in part of consultation fatigue, seen us as another group of well meaning non-Indigenous people with limited power to actually do anything. Instead, there was meaningful and helpful discussion on the importance and likely benefits of a deeper level of cooperation in the form of joint clinical service planning between First Nations health organisations and clinicians, and those within NSW Health.
- 1.75. Based on the evidence gathered and discussions held, in my view there must be more meaningful consultation and collaboration between the management and clinicians of both ACCHOs and AMSs on the one hand, and the LHDs (and to the extent relevant, the SHNs) on the other, in relation to clinical service planning. As an aspect of that collaborative clinical service planning, ACCHOs and AMSs should be given flexibility to use the funding allocated to them (whether from State or Commonwealth sources) to design and deliver the services they consider are required to meet the needs of the communities they service. Twelve month and other short term funding cycles should be avoided. While analysis and reporting of outcomes is important, the requirements on ACCHOs and AMSs in this regard must be rationalised and simplified.

Affiliated Health Organisations (AHOs)

- 1.76. For the services it provides, Tresillian is primarily funded through Sydney LHD (with whom it has a service agreement), however, it also receives funding from and holds agreements with the Ministry of Health and other LHDs, including Murrumbidgee LHD, Southern NSW LHD, Western NSW LHD, Hunter New England LHD, Far West LHD and Northern NSW LHD together with Healthy North Coast PHN.¹⁰⁵ Karitane (which provides similar but not identical services to Tresillian) has a service agreement with South Western Sydney LHD, and also receives some grant funding from the Ministry of Health.¹⁰⁶ The Royal Rehab Group provides specialist rehabilitation and disability services across various LHDs but receives its funding from Northern Sydney LHD. During public hearings which touched on this issue, I was told that due to disagreements over the adequacy of that funding, it had not signed an annual service agreement since 2012.¹⁰⁷

¹⁰⁵ Exhibit D. 122, Outline of evidence for Robert Mills (11 April 2024) [24]-[26] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024, T2055.41-2060.13 (Mills); Exhibit D.43, Service Agreement 2023-24 between Sydney LHD and the Tresillian Family Care Centres Affiliated Health Organisation (12 December 2023) p 26 [SCI.0008.0010.0001 at 0026].

¹⁰⁶ Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (undated) [8] [9] [SCI.0008.0343.0001 at 0001, 0002]; Transcript of the Commission, 18 April 2024, T2013.4-19, 2014.18-25 (O'Loughlin).

¹⁰⁷ Transcript of the Commission, 18 April 2024, T2101.6-31, 2102.26-2103.8 (Mackay); Exhibit D.123, Outline of Evidence for Matthew Mackay (undated) [12]-[13] [SCI.0008.0341.0001 at 0003].

- 1.77. St Vincent’s Hospital Sydney Limited (a wholly owned subsidiary of St Vincent’s Health Australia) is a networked AHO in respect to St Vincent’s Hospital Sydney and the Sacred Heart Health Service, at Darlinghurst, (collectively known as the St Vincent’s Health Network).¹⁰⁸ The St Vincent’s Health Network delivers 2.5 per cent of the State’s acute inpatient activity as well as a comprehensive range of subacute and non-admitted medical and surgical services.¹⁰⁹ It is the sole provider of heart and lung transplantation services and haematopoietic stem cell transplantation for severe scleroderma in NSW.¹¹⁰ Witnesses from each of St Vincent’s Health Network, the Royal Rehab Group, Tresillian and Karitane gave evidence that the funding provided to them is insufficient to meet the costs of the services they deliver.
- 1.78. To offset what it says is a shortfall in funding, Karitane relies on funds from various community and interstate programs, as well as from philanthropy.¹¹¹ Tresillian had to rely on other sources of funding, including from philanthropy.¹¹² The Royal Rehab Group told this Special Commission that its shortfall of funding for the services it delivers varies between \$2 to \$4 million annually.¹¹³ In each case, the shortfall is a matter disputed by NSW Health.
- 1.79. At least from November 2023, the St Vincent’s Health Network has engaged in negotiations with the Ministry of Health during which it has claimed a large shortfall in the funding made available to it compared to the cost of delivering its services. This culminated in a \$60.2 million deficit for the 2023–2024 Financial Year.¹¹⁴ However, a subsidy of \$30 million was agreed to by NSW Health in February 2024 on the condition that this money was recouped in the following financial year, and on the basis that the St Vincent’s Health Network implement a financial recovery plan.¹¹⁵ In correspondence with the Health Secretary, St Vincent’s Health Australia stated that the St Vincent’s Health Network would not be in a position to execute the 2023–2024 Service Agreement without some discussions at least concerning the state of the funding gap, and also with the view to negotiating a longer-term agreement between the St Vincent’s Health Network and the Health Secretary.¹¹⁶

¹⁰⁸ St Vincent’s Hospital Network also operated St Joseph’s Hospital in Auburn up until the hospital’s closure in 2023: Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [2], [10], [12], [14]–[18] [SVH.9999.0002.0001 at 0001, 0002, 0003].

¹⁰⁹ Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [19a] [SVH.9999.0002.0001 at 0003].

¹¹⁰ Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [19b] [SVH.9999.0002.0001 at 0003].

¹¹¹ Exhibit D.121, Outline of Evidence for Grainne O’Loughlin (undated) [17]–[18] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2025.25–2028.24 (O’Loughlin).

¹¹² Transcript of the Commission, 18 April 2024, T2062.12–24, 2085.31–45 (Mills).

¹¹³ Transcript of the Commission, 18 April 2024, T2112.42–2113.8 (Mackay).

¹¹⁴ Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services - *SVHNS Financial Support 2023-24* (19 February 2024) [SVH.9999.0002.0255_R at 0256]; Transcript of the Commission, 13 June 2024, T3603.8–35 (McFadgen); Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [63]–[68] [SVH.9999.0002.0001 at 0012–0013].

¹¹⁵ Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [67] [SVH.9999.0002.0001 at 0012]; Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services, *SVHNS Financial Support 2023-24* (19 February 2024) [SVH.9999.0002.0255_R]; Exhibit G.29.20, AM-20 Letter from Secretary, NSW Health to Anna McFadgen - *Response to SVHNS Financial Support 2023-24* (28 February 2024) [SVH.9999.0002.0259_R].

¹¹⁶ Transcript of the Commission, 12 June 2024, T3550.2–44 (Blake); Exhibit G.29.22, AM-22 Letter from Chair, SVHA to Secretary, NSW Health, *Funding Agreement with SVHS* (25 March 2024) [SVH.9999.0002.0262].

- 1.80. Several matters arise from this evidence. First, I accept the evidence given by the witnesses for the St Vincent’s Health Network, Karitane, Tresillian and the Royal Rehab Group as to their financial position in relation to funding. For example, as a matter of fact, I find that they are suffering from the budgetary deficits that they claim to be.
- 1.81. Whether, though, this is a result of them being underfunded to deliver the services they do, or because of some inefficiency on their behalf, or some other cause or causes, I am not in a position to finally determine. However, no evidence was presented by NSW Health that would enable me to draw the conclusion that the AHOs are not underfunded to deliver the services they do.
- 1.82. I note that in the 2023–2024 financial year, all of the LHDs and the SHNs exceeded their expenditure budgets, even after they had received supplemental funding in the 2023–2024 financial year.¹¹⁷ In light of this, and the evidence of the AHOs as to what they say are their funding shortfalls, it would be an unlikely coincidence if their funding issues were related to some general uniformity of waste or inefficiency (of which there is no evidence). Without needing to make a firm finding, there is evidence from which the conclusion could rationally be drawn that there is some level of underfunding of AHOs. I say “without needing to make a firm decision” for two reasons.
- 1.83. First, as a matter of firm principle, all AHOs should receive a level of funding to cover the reasonable costs of them delivering the health services they are required to deliver under their service agreements. Each of the AHOs provide extremely important health services to the system. If they are not adequately funded to cover the cost to deliver those services, the ongoing viability of these organisations is placed at risk. There is no good reason why AHOs should be expected to use philanthropic funds to supplement the costs to them of delivering the services they are required to deliver under their service agreements, as part of the NSW Public Health System. It should also not be assumed that the reasonable cost to an AHO of delivering the services that they are required to equate to the cost that NSW Health would incur if it delivered those services itself.
- 1.84. Secondly, it should not be beyond the capacity of the Ministry of Health and the AHOs working and negotiating together to reach agreement as to both the reasonable costs of delivering the services they do, and as to a level of funding that does not result in deficit. Currently, though, it seems that this is too optimistic a view. In those circumstances, an independent mechanism is required to help resolve any disagreements as to whether the amount of funding AHOs are offered is sufficient to meet the costs of delivering the services contemplated by any proposed service level agreement. This mechanism must be independent (that is, the determination is to be

¹¹⁷ Exhibit N3.45, NSW Health Revised Budget Data Report (10 December 2024) [MOH.0010.0753.0001].

made by a person or persons independent of the Ministry of Health and the AHOs, but jointly acceptable to them) and able to be unilaterally triggered by either the Ministry of Health or an AHO. The structured process for dispute resolution should be expeditious, and it of course cannot take away from the Minister for Health's power to determine the subsidy to be paid to an AHO contained in s 127(2) of the *Health Services Act*. That process and its structure should be implemented within six months of the date of this Report.

- 1.85. Service agreements with AHOs (particularly those that provide services across the State, not only within the boundaries of one LHD) should not be with the LHDs nor should their funding come from LHDs. Each AHO should enter into a single service agreement with the Health Secretary. This in no way means that an AHO and an LHD will not have a close working relationship. It simply means that the funding of AHOs for the services they deliver under their service agreements should come directly from the Ministry of Health.

Statewide Services

- 1.86. There are a range of highly specialised, high cost, but low volume services provided within NSW Health. For good reason, they are concentrated in one, or a few, facilities rather than replicated widely across the State. They are referred to as "Statewide Services" or "Supra-LHD services" because, as the name suggests, although they are hosted by a particular LHD, they are provided for the whole of the NSW population.
- 1.87. The State Spinal Cord Injury Service and the Statewide Brain Injury Rehabilitation Services were chosen for case studies.
- 1.88. At least partly because the State Spinal Cord Injury Service is not made aware of all cases of serious spinal cord injuries across NSW (as it should be), there are many people with such injuries who are not receiving the level of specialist care that they need in a timely way.
- 1.89. There are insufficient specialist rehabilitation beds for people who have suffered spinal cord injury, which is exacerbated by the fact that patient flow is not coordinated well across LHD boundaries.
- 1.90. There are also not enough beds across NSW to provide rehabilitation services for all people who have suffered traumatic brain injury. There has been no increase in the number of inpatient beds available for people suffering from such injury in over 20 years. Despite the Statewide nature of that service, its funding is not centrally coordinated and depends on allocations from individual LHDs. It therefore must compete with many other services for funding in a context of stretched LHD budgets. None of this should be the case.
- 1.91. Despite those facts, and the Statewide nature of these services, there is a lack of centralised decision making and planning for them. That is untenable. While recognising the importance of the host LHDs, and their involvement in and knowledge

of service delivery, the planning function and funding responsibilities for all Statewide or Supra-LHD services should sit within the Ministry of Health, not individual LHDs. In addition to implementing that approach, as recommended, NSW Health is to regularly report to the Minister of what progress has been made to ensure all patients with spinal cord and traumatic brain injuries have access to the specialist rehabilitation services they need in a timely way and how the care of them and future patients like them is to be coordinated.

- 1.92. There is no Statewide plan and strategy for paediatric services. Meanwhile, there is evidence of long delays for certain childhood interventions – as long as two to five years. I was told this was way beyond what could be considered clinically appropriate. Again, waitlists as long as this for paediatric services (which may bring lifelong benefits) are not compatible with the notion of universal healthcare.
- 1.93. Part of the NSW Health *First 2000 days Implementation Strategy 2020–25* has this as one of its goals:¹¹⁸
- 3.1 *Ensure that children identified as developmentally at risk receive early, integrated assessment and intervention services.*
- 1.94. Waitlists as long as two to five years are clearly not consistent with the goal of “early, integrated ... intervention services”.
- 1.95. In *Brighter Beginnings: The First 2000 Days of Life*, NSW Health claims that “[I]ate intervention [presumably across the spectrum of services referred to in this document] is estimated to cost \$15.2 billion/year through high intensity and crisis services.”¹¹⁹ It states that for every dollar invested in such interventions there is a “return on investment of \$13”.¹²⁰
- 1.96. The cost of \$15.2 billion per year represents the cost of not doing something (i.e. not intervening a clinically appropriate time). What funding is currently spent on early interventions is not known, but with a return on investment of \$13 for every \$1 spent (presumably a figure reached after comprehensive cost benefit analysis and modelling) it is obviously not enough in light of waitlists of two to five years in some LHDs for certain paediatric services. In saying that, I accept that part of the cause of these long waitlists is not merely funding, but relevant workforce availability problems (particularly in regional areas) also contribute to them.¹²¹

¹¹⁸ Exhibit A.60, NSW Health, *First 2000 days Implementation Strategy 2020-25* (21 February 2021) p 11 [SCI.0001.0052.0001 at 0006].

¹¹⁹ NSW Health, *Brighter Beginnings: The First 2000 Days of Life Factsheet* (Web page, April 2021) <<https://www.health.nsw.gov.au/kidsfamilies/programs/Factsheets/brighter-beginnings.pdf>> p 2 [SCI.0011.0808.0001 at 0002].

¹²⁰ NSW Health, *Brighter Beginnings: The First 2000 Days of Life Factsheet* (Web page, April 2021) <<https://www.health.nsw.gov.au/kidsfamilies/programs/Factsheets/brighter-beginnings.pdf>> p 2 [SCI.0011.0808.0001 at 0002].

¹²¹ Transcript of the Commission, 19 November 2024, T6381.41-6382.43 (Cox).

- 1.97. A Statewide plan for paediatric services that clearly outlines the roles of the Sydney Children’s Hospitals Network (SCHN), the John Hunter Children’s Hospital and paediatric services within LHDs should now be developed. In addition, NSW Health is to provide detailed and comprehensive report to the Minister as to what progress has been made in reducing wait times for paediatric services where those wait times exceed what is clinically appropriate within 12 months of the date of this Report, and a further report 12 months thereafter.

Justice Health and Forensic Mental Health Network

- 1.98. While its funding should be informed by the system wide service planning process I discuss elsewhere, there is evidence that the Justice Health and Forensic Mental Health Network (Justice Health) is underfunded in relation to the demand for its services. It exists in a “capped financial environment”¹²² which does not appear to reflect (or be based on) the health service needs of the vulnerable population it serves, and the extent of demand for the services it provides. A high proportion of the prison population has moderate to severe mental health conditions, as well as high rates of chronic disease. Adequate treatment for these conditions is an investment not just in better health outcomes for prisoners, but for the communities most will ultimately be released into. No aspect of adequate funding for health services for those in custody should be considered “soft on crime”.
- 1.99. Rates of obesity (and conditions associated with it) are high in prison populations. This again is ultimately a burden on the public health system when prisoners with metabolic and related diseases are released. By way of one example only, inmates of Long Bay Correctional Centre, which was visited by this Special Commission, are currently provided with large quantities of white bread before being locked in their cells after “dinner” in the afternoon. Making recommendations about complex carbohydrate consumption might be beyond even my TORs,¹²³ but from a health system perspective, this should stop. The evidence I heard was that the diet of inmates is not one designed for best health outcomes upon release. That should change. Funding should be provided (or redirected) to Justice Health, supported as appropriate by, a suitably qualified group or agency within NSW Health, to enable it to set the minimum nutritional requirements of the diet of the prison population, which **must** be met by those responsible for feeding that population. To the extent that legislative amendment is required to give effect to that, it should occur promptly.¹²⁴

¹²² Transcript of the Commission, 19 November 2024, T6323.42-43 (Hoey).

¹²³ But probably not.

¹²⁴ See *Crimes (Administration of Sentences) Act 1999* (NSW) s 236A.

- 1.100. There are also bed block problems in transitioning patients under mental health orders from high security settings to medium and low security. This is the result of a lack of bed availability. This should change. No doubt the transition of patients from high, to medium, to low security settings is a complex matter for the most experienced relevant health experts. The decisions should not be complicated by bed availability issues. That is not in the interests of the patients concerned or the communities (including the health services within them) to which they will return.
- 1.101. There is also an issue in my mind as to the utility or appropriateness of the division of funding between Justice Health and Corrective Services NSW concerning psychiatric services (Justice Health) and psychological services (Corrective Services NSW).
- 1.102. Time, resources, and the need to inquire into so many matters raised by the TORs did not enable this Special Commission to examine those issues in the manner that would enable a firm view to be reached. I am concerned enough about them to recommend that they be independently examined as a discrete topic as a matter of urgency.

Ambulance services

- 1.103. While the funding envelope for NSW Ambulance should also be informed by the system wide service planning process discussed elsewhere, something should be said separately about the funding provided to it.
- 1.104. It seems well accepted that the services provided by NSW Ambulance have changed considerably over the last decade (or more). What was once a (highly trained) first aid and transport service for the sick and injured has undergone considerable advancement, along with the increased skills and professional recognition of paramedics. Many health services (including sometimes just advice) now provided by NSW Ambulance are aimed at (and achieve the goal of) keeping people out of the hospital system and Emergency Departments wherever there is an appropriate alternative. This includes the ageing cohort of patients who, with the right advice, can be appropriately guided to community settings for their care rather than Emergency Departments.¹²⁵ Between 25 to 30 per cent of “incidents” addressed by NSW Ambulance now do not result in transport to a hospital.¹²⁶
- 1.105. While NSW Ambulance now routinely adopts this as its approach – as well as providing very sophisticated treatment requiring a great level of skill – its budget still seemingly has its origins in its historical role as an “ambulatory first aid” corps. To that historical budget, growth including from “*ad hoc* political announcements” has been applied. What has not been done, however, is a comprehensive analysis of the

¹²⁵ Transcript of the Commission, 19 November 2024, T6364.24-6365.16 (Morgan); Exhibit H.2.51, NSW Health, *Corporate Governance and Accountability Compendium* (May 2024) p 1.03 [MOH.0010.0256.0001 at 0012]; Exhibit B.36, NSW Health, *Annual Report 2022-2023* (Report, November 2023) pp 4, 30, 40 [SCI.0001.0059.0001 at 0013, 0039, 0049]; *State Emergency and Rescue Management Act 1989* (NSW) s 3.

¹²⁶ Transcript of the Commission, 19 November 2024, T6367.16-18 (Morgan).

modern services that NSW Ambulance and its staff provide (or could be utilised to provide with adequate resourcing), with funding based on that reality. That should now occur, not least because the evidence supports the conclusion that the service demands on NSW Ambulance (and the demands placed on its staff who of necessity can work very long hours) are not adequately reflected in the historical based block funding it receives.¹²⁷

Planning and funding the NSW public health system

- 1.106. As set out elsewhere in this Report, funding is currently the “tail that wags the dog” when it comes to the provision of health services in NSW. As was said to me in evidence, funding “shouldn’t be the thing that’s setting the agenda”.¹²⁸ A new approach is required where the focus is on what is hoped to be achieved from the health system as a whole.
- 1.107. The funding of LHDs and SHNs (and, at least to some extent, the AHOs) – noting the important matter that the health portfolio only has available to it the funds allocated by the NSW Government – is based on historical precedent. The “base”, I was told, is the “full recurrent budget for health, which is ... around \$33 billion or so...”.¹²⁹ This amount “reflects the history of incremental budgeting over time.”¹³⁰ Growth increases in the health budget seem to reflect “fiscal capacity at the time”, not (increased) health service needs.¹³¹ However, no one within NSW Health or NSW Treasury seems to have an understanding as to how or why those budgets were originally set when the LHDs and SHNs were brought into existence in 2011, or how the budgets were set for Area Health Services before that, except in the most general terms.¹³² The origin of the “base” is elusive. Disappointingly, many of the capable people who sit on the boards of LHDs do not fully understand how their district’s budgets are set now, or whether they are funded equitably compared with other districts. This is not for want of trying on their part. This must also change but is a slightly different issue.
- 1.108. I suppose that a growth rate that reflects “fiscal capacity” is not entirely arbitrary, but it is trending that way. In any event, at least part of the growth rate that is applied to the “base” is admittedly not “overly scientific”.¹³³ While the Ministry of Health takes some account for age, sex and socio-economic factors in determining budgets for LHDs and

¹²⁷ Transcript of the Commission, 19 November 2024, T6365.18-29 (Morgan); Exhibit M.30, NSW Ambulance data table and graph of percentage change for the number of FTE and emergency incidents by financial year 2010/11-2023/24 (undated) [SCI.0011.0587.0001].

¹²⁸ Transcript of the Commission, 12 December 2024, T6970.7-11 (Wilson). See also: Transcript of the Commission, 18 September 2024, T5342.11-28 (Maisey).

¹²⁹ Transcript of the Commission, 18 November 2024, T6250.1-3 (Cornelius).

¹³⁰ Transcript of the Commission, 18 November 2024, T6250.24-29 (Cornelius).

¹³¹ Transcript of the Commission, 18 November 2024, T6268.33-45 (Cornelius).

¹³² Noting the change in NSW from the resource distribution formula to activity based funding for public hospitals introduced under the NHRA in 2011.

¹³³ Transcript of the Commission, 18 November 2024, T6269.20-34 (Cornelius).

(to the extent relevant) the SHNs,¹³⁴ the consensus view of management and board representatives is that increases in their budgets do no more than meet the cost of existing service commitments and demands, with very little (if any) capacity for expansion.¹³⁵ Mr Spittal, said that:¹³⁶

In my view the current funding system pays marginal attention to issues of allocative efficiency and social equity. The system itself has largely evolved from an a-priori assumption that the distribution of healthcare resources across NSW that existed prior to the introduction of ABF was both equitable and optimal. The evidence of profound differences in health outcomes and access to services provides very little support for that assumption.

- 1.109. Given that its historical details and origins are not known, the “base” on which the funding model is calibrated is no longer a sensible starting point. What is required now, **before** the funding envelope is set, is a forward looking examination of the service needs of each LHD and SHN, rather than the application of some growth factor to historically based funding. By that I mean there needs to be a thorough and detailed assessment of the health needs of the population (or populations) to be served by each LHD and SHN. Those health service “needs” will be identified by a number of factors. They include a variety of socio-demographic factors, the health and age profile of populations, and service demand analysis.¹³⁷
- 1.110. There is a perception – and, in my view, the evidence supports it – that the funding provided to some regional LHDs and those metropolitan LHDs with significant areas of socio-economic disadvantage is not sufficient to reasonably and adequately meet the health service needs of their populations, and is to some degree inequitable compared to budgetary arrangements for some metropolitan LHDs.¹³⁸ There are concerns that changes need to be made to ensure that “the population is actually getting the funding relative to sociodemographics [sic] ... need”.¹³⁹
- 1.111. Transparent decisions – based on both input from the highly skilled medical workforce and other clinicians that exist within the system, and of the community – will need to be made not only about what services are required (beyond acute health services), but what is sought to be achieved. To pick up some of the statutory language in the

¹³⁴ The somewhat oblique Equity Adjustor: see Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [13]-[15] [MOH.0011.0089.0001 at 0003-0004].

¹³⁵ See, for example, Transcript of the Commission, 19 November 2024, T6331.8-6333.35 (Wilson), 6334.4-14 (Collins); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [113] [MOH.9999.1202.0001 at 0022].

¹³⁶ Exhibit E.47, Statement of Mark Spittal (30 April 2024) [105] [MOH.9999.1202.0001 at 0021].

¹³⁷ On this topic, see for example, Transcript of the Commission, 19 November 2024, T6341.36-40, 6345.18-29 (Mains); Transcript of the Commission, 20 November 2024, T6472.13-6473.35 (Viney).

¹³⁸ See, for example, Transcript of the Commission, 19 November 2024, T6334.16-6336.45 (Collins); Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [92]-[100] [MOH.0011.0041.0001 at 0020-0022]; Exhibit E.47, Statement of Mark Spittal (30 April 2024) [5f], [5g] [MOH.9999.1202.0001 at 0002].

¹³⁹ Transcript of the Commission, 19 November 2024, T6407.33-35 (Mains).

Health Services Act, the “promotion” and “protection” of the population’s health would be a good starting point (but only a starting point) for the aim of public health services. That involves something more than acute care services for the injured or sick. It must also include services that seek to improve the health of the population, and prevent and reduce rates of chronic disease. In short, the issue to be addressed is: what is needed to keep the population well and in good health?¹⁴⁰

- 1.112. The health needs identification process is best coordinated by the LHDs and SHNs, in consultation with their medical and clinical workforces and the communities that they serve. It is the LHDs and SHNs that have the population health knowledge to feed up to the Ministry of Health. As part of that process, the LHDs and SHNs must work and coordinate with other service providers such as the traditional primary care sector, NGOs, ACCHOs, AMSs, and AHOs. They will need to identify those services of greatest importance (as a matter of population health needs and utility), those that are currently being provided (whether within the NSW public health system or by other providers), and service gaps.
- 1.113. The level of planning will need to get down to the detail of specific health needs and the specific services required to address them. It is only then, together with the Ministry of Health, that evidence based decisions concerning the scope of public health services that each of the LHDs and SHNs can (and **should**) be made, including as to how services are to be distributed across the State in a safe and (technically and allocatively) efficient way. It will need to include not just analysis of population health needs, but, in relation to any new services, an analysis of what the consequences might be (including long term consequences concerning both population health and economic impacts) of not providing that service.¹⁴¹ The NSW public health system is a Statewide system with multiple “networks”, formal and informal, within it. That planning process should seek to make the most of those features of the system and formalise those networks where necessary to ensure the efficient distribution of the (finite) resources at the disposal of the system.
- 1.114. Given that the resources available to NSW Health are not now, nor will they ever be, unlimited, it is almost certain that during that detailed and robust planning process, services will be identified that either **cannot**, or **should not**, be maintained. I have been told that most (if not all) Chief Executives of LHDs could identify services in their districts that do not have a level of demand that justifies their continuation, and that the funds used to sustain them could be redirected to other services that better address the needs of the community. However, because of political, clinician, and community pressure, those decisions are difficult, if not impossible, for a Chief Executive to implement. That must change.

¹⁴⁰ Transcript of the Commission, 20 November 2024, T6416.35-6417.25 (Braithwaite).

¹⁴¹ Transcript of the Commission, 20 November 2024, T6460.2-17 (Viney).

- 1.115. Part of that change must involve meaningful and genuine consultation and information sharing so that the rationale for decisions can be understood by the community. That, of course, will not result in universal acceptance or approval, but it will go some way to ensuring that any subsequent debate can be grounded in the facts. The other part of that change is that there must be greater leadership and courage from our elected representatives. Unless governments of all persuasions are willing to dramatically increase the health budget by multiples of the growth rates that have historically been applied to it, the simple and incontrovertible fact is that not every health service can be available in every LHD. Likewise, not every decision to close, relocate or rationalise a service is “taking something away” from a community. On the contrary, those decisions are almost certain to be for the benefit of the wider community if it results in the redirection of resources to establish or expand a service for which there is a greater need. That message will be lost if leaders, including elected leaders, do not engage with the issues at that level.
- 1.116. While the LHDs and SHNs will have a great deal of important local and service specific knowledge, the Ministry of Health must have a greater role in the planning process than it does presently. In part (but not exclusively), that oversight role will be required because of the flood (also described to me as a “tsunami”¹⁴²) of new and expensive treatments that are upon us for a variety of conditions for which there has previously been limited treatment. There will need to be collaboration between LHDs and SHNs and the Ministry of Health in the task of making budgetary choices between some of these new and groundbreaking treatments as against, for example, community health services.¹⁴³ Ultimately, in a condensed form, what is required for health services planning is set out in Recommendations 21 to 26. In her evidence to this Special Commission, the Health Secretary thought that this planning process could take up to two years to complete.¹⁴⁴ I accept this, given that the planning process is detailed and will require significant consultation. That process should be the subject of regular – six-monthly – updates to the Minister.
- 1.117. Workforce availability should not drive the health service planning process. What is necessary **first** is an identification of what the health service needs of a population are. It is only **after** this is done that the workforce essential to deliver those services can be identified and becomes part of the planning process. It is after this planning process is completed that funding considerations arise, and the question can be properly posed: what is the funding structure and envelope required to ensure that system has the financial resources to adequately provide the health services that are needed? Beyond the Commonwealth contribution of money through the NHRA, this will require (particularly for any primary health services) funding models in addition to MBS fee-for-service payments, which have long been acknowledged as

¹⁴² Exhibit N.3.8, Statement of Professor Ian Alexander (17 June 2024) [8] [MOH.0006.0024.0001 at 0003].

¹⁴³ Transcript of the Commission, 19 November 2024, T6354.9-20 (Cox).

¹⁴⁴ Transcript of the Commission, 26 February 2025, T7092.24-33 (Pearce).

having unwarranted limitations and disincentives.¹⁴⁵ Instead, fee-for-service payments will need to be supplemented by blended and bundled funding mechanisms, as recommended in the *Strengthening Medicare Taskforce Report*,¹⁴⁶ the *Medicare Benefits Schedule Review Taskforce Final Report*,¹⁴⁷ *Australia's Primary Health Care 10 Year Plan 2022–2032*,¹⁴⁸ and the *Scope of Practice Review* led by Professor Cormack.¹⁴⁹

Workforce and training

Introduction

- 1.118. A great deal of statistics related to the considerable workforce employed by NSW Health – almost 140,000 full time equivalent (FTE) employees and about 165,000 individuals¹⁵⁰ – are set out in this Report. Given the size of the health workforce across NSW, it will come as little surprise to anyone that employee, Visiting Medical Officer, and locum and agency costs consume about 60 per cent of NSW Health's annual budget.
- 1.119. Some general observations should be made about the NSW Health workforce: it is committed, hardworking, well trained, and skilled. To state the obvious, the health workforce provides a vital service to the people of NSW.
- 1.120. The management of NSW Health – both within the Ministry of Health and across the system – is capable and hardworking. Not everyone will agree with that. Based on some social media posts I have (but perhaps should not have) read, a few people in the health system are likely to become full of apoplectic rage at the suggestion that the Ministry of Health, LHDs, SHNs or facilities for that matter are managed by hardworking, dedicated professionals. They have the same entitlement to their views as anyone, including me, but I do not share them and maintain that NSW Health is, overall, well served by those within management.
- 1.121. Of course, when industrial disputes arise, tensions emerge. Within any organisation of about 165,000 people, it is inevitable that there will be relationship breakdowns from time to time, including on a micro scale, as well as more widespread and organised levels of disputation.

¹⁴⁵ See for example Exhibit O.16, The Medicare Benefits Review Taskforce Final Report to the Ministry for Health, *An MBS for the 21st Century, Recommendations, Learnings and Ideas for the Future* (December 2020) pp 36-37 [SCI.0011.0810.0001 at 0042-0043].

¹⁴⁶ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 5 [SCI.0001.0053.0001 at 0005].

¹⁴⁷ Exhibit O.16, The Medicare Benefits Review Taskforce Final Report to the Ministry for Health, *An MBS for the 21st Century, Recommendations, Learnings and Ideas for the Future* (December 2020) Recommendation 11 p 39 [SCI.0011.0810.0001 at 0045].

¹⁴⁸ Exhibit O.19, Australian Government, *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032* (March 2022) pp 7, 14-15, 33 [SCI.0011.0806.0001 at 0018, 0025-0026, 0044].

¹⁴⁹ Exhibit O.31, Professor Mark Cormack, *Unleashing the Potential of our Health Workforce: Scope of Practice Review* (Final Report, October 2024) Recommendation 10 pp 36-37 [SCI.0011.0839.0001 at 0036-0037].

¹⁵⁰ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [6] [MOH.0011.0022.0001 at 0003].

- 1.122. There is a bigger picture, though. The employed workforce of NSW Health – the staff specialist doctors, career medical officers, Junior Medical Officers, the nursing workforce, the allied workforce, and all of the support workers including cooks and cleaners who are all part of this invaluable health service – have not had a pay rise of any significance for well over a decade,¹⁵¹ primarily because of a so called public sector wage “freeze” or “cap” imposed in 2011.¹⁵²
- 1.123. An economist could no doubt express an opinion concerning the benefits to the NSW State budget that resulted from this policy. However, if the NSW Health workforce was not, as a whole, particularly receptive to hearing what those benefits are, I would not blame them.
- 1.124. In addition to what I will call the “wage cap”, the NSW Health workforce was then faced with the COVID-19 pandemic, from early 2020. The workload imposed on staff as a result of COVID-19 need not be stated in detail in this Overview, suffice to say it was beyond considerable. In the face of unprecedented challenges, the NSW Health workforce displayed a level of professionalism and resilience that is impossible to adequately capture in a Report such as this. Soon thereafter, what is commonly called “the cost of living crisis” occurred. In short, the costs of goods and services went up, as did bank lending rates. A significant portion of the health workforce have demanding jobs, that frequently involve high levels of stress. Many, if not most, of the relevant industrial awards are antiquated. In the face of all these headwinds, no one should be surprised at a certain level of industrial unrest or workforce disharmony.
- 1.125. A stronger and more direct finding than this, though, in my view is warranted. On the evidence before this Special Commission, I find that there are high levels of fatigue and “burnout” within sections of the NSW Health workforce. By that I do not mean merely a form of tiredness that might be expected of intense duties and jobs involving the provision of services within a public health system. Dr Bethan Richards, Chief Wellness Officer, Sydney LHD, aptly described the concept of “burnout” across the NSW public health system as follows:¹⁵³
- So when you look at the domains of burnout, it's got three domains. The first one's emotional exhaustion; the second one is depersonalisation or cynicism; and the third one is around professional efficiency or your efficiency of practice.*
- 1.126. Through the appointment of Dr Richards to the position of Chief Wellness Officer, and through the collection of relevant data, Sydney LHD has made a proper initial investment in at least understanding the extent of and causes of burnout. Data collection of this type should be replicated throughout all LHDs and SHNs.

¹⁵¹ Cf The 28 per cent wage increase over 18 months that NSW paramedics received in 2023: Transcript of the Commission, 17 October 2024, T5871.15-44 (Hayes).

¹⁵² Exhibit H.5.22, Statement of Phil Minns (17 July 2024) [38]-[40] [MOH.0011.0024.0001 at 0015].

¹⁵³ Transcript of the Commission, 2 August 2024, T4539.10-14 (Richards).

Information about the wellbeing of the NSW Health workforce should be routinely collected by the Ministry of Health, and in a way that is significantly more comprehensive than the “People Matter Employee Survey”. Some, I suppose, might regard this as a “woke” topic. It is not. Workforce stress, fatigue, and burnout are serious issues, and particularly so in a public health system.

- 1.127. All LHDs and SHNs should, at regular intervals, collect wellbeing data of the kind collected by the Sydney LHD. This will present important information to each of those LHDs and SHNs and the Ministry of Health about the wellbeing of the workforce. The identification of the levels of burnout or other problems in greater detail and with greater understanding will allow for measures to be crafted and adapted, where reasonable, to make necessary change. This should be a priority.

Award reform

- 1.128. Several unions (for example the Health Services Union (HSU), the Australian Salaried Medical Officers’ Federation (ASMOF), the Nurses and Midwives Association (NMWA)) are, at the time of writing this Report, involved in discussions, negotiations and bargaining with NSW Health concerning the remuneration of their members, as well as about other award conditions. The Australian Medical Association (AMA) is also about to commence an arbitration relating to Visiting Medical Officer determinations.
- 1.129. It is not the task of this Special Commission to determine pay rates or other award conditions for workers in the NSW Health system. It is a fact, though, that many no longer share income parity with their counterparts in other states. Economic circumstances and other relevant considerations might justify that. And they might not. That is a matter for negotiation and agreement, or failing that, for the Industrial Relations Commission of NSW to resolve. What is not in doubt is that medical and clinical staff employed in the NSW public health system, as well as all other workers within that system, should be justly compensated for the labour and services they provide in a manner that is fair and reasonable. A strong case has been made before this Special Commission that this is not universally the case, but a finding of that nature is for another body.
- 1.130. A finding is made, however, that award reform is both desirable and overdue. This is not least because many awards and Visiting Medical Officer determinations are no longer fit for purpose. At the general level, there is a consensus about this from union and representative body leaders who gave evidence in hearings and otherwise assisted this Special Commission – for example, Gerard Hayes of the HSU; Dr Nicholas Spooner of ASMOF; and Dominic Egan of the AMA (concerning Visiting Medical Officer determinations). The desirability of award reform is also the view of senior executives within the Ministry of Health (Philip Minns, Deputy Secretary, People, Culture and Governance, and Melissa Collins, Executive Director, Workplace Relations). How an award reform and consolidation process

plays out and reaches its conclusion is ultimately a matter for the Industrial Relations Commission of NSW, but this should be a process with a clearly identified set of objectives which include modernising, simplifying and, where it is appropriate, consolidating awards, as well as updating them to reflect current and expected future service delivery and workforce needs. This process should include Visiting Medical Officer determinations and should in entirety be completed within an expeditious (but reasonable) time frame.

Training and placements

1.131. In his evidence to this Special Commission, Professor Stephen Duckett AM, Chair of Health Performance Council, South Australia and Deputy Chancellor, Royal Melbourne Institute of Technology,¹⁵⁴ said this: “there’s been a **collapse** of workforce planning in this country”.¹⁵⁵ Unsurprisingly, this view is consistent with the opinion expressed in his book, *The Australian Health Care System*, where he described Australia (as with some other countries) as having a “poor track record” in planning the health workforce (with particular criticism of workforce planning for nursing).¹⁵⁶

1.132. A similar view was expressed by Professor Jeffrey Braithwaite, Director of Centre for Healthcare Resilience and Implementation Science, Founding Director of the Australian Institute of Health Innovation, Professor of Health Systems Research, Macquarie University, in his evidence when he said:¹⁵⁷

We sort of haven’t done a very good job of predicting ahead of time how many doctors we’ll need, how many nurses we’ll need ...

1.133. The preponderance of evidence before this Special Commission suggest that these opinions are fact based and measured. They are consistent with (amongst other facts) the enormous reliance placed by the system on internationally trained doctors and nurses (at what cost to the health system of their country of origin?), particularly in regional and remote settings, because (in words and evidence repeated often) “we have not grown and trained our own”. Further, there are currently shortfalls of general practitioners compared to needs, which are predicted to increase over time.¹⁵⁸ There are also shortfalls in applicants for trainee positions for a number of specialty training programs (including psychiatry, radiology and emergency medicine). Staff Specialist

¹⁵⁴ Chair of the Health Performance Council in South Australia, Chair of the Board of the Eastern Melbourne Primary Health Network, Member of the Board of Healthdirect Australia, Chancellor of RMIT University, Honorary Enterprise Professor, School of Population and Global Health, and Department of General Practice and Primary Care, The University of Melbourne.

¹⁵⁵ Transcript of the Commission, 20 November 2024, T6502.30-31 (Duckett) (emphasis added).

¹⁵⁶ See Stephen Duckett, *The Australian Health Care System*, Chapter 4, p 104 (Oxford University Press, 6th ed, 2022).

¹⁵⁷ Transcript of the Commission, 20 November 2024, T6448.38-40 (Braithwaite).

¹⁵⁸ See Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [6], [12] [SCI.0011.0384.0001 at 0001, 0003]; Exhibit M.13, Royal Australian College of General Practitioners, *General Practice: Health of the Nation 2024* (Report, October 2024) pp v, 20 [SCI.0011.0506.0001 at 0009, 0034], which contains the following relevant statistics: Almost one third (32 per cent) of current GPs plan to cease practice within the next five years. Only 10.5 per cent of medical students reported general practice as their preferred speciality of future practice in 2023, contrast with 13 per cent in 2022. The GP workforce is ageing with the proportion of GPs aged 55 years and older steadily increasing from 37 per cent in 2018, to 49 per cent in 2023. The total number of GPs in Australia (39,449 as at 2023) has increased every year since 2018, however the number of FTE GPs decreased in 2023 to 29, 215.

positions in several specialties (including psychiatry, emergency medicine, radiology and anaesthesia) cannot be reliably filled.

- 1.134. To this can be added a general maldistribution of the medical workforce between metropolitan and rural and regional areas. A significant reason for this is the lack of medical trainees who come from the regions, and who are trained in the regions. There can also be a lack of suitable accommodation, childcare, and other services required to support a contemporary health workforce in many parts of the State. There is the perception (almost certainly misplaced) that working in regional and rural NSW might be less interesting and diverse. There is also a (more reasonably held) view that there is a lack of professional and social support networks. These problems are not new, and many, for example, were noted by the NSW Legislative Council Portfolio Committee in its *Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW* report.¹⁵⁹
- 1.135. There are shortages of midwives and enrolled nurses across all of NSW, in addition to a maldistribution of the nursing and midwifery workforce between metropolitan and rural and regional areas (for many of the same reasons as the medical workforce). Similar problems exist in relation to the allied health workforce, where NSW Health now faces competition from National Disability Insurance Scheme (NDIS) providers (as well as from the private sector) which, the evidence suggests, offer higher rates of remuneration.
- 1.136. While in no way suggesting that LHDs, SHNs and local health facilities do not have an important role to play (given both their local knowledge and perspectives), there needs to be a system wide approach to workforce planning led by the Ministry of Health. In this regard, I accept the evidence of Mr Minns, who spoke about the “missing middle function”¹⁶⁰ in relation to service planning, of Adjunct Professor Kathy Eagar AM, School of Clinical Medicine, Faculty of Medicine and Health, UNSW Sydney,¹⁶¹ who spoke of the need for greater coordination of workforce planning between the Ministry of Health and LHDs,¹⁶² and of Richard Griffiths, Executive Director, Workforce Planning and Talent Development, who said this:¹⁶³

At present, NSW Health focuses too strongly on adapting models of care to the current workforce and the way it currently works, rather than building workforce for delivery of new models of care. Our

¹⁵⁹ Exhibit E.37, Legislative Council Portfolio Committee No 2, NSW Parliament, *Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW* (Final Report, May 2022) [SCI.0009.0077.0001].

¹⁶⁰ Exhibit L.6, Statement of Philip Minns (8 October 2024) [10] [MOH.0011.0082.0001 at 0003].

¹⁶¹ Kathy Eagar AM is an Adjunct Professor, School of Clinical Medicine, Faculty of Medicine and Health, University of New South Wales and Adjunct Professor, Faculty of Health, Queensland University of Technology, and Director, Consultants in Health Services Development.

¹⁶² Transcript of the Commission, 10 December 2024, T6814.10-26 (Eagar).

¹⁶³ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [111]-[112] [MOH.0011.0083.0001 at 0025]; Transcript of the Commission, 14 October 2024, T5663.11-5665.46 (Griffiths).

service planning structure tends to replicate what has previously been done, and then workforce is retrofitted.

In my view, NSW Health needs to move away from looking at networking opportunities after developing individual service plans and instead start with a system level networked approach to service. ... We need to conduct workforce planning not by looking at workforce as a limiting factor but to design Clinical Service Plans in a more connected way between LHDs and consider the new models of care available and the workforce that might be created to deliver them.

- 1.137. This evidence relates back to what I said above about funding being the “tail that wags the dog” of health services. There is the danger that health services are planned, and models of care are adapted, to accommodate health workforce availability. What is needed is a detailed plan of the services that are required to meet the healthcare needs of the population and an identification of the workforce required to deliver those services. Funding models and training pathways can then be designed and implemented to deliver them.
- 1.138. To enable that to occur, a central workforce planning function should be established within the Ministry of Health which will collaborate with LHDs, SHNs, and local facilities with the objective of shaping and guiding the development and deployment of the workforce across the system in a manner that supports the delivery of the services that are needed, where they are needed, across NSW.

Student placements

- 1.139. There should be greater central coordination and planning in relation to student placements. By this, I do not mean that longstanding and valuable relationships between certain universities and local organisations should be dissipated. Further, it is an obvious matter that the capacity for any particular health facility to take on students in clinical placements depends on the availability of a professional workforce to supervise those students. Nevertheless, there was widespread acceptance by relevant witnesses to this Special Commission (from representatives of the medical colleges as well as from NSW Health and agency executives) that the Ministry of Health and the Health Education and Training Institute (HETI) could and should play a greater role in coordinating the placement of students in training positions.
- 1.140. Supported by necessary additional funding, HETI’s role should be expanded to include a coordination function for the allocation of students to clinical placements within NSW Health facilities – while always acting in collaboration with the universities, LHDs, SHNs, and any other relevant NSW Health agencies.
- 1.141. HETI should also play a greater role in overseeing a graduate recruitment program that focuses on recruitment of those who have held placements into areas of need

upon graduation, and the establishment and delivery of specialist medical training networks, prioritising those groups with projected shortfalls in training numbers or serious maldistribution challenges. Again, this will need to be done in collaboration with relevant medical colleges, other training providers, and local organisations and in a manner which delivers on the objectives of the wider health service and workforce planning exercise I have described elsewhere in this Report.

Data

- 1.142. In December 2022, the Strengthening Medicare Taskforce recommended implementing better connections in “health data across all parts of the health system, underpinned by robust national governance and legislative frameworks, regulation of clinical software and improved technology”.¹⁶⁴ This recommendation was contained in the section of the report entitled *Modernising Primary Care*.¹⁶⁵ The concern of the committee that drafted the report was that “[c]ritical patient health information remains locked in siloed clinical information systems and cannot be shared easily across the health system and care settings”.¹⁶⁶ They noted that “poor information flows lead to increased cost and worse patient outcomes”.¹⁶⁷ It was said that “modernising primary care data and digital approaches will also enable better collection of population level clinical information to improve our understanding of local, regional and national health needs, and assist with system planning and resource allocation”.¹⁶⁸
- 1.143. Some 13 years prior to the *Strengthening Medicare Taskforce Report*, Commissioner Garling recommended that “[w]ithin 4 years NSW Health should complete the current information technology program” which would include a “State-wide roll out of [an] electronic health record”; also within four years.¹⁶⁹ That is, by 2013. And just before Commissioner Garling’s recommendation, in June 2009 the National Health and Hospitals Reform Commission recommended that by 2012 “[e]very Australian should be able to: have a personal electronic health record ... [and] approve designated healthcare providers ... to have authorised access to some or all of their personal electronic health record”.¹⁷⁰

¹⁶⁴ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 9 [SCI.0001.0053.0001 at 0009].

¹⁶⁵ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) pp 8-9 [SCI.0001.0053.0001 at 0008-0009].

¹⁶⁶ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 8 [SCI.0001.0053.0001 at 0008].

¹⁶⁷ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 8 [SCI.0001.0053.0001 at 0008].

¹⁶⁸ Exhibit A.61, Australian Government, *Strengthening Medicare Taskforce Report* (December 2022) p 8 [SCI.0001.0053.0001 at 0008].

¹⁶⁹ Exhibit N.4.4, *Final Report of the Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals: Volume 2* (27 November 2008) p501 [SCI.0011.0760.0001 at 0083].

¹⁷⁰ Exhibit E.87, National Health and Hospitals Commission, *A healthier future for all Australians* (Final Report, 30 June 2009) Appendix G [SCI.0009.0108.0001 at 0228].

- 1.144. NSW Health will soon (in 2025) be starting to implement its Single Digital Patient Record (SDPR) project. This project will commence with a rollout in Hunter New England LHD, and is expected to be operational across the entirety of the State by some time in 2029.¹⁷¹ Evidence suggests that the SDPR will bring many benefits to the health system of the kind discussed above in the *Strengthening Medicare Taskforce Report*.
- 1.145. However, a serious limitation of the SDPR is that there is no current plan for it to interface with primary care providers, including general practitioners. There also does not appear to be a plan for it to extend to the St Vincent's Health Network, or other AHOs.
- 1.146. Given what this Special Commission heard were the expected benefits of the SDPR, access to it must be made available to primary healthcare providers, and to the St Vincent's Health Network and other AHOs. One great advantage of linking the SDPR to primary healthcare providers, and in particular general practitioners, is that it will enable data to be collected about services provided by general practitioners, including preventive and chronic disease management services. It will enable greater connection and information sharing between those providing primary care services, and those providing acute services to the same patients.
- 1.147. As to AHOs, unless NSW Health makes the SDPR available to them, it risks a fragmentation of access to important data within the NSW public health system itself, which is obviously undesirable but which could also conceivably pose health risks and contribute to inefficiencies. That is even more so in relation to the St Vincent's Health Network. It operates a large and significant public hospital – the SDPR must be connected to it. This should not wait until after the completion of the rollout to all LHDs in 2029. The cost of this should be borne by the State. AHOs form part of the NSW public health system – they should not be expected to meet the cost of accessing the SDPR.
- 1.148. The integration of the SDPR with primary care (including general practitioners) is clearly an aspect of proper and effective primary care. No one has identified a reason why access to the SDPR by primary care providers is anything other than a benefit – to the individual and the system. Given what was said and recommended in the *Strengthening Medicare Taskforce Report*, and noting that “enhanced health data” is one of the long term reforms of the *Addendum to the NHRA*,¹⁷² and that the Commonwealth has responsibility for funding primary care under the Addendum,¹⁷³ I can think of no compelling reason why the Commonwealth ought not cooperate with the NSW Government (and in particular, NSW Health) to support the work necessary

¹⁷¹ Exhibit B.6, Statement of Dr Zoran Bolevich, Chief Executive of eHealth NSW and Chief Information Officer of NSW Health (31 January 2024) [31(a)] [MOH.0001.0433.0001 at 0014].

¹⁷² See Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) sch C, cls C1(d)(i), C41-C47 [SCI.0001.0024.0001 at 0056, 0063-0064].

¹⁷³ See Exhibit A.28, *Addendum to the NHRA (consolidated) 2020–2025* (2020) cl 13(b) [SCI.0001.0024.0001 at 0010].

to make the SDPR accessible to primary healthcare providers. This must include all providers of First Nations primary health services like AMSs and ACCHOs. That funding should be pursued by the NSW Government. However, in the meantime, NSW Health should take all necessary steps to ensure that the SDPR is accessible by primary care providers promptly. That should not await negotiations with the Commonwealth about funding for that work.

Publicly available data

- 1.149. Amongst other things, the Bureau of Health Information (BHI) currently publishes a *Health Care Quarterly*, which contains statistics concerning matters such as Emergency Department attendances and wait times, elective surgery lists including wait times; ambulance incidents and responses; as well as admitted patient activity. Public reporting about these matters is an important function.
- 1.150. These are by no means the only information or data that provides insights into the functioning of a health system, and its public reporting should be expanded. For example (as I have observed above) this Special Commission heard evidence that wait times for certain critical paediatric interventions can vary between two to five years in some instances. There are also wait times of two years or more for some dental treatments (frankly, an important aspect of primary care and services which should be publicly funded, as recommended by the National Health and Hospitals Reform Commission in 2009).¹⁷⁴
- 1.151. Information in relation to the accessibility of outpatient and specialist services within the NSW public health system is important information that people are entitled to know. They are important parts of the health system, as much as Emergency Departments or elective surgeries.
- 1.152. While statistics about waiting times in Emergency Departments, or elective surgeries, are collected and publicly reported (despite the fact that they are, on any view, a blunt measure of the performance of the wider system), data concerning the accessibility of specialised and other outpatient services is not. Further than that, it appears that data of that kind is not currently collected in a systematic way. That must change. Information of that kind should be collected systematically, including as part of the system's own monitoring of its performance. That information should be reported publicly (there is nothing confidential or secret about it) in the BHI's *Health Care Quarterly*, or some other equally accessible publication.

¹⁷⁴ Exhibit E.87, National Health and Hospitals Reform Commission, *A healthier future for all Australians - final report* (Report, 27 July 2009) [SCI.0009.0108.0001 at 0004, 0261-0262].

- 1.153. Moreover, the BHI's remit should also be extended to include public reporting of information that reveals the extent to which LHDs and SHNs are achieving the objects of the detailed planning process I recommended, as well as the true extent of NSW Health's prevention and health promotion initiatives, including what those activities are, and the amounts expended on them. Transparency of this kind is important if NSW Health is to secure informed community participation (and acceptance of) the difficult rationing decisions that will inevitably need to be made as part of that planning.

Operational matters

- 1.154. As will become evident to the reader of this Report, I have approached the issues raised by the TORs at the system level. There are several reasons for that.
- 1.155. First, I did not consider that it would be helpful (or wise) for me to make recommendations at the operational level. I am conscious that, as a lawyer, I am not well placed to make prescriptive recommendations as to how the NSW public health system should be run on a day to day basis, or how particular services should be delivered. There are others that are far better placed than me to do that. If I were to make recommendations at the operational level, there would have been a very real risk that they would have flow on effects to other aspects of the system that were not foreseen by me, and which might have had unintended consequences. Not only that – given the rate of progress and development of treatments and models of care (to name but two) they were unlikely to have had any lasting impact in any event.
- 1.156. Secondly, and relatedly, to have made meaningful (and appropriate) operational recommendations, I would have needed to have inquired into every aspect of the system in detail. To do so properly would have taken much more time than was available – probably several years. Even with that amount of time (which would have been unreasonable on any view) it would nevertheless have been almost impossible for me to make meaningful recommendations in relation to **all** of the operational or service level issues that warrant attention across the system.
- 1.157. Thirdly, and perhaps most importantly, I did not consider that was the purpose of this Special Commission in any event. The purpose of a Special Commission of Inquiry like this one is to make recommendations that are directed to bringing about improvements to the wider system, and not to address individual or specific operational issues. It is through system level change that lasting improvements can be achieved, and that is how I have attempted to formulate my recommendations.

- 1.158. Accordingly, there are many matters that were referred to in the evidence but that are not the subject of specific attention in this Report. For example, there was a significant amount of evidence relating to the challenges facing mental health services across the system – both in terms of service demand and the available workforce. Mental health is, and has been, a significant healthcare issue over some time and will likely remain so into the future. It is a topic that is apt to be the subject of a standalone inquiry of itself – as it was in the recent NSW Legislative Council Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW,¹⁷⁵ and the Royal Commission into Victoria’s Mental Health System.¹⁷⁶ Attempting to deal comprehensively with those issues at an operational level in the context of this Special Commission (and its broad TORs) would not have done the topic justice.
- 1.159. There were many other operational and service level issues that were the subject of evidence. I heard of the significant difficulties faced by some patients in accessing dialysis (particularly in regional and rural areas); the effect of workforce shortages on the anatomical pathology services; and limitations in patient transport services that (sometimes) result in ambulances being used for patient transfers. There were many other issues of those kinds that were raised across the duration of this Special Commission.
- 1.160. That I have not addressed operational or service level issues of those kinds expressly in this Report should not be understood by anyone as me having ignored or overlooked them. Nor should the reader of this Report think that I do not regard them to be important or deserving of prompt and meaningful action by NSW Health. They were all important, and they informed my assessment of the system level issues to which I have directed my recommendations. Multiple representatives of NSW Health were also present throughout the public hearings and at the visits to NSW Health facilities. They heard what I heard. It is my strong expectation that the many operational issues raised in evidence and at roundtables will be considered and, to the extent necessary, addressed through system wide assessment and planning processes that I have recommended (if they have not already been dealt with at a local level). If done comprehensively, that system wide approach should identify those aspects of the system that are under pressure (whether a particular region, facility or service) and enable substantive – and, importantly, measurable – plans to be developed and actioned to address them.
- 1.161. Another issue that is not expressly addressed in this Report is the privatisation of public hospital services, the most prominent example of which (following the cessation of the arrangements with St John of God Health Care at the Hawkesbury

¹⁷⁵ Exhibit H.2.53.1, NSW Legislative Council Portfolio Committee No 2, *Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales* (Report, 4 June 2024) [SCI.0011.0280.0001].

¹⁷⁶ *Final Report of the Royal Commission into Victoria’s Mental Health System* (Report, February 2021) <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>.

District Hospital) is the Northern Beaches Hospital. There has been significant public discourse in relation to that facility during this Special Commission. As matters transpired, those arrangements were the subject of parallel consideration by the NSW Government that has resulted in the introduction of the Health Services Amendment (PPP Prohibition) Bill 2025 (NSW), which has the effect of amending the *Health Services Act* to prohibit the State, an LHD or Statutory Health Corporation from entering into arrangements of the kind that resulted in the construction and operation of the Northern Beaches Hospital. As of the time of writing this Report, that bill remains before the NSW Parliament, although there is no reason for me to suspect that it will not be passed. Accordingly, there is no utility in me expressing a view as to the appropriateness or otherwise of those arrangements in this Report given that they will soon be statutorily prohibited.

Conclusion

- 1.162. There are three matters I wish to emphasise in these final remarks to the Overview of the Report.
- 1.163. The first is that NSW Health will need additional, ongoing, and quarantined funding if it is to implement, embed, and sustain the benefit of the Recommendations that are made in this Report into the future. I have made a Recommendation to that effect.
- 1.164. The second is that there is a risk in any Special Commission of Inquiry like this to neglect to emphasise what goes right in the health system, because the focus is on examining whether there should be any recommended change. Although I am not the only one to say this, the NSW public health system is a very good one. It comprises doctors, nurses, other clinicians, and workers who are well trained, highly skilled, and dedicated. It is well managed. The money allocated to the NSW public health system by a combination of the NSW and Commonwealth Governments is generally not wasted. Likewise, the LHDs and SHNs do not waste their budgetary allocation. It is not, and is unlikely to be in the near future, entirely mistake or incident free, but any person experiencing an illness or injury who attends a NSW public hospital, facility or service, is very likely to receive treatment and care comparable to the best that is provided in any other developed country.
- 1.165. The final point of emphasis is that, having now read along with my colleagues so many reports, reviews, and so much medical literature, economic literature, and sundry other published work dating back decades and up to the present, it is astonishing to me that we have the national system that we do. The failure to reform Medicare and the funding models for primary care, and to ensure adequate and timely primary care to all Australians, is close to (but not quite) beyond my comprehension. The failure to embed prevention in all its forms into the health system despite repeated and evidence based recommendations to do so is beyond my comprehension. So, too, is how we have allowed NSW public hospitals to have so many patients in wards for extended periods of time beyond any need for acute care

to be provided to them, many of whom are elderly Australians who could and should be cared for in aged care facilities, specialist disability accommodation or supported independent living arrangements for NDIS participants.

- 1.166. If I, generously, take as a starting point the recommendations made by the National Health and Hospitals Reform Commission in 2009, it is 16 years past the date from which the Commonwealth and the states, including NSW, should have been working together and collaborating to ensure gaps in primary and aged care did not emerge, and to embed and fund preventive health services. Based on all I have seen in the last 18 months, the long term health reforms outlined in the *Addendum to the NHRA*, and its aspirations for “shared intentions” and to “work in partnership” towards a “nationally unified and locally controlled health system”, are just words on paper.
- 1.167. It is time for action, and reform that is funded.



Chapter 2:

Key findings

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Introduction

- 2.1. What follows are described as the “Key Findings” I have made. They are by no means the only findings. They have been placed here on the assumption that there might be some people interested in the main findings within this Report, but who nevertheless lack the time or tenacity required to read it in its entirety.
- 2.2. There is some danger in drafting a “Key Findings” section to a Report such as this – most findings are best understood if more context is given to them. On balance, though, it was thought worthwhile to include the findings below, all of which interrelate to (and occasionally repeat) the Recommendations made.

Overview

- 2.3. A fundamental assumption of this Report is that it is desirable for the State of NSW to have and fund a universal healthcare system. Universal healthcare coverage remains supported by the *Addendum to the NHRA*, as well as by provisions within the *Health Services Act*. Universal healthcare coverage is part of the social contract between Australians and their governments.
- 2.4. The NSW health system is a good one. It comprises doctors, nurses, and other clinicians and workers who are well trained, highly skilled, and dedicated. It is well managed. The money allocated to NSW Health by a combination of NSW Treasury and the Commonwealth Government is not wasted. It is neither mistake nor incident free, but any person suffering an acute illness or injury that attends a NSW public hospital is likely to receive treatment and care comparable to the best that is provided in any other developed country.
- 2.5. The system, however, has failings. One significant failure is that adequate and timely primary care is not available to parts of the NSW population.
- 2.6. There has been a failure to embed prevention in all its forms into the health system, despite repeated and evidence based recommendations to do so.
- 2.7. NSW public hospitals have many elderly patients in wards for extended periods of time beyond any need for acute care to be provided to them. These are people who could and should be cared for in aged care facilities.
- 2.8. It is many years past the date from which the Commonwealth Government should have been working and collaborating on a regular basis with the NSW Government and NSW Health to ensure gaps in primary and aged care did not emerge, and to embed preventive services into the system and to fund them.

- 2.9. There are parts of the health workforce who are suffering from “burnout”. At the time of writing, parts of the health workforce are engaged in industrial disputes with the State Government. Outdated awards, a decade long public sector “wage-cap”, and a lack of parity with pay available in other states have all contributed in varying degrees to that situation.
- 2.10. Based on all I have seen in the last 18 months, the Long Term Health Reforms outlined in the *Addendum to the NHRA*, and its aspirations for “shared intentions” and to “work in partnership” towards a “nationally unified and locally controlled health system”, are currently (and have been for five years now) just words on paper. If that situation changes, it will be long overdue.

The health of the population and the need for prevention: Chapter 10

- 2.11. Chronic disease has become the leading cause of illness, disability and death in Australia, accounting for approximately 90 per cent of all deaths. Rising rates of chronic disease have a significant impact on the demand for health services.
- 2.12. Targeted policies that address cohorts with higher rates of chronic disease – for example, those experiencing socio-economic disadvantage and those living in remote areas – can bring significant gains.
- 2.13. The theory that compressing the period of morbidity that people experience may have healthcare cost and other economic benefits is the subject of considerable medical and economic literature. A vast amount of research and academic work has been undertaken suggesting that health services, programs, and policies aimed at disease prevention or early intervention have economic benefits.
- 2.14. An ageing population (with high rates of chronic disease) will, as a matter of certainty, be one of the main contributors to the growth in demand for health services, and the growth in cost to the system. If NSW Health continues to be funded as a system that treats acutely unwell people in public hospitals, there is a risk its resources will soon be overwhelmed by what looms as a huge increase in healthcare demands by an ageing population with high expectations.
- 2.15. The lack of funding or action to adequately prevent (or intervene early in) chronic disease is, at best, a curiosity. It should be a top priority. Not only for potential economic and cost saving benefits, but for population health reasons.
- 2.16. “Prevention and wellbeing” is identified as a “priority” and “Long Term Reform” in the *Addendum to the NHRA*. This has not inspired much action. The evidence demonstrates a greater desire for ephemeral aspiration than the funding of anything actually aimed at “prevention and wellbeing,” ensuring it is done, and analysing the outcomes. No additional funding was provided for it in the *Addendum to the NHRA*.

- 2.17. The Commonwealth Government does not fund the states, including NSW, to do much more than provide acute care services. Partly (but not solely) because of this, prevention is inadequately prioritised and funded in the NSW public health system. Despite being aware for decades of the need to assist health departments and agencies to shift out of a “reactive mode” and embed prevention firmly in the health system, governments - both State and Commonwealth - have largely prioritised shorter term markers. On the basis of an overwhelming amount of expert evidence, that must change.
- 2.18. If one seeks to understand how much NSW Health spends on “prevention,” it is not easy to find a definitive answer. This might be explained by the imprecise way that “prevention” is defined. This is important: a lack of clarity concerning what is “prevention” can act as a barrier to transitioning the health system into a more preventive one, as well as leading to an undesirable opacity about claims made concerning expenditure on prevention.
- 2.19. Executives within the Ministry of Health, management of LHDs, and the health workforces within districts are aware of the need to ensure adequate services are provided (including preventive health measures and community and home based care) to limit the number of people who must be treated in our public hospitals. Collectively, they have the expertise and skills to stand up a more proactive, prevention based health system. They cannot succeed in that endeavour without the required funding and leadership.
- 2.20. “Prevention” of disease (or early intervention) is of such importance that preventive health should be expressly identified as a whole of government priority against which any new initiatives and policy proposals brought forward by all branches of government should be assessed. Prevention and early intervention must be firmly embedded into the NSW public health system. This will almost certainly require greater investment by the Commonwealth Government and the State of NSW in preventive services, as well as some different prioritisation.
- 2.21. This priority should be informed and coordinated by a multiagency, multidisciplinary body led by NSW Health – ideally under the oversight of the Chief Health Officer.

Primary and aged care: Chapter 11

- 2.22. Primary care is a key component of all high performing health systems. The overwhelming body of evidence before this Special Commission reveals that the primary care system in NSW is under severe pressure, and a significant number of people across the State are not able to access comprehensive primary care. While I appreciate this is a funding responsibility of the Commonwealth Government, without meaningful action by NSW Health, this unsatisfactory situation will continue to deteriorate.

- 2.23. With effective primary care, patient outcomes are improved, their need for specialist intervention or inpatient services is minimised, and unnecessary hospital admissions are avoided. Strong primary care is associated with improved population health outcomes for all cause mortality, all cause premature mortality, and cause specific premature mortality from major respiratory and cardiovascular diseases. Effective primary care is a more cost effective form of intervention than acute care delivered in the hospital setting, and increased availability of primary care is associated with higher patient satisfaction and reduced aggregate healthcare spending.
- 2.24. The number of medical graduates pursuing general practice as a vocation has substantially decreased, while the numbers pursuing several specialities has risen.
- 2.25. While the primary care system across NSW is generally under severe strain, it is particularly so in regional, rural, and remote areas. That strain manifests itself in various ways, from the complete absence of any primary care services in some locations, to practices with their books closed to new patients in others, a lack of accessible bulk billing practices, and long appointment waiting times.
- 2.26. The reasons for decline in the availability of primary care are multifactorial. They include the inherent challenges associated with the operation of general practice, including increasing patient complexity, the perceived (and perhaps actual) inadequacy of current MBS rates, and the pressures associated with operating a small business (and their impact on the wellbeing of clinicians). Those challenges exist in all areas of the State, but can be more acute in regional, rural, and remote areas.
- 2.27. Given the role of primary care in promoting and maintaining population health, it is of no surprise that there is a correlation between a decline in access to primary care and a subsequent increase in patients presenting to hospitals with higher levels of acuity.
- 2.28. A high proportion of the population's healthcare needs would benefit from consistent management in the primary care setting, particularly in circumstances where:
- a. 66 per cent of adults, and 26 per cent of children, are overweight or obese;
 - b. 16.6 per cent of adults have diabetes;
 - c. 36 per cent of adults have high cholesterol;
 - d. 31 per cent of adults have high blood pressure; and
 - e. 24 per cent of children are developmentally vulnerable in one or more domains in their first year of school.
- 2.29. Most care for chronic conditions is provided in the primary healthcare setting by general and allied health practitioners.
- 2.30. A lack of access to primary care also means that continuity of care – an important feature of effective primary healthcare, particularly for those with multiple chronic conditions – is difficult to maintain.

- 2.31. Urgent Care Services or Clinics reduce pressure on Emergency Departments by siphoning off a proportion of the lower acuity patients who would otherwise be presenting. Viewed through the infinitely narrow lens of Emergency Department wait times, this might be seen as a solution to the problems caused by the absence of accessible primary care. Viewed more widely, it is plainly not.
- 2.32. Urgent Care Services or Clinics are able to provide episodic care to a cohort of patients who require it. In some cases, that care could have been provided by a functioning primary care market. In others – such as care required afterhours – it may never have been met by conventional primary care and would instead have increased the patient load borne by the local Emergency Department. In this sense, Urgent Care Services or Clinics can make a positive contribution to the health services landscape. However, nobody should pretend that they are any substitute for effective primary care. They are not.
- 2.33. The view that NSW Health should always prioritise acute care over the delivery of effective and accessible primary care fails to grapple in any meaningful way with the fact that the absence of adequate primary care will likely only increase the demand for “a service that only [NSW Health] provide[s]”; namely, that delivered through Emergency Departments or in the acute care setting, at vastly higher cost and with inferior long term clinical outcomes for patients.
- 2.34. Whenever the State has stepped in to provide primary care through a salaried model or otherwise supported the delivery of primary care to a community where it is lacking, the State has obtained access to the MBS (a Commonwealth funding stream) to offset the cost of delivering that service.
- 2.35. The view that it is not the function of the LHDs to invest in the provision of primary care is incompatible with their statutory purpose and functions as set out in ss 9 and 10 of the *Health Services Act*. Those functions include to “promote, protect and maintain the health of the residents of its area” and “establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services”. Activities directed to health protection, promotion, and education are not limited to acute care settings and, in many respects, are core functions of primary care. The statutory regime contemplates that LHDs will deliver the care needed to fulfil their stated primary purposes. In doing so, it does not draw a distinction between primary care and acute care, or hospital and community based services.
- 2.36. Where a community is adequately serviced by a primary care market, there may be no need for the LHD to provide those services itself. However, where there is a thin primary care market, such that it does not meet the needs of the community, or no market at all, the LHD may need to provide primary care services (or support the delivery of primary care in a struggling market) consistent with its primary purpose and statutory function.

- 2.37. There are several examples of where LHDs are currently doing exactly that in areas of need, including (among others) in the Murrumbidgee LHD, the Mid North Coast LHD, the Hunter New England LHD, Western NSW LHD, and the Central Coast LHD.
- 2.38. LHDs – working in collaboration with PHNs and any existing service providers – are best placed to identify and address gaps in primary care services. That enables place based solutions to be designed having regard to the needs of the community, which may include the LHD itself providing, or providing support for, primary care.
- 2.39. Those place based solutions necessarily include attracting a workforce to deliver the care needed in those regions. The overwhelming weight of the evidence supports a conclusion that clinicians who have historical links to regional areas, or who undertake their training in regional areas, are more likely to return to practise in them.
- 2.40. Providing individuals with the opportunity to deliver primary care through a salaried position would likely enhance the prospect of professionals opting to commit to the delivery of primary care in rural and remote areas; perhaps with the added benefit of using that workforce synergistically to address workforce challenges in other areas of the public health system within the regions.
- 2.41. As part of a place based response, consideration must be given to engaging a salaried primary care workforce, whereby general practitioners and other workers are employed by NSW Health to provide accessible primary care in underserviced areas. In the process of award reform, any barriers to this occurring – including what I have been told is a failure to specifically identify general practitioners as specialists capable of being employed as Staff Specialists in the current award – should be removed.
- 2.42. To the extent that NSW Health provides traditional primary care services, the Ministry of Health should pursue funding from the Commonwealth Government – whether through s 19(2) exemptions or otherwise.
- 2.43. Thin or failing aged care markets are also having a significant and detrimental impact on care delivered through public hospitals in NSW.
- 2.44. On any given day, there are significant numbers of elderly patients occupying beds in public hospitals that could, if an aged care bed were available, be discharged. Patients in that category are described as “maintenance patients”.
- 2.45. The high number of maintenance patients occupying hospital beds at any given time has financial implications for the NSW public health system, and creates risks for patients and staff. Maintenance patients are a high cost to the system. Those costs are borne by the LHDs.
- 2.46. The large numbers of maintenance patients also create bed block, impacting the ability of a facility to move patients through the hospital. This in turn can result in ambulance ramping or the treatment of patients in the waiting room, which may not be optimal for all patients and may be unsafe in certain circumstances.

- 2.47. When elderly patients are in maintenance beds, they are not in the optimal environment they should be. Being in a hospital beyond the time when a patient is clinically suitable for discharge brings with it certain risks, including hospital acquired complications, a higher risk of falls in elderly patients, and the effects of long periods of isolation away from their home environment and families.
- 2.48. NSW Health suggested that by stepping in to address this problem, it would be “assuming responsibility for delivering services that are not only squarely within the Commonwealth realm of responsibility but also ancillary to health services”. This significantly oversimplifies the arrangements made under the *Addendum to the NHRA*. Victoria has maintained a presence in the aged care market and, like private providers of aged care services, is funded by the Commonwealth Government to do so. NSW Health has also maintained a presence in the aged care market through MPSs located in rural and regional areas. Commonwealth funding is provided for these services.
- 2.49. Serious problems will continue to bedevil our public hospitals if something is not done urgently to address the lack of aged care beds available for the particularly challenging patients which the private market based providers will not accept. It is unrealistic to think that this problem can be solved without the State stepping in to play a greater role than it presently does in the aged care market – albeit it is entitled to be funded by the Commonwealth Government where it does so, at least to the same extent as would any other market based provider of aged care services.
- 2.50. A similar issue arises in relation to patients who are suitable for discharge but waiting on National Disability Insurance Scheme (NDIS) acceptance and support. This has a similar impact on the bed flow of facilities to aged care patients.
- 2.51. There are also instances where NDIS providers seek to relinquish care of their clients to district facilities, where the accommodation provider for that client does not have staff with the appropriate skill set to effectively manage the challenging behaviours of that client. Likewise, there are also “social admissions”, where the district becomes the “default provider” for NDIS participants due to breakdown of their living arrangements or carer fatigue and inability to obtain respite care.
- 2.52. Although the evidence does not suggest that patients waiting on NDIS acceptance and unable to obtain appropriate support are creating problems of the same scale as those awaiting placement in an aged care facility, this situation should be closely monitored and action taken early to avoid the development of a system wide problem.

First Nations Healthcare: Chapter 12

- 2.53. In 2005, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma AO, delivered his *Social Justice Report*, which recommended, (among other things) that:
- a. the governments of Australia commit to achieving equality of health status and life expectation between First Nations Peoples and non-Indigenous people within 25 years;
 - b. the governments of Australia commit to achieving equality of access to primary healthcare and health infrastructure within 10 years for First Nations Peoples;
 - c. resources available for First Nations Peoples' health, through mainstream and First Nations specific services, be increased to levels that match need in communities and to the level required to achieve clearly identified benchmarks, targets and goals; and
 - d. arrangements to pool the funding available for First Nations Peoples' health should be made, with states and territories matching additional funding contributions from the Federal Government, with the ultimate objective of increasing the level of flexibility in the deployment of that funding pool.
- 2.54. In the almost 20 years since that report was delivered (and despite the well intentioned efforts of many working within the public health system across Australia), little progress has been made in relation to what can readily be discerned as the objectives of Mr Calma's recommendations.
- 2.55. NSW Health is aware of the importance of Closing the Gap, and has taken action over a number of years in an attempt to improve services for, and health outcomes of, First Nations people.
- 2.56. AMSs and ACCHOs are vital to the communities they serve. They are an indispensable, central hub of those communities.
- 2.57. First Nations people are under represented in the medical, nursing and allied health professions in NSW. A strong First Nations health workforce is rightly seen as critical to ensuring cultural safety in the health system. However, there are unintended negative consequences of setting targets that NSW Health organisations must meet for their First Nations health workforce. AMSs and ACCHOs expressed frustration that they have long recruited and trained staff, only to lose them to jobs with higher salaries in LHDs or NGOs that have been given funding to provide First Nations health services but do not have the First Nations workforce required to deliver the service.
- 2.58. No one within an ACCHO or AMS expressed any criticism of staff members who have moved to take up LHD roles, and they uniformly agreed that First Nations health workers should receive the highest remuneration on offer for the important work that they do. However, the cannibalisation of the workforce they recruit and nurture is a

- substantial drain on their limited resources and makes it challenging for them to deliver the care required by their communities.
- 2.59. Problems like this will persist in the absence of truly collaborative health service planning and delivery of First Nations health services. Only with constant and meaningful collaboration will it be possible for LHDs and ACCHOs/AMSs to properly explore opportunities to seamlessly coordinate services and share staff rather than having to compete for those that are in short supply.
- 2.60. The importance of meaningful consultation and collaboration between NSW Health agencies and First Nations communities and care providers cannot be overstated. It is critical to ensuring that health services and research are culturally appropriate and has the added benefit of promoting efficient use of available resources. Effective collaboration can also help to prevent waste, avoid service gaps that exacerbate unmet need, and facilitate coordinated planning focussed on optimising outcomes.
- 2.61. Meaningful consultation does not mean simply telling the community what is planned. It means identifying a specific community's needs and priorities in collaboration with that community, and codesigning solutions. Needs may differ between communities, but systemic change is about policies and practice, and these must recognise the barriers experienced, including in rural and remote areas, through local consultation with First Nations people.
- 2.62. Joint clinical service planning between ACCHOs, AMSs, and LHDs would address a lot of concerns. This would reduce duplication and allow them to work together to address workforce shortages and resource limitations. It would enable coordination of patient journeys in the community and in hospital, and collaboration to address issues earlier, rather than relying on siloed, output driven funding agreements. Joint clinical services planning would enable each group to optimise the value of their contribution and facilitate sharing of resources, communication and effective referral pathways in both directions. It is precisely what was recommended by Commissioner Calma.
- 2.63. Aboriginal health services are underfunded. In addition, AMSs and ACCHOs have little autonomy as to how they can spend funds they receive, particularly from the Commonwealth Government.
- 2.64. AMSs and ACCHOs could use funds more effectively from a health outcomes perspective if they were allowed to make the decisions about where to and to what extent they should allocate those funds based on the needs of their communities. Undoubtedly, they are best placed to make those decisions.
- 2.65. The funding that those organisations receive is often short term. It should be blindingly obvious that short term funding in healthcare is undesirable. It makes the establishment and maintenance of health services and programs attached to that funding difficult to the extent that the funding almost becomes counterproductive. Workforce planning based on short term funding is stressful for everyone involved, and burdened by obvious disincentives relating to both recruitment and retention.

- 2.66. Reporting requirements in relation to funding are considered burdensome. There is evidence that supports this view. That is not to suggest there should not be proper accountability for the use of public funds, including as to the outcomes achieved from funding particular projects or services. The preponderance of evidence, however, is that the administrative burdens on AMSs and ACCHOs relating to funds they receive from government is unreasonably onerous, time consuming, and a financial drain on them.

Statewide Services: Chapter 13

- 2.67. There are patients with a spinal cord injury who are not accessing the highly specialised care offered by the NSW Spinal Cord Injury Service, or who are not accessing those services in a timely way. This occurs because the NSW Spinal Cord Injury Service does not have a centralised registry of all patients with spinal cord injuries who may be receiving care without having been referred to the specialist service.
- 2.68. A coordinated “State based” approach to the planning and delivery of highly specialised services like the NSW Spinal Cord Injury Service is critical to its effective operation.
- 2.69. There are presently insufficient specialist rehabilitation beds at the Royal Rehab Group’s facility at Ryde and Prince of Wales Hospital to enable patient flow, and therefore those services are difficult to access. There are also associated bottlenecks in intensive care and the acute services at Royal North Shore Hospital and Prince of Wales Hospital because there are insufficient rehabilitation beds.
- 2.70. The three adult brain injury units cannot presently provide traumatic brain injury rehabilitation for all people in NSW that require it because there are not enough beds. There has been no increase in the number of inpatient beds available in over 20 years.
- 2.71. The inability of Statewide Services like these to keep up with population demand in part reflects the lack of central decision making in relation to the nature and volume of services to be provided. Similarly, there is no centralised decision making process for decisions relating to funding, the location of services, or staffing of services. For example, the various brain injury rehabilitation services are managed and funded by the LHDs in which they are situated, and the NSW Brain Injury Rehabilitation Program does not receive any funding directly for its services or patients. As a result, differences in the relative funding allocated to services within the NSW Brain Injury Rehabilitation Program can arise between LHDs.
- 2.72. A centralised body – involving representatives of the Agency for Clinical Innovation (ACI), LHDs, and appropriate divisions or units within the Ministry of Health – should have oversight and responsibility for the governance and operation of supra-LHD and Statewide Services; including in relation to matters such as planning, implementation, funding, data management, performance agreements, monitoring outcomes and review of the ways in which services are delivered.

- 2.73. Funding for Statewide Services should be allocated centrally, before flowing to the host LHDs via service agreements that clearly specify the services to be provided, as well as a series of measurable outcomes to be achieved.
- 2.74. An effective centralised approach to the planning, funding, and delivery of supra-LHD and Statewide Services – facilitated and coordinated by the Ministry of Health – must necessarily draw on relevant expertise and knowledge from within the particular service, the LHDs which host those services, and other parts of the wider system, such as the Pillars.
- 2.75. The delivery of paediatric services across NSW would be enhanced by the development of a Statewide plan and strategy dedicated to those services.
- 2.76. There would be benefit in such a plan addressing matters such as: an identification of the services that can be expected to be provided in the specialist children’s hospitals and those services that sit within LHDs; how those services interact with and support each other; and a clear identification of the referral pathways into the specialist children’s hospitals (including referrals from general practitioners) and then back to local services for ongoing care and management.
- 2.77. That plan and strategy could also support the development of approaches for LHDs to receive specialist support when managing paediatric patients through virtual care models, or a hybrid of virtual and face to face care.
- 2.78. While its funding should be informed by the system wide service planning process discussed elsewhere, there is evidence that Justice Health is underfunded in relation to the demand for its services. It exists in a “capped financial environment” that does not appear to reflect (or be based on) the health service needs of the population it serves, and the extent of demand.
- 2.79. Rates of obesity (and conditions associated with it) are high in prison populations. This becomes a burden on the public health system when prisoners with metabolic and related diseases are released. Funding should be provided (or redirected) to Justice Health (supported as appropriate by a suitably qualified group or agency within NSW Health) to enable it to set the diet of the prison population.
- 2.80. There are bed block problems in transitioning patients under mental health orders from high security settings to medium and low security. This is the result of a lack of bed availability. This should change. No doubt the transition of patients from high, to medium, to low security settings is a complex matter for the most experienced relevant health experts. Those decisions should not be complicated by bed availability issues. That is not in the interests of the patients concerned, or the LHDs or communities to which they will return.

- 2.81. There is also an issue in my mind as to the utility or appropriateness of the division of funding between Justice Health and Corrective Services NSW concerning psychiatric services (Justice Health) and psychological services (Corrective Services NSW).
- 2.82. I am concerned enough about both of those issues to recommend that they be independently examined as a matter of urgency.

Affiliated Health Organisations: Chapter 14

- 2.83. The current processes for negotiating service agreements with AHOs lacks transparency in terms of their budget allocations.
- 2.84. There is little in the way of genuine “negotiation” in relation to AHO yearly budget allocations.
- 2.85. There is no reason why philanthropic funds donated to not for profit organisations should be used to subsidise the delivery of the public health system because the funding provided by NSW Health does not meet the cost of delivering certain services.
- 2.86. The existing processes for AHOs to secure capital funding would benefit from improved transparency and certainty to promote longer term capital planning. There are significant budgetary and governance implications if they are unable to maintain the capital required to operate those services. Those risks flow to the public health system as a whole, which is heavily reliant on those organisations for the delivery of a range of services, including highly specialised services.
- 2.87. AHOs should receive funding sufficient to cover the costs of delivering the services they are required to deliver under their service agreements. As a basal proposition, this much is accepted by NSW Health.
- 2.88. It should not be assumed by anyone (including NSW Health) that, when assessing the fair cost of an AHO delivering any particular service, the unique circumstances of that organisation can be ignored. It is possible (maybe likely) that the fair cost of having an AHO deliver a service exceeds what it might hypothetically cost NSW Health if it were to attempt to deliver that service itself.
- 2.89. To the extent that AHOs incur capital costs in connection with the delivery of the services required of them, these must also be taken into account in determining the level of funding that they receive.
- 2.90. AHOs are, by reason of their status under the *Health Services Act*, part of the public health system. However, unlike LHDs, they remain independent organisations with their own legal obligations. Accordingly, if they do not receive funding sufficient to cover the cost of delivering services, their long term sustainability is at risk. While a series of negative results against budget for an LHD is not an optimal result, it does not risk their survival as an organisation, nor does it expose those responsible for controlling them to action for trading while insolvent. The same cannot be said of AHOs and their directors.

- 2.91. AHOs are in an inferior bargaining position to the Ministry of Health or LHDs in their respective negotiations with them. There is a risk that this power imbalance will continue to operate to the detriment of AHOs (and the system of which they are a part) for so long as they are required to enter into service agreements with LHDs and thereby compete with all of the other services to be delivered by those districts out of their limited budgetary envelope. Adjusting the arrangements so that it is the Ministry of Health that is responsible for funding AHOs through service agreements may help to overcome these problems.
- 2.92. Each AHO should enter into a single service agreement with the Health Secretary – in much the same way as currently occurs for the only networked AHO – and negotiations with those organisations regarding funding and the nature and location of services to be delivered under those agreements should principally occur at Ministry level. Relevant LHDs can, and should, be involved in that process when necessary.
- 2.93. Planning the services to be provided by each AHO, and where those services are to be provided, should form an integral part of the wider service planning process discussed elsewhere in this Report.
- 2.94. On an annual basis, and in conjunction with the planning and identification of the services to be provided by each AHO under their respective service agreements, Schedule 3 to the *Health Services Act* should be reviewed to ensure that it accurately records the recognised services and establishments of each of them and amended to the extent necessary to reflect those services. There is no good reason why it ought not be accurate at all times.
- 2.95. A structured process should be implemented to promptly resolve any dispute between the Ministry of Health and an AHO regarding the extent to which funding offered is sufficient to meet the cost of delivering the level of service required under a proposed service agreement. Whatever process might be adopted, it must be independent, able to be unilaterally triggered by either the AHO or the Ministry of Health in the event of a dispute, and capable of meaningfully regulating the “purchaser/provider” nature of the relationship to be reflected in any subsequent service agreement. Such a process will not, however, interfere with or usurp the Minister’s power to determine the subsidy to be paid to each AHO.

Single Digital Patient Record: Chapter 15

- 2.96. NSW Health has commenced its SDPR project. Evidence suggests that the SDPR will bring many benefits to the health system of the kind discussed in the *Strengthening Medicare Taskforce Report*, and other reports.
- 2.97. Something akin to an SDPR was recommended by Commissioner Garling more than 16 years ago. It is a failure of government that an SDPR has not been implemented in the timeframe recommended in that report (i.e., by 2013).

- 2.98. A serious limitation of the SDPR is that there is no current plan for it to interface with primary care providers including general practitioners. There also does not appear to be a plan for it to extend to the St Vincent's Health Network, or other AHOs.
- 2.99. Access to the SDPR should be made available to primary healthcare providers. One advantage of linking the SDPR to primary healthcare providers, and in particular general practitioners, is that it will enable data to be collected about services provided by general practitioners, including preventive and chronic disease management services. It will enable greater connection and information sharing between those providing primary care services, and those providing acute services to the same patients.
- 2.100. The SDPR should also be accessible to the St Vincent's Health Network and other AHOs. Unless NSW Health rolls out the SDPR to them, it risks a fragmentation of access to important data within the NSW public health system itself; the very thing that it is intended to overcome. That is obviously undesirable, and could pose health risks and lead to inefficiencies. As to the St Vincent's Health Network, it is a networked AHO, and operates a public hospital – the SDPR must be connected to it. This should not wait until after its expected completion in 2029. The cost of making the SDPR accessible to AHOs (in their capacity as part of the NSW public health system) should be borne by NSW Health.

Planning: Chapter 16

- 2.101. A robust health service planning function is critical to the delivery of healthcare in NSW.
- 2.102. The capability of NSW Health to design and implement a feasible and successful system wide approach to health service planning relies on its decision making as to what the public health system is, and the boundaries of “the civil contract ... between taxpayers and the Government about what [public health services] might be received in a particular community”; particularly in the context of a “constrained financial environment”.
- 2.103. The current approach to public health service and workforce planning in NSW is not built upon a comprehensive understanding of population health needs from the bottom up.
- 2.104. The widespread disinvestment in planning resources within NSW Health and dissolution of its service planning branches, as well as underinvestment in retaining planning skill at the LHD level, has fostered a “patchy” approach to service and workforce planning.
- 2.105. The emphasis on workforce availability (rather than population need) as a driver of service planning reflects the deficiencies in the current workforce planning processes, as well as the limited integration of workforce and service planning. In particular, NSW has not “done a very good job of predicting ahead of time how many doctors [it will]

need, [and] how many nurses [it will] need”, nor facilitating collaboration between educational institutions and medical colleges for the delivery of that workforce.

- 2.106. Because LHDs and SHNs have traditionally delivered facility based services, planning processes have had a tendency to be driven by the needs of capital processes, infrastructure and prioritisation of limited capital funds. This “bricks and mortar” approach is problematic. The “real planning need or the needs of [a] community [have] nothing to do with a facility”, and instead demand the provision of services in a community in a different way, for example, through extended general practice or extended scope of practice for nurses or allied health.
- 2.107. The absence of strong systematic planning has fostered the development of services in response to other drivers, such as funding and workforce availability, political considerations, and historical service commitments. This method of growth has been ineffective in promoting patient safety and fiscal responsibility, and has culminated in a public health system that is increasingly being stretched unsustainably in an attempt to deliver as many services, in as many locations, as possible.
- 2.108. There is a clear need to approach system wide health service planning in NSW in a way that better combines the local knowledge and assessment of LHDs and SHNs in relation to population health needs, in genuine collaboration with (and information sharing between) them and other providers of healthcare within their catchments, and overarching system wide coordination delivered through the Ministry of Health. Greater central involvement in planning is essential to identifying the most optimal and equitable distribution of services and (finite) resources across the State.
- 2.109. The Ministry of Health should take on an oversight role for service planning, but this should not extend to dictating to LHDs and SHNs the way in which they are to go about delivering their services. This is a matter for local decision making. However, where the Ministry of Health is required to drive the development and maintenance of services that are necessary to service the population needs of more than one district, the Ministry of Health could drive that service delivery through purchasing and activity targets or specific initiatives.
- 2.110. Publicly available planning documents should spell out the identified health needs of the community, the services that it is anticipated will be required to meet those health needs, and how (and by whom) it is intended that those services will be provided. These documents should also be explicit about what members of the community requiring those services should expect in terms of accessibility (including transportation arrangements, where necessary) and waiting times (the metrics around which will inevitably be informed by appropriate clinical evidence).
- 2.111. **The first step** in the process must be the identification of the health needs of the local community. Unless community needs are identified, there will potentially be large gaps in service provision, including gaps that are invisible to service

planners. The health needs of a community should be the core consideration in place based planning.

- 2.112. The identification of need, for the purpose of service planning, should involve population needs analysis, demand analysis, and analysis of socio-demographic factors, as well as genuine community engagement. In recognising that LHDs are but “a single organisation in a health ecosystem”, it should also involve engagement with other local organisations delivering services, in both the primary care and the acute care sector, to determine both the quantitative and qualitative needs of the community.
- 2.113. The “needs identification” step of the process will inevitably be best informed by a ground up approach, whereby LHDs and SHNs with intimate knowledge of the needs of the populations they serve and the associated health matrix can feed information into the planning process while also using information flowing down from the Ministry of Health, which has a broader understanding of service availability within the State.
- 2.114. **The next step** in developing an approach to service planning is deciding what services should in fact be delivered by the public health system in order to meet the identified need. This involves a broader consideration of what the public health system is and what it can deliver in an economic and safe way. There is a need for NSW Health to consider, first, what services fall within the ambit of the “public health system”, and secondly, how the public health system can operate to offer those in scope services to the people of NSW in an optimal and equitable way. That will require decisions about what services should be provided and where. That must be done in a coordinated way across the system as a whole to ensure the optimal deployment of resources. This must be done as part of an open collaboration with community and other providers of healthcare to that community.
- 2.115. Community engagement around health services planning must be a genuinely consultative process. Telling the community what has been decided after a planning decision has been made is not consultation. Good community consultation requires a high degree of transparency.

Albury Wodonga Health: Chapter 17

- 2.116. As a general matter, it is not optimal practice for any health infrastructure to only be conceived and designed around a particular sum of money that happens to be available. That, instead, is an optimal way of risking the wastage of precious public funds.
- 2.117. The money said to be available for health infrastructure should not drive service delivery. Rather, any infrastructure spend should be based on what the health service needs of the catchment population are and will be, which themselves will be based on a variety of factors such as (but not limited to) population growth, ageing profile, and various socio-economic factors.

- 2.118. There is little evidence to suggest that the proposed redevelopment of the Albury Hospital was based on this kind of analysis. Equally, there is little to suggest that the proposed redevelopment of Albury Hospital has had meaningful regard to the views of the medical and other clinical workforce of Albury Wodonga Health, of management, or of the community. While those views are not determinative of any particular outcome, there must be meaningful engagement with them, that appears to be either absent here, or at best insufficient.

Workforce: Chapter 18

- 2.119. The NSW public health system's most important asset is its workforce.
- 2.120. The health workforce in NSW is comprised of dedicated and highly skilled people, who everyday work to provide high quality care to the people of NSW. There is, though, now a need to take steps to ensure that the public health system will have the benefit of such a workforce long into the future.
- 2.121. The causes of the current workforce challenges facing NSW Health are multifaceted. Some reflect societal changes – such as shifts in how and where people want to work – which will take time to address. Others are what might be described as system issues relating to how NSW Health plans, engages, and deploys its workforce.
- 2.122. Most of the awards and other instruments setting the terms and conditions of employment or engagement for NSW Health workers do not reflect contemporary work practices. They have not been reviewed substantively for many years. Many terms of those awards date back decades. There was general consensus (except in relation to the *Public Health System Nurses' and Midwives' (State) Award*) that NSW Health awards are outdated and no longer fit for purpose. Many awards are overly long, not drafted in plain language, are frequently ambiguous, and replete with inconsistencies and incoherences (both internally and with other awards dealing with similar professions). The number of awards dealing with allied health professionals lacks any rational explanation except for history. There is an urgent need for a broad project of award reform in respect of NSW Health awards. Recent history suggests that, if that does not occur, NSW Health, and the industrial organisations and their members, will likely continue to be engaged in a rolling series of negotiations and disputes. Indeed at the time of writing this Report, and throughout the duration of this Special Commission, negotiations and disputes have been ongoing.
- 2.123. Extant Visiting Medical Officer Determinations have not been updated since 2014 and require modernisation.
- 2.124. There presently exists a disparity in the rate of pay between NSW and other Australian jurisdictions for some of the health workforce. That disparity was cited as being a factor in some of the difficulties experienced in recruiting and retaining a permanent workforce, particularly in some specialties and regions.

- 2.125. Whether pay parity is ultimately to be achieved or not, there can be no genuine controversy that the pay and conditions of health professionals in NSW should be appropriate to the work performed. Health professionals in NSW should be fairly and reasonably compensated for the value of their work to the system. This will require an assessment of the nature of their work, the skill and responsibility involved, and the contribution it makes to the system, including any changes in those qualities since the last “work value” assessment. The contribution a profession makes to the system should be viewed broadly, not as limited to questions of productivity, efficiency, or savings.
- 2.126. There are overall shortages in applicants for some specialist training programs, such as psychiatry and emergency medicine. Modelling indicates “significant” career opportunities in psychiatry, diagnostic radiology, ophthalmology, and rehabilitation medicine, as well as neurosurgery. Those “significant career opportunities” correspond with a relatively high number of additional trainees needed each year to meet projected demand.
- 2.127. A shortfall in applications for internship positions or for vocational training positions – at least in relation to some specialties – will impact the future workforce. It is from those pathways that the future medical workforce (including specialists) develops, an extensive or prolonged shortage in those pipelines has the very real potential to lead to future shortages in that workforce.
- 2.128. There have also been shortages of specialists to fill available positions in psychiatry, emergency medicine, radiology, and anaesthesia, as well as general practice.
- 2.129. Many, but not all, of those shortages are seen in rural and regional NSW. The underlying causes of workforce shortages in rural and regional NSW are multifactorial, but include:
- a. a perception (which may be mistaken) that work in rural and regional areas is less interesting and professionally satisfying while being more onerous (including in relation to on call obligations);
 - b. a perception of a lack of professional and social support in rural and regional areas, especially for those clinicians who trained in metropolitan areas;
 - c. insufficient financial incentives for metropolitan based clinicians to relocate to rural or regional areas; and
 - d. limited employment opportunities for spouses and partners of clinicians, a lack of suitable accommodation, childcare and other services in rural and regional areas.
- 2.130. There are significant shortages of midwives and enrolled nurses across the State, and (as with the medical workforce) a maldistribution of the nursing and midwifery workforce between metropolitan and rural and regional areas.
- 2.131. The shortages in the nursing and midwifery workforce in some rural and regional LHDs correlate with difficulties in attracting students for clinical placements and

applicants for graduate positions, notwithstanding the range of incentives, scholarship, and cadetship programs aimed at increasing the attractiveness of rural and regional work. Those shortages are also reflected with a greater use of agency nurses in those areas.

- 2.132. There is value in data that analyses “aged vacancies” - i.e., vacancies in respect of permanent positions that have been advertised but unfilled for some time. Data of that kind is likely to assist in identifying and quantifying the extent (and duration) of a shortage within the permanent workforce at a facility or across a region. The Ministry of Health should take steps to capture and consider data of that kind as part of an enhanced, system level, service planning process into the future.
- 2.133. Modelling indicates that some allied health disciplines are experiencing significant shortages compared with service demand, including, for example, radiation therapy, sonography, psychology, podiatry, and occupational therapy. Maldistribution of the allied health workforce is also a significant issue in most disciplines. The reasons for those shortfalls and workforce maldistribution in the allied health workforce are complex but include:
- a. competition from the private sector and NDIS providers, which typically pay more and offer more flexibility;
 - b. at least a perception of reduced career development or progression opportunities, particularly in rural and regional areas; and
 - c. insufficient supervisors to supervise complete clinical placements for those under training.
- 2.134. Currently, there is no system wide approach to workforce planning, in the sense that the clinical workforce is not established or structured by reference to a detailed assessment of population needs or the supply of clinicians across the system. The need for a system wide approach to workforce planning and engagement has increased in recent times as the effects of “pressure” on the health budget, and workforce shortages and maldistribution have become more acute.
- 2.135. Difficult choices must be made as to what services are made available, where, and in what form if the system is to be sustainable into the future. The advantage of a system wide perspective in responding to that new environment is that it provides an opportunity to maximise the efficient delivery of health services across the State by ensuring the most effective deployment of its workforce and budget to achieve that aim.
- 2.136. It is essential that the Ministry of Health has a key role in that process, given that it alone has oversight over large amounts of workforce data and the ability to analyse and interpret that data at a system level. It also effectively controls the funding allocated to local organisations to fund their workforce needs.
- 2.137. The current structures have given rise to the untenable situation of parts of the system competing with one another for agency nurses and locums. That results in parts of

- the NSW public health system bidding against each other, which only results in increased cost to it.
- 2.138. The need for a system wide approach to workforce planning does not mean that the benefits of devolution are to be discarded. To the contrary, local perspective and input remain critical to effective planning.
- 2.139. One significant benefit of a centralised workforce planning function that leverages the oversight and expertise within the Ministry of Health is that it will provide NSW Health with the ability to better observe the impact of the actions or policies of external stakeholders and societal changes on NSW Health workforce (including its future workforce pipeline), and to plan and implement a response to them.
- 2.140. There is no central coordinating function in relation to clinical placements, which can lead to competition between universities for those placements.
- 2.141. There is considerable scope to enhance the planning, establishment, and allocation of clinical placements for university students and vocational training positions for registrars, which will likely deliver significant benefits to the system.
- 2.142. As part of a system wide approach to workforce planning, there should be greater strategic coordination and planning related to clinical placements and vocational training. HETI is well placed to take a leading role in that process, and to perform that function going forward.
- 2.143. While HETI administers a central computer based system (ClinConnect) that facilitates the “booking” of students into placements, there is no central coordination of where placements are established or how students are allocated to them. This approach creates some obvious problems, including that:
- a. either universities or local organisations end up competing with each other depending on whether demand for placements exceeds supply in the relevant local area or the reverse;
 - b. the matching of students with placements is largely manual rather than allocated in the nature of, for example, the medical intern program;
 - c. because the matching of supply and demand occurs locally and is largely based on relationships, there may be a supply of students at one university and a demand for students at a local organisation that are never matched with one another because there is no central coordination or visibility;
 - d. there is a duplication of administrative work because of the need for both universities and local organisations to make and administer multiple arrangements with one another, with variable terms; and
 - e. there is no central monitoring or direction as to the number of clinical placements that should be established or where they should be established in order to match demand for placements, or future service requirements.

- 2.144. As a result, NSW Health is not able to obtain the benefit that may flow from a more coordinated approach to the allocation of university placements and recruitment of those being placed into identified areas of need at the time of their likely graduation. A more strategic, whole of system approach to allocating clinical placements that aligns (so far as possible) with projected future demand for clinicians in the relevant field is necessary.
- 2.145. The coordination of clinical placements is a function that is best located within HETI, working in close collaboration with Ministry of Health and the LHDs and SHNs. HETI must be appropriately and adequately resourced to perform that role. In doing so, there should be quarantined funding for those roles (perhaps in the form of clinical educators) within HETI that are the interface between universities, students and local organisations to ensure that local organisations are appropriately supported to deliver high quality and effective student placements over the medium to long term. Such roles must be protected from broad brush “efficiency” programs.
- 2.146. Effective consultation between health system management and clinicians is an integral part of a highly performing health system. The Medical Staff Council (and other councils provided for in the Model By-Laws) provides a mechanism for that to occur and for management to harness the benefits of the collective experience and expertise of its clinicians in matters affecting the delivery of care at their hospitals. If Medical Staff Councils (and the other councils) are to achieve that aim, they must provide an effective means of consultation and engagement at the facility and district or network level.
- 2.147. In order to strengthen those processes, the Council structures set out in the Model By-Laws should be reviewed. The role and purpose of each Council should be clearly identified, and they should be complementary of each other.
- 2.148. Following that review, the Model By-Laws should be amended to clearly articulate the purpose and role of each of the Councils, and how they relate or interact with each other.
- 2.149. Having the Chairs of each Council observe Board meetings can only enhance the discourse between management and clinicians. Where a Board has determined not to extend an invitation to Council Chairs to attend Board meetings, they should implement a procedure whereby the Board shall receive reports from the Chair of each of the Councils within their district or corporation on a regular basis (at least quarterly) as to matters that fall within the remit of their respective Councils.
- 2.150. The complaints and grievance policies would benefit from wholesale review and simplification. NSW Health accepted the benefits in doing so, and some work in this respect is under way.
- 2.151. There are high levels of fatigue, stress and “burnout” across the NSW Health workforce.

- 2.152. While the COVID-19 pandemic undoubtedly contributed to this, that high rates of burnout persist within the system should be seen by all of those with an interest in maintaining a strong and effective health workforce as troubling. It is something that must be addressed in a meaningful way, and as a matter of priority.
- 2.153. Given the extent of burnout and low levels of staff wellbeing across the system, more detailed data on those matters should be routinely collected across the system. That will then provide the basis for targeted initiatives (which may differ in different locations) to support and enhance the wellbeing of the workforce and reduce staff distress, including that which is occasioned by burnout.

Funding: Chapter 19

- 2.154. The question of whether the system as a whole is “underfunded” is complex and cannot be answered solely by reference to demand indicators. It requires consideration of what the NSW public health system should be, including the nature of the services that should be available, where those services should be offered, and the timeframes in which patients can expect to be treated. It is only once that system is identified and designed that the necessary funding levels, and optimal models, can be identified.
- 2.155. The historical origins of the “base” figure for funding in the NSW health system – including the size and shape of the health system that it was at least conceptually supposed to have supported – are unknown by those within the Ministry responsible for the preparation of budget submissions, and those within Treasury currently charged with considering and making recommendations in relation to them. That is not a criticism. However, in circumstances where no one can identify the origin of the base from which the NSW Health budget has been (and is being) set, the base cannot be said to reflect an assessment of the level of funding required to deliver a public health system that meets the current and emerging health needs of the population, or that is required to “promote, protect and maintain” the health of the population.
- 2.156. Matters such as cost growth and forecasted activity growth are considered in the budgetary process. However, those are matters that inform a consideration of what it would cost to operate the public health system to continue for another year in its existing form. They say little (if anything) meaningful about the cost of delivering a public health system that is best placed to meet the health needs of the population.
- 2.157. In order to determine the level of funding required to deliver a public health system that meets the needs of the population, it is first necessary to gain a detailed understanding of: what those needs are, the services that are available (both within NSW Health and from other providers) to meet those needs, and what (if any) additional services are needed. That analysis is best performed as part of the system wide planning process that must now be undertaken.

- 2.158. A budget process that does not enable executives or Board members of an LHD (some of whom had extensive business and accounting experience) to readily understand how the budget has been prepared is a process that demands immediate improvement. LHD Board members are offered modest remuneration for the responsibilities they have. An LHD Board cannot discharge its functions unless given a budget that is capable of being readily understood. They should not have to reengineer it to be able to understand it.
- 2.159. Within some parts of the system, the funding available is (at least currently) insufficient. For example:
- a. the funding available to many of the LHDs and AHOs does not enable them to deliver the services necessary to meet the needs of their populations, and maintain infrastructure;
 - b. LHDs have experienced significant budgetary challenges when opening and operating new facilities in circumstances where the ongoing funding made available to them does not meet the cost of doing so and;
 - c. Justice Health does not presently attract the level of funding it requires to meet the demand for its services, with “patients waiting longer than clinically recommended, across all services waitlists”.
- 2.160. Further, there is under-resourcing or underfunding (including by the Commonwealth Government) in aspects of:
- a. primary care (including general practice services and allied health);
 - b. mental health services;
 - c. community health services;
 - d. aged care;
 - e. dental services;
 - f. paediatric services;
 - g. preventive health services; and
 - h. health services for First Nations people.
- 2.161. Ultimately, the funding model should not be “the tail that wags the dog”. Rather, the funding models that are adopted by the Government to fund the NSW public health system, and by the Ministry of Health to fund the public health organisations (and the system more widely), should be those that best support the delivery of the public health system that the Government (through NSW Health) aspires to provide.
- 2.162. A central problem with the provision of health services in NSW is the funding divide between it and the Commonwealth.

- 2.163. There is a series of “Long Term Reforms” in the *Addendum to the NHRA*. The Commonwealth Government – the polity with the most financial power in Australia’s federated system – has not shown any great inclination to act on these reforms, or to (sufficiently) fund them.
- 2.164. The *Addendum to the NHRA* will not achieve its aims unless the State and the Commonwealth Governments can sit down and agree on a funding envelope so that the states, including NSW, are adequately funded to provide health services when and where they are needed that are aimed at reducing rates of chronic disease (including early intervention) as well as having people “age well”.
- 2.165. Having identified, through a system wide planning process of that kind, the health system that the NSW government (through NSW Health) aspires to deliver to the people of NSW, the Ministry of Health should – with expert guidance – reformulate its approach to funding so as to devise a funding structure that will ensure that the LHDs and SHNs are sufficiently resourced to deliver that system. That will inevitably include blended, bundled, or other funding mechanisms.
- 2.166. Services provided by NSW Ambulance have changed over time. Many health services now provided by NSW Ambulance are aimed at (and achieve the goal of) keeping people out of the hospital system and Emergency Departments if there is an appropriate alternative. Between 25 to 30 per cent of “incidents” addressed by NSW Ambulance now do not result in transport to a hospital.
- 2.167. While NSW Ambulance now routinely adopts this as its approach, its budget still has its origins in its prior role of being “ambulatory first aid.” To that historical budget, growth including from “ad hoc political announcements” has been applied. What has not been done, however, is a comprehensive analysis of the services the modern NSW Ambulance and its staff provide, with funding based on that reality. That should now occur.

Procurement: Chapter 20

- 2.168. Delivering the highest value healthcare for the money expended should be a priority in any procurement process – a concept that is sometimes described as “value based healthcare”. As NSW Health rightly submitted, the concept of “value for money” is broader than “value based healthcare”. Accordingly, it must be remembered in any consideration of NSW Health’s approach to procurement that, in the wider government context, a range of criteria beyond monetary value must be incorporated into procurement plans and tender evaluation processes.
- 2.169. The concept of “value” in healthcare should involve a consideration of value not just to an individual patient and those with a direct stake in their care, but to other stakeholders in the system including clinicians and the broader community.

- 2.170. The principal object of centralised procurement should be to ensure that NSW Health achieves the best value for money spent. Only through careful modelling will it be possible for HealthShare to determine which arrangement will deliver greatest value to the entire system. If that arrangement results in rural and remote LHDs paying more for a particular item, or incurring significant freight costs in having goods delivered from a centralised warehouse, it may be that equity can only be achieved through adjustments to the funding provided to those LHDs, rather than seeking to equalise pricing through procurement in a manner that risks system wide value.
- 2.171. Complexity is inevitable in a system of the size and scope of NSW Health, particularly when that occurs within a government context that introduces a range of legislative and NSW Government requirements. NSW Health has ongoing procurement reforms. There are undoubted benefits in NSW Health continuing to:
- a. consolidate its procurement policies, processes and systems where practicable;
 - b. provide clear, practical guidance to staff at all levels of the system (and not just procurement staff) to the steps they need to take to procure different kinds of goods and services; and
 - c. ensure that assistance is readily available if staff experience difficulties.

Innovation: Chapter 21

- 2.172. While a more robust approach to what might be considered to be significant and “game changing” innovations is both necessary and appropriate, there is also a need to adopt a similarly thorough approach to the identification, assessment, prioritisation, and implementation of innovations that target the current burden of disease and public health issues and trends that are prevalent within the community.
- 2.173. There is a risk that ground breaking innovations that, by their nature, will benefit a smaller patient cohort may receive disproportionate attention and support compared to those with the potential to enhance health outcomes for more of the population, thereby yielding greater overall economic benefits and improving the health of many more people. That is not to say that innovations that are likely to benefit smaller patient cohorts are not important and should not be pursued.
- 2.174. There are limitations in current funding models and approaches that impact on efforts to drive and implement innovations across the system. For example, it has been suggested that activity based funding (ABF) can limit the capacity for local innovation that may produce wider system benefits if pursued. There may also be concerns that adopting a new model will have a negative financial impact in an ABF context because it will result in reduced activity and, therefore, will generate lesser reimbursement.

- 2.175. Those limitations in current funding models sit in a context where, unlike some other jurisdictions, NSW does not have an “innovation fund” (or something similar) that is capable of being drawn upon to support innovation across the system. Innovation and research are, in general terms, insufficiently supported. An example of such a fund is the \$2 billion fund that was established in 2020 by the Victorian Government to stimulate industry investment in life sciences.
- 2.176. Unless enough resources are committed to embed implementation of innovation into the system, it is unlikely the benefits will be sustained. That is because change in clinician behaviour and for the relevant processes to be integrated and become business as usual takes time. As a consequence, the ACI takes a cautious approach to the number of initiatives it rolls out Statewide at any one time. That can result in some promising programs not being scaled for wider application due to the time that it will take to implement them, particularly in circumstances where a LHD does not see a particular innovation as a priority for their population.



Chapter 3:

Schedule of Recommendations

Chapter 10: The health of the population and the need for prevention

- 3.1. **Recommendation 1:** Preventive health should be made, and remain over the long term, a standing whole of NSW Government priority.
- 3.2. **Recommendation 2:** The criteria against which all new NSW Government initiatives (including new policy proposals) are to be assessed should include a consideration of how that initiative will support the promotion and maintenance of the health and wellbeing of the population.
- 3.3. **Recommendation 3:** All decisions made in relation to whether a new initiative or policy proposal is to be implemented should be informed by advice from a multiagency, multidisciplinary body led by NSW Health under the oversight of the Chief Health Officer, as to their potential impact on the health and wellbeing of the population, with a view to maximising the long term health benefits achieved through such decisions and insulating them, to the best extent possible, from the vagaries of the political cycle.
- 3.4. These measures should be implemented within 12 months of the date of this Report.

Chapter 11: Primary care and aged care

- 3.5. **Recommendation 4:** In communities where there is an absence of effective and accessible primary care, NSW Health should, via the relevant LHD (and as an integral part of its service planning exercise), assess the nature and extent of the unmet primary care need and collaborate with other stakeholders to deliver adequate primary care. In many cases, this will require NSW Health to deliver that care or support its delivery. Access to Commonwealth funding streams for the delivery of this care should clearly be pursued by the NSW Government, but the delivery of primary care in communities where it is lacking and determined by health planners to be a priority should not await the outcome of those intergovernmental discussions.
- 3.6. **Recommendation 5:** Where an inability to access appropriate aged care is having a direct and adverse impact on the delivery of acute care through public hospitals, NSW Health should, via the relevant LHD, and in consultation with the community and other stakeholders, conduct an assessment of the unmet aged care needs in the relevant community and coordinate with other stakeholders to support or deliver the required aged care services. Commonwealth funding streams for the delivery of this care should be pursued by the NSW Government, but the provision of aged care to the extent required to relieve the existing and unsustainable burden on public hospitals should not await the outcome of those intergovernmental discussions.

- 3.7. **Recommendation 6:** As part of the system wide planning process which is the subject of Recommendations 21-26, NSW Health should facilitate more regional training opportunities for primary care clinicians, and provide the training and support required for those contributing to the delivery of primary care to harness their full range of skills, including by working to the top of their scope of practice wherever clinically appropriate.

Chapter 12: First Nations healthcare

- 3.8. **Recommendation 7:** The planning of services for First Nations people must be a collaborative effort and involve all relevant stakeholders; with a particular focus on identifying and addressing service need and gaps, reducing duplication across providers to ensure an efficient deployment of available resources, ensuring the delivery of culturally safe care, and prioritising continuity of care. This must involve ongoing joint clinical service planning between NSW Health and ACCHOs/AMSs.
- 3.9. **Recommendation 8:** Wherever possible:
- a. yearly and other short term funding cycles for programs to be delivered by ACCHOs and AMS (particularly in relation to core, ongoing services) should be avoided;
 - b. arrangements to pool resources for First Nations healthcare from the Commonwealth and the State that would support the efficient delivery of care to First Nations communities should be prioritised; and
 - c. ACCHOs and AMS should be given flexibility, within the construct of the joint clinical service planning process, to use funding allocated to them to design and deliver the services required to meet the needs of the communities they serve.
- 3.10. **Recommendation 9:** Reporting requirements that attach to funding allocated to ACCHOs and AMS must be rationalised and simplified.
- 3.11. **Recommendation 10:** There should be greater collaboration and coordination with First Nations organisations across the State with a view to building a strong First Nations health workforce, and to optimise training pathways and workplace opportunities including in roles that are shared between, for example, ACCHOs or AMS and NSW Health agencies or facilities.

Chapter 13: Statewide Services

- 3.12. **Recommendation 11:** The functional governance and accountability structures, service planning function, and funding responsibility for all Statewide Services (i.e., highly complex, low volume, services delivered across the State, whether designated supra-LHD services or not) should sit within the Ministry of Health.

- 3.13. **Recommendation 12:** The system wide service planning process which is the subject of Recommendations 21-26 should incorporate a Statewide plan for paediatric services that articulates the roles of the Sydney Children's Hospital Network, John Hunter Children's Hospital and the paediatric services delivered within LHDs. That plan should clearly identify the role of those specialist tertiary and quaternary centres in providing care and supporting the paediatric care that can and should be delivered in LHDs, or the primary care setting, and articulate care pathways for the movement of patients between those settings.
- 3.14. **Recommendation 13:** Justice Health (supported, as appropriate by other NSW Health agencies) should set the minimum nutritional requirements for the custodial population, that must be followed by those responsible for the operation of custodial facilities across the State. To the extent that Justice Health requires additional funding to perform that function, it should be provided. Any necessary amendment to s 236A of the *Crimes (Administration of Sentences Act) 1999* (NSW) – or any other legislative provision – to give effect to this recommendation should be made within 6 months of the date of this Report.
- 3.15. **Recommendation 14:** There should be an independent review undertaken by an appropriately qualified person of:
- a. the current arrangements for access to psychological care in custodial settings; and
 - b. the role of Justice Health in the delivery of care to forensic mental health patients through facilities across the State with a view to facilitating patient flow through that system,

Chapter 14: Affiliated Health Organisations

- 3.16. **Recommendation 15:** Each AHO should enter into a single service agreement with the Health Secretary – in much the same way as is currently contemplated for networked AHOs – and negotiations with those organisations regarding funding and the nature and location of services to be delivered under those agreements should principally occur at Ministry of Health level.
- 3.17. **Recommendation 16:** On an annual basis, and in conjunction with the planning and identification of the services to be provided by each AHO under their respective service agreements, Schedule 3 to the *Health Services Act* should be reviewed to ensure that it accurately records the recognised services and establishments contemplated by those service agreements and amended to the extent necessary to reflect those services.

- 3.18. **Recommendation 17:** A structured process should be implemented to promptly resolve any dispute between the Health Secretary (in her capacity as the counterparty to their respective service agreements) and an AHO regarding the extent to which funding offered is sufficient to meet the cost of delivering the level of service required under a proposed service agreement. Whatever process might be adopted, it must be independent, able to be unilaterally triggered by either the AHO or the Ministry of Health in the event of a dispute, and capable of meaningfully regulating the “purchaser / provider” nature of the relationship to be reflected in any subsequent service agreement. The outcome of that process cannot bind either the AHO or the Minister to enter into a service agreement on any particular terms.

Chapter 15: Single Digital Patient Record

- 3.19. **Recommendation 18:** The SDPR project should immediately be expanded to include facilities and services delivered by AHOs as part of the public health system and each AHO should be adequately funded by NSW Health to implement the SDPR within its operations.
- 3.20. **Recommendation 19:** NSW Health should collaborate with the Commonwealth Government and relevant technology platform providers to facilitate the expansion of the SDPR project to ensure that relevant electronic records generated in public hospitals are accessible to General Practitioners, specialists, allied health professionals, and community health clinicians delivering care outside the NSW public health system and, wherever possible, records created by such clinicians are able to be viewed by those providing care as part of the NSW public health system.
- 3.21. **Recommendation 20:** The NSW Government and NSW Health should urgently initiate discussions with the Commonwealth and their interstate counterparts (if they have not yet done so) with a view to achieving data uniformity and sharing across all public health systems in Australia.

Chapter 16: The planning and delivery of health services in NSW

- 3.22. **Recommendation 21:** NSW Health must implement a transparent, committed, and collaborative approach to system wide service planning that is coordinated and overseen by the Ministry of Health.
- 3.23. **Recommendation 22:** That system wide service planning process must involve at least:
- a. a substantive and detailed identification of
 - i. the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of healthcare within the relevant place;

- ii. those other entities, including other LHDs and providers outside of the NSW public health system, that are already (or are capable of) delivering services to meet the identified needs;
 - iii. any service gaps, or other areas of need within the community that are not currently being met by available services;
 - iv. which of those gaps the public health system *should* fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of healthcare within the relevant place;
 - b. a system wide approach, coordinated within the Ministry of Health, to determining what services are to be provided through the NSW public health system to ensure that the identified health needs of the relevant population are met in an accessible but sustainable way, recognising that not all services can or should be provided everywhere;
 - c. ongoing and genuine collaboration with the community and other providers of health services to:
 - i. determine how emerging service gaps, and areas of need, are to be addressed
 - ii. identify all available funding streams, for example through collaborative commissioning models and the like;
 - iii. generate an evolving strategy which is forward looking and covers short, medium and long term planning horizons; and
 - iv. incorporate a genuinely collaborative and transparent processes of monitoring, to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.
- 3.24. **Recommendation 23:** Capital planning (i.e., planning for new facilities or significant upgrades to existing facilities) must be an integral part of that system wide service planning process and be aligned to its objectives. Decisions to construct new, or make significant upgrades to existing, facilities must reflect an assessment of the health needs of the population, and the most efficient and effective way of meeting them.
- 3.25. **Recommendation 24:** System wide, coordinated planning of that kind needs to be accompanied by a transparent articulation of the planning process, the health needs of the community identified through that process, the way in which those health needs are to be met and, to the extent that they are not, this also needs to be clearly articulated and an explanation provided of the rationale for this decision. It is essential that the extent to which those objectives are being achieved is reported upon in a frank and transparent way, supported by expanded reporting by the Bureau of Health Information.

- 3.26. **Recommendation 25:** The current suite of key performance indicators in Service Agreements and statements of service should be reviewed with a view to reducing the total number and improving the balance between the five types of indicators – input, output, outcome, lead and lag indicators. They should also be adapted to more meaningfully assess the extent to which each individual LHD or SHN is achieving the outcomes of its service planning and fulfilling its core function – including to protect, promote and maintain the health of the population. The development of such key performance indicators for each LHD and SHN should form part of the system-wide service planning exercise, and be tailored to the particular outcomes that are to be achieved by each of them.

Chapter 14: The health workforce

- 3.27. **Recommendation 26:** As part of the system wide approach to service planning, NSW Health should:
- a. establish a central workforce planning function, located within the Ministry of Health, which collaborates regularly and systematically with local organisations to direct the clinical workforce establishment across the NSW health system with the objective of guiding the deployment of the human resources available within the system in a way that best meets the needs of the NSW population as a whole; and
 - b. once that function is established, prioritise a thorough, evidence based, review of specific initiatives that should be implemented to help address current workforce shortages and maldistributions.
- 3.28. **Recommendation 27:** The Health Education and Training Institute’s role should be expanded, with appropriate funding, to include:
- a. coordinating the allocation of students to clinical placements within NSW Health facilities and services in collaboration with universities and relevant NSW Health agencies;
 - b. devising and overseeing a graduate recruitment program that capitalises on the clinical placements offered within the public health system and facilitates the early recruitment of those who have held such placements immediately upon graduation and into areas of need; and
 - c. establishing and delivering specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations, with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need, and focussing upon maximising opportunities for training and recruitment in rural and regional locations.

- 3.29. **Recommendation 28:** There should be an award reform process conducted by the Industrial Relations Commission of New South Wales incorporating at least the following features:
- a. a legislated set of objectives to be achieved by the process, which include:
 - i. simplifying and, where appropriate, consolidating the current range of awards, determinations and other instruments setting terms and conditions of employment or engagement for NSW Health workers, to provide a consistent and coherent framework of terms and conditions that is easy to understand and apply; and
 - ii. updating instruments so that they reflect the current and expected future service delivery and workforce needs of the NSW health system and current and expected future working conditions; and
 - iii. providing fair and reasonable terms and conditions of employment or engagement for workers across the NSW health system, including having regard to the value of their work to system, the impact of those terms and conditions on attraction and retention, and their fiscal and economic impacts;
 - b. a reasonable but expeditious timeframe in which the process is to be completed; and
 - c. an extension of the process to Visiting Medical Officers and the Visiting Medical Officer Determinations.
- 3.30. **Recommendation 29:** To the extent that legislative amendment is necessary for the Industrial Relations Commission of New South Wales to be able to complete the award modernisation process contemplated by Recommendation 28 other than in the context of an industrial dispute (and unconstrained any prior construction given to s 19 of the *Industrial Relations Act*), that amendment should be made urgently.
- 3.31. **Recommendation 30:** The Model By-Laws made under ss 39 and 60 of the *Health Services Act* should be reviewed and amended with a view to clearly identifying the role and functions each Council and committee established by them and ensuring that they:
- a. provide an effective and robust forum for consultation and feedback between clinicians and management; and
 - b. are complementary of each other.

- 3.32. **Recommendation 31:** Steps should be taken to enhance collaboration between boards, executive management and clinicians, in addition to the review and amendment of the Model By-Laws. Such steps should include:
- a. each Board extending invitations to the Chairs of all councils to attend Board meetings;
 - b. if the circumstances and needs of the organisation are such that doing so would be inappropriate, inefficient or would not otherwise enhance consultation between the Board, management and clinicians, a Board need not extend those invitations, however, the reasons why that decision has been made should be recorded in the minutes; and
 - c. where a Board has determined not to extend an invitation to Council Chairs to attend Board meetings, they should implement a procedure whereby the Board shall receive reports from the Chair of each of the Councils within their district or corporation on a regular basis (at least quarterly) as to matters that fall within the remit of their respective Councils.
- 3.33. **Recommendation 32:** The Ministry of Health should review its processes for dealing with workplace complaints and grievances, including:
- a. simplifying and, where appropriate, consolidating its policy directives and guidelines relating to complaints, grievances, incidents, and workplace behaviour;
 - b. establishing a central contact within the Ministry of Health for local organisations to seek advice about conducting those processes;
 - c. establishing a process for monitoring the time taken by local organisations to conduct those processes; and
 - d. establishing a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.
- 3.34. **Recommendation 33:** There should be a routine collection and collation of a granular data set directed to the wellbeing of the workforce (like that which has been collected by the Chief Wellness Officer in the Sydney LHD) with a view to supporting and improving the wellbeing of the workforce within local organisations and across the system more generally.

Chapter 19: Funding

- 3.35. **Recommendation 34:** Once the public health system to be delivered by the State is identified through the system wide service planning process that I recommend, Treasury and the Ministry of Health should – with expert guidance – reformulate the funding model and devise appropriate funding structures to deliver that system. That process should consider the implementation of blended, bundled or other funding mechanisms to support the effective delivery of that system, and must not assume that any historical “base” figure provides a reliable or appropriate starting point.

Chapter 20: Procurement

- 3.36. **Recommendation 35:** NSW Health should develop and implement a systematic approach to embedding value based healthcare in its procurement processes, including developing and implementing clear and specific processes for:
- a. determining the components of value that are to be pursued in a particular procurement process;
 - b. evaluating different options for procurement, including tenders, against each of those components of value;
 - c. formalising and clarifying the role of CEC and the ACI in the procurement function, including by identifying the circumstances when and how those agencies should be involved in procurement activities;
 - d. consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts, in procurement processes.
- 3.37. **Recommendation 36:** NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers at a system wide level, including developing and implementing clear and specific processes for:
- a. formulating clear and measurable KPIs, including with reference to value based criteria applied in the procurement process;
 - b. monitoring those KPIs, including designating clear lines of responsibility for performing that monitoring; and
 - c. obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.

Chapter 21: Innovation

- 3.38. **Recommendation 37:** As part of a system wide approach to service planning and design, the Division of Clinical Innovation and Research must play a clearer role in coordinating the identification and development of innovations, facilitating their implementation Statewide, and continuing to support them until they are embedded. To do this effectively, the Division of Clinical Innovation and Research should clearly identify research priorities, including necessary translational research, which is critical to “demonstrate feasibility and the ability for these things of proven efficacy to be implemented in practice in ways that deliver better outcomes and don't lead to cost blowouts.”

- 3.39. **Recommendation 38:** In setting research priorities, the Division of Clinical Innovation and Research should ensure that:
- a. Funding of research should be driven by community needs and priorities;
 - b. Investment in innovation and research that aligns with capacity to improve health outcomes and include innovations that support prevention and/or are likely to have system management benefits;
 - c. Support for translational research is enhanced, to enable the system to harness the benefits of innovations and prioritise those for wider implementation
 - d. Investment in innovation should be evidence based with controlled introduction and ongoing monitoring to prevent indication creep or indiscriminate use, and to ensure costs are properly reflected and anticipated savings are realised.
- 3.40. **Recommendation 39:** There must be strong leadership (at the Ministry of Health and executive management levels) that empowers clinical and non-clinical staff to reduce unwarranted clinical practice variation, withhold low value care, and prevent over investigation, over diagnosis, and over treatment.

Chapter 22: Conclusion

- 3.41. **Recommendation 40:** NSW Health must be funded adequately to implement, embed, and sustain into the future the recommendations made in this Report. That funding should be ongoing, in addition to NSW Health's existing budget allocation, and quarantined for those purposes.
- 3.42. **Recommendation 41:** The Health Secretary should provide a report to the Minister as to the progress in implementing these recommendations at six monthly intervals following the delivery of this Report.



Chapter 4:

Glossary

Term	Abbreviation
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACCHO/ACCHS	Aboriginal Community Controlled Health Organisation/Services
ACEM	Australasian College for Emergency Medicine
ACI	Agency for Clinical Innovation
ACD	Australasian College of Dermatologists
ACRRM	Australian College of Rural and Remote Medicine
AHO	Affiliated Health Organisation
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMA NSW	Australian Medical Association (NSW) Limited
AMS	Aboriginal Medical Service
ANZCA	Australian and New Zealand College of Anaesthetists
ASA	Australian Society of Anaesthetists
ASMOF	Australian Salaried Medical Officers' Federation
BHI	Bureau of Health Information
CALD	Culturally and Linguistically Diverse
CCLHD	Central Coast Local Health District
CE/CEO	Chief Executive/Chief Executive Officer
CEC	Clinical Excellence Commission
CICM	College of Intensive Care Medicine of Australia and New Zealand
COAG	Council of Australian Governments
Future Health Report	NSW Health, <i>Future Health: Guiding the next decade of care in NSW 2022–2032</i> (Report, May 2022)
FTE	Full Time Equivalent

Term	Abbreviation
FWLHD	Far West Local Health District
GDP	Gross Domestic Product
GP	General practitioner
GST	Goods and Services Tax
HAC	Health Administration Corporation
Health Secretary	Secretary of NSW Health, with the functions set out at s 122 of the <i>Health Services Act 1997</i>
HETI	Health Education and Training Institute
HNELHD	Hunter New England Local Health District
HSA NSW	Health Services Association of New South Wales
HSU	Health Services Union
ICU	Intensive Care Unit
IHACPA	Independent Health and Aged Care Pricing Authority
ISHLHD	Illawarra Shoalhaven Local Health District
Justice Health	Justice Health and Forensic Mental Health Network
KPIs	Key Performance Indicators
LHD	Local Health District
MBS	Medicare Benefits Schedule
MDANZ	Medical Deans Australia and New Zealand
MLHD	Murrumbidgee Local Health District
MNCLHD	Mid North Coast Local Health District
Ministry of Health	NSW Ministry of Health listed in Part 1 of Schedule 1 of the <i>Government Sector Employment Act 2013</i>
MMM	Modified Monash Model
MPRA	Murdi Paaki Regional Assembly

Term	Abbreviation
MPS	Multi Purpose Service
NBMLHD	Nepean Blue Mountains Local Health District
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NEC	National Efficient Cost
NEP	National Efficient Price
NGO	Non-Government Organisation
NHA	National Healthcare Agreement
NHRA	National Health Reform Agreement
NNSWLHD	Northern NSW Local Health District
NSLHD	Northern Sydney Local Health District
NPP	New Policy Proposal(s)
NSW	New South Wales
NSWNMA	NSW Nurses and Midwives' Association
NUM/NM	Nurse Unit Manager / Nurse Manager
NWAU	National Weighted Activity Unit
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PPP	Public Private Partnership
PREMs	Patient-Reported Experience Measures
PRMs	Patient-Reported Measures
PROMs	Patient-Reported Outcome Measures
RACGP	Royal Australian College of General Practitioners

Term	Abbreviation
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCPA	Royal College of Pathologists of Australasia
RDANSW	Rural Doctors' Association NSW
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
SCH	Sydney Children's Hospital
SCHN	Sydney Children's Hospitals Network
SDPR	Single Digital Patient Record
SESLHD	South Eastern Sydney Local Health District
SHN	Specialty Health Network
SLHD	Sydney Local Health District
SNSWLHD	Southern NSW Local Health District
SVHA	St Vincent's Health Australia
SVHN	St Vincent's Health Network
TOR(s)	Term of Reference/Terms of Reference
WHO	World Health Organization
WNSWLHD	Western NSW Local Health District
WSLHD	Western Sydney Local Health District



Chapter 5:

Dramatis personae

Name	Role ¹⁷⁷
Agar, Associate Professor Ashish	Ophthalmologist with subspeciality in glaucoma, South Eastern Sydney Local Health District Conjoint Associate Professor, School of Clinical Medicine, University of NSW
Alexander, Dr Shirley	Staff Specialist and Head of the Department of the Children’s Hospital Institute of Sports Medicine and Weight Management, Sydney Children’s Hospitals Network
Anderson, Professor Debra	Dean, Faculty of Health, University of Technology Sydney
Angelico, Daniel	Chief Executive Officer, College of Intensive Care Medicine of Australia and New Zealand
Arnold, Professor Mark	Chief Medical Officer, Western NSW Local Health District
Astill, Brad	Chief Executive, Far West Local Health District (Now Chief Executive, Nepean Blue Mountains Local Health District)
Awad, Dr Ramsey	Executive Director, Infrastructure, Planning and Sustainability, Hunter New England Local Health District
Ayers, Dr Serena	Network Director of Medical Services, Inland Network, Southern NSW Local Health District
Baird, Professor Kathleen	Head, School of Nursing and Midwifery, University of Technology Sydney
Bedford, Professor David	Professor, Business School, Accounting Discipline, University of Technology Sydney
Begbie, Dr Stephen	Executive Clinical Director, Hastings Macleay Clinical Network Medical Oncologist and General Physician

¹⁷⁷ As at the time the individual gave evidence or provided a statement to this Special Commission.

Name	Role ¹⁷⁷
Belleair, LaVerne	Chief Executive Officer, Aboriginal Medical Service Cooperative Limited, Redfern
Bennett OAM, Margaret	Chief Executive, Southern NSW Local Health District
Binge, Chris	Chief Executive Officer, Rekindling the Spirit Health Service
Blake, Christopher	Group Chief Executive Officer, St Vincent's Health Australia
Bolevich, Dr Zoran	Chief Executive of eHealth NSW; Chief Information Officer, NSW Health (Now Chief Executive Officer, Australian Institute of Health and Welfare)
Bonning, Dr Michael	General Practitioner Former President, Australian Medical Association NSW
Bottrell, Jenna	Area Manager, Western and Far West NSW, Mission Australia
Braithwaite, Professor Jeffrey	Director of Centre for Healthcare Resilience and Implementation Science Founding Director of the Australian Institute of Health Innovation Professor of Health Systems Research, Macquarie University
Branley, Adjunct Associate Professor James	Local Pathology Director, Nepean Hospital NSW Health Pathology Lead Clinician, Nepean Laboratory
Browne, Dr Stuart	Clinical Director, NSW Brain Injury Rehabilitation Program
Bruce, Professor Lenert	General Manager of Wagga Wagga Base Hospital Executive Director Medical Services, Murrumbidgee Local Health District

Name	Role¹⁷⁷
Buist, Prudence	Chief Executive Officer, South Eastern NSW Primary Health Network (Coordinare)
Burling, Mark	Chief Executive Officer, Wellington Aboriginal Corporation Health Service
Burnand, Dr Josephine	Acting Medical Director, Health Education and Training Institute
Callander, Professor Emily	Head of Discipline, Health Services Management University of Technology Sydney
Callinan, Megan	Chief Executive Officer, Marathon Health
Candish, Shaye	General Secretary, New South Wales Nurses and Midwives' Association
Carey, Josh	Executive Director of Service Delivery, Western NSW Local Health District
Carley, Cassandra	Aboriginal Mental Health Clinician, National Centre of Indigenous Excellence
Carr, Steven	Executive Director, System Financial Performance Deputy Chief Financial Officer, NSW Health
Carter, Peter	Board Chair, Northern NSW Local Health District
Cawthorne, Joann	Deputy Director of Nursing and Midwifery, Southern NSW Local Health District
Chan, Professor Steevie	District Director Medical Services, Central Coast Local Health District
Chant AO PSM, Dr Kerry	Chief Health Officer and Deputy Secretary, Population and Public Health, Ministry of Health

Name	Role ¹⁷⁷
Cheung, Clinical Associate Professor Winston	Senior Staff Specialist, Intensive Care Unit, Concord General Repatriation Hospital Chair of the Concord Hospital Medical Staff Council Clinical Associate Professor, Sydney Medical School, University of Sydney
Chiumento, Jodi	Director of Procurement, Illawarra Shoalhaven Local Health District
Christmas, Dr Rachel	General Practitioner President of Rural Doctors Association NSW
Chua, Dr Ai-Vee	General Practitioner, Dubbo
Clancy, Mitchell	District Procurement Manager, South Western Sydney Local Health District
Clarke, Dr Andrew	Visiting Medical Officer and Acting Clinical Lead, Emergency Department, Cooma Hospital and Health Service
Clements, Vanessa	Director, Planning, Redevelopment and Project Management Office, Nepean Blue Mountains Local Health District
Clota, Dr Stephanie	Chief Executive Officer, Royal Australasian College of Surgeons
Clout PSM, Terry	Deputy Board Chair, Southern NSW Local Health District
Cobb, Allan	Chair, Lightning Ridge Community Working Party
Cohen, Associate Professor Martin	Board Chair, Hunter New England Local Health District
Colagiuri AO, Professor Stephen	Professor of Metabolic Health and Director of The Boden Institute, University of Sydney
Collins, Melissa	Acting Executive Director, Workplace Relations, NSW Health

Name	Role¹⁷⁷
Collins AM KC, The Honourable Peter	Board Chair, Nepean Blue Mountains Local Health District
Condon, Dr Stewart	Director, Medical Services, Concord Hospital, Sydney Local Health District
Constable, Jude	Acting Chief Executive, Central Coast Local Health District
Cornelius, Julian	Director, Health Team, Policy and Budget Group, NSW Treasury
Cornwell McKean, Dr Julia	Mayor, Berrigan Shire Council
Cox PSM, Cathryn	Chief Executive, Sydney Children's Hospitals Network
Craven, Paul	Executive Director, Children and Young People and Families, Medical Services and of Networks and Streams, Hunter New England Local Health District
Cross PSM, Jacqui	Chief Nursing and Midwifery Officer, NSW Health
Crothers, Annette	Chair, Marathon Health
D'Amato, Adjunct Professor Alfa	Deputy Secretary, Financial Services and Asset Management, Ministry of Health
Dale, Paul	Director, Policy, Medical Technology Association of Australia
Daly, Matthew	Deputy Secretary, System Sustainability and Performance, Ministry of Health
Danos AM, Trevor	Board Chair, Northern Sydney Local Health District
Davies, Dr Robert	Director of Emergency Medicine, Tweed Valley Hospital, Northern NSW Local Health District
Dewhurst, Emma-Kate	Director, Occupational Therapy, Illawarra Shoalhaven Local Health District

Name	Role ¹⁷⁷
Dickinson, Michael	Chief Information Officer and Director of Digital Health, South Western Sydney Local Health District
Dixon, Elizabeth	Board Member, Murrumbidgee Local Health District Board Chair, Health Care and Quality Subcommittee
Dominish OAM, Jacqueline	Health Professional Workforce, NSW Health
Donoghue PSM, Tony	General Manager, Coolamon Shire Council
Ducat, Jacinta	Chief Information Officer, Southern NSW Local Health District
Duckett AM, Professor Stephen	Chair of Health Performance Council, South Australia Deputy Chancellor, Royal Melbourne Institute of Technology
Duroux, Kevin	Deputy Chief Executive Officer, Tamworth Aboriginal Medical Services, Aboriginal Corporation
Eagar AM, Adjunct Professor Kathy	Adjunct Professor, School of Clinical Medicine, Faculty of Medicine and Health, University of NSW
Edwards, Benjamin	Chief Operating Officer, St John of God Health Care
Edwards, Dian	Manager, Namatjira Haven Drug and Alcohol Healing Centre
Egan, Darryn	Team Leader, Penrith Community Mental Health Team, Nepean Blue Mountains Local Health District
Egan, Dominique	Director of Workplace Relations and Legal Counsel, Australian Medical Association NSW
Ewer, Karina	Chief Executive Officer, Berrigan Shire Council
Falzon, Kristine	Chief Executive Leadership Team, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)

Name	Role¹⁷⁷
Field, Emma	Director, Integrated Care and Allied Health, Murrumbidgee Local Health District
Fielding, Associate Professor Kerin	President, Royal Australasian College of Surgeons
Files, Justin	Board Member, and Co-Chair of Aboriginal Health and Workforce Committee, Far West Local Health District
Findley, Duane	Chief Executive Officer, Royal Australian and New Zealand College of Radiologists
Fontana, Professor Luigi	Scientific Director, Charles Perkins Centre, School of Life and Environmental Sciences, University of Sydney
Francis, Derek	General Manager, Bogan Shire Council
Gendy, Michael	Chief Procurement Officer, NSW Health
Gill AM, Professor Anthony	Head of Department of Anatomical Pathology, Royal North Shore Hospital
Ging, Dr Joanne	Executive Director Clinical Operations, Sydney Children's Hospitals Network
Gordon, Grace	Independent Chairperson, Murdi Paaki Regional Assembly
Gordon, Jennifer	Project Manager, South East NSW Regional Training Hub, School of Medicine and Psychology Rural Clinical School, Australian National University Board Member, Southern NSW Local Health District
Gow, Andrew	Director of Strategy and Performance, South Eastern NSW Primary Health Network (Coodinaire)
Green, David	Director of People and Culture, Far West Local Health District
Gregory, Lee	Chief Executive, Nepean Blue Mountains Local Health District

Name	Role¹⁷⁷
Griffiths, Richard	Executive Director, Workforce Planning and Talent Development, NSW Health
Grotowski, Dr Miriam	Clinical Dean, Peel Clinical School, Department of Rural Health, University of Newcastle; General Practitioner, Tamworth
Habashy, Dr Nardeen	Advanced Trainee, Endocrinology, Nepean Hospital, Nepean Blue Mountains Local Health District
Haines, Paul	Registered Nurse and Paramedic Member of NSW Nurses and Midwives' Association
Hall AO, Distinguished Professor Jane	Centre for Health Economics Research and Evaluation, University of Technology, Sydney
Hallahan, Dr Andrew	Executive Director, Medical Services, Clinical Governance and Risk, Sydney Local Health District
Halse, Dr Dustin	Division Secretary (Strategy, Research and Projects), Health Services Union NSW/ACT/QLD
Haq, Professor Inam	Executive General Manager Education, Learning and Assessment, Royal Australasian College of Physicians
Harfield, Dr Michael	Director of Medical Services, Mudgee Hospital Acting Rural Health Director Medical Services (Mudgee, Cowra, Parkes and Forbes Hospitals), Western NSW Local Health District
Harris MP, The Honourable David	Minister for Medical Research
Harris, Dr Justine	Chief Medical Workforce Advisor, NSW Health
Hawkins, Rachael	Aged Care Nurse Unit Manager, Wollongong, Illawarra Shoalhaven Local Health District
Hawthorn, Maryanne	Executive Director Strategic Reform, Planning and Partnerships, Western NSW Local Health District

Name	Role¹⁷⁷
Hayes AM, Gerard	State Secretary, Health Services Union (NSW)
Haywood, Associate Professor Philip	Health Systems and Financing, Menzies Centre for Health Policy and Economics, University of Sydney
Hislop, Dr Robert	Intensive Care Specialist, General Physician, Port Macquarie Base Hospital Chair of the Medical Staff Council, Port Macquarie Base Hospital, Mid North Coast Local Health District
Hockey, Professor Peter	Executive Director for Quality and Safety, Western Sydney Local Health District
Hodge, Dr Bruce	Director of Surgery, Port Macquarie Base Hospital, Mid North Coast Local Health District
Hoey PSM, Wendy	Chief Executive, Justice Health and Forensic Mental Health Network
Hoffman, Dr Rebekah	Chair, NSW and ACT Faculty Council, Royal Australian College of General Practitioners
Holland, Andrew	Executive Director, Australian Salaried Medical Officers' Federation of NSW
Hoskins, Elizabeth	Board Chair, Southern NSW Local Health District
Howard, Professor Kirsten	Co-Director, Menzies Centre for Health Policy and Economics, University of Sydney
Howson, Nicholas	Registered Nurse, Member of NSW Nurses and Midwives' Association
Hua, Dr Martin	Acting Rural Health Director Medical Services Co-Clinical Lead, Virtual Rural General Service General Practitioner Visiting Medical Officer, Western NSW Local Health District

Name	Role ¹⁷⁷
Huckel Schneider, Associate Professor Carmen	Senior Advisor, Evidence Connect, Sax Institute Deputy Director, Leeder Centre for Health Policy, Economics and Data, University of Sydney
Hull AO, Kay	Chair, Palliative Care Enhancement Council
Ingram, Dr Matthew	Staff Specialist Emergency Medicine, Wyong Hospital, National Program Steering Committee, Accreditation Committee, and Trainee Review Panel Representative, Australian College of Emergency Medicine
Jackson MLC, The Honourable Rose	Minister for Mental Health
Janissen, Vanessa	Chief Executive, NSW Health Pathology
Jewitt, Joseph	Acting General Manager of Concord Repatriation General Hospital, Sydney Local Health District
Jones, Professor Debra	Head of Rural Clinical School, Broken Hill University Department of Rural Health, Sydney Nursing School, Faculty of Medicine and Health, University of Sydney
Kahawita, Apsara	Director of Finance and Corporate Services, Far West Local Health District
Kanhutu, Associate Professor Kudzai	Dean, Royal Australasian College of Physicians
Kastoun, Louis	Executive Director, Health and Stronger Communities Division, Policy and Budget Group, NSW Treasury
Kealy-Bateman, Dr Warren	Clinical Director Mental Health Drug and Alcohol, Dubbo and Regions, Western NSW Local Health District
Kennedy, Councillor Thomas	Mayor, Broken Hill City Council

Name	Role ¹⁷⁷
Kerridge, Dr Ross	Senior Staff Specialist, Anaesthesia and Perioperative Medicine, John Hunter Hospital Conjoint Associate Professor, University of Newcastle
Knight, Anthony	Chair, Weilmoringle Community Working Party
Kokkinakos, Maria	Director Strategic Health Sourcing, Sydney Local Health District
Kolbe, Anthony	Board Member, Murrumbidgee Local Health Chair of Planning Resources and Performance, Board Subcommittee,
Koschel, Dr Alison	Executive Manager Populations, Access and Performance, Hunter New England and Central Coast Primary Health Network
Lawrence, Kevin	Executive Director Finance and Performance, Murrumbidgee Local Health District
Layer, Craig	Chief Operational Officer, Ungooroo Aboriginal Corporation
Layer, Taasha	Chief Executive Officer, Ungooroo Aboriginal Corporation
Lester, Cecil	Chief Executive Officer, Condobolin Aboriginal Health Service
Levesque, Adjunct Professor Jean-Frédéric	Deputy Secretary, Clinical Innovation and Research, Ministry of Health Chief Executive, Agency for Clinical Innovation
Lim, Professor Boon	Vice-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Lindner, Adrian	Interim Board Chair, Murrumbidgee Local Health District
Longbottom, Hayley	Chief Executive Leadership Team, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)

Name	Role¹⁷⁷
Loy, Graeme	Chief Executive Western Sydney Local Health District, Acting Chief Executive, Sydney Local Health District
Ludford PSM, Jill	Chief Executive, Murrumbidgee Local Health District
Lyons, Dr Nigel	Special Advisor, NSW Health
MacIsaac, Dr Mary	General Practitioner, Coomealla Health Aboriginal Corporation
Mackay, Matthew	Chief Executive Officer, Royal Rehab Group, President, Health Services Association
Mackenzie, Professor Tara	Associate Dean of Rural Health, School of Clinical Medicine, University of NSW
MacLellan, Professor Donald	Board Chair, Central Coast Local Health District
MacPherson, Dr Linda	Director, Workforce Reform, NSW Health
MacQueen, David	Acting Chief Executive Officer, Katungal Aboriginal Corporation Regional Health and Community Services
Mains, Margot	Chief Executive, Illawarra Shoalhaven Local Health District
Maisey, Tracey	Chief Executive, Northern NSW Local Health District
Maley, Dr Michael	Local Pathology Director, South Western Sydney Local Health District
Mallows, Associate Professor James	Chair, Nepean Medical Staff Council Senior Emergency Physician at Nepean Hospital, Nepean Blue Mountains Local Health District
Manzie, Robyn	Independent Chair, Murrumbidgee Mental Health and Drug and Alcohol Alliance

Name	Role ¹⁷⁷
Marchioni, Dean	Registered Nurse, Cluster Manager, Narrandera/Leeton Cluster, Murrumbidgee Local Health District
Marsden, Councillor Jarrod	Mayor, Cobar Shire Council
Marshall PSM, Sonia	Chief Executive, South Western Sydney Local Health District
Mason, Carl	Chair, Collarenebri (“Colli”) Community Working Party
Mastersson, Nadia	Head, Prevention, Sax Institute
May AM, Professor Jennifer	Commissioner, Office of the National Rural Health Commissioner, Betty Fyffe Chair of Rural Health Director, Department of Rural Health, University of Newcastle
McCann OAM, Councillor David	Mayor, Coolamon Shire Council
McClintock, Dr Colin	Renal Physician, General Medicine Physician Board Member, Western NSW Local Health District
McCosker PSM, Tracey	Chief Executive, Hunter New England Local Health District
McCowen, Debbie	Chief Executive Officer, Armajun Aboriginal Health Service
McFadgen, Anna	Chief Executive Officer, St Vincent’s Health Network Sydney
McFarlane, Helen	Director, Mental Health, Drug and Alcohol and Regions, Western NSW Local Health District
McHughes, Doreen	Chair, Brewarrina Community Working Party
McLachlan, Scott	Chief Executive, Central Coast Local Health District
McNamara, Dr Martin	Chief Executive Officer, Sax Institute

Name	Role ¹⁷⁷
McRae, Dr Michelle	Senior Director of Training, Australasian College of Dermatologists
Middleton, Professor James	Clinical Director, NSW State Spinal Cord Injury Service Professor of Rehabilitation Medicine, John Walsh Centre for Rehabilitation Research
Milat, Professor Andrew	Professor of Public Health, University of Sydney
Mills, Narelle	Interim Chief Executive Officer, Murrumbidgee Primary Health Network
Mills, Robert	Chief Executive Officer, Royal Society for the Welfare of Mothers and Babies (Tresillian)
Minns, Philip	Deputy Secretary, People, Culture and Governance, Ministry of Health
Misevska, Karolina	Business Manager, Sydney Local Health District
Mitchell PSM, Dr Jo	Director, Policy by Proxy
Morgan ASM, Dr Dominic	Chief Executive and Commissioner, NSW Ambulance
Morrison, Dr Tom	Neurosurgery Registrar, St Vincent's Hospital Sydney
Moyle, Dr Michelle	Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists, Director of Anaesthetic Department, St Vincent's Hospital Sydney
Murphy, Dr Karen	Acting Executive Director, Medical Services and Clinical Governance, Illawarra Shoalhaven Local Health District
Nankervis, Dr Richard	Chief Executive Officer, HNECC Limited / Hunter New England Central Coast Primary Health Network Founding Director on the Board of the Centre of Innovation in Regional Health
Nankivell, Jay	General Manager, Broken Hill City Council

Name	Role¹⁷⁷
Neal, Melissa	Senior Advisor, Murrumbidgee Primary Health Network
Newman, Jamie	Chief Executive Officer / Managing Director and Chairperson, Orange Aboriginal Medical Service and Bila Muuji Aboriginal Corporation Health Service
Newton, Libby	Manager of Education, Policy, Research and Evaluation, Education, Learning and Assessment, Royal Australasian College of Physicians
Newton-John, Professor Toby	Head of Graduate School of Health, University of Technology Sydney
Nicholl, Adjunct Professor Michael	Chief Executive, Clinical Excellence Commission
Nogajski, Dr Rebecca	Executive Director, Medical Services, Western Sydney Local Health District
Nott, Associate Professor Shannon	Executive General Manager, Health and Clinical Services Chief Medical Officer, Royal Flying Doctor Service, South Eastern Section
Nutbeam, Professor Don	Professor of Public Health, University of Sydney Executive Director, Sydney Health Partners
O'Loughlin, Grainne	Chief Executive Officer, Karitane
Oates, Dr Nathan	Visiting Medical Officer Anaesthetist Director of Prevocational Education and Training, South East Regional Hospital, Southern NSW Local Health District
Okulicz, Amy	Nurse Unit Manager, Rehabilitation and Geriatric Rehabilitation, Central Coast Local Health District
Onley, Neville	Director, Activity Based Management Taskforce, NSW Health

Name	Role ¹⁷⁷
Page, Dr Frances	Elected Member (Safety and Quality Officer) Co-Deputy Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists
Park MP, The Honourable Ryan	Minister for Health and Minister for Regional Health
Pearce AM, Susan	Secretary, NSW Health
Pearce, Sally	Board Chair, Far West Local Health District
Peckham, Christine	Chief Executive Officer, Peak Hill Aboriginal Medical Service
Penm, Dr Jonathan	Vice Chair, NSW Branch Committee, Advanced Pharmacy Australia
Penrith, Lisa	Practice Manager, Griffith Aboriginal Medical Service Incorporated
Pickering, Melissa	Acting Director, Nursing Community, Chronic and Complex Care, Central Coast Local Health District
Piper, Dr Susie	District Medical Lead, Paediatrics Department, Southern NSW Local Health District
Pitt, Fred	Executive Assistant, Rekindling the Spirit
Portelli, Joseph	Executive Director, System Purchasing Branch, System Sustainability and Performance, NSW Health
Potter, Professor Jan	Geriatrician Staff Specialist and Divisional Co-Director of Aged Care and Rehabilitation Division, Illawarra Shoalhaven Local Health District
Preddy, Associate Professor John	Clinical Director of Paediatrics Department, Murrumbidgee Local Health District Associate Professor, Wagga Wagga Rural Medical School, University of NSW

Name	Role ¹⁷⁷
Prineas, Dr Stavros	Chair, Blue Mountains Medical Staff Council, Nepean Blue Mountains Local Health District Anaesthetist, Nepean Hospital, and Head of Anaesthetics, Blue Mountains Hospital
Rainger, Dr Natalie	Consultant Otolaryngologist, Head and Neck Surgeon (ENT), Orange, Western NSW Local Health District Training Supervisor, Australian Society of Otolaryngology, Head and Neck Surgery
Raudino, Caine	Office Manager, Albury Wodonga Aboriginal Health Service
Rechbauer, Carmen	Chief Executive, HealthShare NSW
Reid AM, Professor Michael	Michael Reid & Associates, Adjunct Professor of Health Policy, University of Sydney and University of Western Sydney
Richards, Dr Bethan	Chief Medical Wellness Officer, Sydney Local Health District Senior Staff Specialist, Department of Rheumatology, Royal Prince Alfred Hospital Co-Director, Institute for Musculoskeletal Health, Sydney Local Health District
Richter, Jennifer	Nurse Manager, Nursing and Midwifery Workforce, Tweed Valley Hospital, Northern NSW Local Health District
Ridley, Dr Lloyd	Staff Specialist, Department of Radiology, Concord Repatriation General Hospital, Sydney Local Health District
Rose, Rosemary	Nurse Manager / Clinic Coordinator, Pius X Aboriginal Corporation
Roxburgh, Josh	Manager, Public Health and Community Relations, Aboriginal Medical Services Redfern

Name	Role ¹⁷⁷
Russell, Matthew	Director of Mental Health, Nepean Blue Mountains Local Health District
Rutledge AM, Pamela	Board Member, Nepean Blue Mountains Local Health District
Sam, Greg	Chief Executive Officer, Royal Flying Doctor Service, South Eastern Section
Samuelsson, Payden	Chief Executive Officer, Bullinah Aboriginal Health Service
Schembri AM, Adjunct Professor Anthony	Chief Executive, Northern Sydney Local Health District
Scott, Dr David	Physical and Gastroenterologist Visiting Medical Officer Chair of Medical Staff Council, Hunter New England Local Health District
Shenouda, Associate Professor Ayman	Immediate Past Chair and Current Rural Faculty Chair, Royal Australian College of General Practitioners General Practitioner, Wagga Wagga
Shillingsworth, Millie	Chair, Enngonia Community Working Party
Shortis, Brendan	Acting Nurse Manager, Community Health, Nepean Blue Mountains Local Health District
Simon, Isaac	Chief Executive Officer, Tobwabba Aboriginal Medical Service
Simpson, Professor Stephen	Academic Director, Charles Perkins Centre, School of Life and Environmental Sciences, University of Sydney
Slaven, John	Director of Finance and Performance, Mid North Coast Local Health District
Sloane, Luke	Deputy Secretary, Rural and Regional Health, Ministry of Health

Name	Role¹⁷⁷
Smith, Kylie	Director Corporate and Community Services, Cobar Shire Council
Smith, Sharon	Executive Director, System Information and Analytics Branch, NSW Health
Solman, Adjunct Professor Annette	Chief Executive, Health Education and Training Institute Adjunct Professor, University of Technology, Sydney
Spencer OAM, Dr Ian	General Practitioner, Wellington
Spittal, Mark	Chief Executive, Western NSW Local Health District
Spooner, Dr Nicholas	Director of Emergency Medicine, Wyong Hospital, Central Coast Local Health District
Stapleton, Dr Stuart	Director, Emergency Department, Eurobodalla Health Service, Southern NSW Local Health District
Stephenson, Dr Nicholas	Senior Radiologist (Clinical Director), I-MED Riverina
Swingler, Michelle	Corporate Category Procurement Manager, South Western Sydney Local Health District
Tastula, Kylie	Nurse Practitioner, Member of NSW Nurses and Midwives' Association
Tongs OAM, Julie	Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health and Community Services
Tory, Greg	General Manager, Lachlan Shire Council
Treseder AO, Peter	Board Chair, Mid North Coast Local Health District
Tribbia, Nicholas	Registered Nurse, Member of NSW Nurses and Midwives' Association

Name	Role ¹⁷⁷
Twigg, Professor Stephen	Head of Department of Endocrinology, Royal Prince Alfred Hospital Sydney Local Health District, Head of Central Clinical School, Sydney Medical School, University of Sydney
Van de Water, Georgina	Chief Executive Officer, The Royal Australian College of General Practitioners
Van Gool, Professor Kees	Health Policy and Systems, Menzies Centre for Health Policy and Economics, University of Sydney
Viney, Professor Rosalie	Professor of Health Economics and Director of Centre for Health Economics Research and Evaluation, University of Technology, Sydney
Vinton, Ashleigh	Clinical Nurse Specialist, Clinical Products Coordinator, Illawarra Shoalhaven Local Health District
Virgona, Dr Angelo	Chair, NSW Branch Committee, Royal Australian and New Zealand College of Psychiatrists
Wakeling, Benjamin	Director, Clinical Strategy and Outcomes, Registered Nurse, Illawarra Shoalhaven Local Health District
Ward, Professor Robyn	Executive Dean and Pro Vice-Chancellor Medicine and Health, Faculty of Medicine and Health, University of Sydney
Wenham, Dr Sarah	Executive Director, Medical Services, Far West Local Health District
Whaites, Michael	Assistant General Secretary, NSW Nurses and Midwives' Association
Wheeler, Jessica	Manager of Strategy and Operations, Health and Medical, Eleanor Duncan Aboriginal Services
Wilkinson, Fiona	District Director of Quality, Strategy and Improvement, Central Coast Local Health District

Name	Role ¹⁷⁷
Willcox AM, Deborah	Deputy Secretary, Health System Strategy and Patient Experience, Ministry of Health (Now Chief Executive, Sydney Local Health District)
Williams, Dr Robin	Chair, Western Health Alliance Ltd Board, General Practitioner, Molong
Wilson AO, Professor Andrew	Co-Director, Leeder Centre for Health Policy, Economics and Data, University of Sydney
Wilson, Tobi	Chief Executive, South Eastern Sydney Local Health District
Wolfenden, Professor Luke	School of Medicine and Public Health, University of Newcastle
Wong, Jill	District Director Integrated Care, Allied Health and Community Services, Mid North Coast Local Health District (Now Chief Executive, Mid North Coast Local Health District)
Wood, Debborah	Director, People and Community Services, Bogan Shire Council
Wood, Michael	Director of Clinical Governance, Nepean Blue Mountains Local Health District
Yik, Jerry	Head of Policy and Advocacy, Advanced Pharmacy Australia
Yoosuff, Associate Professor Alam	Board Director, Murrumbidgee Local Health District, Principal General Practitioner, Finley Regional Care, Board Director, Murrumbidgee Primary Health Network, Vice President, Rural Doctors Association NSW
Zacka, Mark	Executive Director, Clinical Governance and Patient Experience, Northern Sydney Local Health District

Agency/Entity	About the Agency/Entity
Agency for Clinical Innovation (ACI)	The Agency for Clinical Innovation (ACI) is a chief executive-governed statutory health corporation responsible for bringing clinicians, consumers, and system leaders together to design and implement innovations in healthcare.
Australasian College of Dermatologists (ACD)	The Australasian College of Dermatologists (ACD) is a specialist medical college providing medical practitioners with specialist training in dermatology.
Australasian College for Emergency Medicine (ACEM)	The Australasian College for Emergency Medicine (ACEM) is a specialist medical college responsible for training emergency physicians and advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.
Australian and New Zealand College of Anaesthetists (ANZCA)	The Australian and New Zealand College of Anaesthetists (ANZCA) is a specialist medical college responsible for training, assessing, and setting standards for all specialist anaesthetists and special pain medicine physicians wishing to practice in Australia and New Zealand.
Australian College of Rural and Remote Medicine (ACRRM)	The Australian College of Rural and Remote Medicine (ACRRM) is a specialist medical college responsible for setting professional medical standards for training, assessment, certification and continuing professional development in the specialty of general practice.
Australian Medical Association (NSW) (AMA NSW)	The Australian Medical Association (NSW) (AMA NSW) is an independent association representing the interests of medical professionals and patients in NSW through advocacy and the provision of individual support and services to members at all stages of their careers.
Australian Salaried Medical Officers' Federation (ASMOF)	The Australian Salaried Medical Officers' Federation (ASMOF) is the Australian trade union representing salaried doctors. The Australian Council of Trade Unions recognises ASMOF as the principal union for salaried medical practitioners.

Agency/Entity	About the Agency/Entity
Benevolent Society of NSW	The Benevolent Society of NSW is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> which provides programs and services to support older Australians, people with disabilities, children and families.
Bureau of Health Information (BHI)	The Bureau of Health Information (BHI) is a board governed organisation that provides independent reports to government, the community and healthcare professionals about the performance of the NSW public healthcare system, including in relation to the safety and quality, effectiveness, efficiency, cost and responsiveness of the system to the health needs of the people of NSW.
Calvary Health Care (Newcastle) Limited	Calvary Health Care (Newcastle) Limited is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> providing care for the maintenance and enhancement of overall quality of life, dignity and wellbeing of individuals, particularly those in vulnerable stages of life.
Calvary Health Care Sydney Limited	Calvary Health Care Sydney Limited is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> providing rehabilitative, palliative and community care.
Cancer Institute NSW	Established under the <i>Cancer Institute (NSW) Act 2003</i> to lessen the impact of cancer across the State, the Cancer Institute NSW's statutory objectives are to reduce the incidence of cancer in the community, increase survival rates, and improve the quality of life for people with cancer and their carers and provide a source of expertise on cancer control for the government, health service providers, medical researchers and the general community.
Central Coast Local Health District (CCLHD)	The Central Coast Local Health District (CCLHD) provides public health services in the Local Government Areas of Gosford and Wyong.

Agency/Entity	About the Agency/Entity
Clinical Excellence Commission (CEC)	The Clinical Excellence Commission (CEC) is a board governed statutory health corporation, responsible for leading safety and quality improvement in the NSW public health system. It was established in 2004 to reduce adverse events in public hospitals, support improvements in transparency and review of these events in the health system and promote improved clinical care, safety and quality in health services across NSW.
College of Intensive Care Medicine of Australia and New Zealand (CICM)	The College of Intensive Care Medicine of Australia and New Zealand (CICM) is a specialist medical college responsible for intensive care medicine specialist training and education in Australia and Aotearoa New Zealand.
eHealth NSW	eHealth NSW provides Statewide services on the shape, delivery and management of Information Communication Technology (ICT) led healthcare. eHealth NSW is responsible for establishing, implementing and ensuring compliance with eHealth strategy, policy and standards across the NSW Health system.
Far West Local Health District (FWLHD)	Far West Local Health District (FWLHD) provides public health services in the Local Government Areas of Balranald, Broken Hill, Central Darling, and Wentworth, as well as the Unincorporated Far West Area of NSW (excluding Lord Howe Island).
HammondCare Health and Hospitals Limited	HammondCare Health and Hospitals Limited is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> providing health, aged and dementia care.
Health Administration Corporation (HAC)	The Health Secretary is incorporated as a corporation sole under s 9 of the <i>Health Administration Act 1982</i> . The Health Administration Corporation includes Public Health System Support (comprising Health System Support Group, HealthShare NSW and eHealth NSW), Health Infrastructure, NSW Ambulance and NSW Health Pathology.

Agency/Entity	About the Agency/Entity
Health Education and Training Institute (HETI)	The Health Education and Training Institute (HETI) works closely with Local Health Districts, Specialty Health Networks, other public health organisations and health education and training providers to ensure that education and training resources are available to support the full range of roles across the public health system including patient care, administration and support services.
Health Infrastructure	Health Infrastructure is responsible for the delivery of the NSW Government's major works hospital building program, under the auspices of a Board appointed by the Secretary.
Health Protection NSW	Reporting to the Chief Health Officer, Health Protection NSW is responsible for surveillance and public health response in NSW including monitoring the incidence of notifiable infectious diseases and taking appropriate action to control the spread of diseases. It also provides public health advice and response to environmental issues affecting human health.
Health Services Union (HSU)	The Health Services Union (HSU) is a federated union with individual branches in every state and territory. Union members work across the health and community services sectors in every State and Territory of Australia.
HealthShare NSW	HealthShare NSW provides high quality shared services to support the delivery of patient care within the NSW Health system, including providing payroll and procurement functions, supporting patient care through food and linen services, and assisting people with a disability to live and participate in the community.
Hunter New England Local Health District (HNELHD)	The Hunter New England Local Health District (HNELHD) provides public health services in the Hunter, New England, and Lower Mid North Coast regions.
Illawarra Shoalhaven Local Health District (ISLHD)	The Illawarra Shoalhaven Local Health District (ISLHD) provides public health services in the Wollongong, Kiama, Shellharbour, and Shoalhaven Local Government Areas.

Agency/Entity	About the Agency/Entity
Justice Health and Forensic Mental Health Network (JHFMHN)	The Justice Health and Forensic Mental Health Network (JHFMHN) provides healthcare services to adults and young people involved in forensic mental health and criminal justice systems in NSW.
Karitane	Karitane is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> offering expert parental support, education and advice.
Mercy Hospitals NSW Ltd	Mercy Hospitals NSW Ltd is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> offering acute and subacute hospital care, aged care, mental health programs, specialist women's healthcare, early parenting services, palliative care, home and community care.
Mid North Coast Local Health District (MNCLHD)	The Mid North Coast Local Health District (MNCLHD) provides public health services from the Port Macquarie-Hastings Local Government Area in the south to the Coffs Harbour Local Government Area in the north.
Ministry of Health	The Ministry of Health is a ministerial department within the NSW Government that supports the Health Secretary, the Minister for Health, the Minister for Regional Health, the Minister for Mental Health, and the Minister for Medical Research in the performance of their executive and statutory functions. NSW Health is also the systems manager for the NSW public health system.
Murrumbidgee Local Health District (MLHD)	The Murrumbidgee Local Health District (MLHD) provides public health services in the Riverina, Murrumbidgee Irrigation Area, and South Western Slopes of NSW.
Nepean Blue Mountains Local Health District (NBMLHD)	The Nepean Blue Mountains Local Health District (NBMLHD) provides public health services in the Penrith, Hawkesbury, Blue Mountains, and Lithgow Local Government Areas.

Agency/Entity	About the Agency/Entity
Northern NSW Local Health District (NNSWLHD)	The Northern NSW Local Health District (NNSWLHD) provides public health services from Tweed Heads in the north to Tabulam and Urbenville in the west and Nymboida and Grafton in the south.
Northern Sydney Local Health District (NSLHD)	The Northern Sydney Local Health District (NSLHD) provides public health services from Sydney Harbour to the Hawkesbury River, including the Local Government Areas of Hornsby, Ku-ring-gai, North Sydney, Mosman, Northern Beaches, Ryde, Hunters Hill, Lane Cove, and Willoughby.
NSW Ambulance	NSW Ambulance is responsible for providing responsive, high quality clinical care in emergency situations, including prehospital care, rescue, retrieval and patient transport services.
NSW Health Pathology	NSW Health Pathology is a Statewide clinical and scientific service that provides quality, reliable public pathology, forensic and analytical science services across NSW.
NSW Nurses and Midwives' Association (NSWNMA)	The NSW Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in NSW. NSWNMA represents the industrial interests of nurses and midwives employed in NSW in the public, private, aged care and primary health sectors.
NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> that provides culturally relevant psychological treatment and support, and community interventions, to help people and communities heal the scars of torture and refugee trauma and rebuild their lives in Australia.
Royal Australasian College of Medical Administrators (RACMA)	The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college that provides education, training, knowledge and advice in medical leadership and management.

Agency/Entity	About the Agency/Entity
Royal Australasian College of Physicians (RACP)	The Royal Australasian College of Physicians (RACP) is a specialist medical college that connects, represents and trains physicians and trainee physicians across Australia and New Zealand. RACP specialises in education, advocacy and innovation.
Royal Australasian College of Surgeons (RACS)	The Royal Australasian College of Surgeons (RACS) is a specialist medical college responsible for training surgeons and maintaining surgical standards in Australia and Aotearoa New Zealand.
Royal Australian and New Zealand College of Gynaecologists (RANZCOG)	The Royal Australian and New Zealand College of Gynaecologists (RANZCOG) is a specialist medical college that trains and accredits doctors in the specialties of obstetrics and gynaecology.
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)	The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) is a specialist medical college responsible for the training and professional development of ophthalmologists in Australia and New Zealand.
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a specialist medical college responsible for training, educating and representing psychiatrists in Australia and Aotearoa New Zealand. RANZCP is accredited by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) to deliver specialist medical education and training, and professional development programs.
Royal Australian and New Zealand College of Radiologists (RANZCR)	The Royal Australian and New Zealand College of Radiologists (RANZCR) is a specialist medical college for clinical radiologists and radiation oncologists in Australia, New Zealand and Singapore. RANZCR administers training programs for admission into its professions, accreditation for overseas-trained specialists, and a continuing professional development program for its members.

Agency/Entity	About the Agency/Entity
Royal Australian College of General Practitioners (RACGP)	The Royal Australian College of General Practitioners (RACGP) is a specialist medical college representing General Practitioners in Australia and is responsible for maintaining standards for quality clinical practice, education, training and research in Australian general practice.
Royal College of Pathologists of Australasia (RCPA)	The Royal College of Pathologists of Australasia (RCPA) is a specialist medical college comprising of Fellows, Diplomates, Affiliates and trainees which oversees the training of pathologists and scientists working in 17 different specialties
Royal Rehab Group	Royal Rehab Group is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> offering a range of rehabilitation, wellbeing and disability services across Australia
Royal Society for the Welfare of Mothers and Babies (Tresillian)	Royal Society for the Welfare of Mothers and Babies (Tresillian) is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> that provides support to families caring for children under the age of five years
Single Digital Patient Record Implementation Authority	The Single Digital Patient Record Implementation Authority has been established to lead the implementation of the Single Digital Patient Record (SDPR) across NSW Health.
South Eastern Sydney Local Health District (SESLHD)	The South Eastern Sydney Local Health District (SESLHD) provides public health services from Sydney's Central Business District to the beaches from Bondi to Cronulla and the Royal National Park, including the Local Government Areas of Woollahra, Waverley, Randwick, Bayside, Georges River, and Sutherland Shire. SESLHD also plays a key role in providing public health services on Lord Howe Island.
South Western Sydney Local Health District (SWSLHD)	The South Western Sydney Local Health District (SWSLHD) provides public health services in South Western Sydney from Bankstown to Bowral.

Agency/Entity	About the Agency/Entity
Southern NSW Local Health District (SNSWLHD)	The Southern NSW Local Health District (SNSWLHD) provides public health services in the South Coast, Southern Tablelands, Great Dividing Range, and Snowy Mountains, including the Local Government Areas of Bega Valley, Eurobodalla, Goulburn Mulwaree, Queanbeyan-Palerang, Snowy Monaro, Upper Lachlan, and Yass Valley.
St Vincent’s Health Network	St Vincent’s Health Network (a wholly owned subsidiary of St Vincent’s Health Australia) is a networked affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> , in respect of two recognised establishments and services: St Vincent’s Hospital Sydney, and Sacred Heart Health Service, Darlinghurst. In this report, the networked AHO is referred as the St Vincent’s Health Network.
Sydney Children’s Hospitals Network (SCHN)	The Sydney Children’s Hospitals Network (SCHN) incorporates The Children’s Hospital, Westmead, Sydney Children’s Hospital, Randwick, Bear Cottage, the Newborn and Paediatric Emergency Transport Service (NETS), the NSW Poisons Information Centre, and the Children’s Court Clinic.
Sydney Local Health District (SLHD)	The Sydney Local Health District (SLHD) provides public health services in the centre and inner west of Sydney, including the Local Government Areas of the City of Sydney, Inner West Council, Canterbury-Bankstown, Canada Bay, Burwood, and Strathfield.
Uniting Church in Australia (War Memorial Hospital)	The Uniting Church in Australia (War Memorial Hospital) is an affiliated health organisation pursuant to Schedule 3 of the <i>Health Services Act 1997</i> specialising care and support for people of all ages and stages of life, with a focus on people experiencing disadvantage and exclusion. Services include aged care, retirement and independent living, early learning, disability, chaplaincy, and community services.

Agency/Entity	About the Agency/Entity
Western NSW Local Health District (WNSWLHD)	The Western NSW Local Health District (WNSWLHD) provides public health services in 23 Local Government Areas in Western NSW, including Bathurst Regional, Dubbo Regional, and Orange.
Western Sydney Local Health District (WSLHD)	The Western Sydney Local Health District (WSLHD) provides public health services in the Blacktown, The Hills Shire, Cumberland, and Parramatta Local Government Areas.



Chapter 6:

Staff of the Special Commission

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Ed Muston SC

Ross Glover

Ian Fraser

Dan Fuller

Tamsin Waterhouse

Operations

Andrew Monk

Rosie Castle

Keira Veliscech

Legal and Legal Support

Ananya Agrawal

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