Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley

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The Terms of Reference

7.1. The Terms of Reference (as amended) required me to inquire into, and report on:[1]

A. The funding models used to provide health services in NSW and whether they most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.

B. The existing governance and accountability structure of NSW Health, including whether:

(i) it provides the best balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);

(ii) local communities are appropriately engaged in health service development and delivery;

(iii) the governance structures best support efficient implementation of state-wide reform programs;

(iv) privatisation and outsourcing has adversely impacted on the delivery of health services and health outcomes to the people of NSW or otherwise;

(v) governance structures support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population;

C. Whether the funding models for health services or the way NSW Health funds health services delivered in public hospitals and community settings

(i) incentivises the delivery of health services that provide the overall best health outcomes for the people of NSW;

(ii) provides the best value for the costs incurred in providing such health services;

(iii) best supports (and does not obstruct) access to preventive and community health initiatives that provide the best overall health outcomes;

(iv) maintains a financially sustainable healthcare system;

[1] Copies of the Letters Patent are contained in Appendix A to this Report.

D. *Whether the strategies of NSW Health that are in place or in the process of implementation best manage escalating costs, the limitation of wastage, minimise overservicing and appropriately identify gaps and improvements in financial accountability and efficiency;*

E. *Whether the current procurement strategies and processes of NSW Health are appropriate and enhance support for operational decision making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;*

F. *The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including inquiry into:*

   (i) *the existing skills and distribution of health workers in NSW, including whether there are shortages of workers and particular skill sets in any locations;*

   (ii) *the financial and non-financial factors impacting on the retention and attraction of staff;*

   (iii) *existing employment standards;*

   (iv) *the role and scope of workforce accreditation and registration;*

   (v) *the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;*

   (vi) *the relationship between NSW Health agencies and medical practitioners;*

   (vii) *whether there are opportunities for an expanded (or working to full) scope of practice for the health workforce including paramedics, pharmacists, community and allied health workers, nurses and midwives;*

   (viii) *the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;*

   (ix) *opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;*

G. *Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:*

(i) *placements;*

(ii) *the way training is offered and overseen (including for internationally trained specialists);*

(iii) *how colleges support and respond to escalating community demand for services;*

(iv) *the engagement between medical colleges and local health districts and speciality health networks;*

(v) *how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;*

H. *New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and*

I. *Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry.*

7.2. On any view, the Terms of Reference were exceptionally broad. There was almost no aspect of the public health system or issue related to the delivery of healthcare in NSW that fell outside of them. As a result, given the fragmented nature of the healthcare system both within NSW and across Australia,[2] a consideration of all issues that could reasonably be said to fall within the Terms of Reference would have taken considerably longer than the time available - likely years.

7.3. However, the Terms of Reference must be read sensibly. When read together (as they must be), the clear focus of this Special Commission was on the funding and delivery of healthcare in NSW. Although vast topics of themselves, those core themes were the thread that ran through each of the Terms of Reference. Unsurprisingly, given the complex nature of the system, many of the issues that emerged in the evidence relating to those core themes were interrelated. For example, the various issues and challenges that have emerged in relation to the health workforce (including training) were inherently linked to issues concerning service and system planning, as were issues of governance such as the balance to be struck between the "centre" (i.e., Ministry of Health) and local organisations within a largely devolved

[2] See, for example, the discussion in Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) [SCI.0001.0041.0001].

system. All issues, to some degree, involved a consideration of how the system (and the various entities within it) were funded.

7.4. This Special Commission was of a different kind to others established in recent times. Unlike other Commissions, this was not one that involved an examination of a tragedy or disaster of some kind, nor was it one that was established to review a chronically underperforming system or to identify instances of wrongdoing. It was, in many ways, unique in the sense that its fundamental purpose was to identify measures to improve the NSW public health system – a system that is already regarded as being a high performing one by world standards.[3]

7.5. Those unique features of this Special Commission, together with the breadth of the Terms of Reference, presented several advantages. It meant that issues were largely able to be explored through an exchange of ideas, directed to how system enhancements or improvements could be made. Even where there was a difference in views as to what should, or should not, be done, it was clear that all those who engaged with this Special Commission had a common aim – to improve the NSW public health system. However, those same features also presented challenges. Unlike other inquiries, this Special Commission did not have a particular set of facts that provided the context in which issues fell to be considered. That meant that a thorough analysis of the core issues and themes raised by the Terms of Reference neither necessitated nor produced direct responses to them, or their (in some cases, many) constituent elements.

7.6. Those core themes were explored through a consideration of the views and experiences of a wide range of people involved in the NSW public health system, or who interact with it, together with those of a range of health system experts.

7.7. That exploration was aided by a consideration of examples, or mini case studies, that informed an understanding of how the particular system level issue could affect the delivery of healthcare "on the ground". In many instances, I have not found it necessary to make specific findings about those examples in addressing the Terms of Reference or to refer to them expressly in the body of this Report. That is not to say they were ignored or unimportant to the work of this Special Commission. On the contrary, they provided essential context and greatly assisted me in understanding the significance and impact of the systemic issues that emerged in the evidence.

7.8. In this Chapter, I summarise (at a high level) the work of this Special Commission. It was extensive, and – in addition to the public hearings – involved visits to each of the LHDs and SHNs, briefings, meetings, and consultation sessions with stakeholders, community engagement, and submissions. All were critical to the work of this Special

[3] Despite some labelling the system as being in "crisis" or "on the brink" (and from the perspective of some people within the workforce those labels are not necessarily hyperbole), it is important to recognise that the public health system is, by world standards, a high performing one, particularly in relation to acute care services. None of that is to say that improvements are not required.

Commission. The relatively short summary that follows is inapt to convey the value of each interaction with those involved in the system on a day to day basis.

7.9. Before going much further, I should say something about the the label “NSW Health”. That label is used throughout the Terms of Reference and, unsurprisingly, was used consistently over the course of this Special Commission. Despite its widespread use, it was used by different people to mean different things. For example, on some occasions, it was used as a reference to the Ministry of Health, and on others as a shorthand description for the wider public health system in NSW.[4] It was sometimes used in a way that shifted from one to the other and back again as the context dictated. That is not a criticism of anyone but rather is just the way that those that are deeply familiar with the operation of the system speak of it.

7.10. However, in order to be as clear as I can be in this Report, it is necessary for me to describe what I mean when I use that label. Section 4(1A) of the *Health Administration Act 1982* (NSW) provides that the label “NSW Health” may be used to describe the Health Administration Corporation, the Ministry of Health, and any other body and organisation under the control and direction of the Health Secretary. That is, as a reference to the wider system. It is apparent that it was used in that way in the Terms of Reference, and I have adopted that same approach in this Report.

7.11. As a result, where I have used the label “NSW Health” in this Report, I should be understood as a referring to the NSW public health system as a whole or – as the context dictates – the relevant part of it being discussed or considered. Thus, where in this Report an observation or recommendation is made that “NSW Health” should consider or do something, that should be understood as a reference to the particular part of the NSW public health system that has responsibility for the management of the issue being considered, or the exercise of the function in question, whether that be the Ministry of Health, the Health Secretary, a Pillar, or any other part of the system.

Previous inquiries and reviews

7.12. As noted elsewhere in this Report, this Special Commission is the latest in a very long line of reviews and inquiries into the public health system, both in NSW and across the Nation. I have read and considered a great many of them. My consideration of those previous inquiries and reviews – including the recommendations made by them, and the actions taken (or not taken) to implement those recommendations – provided a useful baseline for the work of this Special Commission. Given the regularity at which inquiries and reviews into the health system in NSW have been held over the past century and a half, some may be inclined to suggest that another will be held in the not

[4] See, for example, Exhibit H.2.51, NSW Health, *Corporate Governance and Accountability Compendium* (May 2024), p 1.01 [MOH.0010.0256.0001 at 0010]; *Health Administration Act 1982* (NSW) s 4(1A).

too distant future. It is my hope, however, that the Recommendations I have made will delay the need for another inquiry for many years.

Public submissions

7.13. On 20 September 2023, a call for written submissions directed to the Terms of Reference was made. That call was widely published and several key stakeholders (including all NSW Health agencies) were directly invited to make a submission.

7.14. In response to that call, 206 written submissions were received from a large cross section of stakeholders. A further 20 written submissions were received during the course of this Special Commission . Those appropriate to be made public were placed on this Special Commission's website

7.15. All submissions received were considered and provided valuable information and insight into the issues raised by the Terms of Reference. I am grateful to all those who took the time to prepare a submission.

7.16. A list of all the submissions received is set out in Appendix B.[5]

Production of documents

7.17. A great many volume of documents was gathered and reviewed, by both me and those assisting me.

7.18. Some of that material was publicly available, although a significant number of documents were produced in answer to the 118 summonses for the production of documents that I issued pursuant to the *Special Commission of Inquiry Act 1983* (NSW). The majority of those summonses (63 of 118) were directed to the Health Secretary or other public health organisations. In answer to those summonses, 9,562 documents were produced (many of which comprised hundreds of pages) a significant portion of which were tendered into evidence.

7.19. A list of all the summonses to produce documents I issued is set out in Appendix C.

NSW Health briefings and workshops

7.20. In the initial stages of this Special Commission, NSW Health facilitated several briefings and workshops, each of which focussed on a particular Term of Reference and the issues and themes that emerged from it. A list of those briefings is set out in Table 1 below.

[5] Some authors of submissions requested that their identity, or their submission, be kept confidential. In all cases, I acceded to those requests. Accordingly, the names of the authors of those submissions are not set out in Appendix B.

7.21. During those briefings, NSW Health staff provided me, and those assisting me, with a great deal of useful information, including an explanation of the current structures and processes, current challenges facing the system, and also opportunities for improvements relevant to each Term of Reference. They were all valuable, and particularly so in the early stages of this Special Commission's work.

Table 1: List of briefings and workshops facilitated by NSW Health

Date	Topic	NSW Health Personnel
22 September 2023	Funding briefing (TOR A)	Amanda Larkin, Lead NSW Health Response Team, Alfa D'Amato, Chief Financial Officer, and Dr Nigel Lyons, Special Advisor.
11 October 2023	Governance briefing (TOR B)	Amanda Larkin, Dr Nigel Lyons, Philip Minns, Deputy Secretary, People, Culture and Governance, and Matthew Daly, Deputy Secretary, System Sustainability and Performance.
17 October 2023	Preventive Health and Care in the Community briefing (TOR C)	Amanda Larkin, Dr Nigel Lyons, Dr Kerry Chant, Chief Health Officer and Deputy Secretary, Population and Public Health, and Deborah Willcox, Deputy Secretary, Health System Strategy and Patient Experience.
19 October 2023	Funding workshop (TOR A)	Amanda Larkin, Dr Nigel Lyons, Steven Carr, Executive Director, System Financial Performance and Deputy CFO, and Neville Onley, Director Activity Based Management Taskforce.
25 October 2023	Accountability, efficiency and Procurement briefing (TORs D and E)	Amanda Larkin, Dr Nigel Lyons, Carmen Rechbauer, Chief Executive HealthShare NSW, and Michael Gendy, Chief Procurement Officer.

Date	Topic	NSW Health Personnel
2 November 2023	Workforce briefing (TOR F)	Amanda Larkin, Philip Minns, Dr Nigel Lyons and Richard Griffiths, Executive Director Workforce Planning and Talent Development.
6 November 2023	Innovation briefing (TOR H)	Amanda Larkin, Matthew Daly, Deborah Willcox and Dr Jean-Frédéric Levesque, Chief Executive NSW Agency for Clinical Innovation.
9 November 2023	Education and Training briefing (TOR G)	Amanda Larkin, Richard Griffiths, Dr Linda Macpherson, Director, Workforce Reform, Dr Mary McCaskill, Director of Medical Services and Clinical Governance Sydney Children's Hospitals Network, Dr Tim Williams, Executive Director Medical Services, Northern NSW LHD, and Dr Jo Karnaghan, Director Clinical Governance and Medical Services, South Eastern Sydney LHD.
9 November 2023	Funding workshop (TOR A)	Amanda Larkin and Alfa D'Amato.

Stakeholder engagement

7.22. This Special Commission met with many stakeholders, including government and non-government medical services, clinicians, specialist medical colleges, industry representatives, consumers, training institutions, PHNs, administrators, funding bodies, and health system and policy experts. All provided valuable information and insight into the issues raised by the Terms of Reference that greatly assisted this Special Commission in its work.

7.23. A list of those meetings is set out in Appendix D.

Community consultation

7.24. This Special Commission held community consultation sessions during its visits to Murrumbidgee LHD, Western NSW LHD and Far West NSW LHD.

7.25. The sessions were publicised and were open to anyone who had an interest in the work of this Special Commission. Those who participated were provided with the opportunity to meet with me (and other members of the Special Commission team) so that they could share their experiences, views, and perspectives on any issue within the Terms of Reference. Those sessions were attended by a range of health consumers and clinicians and enabled me to hear the firsthand experiences of those who are engaged in, or who have had contact with, the NSW public health system in those regions.

Engagement with health system experts

7.26. Health systems have long been the subject of analysis and discussion across the world, including by researchers and academics. Given that I am a lawyer, the need for me to obtain the benefit of the wealth of experience and expertise in relation to those topics held by others was, perhaps, obvious from the outset. In addition to engaging with and hearing from those involved in the delivery of the system at all levels, I assembled an Expert Advisory Panel.

7.27. That panel was established to enable me to hear from and engage with a wide range of experts in various fields (both individually and collectively). It was comprised of leading academics, researchers, clinicians, and healthcare professionals from across the spectrum of healthcare delivery and research.

7.28. The following institutions and individuals were members of the Expert Advisory Panel:

a. Australian Institute of Health Innovation - Professor Jeffrey Braithwaite

b. Charles Perkins Centre – Professor Stephen Colagiuri

c. Charles Perkins Centre – Professor Luigi Fontana

d. Charles Perkins Centre – Professor Stephen Simpson

e. Menzies Centre – Professor Kees van Gool

f. Menzies Centre – Associate Professor Philip Haywood

g. Menzies Centre – Professor Kirsten Howard

h. Menzies Centre – Professor Andrew Wilson AO

i. Michael Reid & Associates – Michael Reid AM

j. Professor Stephen Duckett AM

k. Sax Institute – Dr Martin McNamara

l. University of New South Wales Sydney - Professor Kathy Eagar AM

m. University of Newcastle – Associate Professor Leanne Brown

n. University of Newcastle – Professor Jennifer May AM

o. University of Sydney - Professor Robyn Ward AM

p. University of Technology Sydney – Professor Debra Anderson

q. University of Technology Sydney – Professor David Bedford

r. University of Technology Sydney – Professor Emily Callander

s. University of Technology Sydney – Distinguished Professor Jane Hall

t. Wiser Healthcare

7.29. The Expert Advisory Panel first met on 6 December 2023 and participated in an all day workshop in Sydney on 31 January 2024.

7.30. In addition to those meetings, members of the Expert Advisory Panel provided this Special Commission with the benefit of their expertise in relation to a range of issues and topics. Several of its members were called to give evidence during public hearings as expert witnesses.

7.31. In addition to the assistance provided by the Expert Advisory Panel, the Sax Institute was engaged to prepare three reports addressing some of the core themes that flowed through the Terms of Reference. On 29 November 2024, the following reports were delivered:

a. *Resource* management *in NSW Health*, authored by Michael Reid, Professor Andrew Wilson, Professor Kees Van Gool, Associate Professor Carmen Huckel Schneider, and Dr Martin McNamara.

b. *Strengthening the focus on prevention of chronic disease through applying evidence-based insights*, authored by Dr Jo Mitchell, Helen Signy, Nadia Mastersson, Professor Wilson, and Dr Martin McNamara.

c. *Building capabilities to drive health system improvements*, authored by Professor Luke Wolfenden, Professor Andrew Milat, Professor Don Nutbeam, Associate Professor Sarah Thackway, and Dr Martin McNamara.

7.32. Each of those reports was tendered in evidence, and some of the authors were called to give evidence in relation to the opinions expressed in them.

7.33. The assistance of all the experts who engaged with this Special Commission, whether as a member of the Expert Advisory Panel, as an expert witness, or as an author of one of the expert reports, was invaluable.

Public hearings, site visits, and roundtables

7.34. As noted above, this Special Commission visited each of the LHDs and the SHNs across NSW, as well as NSW Ambulance.[6] Those visits included site visits to facilities operated by NSW Health and other providers. This provided me, and those assisting me, with opportunities to tour facilities, observe demonstrations, and to hear about some of the challenges (and successes) in delivering care across the region or network.

7.35. Importantly, these site visits also enabled me to hear directly from clinicians and management within NSW Health during a series of roundtable discussions. On some occasions, others involved in the wider healthcare system (such as PHNs, ACCHOs, training institutions, and local government representatives) also attended. During those roundtables, I heard directly about the issues that affect them and their communities on a daily basis, and their ideas for improvements that could be made to support them to deliver high quality care to their communities. All those discussions were valuable, and on many occasions they identified issues that were later explored in the evidence.

7.36. A list of those site visits is set out in Appendix E, and a list of the attendees of each of the roundtables is set out in Appendix F.

7.37. The public facing aspects of this Special Commission's work was conducted through public hearings. To ensure the hearings were as accessible as possible to those interested, they were live streamed and daily transcripts were placed on the website.

7.38. Those hearings occupied 71 sitting days across 18 hearing blocks and generated 7203 pages of transcript. Hearings were held in Sydney, Wagga Wagga, Dubbo, Broken Hill, Batemans Bay and Tamworth. 259 witnesses were called to give evidence, some of whom gave evidence on multiple occasions. A list of all the witnesses called to give evidence during each hearing block is set out in Appendix H.

7.39. During those hearings, 2,277 documents were tendered as exhibits,[7] including 231 witness statements. A list of all public exhibits is set out in Appendix I.

7.40. On application of interested parties, I made a small number of orders pursuant to ss 7 and 8 of *Special Commissions of Inquiry Act 1983* (NSW), restricting the publication of a small portion of the evidence. Those orders were made to guard against the risk that disclosure of that material could reveal information that was of a commercial in confidence nature or was personal patient information. Those orders did not impact my consideration of the issues, or the preparation of this Report.

[6] Additionally, the Special Commission visited Albury and met with Albury Wodonga Health, a cross-border Health service which operates under the jurisdiction of the Department of Health, Victoria, and delivers care in both NSW and Victoria.

[7] Including 49 confidential documents.

Northern Sydney LHD, 8 November 2023

7.41. The Special Commission visited the Northern Sydney LHD on 8 November 2023.

7.42. Discussions were held with members of the LHD board, clinicians, and management about important issues facing the LHD, including the impacts of short-term funding cycles, workforce challenges (particularly in relation to nursing) and the importance of allocating sufficient funding for innovation to drive efficiencies and service improvements. I also heard about innovative models of care being trialled within the LHD, including same day joint replacement surgery.

7.43. Site visits were conducted at:

a. Royal Northshore Hospital;

b. Breast Screen NSW;

c. Community Health – Dialysis;

d. Hornsby-Ku-ring- gai Hospital, including the Robotic Pharmacy; and

e. Bungee Bidgel Aboriginal Health Clinic, which aims to provide a culturally safe, secure and friendly place for Aboriginal and Torres Strait Islander people to access primary care.

7.44. As this visit occurred early in the work of this Special Commission, the broad nature of this Special Commission's Terms of Reference were also explored, including how structural issues can impact the way that healthcare is actually delivered by clinicians in several ways.

Public Hearings 27–30 November 2023 – Sydney

7.45. Public hearings were held between 27 November 2023 and 30 November 2023 in Sydney, during which Counsel Assisting and Senior Counsel for NSW Health made opening remarks. Evidence was also called in relation to the following general issues:

a. the governance and structure of the NSW public health system;

b. health services provided by NSW Health and other providers;

c. the healthcare needs of the NSW population;

d. the budget process and funding structure for healthcare services in NSW; and

e. current challenges facing the NSW public health system.

Public Hearings 19–26 February 2024 – Sydney

7.46. Public hearings were held between 19 February 2024 and 26 February 2024 in Sydney. The evidence called during those hearings focussed on the issues of procurement and innovation raised by the Terms of Reference, including the following:

a. policies, processes and systems applying to the procurement of goods and services within NSW Health;

b. recent and ongoing reforms of the procurement framework; and

c. the structures, processes and systems within NSW Health for considering and driving innovation within the system, including new models of care and other technical and clinical innovations to improve health outcomes for the NSW population.

Murrumbidgee LHD, 13–22 March 2024

7.47. This Special Commission visited the Murrumbidgee LHD between 13 and 22 March 2024.

7.48. Between 13 and 15 March 2024, this Special Commission conducted site visits to the facilities:

a. Wagga Wagga Base Hospital;

b. Batlow-Adelong MPS;

c. Tumut Health Service;

d. Finley Health Service;

e. Finley Medical Centre;

f. Riverina Medical and Dental Aboriginal Corporation (Riv-Med); and

g. Berrigan MPS.

7.49. During those visits, discussions were held with management, clinicians, and local community members, about the challenges of delivering healthcare in those regions, and also about many initiatives and innovations that have been implemented to address some of those challenges. Some of the common themes that emerged in those discussions were the reliance on agency staff caused by recruitment and staff retention issues, the implementation and effectiveness of virtual care in coordinating and delivering services, and the fragmented nature of system funding.

7.50. A community consultation session was also held at Wagga Wagga PCYC on 14 March 2024, which was fully subscribed.

7.51. Public hearings were held between 18 March 2024 and 22 March 2024 at the Wagga Wagga Court House. The evidence that was called during those hearings focussed on the delivery of healthcare in rural and regional NSW, and particularly the Murrumbidgee LHD, and explored a range of issues, including:

a. challenges in recruiting and retaining both primary healthcare practitioners and a specialist workforce in rural, regional, and remote NSW;

b. the effect of fragmented funding structures;

c. challenges in arising from the ABF model;

d. the increasing demand for acute healthcare services particularly in regional areas due to an ageing population; and

e. information barriers between the primary care and the acute care settings.

Public Hearings 15–29 April 2024 – Sydney

7.52. Public hearings were held between 15 April 2024 and 29 April 2024 in Sydney that explored the issues of governance and waste minimisation raised by the Terms of Reference. The evidence called during these hearings covered a range of topics, including:

a. the benefits of, and any limitations in, the current governance and accountability structures of NSW Health;

b. the process of establishing and renewing service agreements and setting and monitoring of key performance indicators (KPIs); and

c. strategies to identify and minimise waste and enhance efficiency within the NSW public health system.

Western NSW LHD, 8–17 May 2024

7.53. This Special Commission visited the Western NSW LHD between 8 and 17 May 2024.

7.54. Between 8 and 10 May 2024, this Special Commission conducted site visits the following facilities:

a. Western NSW LHD virtual care hub in Dubbo;

b. Dubbo Health Service;

c. Coonamble MPS;

d. Coonamble Aboriginal Medical Service;

e. Bogan Shire Council Medical Centre; and

f. Nyngan MPS.

7.55. On each of those visits, discussions with management and clinicians were held (including in a roundtable format, with a large number of participants) that focussed on their experiences in delivering healthcare to their communities in rural and regional NSW. Some of the key matters discussed were the significant gaps in mental health services in the region, challenges posed by short-term funding cycles, and the difficulties in attracting and retaining staff, including international staff, in rural and regional areas. During the visit to the Bogan Shire Council Medical Centre, representatives from the Council shared their experiences in becoming a provider of primary care in the region.

7.56. A community consultation session was also held at Western Plains Cultural Centre on 8 May 2024, which was fully subscribed.

7.57. Public hearings were held between 13 May 2024 and 17 May 2024 in Dubbo. Those hearings were focussed on issues relating to the delivery of healthcare in rural and regional NSW, particularly the Western NSW LHD, including:

a. workforce challenges;

b. the healthcare needs of rural and regional populations;

c. the limitations of the traditional General Practitioner Visiting Medical Officer model in meeting current demand for services in the primary and acute care settings across rural and regional NSW; and

d. the limitations of, and challenges created by, current funding models.

7.58. As part of those hearings, this Special Commission adapted its processes to receive evidence of representatives of the Murdi Paaki Regional Assembly (MPRA) in a discussion format. The MPRA is the peak Aboriginal governance body for the Murdi Paaki Region and represents the interests of First Nations populations in western NSW through the implementation of programs and services for those communities.

7.59. I was grateful to the representatives of the MPRA that they came to share their experiences with me, including in relation to:

a. the importance of cultural safety and appropriate consultation in the planning and delivery of healthcare to First Nations people;

b. negative experiences that First Nations populations have reported when interacting with the NSW public health system; and

c. the challenges of obtaining sufficient healthcare services in remote communities, and initiatives to address those challenges.

Far West NSW LHD, 20–23 May 2024

7.60. This Special Commission visited the Far West NSW LHD between 20 and 23 May 2024.

7.61. On 20 and 21 May 2024, site visits to the following facilities were conducted:

a. Broken Hill Health Service;

b. Menindee Health Service;

c. Wilcannia MPS;

d. The Royal Flying Doctor Service base at Broken Hill; and

e. Maari Ma's facilities in Broken Hill and Wilcannia.

7.62. During those visits, discussions were held with clinicians and health service management (on some occasions in a roundtable format with a large number of participants), and I heard their firsthand experiences of delivering healthcare across rural and remote NSW, including to isolated communities. Those discussions centred around the significant challenges of offering healthcare in such remote communities, particularly due to the erosion of primary care markets, the centralisation of services to Broken Hill and Dubbo, and the lack of coordination between services. The causes of staff fatigue and burnout were also explored in detail.

7.63. A community consultation was held at Broken Hill PCYC on 20 May 2024, that was, again, fully subscribed.

7.64. Public hearings were held on 22 May 2024 and 23 May 2024 in Broken Hill, that focussed on some of the unique challenges of delivering healthcare to isolated communities in remote areas of NSW. The evidence called during those hearings explored a range of topics, including:

a. the healthcare needs of First Nations communities in the region;

b. the difficulties faced by communities in accessing the care they need in declining general practice and aged care markets;

c. increasing reliance on premium labour;

d. engagement between the Far West NSW LHD and other healthcare providers in the region; and

e. the limitation of current funding models when applied to rural and remote care settings.

Public hearings 11–14 June 2024 – Sydney

7.65. This Special Commission held public hearings between 11 June 2024 and 14 June 2024 in Sydney that focussed on certain issues relating to the SCHN, the St Vincent's Health Network, and the Hawkesbury District Health Service, including:

a. current structures and approaches to planning the delivery of paediatric services across NSW;

b. the role of AHOs, including that of the St Vincent’s Health Network as the only networked AHO;

c. the approach to funding AHOs, including the St Vincent’s Health Network;

d. the governance and funding models applied to public private partnerships, such as the Hawkesbury District Health Service; and

e. the involvement of AHOs like the St Vincent’s Health Network and operators of public private partnerships in broader planning processes within the local LHD and across the NSW public health system.

Public Hearings 22 July–7 August 2024 – Sydney

7.66. This Special Commission held public hearings between 22 July 2024 and 7 August 2024 in Sydney that focussed on current issues affecting the health workforce in NSW, including:

a. the current composition of the health workforce in NSW;

b. causes of workforce shortages in particular regions or across specialties and practice areas;

c. current approaches to training, recruitment, and engagement of the health workforce within the NSW public health system;

d. barriers to training, recruiting and retaining a sustainable health workforce to meet the current and future healthcare needs of the NSW population; and

e. the manner in which NSW Health engages its staff.

Southern NSW LHD, 12–16 August 2024

7.67. This Special Commission visited the Southern NSW LHD between 12 and 16 August.

7.68. Between 12 and 14 August 2024, this Special Commission visited the following facilities:

a. Bega South East Regional Hospital;

b. Cooma Hospital;

c. Bombala MPS;

d. Katungul Aboriginal Corporation Regional Health and Community Services (Narooma).

7.69. During each of those visits, discussions were held with clinicians and health service managers, including in roundtable discussions involving a range of participants. The topics discussed included initiatives to grow a junior medical workforce, the effectiveness of urgent care centres/clinics, and the challenges posed by the geography of the region, and cross-border issues between NSW and the ACT.

7.70. Public hearings were held between 15 August 2024 and 16 August 2024 in Batemans Bay, that were focussed on the delivery of healthcare in the Southern NSW LHD. The topics explored during the hearings included:

a. particular challenges faced by the LHD, including geographic and population based challenges and the impacts of seasonal tourism;

b. the impact of contracting primary care and aged care markets;

c. challenges in attracting and retaining staff within the region, and the associated cost of premium labour; and

d. the adequacy (or lack thereof) of the funding available to the LHD to deliver the services required to meet the health needs of the population and maintain its infrastructure.

Central Coast LHD, 20 August 2024

7.71. This Special Commission visited the Central Coast LHD on 20 August 2024.

7.72. During that visit, site visits to Wyong Hospital and Long Jetty Urgent Care Centre were conducted, which provided this Special Commission with the opportunity to view those facilities and have roundtable discussions with clinicians and management in relation to a range of issues relating to the delivery of healthcare across the LHD.

7.73. The issues explored during these discussions included the challenge of finding alternative pathways for aged care patients, the rapid increase in Emergency Department presentations, the lack of sufficient funding, the inability of the ABF model to incentivise the delivery of community care that may ease the burden on Emergency Department presentations, and the inaccessibility of primary care services in the region.

Illawarra Shoalhaven LHD, 21 August 2024

7.74. This Special Commission visited Wollongong Hospital on 21 August 2024.

7.75. During that visit, aspects of the facility were viewed, including the aged care ward, and I was able to engage with clinicians and management, as well as representatives from the PHN and local ACCHOs across two roundtable discussions. Those discussions focussed on the particular issues impacting the delivery of care across

the region, including the significant impact of failing aged care markets on hospitals and services across the LHD, and staffing issues, including deficiencies in the various industrial instruments.

Public Hearing 28 August 2024 – Sydney

7.76. A public hearing was held on 28 August 2024 in Sydney, at which evidence was given by Professor Jennifer May, then Director of the University of Newcastle Department of Rural Health, and now National Rural Health Commissioner. Her evidence covered a wide range of topics relevant to the planning and delivery of healthcare in rural, regional and remote NSW, including:

a. the decreasing General Practitioner workforce in NSW, particularly in rural and regional areas;

b. practical barriers to certain specialist clinicians practising in rural and regional areas, such as access to appropriate infrastructure and allied health and nursing expertise to deliver care;

c. challenges in attracting and retaining clinicians in rural and regional areas;

d. the benefits that can be gained by training clinicians in rural and regional areas;

e. various means by which to support services in rural areas, including the role of workforce planning and the provision of incentives; and

f. the need to support rural general practice and primary care to reduce demand on acute facilities.

Northern NSW LHD, 4–6 September 2024

7.77. Between 4 and 6 September 2024, this Special Commission visited the Northern NSW LHD.

7.78. During that visit, this Special Commission visited the following facilities:

a. Lismore Base Hospital;

b. Tweed Valley Hospital;

c. Rekindling the Spirit Health Service (Jullums House);

d. Namatjira Haven Drug & Alcohol Healing Centre;

e. The University of Sydney Centre for Rural Health Lismore;

f. Healthy North Coast PHN;

g. First Light Healthcare; and

h. Bulgarr Ngaru Medical Aboriginal Corporation.

7.79. A range of discussions were held with clinicians and management (including in roundtable formats) that explored the issues and challenges that arise in delivering care across the region. Some of the key topics explored included the impact of discrepancies in employment terms and conditions between NSW and Queensland, the difficult process of hiring international staff, particularly nurses, the lack of aged care services in the region, and the fragmentation of funding for, and reporting burden on, ACCHOs.

Mid North Coast LHD, 9–11 September 2024

7.80. Between 9 and 11 September 2024, this Special Commission visited the Mid North Coast LHD, and held site visits to the following facilities:

a. Coffs Harbour Health Campus;

b. Bowraville HealthOne;

c. Macksville District Hospital;

d. Port Macquarie Base Hospital;

e. Galambila Aboriginal Health Service;

f. Coffs Medical Centre; and

g. Durri Aboriginal Corporation Medical Service.

7.81. Discussions where held with clinicians and management about their experiences in delivering care across the LHD (including in roundtable formats). The matters discussed included the disconnect between NSW and the Commonwealth in addressing health priorities, the need for shared governance and communication between LHDs, PHNs and First Nations health services, the impact of the unavailability of aged care services, and the causes of medical and non-medical staff fatigue and burnout.

Hunter New England LHD, 16–20 September, 25 November

7.82. Between 16 and 20 September 2024, this Special Commission visited the Hunter New England LHD.

7.83. A site visit to Tamworth Hospital was held, during which there were roundtable discussions with clinicians and management that focussed on issues and challenges in delivering care across this large LHD, and some of the initiatives that have been implemented to address some of those challenges. Visits to the Tamworth Aboriginal Medical Service and the University of Newcastle Department of Rural Health were also made.

7.84. Public hearings were held between 17 September 2024 and 20 September 2024 in Tamworth that explored the delivery of care across the Northern NSW LHD, the Mid

North Coast LHD and the Hunter New England LHD. The evidence given during those hearings touched on a wide range of topics, including:

a. the benefits of medical and allied health students undertaking training in rural and regional areas;

b. challenges in recruiting and retaining workforce in the region given cross border pay disparity for some roles between NSW and Queensland;

c. the benefits of joint planning and commissioning across the primary and acute care sectors;

d. the impact of failing aged care markets, limited access to timely primary care in some regions, and the NDIS on hospitals; and

e. the annual LHD budget processes.

7.85. This Special Commission returned to the Hunter New England LHD on 25 November 2024 and visited John Hunter Hospital in Newcastle. During that visit, additional roundtable discussions were held, which included discussion concerning the networking of services, current research and innovation projects, and challenges that can come from John Hunter Children's Hospital not being part of the Sydney Children's Hospital Network (SCHN).

Public Hearings 14–18 October 2024 – Sydney

7.86. Public hearings were held between 14 October and 18 October 2024 in Sydney that explored a range of possible responses, solutions and initiatives to address the workforce issues and challenges that had emerged in the evidence, including during the public hearings held between 22 July and 7 August 2024, and in the regional centres. The evidence called during those hearings highlighted several possible responses to existing workforce challenges within the wider system, including measures to:

a. respond to the maldistribution of the health workforce between metropolitan and rural, remote and regional locations, and the reliance on temporary staffing arrangements, including locums and agency staff;

b. enhance the ability of NSW Health to recruit and retain a health workforce sufficient to meet the healthcare needs of the NSW population into the future;

c. update industrial instruments that were recognised as being out of date;

d. increase the attractiveness of generalist practice, including as General Practitioners and rural generalists; and

e. enhance workforce planning, including through greater collaboration with stakeholders external to NSW Health.

Nepean Blue Mountains LHD – 21 October 2024

7.87. On 21 October 2024, this Special Commission visited Nepean Hospital and held roundtable discussions with clinicians and management, that focussed on issues affecting the delivery of care in the LHD, including the effect of increasing rates of chronic disease, inequalities in health literacy, the limitation of current funding models, and workforce challenges.

Western Sydney LHD, 23 October 2024

7.88. On 23 October 2024, this Special Commission visited Westmead Hospital. During that visit, three roundtable discussions were held that covered a wide range of topics, including current shortfalls in the psychiatry workforce and their impact on the delivery of care, innovations in technology and models of care, and workforce challenges faced across the LHD.

Sydney LHD, 24 October 2024

7.89. On 24 October 2024, this Special Commission visited Concord Repatriation General Hospital, during which it toured the facility, including the National Centre for Veterans' Healthcare, and held two roundtable discussions. Those discussions explored a wide range of issues, including the limitation of current funding models and approaches, positive impacts of innovative models of care, and the impact of barriers to collaboration across government departments and with other healthcare providers.

Aboriginal Medical Service Redfern, 28 October 2024

7.90. On 28 October 2024, this Special Commission visited the Aboriginal Medical Service Redfern, and held discussions with its CEO, LaVerne Bellear. A range of issues were discussed relating to the provision of care to the First Nations population in metropolitan areas, including the limitations of current funding models, the benefits of collaboration with the services provided in the NSW public health system, the importance of cultural safety within the healthcare sector, and the impact of chronic disease on the First Nations population.

Albury Wodonga, 29–30 October 2024

7.91. On 29 and 30 October 2024, this Special Commission visited Albury Wodonga.

7.92. During that visit, this Special Commission visited Albury Base Hospital, and held three roundtable discussions that explored several topics relevant to the delivery of care in the cross border region, including the unique challenges associated with operating a cross border health service, the interface between Albury Base Hospital and Wodonga Hospital, challenges created by the fragmented delivery of care in the region, and the plans for the new Albury Wodonga Regional Hospital Project.

7.93. This Special Commission also visited the Albury Wodonga Aboriginal Health Service, and held discussions with its staff in relation to issues such as the lasting effects of intergenerational trauma, challenges associated with short term funding, the burden of reporting placed on the service from multiple funding sources, and the expectations of the community in relation to the range of services that should be able to be delivered by the service.

7.94. Meetings were also held with two of the elected representatives of the area – Dr Amanda Cohn MLC, the Greens NSW spokesperson for Health, and the Member for Albury, Justin Clancy MP.

NSW Ambulance, 1 November 2024

7.95. On 1 November 2024, this Special Commission visited the NSW Ambulance Control Centre, Bankstown Ambulance Station, and the Bankstown Helicopter Base.

7.96. As part of its visit, this Special Commission observed demonstrations of mechanical cardiopulmonary resuscitation and extracorporeal membrane oxygenation (ECMO), and the 'Make Ready Model'. This Special Commission was also shown the training facilities at the Bankstown Helicopter Base and toured each of the facilities.

7.97. Two roundtable discussions were held during the visit that touched an several issues of particular relevance to NSW Ambulance, including the funding models applied to NSW Ambulance, workforce demands and challenges, the importance of data in planning and funding the service, and the interface between the service and NSW Health more generally.

South Western Sydney LHD, 4 November 2024

7.98. This Special Commission visited Liverpool Hospital on 4 November 2024 and held roundtable discussions in the Interventional Radiology Department and the Research and Education Centre. Those discussions explored a number of topics and issues, including:

a. the development of innovative models of care, including the use of artificial intelligence;

b. mechanisms to share developments and knowledge with other LHDs;

c. workforce challenges;

d. the adequacy of current and historical funding models in responding to the complex care needs of a socio-economic and culturally diverse population; and

e. the impacts of primary care, aged care and NDIS service failures on the health of the population and the acute services within the LHD.

7.99. This Special Commission also visited the Budyari (Miller) Community Health Centre, an Aboriginal Community Health Centre operated by the South Western Sydney LHD, and held a roundtable discussion with clinicians and management, which explored several topics relating to the delivery of care to the First Nations populations in the area.

Sydney Children's Hospitals Network, 6 November 2024

7.100. On 6 November 2024, this Special Commission visited the SCHN at both of its locations – The Children's Hospital at Westmead and the Sydney Children's Hospital at Randwick.

7.101. During those visits, this Special Commission conducted roundtable discussions with management and clinicians that explored a number of issues of particular relevance to the network, including:

a. the limitations of the ABF model to account for the nature of paediatric care;

b. limited professional opportunities and the lack of a fit for purpose industrial award for research staff;

c. the role of artificial intelligence in innovation and the delivery of care to children;

d. the role of philanthropy in paediatric medicine, including the (misguided) expectation that philanthropy should fund general services;

e. the positive impact of new models of care;

f. increasing rates of staff fatigue and burnout;

g. the difficulties created by the perception that the SCHN hospitals are the first port of call for any health issues involving a child;

h. the need to balance infrastructure developments with the delivery of safe care; and

i. the benefits of the virtualKIDS Statewide service.

South Eastern Sydney LHD, 7 November 2024

7.102. This Special Commission visited the South Eastern Sydney LHD on 7 November 2024, and held roundtable discussions at Prince of Wales Hospital and Headspace Bondi Junction. These discussions covered matters such as the:

a. challenges associated with operating new facilities, including in relation to funding;

b. development of new models of care for short stay hospital patients;

c. impact of increases in violent patients presenting to hospitals;

d. reduction in the availability of aged care services in the LHD, and the knock on effect on patient flow through the LHD's facilities;

e. challenges associated with patient transportation;

f. challenges of short term funding for some services, including on service planning and staffing;

g. benefits of early intervention in relation to child and adolescent mental health; and

h. effect of a shortage in the number of psychiatrists in the NSW public health system.

Justice Health and Forensic Mental Health Network, 8 November 2024

7.103. On 8 November 2024, this Special Commission visited Justice Health, including the Forensic Hospital, Long Bay Hospital, and the Metropolitan Special Programs Centre 2.

7.104. During that visit, three roundtable discussions were held that focussed on the unique role and service offering of the network. The issues discussed included:

a. the effect of the prevailing shortages in the public psychiatry workforce on Justice Health;

b. difficulties in discharging well patients from the Forensic Hospital due to the lack of available community services, resulting in bed block;

c. the difficult working conditions for staff as a result of the high risk environment, and the resultant effect on wellbeing;

d. underfunding of custodial health services; and

e. the lack of capacity to focus on preventive care, due to workforce and funding constraints.

Public Hearings 14–15 November 2024 – Sydney

7.105. Public hearings were held between 14 November 2024 and 15 November 2024 in Sydney. During those hearings, evidence was called from several clinicians of their experiences within the NSW public health system. That evidence covered several issues, including:

a. the future sustainability of the public health system and what it can reasonably be expected to provide;

b. measures to manage community expectations and divert funding from low value, high cost interventions and treatments, which are unlikely to improve a patient's quality of life, to areas of need;

c. concerns about inadequate and inequitable funding of outer metropolitan and rural LHDs;

d. the impact of patients waiting for long periods in hospitals for a residential aged care place or NDIS plans; and

e. workforce challenges across the system, and their impact of care delivery.

Public Hearings 18–21 November 2024 – Sydney

7.106. Public hearings were held between 18 November 2024 and 21 November 2024 in Sydney. During those hearings, several issues relating to the funding of healthcare in NSW were explored, including:

a. the fragmented nature of the funding arrangements between the Commonwealth and the states and territories, and its impact on the delivery of care;

b. the interface between NSW Treasury and NSW Health, including during the annual State budget process;

c. the processes for setting NSW Health's budget, and the budgets of the LHDs and other public health organisations;

d. the increase in "pressure" on NSW Health's budget over time, and in particular, following the COVID-19 pandemic; and

e. the adequacy of the current levels of funding for the NSW public health system.

7.107. As observed later in this Chapter, in exploring those issues, I sought input from the Commonwealth Department of Health and Aged Care (DOHAC). Ultimately, DOHAC declined to provide such input, citing the inappropriateness of taking that step in the context of the Commonwealth's negotiation of the next iteration of the NHRA with the states and territories.

7.108. This Special Commission also sought input from the Independent Health and Aged Care Pricing Authority (IHACPA). In response to this Special Commission's call for submissions, IHACPA provided a submission on 31 October 2023. Representatives of IHACPA also contributed to the work of this Special Commission by participating in meetings in December 2023 and in March, August and November 2024, and in the provision of documents. While the IHACPA's CEO declined to give oral evidence at these hearings, IHACPA did provide detailed written responses to a number of funding related questions issued by this Special Commission following the hearings, which was tendered.

Public Hearings 27 and 28 November 2024 – Sydney

7.109. On 27 and 28 November 2024, public hearings were held in Sydney for the purpose of taking evidence from a number of organisations involved in the provision of healthcare to First Nations people. That evidence was heard in a roundtable format. Two sessions were held, one in person (at the National Centre for Indigenous Excellence at Redfern), and another by audiovisual link for those participants who were unable to travel to Sydney.

7.110. During those hearings, a number of issues relating to the funding and delivery of healthcare to First Nations populations were explored, including:

a. the often short term, limited purpose and fragmented nature of funding for ACCHOs and AMSs;

b. the burdensome reporting obligations that can apply to grant funding;

c. the effect of short term funding cycles on the ability of organisations to attract and retain a workforce;

d. barriers to better collaboration between ACCHOs and AMSs and public health organisations (including LHDs, the Ministry of Health and PHNs); and

e. the importance of cultural safety in delivering care to First Nations patients.

Public Hearings 10–12 December 2024 – Sydney

7.111. Public hearings were held between 10 December 2024 and 12 December 2024 in Sydney. During those hearings, evidence was called from a range of health system experts, including some of the authors of the Sax Institute reports. Several key themes and issues were explored during that evidence, including:

a. the importance of transparency in budget processes, including in relation to the allocation of funding to LHDs, SHNs and other public health organisations;

b. the advantages and disadvantages of centralised governance over the public health system;

c. approaches to the planning of healthcare services, including the importance of identifying the healthcare needs of a population when planning how the resources of the wider system are to be deployed to meet those needs;

d. potential improvements to existing funding models; and

e. the importance of preventive care, now and into the future.

Final submissions

7.112. On 20 December 2024, Counsel Assisting delivered their written outline of submissions, which set out a range of potential findings and recommendations that they submitted were open to me to make. NSW Health's response to that outline was received on 18 February 2024.

7.113. In addition, several interested parties made short written submissions commenting on the submissions made by Counsel Assisting, and NSW Health made a short written reply to the submissions that had been received from those interested parties on 6 March 2025.

7.114. All the written submissions were placed on this Special Commission's website, and a list of the final written submissions is set out in Appendix B. I gave all of them careful consideration, and was greatly assisted by them.

Public Hearings 26 and 27 February 2025 – Sydney

7.115. Public hearings were held between 26 February 2025 and 27 February 2025 in Sydney. During those hearings, the Health Secretary was called to give evidence, together with Adjunct Professor D'Amato and Mr Minns.

7.116. The evidence called during those hearings was directed to several issues that had emerged from the exchange of written submissions.

7.117. At the conclusion of the evidence, Senior Counsel for NSW Health and Senior Counsel Assisting made closing oral submissions.

The role of the Commonwealth in this Special Commission

7.118. Regrettably, the Commonwealth DOHAC did not participate in this Special Commission. On 17 October 2023, I wrote to the Secretary of that Department, and amongst other matters sought assistance by being provided with an answer to the following questions:

> (c) *What improvements to care coordination for people with chronic and complex needs is the Commonwealth supporting and/or partnering with NSW per Clause 7c of the [National Health Reform Agreement 2020–2025] Addendum?*
>
> (d) *What improvements to local accountability and responsiveness to the needs of communities through continued operation and collaboration between Local Hospital Networks and Primary Health Networks in NSW is the Commonwealth supporting and/or partnering with NSW per Clause 7g of the Addendum?*
>
> (e) *What reforms to primary healthcare is the Department undertaking or planning to, as part of clause 13 g of the Addendum?*
>
> …
>
> (g) *What (if any) "innovative approaches to public hospital funding" is the Department aware of or participating in, related to clause A96 of the Addendum?*

7.119. I did not receive an answer to any of those important questions. On 24 October 2024, I caused a letter to be sent to the Secretary of DOHAC inviting that Department to make a submission to this Special Commission. On 13 November 2024, I received the following response:

> *I appreciate the invitation for the department to voluntarily provide a submission and evidence in the public hearing on behalf of the Commonwealth. However, in light of the Commonwealth's position in negotiating the upcoming National Health Reform Agreement (NHRA) with states and territories, I consider the department's involvement in the Inquiry may not be appropriate at this time. To this end, the department politely declines your invitation.*

7.120. It is not entirely clear to me how a submission by the Commonwealth to this Special Commission, or an answer to the fact based questions posed in my letter of 17 October 2023, could have impacted the Commonwealth's role of "negotiating the upcoming … NHRA". Perhaps I am missing something. And perhaps not. In any event, on 4 February 2025, the Secretary was provided with a copy of the submissions of Counsel Assisting, to which there was also no substantive response.

7.121. As the Commissioner of a State inquiry, I did not wish to get into an argument with the Commonwealth about intergovernmental immunities. Nevertheless, I was hopeful (and perhaps expected) that I would receive assistance from the Commonwealth given the importance of the public healthcare system, and joint responsibilities of the Commonwealth and the states in delivering care to the Australian people (including those in NSW). It would have assisted this Special Commission enormously to hear the Commonwealth's perspective on many of the issues that arose for my consideration. It may have even resulted in significant enhancements in the public health system more generally. However, that was not to be. As the authors of the insightful paper, *Australian Health Services: Too Complex to Navigate* observed, unless and until there is proper engagement at all levels of government on the issues and challenges facing the healthcare system in this nation, the cycle of reviews or inquiries that lack the capacity to effect meaningful change will continue.[8]

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[8] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) pp viii-ix [SCI.0001.0041.0001 at 0008-0009].

Conclusion

7.122. It is self evident from this general summary of the processes of this Special Commission that its work was extensive and involved wide ranging engagement with many people and organisations involved in the healthcare sector in NSW. I was left in no doubt that all of those who engaged with this Special Commission approached it with a commitment to improving the public health system for the benefit of the people of NSW.

7.123. Throughout the duration of this Special Commission, I was also acutely aware that, in many instances, engaging with it was an imposition on those with already significant workloads and pressures in delivering care to the people of NSW. I again, extend my gratitude to all those who were willing to provide me with their time so I may benefit from their experience, insight, and expertise. At the risk of repeating myself – the work of this Special Commission was significantly enhanced by it.

Chapter 8:

A short history of health reviews

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Better Health Commission, *Looking Forward to Better Health* (1987) 184

Public Accounts Committee, Parliament of NSW, *Funding of Health Infrastructure and Services in NSW* (1992) 184

Industry Commission, *Private Health Insurance* (1997) 186

Commonwealth Government, House of Representatives Standing Committee on Family and Community Affairs: *Health On Line: Report into health information management and telemedicine* (1997) 186

Commonwealth Department of Treasury, *Intergenerational Report 2002–03* (2002).. 187

NSW Parliament, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in NSW* (2002) 188

Productivity Commission, *Australia's Health Workforce* (2005) 189

Commonwealth House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the Inquiry into Health Funding* (2006)..... 190

Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (2008) 192

Productivity Commission, *Performance of Public and Private Hospital Systems* (2009) 201

National Preventative Health Taskforce, Australia: *The Healthiest Country by 2020* (2008) 202

National Health and Hospitals Reform Commission, *Healthier Future for All Australians* (2009) ... 202

Commonwealth Department of Health and Ageing, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (2010) ... 204

NSW Director-General, Future Arrangements for Governance of NSW Health (2011) ... 205

Department of Prime Minister and Cabinet, Reform of the Federation, *Issues Paper 3, Health* (2014) ... 206

National Mental Health Commission, *Contributing Lives, Thriving Communities* (2014) ... 206

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Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Conditions* (2015) ... 208

Commonwealth Department of Treasury, *Intergenerational Report – Australia in 2055* (2015) ... 208

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NSW Parliament, Public Accounts Committee, Inquiry into the Management of Healthcare Delivery in NSW (2018) ... 211

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Introduction

8.1. This Special Commission is the latest in a long line of reviews that have been undertaken since the emergence of an organised public health system in about the mid-1800s.

8.2. Given the importance of public healthcare to the population, perhaps frequent reviews of it are to be expected. On one view, that approach reflects a continued interest by government in the ongoing improvement of the public health system more broadly. However, a striking feature of many of these reviews is that they identified similar themes, which are yet to be fully resolved or addressed, and many of which emerged in the evidence again before this Special Commission.

8.3. The authors of the Australian Health Policy Collaboration paper *Australian Health Services: Too Complex to Navigate*[9] considered a number of reviews into aspects of the public health system at the national level, and observed:[10]

> *Reviews have agreed that the fundamental challenge facing Australian health care is how to meet and reduce the rising demand for care of chronic disease. The complexity of the Australian health care system provides significant challenges for reform. A recent OECD comparative review described the Australian health care system as 'too complex for patients'; and, this report shows that Australia's current health arrangements fall well short of the goals of Medicare.*
>
> *There is also a very high level of agreement on what needs to change. A first step towards meaningful reform is to re-cast the current policy debates to focus on areas of agreement, rather than disagreement.*
>
> *…*
>
> *Australia's health care system continues to be too complex to navigate for governments and funders, and for consumers and providers alike. We have decades of consistent, unambiguous advice on what needs to be done and there are strong international models and examples of how to do what needs to be done.*
>
> *Australia needs governments and health leaders to take the advice that is in place and get on with building a health system that is simpler, fairer and more affordable for all Australians.*

8.4. Those observations are as apt now as when they were made.

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[9] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) [SCI.0001.0041.0001].

[10] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) pp 2–3 [SCI.0001.0041.0001 at 0011–0012].

8.5. I have set out below a high level summary of some of the reviews into the public health system that have been undertaken in NSW and across Australia, and that have identified similar issues or themes to those that emerged in the course of this Special Commission. One of the purposes for doing this is to illustrate and emphasise that, as a country, we may have reached the stage where health system reviews, reports and the body of literature on it generally could be seen to have recommended the same reforms over and over again. While what those with the power to make change do is entirely at their discretion, it arguably might be time for them to either say to the public that they are unpersuaded by the need for reform, or that significant reform is fiscally beyond government, or to finally act on the advice and recommendations that have been so consistently given.

Early reviews into the public health system in NSW: 1850–1900

8.6. Commencing from about the mid-1800s, a series of reviews into the health system within NSW were undertaken at a time when a structured public health system under government control and oversight was beginning to emerge. Those inquiries, as may be expected, focussed on the prevailing health issues of the time; mental health and infectious diseases, and included:

(a) an 1855 inquiry into the Benevolent Society of NSW, a charity that operated the Benevolent Asylum and other sites to provide care to the “poor, aged and infirm” of NSW. That inquiry considered issues relating to the funding of that service, including whether the Government should continue to provide its funding.[11] Ultimately, in 1862, the NSW Government took over the care of the aged and infirm from the Benevolent Society, creating the Board of Government Asylums for the Infirm and Destitute;[12]

a. an 1867 study by Dr Frederick Norton Manning of asylum systems in the United Kingdom, Continental Europe, and the United States.[13] Following that study, changes were made to the classification and organisation of asylums, and a system of “defined legal procedures for admission and committal, care of the persons’ assets, and the right[s] of the patient after committal” was also established;[14]

[11] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 53 [SCI.0011.0778.0001 at 0065].

[12] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 53 [SCI.0011.0778.0001 at 0065].

[13] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 41 [SCI.0011.0778.0001 at 0053].

[14] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 41 [SCI.0011.0778.0001 at 0053].

b. an 1881 Royal Commission into the management of the Quarantine Station at North Head.[15] As a result of that Royal Commission, new standards for the Quarantine Station were established, as were procedures for the admission, care, isolation and discharge of those quarantined within the facility;[16] and

c. an 1892 inquiry by Sir Normand MacLaurin into sanitary legislation in England. In his report, Sir Normand was critical of the fragmented public health legislation in NSW, and recommended that the NSW Government introduce a full and complete sanitary code including notification and prevention of epidemic disease, and several other recommendations to improve sanitary conditions and prevent infectious diseases.[17]

8.7. Between 1873 and 1899, there were several iterations of the Royal Commission into Public Charities, which were called to inquire into and report on the working and management of public charities, which at the time were significant providers of healthcare. By the end of the 1870s, a system of voluntary hospitals, each with independent boards of management, had emerged in NSW. Although these voluntary hospitals usually required financial support from the NSW Government, they generally resisted government supervision or control over their operations. As a result, there was no control over quality of care.

8.8. Following recommendations made in about 1889 by the Royal Commission into Public Charities, a regime of government inspection and financial control over public charities involved in the delivery of healthcare was implemented, along with enhancements to the administration of health services.[18] In 1897, a fourth iteration of the Royal Commission into Public Charities resulted in the creation of a Division of Charitable Institutions, dedicated to the oversight of general (voluntary) hospitals,[19] and in 1899, the Royal Commission into Public Charities recommended that private hospitals also be placed under government supervision, and that they be licensed after inspection.[20]

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[15] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 66 [SCI.0011.0778.0001 at 0077].

[16] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 67 [SCI.0011.0778.0001 at 0078].

[17] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 76 [SCI.0011.0778.0001 at 0086].

[18] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 58 [SCI.0011.0778.0001 at 0070].

[19] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 136 [SCI.0011.0778.0001 at 0146].

[20] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 186 [SCI.0011.0778.0001 at 0196].

A new mental health system: 1900–1962

8.9. In 1923, a Royal Commission was established in response to complaints of overcrowding, poor staff attitudes, and inadequate treatment regimes due to staff shortages in mental health facilities, as well as criticisms of the *Lunacy Act* and its procedures.[21] Ultimately, however, the Royal Commission's report did not recommend any significant change.[22]

8.10. The outbreak of World War II had a significant impact on government finances, and as a result essential government services had to be sustained within constrained budgets.[23] In order to respond to those challenges, it was proposed that all government-run medical units be aggregated in order to eliminate competition, improve service quality, and stimulate recruitment through enhanced career prospects.[24] Dr Emanuel Sydney Morris, then Director-General of Public Health, was instructed to prepare a report, with the leads of the other health agencies, to progress the proposal. He ultimately recommended that a department, led by a single professional head with responsibility for both public health and mental health, be established, which occurred in 1941.[25] The intent of the new structure was to deliver services in line with national policy on preventive medicine, by focussing on maternal and infant health, school children, industrial hygiene, environmental sanitation, prevention and control of infectious diseases, mental health, health education, and research.[26]

8.11. In 1955, a study of mental health services across Australia, conducted by Dr Alan Stoller, the Chief Clinical Officer of the newly established Mental Health Authority of Victoria, was published. That study was commissioned by the Commonwealth Minister for Health, with a view to formulating a national policy for the upgrade of State mental health facilities as part of a national health scheme.[27] As a result of that study, the Commonwealth Government agreed to provide financial assistance to the states to renovate and modernise mental hospitals.[28]

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[21] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 114 [SCI.0011.0778.0001 at 0124].

[22] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 115 [SCI.0011.0778.0001 at 0125].

[23] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 141 [SCI.0011.0778.0001 at 0151].

[24] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) pp 141, 144 [SCI.0011.0778.0001 at 0151, 0154].

[25] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 144 [SCI.0011.0778.0001 at 0154].

[26] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 144 [SCI.0011.0778.0001 at 0154].

[27] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 115 [SCI.0011.0778.0001 at 0125].

[28] This was ultimately reflected in the *States Grants (Mental Institutions) Act 1955* (Cth): see Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 115 [SCI.0011.0778.0001 at 0125].

8.12. On 13 December 1960, a Royal Commission was established to inquire into the conditions at Callan Park Mental Hospital.[29] That Royal Commission also inquired into several systemic issues in relation to the delivery of mental healthcare, prevailing community and institutional needs, and the state of aspects of the system, including psychiatric nursing, psychiatric therapy, supportive and rehabilitation services, and the division of responsibility for the delivery of mental healthcare.[30] Ultimately, the Royal Commission identified deficiencies in the mental hospital system that, although seemingly accepted in the past, were inconsistent with prevailing standards, which prompted a reorganisation of the Division of State Psychiatric Services.[31] In 1961, the Health Advisory Council and the Division of Establishments were created, in order to plan, manage and deliver that reorganisation.[32]

8.13. The Health Advisory Council was constituted by experts in three disciplines of health administration – hospitals, preventive medicine, and psychiatry – an executive member, and the Director-General of Public Health as Chairman.[33] Its first reference was to consider proposals for a coordinated program of mental healthcare.[34]

8.14. In June 1961, the Health Advisory Council published its *First Interim Report on Preventive Psychiatry*, which emphasised the importance of prevention and early diagnosis through health and community educational programs, together with the need to revise technical education of first contact professionals, medical practitioners, paramedical professionals, nurses, clergymen, and counsellors.[35]

8.15. In March 1962, the Health Advisory Council published its *Second Interim Report*, which focussed on the function of State hospitals and geriatric hospitals.[36] It also considered the role of religious and charitable organisations in the provision of mental healthcare, proposed that they be supported to do so, and recommended that there be better coordination (as opposed to competition) with those services to reduce the burden on mental hospitals.[37]

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[29] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 119 [SCI.0011.0778.0001 at 0129].

[30] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 119 [SCI.0011.0778.0001 at 0129].

[31] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 120 [SCI.0011.0778.0001 at 0130].

[32] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) pp 96, 121–122 [SCI.0011.0778.0001 at 0106, 0131–0132].

[33] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 122 [SCI.0011.0778.0001 at 0132].

[34] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 123 [SCI.0011.0778.0001 at 0133].

[35] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 123 [SCI.0011.0778.0001 at 0133].

[36] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 125 [SCI.0011.0778.0001 at 0135].

[37] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 125 [SCI.0011.0778.0001 at 0135].

8.16. In October 1962, the Health Advisory Council published its *Third Interim Report*, which focussed on the care needs of those with intellectual disabilities, including: diagnosis; case-finding and counselling; supportive services; facilities for care and training; residential and hospital care; hostels; the special needs of babies and infants; parent education; the mechanism of accreditation of services; and financial support.[38]

A reconsideration of the structure the NSW public health system: 1965–1970

8.17. By the mid-1960s, a level of disharmony had developed within State health services, with some wanting to preserve the *status quo* and others advocating for change in the way in which care was being delivered, including around what were then emerging concepts of community medicine and holistic care.[39] At around that time, the then Minister for Health observed that there had never been an evaluation of the organisation and provision of health services in NSW, and that as a consequence there was a poor distribution of facilities and ineffective relationships between official and voluntary agencies.[40] To address this, the Research Division of the Public Service Board and Graham Charles Eglington (a solicitor and research officer) were engaged to review the State's health services.[41]

8.18. In January 1968, an Interim Report was delivered that was critical of the administration of health services, voluntary hospitals, health districts, public health and psychiatric services, and expressed the view that NSW compared unfavourably with the health systems of the United Kingdom and New Zealand (*Eglington Report*).[42] The report proposed the creation of a central agency responsible for all health services, which would employ all health services staff, plan and set policy for services, have inspection and arbitration roles, and be a clearing house for specialist advice and medical research.[43] In the proposed reorganisation of health services, regional authorities with significant autonomy would manage community health services and some hospitals, and delegate oversight of some teaching hospitals to a management board.[44]

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[38] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 125 [SCI.0011.0778.0001 at 0135].

[39] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 145 [SCI.0011.0778.0001 at 0155].

[40] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 39 [SCI.0011.0815.0001 at 039].

[41] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 146 [SCI.0011.0778.0001 at 0156]; Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) pp 7, 39 [SCI.0011.0815.0001 at 0007, 0039].

[42] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 146 [SCI.0011.0778.0001 at 0156].

[43] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 146 [SCI.0011.0778.0001 at 0156].

[44] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) pp 17, 19 [SCI.0011.0815.0001 at 0017, 0019].

8.19. Those recommendations were described by the then Minister as being "very radical" and too complex to permit any opinion to be expressed as to their desirability at that time.[45] No Final Report was ever delivered. A strong argument could be made that this was a missed opportunity. Mr Eglington seems to have foreseen where the system would ultimately head in terms of structure, as well as envisioning something akin to a universal healthcare system. In any event, in April 1968, the Minister of Health appointed the Committee of Community Health Services to consider those recommendations. The Committee saw its main objective as formulating an administrative framework that would be "capable of ensuring that, within the unavoidable limitations of finance and manpower, an optimum standard of health services will be provided to the community".[46]

8.20. On 26 November 1969, the Committee delivered its report and concluded that the *Eglington Report* reflected a historical view rather than an analysis of contemporary health services, and failed to recognise that the NSW health system compared favourably with others in terms of outcomes.[47] Nevertheless, the Committee agreed (at least in part) with several of the conclusions made in the *Eglington Report*, but was of the view that there must be provisions to allow for the closest possible liaison between the private and the governmental sectors to achieve optimum patient care, with its concomitant social and economic benefits.[48]

8.21. The Committee also disputed the conclusion in the *Eglington Report* that there was an imbalance between curative medicine and preventive and restorative medicine, instead characterising it as an issue of limited resources that made it impracticable to implement new measures in both types of medicine.[49] It supported the proposal for a central authority with administration of health services on a regional and integrated basis, but not the proposal for autonomous regional authorities.[50] Rather, it proposed that health services should be administered by a Regional Director of Health, who was delegated functions to the maximum extent that was consistent with maintaining central control.[51]

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[45] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 148 [SCI.0011.0778.0001 at 0158]; Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 39 [SCI.0011.0815.0001 at 039].

[46] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 9 [1] [SCI.0011.0815.0001 at 0009].

[47] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 12 [3.1]–[3.2] [SCI.0011.0815.0001 at 0012].

[48] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) pp 12–13 [3.9] [SCI.0011.0815.0001 at 0012–0013].

[49] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 13 [3.16] [SCI.0011.0815.0001 at 0013].

[50] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 10 [11] [SCI.0011.0815.0001 at 0010].

[51] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) pp 10 [11]–[12], 17 [3.46] [SCI.0011.0815.0001 at 0010, 0017].

8.22. The Committee also recommended the creation of a NSW Health Commission to unify all State health service activities by absorbing the Department of Public Health, the Hospitals Commission of NSW, and the NSW Ambulance Transport Service Board. The Committee recommended that the Health Commission have the power to decide the nature and scope of activities particular hospitals could perform, so as to avoid unnecessary duplication.[52] Accordingly, the NSW Health Commission was established in 1973 by the *Health Commission Act 1972* (NSW). While the Department of Public Health and the Hospitals Commission of NSW were dissolved and their roles assumed by the Health Commission, the NSW Ambulance Transport Service Board was not transferred to the Commission until 1976.[53]

The need for preventive care: Interim Committee of the National Hospitals and Health Services Commission (1973)

8.23. In June 1973, the Interim Committee of the National Hospitals and Health Services Commission delivered its report on the allocation of capital and operating funds to develop and maintain healthcare delivery systems. In that report, the Committee found that there was urgent need to rectify the imbalance in the delivery of healthcare that focussed on curative care rather than preventive health and rehabilitation services (seemingly in agreement with Eglington's "radical" findings made five years earlier), and made several recommendations to do so, including the development of a national community health program.[54]

Funding of public hospitals in NSW: 1980–1982

8.24. On 11 November 1981, the Minister for Health directed the NSW Public Accounts Committee to inquire into the causes of over-expenditure in public hospitals during the 1980–81 financial year, and the standard of public accountability of hospitals.[55] In the course of that inquiry, the Committee heard evidence of several issues contributing to financial mismanagement across the public health system, which included: rigid budgeting structures that prevented hospitals from ensuring an efficient allocation of funds;[56] a lack of financial incentives for hospitals to contain costs;[57] and, the absence of any comprehensive review of appointments of medical staff to ensure alignment with needs of the community, which would be desirable not

[52] Exhibit O.2, Parliament of New South Wales, *Report of the Committee on Community Health Services* (Report No 91, November 1969) p 9 [3]–[5] [SCI.0011.0815.0001 at 0009].

[53] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, 2003) p 150 [SCI.0011.0778.0001 at 0160]; *Health Commission Act 1972* (NSW) s 16.

[54] Exhibit O.70, Interim Committee of the National Hospitals and Health Services Commission, Parliament of Australia, *A Community Program for Australia* (Parliamentary Paper No 66, June 1973) p 3 [SCI.0011.0899.0001 at 0004].

[55] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) p 4.

[56] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) p 25.

[57] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) pp 30–31.

only in the interests of cost containment but also to ensure the maintenance of professional standards and skills.[58]

8.25. The NSW Public Accounts Committee made several recommendations to address those issues, including that a form of modified global budgeting be implemented, which would allocate funds for salaries, wages and operational costs in broader categories, allowing hospitals greater discretion in managing their expenditure within these allocations.[59]

8.26. The Committee also recommended that:

a. there be a program of structural reform, through the establishment of area health boards to integrate hospital and community health services;

b. the implementation of a needs based funding formula to ensure equitable resource allocation; and

c. hospitals be required to develop corporate plans that align their future services with regional healthcare needs.[60]

A review of past reviews into the NSW public hospital system:1986

8.27. In 1985, the NSW Public Accounts Committee initiated a follow up review program to assess the outcomes of past inquiries and the action taken in implementing the recommendations made by them, with a particular focus on over-expenditure in the health system and the accountability of hospitals.[61] It identified areas where action was ineffective or delayed and made recommendations to improve hospital accountability, financial management and the budget process.[62] In April 1986, the Committee delivered its Final Report and found that:

a. hospital budgeting remained problematic, with continued over-expenditure and a lack of adequate cost cutting measures that resulted in fiscal irresponsibility in many health facilities;[63]

[58] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) p 69.

[59] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) p 28.

[60] Public Accounts Committee, Parliament of New South Wales, *Over-Expenditure in Health Funding to Hospitals* (Final Report, April 1982) pp 55–56, 64.

[61] Public Accounts Committee, Parliament of New South Wales, *Follow-Up Report on Inquiries (1982) into the NSW Public Hospital System* (Final Report, April 1986) [2.7].

[62] Public Accounts Committee, Parliament of New South Wales, *Follow-Up Report on Inquiries (1982) into the NSW Public Hospital System* (Final Report, April 1986) [1.2].

[63] Public Accounts Committee, Parliament of New South Wales, *Follow-Up Report on Inquiries (1982) into the NSW Public Hospital System* (Final Report, April 1986) [1.3].

b. the Health Department had failed to appropriately define hospital roles and enforce accountability mechanisms, contributing to inefficiencies in financial management;[64] and

c. the budget process remained largely historical rather than needs based, which created an inequitable distribution of funds;

d. there was a major disconnect between hospitals and the Health Department regarding budgeting and role definitions; and the current incentive budgeting system did not provide sufficient motivation for efficiency improvements.[65]

Better Health Commission, *Looking Forward to Better Health* (1987)

8.28. In 1987, the Better Health Commission inquired into the health status of the Australian population, including the special needs of a number of specific groups, including Aboriginal and Torres Strait Islander Peoples, people with disabilities, immigrants, older people, women, and youth.[66]

8.29. The Commission found that there were several challenges facing the health system, such as a lack of a national focus on illness prevention, medical schools failing to train students to promote health, fragmented and sparse research into illness prevention, small and erratic national funding for preventive care, and limited information and skills sharing.[67] The Commission also observed that, to that point, much of healthcare planning and policy was concerned with how doctors were paid, how hospitals were funded, and how medicines were financed, but that there was a need for greater attention to be paid to preventing ill health.[68]

8.30. Thirty-eight years on from that report, the same thing is emphasised in this Report (as it has been in many reports and reviews in the intervening years).

Public Accounts Committee, Parliament of NSW, *Funding of Health Infrastructure and Services in NSW* (1992)

8.31. In May 1992, the NSW Public Accounts Committee initiated an inquiry into the Port Macquarie Base Hospital Project and wider health system issues. The second phase of that inquiry examined a number of issues relating to State and Commonwealth funding for health infrastructure and services in NSW, including facilities and service

[64] Public Accounts Committee, Parliament of New South Wales, *Follow-Up Report on Inquiries (1982) into the NSW Public Hospital System* (Final Report, April 1986) [1.4].

[65] Public Accounts Committee, Parliament of New South Wales, *Follow-Up Report on Inquiries (1982) into the NSW Public Hospital System* (Final Report, April 1986) [3.51], [4.7]–[4.12].

[66] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) p 84 [SCI.0001.0041.0001 at 0093].

[67] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) p 84 [SCI.0001.0041.0001 at 0093].

[68] Exhibit A.45, Rosemary Calder et al, 'Australian Health Services: Too Complex to Navigate' (Policy Issues Paper No 1/2019, Australian Health Policy Collaboration, February 2019) p 84 [SCI.0001.0041.0001 at 0093].

delivery mechanisms. Its terms of reference included considerations about the impact of demographic trends, the roles of the State and Commonwealth Governments in health funding, and the impact of current financial and organisational arrangements on healthcare delivery.

8.32. In the course of its inquiry, the Committee identified several key issues affecting healthcare funding and service delivery in NSW, and concluded that:

a. overlapping roles and responsibilities of the State and Commonwealth Governments were resulting in inefficiencies, cost shifting and unclear lines of accountability;[69]

b. declining levels of private health insurance were placing increased financial pressure on the public health system, raising concerns about its sustainability;[70]

c. the growing demand for health services due to demographic changes, particularly in the ageing population, required a shift towards integrated and community based care;[71]

d. inefficiencies in funding allocation and hospital budget structures were creating "perverse" incentives that prevented effective service delivery;[72] and

e. there was a need for increased community participation in health planning.[73]

8.33. The Committee made various recommendations to address the identified issues, including that the NSW Government:

a. negotiate with the Commonwealth Government to clarify their respective roles and responsibilities for funding and service provision;[74]

b. implement a structured program for greater community participation in healthcare planning;[75]

c. enhance the integration of hospital and community based services to improve efficiency and patient outcomes;[76] and

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[69] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 9, 58.

[70] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) p 71.

[71] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 36–37.

[72] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 82–83.

[73] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 140–141.

[74] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 5, 19–20.

[75] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) p 142.

[76] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 40, 44.

d. improve resource allocation models, streamline the funding process, and establish performance evaluations to ensure cost effective service delivery.[77]

Industry Commission, *Private Health Insurance* (1997)

8.34. On 20 August 1996, the Prime Minister requested that the Industry Commission (now the Productivity Commission) examine the current state of the private health insurance industry, cost pressures on the industry, and effective measures and frameworks for its future operation.[78]

8.35. The Industry Commission found that the Australian health system was a "mixed" system, where private health insurance provided "top-up" funding for additional services and amenities, as well as displacing the need for public funding for services available under Medicare.[79] However, it noted that the mixed system gave rise to challenges, such as rapidly rising premiums and falling fund membership, and growing demand on the public system as the "safety valve".[80]

8.36. The Industry Commission also found that it was impossible to define the most appropriate role of private health insurance without determining how the wider system was intended to function.[81] It suggested a broad public inquiry into Australia's health system, encompassing topics such as health financing and market forces, integrated health systems, information management and the progress of protocol development.[82] If this broad strategic inquiry was considered unmanageable, the Industry Commission proposed that a number of specific inquiries be undertaken, focussing on themes such as financing issues, quality of healthcare, and competitive neutrality.[83]

Commonwealth Government, House of Representatives Standing Committee on Family and Community Affairs: *Health On Line: Report into health information management and telemedicine* (1997)

8.37. On 18 June 1996, the Minister for Health and Family Services referred an inquiry into Health Information Management and Telemedicine to the House of Representatives Standing Committee on Family and Community Affairs.[84] The Committee was required to inquire into and report on the potential of developments in information

[77] Public Accounts Committee, Parliament of New South Wales, *Funding of Health Infrastructure and Services in NSW* (Final Report, June 1993) pp 19, 46, 85.

[78] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) pp 1, 4.

[79] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) p xxix.

[80] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) p xxix.

[81] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) p 385.

[82] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) p 385.

[83] Industry Commission, *Private Health Insurance* (Report No 57, February 1997) p 385.

[84] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) [1.1].

management and information technology in the health sector to improve healthcare delivery and to increase Australia's international competitiveness.[85]

8.38. The Committee found that healthcare delivery had not kept pace with the development of advanced technologies, particularly telehealth and health informatics.[86] It found that telehealth would significantly benefit rural and remote communities by reducing unnecessary travel for patients and doctors, allowing patients to consult with specialists located within Australia or overseas.[87] To incentivise healthcare professionals to use telehealth, the Committee recommended recognising telehealth consultations as an item in the MBS.[88] It also recommended the introduction of a national framework for mutual recognition to allow telehealth to be practiced across multiple jurisdictions.[89]

8.39. In relation to health informatics, the Committee recommended that the issue of ownership of medical records and patients' right of access could be resolved by introducing an electronic health card, which would be supported by a Defence Signals Directorate-accredited Internet security system.[90] Further, it recommended that Australia adopt a standardised system of coding and classification of health data to adequately plan health information interchange and increase Australia's international competitiveness.[91]

8.40. Almost thirty years later, significant information barriers (even within the NSW public health system) remain.

Commonwealth Department of Treasury, *Intergenerational Report 2002–03* (2002)

8.41. On 14 May 2002, the Commonwealth Treasury delivered an *Intergenerational Report* that considered the long term sustainability of current government policies and how changes to Australia's population and demographics may impact economic growth, workforce, and public finances over the 40 years.[92]

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[85] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) [1.2].

[86] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) p xii.

[87] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) p xiii.

[88] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) pp xiii–xiv, xxvi.

[89] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) pp xiv, xxvii.

[90] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) pp xv, xxiv–xxv.

[91] House of Representatives Standing Committee on Family and Community Affairs, Parliament of Australia, *Health On Line: Report into Health Information Management and Telemedicine* (Report, October 1997) pp xvii–xviii, xxvii.

[92] Department of Treasury (Cth), *Intergenerational Report 2002–03* (Report, 14 May 2002) p iii.

8.42. The Report observed over the preceding three decades, Commonwealth health spending had more than doubled, rising to four per cent of Gross Domestic Product in 2001–02,[93] with the Medicare Levy funding less than 20 per cent of spending.[94] Population growth and ageing contributed to one third of recent growth in expenditure, and were identified as issues that would likely place significant pressure on Commonwealth Government finances into the future.[95]

NSW Parliament, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in NSW* (2002)

8.43. On 11 April 2001, the NSW Legislative Council's General Purpose Standing Committee No 2 tasked itself with inquiring into and reporting on various issues concerning quality of care for public patients and value for money in major non-metropolitan hospitals throughout NSW.[96] The inquiry was established in response to community concerns about Port Macquarie Base Hospital (which at the time was privately owned and operated, but publicly funded).[97] In its *Final Report*, the Committee concluded that some of the problems that had existed at Port Macquarie Base Hospital at the inquiry's commencement had been resolved while the inquiry was under way.[98]

8.44. The Committee noted that, in terms of quality of service, Port Macquarie Base Hospital offered a standard of excellence and range of services comparable to, and in many cases exceeding, services available in other non-metropolitan base hospitals.[99] More generally, the Committee identified several areas requiring further attention, including in relation to what the Committee deemed was the ongoing Statewide manipulation of waiting lists.[100]

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[93] Department of Treasury (Cth), *Intergenerational Report 2002–03* (Report, 14 May 2002) p 8.

[94] Department of Treasury (Cth), *Intergenerational Report 2002–03* (Report, 14 May 2002) p 34.

[95] Department of Treasury (Cth), *Intergenerational Report 2002–03* (Report, 14 May 2002) pp 1, 8.

[96] Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in New South Wales* (Final Report, 4 September 2002) p 1.

[97] Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in New South Wales* (Final Report, 4 September 2002) p 9.

[98] Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in New South Wales* (Final Report, 4 September 2002) p vii.

[99] Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in New South Wales* (Final Report, 4 September 2002) p 29.

[100] Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, *Quality of Care for Public Patients and Value for Money in Major Non-Metropolitan Hospitals in New South Wales* (Final Report, 4 September 2002) p 29.

Productivity Commission, *Australia's Health Workforce* (2005)

8.45. On 22 December 2005, the Productivity Commission delivered a research report, commissioned by the COAG, examining issues affecting the health workforce including the:

a. factors affecting the supply of, and demand for, health professionals;

b. current structure and distribution of the health workforce and its efficiency and effectiveness;

c. efficacy of health workforce planning and its linkages to health services planning and the education sector;

d. workforce related policy measures that would help to ensure efficient and effective delivery of quality health services over the next 10 years in an environment of demographic change, technological advances and rising health costs;

e. health workforce needs in regional and remote areas; and

f. provision of out of hours services by general practitioners adjacent to acute care hospitals.

8.46. The Productivity Commission found Australia's health workforce would be better deployed within multidisciplinary models of patient care,[101] and that there was opportunity for innovation in widening scopes of practice and job redesign.[102] As such, the Productivity Commission recommended the establishment of an advisory health workforce improvement agency to facilitate workforce innovation on a national and systematic scale.[103]

8.47. The Productivity Commission also identified issues within health workforce education and training, including its quality and relevance to contemporary healthcare needs,[104] and ineffective coordination between the education and health sectors.[105] To combat these issues, it made a number of recommendations, such as the establishment of an independent taskforce that would collect and consolidate data on supply and demand across all health professions and facilitate better coordinated training arrangements.[106]

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[101] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) p 53 [SCI.0011.0132.0001 at 0094].

[102] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) pp 55, 58–59 [SCI.0011.0132.0001 at 0096, 0099–0100].

[103] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) p 66 [SCI.0011.0132.0001 at 0107].

[104] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) p 75 [SCI.0011.0132.0001 at 0116].

[105] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) p 83 [SCI.0011.0132.0001 at 0124].

[106] Exhibit H2.5, Productivity Commission, *Australia's Health Workforce* (Research Report, 22 December 2005) p 110 [SCI.0011.0132.0001 at 0151].

8.48. The Productivity Commission also found that health workforce shortages in rural and remote Australia were an ongoing problem, and (in order to address them) proposed health workforce education and training initiatives that were aimed at increasing rural training placements and scholarships, and the creation of rural training networks.[107]

Commonwealth House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the Inquiry into Health Funding* (2006)

8.49. On 16 March 2005, the House of Representatives Standing Committee on Health and Ageing resolved to inquire into and report on how the Commonwealth Government could take a leading role in improving the efficient and effective delivery of high quality health care.[108]

8.50. The Committee identified various issues with the current funding arrangements in the health system, including:

a. a duplication of a range of tasks and "wasted resources" created by the division of funding responsibility between the Commonwealth and State Governments;[109]

b. cost shifting between governments, and to patients via co-payments, that could affect the incentives for providers and patients to access appropriate care options, and result in waste and duplication, a reduction in the overall efficiency of the health system, distorted market signals to private sector providers, and over servicing particularly through over-investigation;[110] and

c. the "blame game" between different levels of government about funding and responsibilities, which was undermining the functioning of political accountability for government actions.[111]

8.51. The Committee concluded that funding arrangements needed to focus more on promoting wellness through prevention,[112] providing incentives to healthcare providers to deliver high quality and safe healthcare,[113] and supporting continuity of

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[107] Exhibit H2.5, Productivity Commission *Australia's Health Workforce* (Research Report, 22 December 2005) p 228 [SCI.0011.0132.0001 at 0267].

[108] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [1.19].

[109] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.6].

[110] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.11], [3.15].

[111] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.16].

[112] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.20].

[113] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.28].

care.[114] To this end, the Committee recommended that the Commonwealth, State and Territory Governments develop and adopt a national health agenda that identified policy and funding principles and initiatives to rationalise the roles and responsibilities of governments, improve the health system's long term sustainability, support appropriate and affordable care, rectify health system inefficiencies and inequities in quality and access, clearly articulate expected standards of service, and provide a reporting framework for service performance.[115]

8.52. The Committee also recommended that the Commonwealth Government ensure that its funding model, including indexation and any supplemental payments,[116] were appropriate to meet the actual level of clinical need and costs, whether this be by variation of existing arrangements or clear definition of the services to be provided.[117]

8.53. The Committee also found that the health system was facing significant pressure due to high community expectations about the delivery of healthcare, in terms of access, quality, timeliness and use of latest technology.[118] It explained that transparency in relation to the entire process of treatment was important to better inform the community about the capacity of the health system.[119] Emphasis was placed on "hidden waiting lists", comprising patients who experience delays in seeing specialists in outpatient clinics prior to being added to elective surgery waiting lists at a public hospital.[120] To improve accountability, the Committee recommended that the Commonwealth Government provide incentives for the states and territories to report consistently on patient waiting times for access to specialists in outpatient clinics,[121] and require all public hospitals to be accredited by the Australian Council on Healthcare Standards (or an equivalent accreditation agency) and publish their accreditation reports.[122]

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[114] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.31].

[115] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [3.52].

[116] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [7.34].

[117] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [7.33].

[118] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [9.4]–[9.5].

[119] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [9.16].

[120] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [9.17].

[121] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [9.29].

[122] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [9.38].

8.54. The Committee noted that the health system was experiencing several health workforce challenges such as workforce shortages in both urban and remote areas,[123] meeting the clinical training needs of an increasing number of health trainees,[124] the unsatisfactory quality of services provided by some oversees trained doctors,[125] and the unavailability of sufficient clinical training opportunities for medical students.[126] To fund a sustainable health workforce, the Committee recommended that the Department of Health and Ageing undertake the principal role in improving the coordination of the existing jurisdiction based recruitment of overseas trained health professionals by different governments.[127]

8.55. The Committee also recommended that the Commonwealth Government develop explicit purchasing agreements for clinical training with public healthcare providers that would cover funding levels, specified outcomes and performance measures.[128] Expanded opportunities for private healthcare providers to conduct clinical training and enter into purchasing arrangements (where appropriate) were also identified.[129]

8.56. It is not entirely clear what action was taken in response to those recommendations. As of the time of writing this Report, the website of the Parliament of Australia records that no government response has been tabled.[130]

Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (2008)

8.57. In 2008, the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling Inquiry) was established in response to two highly publicised events in the NSW public health system. The first was a miscarriage experienced by Jana Horska at Royal North Shore Hospital, while waiting in an overcrowded Emergency Department for medical treatment.[131] The second was the death of a 16

[123] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.16]–[4.17].

[124] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.29].

[125] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.45].

[126] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.73].

[127] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.53].

[128] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.82].

[129] House of Representatives Standing Committee on Health and Ageing, Parliament of Australia, *The Blame Game: Report on the Inquiry into Health Funding* (Report, November 2006) [4.94].

[130] Parliament of Australia, House of Representatives Committees, *Standing Committee on Health and Aging - Committee Activities (Inquiries and Reports)* (Web Page) <https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/reports.htm>.

[131] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [1.1]–[1.4] [SCI.0011.0758.0001 at 0044].

year old girl, Vanessa Anderson, at Royal North Shore Hospital after having been admitted with a head injury inflicted by a golf ball.[132]

8.58. The Garling Inquiry highlighted the tension between limited funding and community expectations. Significantly, Commissioner Garling concluded that it was time for NSW, as a society, to have an organised, comprehensive conversation about:

a. what we expect from our public health system;

b. what we are prepared to pay for through our taxes and other contributions; and

c. how to manage the increasing gap between the two.[133]

8.59. Commissioner Garling observed that this type of conversation had been impeded in the past because neither the public, nor individual patients, seemed to have any idea of the cost of medical services and care provided by public hospitals in NSW.[134] He noted that "it is only when we have some consensus, as a society, on how to balance public expectations with resources that we can ensure a public healthcare system which faces the challenges ahead with clarity and direction in a rational context."[135]

8.60. The need for that conversation remains.

8.61. In relation to the issue of funding, Commissioner Garling found that the funding arrangements between the Commonwealth and NSW were a "systemic impediment to the provision of acute care services in NSW public hospitals"[136] and highlighted the evidence that there were "fundamental flaws" in the allocation and management of funding.[137] He also commented on the effectiveness of the mechanisms by which NSW Health distributed funding to the Area Health Services, including the episodic funding model,[138] which allocated funding based on hospital activity levels, grouped into classifications known as Australian Refined – Diagnosis Related Groups.[139] Commissioner Garling anticipated that the issue of continually high allocations for

[132] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [1.22] [SCI.0011.0758.0001 at 0048].

[133] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [2.42] [SCI.0011.0758.0001 at 0071–0072].

[134] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [2.54] [SCI.0011.0758.0001 at 0074].

[135] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [2.56] [SCI.0011.0758.0001 at 0074].

[136] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [25.105] [SCI.0011.0762.0001 at 0032].

[137] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [25.59] [SCI.0011.0762.0001 at 0023].

[138] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [25.108]–[25.109] [SCI.0011.0762.0001 at 0032–0033].

[139] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [25.130], [25.134] [SCI.0011.0762.0001 at 0035–0036].

acute services, rather than health promotion and prevention, would be exacerbated under episodic funding.[140]

8.62. With respect to the restructure of NSW Health in 2005, the Garling Inquiry heard that the resulting centralised decision making model had fostered a general perception of Chief Executives as inaccessible, with "unfettered power and influence", and decision making that lacked transparency and accountability.[141] To address this, Commissioner Garling recommended improvements to that structure, including the devolution and delegation of decision making, especially in relation to expenditure, planning and budgetary processes, back to hospital management and clinicians.[142]

8.63. Commissioner Garling also found a lack of coordination of paediatric and young people's healthcare in public hospitals throughout the State, and suggested it should be addressed by a single Statewide authority providing the full range of care for children and young people.[143] This was to involve the amalgamation of all paediatric inpatient facilities in the State under the control of that single authority, as well as prevention, early intervention and ongoing specialist care.[144] Commissioner Garling also recommended that the authority should investigate and report on the need for, desirability of, and possible locations for a new children's hospital providing quaternary and tertiary facilities.[145]

8.64. Commissioner Garling was also convinced of the importance of the public reporting of information about the health system and its performance to improve patient choice, encourage improvement in services, create public confidence in the system, improve the engagement of clinicians, and enhance cost efficiency.[146] He therefore recommended the establishment of a Bureau of Health Information to publicly report on the NSW public hospital system's performance.[147]

8.65. Commissioner Garling found that many key performance indicators (KPIs) imposed on NSW public hospitals were not directed to quality of care, and that, for example, in the Emergency Department, the focus was on time of processing.[148] He was of the

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[140] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [25.174] [SCI.0011.0762.0001 at 0043].

[141] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [31.88]–[31.89] [SCI.0011.0762.0001 at 0193].

[142] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [31.209]–[31.210], [31.230], [31.311]–[31.312] [SCI.0011.0762.0001 at 0211, 0213, 0226].

[143] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [5.76], [5.81], [5.118] (Recommendation 9) [SCI.0011.0758.0001 at 0157, 0158, 0163–0164, 0165].

[144] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [5.82] [SCI.0011.0758.0001 at 0158].

[145] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [5.106], [5.115]–[5.118] (Recommendation 11) [SCI.0011.0758.0001 at 0161, 0163–0164].

[146] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [16.267] [SCI.0011.0760.0001 at 0221].

[147] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [16.274] (Recommendations 75–79) [SCI.0011.0760.0001 at 0223–0225].

[148] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [17.43] [SCI.0011.0760.0001 at 0245].

view such KPIs were at risk of distorting clinical decisions,[149] and concluded that the focus of performance assessment in relation to Emergency Departments should measure outcomes, rather than merely processes.[150]

8.66. In relation to service planning, Commissioner Garling was of the view that patient safety must be the critical consideration for determining what hospital service was to be provided where.[151] He noted evidence to the effect that quality and safety is at risk due to the sheer number of services that public hospitals were expected to provide in NSW.[152] Communication was identified as being vital to managing community expectations and understanding.[153]

8.67. Commissioner Garling recognised there were several challenges to the rationalisation of service delivery of hospitals, including politics[154] and public understanding.[155] That said, he considered that the hospital network did not meet the ideal requirements for patient safety, critical mass, or efficiency.[156] It was recommended that a plan be devised for delivery of public acute services in NSW,[157] preceded by the following:

a. a complete Statewide review by NSW Health identifying a set of criteria for the volume and quality of services that should be provided;

b. a determination of whether each hospital was a location for the safe delivery of care;

c. a clear delineation of the role of each hospital, and clear communication of this to its community;

d. specialist services be reallocated where needed; and

e. consideration be given to availability of patient transport services.[158]

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[149] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [17.67]–[17.68] [SCI.0011.0760.0001 at 0248].

[150] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [17.69] [SCI.0011.0760.0001 at 0249].

[151] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.44] [SCI.0011.0762.0001 at 0062].

[152] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.46] [SCI.0011.0762.0001 at 0062].

[153] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.145], [26.147] [SCI.0011.0762.0001 at 0077].

[154] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.135]–[26.141] [SCI.0011.0762.0001 at 0075–0077].

[155] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.142]–[26.147] [SCI.0011.0762.0001 at 0077].

[156] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.95] [SCI.0011.0762.0001 at 0070].

[157] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.97] [SCI.0011.0762.0001 at 0070].

[158] Exhibit N4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [26.96], [26.159] (Recommendation 117) [SCI.0011.0762.0001 at 0070, 0079].

8.68. The Garling Inquiry also heard evidence relating to the adverse impact of a lack of aged care beds (particularly for elderly patients with special needs, e.g., secure, dementia specific care),[159] on bed availability and costs in acute care hospitals,[160] as well as the poor outcomes of elderly patients who were in hospital for prolonged periods of time.[161] To address these issues, Commissioner Garling recommended, (among other things) that NSW Health liaise with the NSW Guardianship Tribunal to ensure that patients who were medically fit for discharge be given priority for a hearing by the Tribunal,[162] and that Aged Care Assessment Team assessments be planned to commence as early as possible in a patient's stay in hospital.[163]

8.69. Commissioner Garling found that the growth in attendances at Emergency Departments was putting significant pressure on those departments, leading to overcrowding and delayed treatment, as well as increasing risk of infection.[164] Overcrowding was being exacerbated by factors including "bed block", caused by a disconnect between the peak times when patients are admitted to hospital (mornings) and when patients are generally discharged (afternoons).[165] It was therefore recommended that hospitals review their policies and work practices affecting patient discharge to ensure discharge at the earliest possible opportunity.[166]

8.70. At the time of Commissioner Garling's report, 44 per cent of all attendances at Emergency Departments were by what were described as "primary care patients", being triage category four and five patients who did not arrive by ambulance and who were not ultimately admitted.[167] He found that the evidence suggested:

> *that reduced access to GP services contributes to more and longer hospitalisations as patients present to hospital in crisis and with greater complications than if they see a GP earlier.*[168]

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[159] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [3.103] [SCI.0011.0758.0001 at 0103].

[160] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [3.102] [SCI.0011.0758.0001 at 0103].

[161] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [3.90] [SCI.0011.0758.0001 at 0099–0100].

[162] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [3.116] (Recommendation 5) [SCI.0011.0758.0001 at 0104].

[163] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [3.120] (Recommendation 6) [SCI.0011.0758.0001 at 0105].

[164] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.82] [SCI.0011.0760.0001 at 0316].

[165] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.152]–[20.154], [20.157] [SCI.0011.0760.0001 at 0328–0329, 0332].

[166] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.157] [SCI.0011.0760.0001 at 0332].

[167] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.6], [20.130] [SCI.0011.0760.0001 at 0303, 0323].

[168] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.177] [SCI.0011.0760.0001 at 0336].

8.71. As a response to this, Commissioner Garling proposed that patients in triage categories four and five be treated in a separate area near the Emergency Department, designated a Primary Care Centre, to allow provision of emergency care to patients in urgent need.[169]

8.72. Commissioner Garling was also “convinced that an efficient non-urgent patient transport system is an important ingredient in delivering hospital treatment in an efficient, economic manner”.[170] He believed that while non-urgent transport needed to be provided across the State, there was no reason why this had to only occur with a Statewide system, but rather it could be coordinated by an Area Health Service.[171] He recommended that NSW Health ensure that non-urgent patient transport be provided, separate from emergency transport orchestrated by NSW Ambulance.[172]

8.73. Commissioner Garling identified the advantages to delivering healthcare in the community, including patient happiness, cost effectiveness, and reducing pressure on hospital occupancy rates and staff workload.[173] He also stressed the importance of an integrated approach to service provision, with a seamless transition between community and hospital care,[174] and recommended that NSW Health articulate the goals of its out of hospital programs and make this information publicly available.[175]

8.74. The Garling Inquiry heard evidence about a range of issues affecting health professionals working for the public health system, including:

a. increasing levels of bureaucracy, tighter budgetary constraints and little support for doctors’ training, education or research needs;[176]

b. the prevalence of overtime for junior doctors, as well as the reluctance, including through written policies of some hospitals, to pay for additional hours;[177]

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[169] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [20.200] (Recommendations 99–101) [SCI.0011.0760.0001 at 0339–0340].

[170] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [27.107] [SCI.0011.0762.0001 at 0108].

[171] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [27.108]–[27.109] [SCI.0011.0762.0001 at 0108].

[172] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [27.112] (Recommendation 123) [SCI.0011.0762.0001 at 0109].

[173] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [21.13]–[21.16] [SCI.0011.0760.0001 at 0362].

[174] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [21.28] [SCI.0011.0760.0001 at 0364].

[175] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [21.53] (Recommendation 104) [SCI.0011.0760.0001 at 0370].

[176] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.122] [SCI.0011.0758.0001 at 0253].

[177] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.139] [SCI.0011.0758.0001 at 0255].

c. the lack of generalists within the NSW Health system, impacting negatively on the coordination of care,[178] and the workforce distribution, particularly of general surgeons;[179]

d. an anticipated shortage in nurses stemming from an ageing workforce in combination with lower trainee nursing numbers;[180]

e. overtime, burnout, and inadequate remuneration causing nurses to leave clinical roles, leading to the loss of experience in wards;[181]

f. the ratio of nurses with different experience levels in a ward needed to address increasing patient acuity and decreased length of stay;[182]

g. allied health professionals being considered “the second-class citizens of the health sector”;[183] and

h. pay levels in the public system when compared with those available in the private sector.[184]

8.75. Commissioner Garling highlighted “a very serious workforce situation presently facing rural and remote areas of NSW,”[185] and recommended that NSW Health take immediate steps to enhance the supply of clinicians to rural areas, including through consideration of the following strategies:

a. introducing a rural term for second or third year junior medical officers; [186]

b. developing education facilities to provide all clinicians working rurally with adequate training;[187]

c. improving recognition and support from Colleges for those interested in rural training;[188]

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178 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.108]–[7.111] [SCI.0011.0758.0001 at 0249–0250].

179 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.116]–[7.118] [SCI.0011.0758.0001 at 0251–0252].

180 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [8.42]–[8.59] [SCI.0011.0758.0001 at 0294–0297].

181 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [8.107]–[8.114], [8.143] [SCI.0011.0758.0001 at 0308–0309, 0315–0316].

182 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [8.117] [SCI.0011.0758.0001 at 0311].

183 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [9.3] [SCI.0011.0758.0001 at 0336].

184 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.147]–[7.155] [SCI.0011.0758.0001 at 0257–0258].

185 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.6] [SCI.0011.0758.0001 at 0174].

186 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.57] (Recommendation 12(a)) [SCI.0011.0758.0001 at 0183–0184].

187 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.57] (Recommendation 12(c)) [SCI.0011.0758.0001 at 0183–0184].

188 Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.67] [SCI.0011.0758.0001 at 0185].

d. reviewing the number and adequacy of prevocational and vocational places in rural regional and outer metropolitan areas;[189]

e. fostering meaningful and challenging work, as well as more flexible policies and working arrangements, and family friendly working hours;[190]

f. partnerships between metropolitan and rural hospitals;[191] and

g. taking sufficient advantage of the possibilities of telehealth.[192]

8.76. While recognising the important role that locums can play in the system, Commissioner Garling commented on the disadvantages associated with a high reliance on locums, including the considerable cost of hiring these staff,[193] the inability to test a locum's competency before they arrive, their unfamiliarity with the hospital,[194] the lack of continuing education requirements,[195] the lack of long term commitment and impact on continuity of care,[196] and challenges in performance managing temporary staff.[197] He recommended that employment agencies for locum staff be centralised, with a system of accreditation as a second best option.[198] He also recommended a centralised database of vacancies and locum shifts, which included the credentials and performance history of locums.[199]

8.77. The Garling Inquiry also identified a number of issues arising out of a lack of support staff, which impacted doctors, nurses, and allied health professionals alike, who spent undue amounts of time on administrative tasks that could be more efficiently, both time and cost wise, completed by support staff.[200] Commissioner Garling therefore recommended that the NSW Health workforce be realigned to recognise a series of principles centred around working in a multidisciplinary environment, providing patient

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[189] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.119] (Recommendation 17(a)) [SCI.0011.0758.0001 at 0252].

[190] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.147]–[6.148] [SCI.0011.0758.0001 at 0197–0198].

[191] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.160] [SCI.0011.0758.0001 at 0199].

[192] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [6.167] [SCI.0011.0758.0001 at 0200].

[193] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.166]–[7.173] [SCI.0011.0758.0001 at 0260–0261].

[194] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.175]–[7.176] [SCI.0011.0758.0001 at 0261].

[195] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.177]–[7.181] [SCI.0011.0758.0001 at 0261–0262].

[196] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.182]–[7.184] [SCI.0011.0758.0001 at 0262–0263].

[197] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.185]–[7.186] [SCI.0011.0758.0001 at 0263].

[198] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.197] [SCI.0011.0758.0001 at 0265].

[199] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [7.200]–[7.201], [7.204] (Recommendation 19) [SCI.0011.0758.0001 at 0266–0267].

[200] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [11.5] [SCI.0011.0758.0001 at 0410].

centred care, and undertaking tasks for which an individual is suitably qualified (i.e., clinical work, rather than administrative).[201] For administrative tasks, it was recommended that NSW Health create the position of clinical support officer.[202]

8.78. The Garling Inquiry heard that the primarily paper based system for clinical notes presented issues, including due to a lack of searchability,[203] legibility,[204] missing information,[205] inability to check entries,[206] inability to easily share records,[207] and significant variation between clinicians, wards and hospitals.[208] Commissioner Garling described the fact that there was no Statewide functioning system of clinical notes as "beyond my belief" and found that it was "unacceptable" that this was not an immediate priority for NSW Health.[209] He made several recommendations in relation to clinical notes, including the creation of a policy outlining the obligations of admitting medical officers in the supervision of clinical notes.[210]

8.79. Commissioner Garling found that there was a real need for an electronic medical record system that was fully compatible across the acute and community health sectors.[211] Accordingly, he recommended that relevant electronic records generated in public hospitals be accessible to "general practitioners, specialists, allied health professionals and community health clinicians".[212]

8.80. The NSW Government accepted 134 of the 139 recommendations made by Commissioner Garling. Two were not accepted and three required further local or national consultation.[213]

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[201] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [11.84] (Recommendation 39) [SCI.0011.0758.0001 at 0424].

[202] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 1, [11.108] (Recommendation 40) [SCI.0011.0758.0001 at 0429].

[203] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.26] [SCI.0011.0760.0001 at 0052].

[204] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.30] [SCI.0011.0760.0001 at 0052].

[205] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.34] [SCI.0011.0760.0001 at 0053].

[206] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.35] [SCI.0011.0760.0001 at 0053].

[207] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.51] [SCI.0011.0760.0001 at 0056].

[208] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.21] [SCI.0011.0760.0001 at 0046].

[209] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.73] [SCI.0011.0760.0001 at 0059–0060].

[210] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.97] (Recommendation 49) [SCI.0011.0760.0001 at 0064].

[211] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [21.60] [SCI.0011.0760.0001 at 0371].

[212] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2, [14.173] (Recommendation 50) [SCI.0011.0760.0001 at 0078].

[213] NSW Health, *Caring Together: The Health Action Plan for NSW* (Report, March 2009) p 2.

8.81. Reading aspects of Commissioner Garling's Report, I was struck by the similarities in the issues that emerged before him and those that arose in the evidence before this Special Commission. Many of the findings and recommendations I have made bear a striking resemblance to those of Commissioner Garling. That so many of the same issues arose again 17 years later demonstrates that there is an important distinction between acceptance and implementation.

Productivity Commission, *Performance of Public and Private Hospital Systems* (2009)

8.82. On 10 December 2009, the Productivity Commission released a research report that examined the relative performance of public and private hospital systems. It considered comparative costs of clinically similar procedures in public and private hospital settings, rates of hospital acquired infections, and relevant performance indicators that inform comparisons of hospital performance and efficiency.[214]

8.83. The Productivity Commission estimated that, on a national level, public and private hospitals incurred similar average costs.[215] However, it noted significant differences in the composition of costs, finding that general hospital costs and capital costs were higher in public hospitals, while medical and diagnostics costs and prostheses costs were higher in private hospitals.[216] Analysis also indicated that efficiency of public and private hospitals was, on average, similar, with the output of individual hospitals in both sectors estimated to be approximately 20 per cent below best practice.[217]

8.84. A major concern held by the Productivity Commission was the limited availability and accessibility of hospital related data, finding that existing data collection methods lacked standardisation across different jurisdictions. It noted that this lack of data integration impeded research and policy development, particularly when making direct comparisons on topics such as costs and infection rates.[218] To address these issues, the Productivity Commission recommended establishing protocols allowing access to data and strengthening the mechanisms through which users could provide ongoing input on how data was collected and made available for analysis and research.[219]

8.85. The Productivity Commission noted that the foreshadowed developments under the National Healthcare Agreement, particularly the introduction of a performance reporting framework and a nationally consistent approach to activity based funding

[214] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) pp iv–v.

[215] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) p xxxii.

[216] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) p xxxii.

[217] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) p xxxii.

[218] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) pp xlvi–xlvii, 4, 92.

[219] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) p 13.

for public hospitals, were expected to improve the quality of hospital related data.[220] However, the Productivity Commission identified further potential improvements, such as consistent national reporting of costs and infections by both public and private hospitals.[221]

National Preventative Health Taskforce, Australia: *The Healthiest Country by 2020* (2008)

8.86. In April 2008, the Commonwealth Government established the National Preventative Health Taskforce to develop a National Preventative Health Strategy.[222]

8.87. The Strategy had seven primary directions, including: shared responsibility (developing strategic partnerships); acting early and throughout life; engaging communities; influencing markets and developing coherent policies; reducing inequity; Indigenous Australians (contributing to "Closing the Gap"); and refocussing primary healthcare towards prevention.[223] Targets included:[224]

a. halting and reversing the rise in obesity;

b. reducing the prevalence of daily smoking to 10 per cent or less;

c. reducing the proportion of Australians who drink at short term risky/high risk levels to 14 per cent, and the proportion of Australians who drink at long term risky/high risk levels to 7 per cent; and

d. contributing to the "Closing the Gap" targets for Indigenous people, reducing the life expectancy gap between Indigenous and non-Indigenous people.

National Health and Hospitals Reform Commission, *Healthier Future for All Australians* (2009)

8.88. In 2008, the Commonwealth Government established the National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system. These reforms were to be aimed at achieving reduction of inefficiencies generated by cost and blame shifting, better integration of care across all aspects, increased focus on prevention, improvement in provision of health services in rural areas and for First Nations people, and the building of a sustainable health workforce.[225] On 30 June 2009, the Commission

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[220] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) pp xxxii, 118.

[221] Productivity Commission, *Public and Private Hospitals* (Report, December 2009) pp 122, 139.

[222] National Preventative Health Taskforce, *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview* (Report, 30 June 2009) p 5.

[223] National Preventative Health Taskforce, *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview* (Report, 30 June 2009) p 6.

[224] National Preventative Health Taskforce, *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview* (Report, 30 June 2009) p 7.

[225] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) p 181.

delivered its report, in which it identified the following challenges facing the healthcare system across Australia:[226]

a. large increases in demand for and expenditure on healthcare;

b. inequities in health outcomes and access to services;

c. concerns about safety and quality of services;

d. growing burden of chronic disease;

e. ageing population;

f. costs and inefficiencies generated by the blame game and cost shifting;

g. escalating costs of new health technologies; and

h. workforce shortages.

8.89. The Commission emphasised that the fragmented system – with its complex division of funding responsibilities and performance accountabilities between different levels of government – was ill equipped to respond to these challenges.[227]

8.90. The Commission made 123 recommendations, which were grouped into four reform themes:

a. taking responsibility: encouraging and supporting greater individual and collective action to build good health and wellbeing, by individuals, families, communities, health professionals, employers, health funders and governments;[228]

b. connecting care: delivering comprehensive care for people over their lifetime, nurturing a healthy start, ensuring timely access and safe care in hospitals, restoring people to better health and independent living, increasing choice in aged care, and caring for people at the end of life;[229]

c. facing inequities: taking action to tackle the causes and impact of health inequities, closing the health gap for Aboriginal and Torres Strait Islander populations, delivering better health outcomes for remote and rural communities, supporting people living with mental illness, and improving oral health and access to dental care;[230] and

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[226] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) pp 3, 181.

[227] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) p 3.

[228] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) pp 17–18.

[229] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) pp 18–23.

[230] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) pp 24–26.

d. driving quality performance: having leadership and systems to achieve the best use of people, resources and knowledge, strengthening the governance of healthcare, raising and spending money for health services, a sustainable workforce for the future, fostering continuous learning in the health system, implementing a national eHealth system.[231]

Commonwealth Department of Health and Ageing, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (2010)

8.91. In 2010, the Department of Health and Ageing released Australia's first National Primary Health Care Strategy, which aimed to provide a roadmap to guide current and future policy, planning and practice in the Australian primary health care sector.[232]

8.92. In developing the Strategy, the Department found that the health system faced significant challenges due to a growing burden of chronic disease, an ageing population, workforce pressures, and unacceptable inequities in health outcome and access to services.[233] It found that primary care operated as a disparate set of services rather than an integrated service system and could not respond effectively to changing pressures (demographic, burden of disease, emerging technologies, changing clinical practice), or coordinate care within and across various elements of the broader health system to meet individual patients' needs.[234]

8.93. The Strategy identified five key building blocks to create a strong, responsive and cost effective primary healthcare system: regional integration, information and technology, skilled workforce, infrastructure, and financing and system performance.[235] It highlighted four key priority areas for change: namely, improving access and reducing inequity, better management of chronic conditions, increasing the focus on prevention, and improving quality, safety, performance and accountability.[236]

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[231] National Health and Hospital Reform Commission, *Healthier Future for All Australians* (Final Report, June 2009) pp 27–35.

[232] Department of Health and Ageing, Commonwealth Government, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Report, 2010) p 7.

[233] Department of Health and Ageing, Commonwealth Government, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Report, 2010) p 9.

[234] Department of Health and Ageing, Commonwealth Government, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Report, 2010) p 9.

[235] Department of Health and Ageing, Commonwealth Government, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Report, 2010) p 10.

[236] Department of Health and Ageing, Commonwealth Government, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (Report, 2010) p 11.

NSW Director-General, Future Arrangements for Governance of NSW Health (2011)

8.94. In May 2011, the then Director-General of the NSW Ministry of Health undertook a review of the governance of NSW Health, that examined the functions and structures of the main entities within NSW Health and their alignment with the NSW Government's policy directions.

8.95. That review found that, inconsistent with the NSW Government's policy direction on devolution of authority for local decision making, the existing governance structure was still centralised and that the Department of Health was heavily involved in day to day operational management.[237] As a result, the review recommended that the Department of Health become the Ministry of Health, an entity of significantly reduced size with a focus on higher level functions in regulation, public health and system management.[238] It also recommended that LHDs and SHNs have responsibility and accountability for managing all local aspects of hospital and health service delivery, pursuant to service agreements.[239]

8.96. Relatedly, the review concluded that the Clusters and Health Reform Transition Organisations were "unnecessary additional layers of health administration", and recommended their abolition, with the majority of their functions and resources (including staff) to be distributed equitably to the LHDs.[240]

8.97. The review also found that there was a lack of strong clinical leadership, engagement, and support, which hindered effective service planning and innovation.[241] To address this, reform of the Pillars to remove areas of overlapping functions and encourage more collaborative processes with, what would become the Ministry of Health, was recommended, including that:[242]

a. the Clinical Excellence Commission (CEC) take responsibility for providing leadership in clinical governance, quality and safety;

b. the Agency for Clinical Innovation (ACI) absorb the Department's clinical services redesign and development functions to become the primary agency for implementing new models of care; and

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[237] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) p 13 [MOH.0001.0309.0001 at 0015].

[238] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 2, 13–14 [MOH.0001.0309.0001 at 0004, 0015–0016].

[239] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 10–11 [MOH.0001.0309.0001 at 0012–0013].

[240] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 6, 25 [MOH.0001.0309.0001 at 0008, 0027].

[241] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) p 19 [MOH.0001.0309.0001 at 0021].

[242] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 19–20 [MOH.0001.0309.0001 at 0021–0022].

c. the Clinical Education and Training Institute become the Health Education and Training Institute, with an expanded focus on clinical and non-clinical leadership development, and undergraduate and vocational training.

8.98. To further streamline the functions of NSW Health, the *Governance Review* recommended the creation of HealthShare NSW and eHealth NSW,[243] and directed that a business case be developed for the creation of NSW Health Pathology.[244]

Department of Prime Minister and Cabinet, Reform of the Federation, *Issues Paper 3, Health* (2014)

8.99. In December 2014, as part of the Australian's Government's White Paper on the reform of the Federation, the Department of Prime Minister and Cabinet delivered *Issues Paper 3* that examined the pressures on current healthcare arrangements.[245] The *Issues Paper* noted that the complex split of government roles meant no single level of government had all the policy levers needed to ensure a cohesive system, which presented a challenge to providing integrated care, particularly for patients with chronic and complex conditions who frequently transitioned between services.[246] It also observed that healthcare systems faced external pressures from an ageing population, more expensive technology, growing rates of chronic disease, and increasing consumer expectations.[247]

8.100. The *Issues Paper* found that better service coordination within and across systems could address service gaps, reduce inefficiencies, and ultimately improve outcomes.[248]

National Mental Health Commission, *Contributing Lives, Thriving Communities* (2014)

8.101. On 30 November 2014, the National Mental Health Commission delivered its report following a national review of mental health programs and services.[249] It considered 11 focus areas across topics such as the efficiency and effectiveness of programs, reporting requirements and regulations, funding priorities and approaches, research,

[243] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) p 21, 24 [MOH.0001.0309.0001 at 0023, 0026].

[244] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) p 23 [MOH.0001.0309.0001 at 0025].

[245] Department of the Prime Minister and Cabinet, Commonwealth Government, *Roles and Responsibilities in Health: Reform of the Federation White Paper* (Issue Paper 3, December 2014) p 2.

[246] Department of the Prime Minister and Cabinet, Commonwealth Government, *Roles and Responsibilities in Health: Reform of the Federation White Paper* (Issue Paper 3, December 2014) p 2.

[247] Department of the Prime Minister and Cabinet, Commonwealth Government, *Roles and Responsibilities in Health: Reform of the Federation White Paper* (Issue Paper 3, December 2014) pp 1–2, 12.

[248] Department of the Prime Minister and Cabinet, Commonwealth Government, *Roles and Responsibilities in Health: Reform of the Federation White Paper* (Issue Paper 3, December 2014) p 41.

[249] Commonwealth Government, National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Report, November 2014) vol 1, p 13.

workforce development and training, and specific challenges for rural areas and Aboriginal and Torres Strait Islander people.[250]

8.102. The Commission concluded that the mental health system was poorly planned and integrated, affecting people's wellbeing and participation, and Australia's productivity and economic growth.[251] It outlined three high level principles to enable systemic reform and improve the long term sustainability of the mental health system, including a person centred approach, a new, population based system architecture, and a shift in funding from costly "downstream" services (Emergency Department presentations, acute admissions, avoidable readmissions and income support payments) to "upstream" services and support (population health, prevention, early intervention, recovery and participation).[252]

8.103. The Commission identified nine strategic themes intended to guide an implementation framework of activity over the following decade. These themes included setting clear government accountabilities and national and local targets, shifting funding priorities to community and primary health services, building of workforce and research capacity to support systems change, and improvement in access to services through innovation in technology.[253]

Productivity Commission, *Efficiency in Health* (2015)

8.104. In April 2015, the Productivity Commission released a research paper that considered opportunities to improve the operation of Australia's healthcare system, that did not require change to existing institutional and funding structures – that is, all recommendations were to be "within system".[254]

8.105. The Productivity Commission found that the growth of Australian health expenditure was exacerbated by inefficiencies, wasteful spending, reduced access to primary care resulting in increased demand for hospital care, and substandard quality and safety outcomes.[255] The Productivity Commission also recommended that health system regulations be improved by amending scope of practice for the health workforce, and enhancing information transparency through the publication of and access to government held data sets.[256]

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[250] Commonwealth Government, National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Report, November 2014) vol 1, p 9.

[251] Commonwealth Government, National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Report, November 2014) Summary, p 3.

[252] Commonwealth Government, National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Report, November 2014) Summary, pp 3, 12.

[253] Commonwealth Government, National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Report, November 2014) Summary, pp 16–17.

[254] Productivity Commission, *Efficiency in Health* (Research Paper, April 2015) p 1.

[255] Productivity Commission, *Efficiency in Health* (Research Paper, April 2015) p 1.

[256] Productivity Commission, *Efficiency in Health* (Research Paper, April 2015) p 3–4.

8.106. The Productivity Commission ultimately recommended a comprehensive review of institutional and funding structures to address systemic problems in the health system, in order to improve and better align financial incentives with policy objectives, and better consider preventive health options.[257] It also identified several reasons why previous reform attempts have failed, including diffused responsibility, inadequate design and implementation, poor resourcing, and absence of political will.[258]

Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Conditions* (2015)

8.107. In August 2015, the Primary Health Care Advisory Group delivered a report that considered options to create a more integrated healthcare system, especially for people living with chronic and complex conditions.[259]

8.108. The report found that the growth in chronic and complex conditions was affecting the performance of primary healthcare system and the ability to integrate those services with secondary care services,[260] and that better integration could be achieved by aligning service delivery with care needs on a regional basis and focussing on ongoing and flexible care.[261] It also recommended the establishment of a national minimum data set for patients with chronic and complex conditions, new performance reporting arrangements, and the integration of evaluation throughout implementation of reforms to enhance the measurability of outcomes.[262]

Commonwealth Department of Treasury, *Intergenerational Report – Australia in 2055* (2015)

8.109. In March 2015, the Department of Treasury delivered its *Intergenerational Report* assessing the long term sustainability of current government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the following 40 years.[263]

8.110. That report projected that Commonwealth Government health expenditure would more than double over in the period to 2055 from around $2,800 per person to $6,500 per person,[264] driven by higher incomes, health sector wages growth, technological

[257] Productivity Commission, *Efficiency in Health* (Research Paper, April 2015) p 2.

[258] Productivity Commission, *Efficiency in Health* (Research Paper, April 2015) p 1.

[259] Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions* (Report, December 2015) pp 3–4.

[260] Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions* (Report, December 2015) p 3.

[261] Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions* (Report, December 2015) p 8–9.

[262] Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions* (Report, December 2015) p 10.

[263] The Treasury, Commonwealth of Australia, *2015 Intergenerational Report: Australia in 2055* (Report, March 2015) p xxiii.

[264] The Treasury, Commonwealth of Australia, *2015 Intergenerational Report: Australia in 2055* (Report, March 2015) p xvi.

change, and increasing consumer expectations.[265] The area of largest projected growth was Medicare services, which were projected to rise by over 15 per cent per person in real terms over the following decade.[266]

Productivity Commission, *Shifting the Dial report, 5 Year Productivity Review* (2017)

8.111. On 16 September 2016, the Commonwealth Treasurer requested that the Productivity Commission undertake an inquiry every five years into Australia's productivity performance and provide recommendations on productivity enhancing reform, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998* (Cth).[267] In recognition of the impact of poor health on workforce productivity,[268] a major focus of the inquiry was to be on Australia's health system and opportunities for greater integrated care.[269]

8.112. In August 2017, the Productivity Commission delivered its first report in the series, titled *Shifting the Dial*.[270]

8.113. The *Shifting the Dial* report highlighted several challenges that were facing the Australian health system at the time, including:

a. a primary focus by the health system on patient crisis rather than prevention and early treatment;[271]

b. the fragmented and ill fitting nature of health services together with poor coordination between care pathways, particularly between primary and acute care;[272]

c. inadequate information flows and haphazard data collection, together with the slow uptake of technologies;[273]

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[265] The Treasury, Commonwealth of Australia, *2015 Intergenerational Report: Australia in 2055* (Report, March 2015) p 61.

[266] The Treasury, Commonwealth of Australia, *2015 Intergenerational Report: Australia in 2055* (Report, March 2015) p xvi.

[267] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 3 [SCI.0001.0057.0001 at 0005].

[268] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 47 [SCI.0001.0057.0001 at 0049];]; Exhibit H2.10, Productivity Commission, *Why a Better Health System Matters* (Supporting Paper No 4, 3 August 2017) p 13 [SCI.0011.0151.0001 at 0016].

[269] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 43 [SCI.0001.0057.0001 at 0045].

[270] Specific to its recommendations on health, see Exhibit H2.10, Productivity Commission, *Why a Better Health System Matters* (Supporting Paper No 4, 3 August 2017) [SCI.0011.0151.0001]; Exhibit H2.11, Productivity Commission, *Integrated Care* (Supporting Paper No 5, 3 August 2017) [SCI.0011.0152.0001]; Exhibit H2.12, Productivity Commission, *Impacts of Health Recommendations* (Supporting Paper No 6, 3 August 2017) [SCI.0011.0153.0001].

[271] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 46 [SCI.0001.0057.0001 at 0048].

[272] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 46 [SCI.0001.0057.0001 at 0048].

[273] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 46 [SCI.0001.0057.0001 at 0048].

d. excessive clinical variations that were contraindicated by evidence, resulting in higher instances of low value services;[274] and

e. funding models provided on the basis of activity rather than on improvements in people's health, which ultimately discouraged an integrated model of care.[275]

8.114. To address these issues, the Productivity Commission made several recommendations, including that:

a. "nimble funding arrangements at the regional level" be implemented, with Australian and state and territory governments allocating funding pools to PHNs and Local Health Networks (in NSW, the LHDs) for improving population health, managing chronic conditions and reducing hospitalisation at the regional level;[276]

b. Local Health Networks (including LHDs in NSW) be permitted to commission the services of general practitioners, including by amending s 19 of the *Health Insurance Act 1973* (Cth) on the proviso that Local Health Networks operate in formal agreement with their region's PHN in doing so;[277]

c. governments focus on improving formal collaboration between Local Health Networks and PHNs;[278]

d. there be a greater focus on consultation with consumer groups and medical colleges to support the extension of patient centred models of care;[279]

e. to reduce the use of low value health interventions, Australian governments revise their policies to:[280]

    i. respond to international assessments indicating low value medical interventions;

    ii. create and disseminate comprehensive guidelines on best practice, primarily through the various medical colleges, the Australian Commission on Safety and Quality in Health Care and similar state based bodies;

    iii. collect and publicise data identifying interventions that had ambiguous clinical impacts (including hospital acquired complications);

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[274] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 46 [SCI.0001.0057.0001 at 0048].

[275] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 51 [SCI.0001.0057.0001 at 0053].

[276] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 59 [SCI.0001.0057.0001 at 0061].

[277] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 59 [SCI.0001.0057.0001 at 0061].

[278] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 59 [SCI.0001.0057.0001 at 0061].

[279] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 66 [SCI.0001.0057.0001 at 0061].

[280] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 63 [SCI.0001.0057.0001 at 0065].

iv. provide accessible advice to patients about potentially low value services and improve their health literacy;

v. ensure that ongoing processes for reviewing existing MBS items were more rapid and comprehensive; and

vi. prioritise defunding interventions that demonstrably failed cost effectiveness tests; and

f. systems should be integrated to allow the collection and linking of data,[281] and that information (particularly on innovations) should be circulated across the system as quickly as possible.[282]

8.115. On the assumption that it would take approximately 20 years for the healthcare system to implement the recommendations, the Productivity Commission estimated the net present value of economic impacts over those 20 years to be around $140 billion, encompassing both savings and benefits.[283] Those estimates were stated to be conservative and did not include personal benefits to patients.[284]

NSW Parliament, Public Accounts Committee, Inquiry into the Management of Healthcare Delivery in NSW (2018)

8.116. In September 2018, the NSW Public Accounts Committee published its report following an inquiry into the management of healthcare delivery in NSW, and in particular current reporting systems, service agreements, and data collection, including whether those systems supported the achievement of broader health objectives.[285] The Committee also examined the state of mental health services in NSW.

8.117. The Committee recommended that NSW Health's performance frameworks be expanded to consider the general health of the community and preventive health outcomes,[286] so as to better ensure quality care and respond to gaps in service delivery.[287]

8.118. The Committee also identified concerns about the approach to collection and collation of accurate data in relation to vulnerable groups (including the LGBTQIA+ community

[281] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 71 [SCI.0001.0057.0001 at 0073].

[282] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 71 [SCI.0001.0057.0001 at 0073].

[283] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 79 [SCI.0001.0057.0001 at 0081].

[284] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 79 [SCI.0001.0057.0001 at 0081].

[285] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) pp 1, 44 [SCI.0011.0213.0001 at 0009, 0052].

[286] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [2.27] (Recommendations 1–2) [SCI.0011.0213.0001 at 0015–0016].

[287] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [2.27] (Recommendations 1–2) [SCI.0011.0213.0001 at 0015–0016].

and people with disabilities),[288] the transparent disclosure of the use of data by government,[289] and the comparability of data sets across the NSW health system.[290] Accordingly, the Committee recommended improving workforce training, internal guidelines, and policies related to health data collection.[291]

NSW Auditor-General, *Governance of Local Health Districts* (2019)

8.119. On 18 April 2019, the NSW Audit Office released a performance audit report evaluating the governance arrangements of 15 LHDs in NSW.

8.120. The NSW Audit Office concluded that the main roles and responsibilities of LHDs, their Boards, and the Ministry of Health were generally well understood, but that there were several areas requiring further clarity and improvement,[292] including as to the nature of the relationship between the LHDs and some of the Pillars.[293]

8.121. The NSW Audit Office found that existing levels of clinician engagement in local decision making was inadequate to meet the objective of devolution,[294] and that, while clinicians had some opportunities to engage, such as through representation on Board subcommittees on healthcare safety and quality, there was not the broader level of engagement as recommended by Commissioner Garling.[295]

8.122. The NSW Audit Office recommended a number of reforms to be implemented between 2019 and 2020 to strengthen governance, accountability and effectiveness across the LHDs. It called for:

a. the Ministry of Health to work with LHDs to identify and overcome restrictions on adequate clinician engagement, develop a statement of principles for guiding decision making in a devolved health system, and clearly delineate the roles and responsibilities of Pillar agencies and LHDs;[296]

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[288] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [3.20], [3.24], [3.27], [3.54]–[3.55] [SCI.0011.0213.0001 at 0024, 0025–0026, 0031].

[289] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [3.35], [3.40] [SCI.0011.0213.0001 at 0027, 0028].

[290] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [3.44]–[3.49] [SCI.0011.0213.0001 at 0028–0030].

[291] Exhibit H2.16, Public Accounts Committee, Legislative Assembly of New South Wales, *Inquiry into the Management of Health Care Delivery in NSW* (Report No 8/56, September 2018) [3.26] (Recommendation 9), [3.29] (Recommendation 10), [3.43] (Recommendations 12–13) [SCI.0011.0213.0001 at 0025, 0026, 0028].

[292] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 3.

[293] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 12.

[294] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) pp 18–19.

[295] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 18.

[296] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 11.

b. LHD Boards improve their induction process, training program, and performance reviews, while ensuring effective oversight of service agreements to align them with the Boards' legislative functions;[297] and

c. the *Health Performance Framework* to be revised to ensure clarity and cohesion, define escalation mechanisms for underperformance, and align performance monitoring with the policy intent of devolution.[298]

NSW Auditor-General, *Ensuring Contract Management Capability in Government – Healthshare NSW* (2019)

8.123. On 31 October 2019, the NSW Auditor-General released a performance audit report examining whether HealthShare NSW had the capability to effectively manage high value (over $250,000) goods and services contracts.[299] That audit assessed HealthShare's capabilities against the following criteria:[300]

a. whether HealthShare's systems, policies and procedures supported effective contract management and were consistent with relevant frameworks, policies and guidelines; and

b. whether HealthShare had capable personnel to effectively monitor activities throughout the life of the contract.

8.124. The report found that HealthShare was not applying the capability needed to effectively manage high value goods and services contracts, and that while HealthShare's procurement framework included elements that should support effective contract management, HealthShare was not implementing the key contract management elements of its own framework.[301] The report found that the inability to implement its own framework gave rise to a risk that the savings HealthShare achieved when it negotiated contracts could erode over their life.

8.125. The report made a series of recommendations directed to improving the performance of HealthShare's contract management capability, all of which were accepted by NSW Health.[302]

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[297] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 11.

[298] NSW Auditor-General, *Governance of Local Health Districts* (Report, 18 April 2019) p 23.

[299] Exhibit B.23.15, NSW Auditor-General, *Ensuring Contract Management Capability in Government – HealthShare NSW* (Report, October 2019) p 13 [MOH.0001.0013.0001 at 0017]; see, eg, contracts relating to food services in hospitals, patient transport services, intravenous equipment, and kidney dialysis services: Exhibit B.23.15, NSW Auditor-General, *Ensuring Contract Management Capability in Government – HealthShare NSW* (Report, October 2019) p 1 [MOH.0001.0013.0001 at 0005].

[300] Exhibit B.23.15, NSW Auditor-General, *Ensuring Contract Management Capability in Government – HealthShare NSW* (Report, October 2019) p 1 [MOH.0001.0013.0001 at 0005].

[301] Exhibit B.23.15, NSW Auditor-General, *Ensuring Contract Management Capability in Government – HealthShare NSW* (Report, October 2019) p 2 [MOH.0001.0013.0001 at 0006].

[302] Letter from Elizabeth Koff to Margaret Crawford, 29 October 2019 [MOH.0001.0022.0001].

Productivity Commission: *Mental Health*

8.126. On 23 November 2018, the Commonwealth Treasurer requested that the Productivity Commission undertake an inquiry into the role that improved mental health across the population could have in supporting economic participation, enhanced productivity, and economic growth.[303]

8.127. The Productivity Commission proposed a long term reform agenda, comprised of short and long term recommended actions which, if adopted, would lead to "a person centred but flexible mental health system: one that could be 'ramped up and down' to meet changing community need, particularly in times of crisis".[304] These recommendations included a combination of large scale institutional changes and small adjustments to existing supports.[305]

8.128. The Productivity Commission made 22 recommendations, encompassing approximately 100 actions, to be implemented across the continuum of mental health services. In totality, the Productivity Commission considered that the package of reforms represented a "whole of government roadmap to a person centred mental health system".[306] Five broad priority reform areas were identified; being: [307]

a. prevention and early help for people;

b. improving people's experiences with mental healthcare;

c. improving people's experiences with services beyond the health system;

d. equipping workplaces to be mentally healthy; and

e. instilling incentives and accountability for improved outcomes.

8.129. The Productivity Commission identified that there was a "missing middle" in respect of the clinical and non-clinical community based services available to people with moderate to severe mental illness.[308] It also observed a shortfall of low intensity services placing increasing demand on less appropriate MBS rebated care. [309] The *Mental Health Review* considered these service gaps had emerged as a consequence of insufficient funding allocations, but also maladministration and use of existing funding.[310]

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[303] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, p iv.

[304] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, p 8.

[305] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 2, pp 100, 107.

[306] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 2, p 107.

[307] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, p 3.

[308] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, pp 6, 30.

[309] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, pp 29–30.

[310] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1135.

8.130. The Productivity Commission considered there were:

a. unclear and inconsistent Commonwealth, state and territory responsibilities for mental healthcare, psychosocial supports, suicide prevention services, and mental health carer supports;[311] and

b. perverse incentives created by funding mechanisms for mental health services, which direct consumers towards hospital based care and MBS rebated care.[312]

8.131. To address these challenges, the Productivity Commission proposed a twofold approach. First, it suggested implementing a model whereby decisions concerning funding allocations would be made at the regional level.[313] Secondly, it suggested an integrated approach to investments in mental health across all levels of government, with no ambiguity regarding responsibilities for service delivery.[314] The Productivity Commission also recommended that the Independent Hospital Pricing Authority (as it then was) develop a new model to enable state and territory governments to use ABF for community ambulatory mental healthcare, and reform to enable private health insurers to fund mental health treatments on a discretionary basis.[315]

8.132. The Productivity Commission considered the National Mental Health Strategy (the Strategy), which underpinned mental health reform nationally for the 30 years prior, was no longer consistent with consumer and carer expectations, and lacked a direct link to funding commitments.[316] It recommended the Strategy be reinforced by "facilitating a genuine whole of government approach; linking funding with strategy; setting a clearer vision; ensuring greater coherence; and widening stakeholder engagement".[317]

8.133. The Productivity Commission recommended that the Commonwealth, state and territory governments should: [318]

a. develop a new National Mental Health Strategy, which comprehensively integrated health and non-health sectors;

b. develop a national vision statement that reflected mental health outcomes of value to consumers and carers, with an appropriate level of ambition for national mental health reforms;

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[311] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, pp 8, 22, vol 3, p 1135.

[312] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, pp 1165–6.

[313] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1135.

[314] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1135.

[315] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1134.

[316] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1086.

[317] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, p 1086.

[318] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 3, pp 1086–1090.

c. ensure that the National Mental Health Strategy was a single, coherent document that outlined a comprehensive approach to improving mental health outcomes; and

d. ensure that broad consultation distinguished the development of the new strategy.

8.134. In relation to the distribution and scope of practice of mental health providers across Australia, the Productivity Commission noted: [319]

> *[T]here is a considerable disparity in workforce numbers between urban and regional areas, and between the public and private sectors, and an inefficient use of skilled professionals (such as mental health nurses) in administrative roles that could likely be undertaken by non-clinical staff. There are also notable gaps in the availability of some specialists in a number of parts of Australia.*

and that:

> *Access to psychiatric care is particularly constrained, with high costs and long wait times in some areas. The number of psychiatrists for Australia's population is at the low end of rates in developed countries. The profound difficulty of children and adolescents, people in aged care and people in rural, regional and remote areas in accessing psychiatrists, should particularly be addressed.*

8.135. To address these workforce challenges, the Productivity Commission proposed the following solutions: [320]

a. a national plan to increase the number of practising psychiatrists, including an increase in the availability of supervision for trainees;

b. a significant increase in the number of mental health nurses practising in Australia, and introduction of a three year direct entry (undergraduate) degree in mental health nursing;

c. a program to build support among clinicians for the role and value of peer workers; and

d. implementation of technology to overcome gaps in access to mental healthcare in rural, regional, and remote parts of Australia, and to augment training and supervision opportunities for remote clinicians.

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[319] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, pp 34–35.

[320] Productivity Commission, *Mental Health* (Inquiry Report No 95, 30 June 2020) vol 1, p 35, vol 2, p 700.

NSW Auditor-General, *Health Capital Works* (2020)

8.136. On 12 August 2020, the NSW Auditor-General released a performance audit report assessing the effectiveness of the planning and delivery of major capital works to meet demand for health services in NSW.[321]

8.137. The report made the following key findings:[322]

a. while NSW Health has developed a significant program of capital works and has substantially expanded health infrastructure across NSW, particularly since 2015, NSW Health's planning and prioritisation processes for infrastructure were not assessed against a long term Statewide health infrastructure plan and lacked rigorous assessment against non-capital options, creating a risk that they did not maximise value for NSW;

b. NSW Health's ability to effectively test and analyse its capital investment options had been compromised by unclear decision making roles and responsibilities between its Health Infrastructure and the Ministry of Health agencies; and

c. substantial delays and budget overruns on some major projects indicated that Health Infrastructure's project governance, risk assessment and management systems could be improved.

8.138. The report made four recommendations that were directed to:[323]

a. ensuring the use of the Health Cluster's capital funds was aligned to the future health needs of the population and would deliver the greatest value to NSW;

b. ensuring that NSW Health worked with Health Infrastructure to strengthen the *Process of Facility Planning* by ensuring that businesses cases produced by Health Cluster agencies were rigorously prepared and considered all feasible options (including non-capital options);

c. embedding systematic monitoring and publicly reporting on the expenditure of funds and how compliance with various policies was achieved; and

d. enhancing governance and project management systems, including the development of a framework for planning, delivery, assessment and improvement.

[321] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (Report, 12 August 2020) p 1 [MOH.9999.0893.0001 at 0005].

[322] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (Report, 12 August 2020) p 2 [MOH.9999.0893.0001 at 0006].

[323] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (Report, 12 August 2020) p 6 [MOH.9999.0893.0001 at 0010].

8.139. NSW Health did not accept the recommendation summarised in c above but did accept the others, and:[324]

a. developed a *Statewide Investment and Prioritisation Framework*, which was issued to all health entities in late July 2020.[325] That framework set out how investment proposals would be reviewed and prioritised, and the type of proposals required to respond to the long term challenges facing the NSW health system;[326]

b. revised the previous *Process of Facility Planning Guideline to NSW Health Facility Planning Process*. The Guideline was also issued to all health entities in late July 2020,[327] and outlines the roles and responsibilities of all Health Cluster agencies involved in developing business cases.[328] The Ministry of Health stated that it would work with Health Infrastructure to strengthen economic appraisals within business cases and ensure that the demand and capacity forecasts of Clinical Services Plans were accurately described in business cases supporting proposed capital solutions.[329]

c. stated that the enhancements to the governance and project management systems would be incorporated into the *Health Infrastructure Corporate Plan for 2021–2023.*[330] The *Health Infrastructure Corporate Strategy 2021–2025* appears to reflect that these enhancements have been at least accounted for and planned.[331]

Royal Commission into Aged Care Quality and Safety (2021)

8.140. On 8 October 2018, the Royal Commission into Aged Care Quality and Safety was established, to inquire into the quality and safety of care provided in residential aged care facilities and community and flexible aged care settings. An *Interim Report* was delivered in September 2019,[332] a special report in response to COVID-19 in aged care in September 2020,[333] and the *Final Report* in February 2021.[334]

[324] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (12 August 2020) pp 33–34 [MOH.9999.0893.0001 at 0036–0037].

[325] Exhibit D.1.141, NSW Health State-wide Investment and Prioritisation Framework (July 2020) [MOH.9999.0895.0001].

[326] Exhibit D.1.141, NSW Health State-wide Investment and Prioritisation Framework (July 2020) p 3 [MOH.9999.0895.0001 at 0003].

[327] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (12 August 2020) p 33 [MOH.9999.0893.0001 at 0036].

[328] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (12 August 2020) p 33 [MOH.9999.0893.0001 at 0036].

[329] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (12 August 2020) pp 33–34 [MOH.9999.0893.0001 at 0036–0037].

[330] Exhibit D.1.139, NSW Auditor-General, *Performance Audit – Health capital works* (12 August 2020) p 34 [MOH.9999.0893.0001 at 0037].

[331] NSW Health, Health Infrastructure, *Corporate Strategy 2021–2025* (2021).

[332] Royal Commission into Aged Care Quality and Safety, *Neglect* (Interim Report, 31 October 2019) vol 1 [SCI.0011.0768.0001].

[333] Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report* (Report, 1 October 2020) [SCI.0011.0766.0001].

[334] Royal Commission into Aged Care Quality and Safety, *Care, Dignity and Respect – Summary and Recommendations* (Final Report, 1 March 2021) [SCI.0011.0774.0001].

8.141. The Royal Commission made 148 recommendations.[335] In broad terms, relevantly to the issues before this Special Commission, the Royal Commission recommended:

a. the introduction of legislation focussed on the rights of those receiving aged care, requiring providers to provide high quality care based on clinically assessed patient needs, and enshrining more integrated care with more stable funding. The *Aged Care Act 2024* (Cth) was passed in November 2024 and is currently scheduled to come into effect on 1 July 2025;

b. a new Aged Care Pricing Authority should be established. In August 2022, amendments made to the *National Health Reform Act 2011* (Cth) by the *Royal Commission Response Act* came into effect, changing the Independent Hospital Pricing Authority to the Independent Health and Aged Care Pricing Authority, and expanding its role to include the provision of aged care pricing and costing advice to the Government;

c. improvements in the provision of healthcare to those receiving aged care, including specialist dementia care services, minimal use of restraints, access to primary care and specialist services (including by way of telehealth where appropriate) best practice oral care, allied health, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, infection control, nutrition, culturally safe care for First Nations patients, and palliative and end of life care; and

d. the Commonwealth, State and Territory Governments should improve the data available to monitor the interaction between the health and aged care systems and improve health and aged care planning and funding decisions. The *Aged Care Data and Digital Strategy 2024–2029* responds to this recommendation.[336]

Productivity Commission, *Innovations in Care for Chronic Health Conditions Case Study* (2021)

8.142. In March 2021, the Productivity Commission published the *Innovations in Care for Chronic Health Conditions Case Study*.[337] This case study focussed on innovative approaches to the management of chronic health conditions, with a view to promoting wellbeing, increasing efficiency in healthcare delivery, and reducing hospitalisations.[338]

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[335] Royal Commission into Aged Care Quality and Safety, *Care, Dignity and Respect – Summary and Recommendations* (Final Report, 1 March 2021) pp 205-310 [SCI.0011.0774.0001 at 0215-0320].

[336] Department of Health and Aged Care, *Aged Care Data and Digital Strategy 2024–2029 – Driving better care and leading a sustainable and productive care and support economy* (2024).

[337] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021).

[338] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) p iii.

8.143. The Productivity Commission highlighted innovative approaches across the following five broad themes:

a. supporting people to actively manage their chronic conditions, through support tools driven by emerging technologies, as a low-cost method to improving health and quality of life;[339]

b. embracing funding innovations, such as shifting to value based outcomes, blended funding models, and the funding of longer term trials, which are important to overcoming the obstacles posed by the present funding arrangements in Australia;[340]

c. workforce innovation through multidisciplinary teams, supporting general practitioners in the provision of more complex care, development of peer support roles, and growing the Indigenous health workforce;[341]

d. collaboration within the health system and across the community sector through formalised, systematic approaches to collaboration within healthcare teams and organisations, support by leadership and management personnel, and partnership funding;[342] and

e. innovations to improve the flow of information across primary, acute, and specialist care providers.[343]

Royal Commission into Victoria's Mental Health System (2021)

8.144. On 22 February 2019, a Royal Commission into Victoria's Mental Health System was established.

8.145. The Royal Commission proposed an extensive reform agenda, across 65 recommendations aimed at delivering "a complete transformation in the way mental health and wellbeing treatment, care and support [would] be provided in Victoria".[344] The Victorian Government adopted all the Royal Commission's recommendations and proposed a 10-year reform plan for implementation.[345]

[339] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) pp 43, 45, 49–51.

[340] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) pp 169–172.

[341] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) p 70.

[342] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) pp 90–92.

[343] Productivity Commission, *Innovations in Care for Chronic Health Conditions* (Productivity Reform Case Study, March 2021) pp 116, 118.

[344] Royal Commission into Victoria's Mental Health System, *Summary and Recommendations* (Final Report, February 2021) p 6.

[345] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, p 83; 'A mental health system to work for every Victorian', *Premier of Victoria* (Web page, 3 May 2022) <A Mental Health System To Work For Every Victorian | Premier>.

8.146. Several of the issues that arose in that Royal Commission were also raised in the evidence before this Special Commission. For example, the Royal Commission found that the mental health system had failed to keep pace with the demand for services, resulting in patients being turned away and extended wait times. [346] That difficulty was exacerbated by a paucity of community based services, which had caused pervasive service gaps and a lack of dependable access to support. [347] As a by-product of these deficiencies, the Royal Commission observed a missing middle whereby patients whose conditions were too complex to be supported through primary care, but not severe enough to meet the threshold for specialist mental health services, were unable to access care.[348]

8.147. The Royal Commission characterised mental health services as disjointed, with fragmentation between primary and specialist structures, limited connections, and unclear pathways for people to access statewide services and other parts of the system.[349] It also observed inadequate investment and planning in statewide services resulting in inequities and inefficiencies in how these services were distributed and accessed.[350]

8.148. With respect to access to services, the Royal Commission identified an imbalance between the mental health resources allocated to young people and adults compared to those allocated to perinatal, infant and child groups. In relation to this, reflections from parents were highlighted, wherein the difficulties in accessing care, as well as the wide ranging and potentially detrimental implications of inaccessibility of care, were canvassed.[351] The Royal Commission also noted the overrepresentation of people living with mental illness in the criminal justice system. It attributed this, in part, to limited investment in mental health services, which left many people unable to access support prior to entering the criminal justice system. [352] It also observed that the interface between the criminal justice system and the mental health system was fragmented, poorly coordinated, and impeded by capacity constraints.[353]

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[346] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, p 196.

[347] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, p 196.

[348] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, pp 196–198.

[349] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, p 206.

[350] Royal Commission into Victoria's Mental Health System, *A new approach to mental health and wellbeing in Victoria* (Final Report, February 2021) vol 1, p 208.

[351] Royal Commission into Victoria's Mental Health System, *Collaboration to support good mental health and wellbeing* (Final Report, February 2021) vol 2, pp 125–126.

[352] Royal Commission into Victoria's Mental Health System, *Promoting inclusion and addressing inequities* (Final Report, February 2021) vol 3, p 358.

[353] Royal Commission into Victoria's Mental Health System, *Promoting inclusion and addressing inequities* (Final Report, February 2021) vol 3, pp 349–350, 352–353.

8.149. The Royal Commission found that there were substantial shortages in the Victorian mental health workforce, which were more pronounced in rural and regional areas, as well as in specific professional disciplines and specialist roles. It also observed a maldistribution of practitioners, with more than 50 per cent of providers delivering exclusively metropolitan services.[354] This issue was exacerbated by challenges in recruiting and retaining a variety of mental health workers, including nurses, psychiatrists, psychologists, social workers, and occupational therapists.[355] Factors such as unsustainable workloads, experiences of occupational violence, fatigue and burnout, the high administrative burdens, limited opportunities for career development and progression, and the attractiveness of private practice, were factors affecting mental health workforce supply.[356]

Productivity Commission, *Advancing Prosperity* (2023)

8.150. On 7 February 2022, the Commonwealth Treasurer requested that the Productivity Commission undertake a second inquiry into Australia's productivity performance.[357]

8.151. From August to October 2022, the Productivity Commission released six interim reports outlining its early analysis and reform directives, and delivered its Final Report on 7 February 2023.[358]

8.152. The Productivity Commission made 71 recommendations under 29 reform directives.[359] Many of the recommendations relating to the healthcare system echoed the sentiments of the *Shifting the Dial* report, particularly with respect to supporting expanded scope of practice, the sharing of healthcare data such as through the My Health Record, and the reform of health funding models.[360]

8.153. The Productivity Commission went on in the *Advancing Prosperity* report to recommend reforms to support a better targeted skilled migration system, such as proposing the expansion of occupational licensing to enable highly skilled migrants to have their qualifications recognised sooner.[361] It emphasised the likely benefit of this reform to the healthcare system.[362]

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[354] Royal Commission into Victoria's Mental Health System, *The fundamentals for enduring reform* (Final Report, February 2021) vol 4, p 460.

[355] Royal Commission into Victoria's Mental Health System, *The fundamentals for enduring reform* (Final Report, February 2021) vol 4, pp 458–460, 470–471.

[356] Royal Commission into Victoria's Mental Health System, *The fundamentals for enduring reform* (Final Report, February 2021) vol 4, p 472.

[357] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p iv.

[358] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p 103.

[359] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p 71.

[360] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, pp xi, 37–38.

[361] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p 56–57.

[362] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p 57.

8.154. With respect to funding, the Productivity Commission commented that, in light of the rate of health system adaptation to the COVID-19 pandemic, there was scope for acceleration of changes in healthcare funding arrangements.[363] The Productivity Commission expanded on the funding reforms raised in the *Shifting the Dial* report by emphasising the importance of "impact investing" or "payment by results" to sharpen incentives to produce higher quality outcomes and encourage coordination between different service groups.[364]

8.155. Another focus was on the minimum length of government contracts. The Productivity Commission identified several disadvantages to shorter contract terms, including the limited capacity of organisations to set up, develop and innovate services in restricted timeframes, and the considerable resources required for the retendering process.[365] It recommended increasing default contract lengths from five to seven years for government funded services, with contract lengths to be determined based on the type of service provided.[366]

NSW Legislative Council Portfolio Committee No 2, *Health Outcomes and Access to Health Services in Rural, Regional and Remote NSW* (2022)

8.156. Between 2020 and 2022, the NSW Legislative Council Portfolio Committee No 2 inquired into healthcare in rural, regional and remote NSW.[367] The Committee examined several issues, including:

a. health outcomes;

b. access to health and hospital services;

c. patient experience, wait times and quality of care;

d. planning and projections used by NSW Health in determining the provision of health services;

e. an analysis of the capital and recurrent health expenditure; and

f. staffing challenges and allocations and strategies and initiatives to address these issues, with particular regard to rural, regional and remote health services.[368]

[363] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 5, p 68.

[364] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 1, p 36.

[365] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 5, p 69.

[366] Productivity Commission, *Advancing Prosperity* (Inquiry Report No 100, 7 February 2023) vol 5, p 69.

[367] 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 New South Wales* (Final Report, May 2022) p viii [SCI.0009.0077.0001 at 0010].

[368] 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 New South Wales* (Final Report, May 2022) p vii [SCI.0009.0077.0001 at 0009].

8.157. In May 2022, the Committee handed down its Final Report, which made 22 findings and 44 recommendations.[369] The Government supported 41 of the recommendations in full or in principle and noted three.[370]

8.158. Overall, the Committee found that patients in rural, regional and remote NSW had significantly poorer health outcomes, less access to healthcare, and significant financial challenges to access diagnosis and treatment compared to their counterparts in metropolitan areas.[371] The Committee made several findings and recommendations that related to some of the core themes that have emerged in the work of this Special Commission, including that:

a. the fragmented nature of the healthcare system, and funding responsibilities, had led to duplication and gaps in service delivery;[372]

b. ABF models were not appropriate for some rural and remote based hospitals;[373]

c. there should be greater collaboration between NSW Health, the rural, regional and remote LHDs, and PHNs in planning, the development of innovative models of care, and data sharing;[374]

d. LHDs should work collaboratively with communities, other government departments, First Nations healthcare providers, and other local healthcare providers (e.g., primary and aged care) to develop place based health needs assessments;[375]

e. there was a critical shortage of health professionals in rural, regional and remote NSW, resulting in staffing deficiencies.[376] There had been a historic failure by various NSW and Commonwealth Governments to attract, support, and retain health professionals to these areas.[377] The Committee made several recommendations to address those challenges, including that NSW Health work with the Commonwealth Government, the PHNs, the university sector and the

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[369] 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 New South Wales* (Final Report, May 2022) pp xii–xxii [SCI.0009.0077.0001 at 0014–0024].

[370] Exhibit N3.2, NSW Government, *Response – Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* (Report, September 2022) p 4 [SCI.0011.0516.0001 at 0005].

[371] 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 New South Wales* (Final Report, May 2022) [1.53], [2.68], [2.77] [SCI.0009.0077.0001 at 0040, 0060, 0062].

[372] 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 New South Wales* (Final Report, May 2022) [3.130] [SCI.0009.0077.0001 at 0098].

[373] 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 New South Wales* (Final Report, May 2022) [3.134] [SCI.0009.0077.0001 at 0099].

[374] 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 New South Wales* (Final Report, May 2022) [5.200], [7.59] [SCI.0009.0077.0001 at 0166, 0205].

[375] 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 New South Wales* (Final Report, May 2022) [7.70] [SCI.0009.0077.0001 at 0208].

[376] 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 New South Wales* (Final Report, May 2022) [5.195] [SCI.0009.0077.0001 at 0164].

[377] 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 New South Wales* (Final Report, May 2022) [5.195] [SCI.0009.0077.0001 at 0164–0165].

specialist medical colleges to increase rural general practice and specialist training positions;[378]

f. staff in rural, regional or remote areas were also found to be significantly under resourced when compared to their metropolitan counterparts;[379]

g. the existing "GP VMO" model was creating difficulties for NSW Health in ensuring doctor coverage in hospitals (with many doctors working under this model experienced enormous pressure) and that NSW Health should review the working conditions, contracts and incentives of general practitioners working in public health facilities; [380]

h. in order to address some workforce shortages, NSW Health should work to implement the Nurse Practitioner model of care in rural, regional and remote NSW including by funding the recruitment and training of additional Nurse Practitioners, particularly in those facilities without 24/7 doctor coverage or that utilise virtual care;[381]

i. the NSW Government should investigate ways to support growth and development of the primary health sector and support the sector's role in addressing the social determinants of health and reducing avoiding hospitalisations;[382]

j. NSW Health and the LHDs should prioritise building their First Nations workforce across all disciplines, job types and locations;[383] and

k. NSW Health, in its review of the nursing and midwifery workforce, should strive to develop stronger partnerships with the university sector to proactively engage local people and support them through rural and regionally based education, training and professional development to become qualified nurses and midwives, as well as implementing greater incentives for nurses and midwives working rurally.[384]

[378] 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 New South Wales* (Final Report, May 2022) [3.146] [SCI.0009.0077.0001 at 0102–0103].

[379] 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 New South Wales* (Final Report, May 2022) [3.128] [SCI.0009.0077.0001 at 0097].

[380] 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 New South Wales* (Final Report, May 2022) [3.143] [SCI.0009.0077.0001 at 0101].

[381] 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 New South Wales* (Final Report, May 2022) [4.78] [SCI.0009.0077.0001 at 0123–0124].

[382] 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 New South Wales* (Final Report, May 2022) [3.132] [SCI.0009.0077.0001 at 0098].

[383] 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 New South Wales* (Final Report, May 2022) [6.62] [SCI.0009.0077.0001 at 0187].

[384] 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 New South Wales* (Final Report, May 2022) [4.89] [SCI.0009.0077.0001 at 0125–0126].

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023)

8.159. On 4 April 2019, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability in Australia was established.[385] Each of the six Australian states subsequently issued letters patent or equivalent to the nominated Commissioners in substantially the same terms as the letters patent issued by the Governor-General.[386]

8.160. The Royal Commission's terms of reference, were "extremely broad",[387] and required inquiry into:[388]

a. what governments, institutions, and the community should do to prevent and better protect people with disability from experiencing violence, abuse, neglect and exploitation, by people with disability in all settings and contexts;

b. what governments, institutions, and the community should do to achieve best practice to encourage reporting of, and effective investigations of, and responses to, violence against, and abuse, neglect, and exploitation of, people with disability, including addressing failures in, and impediments to, reporting, investigating and responding to such conduct; and

c. what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

8.161. The Royal Commission's *Final Report* was tabled in the Australian Parliament on 29 September 2023.

8.162. The *Final Report* highlighted pervasive discrimination and exclusion faced by people with disabilities, including with respect to access to services, employment opportunities, and social inclusion. With respect to the experience of people with disability in the Australian health system, the Royal Commission found that there was a "huge gap between the health outcomes experienced by people with disability and those experienced by the rest of the community", including as a result of systemic neglect and health services not having the requisite knowledge and skills to care for

[385] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *About the Royal Commission* (Final Report, September 2023) vol 2, p 4.

[386] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, About the Royal Commission (Final Report, September 2023) vol 2, p 4.

[387] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 40.

[388] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *About the Royal Commission* (Final Report, September 2023) vol 2, p 95.

people with disability.[389] It found that there were three fundamental areas of reform required to provide access to quality healthcare for people with disability:[390]

a. health professionals – quality healthcare requires good communication and a relationship of trust, confidence and respect between a person with disability and the medical practitioners who provide them with care and treatment;

b. person centred care – an individual's needs and preferences should form the foundations for their care and treatment; and

c. system coordination – the Australian health system is complex, and people with disability should be supported to navigate these systems to access quality healthcare.

8.163. The Royal Commission found that there were "formidable barriers to quality healthcare in Australia for people with cognitive disability"[391] and determined that the right of people with disability to equitably access health services could be strengthened under Australian law. In pursuit of this objective, it recommended the implementation of a *Disability Rights Act* which, among other things, would recognise that right.[392] The Royal Commission also recommended embedding the right to equitable access to health services in key policy instruments, including the Australian Charter of Healthcare Rights, National Safety and Quality Health Service Standards, and the National Safety and Quality Primary and Community Healthcare Standards.[393]

8.164. The majority of the recommendations made by the Royal Commission that are relevant to the work of this Special Commission were those that concerned the education and training of health professionals. The Royal Commission's recommendations on those issues were focussed on ensuring fairness in diagnosis and treatment decisions relating to people with disability and also improving communication between healthcare providers and people with cognitive disability and their families and supporters.[394] Those recommendations included:

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[389] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Enabling Autonomy and Access* (Final Report, September 2023) vol 6, pp 321, 327.

[390] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Enabling Autonomy and Access* (Final Report, September 2023) vol 6, p 322.

[391] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Enabling Autonomy and Access* (Final Report, September 2023) vol 6, p 322.

[392] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Enabling Autonomy and Access* (Final Report, September 2023) vol 6, p 335.

[393] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 230.

[394] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 78.

a. development and implementation of a cognitive disability health capability framework, which would specify the core knowledge, skills and attributes required to provide quality healthcare to people with cognitive disability.[395] This included supporting health workforce capability development at all stages of education and training;[396]

b. that accreditation authorities for health professions review and amend accreditation standards and curriculum where necessary to ensure sufficient coverage of cognitive disability health;[397]

c. improving access to clinical placements in disability health services;[398]

d. the development of specialised training content in cognitive disability health, including expanding and promoting pathways for subspeciality training in cognitive disability health, and review of continuing professional development programs;[399] and

e. the development of specialised health and mental health services for people with cognitive disability, including introducing disability health navigators to support navigation of healthcare for people with disability.[400]

Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 (2023)

8.165. On 24 October 2023, Rosemary Huxtable AO PSM delivered the report of the her *Mid-Term Review of the Addendum to the NHRA*.[401]

8.166. She was tasked with assessing whether the 2020–2025 Addendum to the NHRA was meeting its stated objectives, and:

a. the implementation of the long term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the *Addendum to the NHRA*;

b. the impact of external factors on the demand for hospital services and the flow on effects on *Addendum to the NHRA*;

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[395] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 78.

[396] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 227.

[397] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) pp 78–79, 228.

[398] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023), p 228.

[399] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) p 229.

[400] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Executive Summary, Our Vision for an inclusive Australia and Recommendations* (Final Report, September 2023) pp 232–233.

[401] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of* the National Health Reform Agreement Addendum 2020–2024 (Final Report, 24 October 2024) [SCI.0011.0585.0001].

c. for small rural and small regional hospitals, whether they continue to meet the block funding criteria;

d. whether any unintended consequences such as cost shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of parties to adopt and deliver innovative models, as a result of financial and other arrangements in the *Addendum to the NHRA*;

e. the performance of the national bodies of their functions, roles and responsibilities; and

f. arrangements for approval and funding of high-cost therapies offered in public hospitals.[402]

8.167. Ms Huxtable observed that the next stage of reform would require a collaborative whole of health system Agreement, that incorporated a national health funding and payments framework that could deliver optimal models of care and increase the Commonwealth funding share over time, and that critical system priorities and enablers would need to be embedded into the Agreement, with clear accountabilities and programs of action.[403]

8.168. A number of the conclusions and recommendations were directed (or at least related) to some of the key themes that have emerged in this Special Commission, such as:

a. that ABF has proven value in enabling transparency, accountability and consistency of funded episodic activity, and provides a solid basis from which to enhance and evolve funding incentives to support system improvements.[404] It accordingly recommended that ABF be retained as a foundational element of a future Agreement.[405] However, it has been less successful in improving allocative efficiency, responding to the needs of an ageing population and higher rates of chronic and complex conditions, and incentivising high value care and optimal patient outcomes;[406]

b. the new Agreement should implement a new funding model that gradually increases the Commonwealth contribution to 45 per cent of nationally efficient public hospital activity; and include an initial injection of Commonwealth funds into

[402] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) pp 133–134 [SCI.0011.0585.0001 at 0138–0139].

[403] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 4 [SCI.0011.0585.0001 at 0009].

[404] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 8 [SCI.0011.0585.0001 at 0013].

[405] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 8 [SCI.0011.0585.0001 at 0013].

[406] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 4 [SCI.0011.0585.0001 at 0009].

those states and territories that sit below the current median contribution rate to bring them closer to the national average; [407]

c. that consideration be given to reframing the 6.5 per cent national funding cap to an activity growth cap, with price growth not subject to a cap but based on an efficient price calculation using more contemporary activity and cost data than is presently used;[408]

d. a 10-year National Health Funding and Payments Framework should be established, which would incorporate blended models of care and bundled payments and value/outcome based payments;[409]

e. the process of applying and approving exemptions under s 19(2) of the *Health Insurance Act* be reviewed to improve access to bulk billed primary care;[410]

f. collaboration between aged care sectors and public hospitals should be strengthened through shared responsibility for supporting older patients to be discharged from hospital when clinically ready, and for reducing avoidable emergency presentations and hospitals admissions;[411]

g. the intersectoral architecture set out in the NHRA be reinforced and improved with a commitment to greater alignment and collaboration between PHNs, Local Health Networks and ACCHOs, including through a nationally consistent governance framework;[412]

h. the NHRA should set out the roles and responsibilities in the governance of rural and remote healthcare provision, including by outlining the Commonwealth's stewardship role in ensuring the accessibility and sustainability of primary, aged and disability care in thin rural and remote markets, establishing clear accountability and escalation mechanisms to address market failures in those rural and remote care sectors, and establishing governance and pathways to support the development of flexible models to improve access to care;[413]

[407] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 9 [SCI.0011.0585.0001 at 0014].

[408] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 9 [SCI.0011.0585.0001 at 0014].

[409] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 8 [SCI.0011.0585.0001 at 0013].

[410] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 12 [SCI.0011.0585.0001 at 0017].

[411] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 7 [SCI.0011.0585.0001 at 0012].

[412] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 6 [SCI.0011.0585.0001 at 0011].

[413] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 11 [SCI.0011.0585.0001 at 0016].

i. a new NHRA should develop and implement pricing approaches that reward high value care and penalise low value care;[414]

j. a future NHRA should explicitly recognise the role of the health workforce in the delivery of quality health services as an additional Schedule that should align with existing national workforce strategies, ensure a collaborative focus by the Commonwealth and states and territories on a concise set of strategic priorities and actions, consider dedicated national health workforce planning governance oversight, and include a commitment to the continued development of the national regulation scheme through the Australian Health Practitioner Regulation Authority;[415]

k. greater transparency in funding and investment for education and training;[416]

l. a structured program of work be undertaken to develop and implement bundled payments within the NHRA for certain end to end episodes of care, with an initial focus on maternity care and additional priority areas identified in consultation with the national bodies and relevant stakeholders;[417] and

m. a future NHRA should include an explicit commitment to progress digital health as a key enabler to improving the health system.[418]

Independent review of Australia's regulatory settings relating to overseas health practitioners (Kruk Review) (2023)

8.169. On 30 September 2022, National Cabinet announced a review into the Australian health workforce, in recognition of the fact that Australia is required to supplement the domestically trained workforce with skilled overseas trained practitioners to meet demand, and that to achieve this goal, Australian regulatory settings must be fit for purpose, comparable to similar countries, and not impose unnecessary barriers while still maintaining safety standards.[419] Robyn Kruk AO was appointed to lead the review.[420]

[414] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 8 [SCI.0011.0585.0001 at 0013].

[415] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 12 [SCI.0011.0585.0001 at 0017].

[416] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 10 [SCI.0011.0585.0001 at 0015].

[417] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 8 [SCI.0011.0585.0001 at 0013].

[418] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2024* (Final Report, 24 October 2024) p 12 [SCI.0011.0585.0001 at 0017].

[419] Exhibit H2.45, Robyn Kruk AO, *Independent Review of Australia's regulatory settings relating to overseas health practitioners* (Final Report, 2023) p 84 [SCI.0011.0511.0001 at 0088].

[420] Commonwealth Government, Department of Health and Aged Care, 'Independent Review of Health Practitioners Regulatory Settings' (Media Release, 8 December 2022) [SCI.0011.0514.0001].

8.170. Consistently with some of the issues that emerged in the evidence before this Special Commission, Ms Kruk identified several challenges affecting the health workforce in Australia, including "the ongoing impact of COVID-19 peaks, a growing and ageing population, rising levels of chronic conditions, differences in local needs, and workers wanting more flexibility are increasing pressure on service delivery".[421]

8.171. The review resulted in 28 recommendations directed to improving the effectiveness and efficiency of processes that apply to international medical graduates wishing to practise in Australia.[422] There is a considerable body of work under way to implement those recommendations, including:

a. the Australian Health Practitioner Regulation Agency (AHPRA) has begun work to streamline the average assessment time for international applications to 10 days, down from 29;[423]

b. the Medical Board of Australia has launched an expedited specialist pathway for specialist international medical graduates with qualifications deemed equivalent to Australian standards.[424] AHPRA and other national boards had commenced two further expedited pathway projects in September 2024 for other professions, including occupational therapy, dental, psychology, podiatry, medical radiation, nursing and midwifery;[425]

c. workforce modelling was under way to create a comprehensive view of Australia's health workforce to guide decisions on the future skill mix and distribution of internationally qualified health practitioners;[426]

d. a project to develop a National Maternity Workforce Strategy was under way,[427] and consultation had commenced on a draft National Nursing Workforce Strategy;[428]

e. an Allied Health Workforce Strategy is currently being developed and is expected to be completed in 2025;[429] and

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[421] Exhibit H2.45, Robyn Kruk AO, *Independent Review of Australia's regulatory settings relating to overseas health practitioners* (Final Report, 2023) p 3 [SCI.0011.0511.0001 at 0007].

[422] Exhibit H2.45, Robyn Kruk AO, *Independent Review of Australia's regulatory settings relating to overseas health practitioners* (Final Report, 2023) p 7 [SCI.0011.0511.0001 at 0011].

[423] Australian Health Practitioner Regulation Agency, 'Ahpra statement in response to the Kruk Review final report' (Media Release, 7 December 2023) p 2 [SCI.0011.0509.0001 at 0002].

[424] Health Workforce Taskforce, *Independent Review of Health Practitioner Regulatory Settings: Implementation Update* (October 2024) p 2.

[425] Health Workforce Taskforce, *Independent Review of Health Practitioner Regulatory Settings: Implementation Update* (October 2024) p 3.

[426] Health Workforce Taskforce, *Independent Review of Health Practitioner Regulatory Settings: Implementation Update* (October 2024) p 4.

[427] Health Workforce Taskforce, *Independent Review of Health Practitioner Regulatory Settings: Implementation Update* (October 2024) p 6.

[428] Commonwealth Government, Department of Health and Aged Care, 'Public consultation on Australia's first National Nursing Workforce Strategy' (Media Release, 11 September 2024) [SCI.0011.0508.0001].

[429] 'National Allied Health Workforce Strategy', *Department of Health and Aged Care* (Web Page, 13 March 2025) <https://www.health.gov.au/our-work/national-allied-health-workforce-strategy>.

f. $90 million over three years was allocated in the 2024–2025 Federal Budget to fund the implementation of Ms Kruk's recommendations.[430] That funding was a component of the $1.2 billion package of Strengthening Medicare measures agreed at National Cabinet in December 2023. An additional $9.4 million was allocated to the implementation of the recommendations in the 2024–2025 Federal Budget, of which $1.3 million was used in that period, and $8.1 million was carried over to the 2025–2026 Federal Budget.[431]

Unleashing the Potential of our Health Workforce – Scope of Practice Review (Cormack Review) (2024)

8.172. In December 2022, the Strengthening Medicare Taskforce released its report outlining priority recommendations to enhance primary care. One of the recommendations of the report was that the Commonwealth Government, in collaboration with the states and territories, should review the barriers and enablers for all health professionals to work to their full scope of practice.[432]

8.173. The National Cabinet adopted the Taskforce's recommendations in April 2023, and Professor Mark Cormack was tasked with leading an independent review into "the benefits, risks, barriers and enablers to health professionals working to full scope of practice within multidisciplinary care teams in primary care".[433] Professor Cormack's report was delivered to the Minister for Health and Aged Care in October 2024.[434]

8.174. Professor Cormack found that barriers to working to a full scope of practice contribute to workforce shortages, as they prevent the most effective use of the existing workforce and potentially deter future recruits.[435] He also found that the inability to work to a full scope of practice contributes to some health professionals' decisions to leave the health workforce, with rates of individuals leaving the profession higher among the professional categories who broadly experience the greatest barriers to working to their full scope of practice.[436]

8.175. Eighteen recommendations were made, directed to addressing challenges faced by practitioners in working to their full scope of practice and delivering multidisciplinary

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[430] Michelle Wisbey, 'Federal Budget 2024–25 "Dropped the Ball": RACGP', *newsGP* (Web Page, 14 May 2024) <https://www1.racgp.org.au/newsgp/professional/federal-budget-2024-25-huge-disappointment-for-gps#:~:text=The%20college%20has%20slammed%20the,Federal%20Budget%20is%20%248.5%20billion>; Commonwealth Government, *Budget 2024–2025: Budget Measures* (Budget Paper No 2, 14 May 2024) p 111.

[431] Commonwealth Government, *Budget 2025–2026: Federal Financial Relations* (Budget Paper No 3, 25 March 2025) pp 39, 43.

[432] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 50.

[433] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 50.

[434] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 56.

[435] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 12.

[436] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 12.

care. Those recommendations included proposed reform across three broad areas: workforce design, development and planning, legislation and regulation, and funding and payment policy.[437]

8.176. Professor Cormack recommended the introduction of a new blended payment to enable access to multidisciplinary healthcare delivered by health professionals working to their full scope of practice in primary care.[438]

8.177. Professor Cormack also recommended that governments, working with relevant professional associations, develop and implement communications and training strategies about the intent and substance of reforms to strengthen multidisciplinary primary care teams working to full scope of practice.[439]

8.178. Upon the report being handed over in November 2024, Commonwealth Health Minister Mark Butler noted that the Commonwealth Government would "carefully consider" the findings and recommendations, alongside other primary care and workforce review reports. Minister Butler stated: "Many of the recommendations will require collaboration between the Commonwealth and state and territory governments, as well as consultation with peak professional organisations, AHPRA, patient groups, and the sector more broadly."[440]

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[437] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 15.

[438] Expert Advisory Committee, *Unleashing the Potential of our Health Workforce – Scope of Practice Review* (Final Report, November 2024) p 36.

[439] Expert Advisory Committee, Unleashing the Potential of our Health Workforce – Scope of Practice Review (Final Report, November 2024) p 45.

[440] 'Landmark report on how to unleash the potential of our health professions', *Department of Health and Aged Care* (Web Page, 5 November 2024) <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/landmark-report-on-how-to-unleash-the-potential-of-our-health-professions>

Chapter 9:

The NSW public health system

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Introduction

9.1. The provision of healthcare to the population has been a long standing feature of public services in NSW.

9.2. Starting from relatively narrow beginnings, the nature and extent of the healthcare provided by the State has expanded significantly over time. Hospitals, once the domain of charity and benevolent societies, are now a central and critical part of State Government operations.

9.3. The NSW public health system today is vast. It is the largest of any public health system in Australia, and NSW Health is the largest government department and public sector employer in the State. Reflecting its size and significance within the broader context of State Government operations, the health portfolio in NSW has, in recent years, consistently received the largest share of the State budget.[441]

9.4. The magnitude of the system as a whole means that any attempt to describe all its component parts, and their roles and functions, in a Report such as this, will inevitably fail to do so adequately and comprehensively. That is not the purpose of this Chapter in any event. Rather, the purpose of this Chapter is to introduce the key components of the system, and the statutory framework in which it operates.

Health administration in NSW from 1881

Public health at the turn of the 20th century

9.5. Prior to 1881, government health services, other than for 'lunacy',[442] lacked coordination and central direction. Health and welfare institutions were operated by voluntary agencies independently of government control, although supported by government financial assistance.[443]

9.6. Those institutions included general hospitals (also known as voluntary hospitals), which began in the nineteenth century as charities for the poor, with their own boards and irregular government assistance.[444] Over time, State hospitals grew out of State

[441] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p iii [SCI.0011.0717.0001 at 0005]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO and Deb Willcox (17 November 2023) [50] [MOH.9999.0001.0001 at 0009]; Exhibit N.3.42, *NSW Budget Statement 2024–25* (Budget Paper No 1, June 2024) p 97 [SCI.0011.0545.0001 at 0098].

[442] Lunacy was recognised as a medical service from the last quarter of the nineteenth century, and its independently structured lunatic asylums were drawn together in a Department of Lunacy, within the Colonial Secretary's Department, as a sequel to the *Lunacy Act of 1878* (42 Vic. No. 7). See Exhibit O2, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 63 [SCI.0011.0778.0001 at 0074].

[443] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 63 [SCI.0011.0778.0001 at 0074].

[444] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 136 [SCI.0011.0778.0001 at 0146].

asylums for the infirm, and came to supplement the care offered by general hospitals including by caring for the aged and people with intractable chronic diseases.[445]

9.7. The 1881 smallpox epidemic prompted change to public healthcare in NSW, and, as part of the response to it, government began to take a more active role in public health regulation and preventive health services. Part of that response was the establishment of the Board of Health.[446] The Board of Health was established as a statutory corporation and had the power to make regulations to prevent the spread of communicable diseases.[447]

9.8. In 1898, the Board of Health established two Health Districts, one for the Hunter River region and one for metropolitan Sydney.[448] Each Health District was led by a medical officer with a Diploma of Public Health, and provided local governments with professional expertise and inspection assistance.[449] Adapted from the English model of local government responsibility for health, the Health Districts submitted reports describing the state of health in their region with statistics, tables of notifiable infectious disease outbreaks, and details of sanitary inspections.[450] Over the next 70 years, a further seven Health Districts were established.[451]

9.9. Over time, the Board of Health came to have a significant degree of executive authority.[452] It became the central point of control of public health administration and personnel, in part to ensure equity of service provision and impartial application of public health laws.[453] In about 1896, its role was expanded to include the power to institute inquiries where there was a danger to public health. That power included rights of entry by its authorised officers.[454]

9.10. The Medical Adviser to the Government controlled a small department within the Chief Secretary's Department and was also President of the Board of Health, making them responsible to both the Colonial Secretary and the Colonial Treasurer

[445] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 139 [SCI.0011.0778.0001 at 0149].

[446] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 63, 65 [SCI.0011.0778.0001 at 0074, 0076]; *Infectious Diseases Supervision Act* (43 Vic. No. 25).

[447] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 73–74 [SCI.0011.0778.0001 at 0083–0084].

[448] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 93 [SCI.0011.0778.0001 at 0103].

[449] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 93–94 [SCI.0011.0778.0001 at 0103–0104].

[450] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 96 [SCI.0011.0778.0001 at 0106].

[451] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 94, app 6 [SCI.0011.0778.0001 at 0104, 0173].

[452] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 92 [SCI.0011.0778.0001 at 0102].

[453] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 68 [SCI.0011.0778.0001 at 0079].

[454] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 76 [SCI.0011.0778.0001 at 0086].

respectively.[455] That dual responsibility governance structure continued until 1904, when the Department of Public Health was established within the Colonial Secretary's Department, and which incorporated the administrative functions of the Board of Health.[456]

9.11. Between 1904 and 1913, the health service expanded as its focus broadened to a range of infectious diseases affecting the population at the time.[457]

Establishment of the Ministry of Health

9.12. In 1913, the Ministry of Health was established and the first Minister for Health was appointed.[458] The Department of Public Health and the Office of the Inspector-General of the Insane were transferred from the Colonial Secretary's Department, and the Board of Health from the Treasury to the new Ministry.[459]

9.13. Upon the Ministry of Health being established, the Department of Public Health constituted its largest and most diverse component.[460] That Department included, for example, the Office of the Chief Medical Officer, public health and infectious diseases services including laboratories, the Government Medical Officer responsible for jail medical services;,and the Hospitals Admission Depot.[461] Initially, the Board of Health was the only statutory authority within the Ministry of Health, but several more were later established, including the Ambulance Transport Board (1920–1976), Hospitals Commission of NSW (1929–1972), Milk Board (1931–1955), NSW Cancer Council (from 1955), and NSW Institute of Psychiatry (from 1964).[462]

9.14. The structure of the Ministry of Health remained largely constant in the pre-World War II period, and in that time the Offices of the Director-General of Public Health and Inspector-General of Mental Hospitals continued to operate independently.[463] Some

[455] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 77–78 [SCI.0011.0778.0001 at 0087–0088].

[456] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 79, 83 [SCI.0011.0778.0001 at 0089, 0093].

[457] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 83 [SCI.0011.0778.0001 at 0093].

[458] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 95, 133 [SCI.0011.0778.0001 at 0105, 0143].

[459] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) pp 92, 133 [SCI.0011.0778.0001 at 0102, 0143].

[460] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 141 [SCI.0011.0778.0001 at 0151].

[461] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 133 [SCI.0011.0778.0001 at 0143].

[462] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 140 [SCI.0011.0778.0001 at 0150].

[463] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 141 [SCI.0011.0778.0001 at 0151].

health units external to the Ministry of Health also continued to operate, the largest being the Department of Education's medical and dental service for school children.[464]

Mid-century developments

9.15. The impact of World War II meant essential public services had to be maintained within reduced budgets.[465] Following the recommendations made in the *Morris Report*, in 1941 a single professional head with responsibility for public health and mental health was appointed.[466] That structure remained in place until about 1952, when the organisational structure of the Ministry of Health largely reverted to that in place before 1941.

9.16. Advances in medical science and technology in the post-World War II era prompted growing demand for public health services of increasing complexity. As a result, the Ministry of Health needed to enhance its levels of expertise and specialisation.[467] One response to this dynamic environment in NSW was to establish an independent Health Advisory Council in 1961.[468] Chaired by the Director-General of Public Health and State Psychiatric Services, its membership included an executive member and an expert in hospitals, preventive medicine, and psychiatry.[469]

9.17. By the mid-1960s, there was a level of disharmony in State health services, with some wanting to preserve the *status quo* and others advocating for new concepts of community medicine and social medicine in the form of holistic care. In response to this disharmony the Minister for Health commissioned a series of reviews of the State's health services, including the *Eglington Review* and the subsequent *Starr Review*.[470] Although the report of the *Eglington Review* was considered radical at the time, its conclusion that there was an imbalance between the curative medicine and preventive medicine has, in the decades since, been the subject of widespread (if not near universal) agreement in the literature. If Mr Eglington's recommendations to address that imbalance were "radical" at the time, perhaps he understood that the time for a revolution in health service had arrived (Mr Eglington was, after all, a lawyer). The flow on effects of the failure to embrace those concepts at that time have had a long lasting effect on the public health system to this day.

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[464] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 141 [SCI.0011.0778.0001 at 0151].

[465] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 141 [SCI.0011.0778.0001 at 0151].

[466] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 144 [SCI.0011.0778.0001 at 0154].

[467] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 93 [SCI.0011.0778.0001 at 0103].

[468] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 122 [SCI.0011.0778.0001 at 0132].

[469] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 122 [SCI.0011.0778.0001 at 0132].

[470] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 145 [SCI.0011.0778.0001 at 0155].

9.18. In 1973, the Health Commission was established, "for the purposes of promoting, protecting, developing, maintaining and improving the health and wellbeing of the people of New South Wales to the maximum extent possible".[471] The Health Commission was vested with wide powers to investigate, plan, conduct health services and support research.[472] It was also granted the powers of delegation essential to regionalisation.[473] It was responsible for running hospitals and mental health institutions from 1973 until 1982, when it was abolished upon the creation of the NSW Health Department. During this period, 137 separate public hospital administrations were established throughout the State, as well as six regional offices of the Health Commission, which oversaw the Country Health Regions.[474]

The Area Health Services

9.19. Throughout the 1980s, 1990s and early 2000s, the NSW public health system underwent significant (and frequent) change.

9.20. In 1982, the NSW Health Department was established by the *Health Administration Act 1982* (NSW). The purpose of creating that Department was to establish a simpler, more efficient organisational structure able to meet the changing needs of the community.[475]

9.21. In 1986, a significant restructure of the public health system took place, in part to facilitate greater levels of autonomy and authority in local administration. Twenty-three Area Health Services were established, in addition to Area Health Boards in the Sydney, Newcastle, and Wollongong regions.[476] In 1988, the 23 Area Health Services were amalgamated into 10.[477]

9.22. In 1993, the six Country Health Regions were split into 23 District Health Services, and on 1 July 1993, a Rural Health Directorate was established to supervise them.[478]

9.23. In 1995, the Eastern Sydney and Southern Sydney Area Health Services were amalgamated to form the new South Eastern Sydney Area Health Service, reducing the number of Area Health Services to nine.[479]

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[471] Health Commission Act 1972 (NSW) s 18.

[472] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 150 [SCI.0011.0778.0001 at 0160].

[473] Exhibit O.5, CJ Cummins, *A History of Medical Administration in NSW: 1788–1973* (NSW Health, 2nd ed, October 2003) p 150 [SCI.0011.0778.0001 at 0160].

[474] NSW Health, *Annual Report 1996-1997* (Report, December 1997), p 9; NSW Health, *Annual Report 1997-1998* (Report, December 1998), p 15; NSW Health, *Annual Report 1992-1993* (Report, December 1993), p. 10

[475] Exhibit O.4, NSW Health, *Annual Report 1999–2000* (Report, December 2000) p 15 [SCI.0011.0863.0001 at 0017].

[476] Exhibit O.4, NSW Health, *Annual Report 1999–2000* (Report, December 2000) p 15 [SCI.0011.0863.0001 at 0017].

[477] Exhibit O.4, NSW Health, *Annual Report 1999–2000* (Report, December 2000) p 15 [SCI.0011.0863.0001 at 0017].

[478] NSW Health, *Annual Report 1997-1998* (Report, December 1998), p 15; NSW Health, *Annual Report 1992-1993* (Report, December 1993), p. 6

[479] Exhibit O.4, NSW Health, *Annual Report 1999–2000* (Report, December 2000) p 15 [SCI.0011.0863.0001 at 0017].

9.24. In March 1996, eight Rural Health Services were established, replacing the 23 District Health Services.[480]

9.25. In 1998, the *Health Services Act 1997* (NSW) came into effect. One of its purposes was to give statutory recognition to the role of health promotion and education, community health, and environmental health services. The Act also provided that Rural Health Services would have the same status as metropolitan Area Health Services, with the result that there were then 17 Area Health Services.[481]

9.26. In 2005, the 17 Area Health Services were consolidated into eight, namely: Sydney South West; South Eastern Sydney and Illawarra; Sydney West; Northern Sydney and Central Coast; Hunter and New England; North Coast; Greater Southern; and Greater Western. [482]

The Garling Report and subsequent developments

9.27. Several of the recommendations made in the *Garling Report* related to the structure of the NSW public health system,[483] some of which were directed to remedying what Commissioner Garling considered to be deficiencies in the 2005 restructure.[484]

9.28. One of the key recommendations made by Commissioner Garling directed to the structure of the NSW public health system was that there be "four pillars of reform of the public hospital system", being: the CEC; the Clinical Innovation and Enhancement Agency; the Institute of Clinical Education and Training; and the Bureau of Health Information (BHI).[485] Aside from the CEC (which had been established in 2004), each of the other "pillars" identified by Commissioner Garling were established between 2009 and 2012.[486]

9.29. Commissioner Garling also recommended that there be a single Statewide authority responsible for providing the full range of care for children and young people. Although not entirely in the form envisaged by Commissioner Garling, the SCHN was established in 2010.[487]

9.30. In January 2011, the Area Health Services were replaced by 15 geographically based LHDs[488] (eight covering the Sydney metropolitan region and seven covering rural and

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[480] NSW Health, *Annual Report 1997-1998* (Report, December 1998), p 15.

[481] Exhibit O.4, NSW Health, *Annual Report 1999–2000* (Report, December 2000) p 15 [SCI.0011.0863.0001 at 0017].

[482] Exhibit O.7, NSW Health, *Annual Report 2004–2005* (Report, November 2005) p 10, 56 [SCI.0011.0858.0001 at 0018, 0064].

[483] For a more comprehensive summary of the Garling Report, see Chapter 4 of this Report.

[484] Exhibit N.4.5, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 3, [31.88], [31.209]–[31.210], [31.230], [31.311]–[31.312] [SCI.0011.0762.0001 at 0193, 0211, 0213, 0226].

[485] Exhibit N.4.2, *Special Commission of Inquiry Acute Care Services in NSW Public Hospitals* (Overview of Final Report, 27 November 2008) [1.34] [SCI.0011.0756.0001 at 0009].

[486] See Exhibit O.10, Independent Panel, *Third Progress Report: Appendices* (Report, November 2010) p 187 [SCI.0011.0856.0001 at 0129].

[487] Submission of the Sydney Children's Hospitals Network to the Special Commission of Inquiry into Healthcare Funding (31 October 2023).

[488] Initially called Local Health Networks.

regional NSW).[489] The LHDs were established, at least in part, based on the then Director-General of NSW Health (now Health Secretary) "adopt[ing] a fundamental principle of a commitment to devolution and localism" which moved the function of clinical service planning from the Ministry to the local organisation level, limiting "broader Statewide oversight of service design and alignment".[490]

9.31. As discussed above, the 2011 *Governance Review* by the then Director-General of NSW Health, examined the functions and structures of NSW Health's main entities and their alignment with the NSW Government's policy directions, with a view to ensuring clear delineation of responsibilities and to support collaboration between entities.[491]

9.32. The *Governance Review* resulted in the most significant overall change to the NSW public health system in its history. Those changes included:

a. the Department of Health becoming the Ministry of Health on 5 October 2011;[492]

b. that LHDs and SHNs being given responsibility and accountability for managing all local aspects of hospital and health service delivery, pursuant to service agreements;[493]

c. reforming the Pillars to reduce the extent of overlap between their functions and encourage more collaborative processes with the Ministry of Health;[494]

d. the establishment of NSW Health Pathology as an Administrative Division of the Health Administration Corporation in May 2012;[495]

e. the renaming of the Public Health System Support Division of the Health Administration Corporation to HealthShare NSW in August 2012;[496] and

f. the creation of eHealth NSW to, among other functions, improve their information and communications technology (ICT) across the system.[497]

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489 Exhibit O.54, 'Local Health Districts', *Health Stats NSW* (Web Page) <https://www.healthstats.nsw.gov.au/page/LHD-definition> [SCI.0011.0883.0001].

490 Exhibit L.6, Statement of Philip Minns (8 October 2024) [12] [MOH.0011.0082.0001 at 0003].

491 For a more comprehensive summary of the Governance Review, see Chapter 4 of this Report.

492 Exhibit O.11, NSW Health, *Annual Report 2011–2012* (Report, October 2012) pp 2, 6 [SCI.0011.0859.0001 at 0006, 0010].

493 Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 10–11 [MOH.0001.0309.0001 at 0012–0013].

494 Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) pp 19–20 [MOH.0001.0309.0001 at 0021–0022].

495 Exhibit B.10, Statement of Venessa Janissen (8 February 2024) [6] [MOH.9999.0008.0001 at 0001-0002].

496 See Exhibit B.23.37, *Delegation of Functions – HealthShare NSW Board* (29 November 2012) [MOH.0001.0308.0001].

497 Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (Report, August 2011) p 21, 24 [MOH.0001.0309.0001 at 0023, 0026]; Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [7] [MOH.0001.0433.0001 at 0002].

The current structure of the NSW public health system

9.33. The NSW public health system in its present form is a product of two primary pieces of legislation - the *Health Services Act* and the *Health Administration Act.* Its structure is set out in Figure 1.

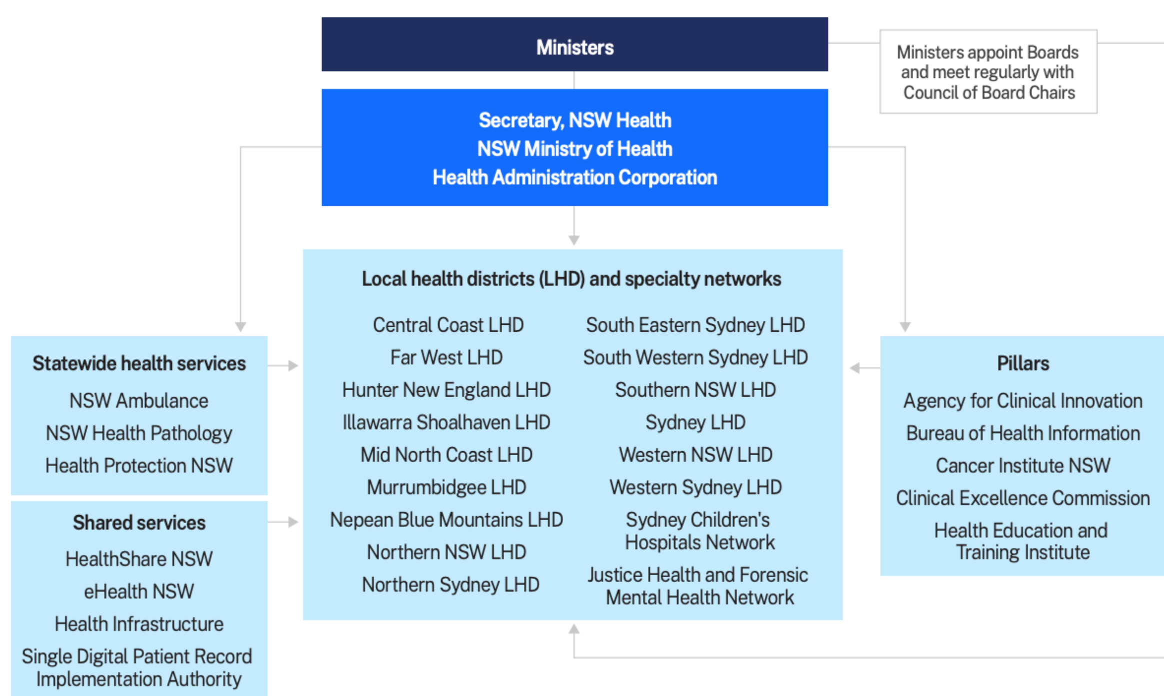

Figure 1: NSW Health organisational chart[498]

9.34. In broad terms, the *Health Services Act* regulates the governance and management of the NSW public health system. It creates each of the component parts of the system and identifies their respective functions and governance structures.[499] It also prescribes the arrangements for employment of staff within the "NSW Health Service"[500] and for visiting practitioners.[501]

[498] *Health Services Act 1997* (NSW) ss 8–14, chs 3, 4, 5, 5A, 8, 10; Exhibit N.3.27, NSW Health, Annual Report 2023–2024 (Report, October 2024) p 3 [SCI.0011.0717.0001 at 0011].

[499] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) p 1.01 [MOH.0010.0256.0001 at 0010].

[500] Health Services Act 1997 (NSW) ch 9.

[501] Health Services Act 1997 (NSW) ch 8.

9.35. The *Health Administration Act* sets out the functions of the Minister and the Health Secretary, establishes the Health Secretary as a corporation sole known as the Health Administration Corporation; establishes the NSW Health Foundation; creates the Medical Services Committee; provides for the establishment of approved quality assurance committees; and sets out the processes required for the review of health services incidents.[502]

9.36. A range of other powers and functions are conferred on aspects of the NSW public health system, or those within it, by other statutes.[503] For example, the *Public Health Act 2010* (NSW) confers power on the Minister for Health to take actions and make orders in relation to public health risks generally, during a state of emergency, and when risks arise from the conduct of public authorities.[504] Other statutes confer functions in relation to matters such as the advertising and sale of tobacco and other smoking products[505], the fluoridisation of public water supply,[506] the provision of care to people with mental illnesses and disorders in hospitals and community facilities,[507] licensing of private health facilities,[508] and the effective operation of the medical indemnity sector.[509]

9.37. Reflective of the "fragmented" nature of the health system more broadly in Australia, there is also a range of Commonwealth legislation that is relevant to the operation of the NSW public health system. For present purposes, the most relevant is Commonwealth legislation dealing with the funding of public health services, the operation of the aged care sector and the NDIS, and the collection of health related information.[510]

The component parts of the NSW public health system

9.38. In this section of the Report, the role and function of the component parts of the NSW public health system are explored at a general level.

Ministers

9.39. There are currently four Ministerial appointments with portfolio responsibility for health; namely the Minister for Health, the Minister for Regional Health, the Minister

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[502] Health Administration Act 1982 (NSW) pts 2, 2A.

[503] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 98 [SCI.0011.0717.0001 at 0106].

[504] Public Health Act 2010 (NSW) ss 7–9.

[505] Public Health (Tobacco) Act 2008 (NSW) pts 2–6.

[506] Fluoridation of Public Water Supplies Act 1957 (NSW) s 6A.

[507] Mental Health Act 2007 (NSW) s 3, chs 2–6.

[508] Private Health Facilities Act 2007 (NSW) s 4, pt 2.

[509] Health Care Liability Act 2001 (NSW) ss 3, 4.

[510] See, eg, National Health Reform Act 2011 (Cth) s 4, chs 2, 4, 5; Health Insurance Act 1973 (Cth) pts II, IIA, IIB; National Health Act 1953 (Cth) pt VII; Aged Care Act 1997 (Cth); Aged Care Quality and Safety Commission Act 2018 (Cth); National Disability Insurance Scheme Act 2013 (Cth); Australian Institute of Health and Welfare Act 1987 (Cth).

for Mental Health, and the Minister for Medical Research.[511] The Ministers for Health, Regional Health, and Mental Health have joint responsibility for the administration of health related legislation.[512]

9.40. As is frequently the case, the *Health Administration Act* and the *Health Services Act* refer to the "Minister" without specifying which of the relevant Ministers has primary responsibility for the power or function that is conferred. Such references are to be understood as referring to the Minister with responsibility for administering the particular Acts, or such as here in the case of shared administration, the Minister with responsibility for exercising the particular power or performing the function in question.[513]

9.41. For ease of reference in this Report, references to the "Minister" are to the Minister for Health. To the extent that this Report discusses a function or responsibility of the "Minister" that sits within the remit of another Ministerial portfolio, the reader of this Report will be able to readily understand those references as being to the Minister who ultimately has that particular function or responsibility.

9.42. Section 5 of the *Health Administration Act*[514] sets out what might be described as the core functions of the Minister vis-à-vis the NSW public health system. It provides:

> *(1) The Minister may formulate general policies, in accordance with which the functions of the Minister, Ministry, Health Secretary, Corporation and Foundation are to be exercised, for the purpose of promoting, protecting, developing, maintaining and improving the health and wellbeing of the people of New South Wales to the maximum extent possible having regard to the needs of and financial and other resources available to the State.*
>
> *(2) The Minister may—*
>
> *(a) provide, conduct, operate and maintain and, where necessary, improve and extend any health service or any ancillary or incidental service and arrange for the construction of any buildings or works necessary for or in connection with any such service,*
>
> *(b) enter into any agreement or arrangement for any other person to provide, conduct, operate and maintain any health service, and*

[511] Exhibit O.55, 'Ministers', *Parliament of New South Wales* https://www.parliament.nsw.gov.au/members/Pages/ministers.aspx [SCI.0011.0884.0001].

[512] *Administrative Arrangements (Minns Ministry—Administration of Acts) Order 2023*, sch 1; Exhibit H2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) p 1.01 [MOH.0010.0256.0001 at 0010]. The Minister for Medical Research does not presently have responsibility for the administration of any health related legislation.

[513] Interpretation Act 1987 (NSW) s 15.

[514] The Minister is also responsible for managing the functions of the NSW Health Foundation and appointing advisory bodies and members of the Medical Services Committee under that Act: *Health Administration Act 1982* (NSW) ss 16, 20, 20B.

> (c) *do such supplemental, incidental or consequential acts as may be necessary or expedient for the exercise of the functions under the foregoing provisions of this subsection.*

9.43. Consistently with those functions, and as explored elsewhere in this Report, the Minister has a central role in the determination of the amount of money (if any) that is to be paid to LHDs, AHOs, and the Statutory Health Corporations from that which is appropriated from the Consolidated Fund.[515]

9.44. The Minister has a range of other powers and functions, including: the power to appoint and remove LHD Board members; appoint such councils, committees and advisory bodies as the Minister may consider appropriate; appoint members to the Medical Services Committee; establish quality assurance committees; and appoint committees of review to determine appeals by visiting practitioners against decisions of public health organisations.[516]

9.45. The Minister for Mental Health has responsibility for Statewide policy in relation to mental health and a range of functions relating to the NSW Mental Health Commission, the Mental Health Review Tribunal, and the Mental Health Official Visitors Program.[517] The Minister for Medical Research has responsibilities for medical research and innovation within NSW, including strategy setting.[518] The Minister for Regional Health is responsible for overseeing and improving health services in regional, rural, and remote areas of the State by addressing the unique challenges faced by these communities, such as healthcare accessibility, workforce shortages, and infrastructure needs.[519]

[515] *Health Services Act 1997* (NSW) s 127. The power cannot be delegated: *Health Services Act 1997* (NSW) s 127(3); *Health Administration Act 1982* (NSW) s 21(23).

[516] *Health Services Act 1997* (NSW) ss 26, 29, 49, 52 and 108; *Health Administration Act 1982* (NSW) ss 20, 20B, 20E.

[517] Exhibit H2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) p 1.02 [MOH.0010.0256.0001 at 0011].

[518] Exhibit H2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) p 1.02 [MOH.0010.0256.0001 at 0011].

[519] Exhibit O.56, NSW Health, *Regional Health* (Web Page, 23 November 2023) <https://www.health.nsw.gov.au/about/ministry/Pages/regional.aspx> [SCI.0011.0885.0001].

The Health Secretary

9.46. The Secretary of the Ministry of Health (also described as the Health Secretary) has a range of critical statutory responsibilities. As the head of the NSW Government department with responsibility for the public health system (i.e., the Ministry of Health), the Health Secretary is ultimately responsible for its management and strategic direction.[520]

9.47. The core functions of the Health Secretary are set out in s 8(2) of the *Health Administration Act*, which provides:

> *(2) The Health Secretary shall have and may exercise the following functions-*
>
> *(a) to initiate, promote, commission and undertake surveys and investigations into—*
>
> *(i) the health needs of the people of New South Wales,*
>
> *(ii) the resources of the State available to meet those needs, and*
>
> *(iii) the methods by which those needs should be met,*
>
> *(b) to inquire into the nature, extent and standards of the health services, facilities and personnel required to meet the health needs of the people of New South Wales and to determine the cost of meeting those needs,*
>
> *(c) to plan the provision of comprehensive, balanced and coordinated health services throughout New South Wales,*
>
> *(d) to formulate the programs and methods by which the health needs of the people of New South Wales may be met,*
>
> *(e) to undertake, promote and encourage research in relation to any health service,*
>
> *(f) to facilitate the provision of health services by any council (within the meaning of the Local government Act 1993) or by any other body or person,*

[520] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 7 [SCI.0011.0717.0001 at 0015]; *Government Sector Employment Act 2013* (NSW) s 22, 23, 25, sch 1.

> (g) *to facilitate the provision by any Public Service agency, statutory authority, other body or person of social welfare services necessary or desirable to complement any health service,*
>
> (h) *to promote and facilitate the provision of the professional, technical or other education or training of any persons employed or to be employed in the provision of any health service,*
>
> (i) *to promote and facilitate a system of health care for the people of New South Wales provided by private bodies, institutions, associations and persons, as well as by the State and public bodies,*
>
> (j) *to do such supplemental, incidental or consequential acts as may be necessary or expedient for the exercise of the Health Secretary's functions under the foregoing provisions of this subsection.*

9.48. The Health Secretary also has a range of governance responsibilities. For example, s 122(1) of the *Health Services Act* provides that the Health Secretary has the following functions:[521]

> (a) *to facilitate the achievement and maintenance of adequate standards of patient care within public hospitals and in relation to other services provided by the public health system,*
>
> (b) *to facilitate the efficient and economic operation of the public health system consistent with the standards referred to in paragraph (a),*
>
> (c) *to inquire into the administration, management and services of any public health organisation,*
>
> (c1) *to provide governance, oversight and control of the public health system and the statutory health organisations within it,*
>
> (d) *to cause public health organisations (including public hospitals controlled by them) to be inspected from time to time,*
>
> (e) *to recommend to the Minister what sums of money (if any) should be paid from money appropriated from the Consolidated Fund in any financial year to any public health organisation,*

[521] Health Services Act 1997 (NSW) s 122.

> *(f) to enter into performance agreements with public health organisations, to review the results of organisations under such agreements and to report those results (and make recommendations about the results) to the Minister,*
>
> *(f1) to give directions to statutory health organisations, including (subject to section 121E(3)) directions relating to the employment of NSW Health Service senior executives,*
>
> *(g) such other functions as may be conferred or imposed by or under this Act.*

9.49. Subject to some limited exceptions (such as Chief Executives of LHDs), the Health Secretary exercises the employer functions on behalf of the NSW Government in relation to the NSW Health workforce. In exercising those functions, the Health Secretary may fix the salary, wages and employment conditions of a wide range (but not all) of NSW Health staff, direct the transfer of senior executives and redundant staff members, and arrange for secondments or for the use of facilities outside NSW Health to assist with the performance of public health system functions.[522]

9.50. The Health Secretary is subject to the control and direction of the Minister, other than when making recommendations to the Minister.[523]

Ministry of Health

9.51. The Ministry of Health is a public service department and acts as the "system manager" of the NSW public health system. In the performance of that function, the Ministry is responsible for the delivery of services through the NSW public health system. This includes developing system wide policy and strategy, as well as ensuring compliance with the requirements of the NHRA.[524] It is also responsible for providing support to the Ministers in the exercise of their respective functions.[525]

9.52. As depicted in Figure 2, within the Ministry of Health, there are several divisions, each with lead responsibility for specific aspects of its operations.

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[522] Health Services Act 1997 (NSW) ch 9; Government Sector Employment Act 2013 (NSW) s 26.

[523] *Health Administration Act 1982* (NSW) s 8(3) provides that: The Health Secretary is, in the exercise of functions conferred or imposed on the Health Secretary by or under any Act administered by the Minister for Health, subject to the control and direction of the Minister, except in relation to the contents of a recommendation or report made by the Health Secretary to the Minister.

[524] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [36]–[37] [MOH.9999.0001.0001 at 0005]; Exhibit A.28, *Addendum to the National Health Reform Agreement 2020-2025* (2020) cl 10 [SCI.0001.0024.0001 at 0009]; Exhibit H2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) pp 1.03, 6.02 [MOH.0010.0256.0001 at 0012, 0067]; Transcript of the Commission, 28 November 2023, T69.9–29, 74.12–75.1 (Lyons).

[525] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 5 [SCI.0011.0717.0001 at 0013].

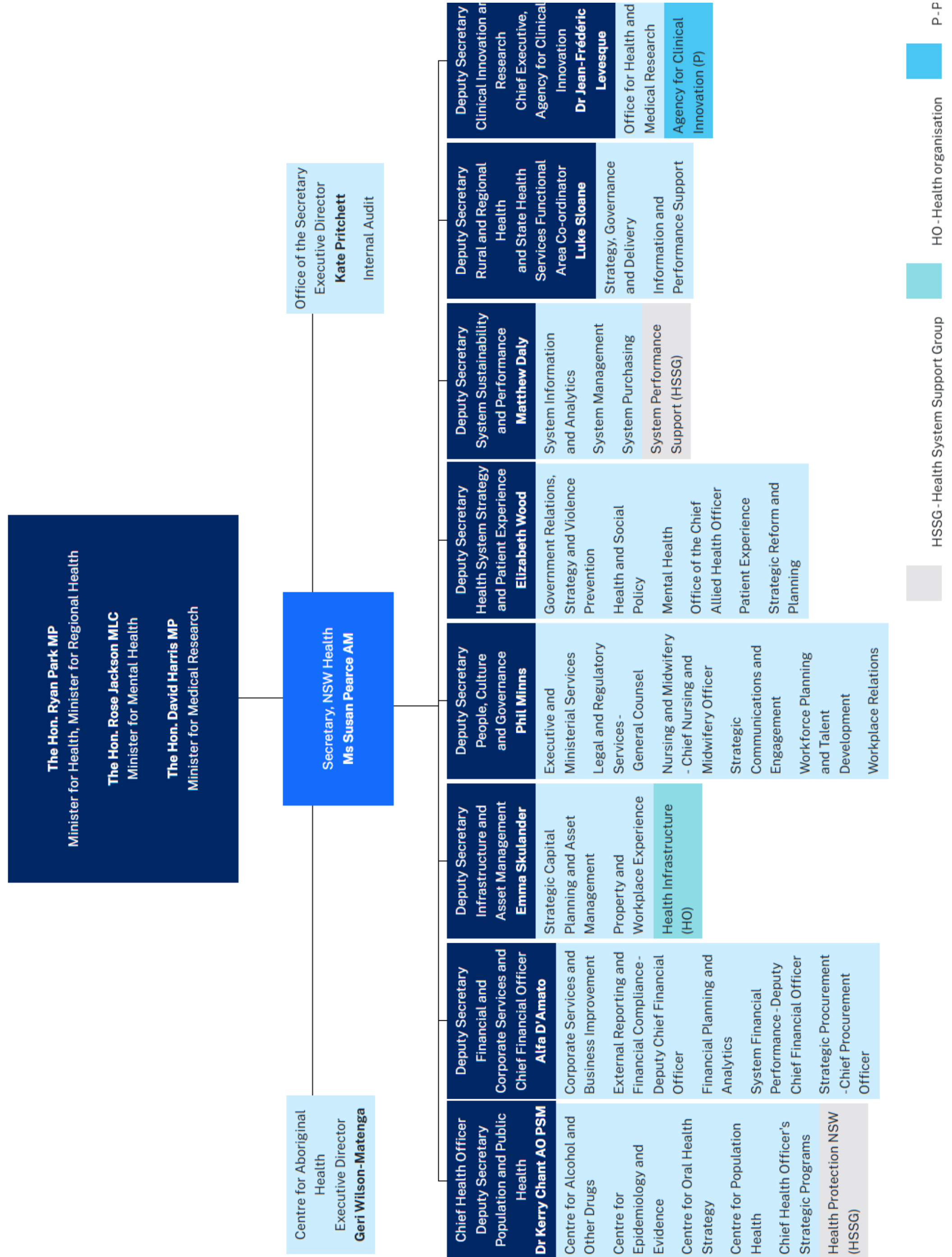

Figure 2: Ministry of Health organisational chart[526]

[526] Exhibit O.58, 'Ministry of Health Organisation Chart', *NSW Health* (Web Page, 17 February 2025) <https://www.health.nsw.gov.au/about/ministry/Pages/chart.aspx> [SCI.0011.0888.0001].

9.53. It is not necessary to engage in a detailed exploration of each of those divisions or their areas of responsibility. At a high level, the roles and responsibilities of each of the divisions within the Ministry may be summarised as follows:

a. The Population and Public Health Division is responsible for the strategy, planning, monitoring, and performance of population and public health services. It also leads the public health responses to major incidents and leads the Statewide health protection network.[527] In addition to leading the Population and Public Health Division within the Ministry, the Chief Health Officer has a range of statutory responsibilities associated with that office, including under the *Public Health Act*;[528]

b. The Financial Services and Corporate Services Division (previously known as the Financial Services and Asset Management Division) is responsible for financial and corporate functions, including financial performance, analysis and reporting, accounting functions, activity based management and procurement functions;[529]

c. The Infrastructure and Asset Management Division was created on 9 December 2024 and the former Health Infrastructure Board was dissolved. This new Division brings together NSW Health's infrastructure planning and delivery and asset management functions under a single leadership structure;[530]

d. The People, Culture and Governance Division is responsible for regulatory and corporate governance functions, including legal services and management of the Health Secretary's function as employer of the NSW Health Service;[531]

e. The Health System Strategy and Patient Experience Division responsibilities include government relations, strategic reform, and oversight of programs aimed at enhancing patient experience. The Division has responsibility for engagement with other agencies and jurisdictions, including negotiations concerning the National Health Reform Agreement; [532]

f. The System Sustainability and Performance Division is responsible for the management of performance within the NSW public health system in accordance with the *NSW Health Performance Framework*, and the coordination of the annual service agreement process. The Division also has responsibility for "developing

[527] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 7 [SCI.0011.0717.0001 at 0015]; Transcript of the Commission, 28 November 2023, T66.26–38 (Chant).

[528] For example, issuing public warnings about identified health risks, advising the public regarding the safety of drinking water, making public health orders in respect of individuals with certain diagnoses, and approving the NSW Immunisation Schedule: *Public Health Act 2010* (NSW) ss 12A, 22, 62, 85.

[529] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 8 [SCI.0011.0717.0001 at 0016]; Transcript of the Commission, 28 November 2023, T71.43–72.4 (Willcox); 'Ministry of Health Organisation Chart', *NSW Health* (Web Page, 17 February 2025) <https://www.health.nsw.gov.au/about/ministry/Pages/chart.aspx>.

[530] 'Structure', *NSW Health Infrastructure* (Web Page, 17 February 2025) <https://www.hinfra.health.nsw.gov.au/about/structure>.

[531] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 8 [SCI.0011.0717.0001 at 0016]; Transcript of the Commission, 28 November 2023, T72.6–10 (Willcox).

[532] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 9 [SCI.0011.0717.0001 at 0017].

collaborative partnerships with primary health providers to establish innovative models of care"; [533]

g. The Rural and Regional Health Division was established in 2022 to oversee and support health service delivery in regional, rural and remote NSW;[534]

h. The Clinical Innovation and Research Division. The Division integrates the Office for Health and Medical Research (OHMR) and the ACI, although the ACI remains a Pillar. The Division is headed by a Deputy Secretary, who also holds the position of Chief Executive of the ACI. The Division has responsibility for coordination and strategy setting in relation to Statewide research and innovation priorities.[535]

9.54. Within any large system or organisation, there will inevitably be a range of views as to the merit of the organisational structure adopted from time to time. I accept that some (perhaps many) may take the view that the structure adopted within the Ministry of Health, and its division of roles and responsibilities, could be enhanced. However, the evidence does not suggest to me that the current structures that have been adopted within the Ministry are ineffective or appropriate. Accordingly, I have not found it necessary to make any recommendations concerning the organisational structures that are in place across NSW Health. They should, however, be regularly reviewed by the Health Secretary to ensure that they continue to support the wider system to meet the health needs of the population, and respond to the many challenges it faces.

Health Administration Corporation

9.55. As observed above, the Health Secretary is also incorporated as a corporation sole called the Health Administration Corporation (HAC).[536] Through the organisations that have been established as part of HAC, the Health Secretary performs a range of functions and provides services to other parts of the NSW public health system. In doing so, the Health Secretary forms part of the public health system.[537]

9.56. As set out in Figure 1 above, the organisations within HAC fall into two broad categories – Statewide health services and shared services. The Statewide health services include NSW Ambulance, NSW Health Pathology, and Health Protection NSW. The shared services are HealthShare NSW, eHealth NSW, Health Infrastructure, and the Single Digital Patient Record Implementation Authority. The paragraphs that follow set out a brief overview of the roles and responsibilities of each organisation within HAC, together with their governance arrangements.

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[533] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 9 [SCI.0011.0717.0001 at 0017]; Transcript of the Commission, 28 November 2023, T72.12–18 (Willcox).

[534] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 9 [SCI.0011.0717.0001 at 0018]; Transcript of the Commission, 28 November 2023, T72.20–73.3 (Willcox).

[535] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 10 [SCI.0011.0717.0001 at 0018].

[536] Health Administration Act 1982 (NSW) s 9.

[537] *Health Services Act 1997* (NSW) ss 6, 67B, 126B.

NSW Ambulance

9.57. Through NSW Ambulance, the Health Secretary provides the range of ambulance services set out in s 67B of the *Health Services Act*. In general terms, modern ambulance services include out of hospital care, emergency care, medical retrieval, and health related transport across the State.[538] NSW Ambulance also provides support for the whole of government planning in relation to major events and mass gatherings and is involved in State emergency and rescue management.[539]

9.58. NSW Ambulance is led by a Chief Executive and an Advisory Board with between eight and 12 members, each appointed by the Health Secretary.[540]

Health Protection NSW

9.59. Health Protection NSW develops strategies and policies for the surveillance, prevention, control, and response to infectious and environmental health threats, together with LHD public health units, other agencies, and healthcare providers.[541] It monitors notifiable disease incidence and provides public health responses to control the spread and reduce the burden of disease.[542]

9.60. Health Protection NSW is headed by an Executive Director who reports to the Chief Health Officer.[543]

NSW Health Pathology

9.61. NSW Health Pathology's primary function is to operate as the preferred provider and commissioner of services for the diagnosis and monitoring of disease, and operate a forensic and analytical science service within the NSW public health system.[544] Subject to some limited exceptions, public health organisations must acquire their pathology, forensic, and analytical science services from NSW Health Pathology.[545] NSW Health Pathology is primarily funded through service recovery charges levied to LHDs and SHNs, revenue generated from private patients and corporate customers, and block grants.[546]

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[538] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012]; Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) p 1.03 [MOH.0010.0256.0001 at 0012].

[539] State Emergency and Rescue Management Act 1989 (NSW) s 3.

[540] *Health Services Act 1997* (NSW) ss 67A, 67C, sch 6.

[541] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012].

[542] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [56] [MOH.9999.0001.0001 at 0007].

[543] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012]; Exhibit H.1.0, NSW Health, *Delegations Manual – Combined Administrative Financial Staff* (May 2015) [MOH.9999.0817.0001].

[544] Exhibit B.23.173, *Instrument of Establishment – NSW Health Pathology* (6 June 2019) [MOH.0001.0382.0001].

[545] Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [19] [MOH.9999.0008.0001 at 0005]. By consent in the case of Affiliated Health Organisations: Exhibit B.23.86, Order pursuant to s 126G of the *Health Services Act 1997* (13 June 2019) [MOH.0001.0383.0001].

[546] Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [32]–[50] [MOH.9999.0008.0001 at 0010–0014].

9.62. NSW Health Pathology is led by a Chief Executive and a Board, the members of which are appointed by the Health Secretary.[547]

HealthShare NSW

9.63. HealthShare NSW provides services that support the delivery of patient care, including procurement, food and linen, patient transport, and payroll services. HealthShare NSW also administers Statewide (whole of government and whole of health) contracts, and the warehousing and distribution of goods supplied under those contracts.[548] Generally, public health organisations must acquire any health support services from HealthShare NSW.[549]

9.64. Previously, HealthShare NSW entered into Service Agreements with LHDs and SHNs for the provision of its services. This no longer occurs. Instead, HealthShare NSW enters into an annual agreement with the Health Secretary, described as a "Statement of Service", which sets out the budget allocated to HealthShare NSW and a range of KPIs.[550]

9.65. HealthShare NSW is Board governed, and its members are appointed by the Health Secretary.[551] The Board has strategic oversight and corporate governance functions, together with an advisory role including in relation to strategies and business improvements that may support improved efficiency and customer service by HealthShare NSW.[552]

9.66. HealthShare NSW is funded through a combination of block funding and "intrahealth charges" levied to other parts of the NSW public health system for the provision of services.[553]

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[547] Exhibit B.23.82, *Instrument of Constitution – NSW Health Pathology Board* (8 October 2018) cl 2 [MOH.0001.0377.0001 at 0001].

[548] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012]; Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31] [MOH.9999.0009.0001 at 0011].

[549] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) [MOH.0001.0404.0001]; Exhibit B.23.35, NSW Health, *Accounts & Audit Determination for Public Health Entities in NSW* (9 March 2020) pp 26–27 [MOH.0001.0278.0001 at 0027–0028]. By consent in the case of Affiliated Health Organisations.

[550] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [14] [MOH.9999.0009.0001 at 0004]; Exhibit B.23.129, HealthShare NSW, *Statement of Service 2023–2024* (8 February 2024) pp 8–16 [MOH.9999.0010.0001 at 0009–0017].

[551] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [7] [MOH.9999.0009.0001 at 0002].

[552] Exhibit B.23.37, *Delegation of Functions – HealthShare NSW Board* (29 November 2012) [MOH.0001.0308.0001].

[553] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [25]–[28] [MOH.9999.0009.0001 at 0009].

eHealth NSW

9.67. eHealth NSW is responsible for the development and implementation of the whole of NSW Health digital strategy, policy, standards, and investment plans; the delivery and management of information communication; and establishing, implementing, and ensuring compliance with policy and standards.[554] Its functions broadly include the design, procurement, build, operation and maintenance of ICT, digital infrastructure and cyber security services, Statewide support, and ICT related procurement.[555]

9.68. eHealth NSW is funded primarily on a cost recovery model. In addition, eHealth NSW also receives capital funding for Statewide programs and a level of recurrent funding from the Ministry to support its core functions.[556]

9.69. eHealth NSW is led by a Chief Executive, who reports to the Secretary. In January 2024, the Health Secretary established a Board of eHealth (as an advisory board) to oversee its operations, replacing the previous Executive Council.[557]

Health Infrastructure NSW

9.70. Health Infrastructure NSW delivers the NSW major works hospital building program and can also be engaged by LHDs to assist with smaller projects.[558]

9.71. Its core functions include:

a. managing capital works projects with an estimated construction cost of $10 million or more in partnership with public health organisations;

b. managing or provide support and advice as requested by public health organisations for capital works projects with an estimated cost of less than $10 million;

c. system risk management for approved capital works projects by developing standardised contracts and other documents that support best practice and government policy compliance;

d. supporting and overseeing asset management by public health organisations; and

e. providing such other infrastructure delivery services in connection with public health organisations as may be determined from time to time.[559]

9.72. Health Infrastructure NSW is led by a Chief Executive and has a Board.[560]

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[554] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [7]–[9] [MOH.0001.0433.0001 at 0002].

[555] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [10]–[12] [MOH.0001.0433.0001 at 0002–0003]; Exhibit B.23.124, *Instrument of Establishment – eHealth NSW* (2 June 2023) [MOH.0001.0312.0001].

[556] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [15]–[17] [MOH.0001.0433.0001 at 0003].

[557] Exhibit D.5, Statement of Philip Minns (9 April 2024) [141] [MOH.9999.0764.0001 at 0039].

[558] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [57] [MOH.9999.0001.0001 at 0008].

[559] Exhibit B.35, Health Infrastructure, *Statement of Service 2023–2024* (31 October 2023) cl 1.2 [SCI.0003.0001.0386 at 0389].

[560] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 259 [SCI.0011.0717.0001 at 0267].

The Single Digital Patient Record Implementation Authority

9.73. Established in May 2024, the Single Digital Patient Record Implementation Authority is responsible for leading the implementation of the SDPR.[561] It is headed by a Chief Executive who reports to the Health Secretary.[562]

The structures and governance arrangements adopted within HAC organisations

9.74. Elsewhere in this Report, I have made recommendations directed to enhance the delivery of services delivered by some HAC organisations. While the evidence revealed (perhaps as may be expected) that there can be improvements made to the operations and service delivery functions of some HAC organisations, it does not suggest that there is an immediate need for significant (or indeed any) changes to their current organisation or governance arrangements. However, these are matters that should be under the continual review of the Health Secretary.

Local Health Districts

9.75. LHDs are established by Chapter 3 of the *Health Services Act* for the "principal reason" of facilitating the conduct of public health facilities and provision of health services in those areas of the State in respect of which the district is constituted.[563] It is unsurprising, then, that the LHDs, together with the SHNs, are the "engine room" of the NSW public health system. It is through their facilities and services that the 340,000 surgeries and 2 million inpatient episodes occur each year. [564]

9.76. The "primary purposes" of LHDs is to provide relief to sick and injured persons in their geographical area through the provision of care and treatment, and to promote, protect and maintain the health of the community.[565] Section 10 of the *Health Services Act* relevantly provides:

> *The functions of a local health district are as follows-*
>
> *(a) generally to promote, protect and maintain the health of the residents of its area,*
>
> *(b) to conduct and manage public hospitals, health institutions, health services and health support services under its control,*
>
> *(c) to give residents outside its area access to such of the health services it provides as may be necessary or desirable,*

[561] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012].

[562] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 4 [SCI.0011.0717.0001 at 0012].

[563] *Health Services Act 1997* (NSW) s 8; Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.2.1] [MOH.0010.0256.0001 at 0015].

[564] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p iii [SCI.0011.0717.0001 at 0005].

[565] Health Services Act 1997 (NSW) s 9.

(d) to achieve and maintain adequate standards of patient care and services,

(e) to ensure the efficient and economic operation of its health services and health support services and use of its resources,

(f) generally to consult and cooperate (as it considers appropriate) with any one or more of the following—

(i) the Health Care Complaints Commission constituted under the Health Care Complaints Act 1993,

(ii) health professionals practising in its area,

(iii) other individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the promotion, protection and maintenance of health,

(f1) to cooperate with other local health districts and the Health Secretary in relation to the provision of services involving more than one public health organisation or on a Statewide basis,

(g) to investigate and assess health needs in its area,

(h) to plan future development of health services in its area, and, towards that end—

(i) to consult and plan jointly with the Ministry of Health and such other organisations as it considers appropriate, and

(ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services, and

(iii) to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister,

(i) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services,

(j) to provide services to persons with whom it has contracted or entered into an agreement under section 37(2),

(k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129,

(l) *to provide training and education relevant to the provision of health services,*

(m) *to undertake research and development relevant to the provision of health services,*

(n) *to make available to the public information and advice concerning public health and the health services available within its area,*

(o) *to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.*

9.77. There are currently 15 LHDs across NSW, each constituted as a body corporate.[566]

[566] *Health Services Act 1997* (NSW) s 17, sch 1; Exhibit A.5, NSW Health, *NSW Local Health Districts Map* [SCI.0001.0001.0001].

Figure 3: NSW Health, Local Health Districts

9.78. In fulfilling its primary purpose, and performing its functions, an LHD may establish such health facilities, services and support services as it thinks necessary for the exercise of its functions. It may also close a public health facility or cease or restrict a service or support service. However, decisions to establish, close, or restrict a service may only be implemented if the LHD has first notified the Health Secretary of the decision, and ensured that the decision is appropriate having regard to its functions.[567]

9.79. Each LHD remains subject to the oversight and control of the Health Secretary and the Minister.[568] For example, the Health Secretary may determine, and give directions in relation to, the role, functions and activities of a public health facility or service that is under the control of an LHD.[569] The Minister may also direct an LHD to establish, close, or restrict a public health facility or service if satisfied it is in the public interest to do so.[570]

9.80. In exercising their functions, LHDs are expected to engage in planning over both the short and long term to support service delivery that meets the health needs of the population for which they are responsible.[571] As part of that planning process, LHDs are required to ensure that government health policy goals are achieved through the planning and funding of a range of health services, whether those services are provided by that LHD, by other LHDs, or the SHNs, or other service providers.[572] Through that approach, LHDs are expected to plan their services in a holistic way, including by reference to the availability of services in other districts, SHNs, and by providers outside of the NSW public health system. As part of that planning function, LHD Boards must ensure the views of providers, consumers and other community members are sought about the district's policies and plans for provision of health services.[573]

9.81. The most comprehensive plan generated by an LHD is the Health Care Services Plan, which details priorities and service direction over a five to 10 year horizon. Health Care Services Plans should contain foundational planning for clinical and support services, workforce, health improvement, and assets, including for individual facilities and particular categories of services. They ought to reflect what can be done safely and efficiently within the available budget, opportunities to

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[567] *Health Services Act 1997* (NSW) s 31. The practical ability of Local Health Districts to exercise those functions, however, is significantly affected by external factors, some of which will be explored below.

[568] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.2.3] [MOH.0010.0256.0001 at 0015].

[569] Health Services Act 1997 (NSW) s 32(1).

[570] Health Services Act 1997 (NSW) s 32(2).

[571] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [6.1.1] [MOH.0010.0256.0001 at 0066].

[572] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [6.1.1] [MOH.0010.0256.0001 at 0066].

[573] Health Services Act 1997 (NSW) s 28(1)(h).

network/partner with other providers, and continuing improvement processes to ensure intended outcomes are met.[574]

9.82. In performing their functions, LHDs may enter into contracts or agreements for goods, machinery, materials, and services.[575] However, they cannot employ staff. Instead, their functions are performed through NSW Health Service staff employed by the Government of NSW in the service of the Crown, but not as part of the Public Service.[576]

The governance and management structure of LHDs

9.83. Each LHD is established as a body corporate, is headed by a Chief Executive, and has a Board.[577]

The Chief Executive

9.84. Chief Executives of LHDs are appointed by the Board with the concurrence of the Health Secretary, and are employed by the NSW Government. They are responsible for the management and control of the affairs of the LHD and are accountable to the Board.[578]

The Board

9.85. LHD Boards are comprised of between six and 13 members who are appointed by the Minister. In making appointments to the Board of an LHD, the Minister is required to select its members so that it has an appropriate mix of skills and expertise required to oversee and provide guidance to the district.[579]

9.86. Section 28 of the *Health Services Act* provides that LHD Boards have the following functions:

> *(a) to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the local health district and to approve those frameworks,*

[574] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069–0070].

[575] Health Services Act 1997 (NSW) s 37.

[576] Health Services Act 1997 (NSW) ss 22, 115.

[577] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [39] [MOH.9999.0001.0001 at 0005].

[578] *Health Services Act 1997* (NSW) ss 23–25; Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.2.4] [MOH.0010.0256.0001 at 0016].

[579] *Health Services Act 1997* (NSW) s 26. In doing so, ss 26(3) and (4) identify specific fields of experience and expertise that must be represented in the board membership.

(b) to approve systems—

(i) to support the efficient and economic operation of the local health district, and

(ii) to ensure the district manages its budget to ensure performance targets are met, and

(iii) to ensure that district resources are applied equitably to meet the needs of the community served by the district,

(c) to ensure strategic plans to guide the delivery of services are developed for the local health district and to approve those plans,

(d) to provide strategic oversight of and monitor the local health district's financial and operational performance in accordance with the Statewide performance framework against the performance measures in the performance agreement for the district,

(e) to appoint, and exercise employer functions in relation to, the chief executive of the local health district,

(e1) to ensure that the number of NSW Health Service senior executives employed to enable the local health district to exercise its functions, and the remuneration paid to those executives, is consistent with any direction by the Health Secretary or condition referred to in section 122(2),

(f) to confer with the chief executive of the local health district in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement,

(g) to approve the service agreement for the local health district under the National Health Reform Agreement,

(h) to seek the views of providers and consumers of health services, and of other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services, and to confer with the chief executive of the district on how to support, encourage and facilitate community and clinician involvement in the planning of district services,

(i) to advise providers and consumers of health services, and other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services,

(j) to endorse the local health district's annual reporting information for the purposes of the Government Sector Finance Act 2018,

(k) to liaise with the boards of other local health districts and specialty network governed health corporations in relation to both local and Statewide initiatives for the provision of health services,

(l) such other functions as are conferred or imposed on it by the regulations.

9.87. LHD Boards must establish the following committees:

a. Audit and Risk;

b. Finance and Performance;

c. Quality and Safety; and

d. Medical and Dental Appointments Advisory (with at least one Credentials (Clinical Privileges) Subcommittee).[580]

9.88. In addition, LHD Boards may establish other committees as it considers appropriate to provide advice or assistance to enable the LHD to perform its functions.[581]

Should the employment arrangements for LHD Chief Executives be changed?

9.89. It is convenient at this point to deal with a matter raised by NSW Health in its initial submission to this Special Commission related to the role and function of LHD Boards. In that submission, NSW Health contended that a review of "employment arrangements for Chief Executives to ensure a single line of accountability to the Secretary NSW Health could also be undertaken".[582] That submission was not repeated in NSW Health's final written submission.

9.90. The effect of NSW Health's submission, if adopted, would be that the role of the LHD Board to "appoint, and exercise employer functions in relation to, the Chief Executive" as set out in s 28(1)(e) of the *Health Services Act*, would be transferred to the Health Secretary. I am not persuaded that should occur. Significantly, none of the Chief Executives or LHD Board members who were asked about the proposal supported or embraced it. Indeed, several of them identified a range of benefits of the current arrangements that would be lost if the LHD Board did not exercise the employer

[580] The purpose of which is to provide advice, and make recommendations to, the Chief Executive in relation to the appointment of visiting practitioners or staff specialists, and the clinical privileges that should be allowed to visiting practitioners and staff specialists: Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [5.2.2] [MOH.0010.0256.0001 at 0061].

[581] Exhibit H.2.57, NSW Health, *Model By-laws for Local Health Districts and Specialty Health Networks*, pts 5, 10, 11 [SCI.0001.0002.0001 at 0004–0006, 0016–0019].

[582] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (7 November 2023) [193] [SCI.0002.0001.0001 at 0036].

function in relation to the Chief Executive.[583] No significant impediments or limitations of the current arrangements were identified.

9.91. In my view, the benefits that are gained by the current employment arrangements for LHD Chief Executives outweigh any limitations, and they should be maintained.

Committees and Councils

9.92. The Health Secretary has made Model By-Laws dealing with governance and management responsibilities.[584] LHDs (and SHNs) may make by-laws that adopt the provisions of the Model By-Laws. In doing so, they may only omit or modify aspects of the Model By-Laws with prior approval of the Health Secretary although they are free to make additional by-laws in respect of matters that are not covered by the Model By-Laws provided they are not inconsistent with them.[585]

9.93. The Model By-Laws require LHDs (and SHNs) to establish certain "structures and forums to provide input for medical, nursing and allied health staff" including "Medical Staff Councils", "Medical Staff Executive Councils" and several "Clinical Councils".[586] Such structures have the following objectives:[587]

> *a) facilitate effective patient care and services through a cooperative approach to the management and efficient operation of public hospitals between hospital executive management, clinical staff (including medical practitioners, nurses, midwives and allied health practitioners) and clinical support staff; and*
>
> *b) provide a forum for information sharing and to support feedback to staff on issues affecting the administration of the hospital(s) through the members of the councils.*

9.94. The Model By-Laws go on to set out a range of matters relevant to the establishment and operations of these structures.

9.95. In relation to Medical Staff Councils, the Model By-Laws provide that include that:[588]

a. the Chief Executive is to establish at least two Medical Staff Councils in the case of LHDs and at least one Medical Staff Council in the case of SHNs;

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[583] See, eg, Transcript of the Commission, 20 September 2024, T5521.28–5522.31 (Cohen/Carter/Treseder); Transcript of the Commission, 16 August 2024, T5035.14–46 (Clout/Hoskins); Transcript of the Commission, 24 April 2024, T2472.37–2473.33 (Danos); Transcript of Commission, 23 April 2024, T2329.39–2340.38 (MacLellan); Transcript of the Commission, 22 April 2024, T2253.45–2254.44, T2268.19–33 (Schembri); Transcript of the Commission, 22 April 2024, T2310.37–47 (McLachlan).

[584] Exhibit H.2.57, NSW Health, Model By-Laws for Local Health Districts and Specialty Health Networks [SCI.0001.0002.0001].

[585] Health Services Act 1997 (NSW) s 39.

[586] Exhibit H.2.57, NSW Health, Model By-laws for Local Health Districts and Specialty Health Networks, cl 21 [SCI.0001.0002.0001 at 0006].

[587] Exhibit H.2.57, NSW Health, *Model By-laws for Local Health Districts and Specialty Health Networks*, cl 22 [SCI.0001.0002.0001 at 0006–0007].

[588] Exhibit H.2.57, NSW Health, *Model By-laws for Local Health Districts and Specialty Health Networks*, cls 24–26 [SCI.0001.0002.0001 at 0007–0008].

b. the Medical Staff Councils are to be comprised of all visiting practitioners, staff specialists, career medical officers and dentists appointed to the organisation or the hospital or hospitals the Council represents;

c. sufficient Medical Staff Councils should be established to ensure that all visiting practitioners, staff specialists, career medical officers and dentists are members; and

d. unless there is only one Medical Staff Council in an LHD or SHN, there is then to be a Medical Staff Executive Council composed of representatives of the Medical Staff Councils for the hospitals under the control of an LHD (and representatives of the Mental Health Medical Staff Council), with the number of representatives from each Medical Staff Council depending on its size (generally one representative per 50 members). The function of the Medical Staff Executive Council is to provide advice to the Chief Executive and the Board on "medical matters" and nominate medical practitioners for consideration as members of the Board. The Chair of the Medical Staff Executive Council is a standing invitee to board meetings.[589]

9.96. The Model By-Laws also provide for the establishment of:[590]

a. Hospital Clinical Councils, for the purposes of providing "a structure for consultation with, and involvement of, clinical staff in management decisions impacting public hospitals and related community services". Hospital Clinical Councils include representatives of nursing and midwifery and allied health staff as well as medical staff and the general manager of the relevant hospital; and

b. LHD Clinical Councils and SHN Clinical Councils, which include members from the relevant Hospital Clinical Councils as well as the Chair of the Medical Staff Executive Council, have the function of providing advice to the Board and Chief Executive on "clinical matters affecting the organisation".

9.97. In addition, the Chief Executive may establish such other committees and councils as may be required to assist the LHD to exercise its functions.[591]

9.98. Clinician input into the planning and delivery of healthcare within the NSW public health system is critical. No one argued against that proposition. Although the Model By-Laws create structures and opportunities for that to occur, as considered in more detail in Chapter 18 below, there is a need to review the Model By-Laws to create robust structures for meaningful clinician engagement.

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[589] *Health Services Act 1997* (NSW) sch 4A, cl 18(1)(b).

[590] Exhibit H.2.57, NSW Health, *Model By-laws for Local Health Districts and Specialty Health Networks*, cls 33–37, 43–44 [SCI.0001.0002.0001 at 0010–0013, 0015–0016].

[591] Health Services Act 1997 (NSW) s 29B.

Service agreements and KPIs

9.99. Every year, the Health Secretary enters into a service agreement with each LHD and SHN.

9.100. Those service agreements set out the initial budget allocation,[592] a large number of KPIs (which are classified according to categories identified in the *Future Health Report* and are similar between districts), particular performance deliverables with milestones and timeframes for reporting on progress, and a series of other provisions that are largely common to all service agreements.[593]

9.101. LHDs and SHNs must, as far as practicable, exercise their functions in accordance with the terms of their service agreements with the Health Secretary.[594] Their performance is monitored in accordance with the *NSW Health Performance Framework*. At a general level, performance monitoring includes:[595]

a. monthly reports produced by the Ministry of Health for each LHD/SHN, which set out variations in performance against KPI targets and performance from the previous year;

b. monthly reports submitted by the LHD/SHN showing cost, budgeting and forecast data and a narrative regarding the results, as well as progress with Efficiency Improvement Plans;

c. quarterly performance meetings between the Ministry and LHD/SHN executives to review performance against KPIs, progress against *Future Health* strategic outcomes, priority areas impacting service delivery, and opportunities to collaborate to improve performance;

d. an annual safety and quality account produced by the LHD/SHN that documents outcomes for planned safety and quality initiatives, performance against KPIs, and commitment to consumer participation and staff culture; and

e. an annual *Aboriginal Health Progress Report*.

9.102. Each LHD/SHN is assigned a performance level from zero (nil performance concerns) to four (the recovery strategy for serious under performance and changes that may be required to governance of the organisation).[596]

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[592] Which generally includes a breakdown of funding to be allocated on an activity or block basis, capital funding and own source revenue targets, and other program services that are to be purchased (eg, Transitional Aged Care Program services).

[593] See, eg, Exhibit B.23.27, NSW Health, *Sample Local Health District Service Agreement 2023-2024* [MOH.0001.0288.0001]; Transcript of the Commission, 28 November 2023, T90.10–42 (Lyons). Some common features of service agreements include: an overview of the legislative and governance framework that underpins the agreement, strategic priorities from the "Future Health: Strategic Framework", "Regional Health Strategic Plan", Government priorities and the NSW Health Outcome and Business Plan, and a list of cross district referral networks, supra-LHD Services and nationally funded centres.

[594] Health Services Act 1997 (NSW) s 126.

[595] Exhibit B.23.26, NSW Health, *Performance Framework* (June 2023) pp 8–9 [MOH.0001.0363.0001 at 0010–0011].

[596] Exhibit B.23.26, NSW Health, *Performance Framework* (June 2023) p 10 [MOH.0001.0363.0001 at 0012].

9.103. Performance is reviewed monthly through the Ministry of Health's Performance Advisory Meeting, which makes recommendations to the Health System Performance Monitor Committee (consisting of the Health Secretary and Deputy Secretaries). When a decision is made to escalate or de-escalate the performance level allocated to an LHD/SHN, the Chief Executive and Board chair is formally notified and given reasons for the change.[597] Ministry support is provided to assist performance recovery, with more frequent performance meetings and strategies, such as independent reviews, if an organisation reaches level three or four.[598]

Health service types

9.104. A range of services are delivered through the public health system, including public hospitals, community and preventive health services, Supra-LHD and other Statewide services. Some features of key service types are explored in the paragraphs below.

Public hospitals

9.105. There are more than 220 public hospitals in NSW,[599] from MPSs (small facilities that integrate hospital and aged care services) to tertiary and quaternary facilities providing highly specialised care. They provide a mix of emergency, inpatient, medical, surgical, maternity, paediatric and subacute care in accordance with their role delineation.[600] In addition to acute care, public hospitals also provide secondary care, such as outpatient clinics, ambulatory care, and rehabilitation services.[601] They operate in networks that facilitate the transfer of patients to higher level services as required.[602]

Community and preventive health services

9.106. Community health services are designed to complement care given in public hospitals. The aim of such services is to ensure adequate clinical care, while attempting to address the social and environmental determinants of health.[603] Community health services delivered in the public health system include mental health and drug and alcohol services, dental care, palliative care, Hospital in the

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[597] Exhibit B.23.26, NSW Health, *Performance Framework* (June 2023) p 10 [MOH.0001.0363.0001 at 0012].

[598] Exhibit B.23.26, NSW Health, *Performance Framework* (June 2023) p 11 [MOH.0001.0363.0001 at 0013].

[599] Exhibit N3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p iii [SCI.0011.0717.0001 at 0005]. For the purposes of the *Health Services Act*, a "public hospital" is a hospital controlled by a LHD or Statutory Health Corporation, recognised establishments of Affiliated Health Organisations, and hospitals controlled by the Crown (including the Minister or Health Administration Corporation).

[600] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [68]–[70] [MOH.9999.0001.0001 at 0009].

[601] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Ms Deb Willcox (17 November 2023) [73] [MOH.9999.0001.0001 at 0010].

[602] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [71] [MOH.9999.0001.0001 at 0009].

[603] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [74]–[76] [MOH.9999.0001.0001 at 0010].

Home, and community nursing, child, youth and family health, Aboriginal health, women's health, refugee health, and urgent care services.[604]

9.107. Preventive health services delivered through the NSW public health system include measures to support the prevention and worsening of disease, support healthy living in those with chronic disease, support healthy ageing, and a range of preventive actions to keep people healthy and well, such as those designed to improve immunisation rates, health promotion in vulnerable cohorts, and early detection and treatment of health conditions.[605] As discussed in more detail in Chapter 10 below, the evidence received by this Special Commission, coupled with decades of health literature including many reports and reviews, establishes beyond sensible argument that much more needs to be done to deliver more of this type of care given its critical importance to the wellbeing of the population of NSW, and the sustainability of its public health service.

Supra-LHD services

9.108. Some highly specialised services delivered in relatively low volumes but at high cost are described as supra-LHD services. Those services are delivered across district/network boundaries at a limited number of sites. The consolidation of those services in that way is needed so as to concentrate the skills and infrastructure required to deliver those services, to ensure that they available at all times, and to provide best clinical outcomes for the patients accessing them.[606]

9.109. Recognised supra-LHD services are listed in annual service agreements and include:

a. intensive care services – adult (selected), paediatric, neonatal, and mental health;

b. transplantation services – heart and lung, adult liver, blood, and marrow;

c. retrieval services – organ and extracorporeal membrane oxygenation;

d. stroke services – neurointerventional (endovascular clot retrieval) and Telestroke;

e. high-risk Transcatheter Aortic Valve Implantation;

f. severe burn services;

g. genetic therapies;

h. CAR T-cell therapy;

i. State Spinal Cord Injury Service (adult and paediatric); and

j. hyperbaric medicine.[607]

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[604] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [79] [MOH.9999.0001.0001 at 0010].

[605] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [80]–[88] [MOH.9999.0001.0001 at 0011]; Transcript of the Commission, 28 November 2023, T190.29–193.5, 224.38–226.3 (Willcox/Chant),

[606] Transcript of the Commission, 28 November 2023, T81.15–82.37 (Lyons/Chant).

[607] Exhibit B.23.27, NSW Health, *Sample Local Health District Service Agreement 2023–2024*, pp 8–12 [MOH.0001.0288.0001 at 0008–0012].

9.110. In addition, NSW hosts three nationally funded centres providing pancreatic, islet cell, and paediatric liver transplant services.[608] The Ministry of Health is responsible for planning and oversight of those highly specialised services, which includes analysing and prioritising new health technologies proposed for Statewide adoption.[609]

9.111. The need to concentrate highly specialised services is clear. However, as discussed in Chapter 13 below, more can and should be done within the Ministry to enhance and support them.

Statutory Health Corporations

9.112. Statutory Health Corporations form part of the public health system and are constituted to enable health services and health support services to be provided across the State, rather than on an area basis.[610] There are currently six Statutory Health Corporations, those being:[611]

a. the Agency for Clinical Innovation;

b. the Bureau of Health Information;

c. the Clinical Excellence Commission;

d. the Health Education and Training Institute (HETI);

e. the Cancer Institute (NSW);

f. the Justice Health and Forensic Mental Health Network; and

g. the Sydney Children's Hospitals Network.

9.113. As mentioned above, “Pillars” is the collective term used for five of the Statutory Health Corporations, being the: ACI, BHI, CEC, HETI, and Cancer Institute (NSW).[612] Justice Health and the SCHN are described as ”Specialty Health Networks”.

The functions of Statutory Health Corporations

9.114. Section 12 of the *Health Services Act* provides that the functions of the Statutory Health Corporations are:

> *(a) to conduct public hospitals or health institutions or to provide health services or health support services (or any combination of these),*

[608] Exhibit B.23.27, NSW Health, *Sample Local Health District Service Agreement 2023–2024*, p 12 [MOH.0001.0288.0001 at 0012].

[609] Exhibit B.23.68, NSW Health, *New Technologies and Specialised Services* (Guideline No GL2022_012, 28 October 2022) pp 3–5 [MOH.0001.0343.0001 at 0006–0008].

[610] *Health Services Act 1997* (NSW) ss 6(b), 11(2).

[611] *Health Services Act 1997* (NSW) s 11(1), sch 2.

[612] Exhibit A.56, NSW Health, Financial Requirements and Conditions of Subsidy (Government Grants) for year ending 30 June 2024, p 4 [SCI.0001.0048.0001 at 0005].

(b) *to conduct such public hospitals and health institutions and provide such health services or health support services as the Minister determines from time to time under section 53,*

(c) *to achieve and maintain an adequate standard in the conduct of any public hospital or health institution, or the provision of a health service or health support service, under its control,*

(d) *to ensure the efficient and economic operation of any such public hospital, health institution, health service or health support service,*

(e) *to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.*

Governance arrangements for Statutory Health Corporations

9.115. Statutory Health Corporations are bodies corporate and may be either Chief Executive governed, board governed, or a specialty network governed health corporation.[613] Irrespective of their particular governance arrangements, each has a Chief Executive.[614]

9.116. Each Statutory Health Corporation also has a "relevant authority".[615] The Minister is the relevant authority for board governed Statutory Health Corporations, and the Health Secretary is the "relevant authority" for Chief Executive and specialty network governed Statutory Health Corporations. The "relevant authority" may determine the role, functions and activities of facilities and services under the Statutory Health Corporation's control, and the Minister may give directions about starting, ceasing, or restricting facilities or services if satisfied that it is in the public interest.[616]

9.117. The "relevant authority" may also make Model By-Laws for Statutory Health Corporations regarding governance and management functions.[617] As observed above, the SHNs are subject to the same Model By-Laws as LHDs.[618]

9.118. Statutory Health Corporation Boards have between five and 11 members who are appointed by the Minister.[619]

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[613] Health Services Act 1997 (NSW) s 41.

[614] Appointed by the Secretary in relation to board governed and chief executive governed statutory health corporations, and by the specialty network board with the concurrence of the Secretary in relation to specialty network governed statutory health corporations: *Health Services Act 1997* (NSW) ss 51, 52A, 52G.

[615] *Health Services Act 1997* (NSW) ss 53, 58, 60–61.

[616] Health Services Act 1997 (NSW) s 53.

[617] Health Services Act 1997 (NSW) s 60.

[618] Exhibit H.2.57, NSW Health, Model By-laws for Local Health Districts and Specialty Health Networks [SCI.0001.0002.0001].

[619] *Health Services Act 1997* (NSW) s 49. The Chief Executive is an *ex-officio* member.

9.119. Like the LHDs, Statutory Health Corporations cannot employ staff. Instead, their functions are exercised through the NSW Health Service staff employed by the Government of NSW in the service of the Crown, not as part of the Public Service.[620]

9.120. The SHNs (which also have a responsibility to ensure the needs of their catchment populations are met) have a relevantly similar planning function to that of LHDs.[621]

The Agency for Clinical Innovation

9.121. The ACI is a Chief Executive governed Statutory Health Corporation.[622] It was established in 2010 pursuant to one of the recommendations in the *Garling Report*.[623] Its primary role is to bring clinicians, consumers and system leaders together to design and implement innovations. Its functions include to:

a. work with public health organisations (and their consumers, clinicians, managers and leaders) to adopt evidence based clinical guidance, adapt best practice models to fit the local context, and collaborate on or lead new models of care and clinical guidance;

b. connect leaders across NSW Health to progress innovative ideas that will address local needs and the system agenda;

c. identify and develop promising clinical innovations to pilot and scale across NSW Health;

d. ensure that clinical guidance and models of care focus on priority challenges and: are evidence driven; are multidisciplinary; improve accessibility, effectiveness and efficiency of care including non-hospital settings; reduce unwarranted clinical variation; are well coordinated and promoted; and involve research and evaluation as to their implementation and impact;

e. use and foster consumer and clinician engagement structures; and

f. advise the Health Secretary and Ministry Executive Group, Health System Advisory Council and public health organisations.[624]

9.122. It has two clinical directorates and four expertise focussed directorates.[625]

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[620] Health Services Act 1997 (NSW) ss 45, 115.

[621] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [6.1] [MOH.0010.0256.0001 at 0066].

[622] Health Services Act 1997 (NSW) s 41, sch 2.

[623] Exhibit B.3, Statement of Dr Jean-Frédéric Levesque (30 January 2024) [16]–[17] [MOH.0001.0435.0001 at 0004].

[624] Exhibit B.23.48, *Determination of Functions – Agency for Clinical Innovation* (21 August 2023) [MOH.0001.345.0001]; Exhibit B.3, Statement of Dr Jean-Frédéric Levesque (30 January 2024) [22]–[23] [MOH.0001.0435.0001 at 0005]; Transcript of the Commission, 26 February 2024, T1020.24–43, T1040.42–1041.7 (Levesque); Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [50] [MOH.9999.0001.0001 at 0007].

[625] Exhibit B.3, Statement of Dr Jean-Frédéric Levesque (30 January 2024) [25]–[26] [MOH.0001.0435.0001 at 0006].

9.123. The clinical directorates are:

a. Preserving and Restoring Interventions in Surgery and Medicine (PRISM), which focusses on acute health crises and their aftermath, and has streams for surgery and anaesthesia; intensive and urgent care; interventional medicine; and trauma, pain and rehabilitation; and

b. Care Across the Lifecycle and Society (known as CATALYST), which seeks to address the needs of groups with complex chronic or multiple conditions, with streams for child and family care; acute, aged and end of life care; chronic and long term care; and integrated care and Aboriginal health.[626]

9.124. The "expertise focussed" directorates are:[627]

a. the EVIDENCE directorate, which seeks to ensure the availability of sound evidence relating to clinical care, change and effectiveness through research, evidence synthesis, data analytics, evaluation and audit;

b. the System Transformation, Enablement and Patient Partnerships (STEP) directorate, which purports to provide clinical networks with expertise and coaches LHD staff in project co-design and implementation;

c. the Integrated Digital Enablement Accelerator (IDEA) directorate, which includes the patient reported measures program, clinician reported measures, and virtual care teams; and

d. the Strategy, Communication and People Engagement (SCOPE) directorate, which aims to ensure consistent planning, prioritisation, communication, and dissemination of projects and resources.

9.125. The ACI must develop annual workplans and three year strategic plans, and work consistently with these and its performance agreement with the Health Secretary.[628] The 2023–2026 Strategy sets a path for the ACI to build on core competencies while rebalancing to focus on transformational change in light of the Future Health Strategy, new Regional Health Division, pandemic response, and virtual care.[629] The strategic areas adopted by the 2023–2026 plan include:[630]

a. taking a portfolio approach by refining the guidance processes for existing models of care and shifting to focus on evolving models through incremental change as well as supporting the system to transform;

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[626] Exhibit B.3, Statement of Dr Jean-Frédéric Levesque (30 January 2024) [25] [MOH.0001.0435.0001 at 0006].

[627] Exhibit B.3, Statement of Dr Jean-Frédéric Levesque (30 January 2024) [26] [MOH.0001.0435.0001 at 0006].

[628] Exhibit B.23.48, *Determination of Functions – Agency for Clinical Innovation* (21 August 2023) p 2 [MOH.0001.0345.0001 at 0002].

[629] Exhibit B.23.50, Agency for Clinical Innovation, *Strategy 2023–2026*, p 2 [MOH.0001.0350.0001 at 0002].

[630] Exhibit B.23.50, Agency for Clinical Innovation, *Strategy 2023–2026*, pp 7–13 [MOH.0001.0350.0001 at 0007–0013].

b. expanding current structures for agile clinician engagement, strengthening consumer voices, partnering with leaders to support system change, and connecting innovators with stakeholders to progress ideas;

c. triangulating experiential, empirical and research evidence and enhancing the use, translation and dissemination of research; and

d. building capability for redesign and implementation of change through various methods that can be tailored to local context and needs to facilitate innovation.

Bureau of Health Information

9.126. The BHI is a Board governed statutory health organisation.[631] It has the following functions:

a. to prepare and publish reports about the performance of the public health system in NSW, describing its safety and quality, effectiveness, efficiency, and responsiveness to health needs;

b. to publish reports that benchmark performance of the NSW public health system with comparable health systems;

c. to maintain a website that has information, analysis, and tools for data analysis in relation to the performance of the NSW public health system;

d. to develop reports and tools that enable data analysis of the performance of health services, clinical units and clinical teams across the NSW public health system;

e. to analyse data, when requested by the Health Secretary, to facilitate the planning and oversight of effective, efficient and safe health services, and to meet national commitments (such as those under the NHRA);

f. to advise the Ministry of Health as to the quality of existing data sets and development of enhanced information analysis and reporting for clinicians, the community and Parliament;

g. to undertake and/or commission research that supports the BHI to perform its functions; and

h. to liaise with other entities that report on health system performance in Australia and internationally.[632]

9.127. It must also provide an annual report to the Minister and Parliament about the performance of the public health system, and provide advice to the Minister and Health Secretary about issues arising from its functions.[633]

[631] Health Services Act 1997 (NSW) s 41, sch 2.

[632] Exhibit D.26, *Determination of Functions – Bureau of Health Information* (27 June 2018) [SCI.0008.0033.0001]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [51] [MOH.9999.0001.0001 at 0007].

[633] Exhibit D.26, Determination of Functions – Bureau of Health Information (27 June 2018) [SCI.0008.0033.0001].

9.128. A key purpose of the BHI is to provide independent information about health system performance for the community, health professionals and policymakers.[634] In seeking to achieve that purpose, the BHI has a stated focus on:

a. driving awareness and effective use of information with enhanced digital access and by leveraging its measurement expertise to advance value based healthcare;

b. delivering high value information through timely and meaningful analysis, data linkage and sharing actionable insights based on advanced analytics, and new sources of information;

c. sustaining trust in the BHI and its data with rigorous data management and governance and stakeholder engagement; and

d. investing in its people and capabilities and encouraging innovation and improvement.[635]

9.129. As discussed elsewhere in this Report there is significant scope to expand the range of matters on which the BHI reports.

Clinical Excellence Commission

9.130. The CEC is a Board governed Statutory Health Corporation.[636] Established in 2004 to reduce adverse events in public hospitals, support improvements in transparency and review of those events, and to promote improved clinical care, safety and quality, it is responsible for leading Statewide safety and quality improvement.[637]

9.131. Its functions include to:[638]

a. provide system wide clinical governance leadership, and support the implementation and ongoing development of local quality systems;

b. develop policy and strategy for clinical quality and safety improvement in the public health system, and promote and support improvement in both public and private health services;

c. identify, develop and disseminate clinical quality and safety information, including by:

i. working on programs with HETI; and

ii. identifying priorities for, and promoting conduct of, relevant research;

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[634] Exhibit D.27, Bureau of Health Information, *Strategic Plan 2023–2026*, p 2 [SCI.0008.0036.0001 at 0003].

[635] Exhibit D.27, Bureau of Health Information, *Strategic Plan 2023–2026*, pp 8–10 [SCI.0008.0036.0001 at 0009–0011].

[636] Health Services Act 1997 (NSW) s 41, sch 2.

[637] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [8], [19] [MOH.0001.0262.0001 at 0001, 0005]; Exhibit D.2, Statement of Adjunct Professor Michael Nicholl (8 April 2024) [26] [MOH.9999.0761.0001 at 0007]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [53] [MOH.9999.0001.0001 at 0007].

[638] Exhibit B.24, *Determination of Functions – Clinical Excellence Commission* (13 July 2012) [SCI.0003.0001.0385]; Exhibit D.2 Statement of Adjunct Professor Michael Nicholl (8 April 2024) [27] [MOH.9999.0761.0001 at 0007].

d. review adverse clinical incidents and develop responses including:

   i. coordinating responses to incidents with system or Statewide implications; and

   ii. advising the Secretary on urgent or emergent patient and staff safety issues in a clinical setting;

e. monitor and report to the Health Secretary and Minister on clinical quality and safety processes and performance of public health organisations;

f. provide the BHI with clinical quality and safety performance data for the public health system to support its public reporting function;

g. consult broadly with public health organisations, health professionals and members of the community in performing its functions; and

h. provide advice to the Health Secretary and Minister on issues arising out of its functions.

9.132. The CEC also conducts improvement programs that address national and State priorities, and monitors data on clinical outcomes, incidents and healthcare acquired complications.[639] Rather than managing performance issues, it escalates any concerns to the Patient Safety First Unit within the Ministry, which then oversees the system response.[640]

9.133. The CEC is required to develop annual work plans and three year strategic plans that link to NSW Health directions and priorities, and must work in accordance with these plans and its performance agreement with the Health Secretary.[641] In its 2021–2024 *Strategic Plan*, the CEC defined three overarching system level goals it sought to achieve: mature safety systems, increased safety capability, and reduced preventable harm.[642] Four strategic priorities were identified to achieve those outcomes:[643]

a. embedded safety systems in a whole care system model underpinned by governance, partnerships, roles and responsibilities, capability and capacity;

b. safety intelligence using triangulated data, connected technologies and real time insights to enable a predictive and proactive approach to safety;

c. safety culture with accountability, meaning the whole care system (patients, staff, management and boards) is equipped to lead a positive culture and improve performance; and

639 Exhibit D.2, Statement of Adjunct Professor Michael Nicholl (8 April 2024) [32] [MOH.9999.0761.0001 at 0010].

640 Exhibit D.2, Statement of Adjunct Professor Michael Nicholl (8 April 2024) [30] [MOH.9999.0761.0001 at 0009].

641 Exhibit B.24, Determination of Functions – Clinical Excellence Commission (13 July 2022) [SCI.0003.0001.0385].

642 Exhibit D.1.189, Clinical Excellence Commission, *Strategic Plan 2021–2024*, p 5 [MOH.9999.0935.0001 at 0003].

643 Exhibit D.1.189, Clinical Excellence Commission, *Strategic Plan 2021–2024*, pp 6–7 [MOH.9999.0935.0001 at 0004].

d. safety priorities and programs targeting priority groups and focus areas using programs, tools, resources and safety expertise, with flexibility and agility to respond to urgent needs.

Health Education and Training Institute

9.134. HETI is a Chief Executive governed health corporation.[644]

9.135. The primary role of HETI is to assist public health organisations and training providers with the development and delivery of education and training across the public health system. In undertaking that role, it must seek to ensure that education and training across the public health system supports safe, high quality, multidisciplinary team based patient centred care; meets service delivery needs and operational requirements; and enhances workforce skills and productivity.[645] It also supports education and training by working with the colleges and other training providers and providing mandatory training modules.[646]

9.136. The stated functions of HETI include:[647]

a. designing, commissioning, conducting, coordinating, supporting and evaluating:

b. education and training programs for clinical, corporate and support staff;

c. management, leadership and professional development programs; and

d. other education and training programs as directed by the Health Secretary;

e. establishing governance for whole of health education and training programs for NSW Health;

f. supporting reform and improve workforce capacity and quality of training by:

g. identifying and developing Statewide programs for clinicians to become skilled teachers, trainers and supervisors;

h. managing a registered training organisation;

i. maintaining an online learning management system (including provision of quality assurance standards and resource development);

j. Statewide oversight, coordination and implementation of best practice learning including simulation and other technologies;

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[644] Health Services Act 1997 (NSW) s 41, sch 2.

[645] Exhibit H1.17.1, *Determination of Functions – Health Education and Training Institute* (13 September 2017) [SCI.0001.0060.0001]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [54] [MOH.9999.0001.0001 at 0007].

[646] Transcript of the Commission, 28 November 2023, T101.19–30 (Willcox).

[647] Exhibit H.1.17.1, Determination of Functions – Health Education and Training Institute (13 September 2017) [SCI.0001.0060.0001].

k. maintaining registration as a higher education provider and developing and delivering higher education courses as appropriate for identified workforce needs;

l. instituting, coordinating, overseeing and evaluating education and training networks that support service delivery needs, meet operational requirements, optimise education and training resource use, and are consistent with clinical service networks to the extent possible;

m. setting standards for education and training including medical training, and accrediting institutions for prevocational education and supervision;

n. establishing effective systems to meet Statewide and national reporting requirements for education and training in the health sector;

o. ensuring that education and training programs and other projects it undertakes:

    i. are responsive to local needs;

    ii. are cost effective, affordable and accessible;

    iii. meet local and whole of system needs;

    iv. support staff to provide safe, high quality, multidisciplinary team based, patient centred care;

    v. support interprofessional learning and team based practice;

p. working closely with LHDs, SHNs and education providers; and

q. providing advice to the Health Secretary on matters relevant to its functions.

9.137. HETI is also required to develop annual workplans and a three year Strategic Plan that align with the Statewide directions and priorities of NSW Health, and to work consistently with these plans and the performance agreement with the Health Secretary.[648]

9.138. In its *Strategic Plan* for 2023–2026, HETI identified the following strategic priorities and key initiatives:[649]

a. targeted learning and pathways – through delivery of world class education and training for the NSW Health workforce to respond to system priorities;

b. trusted partnerships – with collaborative relationships driving compassionate, sustainable and safe care and improved patient outcomes and experiences; and

c. inspired people – supported to thrive and deliver exceptional learning outcomes.

[648] Exhibit H.1.17.1, Determination of Functions – Health Education and Training Institute (13 September 2017) [SCI.0001.0060.0001].

[649] Exhibit H.1.46, Health Education and Training Institute, *Strategic Plan 2023–2026* (October 2023) pp 10–11 [MOH.0010.0045.0001 at 0006].

9.139. As discussed in Chapter 18 below, it is time to reconsider and reform the role of HETI and how it may support the long term development of a strong workforce within the NSW public health system.

Cancer Institute NSW

9.140. The Cancer Institute NSW is created and constituted by its own statute.[650] It is the NSW Government's dedicated "cancer control agency"[651] and looks at "survival rates and mortality rates for different types of cancers in patients … to maximise their survival outcomes and their quality of life outcomes by identifying the most suitable hospitals for patients".[652]

9.141. The Board of the Cancer Institute NSW has five to 11 members (plus the Chief Cancer Officer, who is the Cancer Institute Chief Executive).[653] The Board must establish an ethics committee, clinical services advisory committee, research advisory committee, and quality and clinical effectiveness advisory committee, and may establish other committees as appropriate.[654]

9.142. The objectives of the Cancer Institute NSW are to reduce the incidence of cancer, increase survival rates, improve quality of life, and be a source of expertise on cancer control for government, practitioners, researchers, and the community.[655]

9.143. The Cancer Institute NSW may do whatever is necessary or convenient to give effect to those objectives, including but not limited to:[656]

a. undertaking, commissioning or sponsoring cancer research, facilitating collaboration between cancer research bodies, and providing a system for expeditious ethics approval;

b. fostering evidence based best practice to cancer control including through development or endorsement of guidelines and protocols;

c. accrediting cancer prevention and screening programs;

d. reviewing, evaluating and making recommendations about cancer programs and proposed initiatives, and developing or commissioning innovative programs for cancer control;

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[650] Cancer Institute (NSW) Act 2003 (NSW).

[651] Exhibit M.2, Statement of Professor Tracey O'Brien (12 November 2024) [7] [MOH.0011.0087.0001 at 0002].

[652] Transcript of the Commission, 28 November 2023, T100.32–45 (Willcox).

[653] Cancer Institute (NSW) Act 2003 (NSW) ss 7–8, 10, sch 1.

[654] Cancer Institute (NSW) Act 2003 (NSW) s 9.

[655] *Cancer Institute (NSW) Act 2003* (NSW) s 5; Exhibit M.2, Statement of Professor Tracey O'Brien (12 November 2024) [7] [MOH.0011.0087.0001 at 0002]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant and Deb Willcox (17 November 2023) [52] [MOH.9999.0001.0001 at 0007].

[656] Cancer Institute (NSW) Act 2003 (NSW) s 12.

e. investigating, evaluating and advising on complementary therapies having regard to their clinical effectiveness, safety and effect on quality of life for cancer patients;

f. obtaining and analysing information relating to cancer control;

g. disseminating information and advice about cancer control;

h. providing training and education relevant to cancer control;

i. consulting and collaborating with public health organisations, consumers, health professionals, government agencies, non-government organisations and others involved in cancer control;

j. engaging in fundraising activities for cancer related purposes and establishing a publicly available register of the bodies that conduct any such fundraising activities;

k. advising and recommending to the Minister how funding designated for the Cancer Institute is to be expended; and

l. advising the Minister and the Health Secretary as required on cancer control matters including assessing and reporting on cancer control services or programs in the public health system.

9.144. The Cancer Institute NSW leads and implements the *Statewide Cancer Plan* in conjunction with the Ministry and other public health organisations.[657]

9.145. The Cancer Institute NSW also:[658]

a. collects feedback about patients' experiences;

b. provides information in multiple languages;

c. maintains an online specialist directory to facilitate referrals;

d. maintains a database for clinicians with evidence based, peer reviewed cancer treatment protocols and provides actionable data insights to the health system through its "Reporting for Better Cancer Outcomes" program; and

e. delivers public education campaigns aimed at prevention, funds research fellowships, and prioritises value based care with data analysis, benchmarking and providing support and information.

[657] Exhibit M.2, Statement of Professor Tracey O'Brien (12 November 2024) [11]–[12] [MOH.0011.0087.0001 at 0003]; *Cancer Institute (NSW) Act 2003* (NSW) s 12(i).

[658] Exhibit B.36, NSW Health, *Annual Report 2022–2023* (Report, November 2023) pp 19, 25, 31, 44, 54, 273 [SCI.0001.0059.0001 at 0028, 0034, 0040, 0053, 0063, 0282].

The Specialty Health Networks

9.146. As noted above, there are two SHNs that are also Statutory Health Corporations - SCHN, and Justice Health.

9.147. The SHNs have Boards that are appointed by the Minister.[659] The membership and functions of those Boards are comparable to those of the LHDs, modified as required to accommodate the SHN context.[660] The Chief Executives of the SHNs are, as with LHDs, appointed by their respective Boards with the concurrence of the Health Secretary.[661] The role and functions of SHN Chief Executives are largely consistent with those of the LHD Chief Executives.[662]

9.148. The SHNs have the same type of annual service agreement with the Health Secretary as the LHDs and are (as noted above) subject to the same Model By-Laws.[663]

Sydney Children's Hospitals Network

9.149. The SCHN is a specialty network governed health corporation.[664]

9.150. It is the largest provider of paediatric services nationally and includes Sydney Children's Hospital Randwick, The Children's Hospital at Westmead, the Newborn and Paediatric Emergency Transport Service, Bear Cottage, the Children's Court Clinic, the virtualKIDS service, and the NSW Poisons Information Centre.[665]

9.151. The SCHN's core function is the provision of specialist paediatric services in an acute setting – rather than lower complexity acute care and community health services provided within LHDs.[666] It does not currently have responsibility for the overall governance of paediatrics.[667]

9.152. The SCHN *Strategic Plan* for 2023–2027 sets six priorities, namely:[668]

a. "What we do matters", which includes:

i. engaging with patients and families as equal partners, codesigning services and building on partnership models to deliver shared care closer to home; and

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[659] Health Services Act 1997 (NSW) s 52F(1).

[660] Health Services Act 1997 (NSW) s 52F(2).

[661] *Health Services Act 1997* (NSW) ss 23, 52G(1).

[662] Health Services Act 1997 (NSW) s 52G(2).

[663] Exhibit B.23.26, NSW Health, *Performance Framework* (June 2023) p 7 [MOH.0001.0363.0001 at 0009]; Exhibit H.2.57, NSW Health, *Model By-laws for Local Health Districts and Specialty Health Networks*, cl 43 [SCI.0001.0002.0001 at 0015].

[664] *Health Services Act 1997* (NSW) ss 12, 41, sch 2.

[665] Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [4]–[5], [10] [MOH.9999.1869.0001 at 0001–0002]; Exhibit B.36, NSW Health, *Annual Report 2022–2023* (Report, November 2023) pp 277–278 [SCI.0001.0059.0001 at 0286–0287].

[666] Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [7] [MOH.9999.1869.0001].

[667] Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [12] [MOH.9999.1869.0001 at 0002].

[668] Exhibit G.22, Sydney Children's Hospitals Network, *Strategic Plan 2023–2027*, p 6 [SCI.0010.0015.0001 at 0008].

    ii. adopting evidence based, contemporary and responsive models of care, and ensuring teams, systems and processes are integrated.

b. "Safe care everywhere", which includes:

    i. providing safe, high quality, evidence based care including extension of integrated models to regional and rural areas through partnerships; and

    ii. strengthening and extending support during the transition to adult care.

c. "Children and young people are healthy and well", which includes:

    i. targeting priority populations and supporting diversity and inclusion; and

    ii. focussing on mental health and wellbeing, health promotion and harm prevention.

d. "We value our people", which includes:

    i. creating a unified organisation and advancing a values based, learning culture; and

    ii. prioritising collaboration and enabling leaders to engage with their people and build constructive, effective relationships and teams.

e. "Leverage research, innovation and technology – to transform clinical service delivery" which includes:

    i. embedding an integrated approach to education, research and innovation, and optimising systems, processes, governance and digital and data capability;

    ii. expanding the connection between research and practice, supported by data, and ensuring data and information are high quality, integrated and accessible; and

    iii. leveraging partnerships with health and innovation partners.

f. "Sustainability for the future", which includes:

    i. prioritising sustainability across systems, procurement and practices;

    ii. focussing on environmental design that supports health and wellbeing; and

    iii. aligning the workforce for the future to deliver on emerging opportunities.

Justice Health and Forensic Mental Health Network

9.153. Justice Health is a specialty network governed Statutory Health Corporation.[669] It provides healthcare to adults and young people in contact with the forensic mental health and criminal justice systems in NSW. It is a Statewide service, operating in more than 100 locations and provides care across custodial, inpatient and community settings.[670]

9.154. As of November 2024, in NSW, there were approximately:

a. 37 custodial centres for adult inmates;

b. seven youth justice centres;

c. 13,000 adult inmates; and

d. 220 young people in youth detention centres.

9.155. In a correctional setting, Justice Health is responsible for the provision of health services to those in custody, monitoring the provision of health services in managed correctional centres, implementing measures to prevent the spread of infectious diseases in, or in relation to, correctional centres, maintaining medical records of persons in custody, and providing advice to the Commissioner of Corrective Services NSW on the "diet, exercise, clothing, capacity to work and general hygiene of inmates".[671]

9.156. Like all states and territories in Australia, NSW bears the cost and responsibility for healthcare provision to those in custody, with prison health services being ineligible to access MBS or PBS funding streams (with the exception of highly specialised drugs and some specific arrangements under the National Partnership Agreement such as COVID-19 and Mpox vaccines). This seems to be because Medicare is federally funded and exists as part of Commonwealth legislation, whereas prisons are the responsibility of the states. If this is the reason, it is not a good one for denying prisoners access to Medicare. If there is some other reason, it is highly likely not to be a good one either.

9.157. While there are many gaps in the provision of Medicare services referred to in this Report that have been allowed to emerge and widen, this one is very much in plain sight. That those in custody are denied Medicare services (which might form the basis of a primary care relationship later on), but are eligible for them when released (if they can find a general practitioner or other primary healthcare provider) strikes me as being particularly senseless (at best).

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[669] *Health Services Act 1997* (NSW) ss 12, 41, sch 2.

[670] Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [4]–[5] [MOH.0011.0086.0001 at 0001–0002].

[671] *Crimes (Administration of Sentences) Act 1999* (NSW) s 236A; Transcript of the Commission, 19 November 2024, T6312.12–6314.37 (Hoey).

9.158. Justice Health is also mandated to monitor the provision of health services in NSW's three privately operated correctional centres according to section 236A of the *Crimes (Administration of Sentences) Act 1999* (NSW). The Justice Health Risk and Assurance team monitors the provision of health services in these correctional centres.

Affiliated Health Organisations

9.159. AHOs are not for profit, religious, charitable or other non-government organisations and institutions that provide health services and are recognised as part of the public health system under the *Health Services Act*.[672]

9.160. Their recognition in this way enables those organisations to be treated as part of the public health system for health facilities and services they control that contribute significantly to the system.[673] That approach was adopted to recognise the historically integral part the religious and charitable sector has played in the NSW public health system.[674]

9.161. Many AHOs are engaged in a range of philanthropic activities, some of which are not related to the health system. As a result, AHOs constitute part of the public health system only in relation to their recognised establishments or recognised services. It is in respect of those recognised establishments or services that the AHO falls within the meaning of a "public health organisation" for the purposes of the *Health Services Act*.

9.162. There are currently 13 AHOs. Those organisations, and their recognised establishments and services, are as follows:[675]

Name of organisation	Recognised establishment or recognised service
Benevolent Society of New South Wales	Central Sydney Scarba Services. Early Intervention Program. Eastern Sydney Scarba Services. South West Sydney Scarba Services.
Calvary Health Care (Newcastle) Limited	Calvary Mater Newcastle.
Calvary Health Care Sydney Limited	Calvary Health Care Sydney.

[672] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.4] [MOH.0010.0256.0001 at 0018]; Exhibit B.36, NSW Health, *Annual Report 2022–2023* (Report, November 2023) p 5 [SCI.0001.0059.0001 at 0014].

[673] Health Services Act 1997 (NSW) s 13(3).

[674] NSW, *Health Services Bill Second Reading Speech,* Legislative Assembly, 12 November 1997 (Dr Andrew Refshauge).

[675] Health Services Act 1997 (NSW) s 62(1), sch 3.

Name of organisation	Recognised establishment or recognised service
HammondCare Health and Hospitals Limited	Braeside Hospital, Prairiewood. Greenwich Hospital, Greenwich. Neringah Hospital, Wahroonga. Northern Beaches Palliative Care Service.
Karitane	Child and Family health services at Carramar, Fairfield, Liverpool and Randwick.
Mercy Hospitals NSW Ltd	Mercy Care Centre: Young, excluding Mount St Joseph's Nursing Home. Mercy Health Service Albury.
NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).
Royal Rehab Group	General rehabilitation services. Brain injury rehabilitation services. Spinal injury rehabilitation services. Extended care services.
Royal Society for the Welfare of Mothers and Babies	Tresillian Family Care Centres at Belmore, Broken Hill, Coffs Harbour, Dubbo, Lismore, Penrith, Queanbeyan, Taree, Willoughby and Wollstonecraft.
St Vincent's Hospital Sydney Limited	Sacred Heart Health Service. St Vincent's Hospital Sydney.
Stewart House	Child health screening services at Stewart House Preventorium, Curl Curl.
The College of Nursing	Nursing education programs conducted under agreement with the NSW Ministry of Health.
Uniting Church in Australia	War Memorial Hospital (Waverley).

9.163. Where an AHO has more than one recognised establishment or service, or provides Statewide services or services of State significance, the Minister may declare them to be treated as a network for the purposes of receiving funding under the NHRA (with the consent of the AHO concerned).[676]

9.164. AHOs are required to achieve and maintain adequate standards, and to ensure efficient and economic operation, of their recognised establishments and services, and must also carry out such other statutory functions as are conferred or imposed upon them.[677]

9.165. The Minister may determine the role, functions, and activities of any recognised establishment or service of an AHO, and give the necessary directions for that purpose, following consultation with the organisation having regard to its healthcare philosophy.[678]

9.166. Relevantly, s 127(2) of the *Health Services Act* provides that:

> *[i]n determining what amount of money (if any) is to be paid to each statutory health corporation and affiliated health organisation out of money appropriated from the Consolidated Fund, the Minister may have regard to such matters as the Minister thinks fit.*

9.167. The Minister may delegate to LHDs the function of determining the subsidy to be received by any AHO.[679] Significantly, for the purposes of exercising that function, the determination of subsidy to be paid to a LHD by the Minister is assumed to include a sufficient amount to enable a Chief Executive to determine and pay a subsidy to AHOs within the geographic boundaries of the district.[680]

9.168. LHDs may enter into performance agreements with AHOs in respect of their recognised establishments and recognised services. Any such agreement may include performance targets and provide for evaluation and review of results in relation to those targets.[681] Where performance agreements between an AHO and an LHD have been entered into:[682]

a. AHOs must, as far as practicable, exercise their functions in accordance with the performance agreement;

[676] Health Services Act 1997 (NSW) s 62B.

[677] Health Services Act 1997 (NSW) s 14.

[678] Health Services Act 1997 (NSW) s 65.

[679] Health Services Act 1997 (NSW) s 129.

[680] Exhibit N.3.5, NSW Health, *Schedule of Delegates* (1 April 2024) [MOH.9999.1089.0001 at 0020].

[681] Health Services Act 1997 (NSW) s 130.

[682] *Health Services Act* 1997 (NSW) ss 130(3)–(5).

b. AHOs must report the results of their performance under the performance agreement during a financial year to the LHDs within three months of the end of that financial year; and

c. LHDs must evaluate and review the results of the AHOs performance for each financial year under the performance agreement and report the results to the Health Secretary.

9.169. As a matter of practice, the purchasing of services from AHOs has often been managed by the LHD in which they sit geographically, pursuant to local service agreements,[683] although these linkages are often historical and many AHOs provide services that extend across LHD boundaries. As a networked AHO, the St Vincent's Health Network has a service agreement with the Health Secretary.

9.170. The governance and funding of services provided by AHOs is considered in Chapter 14 below.

Other entities within the NSW public health system

Health Professional Councils and the NSW Health Care Complaints Commission

9.171. The Health Professional Councils are statutory bodies established under the Health Practitioner Regulation National Law. In NSW, a Health Professional Council for each registrable health profession participates in a co-regulatory model with the NSW Health Care Complaints Commission to manage complaints about registered health practitioners, rather than this being done by national boards as in other states.[684] There are Health Professional Councils for each of the following professions: Aboriginal and Torres Strait Islander Health Practice; Chinese Medicine; Chiropractic; Dental; Medical; Medical Radiation Practice; Nursing and Midwifery; Occupational Therapy; Optometry; Osteopathy; Paramedicine; Pharmacy; Physiotherapy; Podiatry; and Psychology.

9.172. The Health Professional Councils Authority, an administrative unit of the HAC, supports the Councils to perform their regulatory and legislative functions under the National Registration and Accreditation Scheme.[685]

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[683] Exhibit D.8, Statement of Adjunct Professor Matthew Daly (9 April 2024) [16] [MOH.9999.0976.0001 at 0005].

[684] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.6.2] [MOH.0010.0256.0001 at 0021].

[685] Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.6.3] [MOH.0010.0256.0001 at 0021-0022].

9.173. The NSW Health Care Complaints Commission is an independent statutory body established by the *Health Care Complaints Act 1993* (NSW), which acts in the public interest by receiving, reviewing and investigating complaints about healthcare in NSW.[686]

Mental Health Review Tribunal

9.174. The Mental Health Review Tribunal is a quasi-judicial body established under the *Mental Health Act 2007* (NSW) to conduct mental health inquiries, make and review orders, and hear some appeals, relating to clinical management of people with mental illness.[687]

9.175. The Tribunal has jurisdiction to conduct both civil and forensic hearings and has the power to make orders affecting people detained in a mental health facility (involuntary patients), people being cared for in a mental health facility as a voluntary patient, people on community treatment orders, and forensic patients.

NSW Mental Health Commission

9.176. The NSW Mental Health Commission is an independent statutory agency established under the *Mental Health Commission Act 2012* (NSW). It is responsible for drafting a Strategic Plan for the mental health system in NSW and monitoring its implementation, as well as promoting knowledge, undertaking research, and advocating for prevention and early intervention strategies to promote the mental health and wellbeing of people in NSW.[688]

9.177. The Commission reports to the Minister for Mental Health and, since its establishment, has developed *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024* and its updated counterpart *Living Well in Focus 2020–2024*, which have been adopted by the NSW Government.

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686 Exhibit D.1.79, NSW Health, *GL2020_008 Complaints Management Guidelines* (24 April 2020) p 6 [MOH.9999.0838.0001 at 0006].

687 Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.6.2] [MOH.0010.0256.0001 at 0021].

688 Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.6.4] [MOH.0010.0256.0001 at 0022].

Chapter 10:

The health of the population and the need for prevention

Volume 2

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Introduction

10.1. The provision of care to the sick and injured and the promotion, protection and maintenance of the health of the community are the two core functions of the NSW public health system.[689]

10.2. Any assessment of whether the system is effectively performing those functions must necessarily consider the broader health needs of the population to be served by it. As will be discussed elsewhere, it is only once those needs are identified that a system can be designed and its delivery planned so as to best meet those needs (and thus perform its core function).

10.3. While a detailed assessment of the health needs of the population of NSW is beyond the scope of this Special Commission (that is a task for NSW Health as recommended in this Report), some critical features of the population and its health needs that have emerged in the evidence warrant consideration.

10.4. As this Special Commission travelled across the State, it became clear that, while there were some similarities, each region has its own unique needs and challenges. Additionally, within each region, certain populations – such as culturally and linguistically diverse and First Nations populations – have their own particular health needs. However, without losing sight of, or downplaying the importance of, those differences, there have been some long term trends in population demographics and disease burden that have had, and will continue to have, a significant impact on the broader public health system.

10.5. The population is growing and living longer, but the rates of chronic disease within the population have also been rising for decades. That means that the population is living more years in ill health. Those features of the population alone are already having an impact on the demand for health services, in relation to both the volume and complexity of the services required to address the needs of the community.[690] Those impacts will only increase in the future, and likely significantly so, unless more is done to address chronic disease within the community.

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[689] See *Health Services Act 1997* (NSW) s 9.

[690] See, e.g., Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [102]–[144] [MOH.9999.0001.0001 at 0014–0022]; Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) pp 7–9 [MOH.0001.0320.0001 at 0025–0027].

The size and age of the NSW population

10.6. In the year 2000, the population of NSW was approximately 6.5 million people.[691] By 2020, it had risen by approximately 26 per cent to 8.2 million people,[692] and by 2061, it is projected to be 11.5 million people.[693] That rate of growth represents an increase of approximately 40 per cent, attributable primarily to natural population increases (i.e., births exceeding deaths) and net migration.[694]

10.7. The NSW population is also ageing. In 2000, the median age in NSW was about 36 years.[695] In 2021, it had increased to 38 years and by 2061, the median age is projected to be 44 years.[696] The effect of that growth is that in 2061, 25 per cent of the population of NSW is expected to be 65 or older.[697] The ageing of the population over time has been attributed to the combination of "sustained low fertility and increasing life expectancy",[698] the latter "driven by general improvements in living standards, hygiene and nutrition … [and] advances in medical technology".[699]

10.8. As the "second driver of population change" in NSW, net migration is projected to average 48,000 people per year until 2061.[700]

10.9. Much of the growth in the median age of the population will be seen in regional areas.[701]

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[691] Exhibit O.60, Australian Bureau of Statistics, *Population by Age and Sex, New South Wales, Jun 2000* (Web Page, Catalogue No 3235.1.55.001, 8 December 2006) <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3235.1Main+Features1Jun%202000?OpenDocument> [SCI.0011.0890.0001].

[692] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 8 [SCI.0001.0016.0001 at 0008].

[693] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 8 [SCI.0001.0016.0001 at 0008].

[694] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 8 [SCI.0001.0016.0001 at 0008].

[695] Exhibit O.63, Australian Bureau of Statistics, *Twenty Years of Population Change* (Web Page, 17 December 2020) <https://www.abs.gov.au/articles/twenty-years-population-change> [SCI.0011.0893.0001].

[696] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 26 [SCI.0001.0016.0001 at 0026].

[697] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 26 [SCI.0001.0016.001 at 0026].

[698] Exhibit O.63, Australian Bureau of Statistics, *Twenty Years of Population Change* (Web Page, 17 December 2020) <https://www.abs.gov.au/articles/twenty-years-population-change> [SCI.0011.0893.0001].

[699] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 30 [SCI.0001.0016.0001 at 0030].

[700] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 32 [SCI.0001.0016.0001 at 0032].

[701] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) pp 27, 32 [SCI.0001.0016.0001 at 0027, 0032].

Trends in the life expectancy of the NSW population

10.10. Life expectancy in Australia is among the highest in the world and, in recent decades, has risen significantly.[702] The life expectancy of a female born in 2020 is approximately 86 years, and of a male is 82 years, up from 79.2 and 72.7 years respectively, for those born in 1984. By 2061, life expectancy will rise to approximately 92 years for women and 89 years for men.[703]

10.11. However, like many other features of the population, life expectancy varies according to where people live and their socio-economic status. Generally, people from low socio-economic areas or who experience disadvantage are more likely to suffer poor health outcomes.[704]

10.12. That is reflected in variations in the life expectancy across the State, with those who reside in LHDs in metropolitan Sydney enjoying a higher life expectancy (and greater growth in that life expectancy over time) than those who reside in western parts of the State. As demonstrated below, the average life expectancy decreases the further west one lives:[705]

[702] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 30 [SCI.0001.0016.0001 at 0030].

[703] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [135] [MOH.9999.0001.0001 at 0021]; Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 8 [SCI.0001.0016.0001 at 0008].

[704] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [127] [MOH.9999.0001.0001 at 0020].

[705] Exhibit O.71, Centre for Epidemiology and Evidence, 'Life Expectancy at Birth for Persons by LHD for 2022', *HealthStats NSW* (Web Page) < https://www.healthstats.nsw.gov.au/r/120257> [SCI.0011.0898.0001]. See also Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [106] [MOH.9999.0001.0001 at 0015].

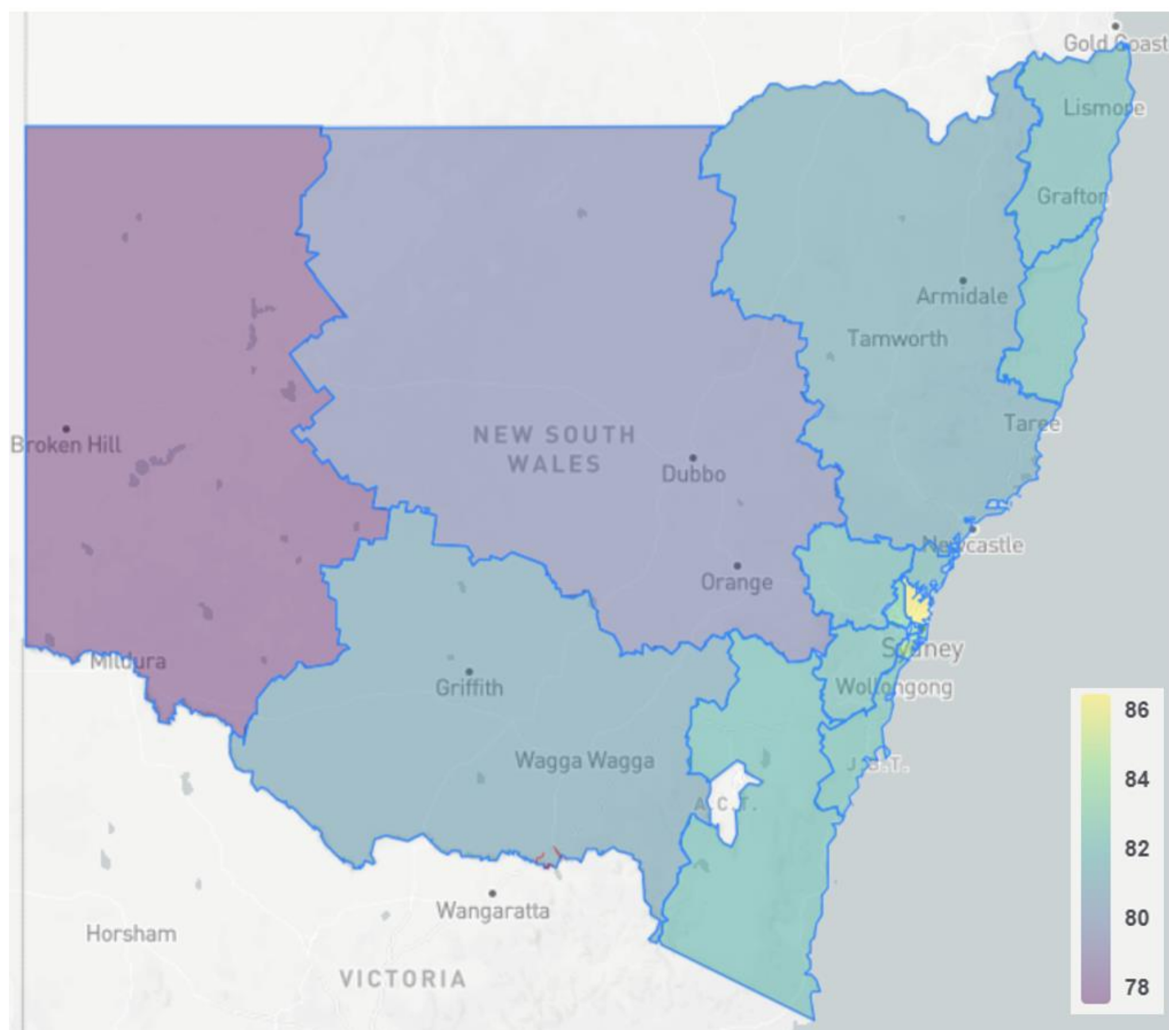

Figure 1: Life expectancy at birth for persons by LHD for 2022

10.13. Consistent with those demographic features of the NSW population, the 2022 *Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* found that:[706]

a. rural, regional and remote patients have significantly poorer health outcomes, greater incidence of chronic disease, and more premature deaths when compared to their counterparts in metropolitan areas;

b. residents in rural, regional and remote NSW have inferior access to health services;

c. rural, regional and remote medical staff are significantly under resourced when compared with their metropolitan counterparts, exacerbating health inequities; and

[706] Exhibit E.37, Legislative Council Portfolio Committee No 2 – Health, Parliament of New South Wales, *Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales* (Report No 57, May 2022) p xii [SCI.0009.0077.0001 at 0014].

d. the Commonwealth/State divide in terms of the provision of health funding has led to both duplication and gaps in service delivery.

10.14. Reflective of the level of disadvantage within their population, First Nations people have a significantly lower life expectancy than other cohorts. The average life expectancy for First Nations people in NSW born in 2020 to 2022 was 73.8 years for men and 77.9 years for women,[707] compared with 81.3 years and 85.3 years for all men and women.[708] While the causes of that discrepancy are multifactorial, high rates of chronic disease (in particular, cardiovascular disease), mental health conditions, diabetes, and cancer are significant contributors.[709]

10.15. The need to address this imbalance has long been recognised, and there have been many statements and plans produced with a view to doing so. These include the *National Agreement on Closing the Gap* and the *Uluru Statement from the Heart*. However, as discussed elsewhere in this Report, there is much more that can, and should, be done to improve the planning and delivery of healthcare to First Nations populations across NSW. Doing so may not, of itself, address the vast discrepancy between the health outcomes experienced by First Nations people and the rest of the population. However, by increasing the involvement of First Nations people in the planning and design of services that are to be delivered to their communities, the NSW public health system will be better placed to provide the care that is needed.

The rise of chronic disease

10.16. As life expectancy has increased, so has the proportion of the population living with one or more chronic diseases. Almost half of all Australians live with at least one chronic condition, and nearly a quarter live with two or more.[710]

10.17. What has been described in the evidence as the "shift" in the burden of disease towards a greater prevalence of chronic disease has been occurring over decades.

10.18. In 1973, the Interim Committee of the National Hospitals and Health Services Commission reported that approximately one quarter of the total population suffered from "chronic infirmities", and that one in 10 were left disabled by such conditions.

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[707] Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander life expectancy: reference period 2020-2022' (Web Page, 29 November 2023) <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release>.

[708] Australian Bureau of Statistics, 'Life expectancy: reference period 2020-2022' (Web Page, 8 November 2023) <https://www.abs.gov.au/statistics/people/population/life-expectancy/2020-2022>.

[709] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [129] [MOH.9999.0001.0001 at 0001 at 0020].

[710] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [116] (MOH.9999.0001.0001 at 0017–0018]; Exhibit O.62, Australian Bureau of Statistics, *Health Conditions Prevalence* (Web Page, 15 December 2023) <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release> [SCI.0011.0892.0001].

The Committee also noted that most of those suffering from “chronic infirmities” had “associated psychological and social disabilities” that worsened with age.[711]

10.19. In 2002, the AIHW reported that chronic diseases were “now of epidemic proportions globally and in Australia”[712] and comprised “around 80% of the total burden of disease, mental problems and injury”.[713]

10.20. In 2006, the AIHW reported that chronic disease “accounted for nearly 70% of the total health expenditure that can be allocated to disease”.[714]

10.21. In 2009, the National Health and Hospitals Reform Commission reported that:[715]

> *Over the last century, chronic disease has become more prominent than infectious disease as a cause of death; this trend is likely to continue … In the future, as the population grows and ages, more people will suffer from chronic disease, some as a consequence of unhealthy behaviours.*

10.22. In 2017, the Productivity Commission described the burden of chronic disease as “massive” and reported that it was “now a driving force behind health costs”.[716]

10.23. Similarly, the NSW Government’s *2021–2022 Intergenerational Report: Towards 2061 – Planning for the Future* described the increasing rate of chronic disease as “one of Australia’s biggest health challenges”,[717] and said that:[718]

> *A national focus on keeping people healthy and effective management of chronic conditions is needed to reduce demand for hospital care and keep health spending sustainable, whilst improving health outcomes.*
>
> *This will require Commonwealth and state cooperation, including to continue to improve the detection and management of health conditions before they become acute, maintain an adequate and skilled health workforce, and improve healthcare accessibility. For*

[711] Exhibit O.70, Interim Committee of the National Hospitals and Health Services Commission, *A Community Health Program for Australia* (Parliamentary Paper No 66, June 1973) p 1 [SCI.0011.0899.0001 at 0010].

[712] Exhibit O.69, Australian Institute of Health and Welfare, *Chronic Diseases and Associated Risk Factors in Australia, 2001* (Report, May 2002) p 2 [SCI.0011.0896.0001 at 0011].

[713] Exhibit O.69, Australian Institute of Health and Welfare, *Chronic Diseases and Associated Risk Factors in Australia, 2001* (Report, May 2002) p 5 [SCI.0011.0896.0001 at 0014].

[714] Exhibit O.68, Australian Institute of Health and Welfare, *Chronic Diseases and Associated Risk Factors in Australia, 2006* (Report, November 2006) p ix [SCI.0011.0897.0001 at 0009].

[715] Exhibit E.87, National Health and Hospitals Reform Commission, *A Healthier Future for All Australians* (Final Report, June 2009) [SCI.0009.0108.0001 at 0052].

[716] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) pp 44, 46 [SCI.0001.0057.0001 at 0046, 0048].

[717] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 75 [SCI.0001.0016.0001 at 0075].

[718] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 15 [SCI.0001.0016.0001 at 0015].

> *example, through digitally-enabled solutions and better targeting of cohorts with higher risks of developing chronic diseases.*

10.24. Other benefits of effective preventive healthcare were described in that Report as follows:[719]

> *Good physical and mental health is integral to wellbeing. It enables people to participate in education and employment, thus contributing to the State's productivity.*
>
> *...*
>
> *Government policies to keep people healthy can help to alleviate the pressures from an ageing population... A healthier population also brings social and wellbeing benefits, and economic dividends as people have the choice to remain in the workforce for longer.*

10.25. In its 2022 report, *Changing Patterns of Mortality in Australia since 1900*, the AIHW observed:[720]

> *As in many other developed nations, Australia experienced a 'health transition' from infectious to chronic diseases in the mid-20th century, with influenza and tuberculosis being replaced by cardiovascular diseases and cancer as the major causes of death (Beaglehole and Bonita 1997). More specifically, as infectious diseases were coming under control, mortality from cardiovascular diseases and cancers increased from what it was in the 1920s and 1930s.*

10.26. As may now be considered uncontroversial, the report concluded that "[t]argeted policies that address cohorts with higher rates of chronic disease – for example those experiencing socioeconomic disadvantage and those living in remote areas – can bring significant gains".[721]

10.27. Consistent with those reports and projections, chronic disease has become the leading cause of illness, disability and death in Australia, accounting for approximately 90 per cent of all deaths. The rates of type 2 diabetes, dementia, mental health conditions and self-inflicted injuries, and osteoarthritis have all increased over the past 20 years, while rates of coronary heart disease, stroke, lung cancer, and bowel cancer have declined.[722]

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[719] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 74 [SCI.0001.0016.0001 at 0074].

[720] Exhibit O.64, Australian Institute of Health and Welfare, *Australia's Health 2022: Data Insights* (Report, 2022) p 168 [SCI.0011.0894.0001 at 0016].

[721] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 75 [SCI.0001.0016.0001 at 0075].

[722] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [116]–[119] [MOH.9999.0001.0001 at 0017–0018].

10.28. These changes have been attributed to lifestyle characteristics of the population, together with advancements in treatments and the quality of care over time. For example, tobacco use has steadily reduced over time,[723] contributing to the decline in lung and heart related diseases such as coronary heart disease and some cancers. Increased and more effective screening and early interventions have also contributed to a decrease in the incidence of some cancers.[724]

10.29. However, obesity is a major contributor to chronic diseases, including type 2 diabetes, chronic kidney disease, coronary heart disease, and osteoarthritis.[725] The increase in the prevalence of those conditions corresponds with the increasing proportion of the adult population who are overweight and obese. In this respect, the percentage of the NSW population aged 16 and over who are overweight or obese has risen from 46 per cent in 2002 to 59 per cent in 2023.[726] The prevalence of other chronic mental health conditions has also been rising. More than 40 per cent of the NSW population have a lifetime mental illness, such as an anxiety disorder or substance use disorder.[727] The number of adults experiencing high or very high psychological distress has also increased from 9.8 per cent of the population in 2013 to 18.1 per cent in 2023.[728]

The impact of population changes on the demand for health services

10.30. Those population changes, particularly the rising rates of chronic disease in the community, are having – and will continue to have – a significant impact on the demand for health services.

10.31. Generally, most interactions with the health system occur later in life. The highest users of health services in NSW are those aged 65 and older, who in 2019 constituted approximately 19 per cent of the population, but accounted for 35 per cent of the activity in the health system, as illustrated in Figure 5.[729]

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[723] Exhibit N.3.18, Centre for Epidemiology and Evidence, ‘Daily Smoking in Adults’, *HealthStats NSW* (Web Page) <https://www.healthstats.nsw.gov.au/r/111277> [SCI.0011.0709.0001]. However, the relatively recent emergence of e-cigarettes or vapes has contributed to a significant increase in vaping in NSW: Exhibit N.3.19, Centre for Epidemiology and Evidence, ‘E-cigarette Use (Vaping)’, *HealthStats NSW* (Web Page) <https://www.healthstats.nsw.gov.au/r/118400> [SCI.0011.0710.0001].

[724] See Exhibit N.3.25, Cancer Institute NSW, ‘Cancer Incidence, Mortality and Relative Survival’, *Cancer Statistics NSW* (Web Page) <https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/data-available-now/cancer-statistics-nsw/cancer-incidence-mortality-survival> [SCI.0011.0716.0001].

[725] Exhibit N.3.20, Australian Institute of Health and Welfare, *Overweight and Obesity* (Web Page, 17 June 2024) <https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/summary> [SCI.0011.0711.0001 at 0010].

[726] Exhibit N.3.21 Centre for Epidemiology and Evidence, ‘Overweight and Obesity in Adults’, *HealthStats NSW* (Web Page) <https://www.healthstats.nsw.gov.au/r/114335> [SCI.0011.0712.0001].

[727] Exhibit N.3.23, Australian Bureau of Statistics, *National Study of Mental Health and Wellbeing* (Web Page, 5 October 2023) <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022> [SCI.0011.0714.0001].

[728] Exhibit N.3.24, Centre for Epidemiology and Evidence, ‘High or Very High Psychological Distress in Adults by Period’, *HealthStats NSW* (Web Page) <https://www.healthstats.nsw.gov.au/r/118402> [SCI.0011.0715.0001].

[729] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 8 [MOH.0001.0320.0001 at 0026].

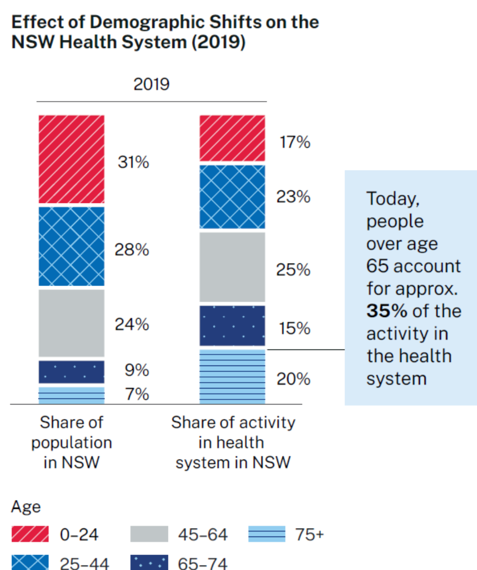

Figure 4: Effect of demographic shifts on the NSW health system (2019), NSW Health

10.32. By 2031, it is predicted that people 65 and older will account for 45 per cent of healthcare activity, and 25 per cent of that cohort will have two or more chronic diseases requiring more complex care.[730] Accordingly, not only will there be a larger cohort of patients 65 and older in future years, but they will likely present with far more complex needs, which in turn will require more intensive care than other cohorts, as is illustrated by the division of the National Weighted Average Units (NWAU) a standard unit of activity used in funding public hospitals – across different age cohorts as shown in Figure 6.[731]

[730] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 8 [MOH.0001.0320.0001 at 0026].

[731] Exhibit M.6, Joint Statement of Alfa D'Amato, Steven Carr and Neville Onley (14 November 2024) [52(b)] [MOH.0011.0091.0001 at 0013–0014].

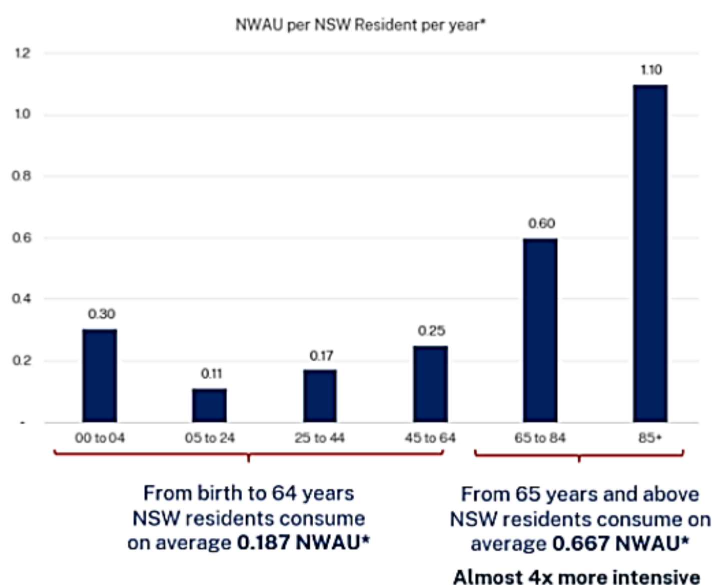

Figure 5: NWAU per NSW resident per year

10.33. The combined effects of population growth, an ageing population, increases in life expectancy, and increases in the rates of chronic disease (including those living with multiple chronic conditions) is already challenging the NSW public health system, and will continue to do so into the future. For example, the *2021–2022 NSW Government Intergenerational Report* recorded that in 2018–2019, "84,281 hospitalisation[s] in New South Wales could potentially have been avoided if appropriate and timely preventative care and early management of chronic conditions had been provided".[732]

10.34. The effect of those combined population changes, including increasing rates of chronic disease, on the system going forward was described in the NSW Government *Future Health* report as follows:[733]

> ***Rising Demand***
>
> *Nearly 90% of citizens come into contact with the broader health system of NSW each year, and of those, about 30% are accessing NSW Health services.*
>
> *Population growth, demographic changes and changes in the disease burden mean that the increasing volume of demand is outpacing the population growth rate, especially in mental health, diabetes and other chronic diseases. Communicable disease, such as that experienced by COVID-19, is also predicted to have high growth over the next*

[732] Exhibit A.20, NSW Treasury, *2021–22 Intergenerational Report: Towards 2061 – Planning for the Future* (Report, 7 June 2021) p 75 [SCI.0001.0016.0001 at 0075] (citations omitted).

[733] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 8 [MOH.0001.0320.0001 at 0026].

> *decade. By 2032, 1.5 million more people will need to access care from the NSW health system compared with today.*
>
> *In addition, the complexity of demand is increasing due to an increase in the number of co-morbidities. By 2032, at least 750,000 more people will have multiple chronic diseases, increasing the complexity of care they need.*
>
> *If the health system continues to rely on the current models of care to address this increase and more complex demand, indicative estimates suggest future demand would drive 1.7 times more activity in the health system by 2032.*

10.35. Not only will the impact of chronic disease drive demand for acute services, the nature of the services required to meet that demand is also expected to change. Those expected changes in the service mix driven by the need to address higher rates of chronic disease were depicted in the *Future Health* report as follows, as illustrated in Figure 7.[734]

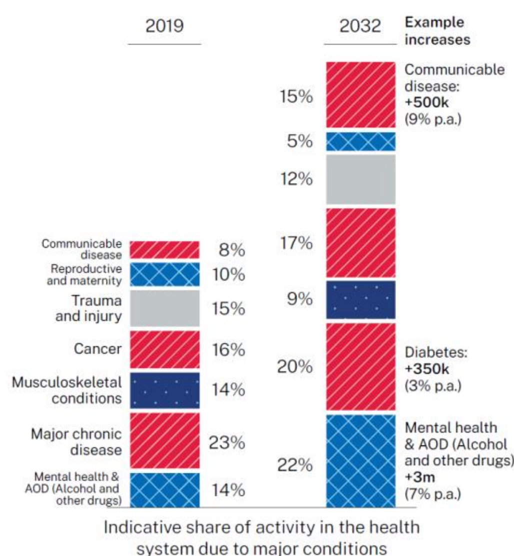

Figure 6: Indicative share of activity in the health system due to major conditions: 2019–2032, NSW Health

[734] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 8 [MOH.0001.0320.0001 at 0026].

10.36. Those projections are consistent with those made in the *National Preventive Health Strategy 2021–2030,* which stated:[735]

> *Health expenditure is currently spent primarily on the treatment of illness and disease. Investment in prevention needs to be enhanced in order to achieve a better balance between treatment and prevention in Australia, as outlined in Australia's Long Term National Health Plan … Investment in preventive health will rise to be 5% of total health expenditure across Commonwealth, state and territory governments by 2030.*

The recognised need to reshape health services to meet changes in demand

10.37. The benefits of reshaping health services to meet the changes in demand caused by population changes (and the expected benefits of doing so) are well recognised, and have been for a century. As Lord Dawson observed in 1920, "[p]reventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close coordination".[736] That observation is as true now as it was over 100 years ago.

10.38. More recently, the Productivity Commission again highlighted the benefits of preventive healthcare, and identified it as a key goal of an integrated health system.[737] In doing so it identified a clear (and, in my view, pressing) "need to create better structures and new incentives that promote efficient prevention and chronic illness management throughout the health system".[738]

10.39. The benefit of that approach extends beyond meeting that need. Those benefits were described in that report as being:[739]

> *An attractive feature of preventative health and better management is that, if effective, not only do they produce benefits for people (their key goal), but they can partly alleviate budget pressures, reducing the extent that governments must increase tax rates or cut needed services and transfers.*

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[735] Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 9 [SCI.0001.0027.0001 at 0009].

[736] Exhibit N.3.1, Consultative Council on Medical and Allied Services, *Interim Report on the Future Provision of Medical and Allied Services* (Report, May 1920) s 1[5] [SCI.0011.0606.0001 at 0004].

[737] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 48 [SCI.0001.0057.0001 at 0050].

[738] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 51 [SCI.0001.0057.0001 at 0053].

[739] Exhibit H.2.10, Productivity Commission, *Shifting the Dial: Supporting Paper No 4 – Why a Better Health System Matters* (Report, August 2017) p 16 [SCI.0011.0151.0001 at 0019].

10.40. Those issues have been acknowledged in health policy, including in the *National Preventive Health Strategy 2021–2030*. That strategy recorded that "chronic conditions make up roughly half of all potentially preventable hospitalisations (46%) which in 2015–2016 cost the health system over $2.3 billion dollars"[740] and stated that "preventive health action is the key to achieving a healthier Australia by 2030".[741] It described the benefits of preventive healthcare as follows:[742]

> *The benefits of prevention extend beyond reducing chronic conditions and living longer, healthier lives. Prevention generates benefits not only by reducing pressure on the health budget, but by also increasing workforce participation and productivity, and improving the health of future generations. To date, Australia's preventive health initiatives have shown how dramatically prevention can positively impact our health. These include our immunisation and cancer screening programs, our tobacco and UV exposure reduction initiatives, the introduction of gun laws, the success in containing the spread of HIV, and the introduction of safe driving measures such as compulsory seatbelt use in cars, random breath testing, and speed monitoring interventions.*

10.41. Those concepts are not new, nor radical. It is beyond rational argument that preventive healthcare is, and will be, central to effective and sustainable health systems. Dr Nigel Lyons, then a Special Advisor, NSW Health, conveniently described the current position, and the change required going forward, in the following way:[743]

> *I think it's work in progress. It's clearly something that we would say where there needs to be an even greater shift over time for the whole system. I think the whole system is geared up around that historical approach of episodic care, around a specific condition, and as the demography has changed and people are living with those chronic conditions, as they are frail and elderly now and have difficulty in accessing services, the whole service system needs to shift in its approach.*
>
> *But examples of where we've done work like shifting the focus is some of the work that has been done around healthcare hubs, which is*

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[740] Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 25 [SCI.0001.0027.0001 at 0025] (citations omitted).

[741] Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 5 [SCI.0001.0027.0001 at 0005].

[742] Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 24 [SCI.0001.0027.0001 at 0024] (citations omitted).

[743] Transcript of the Commission, 29 November 2023, T220.31–221.11 (Lyons).

> *where we are focussed on delivering a range of services in one place and integrating that with other providers. So where primary care might be working alongside our community health teams, allied health, there might be diagnostic services available as well. We need to see more investment in those types of holistic care in the community setting that enable as much care to be provided for somebody who has a range of different conditions and needs to be accessing a range of different providers and services, who can have their diagnosis made without being referred to an emergency department, who can have arrangements for ongoing care with a specialist arranged outside of a hospital setting.*
>
> *That's the shift we need to see and we need to see more investment in those sorts of health service delivery arrangements.*

10.42. Those sentiments are consistent with the Australian Productivity Commission's *Shifting the Dial: 5 Year Productivity Review* in 2017, which observed that "[n]otwithstanding the massive burden of chronic illness, its prevention and proper management is still in its infancy. The system primarily responds to patient crisis".[744]

10.43. An attempt to recognise and promote the importance of preventive care was made in the *Addendum to the NHRA*, which identified prevention and wellbeing" as one of its four "strategic priorities", as well as one of its "long term health reform principles".[745] It described "prevention and wellbeing reform" as comprising the following actions:[746]

a. a national prevention monitoring and reporting framework, with a focus on shared priorities;

b. a commitment to increase investment in primary prevention over time;

c. developing innovative, fit-for-purpose financing mechanisms for scaling primary prevention initiatives;

d. exploring evidence-based regulatory prevention measures; and

e. reviewing and addressing health system barriers to prevention.

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[744] Exhibit A.65, Productivity Commission, *Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 46 [SCI.0001.0057.0001 at 0048].

[745] Exhibit A.28, *Addendum to the National Health Reform Agreement (Consolidated) 2020–2025* (2020) cl 2(c)(ii), sch c cl c1(c)(ii) [SCI.0001.0024.0001 at 0006, 00056].

[746] Exhibit A.28, *Addendum to the National Health Reform Agreement (Consolidated) 2020–2025* (2020) sch c cls c35–c40 [SCI.0001.0024.0001 at 0062–0063].

10.44. The *Addendum to the NHRA* also recognised that, despite a consensus by all governments on the need for preventive healthcare, the current system does not incentivise building prevention into practice, and there are ongoing difficulties measuring the impact, revenue and return on investment for preventive health initiatives.[747]

10.45. However, despite those clear statements, little progress appears to have been made. In the *Mid-Term Review of the Addendum to the NHRA*, Ms Huxtable considered the significance of prevention in the context of the NHRA. Significantly, she concluded (my emphasis):[748]

> *The objectives of the NHRA Addendum 2020–25 recognise that "…responsibility is shared between the Commonwealth and the States and that all governments have a responsibility to ensure that systems work together efficiently and effectively to provide the best outcomes…" (Clause 1e). A key enabler is to ensure sufficient priority is afforded to prevention and holistic health and wellbeing, an area where the efforts of all levels of government need to come together.*
>
> *Prioritising prevention and helping people manage their health across their lifetime, including by empowering people through health literacy and prevention and wellbeing, is one of the four strategic priorities of the Addendum, comprising two of the six long term reform areas.* ***While there are a range of aspirations and objectives set out in the Agreement, little evidence was presented to the Review that progress has been made****.*
>
> *…*
>
> *Pivoting the Agreement to have a greater focus on early intervention and diversion programs that seek to respond to the rising burden of chronic disease…will assist in this regard, but more needs to be done earlier to reduce that burden and to address the related social determinants of health. A prevention action plan should be included in the Agreement which clearly sets out the actions that the parties agree they will take over the course of the Agreement to deliver the prevention reform objectives, the resources that will be made available and the accountabilities and milestones to assess progress.*

[747] Exhibit A.28, *Addendum to the National Health Reform Agreement (Consolidated) 2020–2025* (2020) sch c cls c35–c40 [SCI.0001.0024.0001 at 0062–0063].

[748] Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) p 100 [SCI.0011.0585.0001 at 0105].

10.46. One reason why Ms Huxtable was not presented with evidence of progress towards those aspirations is the absence of clearly articulated actions and funding streams to achieve them, both at the Commonwealth and State level. No policy objective, no matter how important, can be achieved without resourcing.

10.47. True it is that funding is allocated to "health promotion" and "prevention" by NSW Health. However, as discussed in the paragraphs below, precisely what falls within those concepts is unclear. While the *Future Health* report recorded that prevention and promotion accounts for 10 per cent of NSW Health expenditure,[749] it is unclear precisely what that expenditure is directed to. Assessing this is particularly difficult in circumstances where there is no standard or universally accepted definition of "prevention and promotion" activities.[750]

10.48. Dr Kerry Chant AO PSM, Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Health, and Deborah Willcox AM, then the Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, gave evidence that a broad definition has been used, and that "promotion" falls under the category of "prevention",[751] and the umbrella of "prevention" encompasses a wide range of NSW Health initiatives from population health programs (such as campaigns to support people to adopt healthy behaviours)[752] to pre-surgery[753] and screening procedures.[754] I accept that some actions are being taken by NSW Health that fall within the concepts of "prevention" and "promotion". However (and without being at all critical of Dr Chant or Ms Wilcox), the current way in which those activities are categorised does little to shed light on what they are, or to enable a set of clear and measurable outcomes to be identified, against which the success of those initiates may be measured (beyond matters such as smoking and vaccination rates within particular patient cohorts).

10.49. The NSW Health Consolidated Financial Statements classify activities by "Service Areas", as set out below:[755]

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[749] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 9 [MOH.0001.0320.0001 at 0009].

[750] Transcript of the Commission, 29 November 2023, T225.16–28 (Chant).

[751] Transcript of the Commission, 29 November 2023, T224.37–225.9 (Chant).

[752] Transcript of the Commission, 29 November 2023, T190.43–11 (Willcox), T224.45–225.2 (Chant), T225.19–226.6 (Chant/Willcox).

[753] Transcript of the Commission, 29 November 2023, T191.13–20 (Willcox).

[754] Transcript of the Commission, 29 November 2023, T192.41–46, T224.44–45 (Chant).

[755] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) p 180 [SCI.0011.0717.0001 at 0188].

Service area	Purpose
Service area 1 - Population health services	Population health services reflects preventive and population health and is critical to keeping people healthier. It covers a range of functions NSW Health is responsible for including to protect and promote public health, control infectious diseases, reduce preventive diseases and death, help people manage their own health, and promote equitable health outcomes in the community.
Service area 2 - Community health services	Community health services reflects that healthcare extends beyond the hospital and needs to connect across settings to reduce the burden of chronic disease, assist people with conditions to live well and avoid complications, support people to recover from illness and injury, and prevent avoidable hospitalisations. NSW Health services funded to achieve this outcome include non-admitted and community-based services, sub-acute services, hospital in the home, and dental services.
Service area 3 - Emergency services	NSW Health often provides the first point of contact for those needing access to emergency healthcare and is responsible for managing and administering ambulance and emergency services.
Service area 4 - Admitted health services	Admitted health service reflect the state's responsibility to manage and administer public hospitals. When people are admitted to a hospital in NSW, they can expect world-class medical and surgical care within clinically recommended timeframes.
Service area 5 - Teaching and training	Teaching and training reflects the requirement that a skilled workforce with access to world leading education and training is essential to deliver safe, reliable person-centred care driving the best outcomes and experiences.
Service area 6 - Health and medical research	Health and medical research reflects the requirement that clinical service delivery continues to transform through health and medical research, digital technologies, and data analytics.

Figure 7: NSW Health Consolidated Financial Statements classification of service areas

10.50. Service Area 1 captures the "prevention and promotion" activities described by Dr Chant and Ms Willcox, but the expenditure for Service Area 1 on population health services comprises only approximately five per cent of total expenditure.[756] However, given the breadth of the definition of preventive health given by Dr Chant and Ms Willcox, some of the activities captured by Service Area 2 may have been incorporated to reach the figure of 10 per cent.[757] Complicating matters further, the NSW Health, *NSW Activity Based Funding and Activity Based Management Manual in 2022–23* stated that prevention and promotion activities accounted for 4 per cent of NSW health funding, broken down on an outcomes basis. The 2023–24 and 2024–25 versions of that document do not include an equivalent breakdown of funding directed to prevention and promotion activities. [758]

[756] This figure is calculated from the disaggregated disclosure statements of the consolidated entity using the total comprehensive income and net assets for Service Area 1 in 2023 and 2024: Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) pp 178–179 [SCI.0011.0717.0001 at 0186–0188].

[757] This figure is calculated from the disaggregated disclosure statements of the consolidated entity using the total comprehensive income and net assets for Service Area 2 in 2023 and 2024: Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, October 2024) pp 178–179 [SCI.0011.0717.0001 at 0186–0188].

[758] Exhibit CE.51, NSW Health, *NSW Activity Based Funding and Activity Based Management Compendium 2022–23* (2022) p 30 [MOH.0100.0797.0001 at 0030]; Exhibit CE.44, NSW Health, *NSW Activity Based Funding and Activity Based Management*

10.51. To address some of those issues at the National level, Ms Huxtable made the following recommendation to be considered as part of the negotiations for the next iteration of the NHRA (which, as of the time of writing this Report, is yet to be finalised):[759]

> *A renewed focus on prevention activities should be set out in the Agreement which directly addresses the rising burden of chronic disease in the community, complements the National Preventive Health Strategy 2021–2030 and work of the Australian Centre for Disease Control and provides a shared program of action, with clear accountabilities, funding and milestones.*

10.52. However, more must be done at the State level, and not only by NSW Health. Properly coordinated whole of government action is urgently required. Without it, the long term sustainability of the public health system will be at risk.

10.53. There is now an urgent need to adapt existing systems of service delivery and funding across the public health system, and across government more broadly to meet those challenges.[760] That must be reflected in the prioritisation of health promotion and preventive care across all settings, as well as earlier interventions, to address the wider social determinants of health and ensure the mix of investment responds to the needs of the community in a sustainable way.[761]

10.54. NSW Health's own projections clearly demonstrate that enhancements in preventive healthcare to combat the increasing prevalence of chronic disease accompanied by early interventions to manage and treat those conditions are essential to the sustainability of the public health system. As outlined above, there can be little doubt as to the benefits of such an approach.

10.55. In addition to the obvious benefits to the public health system of such an approach, it will also deliver advantages to individual patients and society at large, including through increased wellbeing and economic productivity within the population.[762]

Compendium 2024–25 (2024) p 34 [MOH.0100.0299.0001 at 0034]; Exhibit CE.33, NSW Health, *NSW Activity Based Funding and Activity Based Management Compendium 2023–24* (2023) p 33 [MOH.0100.0295.0001 at 0033].

[759] Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) p 100 [SCI.0011.0585.0001 at 0105].

[760] Transcript of the Commission, 29 November 2023, T200.16–24 (Chant), T217.14–224.35 (Chant/Lyons/Willcox); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [5]–[6] [MOH.9999.1202.0001 at 0001–0003].

[761] Transcript of the Commission, 29 November 2023, T222.34–223.5 (Chant/Lyons), T227.33–228.5 (Lyons).

[762] Transcript of the Commission, 29 November 2022, T223.13–25 (Chant/Lyons/Willcox); Exhibit A.65, *Productivity Commission, Shifting the Dial: 5 Year Productivity Review* (Inquiry Report No 84, 3 August 2017) p 47 [SCI.0001.0057.0001 at 0049]; Exhibit O.24, Productivity Commission, *Reaping Broader Economic Benefits from an Effective Healthcare System: A Visual Lens* (Speech, Consumer Health Summit, 24 July 2019) pp 2–3, 5–6 [SCI.0011.0882.0001 at 0002–0003, 0005–0006].

10.56. While NSW Health has a central role to play in driving the State's preventive health strategy, the prevention and management of chronic disease in the NSW population must be approached as a whole of government endeavour if it is to be addressed in a comprehensive and effective way.

10.57. There will inevitably be a range of measures that have traditionally been within the scope of NSW Health, and should remain so (such as vaccination strategies, screening programs and the like). However, in addition to those initiatives, NSW Health is well placed to play a leadership role in designing and coordinating other preventive health strategies. In this respect, it has the expertise and data that enable it to provide advice across government in relation to measures that are likely to promote and maintain the health of the population, including those that will prevent chronic disease in the first place, and to enhance a patient's ability to manage it in the community.

10.58. There is a need for more targeted funding towards preventive health measures that is accompanied by a **consistent** approach both within NSW Health and more widely across government.

10.59. A barrier to effectively addressing the rise of chronic disease to date has been frequent changes in strategy before benefits have been realised.[763] As is obvious, reducing the rate and impact of chronic disease in the community is a long term (and likely ongoing) project. It cannot be completed within a budget or election cycle. A changing of focus or abandonment of an initiative before its benefits have been realised is a short sighted approach that will not meaningfully address the prevailing issue, or its impact on the NSW public health system.

10.60. What is now required is a long term commitment across the whole government to preventive health initiatives designed to reduce the rates and impact of chronic disease within the community, including through funding. While the benefit of increased investment in such measures may not deliver an immediate return or be readily measurable by KPIs, there can be no doubt that it is a necessary aspect of ensuring system sustainability into the future while also producing long term economic benefits.

10.61. Finally, any improvements or enhancements in preventive care must also include measures to ensure that the healthcare system is simpler to navigate – for both clinicians and patients – to ensure that such care is being delivered in the appropriate setting and in an integrated way.[764]

[763] See, e.g., Transcript of the Commission, 11 December 2024, T6922.34–6923.5 (Mastersson).

[764] Transcript of the Commission, 29 November 2023, T221.39–222.25 (Lyons); Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [136]–[137] [MOH.9999.0001.0001 at 0022]; Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox AM (27 November 2024) [29] [MOH.9999.0005.0001 at 0016].

Conclusion

10.62. The evidence that investment in keeping the population healthy and well is returned, both through benefits to the individual, the system, and the wider economy, is overwhelming. Preventing disease (in particular, chronic disease), reducing the impact of disease, and measures directed to keeping people well throughout their lives not only reduce the demand for acute hospital services, but also promote greater economic activity.

10.63. The literature has long been replete with warnings of the need to invest in preventive care. Yet in 2025, there is still much more to be done. There is now an urgent need to meaningfully respond to those warnings.

10.64. Preventive health – keeping people healthy and well across their lives – must be a whole of NSW Government priority. It must inform government decision making, and spending, across all areas of its operations. That can be best achieved by ensuring that the consideration of all new initiatives (including new policy proposals) involves an assessment of how they will contribute to the long term health and wellbeing of the population. That assessment should be informed by advice from a multi-agency body (i.e., that is drawn from across NSW Government) that is led by NSW Health under the oversight of the Chief Health Officer.

10.65. In saying that, I recognise that there will be some aspects of government operations that do not necessarily intersect with those considerations. In that case, the assessment against that criteria will be relatively simple. However, as was explained to me by Dr Chant, there are many aspects of government operations that sit outside the remit of NSW Health that can impact on the social determinants of health and improve the long term health and wellbeing of the population.

10.66. These steps must be taken now, otherwise there is a real risk that the burden of chronic disease that is now bearing down on the system will become entrenched for generations.

Recommendation 1: Preventive health should be made, and remain over the long term, a standing whole of NSW Government priority.

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.

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.

These measures should be implemented within 12 months of the date of this Report.

Chapter 11:

Primary care and aged care

Volume 2

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11.1. The importance of primary care in the wider health system is uncontroversial. It is a key component of all high performing health systems. However, as I have observed in my Overview, the overwhelming body of evidence received by 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. Without meaningful action by the NSW Government (primarily NSW Health), this unsatisfactory situation will continue to deteriorate.

11.2. A significant decline in the availability of effective and accessible primary care is no small thing. With effective primary care, patient outcomes are improved, their need for specialist intervention or inpatient services is minimised, and unnecessary hospital admissions are avoided.[765] 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. It is uncontroversial that effective primary care is a more cost effective form of intervention than acute care delivered in the hospital setting,[766] and is associated with higher patient satisfaction and reduced aggregate healthcare spending.[767]

11.3. Ensuring the availability and accessibility of effective primary care to the wider population is a fundamentally important part of any health service's response to its population's evolving healthcare needs, and a critical component of the care required by those with chronic disease.[768]

11.4. In light of the above, it is plain beyond argument that the provision of effective and accessible primary care to all communities in NSW should be a core priority at all levels of government. It is essential not only to enhance the health, wellbeing, and productivity of those communities, but also to preserve the economic viability of the public health system as we move forward.

What is primary care?

11.5. The term "primary care" is most commonly associated with general practice, but includes care delivered in community health centres, ACCHOs and AMSs, mental health services, screening services, maternal and child health services, and a range of allied health practices.

[765] Exhibit N.37, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) 10 [SCI.0011.0585.0001 at 0025].

[766] Exhibit N.37, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 48 [SCI.0011.0585.0001 at 0053].

[767] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [17]-[19] [MOH.9999.1202.0001 at 0005]; Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [142] [MOH.9999.0001.0001 at 0022].

[768] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [107]-[111] [MLH.0001.0016.0001 at 0023]; Transcript of the Commission, 17 May 2024, T3081.32-3082.15 (Williams).

11.6. While general practitioners and rural generalists play a central role in the delivery of effective primary care, Dr Michael Bonning, a general practitioner and former President of the Australian Medical Association (NSW), correctly observed those individuals are "not very much without the allied health team and nursing team" that are essential in primary care.[769] Dr Bonning's observation underscores the inherently multidisciplinary nature of effective primary care and its heavy dependence upon a wide range of accessible referral pathways.[770]

11.7. The referral pathways on which effective primary care depends are not confined to allied health professionals, but include a range of specialist and subspecialist clinicians which may, from time to time, be called on to contribute to a patient's care. Such pathways are chimerical if they are not accessible to those who require them. For those referral pathways to be accessible, they must be both available and affordable. Inevitably this means that, for some members of the community, those referral pathways must exist within the public health system and be reasonably available to those patients who genuinely need them.

11.8. Where I refer in this Report to primary care, I am using the term in its widest sense; encompassing general practice, the allied health services and specialist referral pathways required to support it.

11.9. As I develop elsewhere in this Report, accessible primary care is an essential component of any preventive health strategy. It is also, typically (although not exclusively), the first health service visited by patients with a health concern that does not require an urgent or immediate response at a hospital.[771] The importance of primary care is clear; it is key in the prevention, timely detection, and/or effective treatment and management of health conditions, and essential to the promotion of health and wellbeing in a cost effective way. By focussing on proactive measures and addressing health concerns at their initial stages, primary care can prevent the escalation of illnesses, and the need for more costly interventions that are typically performed in hospitals.[772]

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[769] Transcript of the Commission, 16 October 2024, T5811.23-5812.5 (Bonning), T5812.15-36 (Christmas).

[770] Transcript of the Commission, 16 October 2024, T5806.37-44, T5812.38-5813.16 (Sloane).

[771] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [95] [MOH.9999.0001.0001 at 0012]; Exhibit O.53, Department of Health and Aged Care, *'About primary care'* (Web Page, 3 April 2023) <https://www.health.gov.au/topics/primary-care/about> (accessed 18 March 2025) [SCI.0011.0887.0001]; Transcript of the Commission, 23 May 2024, T3343.7-41 (Astill).

[772] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 48 [SCI.0011.0585.0001 at 0053].

The current state of the primary care sector

11.10. There is ample evidence that the primary care system across NSW (and Australia more generally) is under severe strain, particularly 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.[773]

11.11. The reasons for decline in the accessibility of primary care are multifactorial. They include the inherent challenges associated with the operation of general practice, including increasing patient complexity,[774] the perceived (and perhaps actual) inadequacy current MBS rates,[775] and the pressures associated with operating a small business (and their impact on the wellbeing of clinicians).[776] Those challenges exist in all areas of the State, but are often more acute in regional areas.[777]

11.12. While somewhat anecdotal, it has also been suggested by many who have given evidence that there have been changes to the way in which some general practitioners are choosing to work – particularly since the height of the COVID-19 pandemic – with many electing to work fewer hours than they and their predecessors have in the past. As a result, it can no longer be assumed that what might traditionally have been thought of as a single FTE workload will be filled by a single clinician or that any single clinician retained in a full time primary care role will deliver in excess of one FTE worth of care in the way that many of their predecessors did. The consequence is that it is likely that a greater number of general practitioners will be required to meet the population's primary care needs into the future.[778]

11.13. This is particularly concerning given that the number of medical graduates pursuing general practice as a vocation has substantially decreased, while the numbers pursuing other specialties has risen[779] (although there has been a recent upturn in the number of graduates electing to pursue specialist training as a general

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[773] Exhibit E.37, Report of the inquiry into Health Outcomes and Access to Health and Hospital services in Rural, Regional and Remote New South Wales, Legislative Council Portfolio Committee No 2 (May 2022) [2.10]-[2.16] [SCI.0009.0077.0001 at 0047-0048]; Transcript of the Commission, 16 May 2024, T3011.33-3012.17 (Spencer); Transcript of the Commission, 14 May 2024, T2671.22-2673.15 (Chua); Transcript of the Commission, 18 September 2024, T5306.39-5307.43 (Wong); Transcript of the Commission, 19 September 2024, T5380.38-5381.23 (Grotwoski), T5431.3-24 (McCosker), T5475.33-5476.13 (Nankervis/Koschel); Transcript of the Commission, 16 October 2024, T5810.29-5811.6 (Bonning/Sloane).

[774] Transcript of the Commission, 18 March 2024, T1214.32-1215.21 (Shenouda); Transcript of the Commission, 16 October 2024, T5828.24-44 (Christmas).

[775] Transcript of the Commission, 15 August 2024, T4882.25-35 (Buist); Transcript of the Commission, 16 October 2024, T5835.32-42 (Sloane).

[776] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023,* pp vii-viii, 1-7, 34-35, 43-56 [SCI.0001.0029.0001 at 0010-0011, 0014-0020, 0047-0048, 0056-0069].

[777] See, for example, Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [11] [SCI.0011.0384.0001 at 0002-0003]; Transcript of the Commission, 28 August 2024, T5123.3-40 (May).

[778] Transcript of the Commission, 28 August 2024, T5128.38-5129.15 (May).

[779] Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [6]-[7] [SCI.0011.0384.0001 at 0001-0002]; Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, pp 57-58 [SCI.0001.0029.0001 at 0070-0071]; Transcript of the Commission, 28 August 2024, T5122.37-5123.40 (May).

practitioner).[780] Nevertheless, the general practitioner workforce is ageing[781] and, like many aspects of the healthcare workforce, there is significant maldistribution of that workforce, with it being increasingly concentrated towards metropolitan areas.[782]

11.14. Although each city, town, and region has unique features that must be considered,[783] there are increasingly large areas of the State that do not now have, or are at serious risk of losing, accessible access to primary care services.

11.15. For example, in 2019, the Western NSW PHN, which encompasses the Western NSW LHD and the Far West LHD – approximately 53 per cent of the land area of NSW[784] – identified more than 40 towns that were at "significant risk" of not having a general practitioner by 2029, demonstrating the challenges of attracting and retaining a primary care workforce in regional and remote areas of the State.[785] At the halfway point of the period covered by that projection, it remains accurate.[786]

11.16. Similarly, in a 2021 report titled *Rural health care: Paper 1 – Changes in rural medical workforce and health service delivery since 1990*,[787] the Sax Institute concluded that "the ratio of GPs to the population is lower in rural than urban areas, despite the complexities of providing care in remote and small rural communities" and that "[r]ural communities report significant difficulties with the accessibility of high-quality primary care."[788]

11.17. However, difficulty accessing primary care is not confined to rural and regional areas. Dr Rebekah Hoffman, Chair of the NSW and ACT Faculty Council of the Royal Australian College of General Practitioners (RACGP), has suggested that there are pockets of Sydney where it is very difficult to access general practice, particularly at short notice.[789]

11.18. Roundtable discussions and evidence received by this Special Commission confirm that challenges arising out of a declining primary care market exist in every LHD.[790]

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[780] Transcript of the Commission, 14 April 2024, T2684.14-2685.2 (Hoffman); Transcript of the Commission, 16 October 2024, T5818.39-5819.14 (Hoffman).

[781] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, p 33 [SCI.0001.0029.0001 at 0046].

[782] Exhibit A.33, Royal Australian College of General Practitioners, *General Practice Health of the Nation 2023*, pp 34-35 [SCI.0001.0029.0001 at 0047-0048].

[783] Transcript of the Commission, 16 October 2024, T5809.3-5810.27 (Sloane/Christmas/Hoffman/Bonning)

[784] Transcript of the Commission, 17 May 2024, T3076.11-16 (Williams).

[785] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [129] [MOH.9999.1202.0001 at 0025]; Transcript of the Commission, 15 May 2024, T2872.44-2873.28 (Arnold); Transcript of the Commission, 22 May 2024, T3119.36-3121.17 (Nott).

[786] Transcript of the Commission, 17 May 2024, T3095.39-3096.8 (Williams).

[787] Exhibit H.2.25, Sax Institute, *Rural Healthcare Paper 1: Changes in rural medical workforce and health service delivery since 1990* (Paper, 2021) [MOH.0010.0299.0001].

[788] Exhibit H2.25, Sax Institute, *Rural Healthcare Paper 1: Changes in rural medical workforce and health service delivery since 1990* (Paper, 2021) p 21 [MOH.0010.0299.0001 at 0024].

[789] Transcript of the Commission, 16 October 2024, T5818.18-24 (Hoffman).

[790] Exhibit D.3, Statement of Mr Scott McLachlan (9 April 2024) [41] [MOH.9999.0762.0001 at 0013-0014]; Transcript of the Commission, 22 April 2024, T2256.14-41 (Schembri); Transcript of the Commission, 23 April 2024, T2351.35-2352.39 (MacLellan); Transcript of the Commission, 16 October 2024, T5822.30-5823.25 (Bonning); Transcript of the Commission, 19 September 2024,

11.19. All this evidence is consistent with recent projections contained in the Commonwealth Department of Health and Aged Care's *Supply and Demand Study: General Practitioners in Australia*, which indicates that, at the national level, there is a current shortfall of over 800 general practitioners, which is expected to rise to more than 2,600 in 2028 and 8,600 in 2048.[791] In NSW, that study identified a current shortfall of 230 FTE general practitioners from the number required to meet the health needs of the community.[792] That number is predicted to increase to 800 by 2028, and 2,300 in 2048,[793] resulting in a shortfall of approximately 4,000 general practitioners by 2048.[794]

The impact of a lack of access to primary care

11.20. Declining access to primary care has obvious detrimental effects on the health, wellbeing, and productivity of the wider community. 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.[795]

11.21. To cite but one example, in the region served by the Murrumbidgee LHD, a high proportion of the population's healthcare needs would benefit from consistent management in the primary care setting, particularly in circumstances where:

a. 16.6 per cent of adults have diabetes;

b. 36 per cent of adults have high cholesterol;

c. 31 per cent of adults have high blood pressure;

d. 24 per cent of children are developmentally vulnerable in one or more domains in their first year of school; and

e. there is a higher prevalence of many lifestyle associated risk factors when compared with the average across NSW.[796]

T5431.8-17 (McCosker); Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [17] [MOH.0011.0041.0001 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 L.3.4, Primary Health Network Cooperative, *Response to Consultation on Thin Markets in Regional and Remote Australia* (20 October 2023) p 3 [MOH.0010.0689.0001 at 0004]; Transcript of the Commission, 16 October 2024, T5818.18-24, T5824.21-34, T5859.23-230, T5862.3-16 (Hoffman), T5820.45-47 (Van de Water); Transcript of the Commission, 18 March 2024, T1155.26-33 (Christmas); Transcript of the Commission, 16 October 2024, T5805.36-5807.1 (Bonning/Sloane/Christmas); Exhibit K.52, Statement of Jill Wong (6 September 2024) [27], [29] [MOH.0011.0061.0001 at 0007-0008].

[791] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) pp 8-9 [SCI.0011.0392.0001 at 0009-0010]. It may be that those projections are based on conservative assumptions, and the shortfalls are indeed greater: see Transcript of the Commission, 28 August 2024, T5125.2-5126.24, T5128.24-29 (May).

[792] See description of "baseline demand": Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) p 8 [SCI.0011.0392.0001 at 0009].

[793] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) p 12 [SCI.0011.0392.0001 at 0013].

[794] Exhibit J.2, Department of Health and Aged Care, *Supply and Demand Study: General Practitioners in Australia (*August 2024) [Figure 3] p 12 [SCI.0011.0392.0001 at 0013].

[795] Transcript of the Commission, 29 November 2023, T210.38-211.36 (Lyons); Transcript of the Commission, 30 July 2024, T4223.13-44 (Fielding); Transcript of the Commission, 19 November 2024, T6374.25-6375.11 (Constable).

[796] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [28] [MLH.0001.0016.0001 at 0004].

11.22. The Australian Government *Intergenerational Report 2021: Australia over the next 40 years*, concluded that:[797]

> *The cost and prevalence of chronic conditions are relevant to future health spending. Chronic conditions are long lasting with persistent effects, and include conditions such as arthritis, back pain, cardiovascular disease, diabetes, and mental health conditions. These conditions tend to develop gradually and become more common with age. In 2017–18, 1 in 2 Australians had 1 or more of 10 selected chronic conditions. As the population ages, chronic conditions will increase overall health spending. Most care for chronic conditions is provided in the primary health care setting by general and allied health practitioners. Effective primary health care is important to help prevent unnecessary hospitalisations from chronic conditions and improve health outcomes.*

11.23. With limited access to primary care (contributed to by a decline in bulk billing rates within local general practices and limited access to specialist referral pathways), demand on Emergency Departments across NSW has been increasing.[798] That lack of access also amplifies the various health risk factors that exist within the population, particularly in rural areas. A lack of access to appropriate primary care can result in the condition of those suffering from one or more chronic illnesses becoming more acute, resulting in them requiring more extensive care in a hospital setting (not only through Emergency Department presentations).[799]

11.24. Brad Astill, Chief Executive of the Far West LHD, described the impact of limited access to primary care services within that LHD as follows:[800]

> *The market failure of local General Practitioners (GPs) has significantly increased the dependence on FWLHD EDs for fundamental medical care for the community. Since the COVID 19 pandemic there has been significant contraction in the number of GPs providing primary care services to the community in Broken Hill. This has resulted in considerable limitations to access GP services for the community. Patients often wait 6–8 weeks for an appointment with a GP for a routine consultation like a repeat script or a medical certificate. The impact for FWLHD resulted in a marked increase in low acuity presentations to the ED. The result is that the community of Broken Hill*

[797] Exhibit A.22, Australian Government*, Intergenerational Report 2021: Australia over the next 40 years* (Report, June 2021) p 99 [SCI.0001.0018.0001 at 0117].

[798] Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [107] [MLH.0001.0016.0001 at 0023]; Transcript of the Commission, 21 March 2024, T1632.13-45 (Yoosuff); Transcript of the Commission, 16 October 2024, T5846.3-10 (Sloane); Transcript of the Commission, 18 November 2024, T6284.13-19 (Kastoun).

[799] Exhibit E.47, Statement of Mark Spittal (30 April 2024) [18] [MOH.9999.1202.0001 at 0005].

[800] Exhibit F.1, Statement of Brad Astill (8 May 2024) [76]-[80] [MOH.9999.1258.0001 at 0011-0012].

> *is not receiving an equitable share of Medicare funding for primary care and there is likely a subsequent reduction in health in the community.*

11.25. 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.[801] For example, 84,281 hospitalisations in NSW could potentially have been avoided in 2018–19 through timely preventive care and early management of those with chronic conditions.[802]

11.26. That experience is consistent with the views of those within the Ministry of Health. In their joint report Dr Lyons, Dr Chant and Ms Willcox described the importance of primary care in addressing chronic disease as follows:[803]

> *In responding to the changing burden of disease, coordinated investment in preventative health and early intervention is part of a whole of health and social system response, including the need to address the wider determinants of health.*
>
> *Preventive services and early interventions should be strong pillars of Australia's healthcare system to support people to be healthy and well. People living in Australia are experiencing increasingly complex health care needs.*
>
> *Low proportional investment in preventive health, the wider determinants of health and increasing burden of chronic disease has led to increased spending on treatments to manage conditions that could be prevented, detected earlier or managed more effectively in a comprehensive primary care setting reducing the need for hospitalisation.*

11.27. This is a logical point to say something about the Urgent Care Services or Clinics, which have been opened by NSW Health or the Commonwealth Government at various locations around the State, typically where challenges in accessing primary care are most acute. There is little doubt that these facilities reduce pressure on Emergency Departments by siphoning off a proportion of the lower acuity patients who would otherwise be presenting. Viewed through the 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.

11.28. It may be accepted that 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 after

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[801] Exhibit A.20, NSW Treasury, *NSW Intergenerational Report 2021-2022* (Report, June 2021) p 75 [SCI.0001.0016.0001 at 0075]; Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022) [2.16] [SCI.0009.0077.0001 at 0048].

[802] Exhibit A.20, NSW Treasury, *NSW Intergenerational Report 2021-2022* (Report, June 2021) p 75 [SCI.0001.0016.0001 at 0075].

[803] A.1, Joint Report of Dr Nigel Lyons Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [173]-[175] [MOH.9999.0001.0001 at 0025].

hours – 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.

11.29. Notwithstanding those benefits, nobody should pretend that Urgent Care Services or Clinics are any substitute for effective primary care. The overwhelming weight of the evidence before this Special Commission makes very clear that they are not.[804]

11.30. In addition to increasing demand for acute care services, declining numbers of general practitioners in the regions has also had a significant impact on the delivery of hospital services in those areas. Traditionally, the medical workforce in rural and regional areas has included general practitioners who are Visiting Medical Officers, many of whom have specialist qualifications in a range of areas, such as obstetrics, anaesthetics and surgery. That long standing model has been described as being "absolutely critical for rural health".[805]

11.31. As it was suggested during one site visit in regional NSW, given the thin (and in some cases failing) local market, the traditional "GP VMO" model is "in the rearview mirror" and fading fast.[806]

11.32. As is obvious – if there are no general practitioners in a particular region, that model will become unsustainable. Even where there are primary care services available, the proportion of general practitioners in rural and regional areas who are willing to accept appointments to provide care in the acute setting, and take on the significant personal and professional burden associated with it, is in decline.[807] There is already significant pressure on those models in some areas of the State,[808] and any assumption that this model will continue to sustain services delivered through smaller rural and regional hospitals would be wholly flawed.

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[804] Transcript of the Commission, 19 April 2024, T2499.1-2500.19 (Daly); Transcript of the Commission 14 May 2024, T2693.25-2694.35 (Hoffman); Transcript of the Commission, 15 August 2024, T4884.45-4885.28 (Buist); Transcript of the Commission, 16 August 2024, T5102.36-39 (Bennett); Transcript of the Commission, 16 October 2024, T5842.4-5844.12 (Hoffman); Transcript of the Commission, 16 October 2024, T5845.36-41 (Sloane); Transcript of the Commission, 19 November 2024, T6376.6-6377.23 (Constable).

[805] Transcript of the Commission, 16 August 2024 T5095.16-5096.35 (Bennett).

[806] See also Transcript of the Commission, 21 March 2024, T1600.10-31 (Yoosuff); Transcript of the Commission, 22 March 2024, T1697.8-41 (Ludford); Transcript of the Commission, 13 May 2024, T2582.4-9; Transcript of the Commission, 17 May 2024, T3095.39-3096.25 (Williams).

[807] Transcript of the Commission, 21 March 2024, T1600.8-36 (Yoosuff); Transcript of the Commission, 22 March 2024, T1697.8-41 (Ludford); Transcript of the Commission, 17 May 2024, T3096.10-25 (Williams); Transcript of the Commission, 15 August 2024, T4932.30-4933.10 (Stapleton); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022) [3.24] [SCI.0009.0077.0001 at 0073].

[808] Transcript of the Commission, 18 March 2024, T1171.15-21 (Christmas); Transcript of the Commission, 20 March 2024, T1514.2-9 (Marchioni); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022) [3.23] [SCI.0009.0077.0001 at 0072-0073].

Mid-Term Review of the Addendum to the NHRA

11.33. The *Mid-Term Review of the Addendum to the NHRA*[809] considered a range of matters, including the extent to which the objectives of the Addendum are being met, whether the Addendum's health funding, planning and governance architecture remains fit-for-purpose, and reform in the primary care, aged care, disability, and mental health systems as they relate to the operation of the Addendum.[810]

11.34. As discussed above, several findings in relation to primary care, that are consistent with the evidence received by this Special Commission and the findings outlined above were made. Those findings included that:

a. ageing populations and increased rates of chronic disease have seen an increasing demand for primary care. At the same time, there is a fall in the proportion of doctors training as general practitioners and an ageing general practitioner workforce;[811]

b. lack of access to primary care in rural areas has a significant impact on health outcomes and increases reliance on local public hospitals and Emergency Department utilisation;[812]

c. when primary care struggles to meet demand, avoidable hospital presentations result. This is neither cost nor clinically effective, and states and territories need to step in as providers of last resort;[813] and

d. the focus on setting and meeting NWAU or ABF targets to attract Commonwealth funding was seen by stakeholders as driving care to the inpatient setting, rather than preventing hospitalisations through individualised health interventions and early disease management, usually delivered in primary and community based care settings.[814]

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

[810] Exhibit N,3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 14 [SCI.0011.0585.0001 at 0019].

[811] Exhibit N,3.17 Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 40 [SCI.0011.0585.0001 at 0045].

[812] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 37 [SCI.0011.0585.0001 at 0042].

[813] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 27 [SCI.0011.0585.0001 at 0032].

[814] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 32 [SCI.0011.0585.0001 at 0037].

11.35. Ms Huxtable identified, as a key issue raised by relevant stakeholders, that current funding mechanisms and the delineation of roles and responsibilities, particularly between hospital care and aged, disability and primary care, discourage a continuum of health service delivery across multiple settings. This hinders the capacity to deliver the right care in the right place at the right time, detracting from allocative efficiency and patient experience. There are deficiencies in referral networks, patient transfer and transition support.[815]

Interaction between the NSW public health system and the existing primary care market

11.36. Effective interaction between the NSW public health system and primary care providers is essential to providing effective and efficient care, and supporting continuity of care as patients move across care settings.

11.37. The structural barriers that presently exist between primary care givers and the acute care sector can, in some instances, compromise the seamless transition of care from one to the other and generate significant inefficiencies. For example, I was told by the operator of a large primary care practice in Dubbo that there would be significant benefits to the system, and patients, if practices like hers and LHDs worked closely together. When I asked what the potential benefits of the LHD working directly with the providers of primary care (particularly in a region like hers) might be, she answered:[816]

> *Oh, my goodness, the things that we could do. Look, there are simple things like access to pathology and radiology. Take a Friday afternoon and you are needing to have – if someone comes in with atypical chest pain, and you think, "Oh, look, in order to keep them safe, I really need to have that opportunity to do pathology and radiology on them now and I need to know the answer within half an hour or thereabouts."*
>
> *Right now, the pathway to make that happen is not available in the community. I can't request the pathology and radiology department to open up for my patient. I have to send them through to ED in order for that to happen.*
>
> *Another example, I have a fair amount of experience in paediatrics and certainly have had a paediatric registrar position at the hospital in days gone by, and I can see a six-monther with bronchiolitis and know that they need to be admitted and, ideally, I should be able to just work directly with the LHD, phone the paediatrician on call and say "This is the situation with this child. Here is my assessment. Here is what I*

[815] Exhibit N.3.17, Rosemary Huxtable AO PSM, *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025* (Final Report, 24 October 2023) p 27 [SCI.0011.0585.0001 at 0032].

[816] Transcript of the Commission, 14 May 2024, T2704.32-2705.26 (Chua).

> *think needs to be done, including that they need an admission." Right now, the processes don't allow that to happen. Right now, I have to send that child through to the Emergency Department where they will get assessed by, typically, the Emergency Department junior doctor, who then consults with the experienced doctor in the Emergency Department. Then they've got to call the registrar, paediatric registrar for them to assess the patient, who then needs to talk to the paediatric consultant to confirm that admission is possible.*
>
> *There is a lot of health dollar saving we could do if practices could work directly with the LHD on things like that.*

11.38. There are also significant benefits to be achieved by acute care facilities working closely with primary care givers to transfer the care of patients with stable conditions back to, for example, their general practitioner where clinically appropriate, reducing the demand on already stretched specialist outpatient clinics.[817] That transfer of care is not happening as effectively as it might, at least in a systematic way.

11.39. That is highlighted by the fact that primary care providers do not always receive useful discharge summaries; universally critical documents in ensuring continuity of care and achieving good patient outcomes. As Professor Lenert Bruce, General Manager of Wagga Wagga Base Hospital and Executive Director Medical Services, Murrumbidgee LHD told me, although labelled as such, they are "not a discharge summary; it's actually handing over care to another health care provider".[818] I was also told that they are not always received in a timely way, and that their content can be variable.[819] In some cases they are not received at all, which (in addition to not supporting the delivery of care post-discharge) can lead to distressing experiences. As one general practitioner described:[820]

> *So a recent concern of my GPs has been when somebody has died in hospital, one of our patients has died in hospital, we don't get a discharge summary to inform us that patient is now deceased. But we see the family members and we still have existing recalls that we end up sending to that patient, which is hugely distressing to their family members.*

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[817] Transcript of the Commission, 14 May 2024, T2705.31-40 (Hoffman).

[818] Transcript of the Commission, 22 March 2024, T1680.38-40 (Bruce).

[819] See, for example, Transcript of the Commission, 19 March 2024, T1400.34-1401.27 (Mills/Neal); Transcript of the Commission, 22 March 2024, T1638.30-1691.23 (Bruce).

[820] Transcript of the Commission, 14 May 2024, T2706.25-32 (Chua).

11.40. The current lack of reliable access to a complete patient record across the primary care and acute care sectors can also lead to system inefficiencies. As but one example, I was told on several occasions that the inability of an emergency physician to access a full patient history – including recent test results and prescriptions – can result in tests being done again and potentially inconsistent approaches to medication.[821]

11.41. In addition to making the SDPR accessible to the primary care sector so that care givers in both settings can see the full suite of patient information, ongoing dialogue that will facilitate the type of collaboration necessary to overcome these types of problems should be an inherent feature of the planning process I discuss elsewhere in this Report. However, to be effective, that dialogue must be meaningful and identify the means by which the care of patients can be transferred from one sector to the other in a seamless way.

The role of NSW Health in relation to primary care

11.42. Despite the clear recognition by NSW Health of the central role of primary care in the promotion, protection and maintenance of health within communities, evidence given by witnesses from both the Ministry of Health and LHDs is replete with references to the proposition that primary care is the responsibility of the Commonwealth Government, and not NSW.[822] As I have noted in the Overview, this is at best an oversimplification of the position and, at worst, simply wrong. If offered as a description of the role and responsibility of NSW Health in relation to the delivery of primary care, it is far too narrow.

11.43. The notion that primary care is the responsibility of the Commonwealth Government is said to flow primarily from paragraphs 9 and 13 of the *Addendum to the NHRA*, which relevantly provides:

> *13. Under this Addendum the Commonwealth will be responsible for:*
>
> …
>
> *(b) system management and support, policy and funding for GP and primary health care services including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services (noting contributions of the States);*

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[821] See, for example, Transcript of the Commission, 23 February 2024, T981.17–31 (Bolevich); Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [94] [MOH.9999.0008.0001 at 0033–0035]

[822] See for example, Exhibit E.47, Statement of Mark Spittal (30 April 2024) [18] [MOH.9999.1202.0001 at 0005]; Transcript of the Commission, 20 March 2024, T1506.11-1507.33 (Lawrence); Transcript of the Commission, 29 April 2024, T2494.24-2495.41 (Daly), T2532.33-40, 2540.14-30 (Willcox); Exhibit E.37, *Report of the inquiry into Health Outcomes and access to health and hospital services in rural, regional and remote New South Wales*, Legislative Council Portfolio Committee No 2 (May 2022) [3.6] [SCI.0009.0077.0001 at 0066].

> (c) *maintaining Primary Health Networks to promote coordinated GP and primary health care service deliver, and service integration over time;*
>
> (d) *working with each State and with PHNs on system wide policy and State-wide planning for GP and primary health care;*
>
> (e) *supporting and regulating private health insurance to enable an effective private health sector and patient choice;*
>
> …
>
> (g) *continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.*

11.44. As the above extract makes clear, the Commonwealth Government has an important role to play in funding and collaborating with the states and PHNs in the planning of primary health services across Australia.[823] However, nothing in that extract attributes to the Commonwealth Government responsibility for actually delivering that service.

11.45. NSW Health has suggested that characterising the Commonwealth Government's role in the delivery of primary care as mere responsibility for system management, support, policy, and funding "somewhat simplifies the regime agreed under the Addendum to the National Health Reform Agreement 2020-2025".[824] To some extent it does; as noted above, paragraph 13 of the *Addendum to the NHRA* expressly contemplates the Commonwealth having other responsibilities. However, recognising the Commonwealth's wider role does not absolve the State of its responsibility to work with the Commonwealth and PHNs to address the decline in effective and accessible primary care where it is impacting on the health and wellbeing of its communities.

[823] Transcript of the Commission, 29 April 2024, T2540.14-30 (Willcox).

[824] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [9.5] [SCI.0011.0814.0001 at 0043].

11.46. While NSW Health ultimately acknowledged that the *Addendum to the NHRA* does not envisage that the Commonwealth Government would itself deliver primary care – suggesting instead that it requires the Commonwealth Government to "maintain and fund the Primary Health Networks to do so"[825] – NSW Health went on to assert that the State merely has "a supporting role in the **planning** of primary care to the extent it impact on their responsibilities".[826] If this characterisation sought to imply that the State has some lesser responsibility than the Commonwealth to advance the aspirational goals of that agreement in so far as they relate to primary care, it was wrong.

11.47. As NSW Health ultimately accepted, the *Addendum to the NHRA* contemplates that there will be universal cooperation between the Commonwealth Government (including the PHNs) and the State (including the LHDs) to fulfil its objectives in so far as they relate to primary care, with the Commonwealth to provide the funding.[827] Far from having a mere "supporting role" in planning activities, the agreement places the State front and centre with the Commonwealth in pursuing its aspirational objectives; a proposition with which NSW Health also ultimately agreed.[828] This is hardly surprising given the superior information and human resources possessed and controlled by the State in each of its LHDs.

11.48. While the *Addendum to the NHRA* contemplates universal cooperation, no one should lose sight of the practical reality of that arrangement. Mr Spittal's observation that, although the Commonwealth provides funding for primary care through the MBS, it bears no responsibility for delivering these services and thus lacks a clear obligation to rectify market failures, is apt. The funding of PHNs is – as a matter of practical reality – never going to change this situation.

11.49. Consequently, where there is no market available to provide care funded by the MBS scheme, primary care has fallen away and the cost and burden of delivering healthcare to those communities has shifted to the State. Patients who cannot access primary care present to Emergency Departments or require acute services at a later stage of their disease progression.[829]

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[825] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.10] [SCI.0011.0814.0001 at 0045].

[826] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.12] [SCI.0011.0814.0001 at 0046] (emphasis in original).

[827] Transcript of the Commission, 26 February 2025, T7134.17-24 (Commissioner Beasley SC/Cheney SC).

[828] Transcript of the Commission, 26 February 2025, T7136.22-33 (Commissioner Beasley SC/Cheney SC).

[829] See for example, Transcript of the Commission, 16 May 2024, T2941.17-2942.26 (Spittal).

11.50. Against this background, it is plainly in the interest of the State that all of its citizens enjoy the benefit of effective and accessible primary care. Where they do not, the State has been repeatedly described to me as a provider of "last resort", primarily through Emergency Departments.[830] For example, Matthew Daly, Deputy Secretary, System Sustainability and Performance, NSW Health, described the role of the NSW public system in primary care as follows:[831]

> *Q. To what extent, if any, is the negotiation around service level agreements picking up a consideration of the LHD's need to meet unmet service delivery for, say, primary health care within the geographic boundary of the LHD?*
>
> *A. I don't believe chief executives have in the past, nor probably should they be, investing in primary care. That is the responsibility of the Commonwealth. I guess where we've seen leadership in New South Wales is by government policy around Urgent Care Services that is very much jumping into the primary care market, where it's failed, and I think there is increasing evidence around the ED avoidance that that program has been able to deliver that otherwise would have seen patients in EDs.*
>
> *Q. You say the delivery of primary care is the responsibility of the Commonwealth. Why do you say that?*
>
> *A. Because it is - has traditionally been; its funding is from the Commonwealth; we don't attract any funding from the Commonwealth under the National Health Reform Agreement for anything that resembles primary care. The national administrator and the independent hospital pricing and aged care authority polices that and we have had models of care rejected for Commonwealth funding because it was too like primary care services that the Commonwealth is responsible for.*
>
> *…*
>
> *Q. The Commonwealth clearly provides a source of funding for primary care through the MBS.*
>
> *A. (Witness nods).*

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[830] Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [200] [MOH.9999.0001.0001 at 0028]; Transcript of the Commission, 21 March 2024, T1630.34-40, T1633.19-1634.10 (Yoosuff); Transcript of the Commission, 22 April 2024, T2257.4-9 (Schembri).

[831] Transcript of the Commission, 29 April 2023, T2494.24-2495.41 (Daly).

> Q. *But as to who is responsible for the delivery of primary care to the extent that the market based system funded by the MBS might not be working, does it not get picked up by the broad function of the LHD provided for in section 9 of the Health Services Act?*
>
> A. *Well, I guess ultimately, depending upon the level of that primary care market failure, the LHD does pick it up, because it lands in the ED. It's like most social determinants and problems, it's the last port of call, and that is the volume that we have been working to divert to better care settings than the Emergency Departments.*

11.51. Trevor Danos, Chair of the Board of the Northern Sydney LHD, gave evidence that while there are aspects of the services provided by the LHD that "come close" to primary care, "we are not providers of primary care" although "we do have people who turn up to the Emergency Department with conditions that might otherwise be suited to visiting a GP".[832]

11.52. Joseph Portelli, Executive Director, System Purchasing, NSW Health, gave evidence that the system "will always prioritise the most urgent patients" in budgeting decisions because NSW Health is the only, or the primary, provider of acute healthcare and that "if [funding primary care] comes at a cost of a service that only [NSW Health] provide[s], that's not a tenable solution".[833]

11.53. The views reflected in the evidence referred to in the above paragraphs do not fully address the critical issues faced by those without access to primary care, or the consequences of that lack of access for the State. It gives rise to a tension within the system that finds itself delivering care (as a provider of "last resort" and in a setting that is more expensive and less clinically appropriate) that it considers it does not have a responsibility to fund and deliver. It is also at odds with the approach taken by LHDs in some areas of the State. For example, Mr Spittal gave evidence that:[834]

> *The Commonwealth doesn't necessarily fund the NSW health system to be a provider of last resort. And there are many examples, whether it is in aged care … or primary care or general practice, where, in the interests of the community, in the interests of improving health outcomes, chief executives of Local Health Districts and, indeed, officials in the Ministry of Health, will stray far beyond the traditional bounds that one might have expected of a chief executive, let's say, 10, 15 years ago within the NSW health system with problems to solve … simply because there is nobody else who is going to.*

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[832] Transcript of the Commission, 24 April 2024, T2448.21-2451.47 (Danos).

[833] Transcript of the Commission, 21 November 2024, T6540.26-6541.36 (Portelli).

[834] Transcript of the Commission, 16 May 2024, T2940.3-18 (Spittal).

11.54. Mr Portelli's reference to the "most urgent patients" contains an assumption that the areas in which NSW Health has traditionally – and for largely historical reasons – operated, should always be prioritised over the delivery of effective primary care where the latter is not capable of being adequately delivered by an external market. In the case of some services provided through the public health system, this assumption may be sound; in others, it will not be.

11.55. The identification of a community's unmet health needs will be central to the ongoing and dynamic planning exercise I recommend that NSW Health adopt. While individual rationing decisions will vary from one community to the next, those charged with responsibility for health service planning will identify some communities whose health needs would be best met by providing effective and accessible primary care, rather than a locally based acute care service (for example, a locally based Emergency Department that sees very few presentations). NSW Health has submitted that it would be "irresponsible of NSW Health to assume the burden" of providing this care without first securing the requisite long term funding from the Commonwealth.[835] I disagree. In my view, it would be absurd for NSW Health to prioritise the delivery of some less needed acute service over primary care on the basis of what I consider to be a flawed view that the State is not responsible for providing primary care.

11.56. The view that NSW Health should always prioritise acute care over the delivery of effective and accessible primary care also 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.[836] In this sense, there may well be cases in which a narrow minded refusal to provide primary care to a community in need is actually financially disadvantageous to NSW Health and – when the impacts on productivity are taken into account – the State. This is particularly so when it is recalled that patients forced by the lack of primary care to seek treatment in the acute environment must then be treated by the State at greater cost and within the "capped funding environment" that is the ABF system.[837]

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[835] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.35] [SCI.0011.0814.0001 at 0054].

[836] Exhibit A.20, NSW Treasury, *NSW Intergenerational Report 2021–2022* (Report, June 2021) pp 74-75 [SCI.0001.0016.0001 at 0074-0075]; Exhibit A.31, Department of Health (Cth), *National Preventive Health Strategy 2021–2030* (12 December 2021) pp 24-25 [SCI.0001.0027.0001 at 0024-0025]; Exhibit N.3.17, *Rosemary Huxtable AO PSM, Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 48 [SCI.0011.0585.0001 at 0053]; Transcript of the Commission, 29 November 2023, T210.28-212.10 (Lyons); Transcript of the Commission, 21 March 2024, T1632.13-1634.41 (Yoosuff); Exhibit A.1, Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM and Deb Willcox AM (17 November 2023) [142]-[143] [MOH.9999.0001.0001 at 0022]; Transcript of the Commission, 26 February 2025, T7107.45-7108.21 (Pearce).

[837] Transcript of the Commission, 26 February 2025, T7100.22-31 (D'Amato), T7104.4-7 (Pearce).

11.57. This final point is important. The evidence before this Special Commission indicates that 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. At the end of the day, MBS funding is not an intergovernmental agreement, but rather an entitlement enjoyed by Australian citizens as a central component of the universal healthcare promised by Medicare. That right is not confined to people lucky enough to live in a community with a market capable of supporting the delivery of primary care, yet it is not able to be exercised as a matter of practical reality for many people in NSW. Against this background, it is unsurprising that it seems wherever NSW Health has stepped in and constructed a service through which primary care is delivered to a community, the Commonwealth has agreed to provide the MBS funding to the State through (what is known as) a s 19(2) exemption.

11.58. Significantly, MBS funds flowing to the State through those s 19(2) exemptions fall outside the capped funding environment, thereby enabling the State to potentially obtain more funding from the Commonwealth – at least as an overall funding envelope – for the delivery of those services than would have been received if NSW Health were to have waited until those patients presented to an Emergency Department or some other facet of the acute care system to access their care.

11.59. Having regard to the observations I have made above, it is difficult to understand why NSW Health remains reluctant to step in and facilitate the delivery of (or, where necessary, deliver) primary care to communities that no longer have access to it. There are several possible explanations for this reluctance.

11.60. First, NSW Health's approach has historically been heavily influenced by the pervasive (yet incorrect) view that primary care is not its responsibility, and that the *Addendum to the NHRA* in some way supports this proposition. In its written submissions, NSW Health went so far as to suggest that the agreement of all states and the Commonwealth Government to amend that agreement would be needed before it could step in and deliver primary care,[838] and that proceeding to do so without such agreement would be to "trample over the existing regime by which primary care is already managed by Primary Health Networks"[839] (although it properly retreated from this position in its oral submissions). Both propositions were wrong.

[838] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.37] [SCI.0011.0814.0001 at 0055].

[839] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.45] [SCI.0011.0814.0001 at 0058].

11.61. Secondly, NSW Health's submissions disclose a fear about the potential cost of stepping in to deliver primary care where it is needed, including the possibility that MBS funding obtained through s 19(2) exemptions may be insufficient to cover the cost of delivering primary care services in some communities.[840] While I do not doubt that these concerns are genuine, they would appear to be almost entirely untested. It has not been suggested to me that anyone within NSW Health has modelled or conducted any real cost benefit analysis in relation to the delivery of primary care to communities in need across the State. In the absence of place based health service planning of the type discussed elsewhere in this Report, this is unsurprising. However, nothing in the evidence before this Special Commission leads me to think that – when viewed widely – the delivery of primary care will necessarily be cost negative.

11.62. For example, I was told that the excellent primary care service being delivered by the Mid North Coast LHD to a community in Bowraville costs the district approximately $450,000–$500,000 after the funds received through a s.19(2) exemption are accounted for.[841] This is similar to the $500,000–$600,000 cost paid annually by Bogan Shire Council in connection with the exceptional – and entirely bulk billed – primary care service it has established for residents of Nyngan and its surrounds.[842] In both cases, it amounts to a relatively small investment *per capita* for what everyone agrees are substantial health benefits. In contrast to Bogan Shire Council, this is not a substantial sum when viewed in the context of NSW Health's annual budget. Early indications are that the service established at Bowraville is also producing savings elsewhere within the LHD (for example, by reducing pressure on local Emergency Departments).[843]

11.63. Finally, although it is uncontroversial that significantly greater investment in preventive and primary care is necessary to address the shifting burden of disease, there is a perception that the return on that investment would be both difficult to trace and would only materialise many years after the investment is made. For example, Mr Minns indicated that while he thought Treasury would "conceptually" support large scale investment in "preventative or primary care measures that might shorten the morbidity of the population in terms of chronic disease", the difficulty with that proposition is that the effective return on the investment would not present for 20 years.[844] That is, it would take an extended period of time before the benefits of shortened or lessened morbidity from chronic disease, brought about by increased investment in preventive and primary care, would translate to saved costs in acute care and increased productivity in the wider population. In the meantime, the system

[840] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.34], [9.36], [9.39] [SCI.0011.0814.0001 at 0053, 0054, 0055]; Transcript of the Commission, 26 February 2025, T7139.22-7141.34 (Chiu SC).

[841] Transcript of the Commission, 18 September 2024, T5310.21-32 (Wong).

[842] Transcript of the Commission, 13 May 2024, T2616.22-2617.6 (Wood/Francis).

[843] Transcript of the Commission, 18 September 2024, T5310.32-5312.6 (Wong).

[844] Transcript of the Commission, 7 August 2024, T4822.34-4823.19 (Minns).

will still need to deliver levels of acute care similar to those presently being delivered through the relevant Emergency Departments.

11.64. Any approach to the planning and delivery of health services that undervalues longer term economic benefits is inherently short sighted. More importantly, searching for the short term savings potentially generated by filling voids in the availability of primary care across the State tends to obscure one's view of the real point of health services. As was observed by Professor Andrew Wilson in relation to the prioritisation of prevention within the public health system, fundamentally "[i]t's about improving and extending the quality and length of human life... [a] side benefit of that … is that we may reduce the load in certain areas within the health system..."[845] These observations can be applied equally to the delivery or supplementation of effective and accessible primary care where existing market based providers are unable to do so.

11.65. Perhaps most significantly, the prevailing 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*. Relevantly, s 9 provides:

> *9 Primary purposes of local health districts*
>
> *The primary purposes of a local health district in its area are as follows—*
>
> *(a) to provide relief to sick and injured persons through the provision of care and treatment,*
>
> *(b) to promote, protect and maintain the health of the community.*

11.66. Consistently with those primary purposes, their statutory 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".[846] 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.[847] As the Health Secretary properly acknowledged, effective and accessible primary care is critical to the promotion, protection, and maintenance of community health.[848]

[845] Transcript of the Commission, 11 December 2024, T6899.29-31, T6899.35-37 (Wilson).

[846] *Health Services Act 1997* (NSW) s 10(a) and (i).

[847] Transcript of the Commission, 30 November 2023, T276.45-277.45 (Willcox); Transcript of the Commission, 21 March 2024, T1546.15-1548.5 (Dixon/Kolbe); Transcript of the Commission, 22 March 2024, T1724.43-1725.25 (Ludford); Transcript of the Commission, 22 April 2024, T2256.43-2257.2 (Schembri), T2315.34-45 (McLachlan).

[848] Transcript of the Commission, 26 February 2025, T7094.16-20 (Pearce).

11.67. Properly understood, 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.[849]

11.68. Indeed, several Chief Executives embraced the proposition that LHDs had a role in providing access to primary care services where they are not otherwise available in the market. For example, Adjunct Professor Anthony Schembri, Chief Executive, Northern Sydney LHD, gave evidence as follows:[850]

> *Q. …we shouldn't understand you to suggest that there is no role for the local health district in the provision of primary care where it is needed?*
>
> *A. No, there is absolutely a role. So there is a role in health promotion, for example, in public health; there is a role with very vulnerable people; there is also a role for the other jurisdictions as well.*
>
> *Q. What about where there may not be available primary care in a particular part of an LHD, does the LHD have a role to play in the provision of that care in such a circumstance?*
>
> *A. Definitely we become the service of the last resort in those environments.*
>
> *Q. Is there a role for the LHD to proactively provide primary care in such a circumstance?*
>
> *A. Yes, in the absence of other jurisdiction, yes.*

11.69. Accordingly, I reject the repeated suggestion that responsibility for primary care rests solely with the Commonwealth Government. It does not reflect the aspirational arrangements contemplated by the *Addendum to the NHRA* (as was ultimately accepted by NSW Health).[851] The State and NSW Health do have a role and responsibility, through the LHDs, to provide access to primary care services where that is necessary to "provide relief to sick and injured persons" and to "promote, protect and maintain the health of the community", and not merely as a contributor to planning or provider of "last resort" when those patients present to Emergency Departments.

[849] Transcript of the Commission, 23 April 2024, T2334.39-2335.21 (MacLellan).

[850] Transcript of the Commission, 22 April 2024, T2256.43-2257.13 (Schembri).

[851] Transcript of the Commission, 26 February 2025, T7129.40-7136.38 (Cheney SC).

11.70. The extent to which that is to be done will depend on the circumstances of the region or town being considered, including – critically – the availability of other services. As Dr Hoffman rightly observed, "one town is one town is one town".[852] The needs and circumstances will change from region to region, and so too will the response required from the LHD. Accordingly, the extent to which an LHD ought to provide access to primary care services, or offer tangible support to a struggling primary care market, must be approached in a "place based" way and as part of the strategic planning process discussed elsewhere in this outline.

11.71. 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) consistent with its primary purpose and statutory function.

11.72. Indeed, there are several examples of where LHDs are currently doing exactly that in areas of need, including (among others) in the Murrumbidgee LHD,[853] the Mid North Coast LHD,[854] the Hunter New England LHD, Western NSW LHD, and the Central Coast LHD.[855]

11.73. As is clear from those examples, which cannot fairly be described as "isolated", 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.

11.74. 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.[856] The evidence also indicates that 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 utilising that workforce synergistically to address workforce challenges in other areas of the public health system within the regions.

[852] Transcript of the Commission, 14 May 2024, T2698.27-2699.32 (Chua/Hoffman); Transcript of the Commission, 16 October 2024, T5859.10-34 (Hoffman).

[853] Transcript of the Commission, 21 March 2024, T1547.16-37 (Dixon).

[854] Exhibit K.53B, Statement of Stewart Dowrick (12 September 2024) [67]-[68] [MOH.0011.0069.0001 at 0016-0017]; Exhibit K.52, Statement of Jill Wong (6 September 2024) [27] [MOH.0011.0061.0001 at 0007].

[855] Transcript of the Commission, 22 April 2024, T2315.34-2316.3 (McLachlan).

[856] Exhibit J.1, Statement of Professor Jennifer May (27 August 2024) [14] [SCI.0011.0384.0001 at 0003-0004].

11.75. A range of models have been deployed to leverage those connections. For example, the NSW Rural Generalist Single Employer Pathway has been shown to support training and engagement of rural generalists.[857] The concepts underpinning that model could also be effectively used for nursing and allied health professionals.[858]

11.76. 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.[859] In the process of award reform which I discuss elsewhere in this Report, any barriers to this occurring – including what I have been told is a failure to specifically recognise general practitioners as specialists capable of being employed as Staff Specialists – must be removed.

11.77. To the extent that NSW Health provides traditional primary care services, the NSW Government and Ministry of Health should pursue funding from the Commonwealth Government – whether through s 19(2) exemptions or otherwise. Had those services been provided by a private market, Commonwealth funding of that kind would ordinarily flow, and so there is no clear (or seemingly valid) reason why the Commonwealth would resist funding the service to at least the same extent as it would a market based general practitioner delivering the same care (just as it has done on each occasion that LHDs have stepped in and provided primary care and sought MBS funding the Commonwealth for doing so).

Aged care

11.78. Thin or failing aged care markets are also having a significant and detrimental impact on care delivered through public hospitals in NSW.

11.79. On any given day, there are significant numbers of 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”.[860]

11.80. The high number of maintenance patients occupying hospital beds at any given time has financial implications for the public health system, and creates risks for patients and staff.

[857] Transcript of the Commission, 19 September 2024, T5383.5-28 (Grotowski).

[858] Transcript of the Commission, 19 September 2024, T5479.5-37 (Koschel).

[859] See, for example, Transcript of the Commission, 16 October 2023, T5835.1-42 (Sloane).

[860] Transcript of the Commission, 15 November 2024, T6162.5-11 (Potter).

11.81. Maintenance patients are a high cost to the system. For example, the average cost of a bed for a maintenance patient in the Illawarra Shoalhaven LHD is $1,014 per day,[861] while the maintenance fee (i.e., the patient fee) is around $20 per week.[862] In some instances, this fee will be waived due to hardship.[863] Those costs are borne by the LHDs.[864]

11.82. The large numbers of maintenance patients also creates bed block, impacting the ability of a facility to move patients through the hospital.[865] As at November 2024, there were 25 patients in acute beds awaiting a residential aged care placement at Wollongong Hospital, inhibiting the provision of acute care in that facility and resulting in patients being unable to be admitted from the Emergency Department.[866] 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."[867]

11.83. Similarly, in the Broken Hill Health Service, there are 40 "ED accessible beds" through which the facility manages its unplanned acute load.[868] As of May 2024, 26 of those beds were occupied by aged care patients who were suitable for discharge to an aged care facility if a place were available.[869] On at least one occasion, the high numbers of aged care patients occupying hospital beds meant that some elective surgery, including for patients who had been waiting up to 365 days for their procedure, had to be cancelled because of a lack of available post operative beds.[870]

11.84. Furthermore, when elderly patients are in maintenance beds, they are not in the optimal environment they should be.[871] 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.[872]

[861] Transcript of the Commission, 15 November 2024, T6163.43-6164.2 (Wakeling).

[862] Transcript of the Commission, 15 November 2024, T6162.13-21 (Potter).

[863] Transcript of the Commission, 15 November 2024 T6163.16-37 (Okulicz).

[864] Transcript of the Commission, 18 September 2024 T5293.19-37 (Wong).

[865] Transcript of the Commission, 15 November 2024 T6188.23-6190.26 (Wakeling); Transcript of the Commission, 15 November 2024, T6192.2-4 (Okulicz); Transcript of the Commission, 29 November 2023, T215.1-216.23 (Lyons).

[866] Transcript of the Commission, 15 November 2024, T6188.36-42 (Wakeling).

[867] Transcript of the Commission, 15 November 2024, T6189.13-31 (Wakeling).

[868] Transcript of the Commission, 23 May 2024, T3350.10-19 (Astill); see also: Transcript of the Commission, 29 November 2023, T216.24-31 (Willcox).

[869] Transcript of the Commission, 23 May 2024, T3350.21-22 (Astill).

[870] Transcript of the Commission, 23 May 2024, T3350.21-37 (Astill).

[871] Transcript of the Commission, 15 November 2024, T6188.3-11 (Wakeling); Transcript of the Commission, 29 November 2023, T216.18-31 (Willcox).

[872] Transcript of the Commission, 15 November 2024, T6187.13-19 (Wakeling); Transcript of the Commission, 15 November 2024, T6199.14-35 (Hawkins); Transcript of the Commission, 15 November 2024, T6202.14-41 (Okulicz); Transcript of the Commission, 15 November 2024, T6203.20-31 (Shortis); Transcript of the Commission, 29 November 2023, T216.24-31 (Willcox).

11.85. 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".[873] This significantly oversimplifies the arrangements made under the *Addendum to the NHRA*. Further, state involvement in the delivery of aged care is not a radical concept. In this respect, Victoria has maintained a presence in the aged care market and, like private providers of aged care services, is funded by the Commonwealth to do so. NSW Health has also maintained a presence in the aged care market through Multi Purpose Services located in rural and regional areas, and Commonwealth funding is provided for these services.

11.86. In the metropolitan areas of NSW, and particularly in the Illawarra, the serious problems I have alluded to above 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 aged care patients who 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.

National Disability Insurance Scheme patients

11.87. A similar issue arises in relation to patients who are suitable for discharge but waiting on NDIS acceptance and support. In November 2024, in the Illawarra Shoalhaven LHD, there were 38 NDIS patients in this category occupying hospital beds.[874] Of these, 40 per cent were in the LHD's mental health bed base, and 60 per cent in its subacute bed base.[875] This has a similar impact on the bed flow of facilities to aged care patients.[876]

11.88. Pamela Rutledge AM, Board Member of Nepean Blue Mountains LHD, identified the same challenges with bed flow for those waiting on NDIS acceptance and support, and for those otherwise unable to access appropriate supports under the NDIS, as an ongoing issue in the district upon which the Board receives regular reports. [877]

[873] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2024) [9.47] [SCI.0011.0814.0001 at 0058].

[874] Transcript of the Commission, 15 November 2024, T6153.30-38 (Wakeling).

[875] Transcript of the Commission, 15 November 2024, T6153.30-38 (Wakeling).

[876] Transcript of the Commission, 15 November 2024, T6188.26-34 (Wakeling); See also: Transcript of the Commission, 29 November 2023, T215.12-23 (Lyons).

[877] Transcript the Commission, 23 April 2024, T2371.16-33 (Rutledge).

11.89. Ms Rutledge stated that 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.[878] Likewise, Jill Wong, then the Director Integrated Care, Allied Health and Community Services in the Mid North Coast LHD, recounted the practice in her district of what she termed "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.[879] These were not isolated examples. I was told of similar issues during visits to other LHDs.

11.90. Allied health clinicians often absorb the brunt of such circumstances, having become (by default) "expected to undertake onerous and time intensive assessments and report writing" in addition to their core responsibilities.[880] These scenarios also lead to burnout, with staff undertaking significant amounts of overtime, as well as psychological distress from having to deal with behaviourally challenged patients who can also be physically violent.[881]

11.91. 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.

Conclusion

11.92. Access to good primary care is crucial to keeping people healthy and well. However, across the State there are many places where people are unable to access that care – either in a timely way, or at all. Some regions have experienced total market failure in the sense that they do not have general practices (or other primary care providers). In others, those primary care providers that are there have closed books or long waits for appointments.

11.93. The notion that primary care is solely a Commonwealth Government responsibility (one that has been held, at least by some in NSW Government and NSW Health) should be discarded. It was, in my view, always wrong. Not only do I consider it to be inconsistent with the *Addendum to the NHRA* and aspects of the *Health Services Act*, it did not sit comfortably with NSW Health describing itself as a primary care provider "of last resort".

11.94. In any event, having regard to the widespread lack of access to timely primary care across the State, and the importance of primary care to the health and wellbeing of the population, NSW Health must now be proactive – rather than reactive – in

[878] Transcript the Commission, 23 April 2024, T2381.43-2382.18 (Rutledge).

[879] Exhibit K.52, Statement of Jill Wong (6 September 2024) [17] [MOH.0011.0061.0001 at 0004]; Transcript of the Commission, 18 September 2024, T5297.11-33 (Wong).

[880] Exhibit K.52, Statement of Jill Wong (6 September 2024) [18] [MOH.0011.0061.0001 at 0005].

[881] Transcript of the Commission, 15 November 2024, T6209.32-47 (Okulicz).

addressing this issue. That requires NSW Health – as part of the wider needs analysis and service planning process that I discuss elsewhere – to identify where there are service and access gaps in primary care and determine how they are to be filled. Where this analysis identifies that NSW Health should be providing or supporting the provision of primary care to a community, it should do so. NSW Health has demonstrated the significant benefits (to the individual, the community, and the system) that can be achieved when it has done just that.

11.95. In providing that primary care service, or supporting the delivery of primary care, the NSW Government should (of course) seek appropriate funding contributions from the Commonwealth Government. However, the delivery of vital primary care to the people of NSW should not await the outcome of those discussions. Nor should it cease in the unlikely event that the Commonwealth Government abandoned its responsibility to fund the delivery of primary care. If the service planning process that I discuss elsewhere identifies the delivery (or support) of primary care as the best use of NSW Health's limited resources to meet the needs of the population, that should occur irrespective of the status of funding negotiations or agreements between the State and Commonwealth.

11.96. A similar approach is also required in response to widespread market failure in the aged care sector. It is to the detriment of both the individual, and the system, for people to remain in an acute setting when they could (and should) be in an aged care facility. Once again, there will inevitably be locations in which NSW Health will need to step in and deliver that care; just as it is already doing through numerous MPSs located in rural and remote areas of the State.

11.97. As a matter of practical reality, this means that NSW Health must significantly increase its involvement in the delivery of primary care and aged care.

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.

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.

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

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12.1. 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;[882]

b. the governments of Australia commit to achieving equality of access to primary healthcare and health infrastructure within 10 years for First Nations Peoples;[883]

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;[884] 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 Commonwealth Government, with the ultimate objective of increasing the level of flexibility in the deployment of that funding pool.[885]

12.2. That report was the catalyst for a wide range of governmental plans, actions, agreements, and reports that have come to be described as Closing the Gap initiatives. The evidence received by this Special Commission suggests that, in the almost 20 years since that report was delivered (and despite the well intentioned efforts of many working within the public health system), little progress has been made in relation to what I assume to have been the objectives of Mr Calma's recommendations.

12.3. More than 200,000 First Nations people live in NSW, comprising 3.4 per cent of the State's population and 33 per cent of all First Nations people nationally.[886] About 80 per cent of First Nations people in NSW live in cities or inner regional areas, but those living in outer regional and remote areas comprise a higher proportion of the population in those regions.[887]

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[882] Aboriginal & Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005* (Report No 3/2005, 22 November 2005) pp 16, 96 (Recommendation 1).

[883] Aboriginal & Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005* (Report No 3/2005, 22 November 2005) p 96 (Recommendation 2(a)).

[884] Aboriginal & Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005* (Report No 3/2005, 22 November 2005) p 96 (Recommendation 2(c)).

[885] Aboriginal & Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005* (Report No 3/2005, 22 November 2005) p 96 (Recommendation 2(c)).

[886] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022]; Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [60] [MOH.9999.0001.0001 at 0009].

[887] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022].

12.4. Although there have been improvements in some categories of health measures in recent years,[888] the First Nations population continues to have an average life expectancy eight to 10 years less than that of non-Indigenous people, and a higher rate of potentially avoidable deaths.[889] In one survey, fewer than three in 10 First Nations adults aged 18–64 were considered to be in good health compared to more than half of non-Indigenous people in the same age group.[890]

12.5. First Nations people have higher hospitalisation rates and a greater burden of disease, but often less equitable access to medical services and procedures, and a lack of access to culturally appropriate care.[891] Cardiovascular diseases, mental and substance use disorders, cancers, respiratory diseases, and injuries are the leading causes of disease burden.[892]

12.6. First Nations people are also significantly over represented in suicide statistics and incarceration rates (2,500 per 100,000 compared to a rate of 160 per 100,000 for non-Indigenous people).[893]

12.7. An AIHW analysis of survey data identified five social determinants that explain 35 per cent of the health gap for First Nations people, and six health risk factors responsible for another 30 per cent of the gap.[894] Of the five social determinants, those with the greatest impact are: employment status (and hours worked), followed closely by household income, then schooling level, highest non-school qualification, and housing quality.[895] The six risk factors identified were (in order of impact): smoking followed by overweight/obesity, then fruit and vegetable consumption, physical exercise level, binge drinking, and high blood pressure.[896] Based on this analysis, the authors nominated the areas that would contribute most to closing the

[888] Exhibit B.36, NSW Health, *Annual Report 2022–2023* (Report, November 2023) pp 311–312 [SCI.0001.0059.0001 at 0320–0321].

[889] Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander life expectancy: reference period 2020-2022' (Web Page, 29 November 2023) <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release>; Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022]; Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [107] [MOH.9999.0001.0001 at 0016].

[890] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) p 164 [SCI.0011.0499.0001 at 0176].

[891] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 19 [MOH.0001.0320.0001 at 0037].

[892] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022].

[893] Transcript of the Commission, 15 May 2024, T2807.29–35 (Kealy-Bateman). See also Transcript of the Commission, 19 March 2024, T1289.12–42 (Manzie).

[894] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) p 161 [SCI.0011.0499.0001 at 0173].

[895] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) pp 161, 171 [SCI.0011.0499.0001 at 0173, 0183].

[896] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) pp 161, 171 [SCI.0011.0499.0001 at 0173, 0183].

health gap as boosting Year 12 school completion rates, increasing employment and weekly hours of work, and reducing smoking prevalence and obesity rates.[897]

12.8. There is some overlap between social determinants and health risk factors, and First Nations people also have higher rates of chronic stress and intergenerational trauma due to inequities that stem from colonisation.[898] Nevertheless, it is estimated that 49 per cent of the disease burden experienced by First Nations people could be prevented by a reduction in modifiable risk factors.[899]

12.9. Notwithstanding their significantly higher burden of disease, First Nations people only use health services slightly more frequently than the wider population, which has been attributed to barriers such as racism and discrimination, cultural insensitivity of health services, long distances needed to travel, and out of pocket costs.[900] The AIHW has reported that approximately a third of the gap is unexplained by survey data, and as well as access and discrimination, the cumulative effects of life events, social determinants and risk factors may play a role.[901] In contrast, demographic and geographic factors contributed to a limited degree.[902]

The experiences of First Nations people in accessing care

12.10. This Special Commission has heard evidence that many First Nations people will not access mainstream health services, or will avoid particular facilities in their regions, as the care delivered is not culturally safe.[903] Due to a lack of trust in the system, many First Nations people, no matter how sick they are, are more likely to present to an ACCHO or AMS than call Triple Zero or present at a hospital.[904] As a result, First Nations people are potentially missing out on vital care.[905]

12.11. The reasons why individuals make decisions around whether and where to access care are varied. However, this Special Commission has heard that racism remains a pervasive issue impacting the experiences of First Nations people in their interactions with public services, including health services. In this respect, evidence given by First

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[897] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) p 178 [SCI.0011.0499.0001 at 0190].

[898] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) pp 168–169 [SCI.0011.0499.0001 at 0180–0181]; Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022].

[899] Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 5 [SCI.0001.0027.0001 at 0005].

[900] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 15 [SCI.0009.0020.0001 at 0022].

[901] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) pp 169–170 [SCI.0011.0499.0001 at 0181–0182].

[902] Exhibit M.16, Australian Institute of Health and Welfare, *Australia's Health 2024: Data Insights* (Report, 10 June 2024) p 168 [SCI.0011.0499.0001 at 0180].

[903] Transcript of the Commission, 14 May 2024, T2750.15–22 (Knight); Transcript of the Commission, 28 November 2024, T6730.23–32 (L Bellear).

[904] Transcript of the Commission, 27 November 2024, T6629.8–18 (Burling).

[905] Transcript of the Commission, 28 November 2024, T6737.41–6738.2 (Newman).

Nations people to this Special Commission describes their experiences of racism in those public health settings as being sometimes passive and at other times "in your face" and "nasty."[906] They observe that racism may be intentional or unintentional.[907] "Unconscious bias" is another term often used to describe attitudes and stereotypes that change a person's perceptions and affect their decisions or actions without them realising this.[908] An unconscious bias is often subtle, but it leads to discrimination if the bias results in a person being treated differently or not receiving treatment they need.[909] Views may differ as to whether unconscious bias amounts to racism *per se*, however, some believe that using the term "unconscious bias" provides an excuse to be racist.[910]

12.12. Whatever name might be given to it, race based decisions (conscious or otherwise) create the very real potential for serious misdiagnoses in First Nations people.[911]

12.13. I was told that, despite years of training, promotions, and policies aimed at preventing it, culturally unsafe practices and behaviours persist, and will likely continue unless those who display such behaviours are made accountable for them on a consistent basis.[912] It goes almost without saying that any clinically unsafe service or clinician would be promptly addressed by NSW Health and, if faced with the choice between offering a clinically unsafe service or no service at all, NSW Health would always opt for the latter. There is no reason why cultural safety should not be approached in the same way.[913] Evidence received by this Special Commission suggests that, in practice, this may not be happening, at least as promptly as it should.

12.14. In some locations, Aboriginal Liaison Officers have been engaged. However, this has not necessarily reduced the incidence of culturally unsafe behaviours, partly because the Aboriginal Liaison Officers have limited authority to challenge the attitudes and behaviours of others, and in part because they are expected to be everywhere in the hospital at once as there are so few of them.[914] I was told that First Nations people are fearful of making complaints about the behaviours of health staff because they

[906] Transcript of the Commission, 14 May 2024, T2750.27–41 (Knight/McHughes); Transcript of the Commission, 27 November 2024, T6625.28–34 (Tongs), T6628.1–3 (Peckham).

[907] Transcript of the Commission, 14 May 2024, T2753.27–2754.33 (Gordon).

[908] Exhibit H1.95.2, College of Intensive Care Medicine, *Prevention of Bullying, Discrimination and Harassment in the Workplace* (Policy IC-20, 2024) p 11 [SCI.0011.0284.0001 at 0011].

[909] Exhibit H1.95.2, College of Intensive Care Medicine, *Prevention of Bullying, Discrimination and Harassment in the Workplace* (Policy IC-20, 2024) pp 11–12 [SCI.0011.0284.0001 at 0011–0012].

[910] Transcript of the Commission, 28 November 2024, T6736.45–6737.11 (Newman).

[911] Transcript of the Commission, 14 May 2024, T2753.27–2754.33 (Gordon), T2759.22–2760.20 (McHughes); Transcript of the Commission, 27 November 2024, T6641.23–42 (Rose).

[912] Transcript of the Commission, 28 November 2024, T6736.40–6737.6 (Newman).

[913] Transcript of the Commission, 23 May 2024, T3373.12–33 (Astill).

[914] Transcript of the Commission, 27 November 2024, T6644.8–9 (Rose); Transcript of the Commission, 28 November 2024, T6736.7–38 (Newman).

experience repercussions, and there is a perception that there are never any consequences for the staff member about whom they complained.[915]

12.15. The experiences of First Nations people in accessing care have also resulted in high rates of patients being recorded as "did not wait" or "discharged against medical advice".[916] This has led to the term "take own leave" being coined to refer to situations when a person does not wait for care or leaves before their treatment has been completed, and the need to investigate the reasons why this occurs and find solutions.[917]

12.16. Unsurprisingly, the *NSW Aboriginal Health Plan 2024–2034* describes the elimination of racism as being pivotal to success of the Plan.[918] For example, identifying and eliminating racism is a key focus for priority reform area 3 (Transforming government organisations), and it is said there is "an urgent need to address the devastating consequences of racism".[919] However, other than a plan to establish "clear, consistent and easily accessible anti racism policies and procedures", the actions do not identify with clarity how this is to be achieved or measured, nor what responses are to be taken if substantiated instances of racism are identified within the system.[920]

12.17. Racism was also highlighted as an issue in the *NSW Aboriginal Health Plan 2013–2023,* as was the need to develop policies and processes for "culturally safe work environments and culturally respectful and secure health service provision".[921] In the mid-term review of that Plan, it was reported that some LHDs were focussed on preventing it through cultural training and needed to do more work on systems for identifying and responding to incidents of racism.[922] The mid-term review made recommendations about further actions that were required to address racism;[923] although it is somewhat unclear to what extent these were implemented.

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[915] Transcript of the Commission, 14 May 2024, T2764.38–2765.45 (Gordon/Knight/Shillingsworth).

[916] Transcript of the Commission, 27 November 2024, T6630.4–8 (Samuelsson); Transcript of the Commission, 28 November 2024, T6737.10–19 (Newman).

[917] Exhibit F.26, FWLHD, *Safety and Quality Account: 2022–23 Report and 2023–24 Future Priorities* (Report, 28 August 2023) p 67 [MOH.9999.1282.0001 at 0067].

[918] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) pp 2–3, 9 [SCI.0011.0744.0001 at 0006–0007, 0013].

[919] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) pp 19, 21 [SCI.0011.0744.0001 at 0023, 0025].

[920] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 21 [SCI.0011.0744.0001 at 0025].

[921] Exhibit D.1.125, NSW Health, *NSW Aboriginal Health Plan 2013–2023* (December 2012) p 15 [MOH.9999.0881.0001 at 0017].

[922] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 4 [SCI.0009.0020.0001 at 0011].

[923] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 10 [SCI.0009.0020.0001 at 0017].

Initiatives to enhance cultural safety

12.18. NSW Health told me that it has a strong focus on improving health outcomes for First Nations people and that significant work has been done to achieve this.[924] While I do not wish to downplay the importance of this work, there is a significant risk that it has focussed more on process than outcomes. For example:

a. requiring at least one Board member of each LHD Board to have expertise, knowledge or experience in relation to First Nations health[925] is entirely logical, but adds very little if that individual cannot truly influence decisions made by the Board or – as seems most likely – operational matters at every level within the LHD.[926] It is not clear how (if at all) this limitation is to be addressed or monitored;

b. requiring NSW Health organisations to prepare an Aboriginal Health Impact Statement in the early stages of service planning[927] is undoubtedly useful but, as I note below, it will be of limited benefit if First Nations people, ACCHOs and AMSs are not actively engaged as ongoing participants in local health planning and in the delivery of care;

c. reallocating responsibility for the Centre for Aboriginal Health so that it reports directly to the Office of the Secretary[928] indicates that it is being taken seriously by those at the highest level within NSW Health. I have no doubt that it is, but this is not where meaningful change and real action is most needed; and

d. the incorporation of KPIs related to First Nations health in service agreements for LHDs and SHNs[929] will only be of limited use unless they assess the extent and effectiveness of NSW Health's collaboration with First Nations people and ACCHOs in service planning activities, measure the outcomes sought to be achieved through those joint planning activities and measure wider health outcomes for First Nations people within the relevant district.

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[924] Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.4] [SCI.0011.0814.0001 at 0141–0142].

[925] Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.4(a)(i)] [SCI.0011.0814.0001 at 0141].

[926] Transcript of the Commission, 23 May 2024, T3254.37–3256.38 (Files).

[927] Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.4(a)(iii)] [SCI.0011.0814.0001 at 0142].

[928] Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.4(a)(iv)] [SCI.0011.0814.0001 at 0142].

[929] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.4(a)(ii)] [SCI.0011.0814.0001 at 0142].

12.19. While those initiatives are a step in the right direction, they fall well short of ensuring, to the greatest extent possible, that First Nations people are receiving the care they need, where they need it, in a culturally safe way.

12.20. Clinical safety is inextricably linked with cultural safety, and optimising cultural safety involves dedicated, planned actions to effect institutional change.[930]

12.21. The key driver of cultural safety is listening to First Nations people and developing genuine cultural awareness. When it actually occurs, this allows for creation of appropriate policies and guidelines.[931] For example, I was told that Broken Hill Health Service partnered with the community to understand its high rate of “did not waits”, then worked with the Emergency Department to improve cultural safety and communication, which led to a dramatic improvement.[932] However, it is difficult to sustain such improvements if collaboration is not ongoing. Where there is a lack of stability in staffing, improvements tend to slip backwards.[933]

12.22. NSW Health describes cultural safety as a priority and states its focus is to address racism and unconscious bias through delivery of “Respecting the Difference” training.[934] The accounts provided to me by First Nations people during roundtable discussions, together with the evidence provided by First Nations witnesses, suggests that this training module is not a sufficient response to what is a real threat to safe and effective healthcare for First Nations people and a barrier to them accessing that care.

12.23. All NSW Health staff must complete eLearning and face to face “Respecting the Difference” training, which includes consideration of cultural safety and identifying opportunities to implement learnings.[935] Participants are apparently required to reflect on “racism, unconscious bias, white privilege, the dominance of non-Aboriginal cultures as ‘the norm’ in Australia, and how to counteract these ingrained power structures through practicing anti-racism”.[936] Importantly, I was told that staff must acknowledge and analyse their own individual cultural biases.[937]

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[930] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 21 [SCI.0011.0744.0001 at 0025].

[931] Transcript of the Commission, 14 May 2024, T2735.41–2736.16 (McHughes).

[932] Transcript of the Commission, 14 May 2024, T2736.45–2737.45 (Hampton).

[933] Transcript of the Commission, 14 May 2024, T2737.34–42 (Hampton).

[934] Exhibit B.36, NSW Health, *Annual Report 2022–2023* (Report, November 2023) p 86 [SCI.0001.0059.0001 at 0095]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.64]–[14.66] [SCI.0011.0814.0001 at 0158–0159].

[935] Exhibit E.4, NSW Health, *Aboriginal Cultural Training – Respecting the Difference* (Policy Directive No PD2022_028, 15 July 2022) p i [SCI.0009.0017.0001 at 0002].

[936] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 21 [SCI.0011.0744.0001 at 0025].

[937] Exhibit E.32, Australian Health Ministers’ Advisory Council, *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health* (2016) p 9 [SCI.0009.0008.0001 at 0011].

12.24. First Nations cultural awareness training is important for staff from non-Indigenous backgrounds; particularly if working with First Nations patients for short rotations. First Nations communities (rightly and understandably) tire of having to resolve issues created by clinicians who lack cultural awareness.[938] "Respecting the Difference" training may be beneficial in reducing unintentional racism, but much more is needed to address unconscious biases and intentionally racist behaviour, which remain a significant issue within the public health system.

12.25. NSW Health has pointed to the existence of a range of other measures aimed at making improvements in this area, ranging from ongoing initiatives undertaken by LHDs to the establishment by the CEC of an Aboriginal and Torres Strait Islander Patient and Community Serious Incident Review subcommittee to the Clinical Risk Action Group.

12.26. While I certainly do not consider NSW Health's response to issues of racism and cultural safety to be "half-hearted",[939] it is not clear the effectiveness of training and other initiatives that have been implemented is being assessed and monitored. Either way, the preponderance of evidence given to this Special Commission by First Nations people makes clear that the existing training and other initiatives are an insufficient response to what remains a real threat to safe and effective healthcare for First Nations people and a barrier to them accessing the care that they need.

12.27. Cultural safety is also an important consideration in the context of health system innovation. Consultation to explore how best to foster cultural acceptance of an innovation is critical, and uptake should not be assumed simply because it will enhance service access or outcomes. Socio-economic factors and remoteness may affect access to technology, but cultural appropriateness is also important, and this is said to have been a specific consideration in the rollout of virtual care modalities.[940] Innovative models of care also need to reflect a First Nations community's priorities, expectations and cultural context, which will vary from place to place.

12.28. The ACI has a Director of Aboriginal Health and clinical networks to manage the Aboriginal Health program and to assist other networks across the Agency to consider First Nations health issues in an appropriate way.[941] Shared decision making tools have been developed to engage First Nations patients in reducing unwarranted clinical variation, and the Alcohol and Drug Cognitive Enhancement program has been adapted under the name Yellow Gum Healing.[942]

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[938] Transcript of the Commission, 14 May 2024, T2742.16–23 (Gordon), T2766.10–27 (Hampton).

[939] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.52] [SCI.0011.0814.0001 at 0154–0155].

[940] Exhibit B.23.67, NSW Health, *NSW Virtual Care Strategy 2021–2026* (February 2022) pp 12, 15 [MOH.0001.0371.0001 at 0014, 0017].

[941] Transcript of the Commission, 26 February 2024, T1088.19–34 (Levesque).

[942] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [59(d)], [85(e)] [MOH.0001.0435.0001 at 0018, 0033].

12.29. Local innovations are somewhat *ad hoc*, with no shortage of solutions but difficulty obtaining resources to deliver them.[943]

Planning services for First Nations people

12.30. 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 focused on optimising outcomes.

12.31. There are some examples within the system of approaches that support meaningful consultation and collaboration between NSW Health agencies and First Nations healthcare providers when planning services.[944] However, there is abundant evidence to support the conclusion that there is often little or no effective consultation with ACCHOs and AMSs in the planning of health services and facilities locally. Moreover, the evidence suggests reveals that some of the initiatives are viewed by many within ACCHOs and AMSs as tokenistic, rather than substantive collaborations.[945]

12.32. In this context, meaningful consultation does not mean telling the community what is planned, it means identifying a specific community's needs and priorities in collaboration with that community, and codesigning solutions.[946] 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.[947]

12.33. ACCHOs and AMSs expressed frustration to me about what they see as decades worth of missed opportunities to collaborate in the delivery of health services to First Nations people. An example was given of hospital Aboriginal Liaison Officers duplicating part of the assessments being done by the local indigenous services, and leaving them to fill the gap.[948]

12.34. ACCHOs have been told no additional funding is available for the services they provide, only to hear of a request for tender having been issued to provide those same services and of a non-First Nations controlled non-government organisation

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[943] Transcript of the Commission, 14 May 2024, T2746.42–2749.22 (Mason/Gordon); Transcript of the Commission, 28 November 2024, T6800.16–21 (Newman).

[944] See, e.g., Transcript of the Commission, 27 November 2024, T6678.45–6679.24, T6684.25–6685.10 (Falzon).

[945] Transcript of the Commission, 27 November 2024, T6629.23–30 (Burling); Transcript of the Commission, 28 November 2024, T6738.6–36 (Raudino), T6739.34–6740.8 (C Layer), T6774.9–10 (L Bellear).

[946] Transcript of the Commission, 14 May 2024, T2740.4–34 (Hampton).

[947] Transcript of the Commission, 14 May 2024, T2738.18–2739.4 (Hampton).

[948] Transcript of the Commission, 28 November 2024, T6738.45–6739.25 (T Layer).

having been awarded that tender.[949] It was also noted that LHDs are funded to employ Aboriginal cancer navigators, but turn to ACCHOs – which are not funded to perform this function – when they cannot recruit to the positions.[950]

12.35. The evidence indicates that some collaboration occurs at a clinical service level, but it is rare, lacking coordination, and tends to be based on the happenchance of the right individuals in particular roles going out of their way to work together.[951]

12.36. LHDs develop Aboriginal Health Plans to address the needs of First Nations people in their population.[952] ACCHOs are consulted in the development of these plans, but find the level of participation challenging as they are not resourced to perform this role.[953]

12.37. It was suggested, and I accept, that 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.[954] 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.[955] Joint clinical services planning would mean each group can optimise the value of their contribution and facilitate sharing of resources, to reduce duplication through communication and effective referral pathways in both directions.[956] It is also precisely what was recommended by Mr Calma almost two decades ago.

12.38. It is clear that ACCHOs and AMSs want input in the design and planning of new health services and facilities and believe (with good reason) that their knowledge of what works best for their community will make the final result more efficient and effective.[957] Such an approach aligns with the National Safety and Quality Health Service Standards, which require health services to:[958]

a. demonstrate a welcoming environment that recognises the importance of the cultural beliefs and practices of First Nations people; and

b. work in partnership with First Nations communities to meet their healthcare needs.

[949] Transcript of the Commission, 28 November 2024, T6745.8–32 (Newman).

[950] Transcript of the Commission, 27 November 2024, T6697.40–6699.14 (Wheeler/Falzon).

[951] Transcript of the Commission, 27 November 2024, T6683.39–6685.7 (Wheeler/Falzon).

[952] See, e.g., Exhibit D.1.40, NBMLHD, *Aboriginal Health Plan 2021–2026* [MOH.9999.0808.0001]; Exhibit E.13, WNSWLHD, *Improving Aboriginal Health Strategy 2018–2023* [SCI.0009.0037.0001]; Exhibit E.31, FWLHD, *Aboriginal Health Framework 2021* [SCI.0009.0011.0001]; Exhibit I.30.5, SNSWLHD, *Aboriginal Mental Health and Wellbeing Strategy 2020–2025: Implementation Plan* [MOH.0010.0426.0001].

[953] Transcript of the Commission, 27 November 2024, T6635.37–6636.15 (Samuelsson).

[954] Transcript of the Commission, 28 November 2024, T6768.6–15 (Newman).

[955] Transcript of the Commission, 28 November 2024, T6769.2–6770.12 (Newman), T6770.30–6771.42 (L Bellear).

[956] Transcript of the Commission, 28 November 2024, T6776.45–6778.42 (T Layer/Newman); T6782.29–46 (Duroux/Newman).

[957] Transcript of the Commission, 28 November 2024, T6738.13–43 (Raudino), T6740.10–12 (C Layer).

[958] Exhibit D.1.22, Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2021) pp 12, 15 [MOH.9999.0795.0001 at 0016, 0019].

12.39. It is apparent to me that NSW Health genuinely tries to meet these standards. However, the work done by Health Infrastructure NSW "to support the embedding of Aboriginal themes in hospital redevelopment art strategies and the creation of dedicated spaces that support culturally responsive care",[959] while a start, falls short of what is required. As LaVerne Bellear so aptly put it:[960]

> *you know, big hospitals are getting, you know, half a billion dollars worth of resources – "We could do some dot art here and then, mate, that'll make everyone welcome." You know, if that's all that it takes. So, you know, I just think that no one's looking at the needs of the community.*

12.40. There is significant scope to enhance and embed those processes within both system wide planning and at the local level for the benefit of the system and First Nations communities. The *NSW Aboriginal Health Plan 2024–2034* expressly recognises the benefits in doing so.[961]

12.41. However, in pursuing those objectives, it must again be recognised that there is an important difference between "doing things with people" and "doing things to people"; the latter is in no sense a collaboration. An example was given of a town with more than 48 non-government service providers, as well as lead agencies, each working in their own silos, while around them the town was experiencing some of the worst rates of social disadvantage, unemployment, incarceration, and mortality.[962]

Funding services for First Nations people

12.42. LHDs and SHNs are funded in their total budget allocation (not as a separate line item) to provide health services for First Nations people. Some KPIs for health promotion and health services for First Nations people are contained in service agreements,[963] but, like most others, they must be revisited to ensure that they are measuring those things that are likely to result in improved health outcomes, rather than measuring the things that are easily measurable or in respect of which current data sets are available. As I have noted elsewhere in this Report, those KPIs should be geared towards assessing the extent to which the objectives of local planning are being achieved. It goes almost without saying that those objectives must include tangible and measurable strategies aimed at closing the gap.

[959] Exhibit N3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [44] [MOH.0011.0096.0001 at 0009].

[960] Transcript of the Commission, 28 November 2024, T6774.7–12 (L Bellear).

[961] See, e.g., Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) pp 4, 16, 18 [SCI.0011.0744.0001 at 0008, 0020, 0022].

[962] Transcript of the Commission, 14 May 2024, T2740.36–2741.39 (Gordon), T2770.24–30 (Mason).

[963] Exhibit B.23.27, NSW Health, *Sample Local Health District Service Agreement 2023–24*, pp 22–25, 29–31 [MOH.0001.0288.0001 at 0023–0026, 0030–0032].

12.43. The Ministry of Health also gives grants to a range of non-government organisations to provide general and specialised health services to First Nations people and/or to conduct Indigenous health research. In 2023–24, these grants totalled in excess of $40 million.[964]

12.44. Some ACCHOs and AMSs receive funding from NSW Health though those grants in addition to the funding they receive from other sources – such as the Commonwealth Department of Health and Aged Care, PHNs, and the NSW Rural Doctors Network.[965] In addition, they bill Medicare to fund general practitioners, and may pursue business opportunities to generate income they can use to bolster services.[966]

12.45. Evidence received by this Special Commission makes clear that funding received by ACCHOs and AMSs is inadequate given the magnitude of the health gap First Nations people face and the range of services required for their complex healthcare needs.[967] For example, ACCHOs and AMSs identified patient transport as an issue which they are routinely called upon to address, often because a First Nations person requiring that transport has been told by people within the public health system to approach those organisations to arrange that transport. ACCHOs and AMSs do make these arrangements – because without transport, a member of their community would not receive the care they need – but there is no provision for that transport in their funding.[968] Patient transport is a necessary service, particularly in rural areas, because without it people cannot travel to receive medical care they need, so innovative solutions are sought such as trying to negotiate with Transport for NSW to fund bus trips.[969]

12.46. However, this Special Commission has heard that the quantum of funding received by ACCHOs and AMSs is only one of their concerns, with a number of other related challenges being identified that could be addressed without needing to increase the overall funding envelope.

12.47. First, they have little if any autonomy in terms of how they are permitted to use the funding they receive, with the result that they cannot pool resources and allocate them in line with priorities in their communities.[970] They receive several tied funding allocations from different sources, and are often prevented from using funds in ways

[964] Exhibit N.3.27, NSW Health, *Annual Report 2023–2024* (Report, November 2023) pp 123–145 [SCI.0011.0717.0001 at 0131–0153].

[965] Transcript of the Commission, 27 November 2024, T6682.41–45, T6691.26 (McCowen); Transcript of the Commission, 28 November 2024, T6728.31–6729.1 (Lester), T6756.3–38 (T Layer).

[966] Transcript of the Commission, 27 November 2024, T6631.4–6 (Samuelsson); Transcript of the Commission, 28 November 2024, T6723.33–35 (MacQueen), T6727.8–35 (C Layer), T6762.23, T6796.40–47 (Raudino).

[967] Transcript of the Commission, 27 November 2024, T6629.32–35 (Burling), T6633.30–38 (Samuelsson), T6682.39–6683.18 (McCowen).

[968] Transcript of the Commission, 28 November 2024, T6722.42–6723.14 (Duroux/L Bellear/Roxburgh), T6728.9–11 (C Layer).

[969] Transcript of the Commission, 14 May 2024, T2747.25–38 (Mason).

[970] Transcript of the Commission, 28 November 2024, T6773.22–6774.33 (L Bellear/Raudino/C Layer).

they believe would be of more value for patients.[971] They receive little funding for health promotion and preventive care, even though they see these as priorities to reduce the incidence of chronic disease.[972]

12.48. Tying funds to the delivery of particular programs sits uncomfortably with principles of self-determination and sacrifices the benefits of devolution, which have been referred to above in the context of LHDs.

12.49. Funds could be used more effectively if ACCHOs and AMSs had more control over how they could be used, as this would enable them to allocate funding to reflect the needs and priorities of their communities.[973] This is consistent with the Strengthening Medicare Taskforce recommendation to invest in ACCHOs and AMSs to commission primary care services for their communities.[974] It is also consistent with the current NSW Health *Aboriginal Health Plan*.[975] But it does not occur.

12.50. Secondly, funding is regularly provided on a short term basis, yet it frequently takes longer than the period in respect to which funding is provided to establish and implement programs, and ongoing resources are needed to sustain them.[976] As I have observed elsewhere in this Report, similar issues have been raised by other non-government organisations, and even within NSW Health more broadly. There are inconsistencies between the length of existing plans for First Nations health (10 years), and funding duration for programs such as palliative care, which will always be needed.[977] There is a perception that government is not realistic about trusting ACCHOs and AMSs with longer term funding streams.[978]

12.51. The short term nature of the funding has significant workforce disadvantages. It makes it hard to attract staff, particularly if they have to relocate, because only short term contracts can be offered when ongoing funding is uncertain.[979] Alternatively, staff may have to be let go when the funding for a program ceases, and this can have a negative effect on the community.[980] It was also noted that, when a program is working well then suddenly ends because no further funding has been obtained,

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[971] Transcript of the Commission, 28 November 2024, T6782.29–35 (Duroux).

[972] Transcript of the Commission, 28 November 2024, T6749.38–6752.17 (L Bellear/C Layer).

[973] Transcript of the Commission, 27 November 2024, T6708.3–4 (Falzon), T6709.4–24 (Falzon/Longbottom); Transcript of the Commission, 28 November 2024, T6727.37–40 (C Layer).

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

[975] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) pp 9, 17–18 [SCI.0011.0744.0001 at 0013, 0021–0022].

[976] Transcript of the Commission, 27 November 2024, T6695.7–42 (Falzon/Longbottom), T6672.6–17 (Edwards); Transcript of the Commission, 28 November 2024, T6757.43–6758.8 (Raudino), T6760.6–42 (Binge).

[977] Transcript of the Commission, 27 November 2024, T6695.35–39 (Longbottom); Transcript of the Commission, 28 November 2024, T6768.23–34 (Newman).

[978] Transcript of the Commission, 28 November 2024, T6760.6–42 (Binge).

[979] Transcript of the Commission, 28 November 2024, T6768.29–34 (Newman).

[980] Transcript of the Commission, 27 November 2024, T6695.27–31 (Longbottom).

people who work in the ACCHO/AMS sometimes find themselves the target of the community's frustration.[981]

12.52. Access to specialist services is an ongoing challenge, in part because specialists will not relocate to areas of need because programs only have short term funding.[982] Although some ACCHOs and AMSs have outreach services from visiting specialists, others have none and must transport patients further afield.[983] Some specialists accept just the Medicare payment, but in other cases the cost may be prohibitive, and some services fundraise to offset costs so people receive investigations and care they need.[984]

12.53. ACCHOs and AMSs also find that the short term funding for delivery of programs does not fully cover the associated costs of management, administration, transport, and overheads.[985]

12.54. Thirdly, reporting requirements were consistently described as onerous, with a high administrative burden associated with reporting and acquittals across multiple different programs, taking up resources that could be put to better use.[986] Some ACCHOs and AMSs are required to prepare around 100 reports per year for various government agencies.[987] In some instances, the reporting burden may outweigh the benefit of the funding stream.[988] As a consequence, there can be a reluctance to apply for funding, or a need to decline funding that is offered, because the amount in question does not justify assuming the additional reporting obligations.[989] The burden of those onerous reporting obligations is amplified by the fact that funding towards administration costs incurred by those organisations is limited.[990]

12.55. It is also said that the targets and performance indicators against which ACCHOs/AMSs must report always focus on outputs, but there is no reporting on outcomes.[991] There is a strong focus on quantitative data and no apparent interest in qualitative information – for example, they may have to report how many kidney health checks were done, but not what the results were, whether people received

[981] Transcript of the Commission, 28 November 2024, T6762.25–43 (C Layer).

[982] Transcript of the Commission, 27 November 2024, T6688.19–24 (McCowen); Transcript of the Commission, 28 November 2024, T6768.29–34, T6777.9–18 (Newman).

[983] Transcript of the Commission, 27 November 2024, T6617.40–6618.1 (Simon), T6627.8–12 (Peckham), T6629.39–43 (Burling).

[984] Transcript of the Commission, 27 November 2024, T6642.2–33 (Rose), T6706.9–22 (Falzon).

[985] Transcript of the Commission, 27 November 2024, T6686.37–44 (Falzon), T6695.21–25 (Longbottom); Transcript of the Commission, 28 November 2024, T6796.43–6797.18 (Raudino).

[986] Transcript of the Commission, 27 November 2024, T6691.26–34 (McCowen), T6695.44–46 (Longbottom); Transcript of the Commission, 28 November 2024, T6761.29–33 (Binge), T6772.22–31 (Raudino), T6780.30–36 (T Layer).

[987] Transcript of the Commission, 27 November 2024, T6645.9–41 (Tongs).

[988] Transcript of the Commission, 27 November 2024, T6660.33–42 (Samuelsson).

[989] Transcript of the Commission, 27 November 2024, T6690.40–47 (McCowen); Transcript of the Commission, 28 November 2024, T6773.2–9 (L Bellear).

[990] Transcript of the Commission, 27 November 2024, T6660.44–6661.5 (Samuelsson).

[991] Transcript of the Commission, 27 November 2024, T6696.1–21 (Falzon); Transcript of the Commission, 28 November 2024, T6767.40–6768.4 (Newman).

appropriate referrals, how long they had to wait for specialist care, and so on.[992] Organisations feel the need to balance demonstrating outputs such as number of patients seen (which is required to obtain more funding) with the need to ensure patients are seen for as long as it takes to properly deliver the care that they require, as this is what will help to achieve better outcomes for them.[993]

12.56. Finally, it was noted that there are inefficiencies in the funding mechanisms for First Nations health services, including multiple layers between the funding source and the service provider, adding administrative costs and diverting funding streams away from clinical services.[994]

12.57. Some of those challenges are recognised in *NSW Aboriginal Health Plan 2024–2034*.[995]

Current NSW Health initiatives

12.58. I am comfortably satisfied that 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.

12.59. Several NSW Health plans and policies outline such objectives. They include:

a. *Future Health Strategy*, which has a specific objective to "Close the gap by prioritising care and programs for Aboriginal people", by addressing racism, embedding cultural safety, delivering services in partnership, and improving engagement with Aboriginal people.[996] Significantly to the issues outlined above, it highlights the value of learning from Aboriginal people, and emphasises the need to focus on equitable outcomes and strengthen the Aboriginal health workforce;[997]

b. the *NSW Regional Health Strategic Plan 2022–2032*, which includes a number of objectives specifically intended to support Aboriginal people. They include career pathways for Aboriginal health staff, improved access and equity to health services, investment in prevention and early intervention, building engagement, and expanding integrated care;[998]

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[992] Transcript of the Commission, 28 November 2024, T6766.1–39 (L Bellear).

[993] Transcript of the Commission, 27 November 2024, T6661.7–38 (Samuelsson); Transcript of the Commission, 28 November 2024, T6725.25–47, T6763.10–27 (T Layer).

[994] Transcript of the Commission, 27 November 2024, T6710.24–45 (Falzon/Longbottom).

[995] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 4, 16, 18 [SCI.0011.0744.0001 at 0008, 0020, 0022].

[996] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 35 [MOH.0001.0320.0001 at 0053].

[997] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) pp 29, 35, 40 [MOH.0001.0320.0001 at 0047, 0053, 0058].

[998] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) pp 29, 36–38, 44–45, 51–53, 59–60 [MOH.0001.0372.0001 at 0029, 0036–0038, 0044–0045, 0051–0053, 0059–0060].

c. "Brighter Beginnings", a whole of government initiative that aims to give children the best start in life from conception to the age of five, has a particular focus on Aboriginal children and is supported by the *NSW Health First 2,000 Days Framework*;[999] and

d. the Aboriginal Procurement Policy, which is intended to support Aboriginal employment opportunities and business growth by setting targets for government clusters to procure goods and services from Aboriginal businesses.[1000] NSW Health has published the *Aboriginal Procurement Participation Strategy*, which confirms its commitment to the whole of government policy.[1001] The *Participation Strategy* identifies priorities to help NSW Health reach its targets, which for 2022 were $19.6 million spend and 66 contracts.[1002]

12.60. In addition to the above, I have been told by representatives of the Centre for Aboriginal Health about the *NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework* and the *NSW Aboriginal Health Transformation Agenda*.[1003]

12.61. The *NSW Aboriginal Health Plan 2013–2023* defined the following six strategic directions and identified the actions required and the entity responsible for them:[1004]

a. building trust through partnerships;

b. implementing what works and building the evidence;

c. ensuring integrated planning and service delivery;

d. strengthening the Aboriginal workforce;

e. providing culturally safe work environments and health services; and

f. strengthening performance monitoring, management and accountability.

12.62. The mid-term evaluation of the *NSW Aboriginal Health Plan 2013–2023* found there had been "moderate" progress against these six strategic directions, noting some successes and identifying areas that needed improvement.[1005] Successes included an increase in staff who identify as Aboriginal, a reduction in incomplete Emergency

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[999] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) pp 44–45 [MOH.0001.0372.0001 at 0044–0045].

[1000] Exhibit B.23.21, NSW Government, *Aboriginal Procurement Policy* (January 2021) p 1 [MOH.0001.0277.0001 at 0003].

[1001] Exhibit B.23.115, NSW Health, *Aboriginal Procurement Participation Strategy* (March 2022) p 4 [MOH.0001.0276.0001 at 0006].

[1002] Exhibit B.23.115, NSW Health, *Aboriginal Procurement Participation Strategy* (March 2022) pp 3, 5–6 [MOH.0001.0276.0001 at 0005, 0007–0008].

[1003] Exhibit N3.30, Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon (10 December 2024) [28]–[38] [MOH.0011.0096.0001 at 0006–0007].

[1004] Exhibit D.1.125, NSW Health, *NSW Aboriginal Health Plan 2013–2023* (December 2012) pp 10–16 [MOH.9999.0881.0001 at 0012–0018].

[1005] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 5 [SCI.0009.0020.0001 at 0012].

Department visits, and lower rates of unplanned hospital readmissions in some LHDs.[1006]

12.63. The mid-term evaluation report made a number of recommendations to address the deficits identified in the review, which broadly covered the following areas:[1007]

a. build and maintain meaningful partnerships between LHDs and Aboriginal Community Controlled Health Services to drive strategic planning, shared priorities, and accountability to First Nations communities. Additionally, establish tools and mechanisms to evaluate the quality of those partnerships;

b. enhance whole of government activities to address the social determinants of health through education, housing, aged care, and the NDIS;

c. invest in Aboriginal Community Controlled Health Service-led research, elevate the focus on First Nations health in mainstream research, prioritise studies of what works in First Nations health for NSW Health grant schemes, explore ways to ensure engagement in research design and foster knowledge translation;

d. increase the focus on improving access to care, patient experiences and health outcomes of First Nations people in whole of health system integrated care initiatives, investigate integrated care issues and implement solutions, and collaborate to define and implement holistic models of health and wellbeing;

e. strengthen intersectoral work through data sharing and joint planning between State and Federal governments and between NSW Government departments to leverage the potential for data linkage and improve service delivery and health outcomes;

f. build the First Nations health workforce;

g. promote and strengthen implementation of the Aboriginal Health Impact Statement, and drive an increase in completion rates of Respecting the Difference training to 80 per cent;

h. manage episodes of "take own leave"[1008] as clinical incidents to identify triggers like racism, support health organisations to deliver services free from racism with stronger policies and procedures to address instances of racism, and develop strategies and resources to build cultural safety;

i. develop and implement an Aboriginal governance and accountability framework, have Directors/Managers of Aboriginal Health report to LHD Chief Executives,

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[1006] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) pp 3–4 [SCI.0009.0020.0001 at 0010–0011].

[1007] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) pp 6–12 [SCI.0009.0020.0001 at 0013–0019].

[1008] "Take own leave" refers to when a person did not wait for care or left before their treatment was completed: see Exhibit F.26, FWLHD, *Safety and Quality Account: 2022–23 Report and 2023–24 Future Priorities* (Report, 28 August 2023) p 67 [MOH.9999.1282.0001 at 0067].

build ways for the NSW Aboriginal Strategic Leadership Group to inform LHD planning, and enhance First Nations health capacity, focus and expertise on the boards of LHDs and SHNs; and

j. monitor progress towards culturally safe health services through improved information in patient experience surveys, enhance and use dashboards to prioritise action and accountability for First Nations health, and continue to build clinical safety and quality of the health system for First Nations people.

12.64. The *NSW Aboriginal Health Plan 2024–2034* is more comprehensive than its predecessor. It starts by defining commitments to the ways of working with culture at the centre surrounded by self-determination, cultural safety, equity, and truth telling and healing,[1009] and adopts the four interconnected national "Closing the Gap Priority Reforms". It adds a fifth priority reform specifically for NSW, as follows:[1010]

a. formal partnerships and shared decision making;

b. building the community controlled sector;

c. transforming government organisations;

d. shared access to data and information at a regional level; and

e. employment, business growth and economic prosperity (NSW addition).

12.65. The priority reform areas are described as "cross-cutting enablers of change for structural and systemic transformation across the health system".[1011] Underpinning all the priority reform areas are five strategic directions for strategic focus and tactical action:[1012]

a. growing and supporting the Aboriginal health workforce;

b. providing holistic, integrated, and person centred care;

c. enhancing health promotion, prevention and early intervention;

d. addressing the social, cultural, economic, political, commercial and planetary determinants of health; and

e. strengthening monitoring, evaluation, research and knowledge translation.

[1009] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 6 [SCI.0011.0744.0001 at 0010].

[1010] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) pp 8–9 [SCI.0011.0744.0001 at 0012–0013].

[1011] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 8 [SCI.0011.0744.0001 at 0012].

[1012] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 10 [SCI.0011.0744.0001 at 0014].

12.66. Each reform priority and strategic direction identifies one or more focus areas to indicate what the Plan "aspires to change in that area".[1013] These are accompanied by high level strategies outlining how success will be achieved and what success will look like.[1014]

12.67. The *NSW Aboriginal Health Plan 2024–2034* is evidently the product of a consultation process. It is endorsed by an Advisory Committee co-chaired by the Executive Director of the Centre for Aboriginal Health and Interim Chief Executive Officer of the Aboriginal Health and Medical Research Council, who say it is aspirational and will foster optimism for the achievement of real outcomes.[1015]

12.68. However, many of the issues identified as warranting attention in the previous Plan, and also in the mid-term evaluation, have carried over to the 2024–2034 Plan, suggesting that progress has been well short of what was hoped for and required. In effect, none of the actions identified as necessary more than a decade ago has been completed to a point where it can be closed and the focus shifted to new concerns. The range and scope of priorities has simply been expanded.

12.69. Moreover, and unlike the previous Plan and the mid-term evaluation, the *NSW Aboriginal Health Plan 2024–2034* does not allocate responsibility to any entity for achieving identified strategies. It does not articulate specific actions, or discuss accountability, or refer to any consequences for failing to act. Instead, the intention is to develop, through a collaborative process, a Statewide implementation plan (aligned with the *Future Health and Regional Health Strategic Plan*) with detailed information about actions, timeframes, and which part of the health system is to take the lead.[1016]

12.70. With only high level strategies and an implementation plan yet to be developed, I am not confident that the Plan will effectively address the range of issues that emerged in the evidence. In this respect, I was not told what resources (including funding) will be provided to support implementation. Without adequate funding, there is little prospect that it will achieve its aims.

12.71. In addition to those system wide plans and policies, local initiatives have also been developed using a whole of government approaches. For example, the Coonamble Together Project involved a facilitator to engage representatives from health, police, education, and other agencies to identify solutions and coordinate implementation

[1013] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 8 [SCI.0011.0744.0001 at 0012].

[1014] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 8 [SCI.0011.0744.0001 at 0012].

[1015] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 2 [SCI.0011.0744.0001 at 0006].

[1016] Exhibit N3.31, NSW Health, *NSW Aboriginal Health Plan 2024–2034: Sharing Power in System Reform* (October 2024) p 4 [SCI.0011.0744.0001 at 0008].

efforts across relevant agencies. However, the project ceased when funding was discontinued, and its benefits have since been lost.[1017]

12.72. As the success and subsequent dissipation of the benefits secured through the Coonamble Together Project illustrate, it is not enough to formulate and promote a well intentioned plan, strategy, framework or agenda. Even if co-designed, such documents are of limited utility if they are not actually being implemented on the ground. Implementation requires more than good intentions. Adequate resourcing, both human and financial, are critically important. Of equal importance is the identification of tangible and measurable outcomes. Lofty statements of aspiration are of limited utility if it is not possible to identify with precision what is required to achieve those aspirational targets or measure the extent to which that has been achieved.

12.73. Often over the past 18 months, I have been referred to high level strategy documents like those referred to in the above paragraphs and left wondering about how they are being implemented and what difference, if any, they are making to consumers of public health services in the State. Roundtables, meetings with ACCHOs and AMSs, and the evidence given to this Special Commission by First Nations people have made it clear to me that far greater resourcing, much more accountability, and a very large amount of work will be required for there to be any proper movement towards the aspirational goals of the *NSW Aboriginal Health Plan 2024–2034*.

First Nations health workforce

12.74. First Nations people are under represented in the medical, nursing, and allied health professions in NSW.[1018] A strong First Nations health workforce is rightly seen as critical to ensuring cultural safety in the health system.[1019]

12.75. Aboriginal Peer Workers and Care Navigators are employed by all LHDs and SHNs in an attempt to foster a culturally safe workplace for Aboriginal staff and patients.[1020] However, as observed above, ACCHOs and AMSs also find themselves having to provide support for First Nations people within NSW Health facilities because cultural safety has not yet been realised for them.[1021]

12.76. The mid-term evaluation of the *NSW Aboriginal Health Plan 2013–2023* recommended building the First Nations health workforce with all organisations having a target of 2.6 per cent or more, and targeted strategies to increase First

[1017] Transcript of the Commission, 16 May 2024, T2918.30–2920.6 (Spittal).

[1018] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 4 [SCI.0009.0020.0001 at 0011].

[1019] Exhibit B.23.23, NSW Health, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, May 2022) p 40 [MOH.0001.0320.0001 at 0058].

[1020] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 25 [MOH.0001.0372.0001 at 0025].

[1021] Transcript of the Commission, 27 November 2024, T6699.7–22 (Falzon).

Nations people in leadership positions.[1022] Since then, NSW Health organisations have been set a target of 3.43 per cent by 2031 based on the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*, and must report annually on progress.[1023] Six key priority areas have been identified to facilitate meeting that target, namely:[1024]

a. lead and plan Aboriginal workforce development;

b. build cultural understanding and respect;

c. attract, recruit and retain Aboriginal staff;

d. develop and strengthen the capabilities of Aboriginal staff;

e. collaboration to achieve workforce priorities; and

f. track our achievements and improve results.

12.77. Each of the six key priority areas includes a range of actions and identifies where the core responsibility lies for achieving them.[1025] Responsibility for most actions is allocated to LHDs,[1026] and they must identify local opportunities and strategies with limited central coordination.[1027]

12.78. While there are undeniably benefits, there are also unintended negative consequences of setting targets that NSW Health organisations must meet for their First Nations health workforce. During roundtables and in their evidence, ACCHOs and AMSs expressed their frustration that they recruit and train staff only to lose them to jobs with higher salaries in LHDs or non-government organisations that have been given funding to provide First Nations health care services but which do not have the First Nations workforce required to deliver the service.[1028]

12.79. 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

[1022] Exhibit E.1, Centre for Epidemiology and Evidence and Centre for Aboriginal Health, *Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013–2023* (Report, May 2019) p 9 [SCI.0009.0020.0001 at 0016].

[1023] Exhibit H3.60, NSW Health, *Aboriginal Workforce Composition* (Policy Directive No PD2023_046, 18 December 2023) p 2 [MOH.0010.0313.0001 at 0005].

[1024] Exhibit H3.60, NSW Health, *Aboriginal Workforce Composition* (Policy Directive No PD2023_046, 18 December 2023) p 4 [MOH.0010.0313.0001 at 0007].

[1025] Exhibit H3.60, NSW Health, *Aboriginal Workforce Composition* (Policy Directive No PD2023_046, 18 December 2023) pp 5–20 [MOH.0010.0313.0001 at 0008–0023].

[1026] See, e.g., Exhibit E.14, WNSWLHD, *Aboriginal Workforce Affirmative Action Framework 2019–2023* [SCI.0009.0031.0001]; Exhibit F.22, Outline of Evidence of Justin Files (7 May 2024) [7]–[12] [MOH.9999.1262.0001 at 0002–0003].

[1027] Exhibit H3.60, NSW Health, *Aboriginal Workforce Composition* (Policy Directive No PD2023_046, 18 December 2023) [MOH.0010.0313.0001].

[1028] Transcript of the Commission, 28 November 2024, T6734.18–21 (L Bellear), T6740.38–6741.33 (Roxburgh), T6746.6–13 (Newman).

substantial drain on their limited resources and makes it challenging for them to deliver the care required by their communities.

12.80. 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 resources, rather than having to compete for those that are in short supply.[1029]

Aboriginal Health Workers/Aboriginal Health Practitioners

12.81. There are four categories of Aboriginal Health Worker recognised in the NSW Health Service Aboriginal Health Workers' (State) Award:[1030]

a. Aboriginal Health Workers, who have non-clinical roles that provide advocacy, support, liaison and health promotion in hospital and settings;

b. Principal Aboriginal Health Workers, that are degree qualified and may develop, implement and review primary healthcare strategy and policies and be responsible for supervising and training Aboriginal Health Workers;

c. Senior Aboriginal Health Workers, that are chosen based on cultural knowledge, understanding, skills, and roles in a community, and function as cultural navigators for delivery of individual health services or health programs, and may be responsible for supervising and training; and

d. Aboriginal Health Practitioner is a protected title for people with a Certificate IV in Aboriginal Primary Health Care Practice and registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA). They provide a range of clinical services to local Aboriginal communities.

12.82. Aboriginal Health Workers and Aboriginal Health Practitioners are specifically identified as groups that should be developed and supported to take a greater role in NSW Health facilities, in areas such as Emergency Departments and multidisciplinary teams.[1031]

Supporting First Nations students to train in other health professions

12.83. There are some initiatives that support students from First Nations backgrounds to train in what might be termed traditional health professions – medicine, nursing, midwifery, and allied health.

[1029] Transcript of the Commission, 28 November 2024, T6777.35–6778.2 (Newman); Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [14.47] [SCI.0011.0814.0001 at 0153].

[1030] Exhibit H3.25, NSW Health, *Definition of an Aboriginal Health Worker* (Information Bulletin No IB2018_018, 24 May 2018) pp 3–4 [MOH.0010.0308.0001 at 0004–0005].

[1031] Exhibit H3.60, NSW Health, *Aboriginal Workforce Composition* (Policy Directive No PD2023_046, 18 December 2023) pp 6, 11–12 [MOH.0010.0313.0001 at 0009, 0014–0015].

12.84. At a State level, there is an Aboriginal Allied Health Cadetship Program as well as an Aboriginal Allied Health Network that bring together allied health professionals, assistants, technicians, cadets and trainees.[1032] There is also an Aboriginal Medical Workforce Pathway that facilitates the recruitment allocation of Aboriginal medical graduates to prevocational training positions.[1033]

12.85. Examples of local initiatives include:

a. the Western NSW LHD funding trainees to complete the Charles Sturt University's Djirruwang Aboriginal training program, which provides them with a degree as a mental health clinician;[1034] and

b. the Murrumbidgee LHD 'Growing Our Own' initiative, which provides vocational training (with pay) to Year 11 and 12 students who graduate as an Assistant in Nursing or Allied Health Assistant, with First Nations students making up more than half the graduates to date.[1035]

12.86. However, if there is no consensus as to the benefit, efforts to establish a new program may not be successful. For example, a proposal to train local First Nations people as Assistants in Nursing was identified as having the associated benefit of reducing spending on agency staff while boosting the First Nations workforce, however, funding could not be secured to implement it.[1036]

Conclusion

12.87. If we are serious about closing the gap, a collaborative and whole of government approach must be taken to improving the health outcomes of First Nations people. From what I have seen on my visits to each of the LHDs across the State, I am confident that NSW Health is serious, and committed, to making its important contribution to that aim.

12.88. However, there is more that can and should be done across the NSW public health system. 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.

[1032] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 25 [MOH.0001.0372.0001 at 0025].

[1033] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 25 [MOH.0001.0372.0001 at 0025].

[1034] Transcript of the Commission, 15 May 2024, T2810.29–41 (McFarlane).

[1035] Transcript of the Commission, 22 March 2024, T1721.41–1722.33 (Ludford).

[1036] Transcript of the Commission, 14 May 2024, T2742.1–34 (Gordon).

12.89. The result of that process may be that NSW Health delivers a particular program or service to First Nations communities – but not always. There are many opportunities for NSW Health to support the delivery of care by First Nations care providers.

12.90. One of them is to support the development the First Nations health workforce, not just within NSW Health facilities. That will likely require a flexible approach – collaborating with ACCHOs and AMSs to locate First Nations clinicians and care providers in the right setting (inside or outside of NSW Health facilities), rather than competing with ACCHOs and AMSs for a limited pool.

12.91. Another is to ensure funding that is provided to ACCHOs and AMSs to enable them to deliver the services that are needed to address the needs of their communities. That will necessarily involve the elimination of short term funding cycles and unnecessarily onerous reporting requirements, which inhibit, rather than facilitate, the delivery of important services by those organisations.

12.92. Ultimately, what is required are tailored responses that best address the health needs of, and support the delivery of care to, First Nations people. While it should go without saying, tailoring these responses will – like all good health service planning – be inherently place based.

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.

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.

Recommendation 9: Reporting requirements that attach to funding allocated to ACCHOs and AMS must be rationalised and simplified.

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

Volume 2

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13.1. There is a range of highly specialised and resource intensive services that, by their nature, need to be concentrated in a small number of sites – sometimes referred to as supra-LHD or Statewide Services.[1037] Some examples include: selected Adult and Neonatal Intensive Care Units; transplant services (such as blood and marrow, heart and lung transplantations), severe burn units, spinal cord injury services, organ retrieval services; neurointerventional services; and endovascular clot retrieval for acute ischaemic stroke.[1038]

13.2. There are good reasons why services of that kind are performed at a limited number of sites across the State. By their nature, they are low volume services and there is an obvious need to structure them in such a way that ensures that they can be available at all times.[1039] Importantly, it is well accepted that better patient outcomes are achieved when highly specialised procedures are performed by a clinical team that undertakes them on a regular basis.[1040] Accordingly, it is not possible, nor clinically appropriate, to replicate those types of services across multiple sites.[1041]

Current arrangements for Statewide Services

13.3. The process for establishing a supra-LHD or Statewide Service is set out in an NSW Health guideline: *NSW Health Technologies and Specialised Services*.[1042] For the purposes of that guideline, "new health technologies" include implantable devices, medical and surgical procedures, treatment and diagnostic technologies, and gene based diagnostics and therapies. New health technologies or services may be identified in several ways, including through LHD submissions, or the Specialty Services and Technology Evaluation Unit engaging with public health organisations to identify new technologies and emerging clinical evidence.[1043]

13.4. The Ministry of Health's New Technologies and Specialised Services Committee considers and makes recommendations to the Health Secretary about whether new health technologies should be adopted and specialised services established.[1044] That committee determines the requirements of supra-LHD services, and – if approved – LHDs and SHNs are invited to submit expressions of interest to host that new service. In doing so, the LHD or SHN must demonstrate that it is able to meet the requirements

[1037] Transcript of the Commission, 28 November 2023, T81.15-27 (Lyons).

[1038] Transcript of the Commission, 28 November 2023, T81.29-42 (Lyons); Exhibit B.23.27, NSW Health, *Sample Service Agreement 2023-24* (undated) pp 8-12 [MOH.0001.0288.0001 at 0009-0013].

[1039] Transcript of the Commission, 28 November 2023, T82.5-13 (Lyons).

[1040] Transcript of the Commission, 28 November 2023, T82.19-26 (Lyons).

[1041] Transcript of the Commission, 28 November 2023, T149.24-29 (Lyons).

[1042] Exhibit N.4.7, NSW Health, *New Health Technologies and Specialised Services Guideline* (Guideline No GL2024_008, 24 June 2024) [MOH.0100.0022.0001]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.4] [SCI.0011.0814.0001 at 0031-0032].

[1043] Exhibit N.4.7, NSW Health, *New Health Technologies and Specialised Services Guideline* (Guideline No GL2024_008, 24 June 2024) p 6 [MOH.0100.0022.0001 at 0009]; Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [37] [MOH.9999.0981.0001 at 0017].

[1044] Exhibit N.4.7, NSW Health, *New Health Technologies and Specialised Services Guideline* (Guideline No GL2024_008, 24 June 2024) pp-7-9 [MOH.0100.0022.0001 at 0010-0012].

to deliver that service, set by the New Technologies and Specialised Services Committee.[1045]

13.5. Once established, supra-LHD or Statewide Services are overseen by the New Technologies and Specialised Services Committee, which monitors implementation of the service and provides advice concerning the service as part of the annual service agreement process. The Specialty Services and Technology Evaluation Unit, together with other Ministry of Health branches and the Pillar organisations, also provides advice concerning changes to, or enhancements of, supra-LHD services.[1046]

13.6. The involvement of the Ministry of Health in supra-LHD services occurs largely at the implementation phase. Once a service is established, it typically falls to the relevant LHD or SHN to conduct discussions with the Ministry of Health concerning funding for that service, and to undertake the governance and monitoring of the service in accordance with applicable local policies and procedures.[1047] The current Ministry expectation is that “ongoing management will be driven” by LHDs and the ACI, although “issues” may be escalated to the New Technologies and Specialised Services Committee as required.[1048]

13.7. Accordingly, for at least some services, there is little central involvement in relation to how those services are planned and delivered once they have been established. Consequently, services are largely coordinated within the major service hospitals, often without input or negotiation at the LHD or Ministry of Health level.[1049]

13.8. That is not, however, the universal position in relation to all supra-LHD services. There are examples of where a more coordinated approach to the planning, delivery, and oversight of a supra-LHD service occurs.[1050] As will be explored below, there are opportunities for a similar approach to be adopted in relation to other supra-LHD services.[1051]

[1045] Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [37] [MOH.9999.0981.0001 at 0018]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.4]-[8.6] [MOH.0010.0758.0001 at 0031-0032].

[1046] Exhibit D.10, Statement of Deborah Willcox AM (9 April 2024) [37] [MOH.9999.0981.0001 at 0017-0019]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.4]-[8.6] [SCI.0011.0814.0001 at 0031-0032].

[1047] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.6] [SCI.0011.0814.0001 at 0032].

[1048] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.24] [SCI.0011.0814.0001 at 0039].

[1049] See, e.g., Transcript of the Commission, 24 April 2024, T2419.35-2420.10, T2424.17-24, T2438.40-2439.12 (Middleton).

[1050] Exhibit N.3.10, Statement of Olivia Hibbitt (18 June 2024) [19]-[20], [38] [MOH.0006.0008.0001 at 0004-0005, 0010]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.8]-[8.10] [SCI.0011.0814.0001 at 0033-0034].

[1051] See also Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.7]-[8.8] [SCI.0011.0814.0001 at 0033].

Case study examples

13.9. To facilitate a consideration of the kinds of issues that can arise in the planning and delivery of supra-LHD and Statewide Services, the current structures of the NSW Spinal Cord Injury Service and the NSW Brain Injury Rehabilitation Program were explored in the evidence. Both of those services comprise inpatient and community based services that are highly specialised, high cost, and low in volume.[1052] As will be seen, the evidence concerning those services indicates that a largely decentralised approach to their governance and coordination creates challenges in relation to service provision, equity of access, and funding.

NSW Spinal Cord Injury Service

13.10. Spinal cord injuries are relatively rare but, when they occur, they result in significant and complex care needs.[1053]

13.11. The inpatient services provided by the NSW Spinal Cord Injury Service are hosted by three hospitals: Royal North Shore Hospital, Royal Rehabilitation Centre (a facility operated by Royal Rehab Group, an AHO), and Prince of Wales Hospital. They are available to the whole of the NSW population. Additionally, community based services are available in metropolitan Sydney, and in rural LHDs under the supervision of a rural coordinator.[1054]

13.12. The Statewide Spinal Outreach Service, which forms part of the NSW Spinal Cord Injury Service, is a multidisciplinary service through which patients can receive a wide range of community based advice and support for 12 months post injury. It is an important part of the service as it supports the reintegration of patients into their communities, and provides linkages between government and non government services.[1055] Those who may be candidates for the Statewide outreach service are generally identified by word of mouth if they have not already been treated by specialist inpatient services, and may not be identified until "some time down the line" in their care journey.[1056]

13.13. Aside from the services that are offered through the NSW Spinal Cord Injury Service, there are no other specialist spinal cord services available in NSW.[1057]

13.14. Professor James Middleton, Professor of Rehabilitation Medicine at the University of Sydney and the John Walsh Centre for Rehabilitation Research and Clinical Director of the NSW State Spinal Cord Injury Service, gave evidence that within the current

[1052] Transcript of the Commission, 24 April 2024, T2417.43-45 (Middleton).
[1053] Transcript of the Commission, 24 April 2024, T2417.45-47 (Middleton).
[1054] Transcript of the Commission, 24 April 2024, T2417.43-2418.21 (Middleton).
[1055] Transcript of the Commission, 24 April 2024, T2419.4-30 (Middleton).
[1056] Transcript of the Commission, 24 April 2024, T2421.36-2422.2 (Middleton).
[1057] Transcript of the Commission, 24 April 2024, T2418.32-36 (Middleton).

arrangements, 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 are not accessing those services in a timely way.[1058] He explained that this occurs because the NSW Spinal Cord Injury Service does not have a centralised registry of all patients with spinal cord injuries in the State, who may be receiving care for their injury without having been referred to the specialist service. For example, a patient that sustained a spinal cord injury in Dubbo may have been transferred from Western NSW LHD to Sydney for surgery, then transferred directly back to Dubbo without any involvement of or notification to the NSW Spinal Cord Injury Service. It would not be until that patient was receiving treatment through one of the NSW Spinal Cord Injury Service's rural outreach services, or a local rehabilitation practitioner who was aware of the specialist Program, that they would be referred.[1059]

13.15. Encouragingly, NSW Health accepts that there is a need to take steps to support planning and governance of those services in a coordinated way in order to develop a "State-based" approach to the management of those patients, and some work is already under way towards that aim.[1060]

13.16. A coordinated "State-based" approach to the planning and delivery of highly specialised services like the NSW Spinal Cord Injury Service is, in my view, critical to its effective operation. As an example of why that is so, there are presently insufficient specialist rehabilitation beds at Royal Rehabilitation Centre and Prince of Wales Hospital to enable patient flow, and therefore those services are very difficult to access.[1061] 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, as well as challenges in discharging people into the community.[1062]

13.17. Professor Middleton was of the view that those difficulties stemmed from – or at least were contributed to by – the lack of centralised governance with respect to Statewide Services.[1063] He observed that while patient flow data is managed well within LHDs, it is not coordinated across LHD boundaries,[1064] and the absence of overarching governance or coordination of the flow of patients requiring highly specialised care provided by the service across LHD boundaries meant that there was no systematic way of prioritising which patients should attend which service to maximise "right care, right place, right time".[1065] As may be obvious, an efficient flow of patients into and

[1058] Transcript of the Commission, 24 April 2024, T2421.21-2422.12 (Middleton).

[1059] Transcript of the Commission, 24 April 2024, T2422.22-39, T2424.26-33 (Middleton).

[1060] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.20]-[8.21] [SCI.0011.0814.0001 at 0037-0038].

[1061] Transcript of the Commission, 24 April 2024, T2424.35-2425.11 (Middleton).

[1062] Transcript of the Commission, 24 April 2024, T2425.3-11 (Middleton).

[1063] Transcript of the Commission, 24 April 2024, T2424.1-18 (Middleton).

[1064] Transcript of the Commission, 24 April 2024, T2423.3-7 (Middleton).

[1065] Transcript of the Commission, 24 April 2024, T2423.25-34 (Middleton).

out of highly specialised and low volume care settings is critical to maximise access to them. Issues of those kinds can only be resolved by a coordinated approach across the system as a whole.[1066]

13.18. Professor Middleton was not alone in these views. Matthew Mackay, the Chief Executive Officer of Royal Rehab Group, believes that the existing approach, under which service planning and funding for spinal cord injury patients falls largely within the responsibility of one LHD, is not facilitating the distribution of these services to areas of need across the State. He suggested that a centrally coordinated hub and spoke approach would be preferable.[1067]

13.19. Some work has been done to address this problem within the context of the NSW Spinal Cord Injury Service. This includes the development of a networked model of care with an early notification system to coordinate and triage care for people with a spinal cord injury in a timely fashion, and the potential use of the patient flow portal as a mechanism for identifying patients with spinal cord injuries across the system.[1068] The ACI has also been involved in producing data to assist in modelling improved patient flows and timely access to care, and the impact those measures might have on patient outcomes as well as the opportunity cost of maintaining existing systems.[1069] Such developments should be supported.

13.20. However, they have not overcome the limitations in the current approach to supra-LHD services within the system. In this respect, Professor Middleton gave the following evidence:[1070]

> *Q. Does [the designation as a supra-LHD service] make any practical difference to the operation of the service in your view?*
>
> *A. No, not really. I mean, there is a new health technologies and specialised services committee that has been set up. Essentially, that deals with new technologies or services. It has no role or responsibility for existing services and it largely, I think, is focusing on the challenge of new technologies and advances in treatment and the impacts on care that that has. But, essentially, there is nothing – there is no committee, there is no mechanism, there is no central oversight. So we're nominally a Statewide service, and certainly acknowledged to be that, and as I said, I guess it's articulated through a line or two in a service agreement with a few LHDs, but beyond that, it doesn't really mean anything.*

[1066] Transcript of the Commission, 24 April 2024, T2425.30-47 (Middleton).

[1067] Transcript of the Commission, 18 April 2024, T2117.33-2118.24 (Mackay).

[1068] Transcript of the Commission, 24 April 2024, T2422.8-2423.1 (Middleton).

[1069] Transcript of the Commission, 24 April 2024, T2425.18-28 (Middleton).

[1070] Transcript of the Commission, 24 April 2024, T2437.7-19 (Middleton).

13.21. That the Clinical Director of the NSW State Spinal Cord Injury Service considers that the designation of the service he had led for nearly 20 years[1071] as a supra-LHD service "doesn't really mean anything" is telling, and indicative of the need for the planning, governance, and delivery of those Statewide Services to be enhanced. While the ACI is involved in the development of models of care, it does not have any operational responsibility or involvement in the day to day workings of the LHDs or spinal units.[1072]

13.22. The current structures also provide funding challenges for the NSW Spinal Cord Injury Service. While it may be accepted that LHDs and SHNs are able to submit requests for additional funding for supra-LHD services they host,[1073] their ability to do so does not necessarily address those structural challenges in a meaningful way. Requests for additional funding made, in the first instance, to host LHDs encounter the practical problem that LHD budgets are already stretched. Additionally, given the high cost, low volume nature of its services, there may not necessarily be a good awareness within some LHDs of the need for those services and their significance in the context of the wider system when assessing competing requests for funding.[1074] As has been observed in other contexts, there are also limitations in the ability of the ABF model to capture the complexity of the care delivered within the service.[1075]

NSW Brain Injury Rehabilitation Program

13.23. The NSW Brain Injury Rehabilitation Program is comprised of approximately 15 services spread across NSW, which are networked for the purpose of operations and communication.[1076] Those services provide complex and multidisciplinary rehabilitation for patients with severe traumatic brain injuries, across a range of care settings, including inpatient units for both adults and children, transitional living units, and community based rehabilitation programs.[1077] There are approximately 800 people admitted to the Program each year.[1078]

[1071] Transcript of the Commission, 24 April 2024, T2417.28-30 (Middleton).

[1072] Transcript of the Commission, 24 April 2024, T2429.16-24 (Middleton).

[1073] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.21]-[8.22] [SCI.0011.0814.0001 at 0038].

[1074] Transcript of the Commission, 24 April 2024, T2427.24-2428.23 (Middleton).

[1075] Transcript of the Commission, 24 April 2024, T2437.21-42 (Middleton).

[1076] Transcript of the Commission, 23 April 2024, T2397.38-40, T2409.31-33 (Browne).

[1077] Transcript of the Commission, 23 April 2024, T2397.38-2398.6 (Browne).

[1078] Transcript of the Commission, 23 April 2024, T2405.24-27 (Browne).

13.24. The NSW Brain Injury Rehabilitation Program was developed to meet the needs of patients with traumatic brain injuries, and who required care beyond that available in general rehabilitation wards. For some patients, the extent of their brain injury can range from difficulties with memory and communication, to complex physical and/or cognitive impairments.[1079]

13.25. The inpatient units operated through the Program are concentrated in Sydney, given the highly specialised, but low volume, nature of the service.[1080] Those units at the Royal Rehabilitation Centre, Liverpool Hospital and Westmead Hospital see approximately 130 to 150 patients per year.[1081] Regional community rehabilitation services are also available to those outside of Sydney.[1082] Despite operating services on a Statewide scale, the NSW Brain Injury Rehabilitation Program is not designated as a supra-LHD service.[1083]

13.26. The three adult brain injury units cannot presently provide traumatic brain injury rehabilitation for all people in NSW who require it because there are not enough beds.[1084] Dr Stuart Browne, Clinical Director of the NSW Brain Injury Rehabilitation Program, estimated that the three inpatient units in Sydney saw approximately half of the approximately 300 patients "coming through NSW hospitals with serious traumatic brain injuries each year".[1085] In addition to there being insufficient beds, Dr Browne attributed the unseen patient load to the fact that all three inpatient units are located in metropolitan Sydney,[1086] as well as the admission criteria that favour patients of working age.[1087] There had been no increase in the number of inpatient beds available in over 20 years despite a significant increase in population, which has placed a significant burden on the service.[1088]

13.27. The inability of the Statewide Service to keep up with population demand in part reflects the lack of central decision making in relation to the nature and/or volume of services to be provided through the NSW Brain Injury Rehabilitation Program. Similarly, there is no centralised decision making process relating to funding, location, and staffing of services.[1089] Consistent with the approach to such matters summarised above, the various brain injury rehabilitation services are managed and funded by the LHDs in which they are situated (some of which are a product of history), and the NSW Brain

[1079] Transcript of the Commission, 23 April 2024, T2399.17-29 (Browne).

[1080] Transcript of the Commission, 23 April 2024, T2405.12-20 (Browne).

[1081] Transcript of the Commission, 23 April 2024, T2405.24-25, T2409.31-41 (Browne).

[1082] Transcript of the Commission, 23 April 2024, T2400.4-2401.12 (Browne).

[1083] Transcript of the Commission, 23 April 2024, T2412.21-34 (Browne).

[1084] Transcript of the Commission, 23 April 2024, T2404.36-44 (Browne).

[1085] Transcript of the Commission, 23 April 2024, T2405.41-46 (Browne).

[1086] Transcript of the Commission, 23 April 2024, T2405.3-10 (Browne).

[1087] Transcript of the Commission, 23 April 2024, T2406.1-11 (Browne).

[1088] Transcript of the Commission, 23 April 2024, T2411.13-27 (Browne).

[1089] Transcript of the Commission, 23 April 2024, T2406.43-2407.11 (Browne).

Injury Rehabilitation Program does not receive any funding directly.[1090] As a result, differences in the relative funding allocated to services within the NSW Brain Injury Rehabilitation Program can arise between LHDs.[1091]

13.28. Further, there is no central monitoring, oversight or control over service provision, which is the responsibility of the LHD in which the service is provided.[1092] As a result, there is limited ability to identify patients who may be receiving care in a general rehabilitation unit but are in need of specialist inpatient care for their traumatic brain injury. Given the evidence that patients who undergo rehabilitation in specialist inpatient units have better outcomes than those who undergo rehabilitation in general units, a more centralised approach to those matters will likely result in more patients receiving the care they need in the appropriate setting, and therefore improved patient outcomes.[1093]

13.29. One role of the NSW Brain Injury Rehabilitation Program is to bring together various services to consider data and identify service gaps, including by monitoring data relating to the number of patients who come through the Program's services, client demographics, length of stay, and other functional outcomes.[1094] The NSW Brain Injury Rehabilitation Program currently sits within the ACI, which employs Dr Browne, as well as a full time manager, data manager, and education officer, to act in a coordination role with respect to the Program.[1095] However, that coordination is largely limited to information sharing, rather than coordinating service provision or funding.[1096] The Program's ability to identify service gaps is also reliant on data collected by individual service providers and LHDs, rather than its own sources and analysis.[1097]

13.30. NSW Health accepts that "further work" is required within the Ministry of Health to strengthen planning across LHDs and SHNs to enable a "State-based" approach to patients in need of the care that the NSW Brain Injury Rehabilitation Program offers.[1098] That work should be progressed as a priority.

A more formalised approach to supra-LHD and Statewide Services?

13.31. As can be seen, there is presently no coordinated approach to planning or governance of supra-LHD and Statewide Services, and (at least some) supra-LHD and Statewide Services are facing significant challenges as a result. That must

[1090] Transcript of the Commission, 23 April 2024, T2406.45-2407.7, T2408.30-45 (Browne).

[1091] Transcript of the Commission, 23 April 2024, T2407.22-2408.15, T2409.20-23 (Browne).

[1092] Transcript of the Commission, 23 April 2024, T2407.13-20 (Browne).

[1093] Transcript of the Commission, 23 April 2024, T2411.29-2412.19 (Browne).

[1094] Transcript of the Commission, 23 April 2024, T2410.15-23 (Browne).

[1095] Transcript of the Commission, 23 April 2024, T2410.41-2411.4 (Browne).

[1096] Transcript of the Commission, 23 April 2024, T2411.6-11 (Browne).

[1097] Transcript of the Commission, 23 April 2024, T2410.29-33 (Browne).

[1098] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.25] [SCI.0011.0814.0001 at 0039].

change if supra-LHD and Statewide Services are to fulfil their potential, and most effectively and efficiently meet the highly complex needs of their patient cohort.

13.32. One model that could be adopted to achieve that outcome is for a centralised body – involving representatives of the ACI, LHDs, and appropriate divisions or units within the Ministry of Health – to 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.[1099]

13.33. As part of that model, funding for Statewide Services could be allocated centrally, before flowing to the host LHDs via service agreements that clearly specify the services to be provided and identify a series of measurable outcomes to be achieved.[1100] An approach of that kind is well placed to overcome the risk that requests for funding would have to complete against other demands placed on already constrained LHD budgets.[1101] Such a model would also likely enhance and support greater equity of access to highly specialised services across the State,[1102] and facilitate the flow of patients from acute settings, through specialised rehabilitation services and then (where clinically appropriate) to facilities or services closer to their home for ongoing management.

13.34. The Ministry of Health accepts that there is a role for it to play in providing enhanced governance and accountability for supra-LHD services.[1103] As is clear from the paragraphs immediately above, I agree.

13.35. However, the involvement of the Ministry of Health in those matters ought not be seen as diminishing or reducing the ability of supra-LHD services to harness local expertise,[1104] nor involve a wholesale "takeover" of them by the Ministry of Health. 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 that host those services, and other parts if the wider system, such as the Pillars. The only part of the system that can effectively coordinate such an approach is the Ministry of Health.

[1099] Transcript of the Commission, 24 April 2024, T2427.34-2428.10, T2436.10-16, T2442.37-2443.17 (Middleton).

[1100] Transcript of the Commission, 24 April 2024, T2445.24-32 (Middleton).

[1101] Transcript of the Commission, 24 April 2024, T2443.19-43 (Middleton).

[1102] Transcript of the Commission, 23 April 2024, T2408.47-2409.18, T2413.29-2414.37 (Browne).

[1103] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.26] [SCI.0011.0814.0001 at 0039-0040].

[1104] Cf Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.11] [SCI.0011.0814.0001 at 0034]; See also Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.26] [SCI.0011.0814.0001 at 0039-0040].

Paediatric services

13.36. As I have noted in my description of the NSW health system, the SCHN was formed in 2010 and incorporates two tertiary paediatric hospitals which provide specialist inpatient and outpatient services: The Children's Hospital at Westmead, located in Sydney's west, and Sydney Children's Hospital, Randwick, located in Sydney's east. In addition to the hospitals, SCHN also incorporates Bear Cottage (Statewide paediatric hospice service), Newborn and Paediatric Emergency Transport Service (NETS, a Statewide paediatric retrieval service), the Children's Court Clinic, and the NSW Poisons Information Centre.[1105]

13.37. The third tertiary paediatric referral hospital in NSW is John Hunter Children's Hospital, located in Newcastle. John Hunter Children's Hospital does not form part of SCHN and instead falls within the governance of Hunter New England LHD.[1106]

13.38. In addition to the specialist services delivered through those three specialist children's tertiary referral hospitals, local paediatric services are delivered by the LHDs across the State.

13.39. To accommodate service need across NSW, three geographically based children's healthcare "networks" were created. Each of these "networks" contains one of the three specialist paediatric hospitals for the purpose of referral, advice and patient transfer. The northern "network" is hosted by John Hunter Children's Hospital and incorporates Mid North Coast LHD, Hunter New England LHD, and most recently Central Coast LHD. The southern "network" is hosted by Sydney Children's Hospital at Randwick and the western "network" is hosted by The Children's Hospital at Westmead.[1107]

13.40. Those "networks" involve all levels of paediatric care, including primary, secondary, tertiary, and quaternary. While they do not have a distinct governance structure that is separate from LHDs, they play a strategic role in standardising practices, guidelines, education, and quality improvement.[1108] Each of the networks employ medical leads, nursing leads, allied health leads, as well as administrative staff.[1109]

13.41. The ACI's Paediatric Network also serves an advisory role in relation to issues relevant to the delivery of paediatric care across NSW.[1110]

[1105] Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [8], [10] [MOH.9999.1869.0001 at 0002]; Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [4] [MOH.9999.1292.0001 at 0001-0002].

[1106] Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [5]-[6] [MOH.9999.1869.0001 at 0001]; Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [4]-[6] [MOH.9999.1292.0001 at 0001-0002]; Exhibit G.95, Statement of Paul Craven (7 June 2024) [5]-[6] [MOH.9999.1289.0001 at 0002].

[1107] Transcript of the Commission, 14 June 2024, T3665.28-46 (Craven).

[1108] Transcript of the Commission, 14 June 2024, T3666.9-21 (Craven); Exhibit G.97, Statement of Cathryn Cox (6 June 2024) [6] [MOH.9999.1869.0001 at 0001].

[1109] Transcript of the Commission, 14 June 2024, T3665.27-3666.1 (Craven).

[1110] Transcript of the Commission, 14 June 2024, T3641.5-11 (Preddy).

13.42. As part of the networked delivery of paediatric care across the State, the SCHN also operates a Statewide virtual care service, known as virtualKIDS. That service includes the virtualKIDS Urgent Care Service that is delivered jointly by the three NSW tertiary paediatric hospitals, through which patients are remotely reviewed for secondary triage by specialised paediatric clinicians and nursing staff.[1111] These staff then support families to determine whether the patient is safe to remain at home or should present to hospital or another healthcare provider.[1112] The secondary triage process avoids Emergency Department attendance in two thirds of cases. Where appropriate, patients can also receive ongoing at home care through the virtualKIDS Short Stay Ward.[1113] Additional services offered by virtualKIDS include:[1114]

a. acute review for children who have attended an Emergency Department to enable them to return home;

b. follow up care for children to enable them to be discharged earlier from hospital without requiring admission; and

c. paediatric support for clinicians throughout NSW, including within SCHN and in rural areas, depending on the condition and acuity of the patient.

13.43. As with supra-LHD services, some paediatric services are highly specialised and are (for the same reasons) concentrated in one or more of the three paediatric referral hospitals. Paediatric patients from across the State are referred to those tertiary referral hospitals for complex treatment that is not available in local facilities. The tertiary referral hospitals also provide care for children within the surrounding areas.[1115]

13.44. However, there are limitations to the effective integration of highly specialised services delivered in the tertiary paediatric hospital with paediatric care delivered in the LHDs. For example, Associate Professor John Preddy, Clinical Director of Paediatrics at Wagga Wagga Base Hospital, described several challenges that can arise in the interface between local paediatric services (particularly in regional and rural LHDs) and the tertiary referral hospitals, including that:[1116]

a. there can be insufficient beds available in specialist children’s hospitals for patients to access the highly specialised care that they need, sometimes because beds in the specialist hospitals were utilised in the provision of secondary and tertiary care that could be provided elsewhere;

[1111] Exhibit G.94, Statement of Dr Shirley Alexander (6 June 2024) [16] [MOH.9999.1286.0001 at 0004].

[1112] Exhibit G.94, Statement of Dr Shirley Alexander (6 June 2024) [16] [MOH.9999.1286.0001 at 0004].

[1113] Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [6] [MOH.9999.1292.0001 at 0002].

[1114] Exhibit G.96, Statement of Dr Joanne Ging (6 June 2024) [6] [MOH.9999.1292.0001 at 0002]; Exhibit G.94, Statement of Dr Shirley Alexander (6 June 2024) [16]-[17] [MOH.9999.1286.0001 at 0004].

[1115] Exhibit G.97, Statement of Cathryn Cox PSM (6 June 2024) [7]-[8] [MOH.9999.1869.0001 at 0001-0002]; Exhibit G.95, Statement of Paul Craven (7 June 2024) [7]-[8] [MOH.9999.1289.0001 at 0002].

[1116] Exhibit G.33, Statement of John Preddy (30 May 2024) [12]-[15] [SCI.0011.0067.0001 at 0003-0004]; Transcript of the Commission, 14 June 2024, T3646.23-35 (Preddy).

b. children's hospitals do not always transfer patients back into the care of local paediatric departments once the need for specialised care has passed, which can impact continuity of care but also could release capacity within the specialist children's hospitals;

c. there is an absence of consistent referral pathways for general practitioners to refer children for specialist treatment, and as a result general practitioners often refer patients directly to a subspecialist paediatrician rather than general paediatricians (who could better coordinate the care of the patient); and

d. the transfer of patients to specialised services can often be reliant on existing relationships between clinicians as (with the exception of NETS) there is no centralised or coordinated system for managing transfers of children requiring quaternary or other specialised care.

13.45. He described the practical implications of these challenges in his oral evidence:[1117]

> *A. In practice, if I wish to rather than transfer care but involve care from subspecialists it generally means that I would phone somebody on call, I'd phone a friend, I'd phone a junior doctor as part of a team and discuss the care needs. Sometimes it would involve emailing, sometimes it would involve sending a referral, and often it would involve barriers and wait.*
>
> *Q. And from that do I take it that you perceive that those arrangements rely significantly on relationships between clinicians?*
>
> *A. They do. Not entirely. There is always in kids' hospitals someone on call for particular services with whom you can speak some of the time.*

13.46. In an effort to overcome some of those challenges, SCHN has begun to formalise its relationships with several LHDs by entering into Heads of Agreement with them.[1118] Among other matters, those Heads of Agreement:

a. establish the objective that the parties "will work in partnership to develop specialty paediatric services … that facilitate the safe, timely, efficient and equitable delivery of services in a way that is sustainable for both parties";[1119]

[1117] Transcript of the Commission, 14 June 2024, T3647.20-34 (Preddy).

[1118] Transcript of the Commission, 11 June 2024, T3431.20-3434.33 (Cox); see also Transcript of the Commission, 11 June 2024, T3407.45-3408.42, T3409.41-3410.16 (Ging); Exhibit G.114, SCHN and Hunter New England LHD, *Heads of Agreement* (December 2020) [MOH.9999.1676.0001]; Exhibit G.115, SCHN and South Western Sydney LHD, *Heads of Agreement* (30 October 2020) [MOH.9999.1678.0001].

[1119] Exhibit G.114, SCHN and Hunter New England LHD, *Heads of Agreement* (December 2020) cl 3.1 [MOH.9999.1676.0001 at 0006]; Exhibit G.115, SCHN and South Western Sydney LHD, *Heads of Agreement* (30 October 2020) cl 3.1 [MOH.9999.1678.0001 at 0006].

b. set guiding principles including collaboration, openness, respect, empowerment, accountability, communication, innovation, sustainability and integrity;[1120]

c. provide for the establishment of a steering committee to provide leadership and strategic direction, and to ensure compliance with the terms of the Heads of Agreement;[1121] and

d. set out the parties' respective responsibilities in relation to services and operational matters.[1122]

13.47. The formalisation of those arrangements through Heads of Agreement can be seen as progress in overcoming some of the challenges described above. However, there was widespread agreement in the evidence that the delivery of paediatric services across NSW would be enhanced by the development of a Statewide plan and strategy dedicated to those services. For example, and without intending to be exhaustive, the evidence revealed that there would be considerable benefit in such a plan addressing matters such as:

a. an identification of the services that can be expected to be provided in the specialist children's hospitals and those services that sit within the LHDs;

b. how those services interact with and support each other; and

c. 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.[1123]

13.48. 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.[1124]

[1120] Exhibit G.114, SCHN and Hunter New England LHD, *Heads of Agreement* (December 2020) cl 3.2 [MOH.9999.1676.0001 at 0006-0007]; Exhibit G.115, SCHN and South Western Sydney LHD, *Heads of Agreement* (30 October 2020) cl 3.2 [MOH.9999.1678.0001 at 0006-0007].

[1121] Exhibit G.114, SCHN and Hunter New England LHD, *Heads of Agreement* (December 2020) cls 4.1-4.2 [MOH.9999.1676.0001 at 0007-0008]; Exhibit G.115, SCHN and South Western Sydney LHD, *Heads of Agreement* (30 October 2020) cls 4.1-4.2 [MOH.9999.1678.0001 at 0007-0008].

[1122] Exhibit G.114, SCHN and Hunter New England LHD, *Heads of Agreement* (December 2020) cl 5 [MOH.9999.1676.0001 at 0009]; Exhibit G.115, SCHN and South Western Sydney LHD, *Heads of Agreement* (30 October 2020) cl 5 [MOH.9999.1678.0001 at 0009].

[1123] Exhibit G.33, Statement of John Preddy (30 May 2024) [5] [SCI.0011.0067.0001 at 0001]; Transcript of the Commission, 11 June 2024, T3400.13-3401.9 (Alexander), T3434.35-3437.3, T3442.45-3443.32 (Cox); Transcript of the Commission, 14 June 2024, T3641.28-42, T3653.22-3654.10, T3651.27-36 (Preddy), T3700.01-3702.34, T3707.42-3708.2 (Lyons); Exhibit G.17, NSW Health, *Review of Governance for the Sydney Children's Hospitals Network* (Final Report, June 2019) p 4 [SCI.0010.0004.0001 at 0004]; Exhibit G.96, Statement of Joanne Ging (6 June 2024) [31(a)] [MOH.9999.1292.0001 at 0007]; Transcript of the Commission, 19 November 2024, T6355.28-41 (Cox).

[1124] Exhibit G.106, NSW Health, *Paediatric Service Capability (Paediatric Medicine and Surgery for Children)* (Guideline No GL2023_022, 1 December 2023) [MOH.0002.0144.0001]; Transcript of the Commission, 11 June 2024, T3411.40-3414.30 (Ging); Exhibit G.96, Statement of Joanne Ging (6 June 2024) [31(b)] [MOH.9999.1292.0001 at 0007]; Transcript of the Commission, 14 June 2024, T3677.26-3678.35 (Craven), T3691.20-41, T3701.47-3702.24 (Lyons).

13.49. Since its establishment, a number of reviews have examined the operation of SCHN and how its governance may best support the delivery of high quality care for children and young people across NSW. These reviews have also considered the broader governance of paediatric care in the State.

13.50. In 2019, the *Review of Governance for the Sydney Children's Hospitals Network* (the *Alexander Review*) was tasked to identifying the most effective form of governance for the Network.[1125]

13.51. As NSW Health pointed out in its final written submissions,[1126] the creation of a Statewide plan for paediatric services that deals with those matters is entirely consistent with recommendations made in the *Alexander Review* in relation to paediatric services and the functioning of SCHN.[1127] Relevantly, those recommendations included that:[1128]

a. there should be a "clearly articulated strategy for paediatrics in NSW which provides direction for the range of paediatric services in the State";

b. existing committee structures should be reviewed and consolidated to create a streamlined and coordinated NSW paediatric care network;

c. a set of principles that underpin the operation of the NSW paediatric care network should be established; and

d. the membership of the NSW paediatric care network should include SCHN, the John Hunter Children's Hospital, LHDs that provide paediatric services, and Statewide paediatric services.

13.52. Leaving to one side the labels given to the proposed "network" in the *Alexander Review*, the substance of those recommendations was directed to the need for greater coordination and planning of paediatric services across NSW, including in relation to how those services interact with each other. Put another way: a Statewide strategy and plan.

13.53. Those recommendations – and others that it was felt dealt with matters other than the governance of SCHN – were not accepted.[1129] The reasons for that are not entirely clear, although it is apparent that there was a concern that several of the recommendations made (including those referred to above) extended beyond the

[1125] Exhibit G.17, NSW Health, *Review of Governance for the Sydney Children's Hospitals Network: Final Report of the Expert Panel* (Final Report, June 2019) p 6 [SCI.0010.0004.0001 at 0006].

[1126] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [8.13] [SCI.0011.0814.0001 at 0035].

[1127] Exhibit G.17, NSW Health, *Review of Governance for the Sydney Children's Hospitals Network* (Final Report, June 2019) pp 20-24 [SCI.0010.0004.0001 at 0020-0024].

[1128] See especially Recommendations 1, 4, 5, and 6: Exhibit G.17, NSW Health, *Review of Governance for the Sydney Children's Hospitals Network* (Final Report, June 2019) pp 20-22 [SCI.0010.0004.0001 at 0020-0022].

[1129] Transcript of the Commission, 14 June 2024, T3698.7-36 (Lyons).

intended scope of the *Alexander Review*.[1130] In any event, before the *Alexander Review* report had even been concluded, a further "review of health services for children, young people, and families within the NSW Health system" was announced by the then Health Minister – which became to be known as the *Henry Review*.[1131]

13.54. The *Henry Review* made 77 recommendations, all of which were accepted by NSW Health.[1132] Ultimately, the scope of the *Henry Review* came to include a consideration of some of the recommendations that were made in the *Alexander Review*.[1133] In considering those recommendations, it is apparent that the *Henry Review* proceeded on the basis that the *Alexander Review* had called for an expanded role of SCHN that included an "enhanced governance role for the SCHN across the State".[1134] For my part, I do not consider that is what the *Alexander Review* recommended.[1135]

13.55. Irrespective of the precise reason why the recommendations made in the *Alexander Review* discussed above were not accepted and implemented at the time, the need to develop a Statewide plan and strategy for the delivery of paediatric services across NSW is now both clear and widely accepted.

The Justice Health and Forensic Mental Health Network

13.56. Justice Health is a unique, and important, part of the NSW public health system.

13.57. Its remit in delivering healthcare to approximately 13,000 people that are detained within the forensic mental health and criminal justice systems across the State at any one time is, arguably, the widest of any public health organisation. It delivers a broad range of services across the spectrum of primary care, drug and alcohol, mental health, population health, women's and midwifery, oral health, First Nations healthcare, specialist care, and allied health.[1136]

13.58. The challenges faced by Justice Health in delivering care to its patient cohort are many and varied. As I note elsewhere in this Report, the block funding received by Justice Health is, frankly, insufficient to meet the considerable health needs of the vulnerable population it serves. Many of those in the criminal justice and forensic mental health systems have been dealt a particularly poor hand by the social determinants of health (and society more generally) and, accordingly, have highly

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[1130] Transcript of the Commission, 14 June 2024, T3694.43-3695.44 (Lyons).

[1131] The *Henry Review* was announced in February 2019, about four months prior to the report of the Alexander Review: Exhibit G.18, Richard Henry, *Review of health services for children, young people and families within the NSW Health system* (Report, December 2019) p 16 [SCI.0010.0001.0001 at 0016].

[1132] NSW Health, *The Henry Review Implementation Plan* (July 2022) p 3 [SCI.0010.0005.0001 at 0005].

[1133] Transcript of the Commission, 14 June 2024, T3697.32-3698.18 (Lyons).

[1134] Exhibit G.18, Richard Henry, *Review of health services for children, young people and families within the NSW Health system* (Report, December 2019) pp 41-42 [SCI.0010.0001.0001 at 0041-0042].

[1135] Transcript of the Commission, 11 June 2024, T3447.6-3448.39 (Cox).

[1136] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [4]-[5] [MOH.0011.0086.0001 at 0001-0002].

complex care needs. In this respect, those in custody represent "the intersectionality of identified priority populations".[1137] For example: [1138]

a. women in custody experience higher rates of social disadvantage than men. First Nations women are the fastest growing inmate population and have double the incarceration rate of First Nations men, and 15 times that of non-Indigenous women.[1139] Their experience in custody is also different, often reflected in shorter and disruptive custodial terms, consistent with the fact that they often enter prison for less serious offences than men. The loss of access to a range of supports – housing, health, family, social, and the like – while in custody can increase the likelihood of reoffending after release;[1140]

b. young people in contact with the criminal justice system in NSW often present with complex healthcare needs. However, as they tend to spend shorter periods of time in custody, they have limited opportunities for engagement with health services to enable any meaningful assessment of their healthcare needs or the development of a care plan. While I recognise the tension between the wholly correct principle that no person should be deprived of their liberty a day longer than is appropriate, the very short period many of these young people spend in a custodial environment provides limited opportunity for consequential intervention;

c. missed opportunities for early intervention and engagement with crisis services, within custodial settings, diversion programs, or more broadly in the community, is not only detrimental to long term wellbeing of young people at risk; it also represents a significant cost to governments across Australia (estimated by one study at more than $15 billion annually as at 2019, across unemployment services, out-of-home care, and justice sectors);[1141]

d. the majority of individuals in the custodial environment, and all patients detained within the forensic mental health system, suffer from a mental health condition. A great many of them are prescribed antipsychotic medication. When combined with the wider social determinants of health, these factors produce very high rates of metabolic disorders among Justice Health's cohort of patients;

e. it is well known that First Nations people are disproportionately represented in custodial populations, and have been for some time. Presently, the First Nations prison population constitutes 31 per cent of adults and 59 per cent of young people in custody, notwithstanding that they comprise 3 and 5 per cent of those

[1137] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [68] [MOH.0011.0086.0001 at 0015].

[1138] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [25]-[37] [MOH.0011.0086.0001 at 0006-0009].

[1139] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [26] [MOH.0011.0086.0001 at 0006].

[1140] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [26] [MOH.0011.0086.0001 at 0006].

[1141] See William Teager, Stacey Fox and Neil Stafford, How Australia can invest early and return more: A new look at the $15b cost and opportunity. Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia, 2019; Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [29] [MOH.0011.0086.0001 at 0007].

populations respectively across the State.[1142] I discuss the particular health challenges faced by First Nations people elsewhere in this Report. Addressing them is even more challenging in the custodial environment; and

f. for many in contact with the criminal justice or forensic mental health systems, the services provided by Justice Health represent their first (or first substantive) interaction with a health service. A vast majority of those people will have experienced the impact of several social determinants of health, resulting in high rates of mental illness, drug and alcohol addiction, and chronic disease.[1143] Those conditions (particularly mental ill-health) have frequently contributed to their offending.[1144] Providing access to appropriate treatment while these individuals are in the custodial environment is known to produce lower rates of recidivism.[1145] The benefits to this cohort of effective intervention by health services in the custodial environment is obvious.

13.59. In that context, the importance of Justice Health and the services it provides cannot be overstated; both to those within the criminal justice system and to society more broadly.

13.60. There will be some in the wider community who feel that people in custody ought not have access to the same levels of healthcare as the rest of the community. They may think that delivering high quality healthcare to those in custody is reflective of a society that is "soft on crime". Perhaps views of that kind are reinforced by the fact that health services delivered in the custodial environment are ineligible for MBS funding and most of the PBS benefits available to the wider population.[1146] Irrespective of why such views might be held, they are wholly misguided. They ignore the fact that universality is the central premise of a universal healthcare system. They ignore the United Nations Standard Minimum Rules for the Treatment of Prisoners[1147] (a matter that I accept may be of little concern to those that hold such views). And they fail to recognise the undeniable societal benefits of early and effective interventions when dealing with the health of that vulnerable cohort.

[1142] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [30] [MOH.0011.0086.0001 at 0007].

[1143] Transcript of the Commission, 19 November 2024, T6307.20-24 (Hoey).

[1144] Transcript of the Commission, 19 November 2024, T6306.6-6308.5 (Hoey).

[1145] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [60] [MOH.0011.0086.0001 at 0014]; Transcript of the Commission, 19 November 2024, T6306.7-6307.7 (Hoey).

[1146] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [7], [47] [MOH.0011.0086.0001 at 0002, 0011]. I have commented earlier in this Report about this issue. Although those services are delivered by the State (and thus the State would ordinarily be ineligible to receive MBS funding in the absence of an exemption pursuant to s 19(2) of the *Health Insurance Act*), it is perplexing to me that the significant disqualifying factor is seemingly that the relevant patient is in custody. Quite why that ought to disentitle them to the benefit of the national insurance scheme that is Medicare is unclear to me. However, the rationale for that approach was not explored in the evidence before this Special Commission. Nevertheless, if it has not already been done - and given the clear benefits of delivering effective and timely healthcare to those in custody – the Ministry of Health together with the NSW Government more broadly should consider whether that it is a matter that should be raised with the Commonwealth in future funding negotiations as a means of supporting the effective delivery of healthcare to those in custody.

[1147] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [32] [MOH.0011.0086.0001 at 0008].

13.61. There is clear evidence that investment in high quality health services for those in a custodial environment, which seeks to curb the social determinants of health, has wider benefits than those delivered to the individual patient. Effective health intervention materially reduces the risk of recidivism and promotes long term economic benefits.[1148] In this respect, the Statewide Community and Court Liaison Service diversion program has been found to produce a saving to the criminal justice sector at a rate of more than $4 for every $1 spent.[1149]

13.62. In addition to the savings being delivered across the criminal justice system, there are wider economic benefits, such as those described by Ms Wendy Hoey PSM, the Chief Executive of Justice Health, when giving evidence:[1150]

> *THE COMMISSIONER: Your organisation is responsible for the health of the prison population, and did you say 13,000? You did?*
>
> *MS HOEY: Yes.*
>
> *THE COMMISSIONER: And not many of those people are what are called lifers?*
>
> *MS HOEY: No.*
>
> *THE COMMISSIONER: Some will die in prison simply because they might have committed a crime 30 years ago and they –*
>
> *MS HOEY: Correct. The majority of people come --*
>
> *THE COMMISSIONER: If you get a 20-year sentence when you're in your 70s, you're probably not leaving prison. But most people are getting out; correct?*
>
> *MS HOEY: Correct, yes.*
>
> *THE COMMISSIONER: And as a matter of logic when people are released from prison it would be better if, as far as possible, their mental health conditions have been addressed and they're healthy?*
>
> *MS HOEY: Correct.*
>
> *THE COMMISSIONER: Because it would be better if they're not becoming a burden on the public hospitals, is one thing?*
>
> *MS HOEY: That's correct.*

[1148] That is true not only for those in custodial environments, but extends to those experiencing homelessness and other forms of disadvantage: see, for example, Transcript of the Commission, 20 September 2024, T5558.12-5559.24 (Carter).

[1149] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [52]-[57] [MOH.0011.0086.0001 at 0008].

[1150] Transcript of the Commission, 19 November 2024, T6312.24-6313.26 (Hoey)

> *THE COMMISSIONER: And it would be better if they had the best possible chance to become economically active, productive members of society?*
>
> *MS HOEY: Correct.*

13.63. The concepts addressed in the above extract might seem obvious to most people, but they bear repeating in this Report, if only to reinforce the benefit of timely and appropriate healthcare being delivered to those that find themselves in the criminal justice or forensic mental health systems.[1151]

13.64. In addition to the challenges posed by the demographic features of Justice Health's patient cohort, it will come as no surprise to anyone that the delivery of care in custodial settings is far from routine. That care delivery must, necessarily, interact with the operation of custodial facilities across the State. Within those constructs, Justice Health has limited ability to ensure the timely delivery of care to those whose location and availability **it** – as opposed to Corrective Services NSW – does not control.[1152] Accordingly, Justice Health must – and does – work closely with Corrective Services NSW and Youth Justice NSW; although given what I consider to be the high rates of appointment cancellations due to correctional "operational issues",[1153] there is likely to be scope for those with operational responsibility for those facilities to do much more to ensure timely access to healthcare for those in custody. That is a matter that should be explored as part of a whole of government approach to preventive health that I recommend elsewhere in this Report. There is no reason why that same approach should not extend to that portion of the population which transitions through the custodial environment.

13.65. Part of that approach should also extend to creating pathways for the effective transfer of care of those that are in custody from Justice Health to care providers (primary care givers, ACCHOs, community mental health services and the like) in the community. Continuity and reliable access to care in the community is vital to the effective rehabilitation of those leaving the custodial environment and to their ongoing health and wellbeing. The significance of an effective transfer of care upon release was described by Ms Hoey as follows:[1154]

> *The weeks following release from custody are a particularly high-risk period, with high rates of overdose, death and risky behaviours. The service impact for coordination, transfer and continuity of care for people in custody is felt most by Justice Health NSW's primary care service.*

[1151] See also Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [59] [MOH.0011.0086.0001 at 0008].

[1152] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [11], [34]-[35] [MOH.0011.0086.0001 at 0003, 0008-0009].

[1153] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [34]-[35] [MOH.0011.0086.0001 at 0008-0009].

[1154] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [36] [MOH.0011.0086.0001 at 0009].

> *Effective coordination of care for people returning to the community can be impeded by their unexpected release, homelessness, service eligibility criteria or availability, reluctance of providers to accept the referral due to the person's complex care and social support needs…This can leave people with unresolved health issues that impact their wellbeing and offending behaviour, increasing the likelihood of future contact with the criminal justice system.*

13.66. There is also need for an urgent review of the current arrangements for access to psychological services in custodial settings. I was told that under the current Corrective Services NSW service model, unlike those serving a custodial sentence, those on remand (some of whom may be on remand for extended periods) cannot access psychological programs.[1155] As Ms Hoey aptly observed, that reflects a "strange" split.

13.67. Corrective Services NSW is funded to provide psychological services while Justice Health is funded to deliver psychiatric services. That split is (at least in part) explained by the fact that psychological services are delivered through a criminogenic lens. While there may be good reason for that type of approach, the lack of access to other evidence based psychological programs delivered for mental health reasons (because Justice Health is not funded to deliver such programs) for those vulnerable populations means that they are, at least currently, missing out on care that could (and in my view is likely to) produce better health outcomes for them.[1156] At the risk of repeating myself – but given the importance of the point, I will – better health outcomes for those in custody lead to lower rates of recidivism and overall societal and economic benefits.

13.68. To my mind, there is a very real question as to whether that split – including in the funding arrangements for psychological services delivered to the custodial population (including those on remand) – should continue. I have no doubt that there would be significant benefits to the health of the custodial population if it was able to access psychological programs in addition to those delivered through a criminogenic lens by Corrective Services NSW. That is not to say that criminogenic services ought not be utilised by Corrective Services NSW where appropriate; rather, I am unconvinced that the use of those approaches should (at least by default) preclude the custodial population from also accessing other psychological programs that could be delivered by Justice Health if it was funded to do so.

13.69. However, in circumstances where I was told that Justice Health and Corrective Services NSW are collaborating to work though those issues,[1157] and given that time, resources, and the need to inquire into a great many other issues did not permit a

[1155] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [21] [MOH.0011.0086.0001 at 0005].

[1156] Transcript of the Commission, 19 November 2024, T6308.7-6311.6 (Hoey).

[1157] Transcript of the Commission, 19 November 2024, T6308.7-6311.6 (Hoey)

thorough exploration of all of the complexities of delivering psychological care to the custodial population, I will not express a firm view about that issue. However, I am sufficiently concerned about the lack of access to what I consider to be important care for Justice Health's patient cohort to recommend that the current arrangements – along with those for the management of forensic health patients across the State (discussed below) – be independently examined by an appropriately qualified and experienced person as a matter of urgency.

13.70. Another matter that must be urgently addressed as part of a Statewide approach to care of the custodial population relates to their diet, which I am told is currently the responsibility of Corrective Services NSW. That diet has a significant impact on a person's overall health and wellbeing is now so well accepted that it might be considered trite. The importance of diet and exercise is, perhaps, even more significant in the context of a population that has a high propensity for mental illness, metabolic disorders (and associated obesity), and chronic disease.[1158] In those circumstances, I was alarmed when I was told that prisoners in the facility at Long Bay visited by this Special Commission are currently provided with large quantities of white bread before being locked in their cells of an afternoon.

13.71. Although I do not pretend to be an expert in the effects of over consumption of complex carbohydrates, even I can recognise that providing large quantities of white bread to a cohort that experiences high rates of metabolic disease and obesity before locking them in cells for extended periods is inconsistent with the promotion, improvement, or maintenance of their overall health and wellbeing. Whatever the reason may have been for the adoption of that approach – in my view, it cannot be supported from a health system perspective, and it should cease.

13.72. One of Justice Health's statutory functions is to provide advice to the Commissioner of Corrective Services NSW in relation to "diet" and "exercise" of inmates.[1159] The interaction between Justice Health and those responsible for the operation of custodial facilities was highlighted in the passage of evidence:[1160]

> *MR MUSTON: In terms of metabolic disease and other co-morbidities, it's not just the delivery of primary health care which is important in terms of trying to keep these patients well and reducing long term their morbidity?*
>
> *MS HOEY: Correct, yes.*
>
> *MR MUSTON: Also --*

[1158] Transcript of the Commission, 19 November 2025, T6311.19-47 (Hoey).

[1159] *Crimes (Administration of Sentences) Act 1999* (NSW), s 236A.

[1160] Transcript of the Commission, 19 November 2025, T6311.42-6314.37 (Hoey).

MS HOEY: Prevention, health - health literacy, prevention and health promotion.

MR MUSTON: Diet?

MS HOEY: Yes, diet definitely. We saw examples of that in Long Bay.

MR MUSTON: That's what I was going to ask you about. In essence you have a captive audience when it comes to the delivery of a good diet. Is that something which Justice Health is involved in from a dietetics point of view, or is it something that's dealt with by [Corrective Services NSW]?

MS HOEY: Yes, it's got to be dealt with by both of us because Corrections provide the food, … We're providing the advice, if you like. So we have developed our health --

THE COMMISSIONER: Your advice, I assume, doesn't extend to "it's a good idea to give the prisoners a loaf of white bread before they are locked down for the night"?

MS HOEY: No, that's not actually our advice. But we are working together with them to try and change some of the habits that are happening through our healthy prisons framework. So we're starting with what we would call buy-up, so that's the prison shop, if you like, and at least having healthy alternatives available.

…

THE COMMISSIONER: So if you're in charge of health why wouldn't you be in charge of diet, given it's so related to health? Why is Corrections in charge of diet?

MS HOEY: I think we provide health care.

THE COMMISSIONER: Yes.

MS HOEY: To the prison population.

THE COMMISSIONER: Yes.

MS HOEY: Corrections have the broader responsibility to provide a roof over their head, a safe environment.

THE COMMISSIONER: Yes.

MS HOEY: Their food. So it's with Corrections.

THE COMMISSIONER: Does food make sense, though?

MS HOEY: Yes, because Corrective Services --

> *THE COMMISSIONER: It depends what it is, I suppose, doesn't it?*
>
> *MS HOEY: Yes. Yes, that's right, Corrective Services. I think we have a responsibility from a health perspective to work with Corrections to ensure that we're advising and promoting healthy environments, and that's what we're doing. I mean, they're linking in well --*
>
> *THE COMMISSIONER: Would your advice in relation to the diet that prisoners have be different to the diet that's actually provided to them?*
>
> *MS HOEY: Yes. Yes.*
>
> *THE COMMISSIONER: In the sense that it would be --*
>
> *MS HOEY: Wouldn't be white bread.*
>
> *THE COMMISSIONER: It would be a healthier diet?*
>
> *MS HOEY: Definitely a healthier diet.*
>
> *THE COMMISSIONER: In the way we understood a good, healthy --*
>
> *MS HOEY: Correct.*
>
> *THE COMMISSIONER: -- balanced diet to maintain a good levels of weight instead of obesity?*
>
> *MS HOEY: Yes, and exercise as well. You know, the fundamentals of good health is what we'd be trying to push through our healthy prisons framework.*

13.73. In my view, given the obvious significance of a healthy and balanced diet, together with exercise, in managing the health of a population that has a high incidence of metabolic disorders, obesity, and chronic disease, the role of Justice Health (supported, as appropriate, by other NSW Health agencies) should be elevated from an advisory role to one that sets the minimum nutritional requirements for the diet to be delivered to the prison population, which, in turn, must be met by the relevant agency responsible for feeding that population. Justice Health must be funded appropriately to perform that function, and necessary statutory amendments (including to description of the function of Justice Health set out in s 236A of the *Crimes (Administration of Sentences) Act 1999* (NSW)) should be made to give effect to it.

13.74. Thus far, much of what has been said has been directed to the custodial environment. However, Justice Health also faces significant challenges in providing services to forensic mental health patients. One of those challenges is the ability to transition patients through the system – from high security facilities, through medium security facilities and then into a general ward environment – as their care needs evolve.[1161]

[1161] See, generally, Transcript of the Commission, 19 November 2024, T6302.43-6304.46 (Hoey).

While Justice Health has responsibility for high security facilities, medium security facilities are primarily within the remit of the LHDs. In her evidence, Ms Hoey gave the following example of the effect of those challenges in delivering care to that particular cohort:[1162]

> *…within our control in our budget is a 135-bed high secure forensic hospital at Malabar and also our primary care – our primary court diversion centre – service both for adults and for youth, also our community forensic mental health service, which provides advice, risk assessment to all the LHDs across New South Wales, and also have a sort of relationship responsibility to all the medium secures and low secures across the state and also all the forensic patients that are within LHDs, which - where the majority of forensic mental health patients are.*
>
> *… if somebody comes before the court and is given defence under the Mental Health and Cognitive Impairment Forensic Provisions Act, so they would be detained in - or the MHRT, the Mental Health Review Tribunal, would detain them, so that could be to a forensic mental health high secure hospital, medium secure, low secure. They can also detain within the prison setting as well, and unfortunately we have 27 forensic patients in our prison setting just now awaiting health beds, not under a custodial order but under a health order, and that's because within our high secure forensic mental health setting we have patients waiting for medium secure, and as well in medium secure, which is from where the LHDs, they have patients awaiting to get out and to do that rehabilitation. So [there's] just general bed block across the system.*

13.75. There can be no doubt that it is contrary to the interests of patients who require acute care in a forensic mental health facility to remain in a traditional custodial environment. Like all patients, they should be cared for in the setting most appropriate for their condition and the one that provides the greatest prospect of producing good health outcomes.[1163]

13.76. Those challenges are compounded by the fact that, although Justice Health has primary responsibility (as the lead agency) for the NSW forensic mental health system, it has no authority or governance over patient flow outside of the high security environment.[1164]

[1162] Transcript of the Commission, 19 November 2024, T6302.23-6304.11 (Hoey).

[1163] Transcript of the Commission, 19 November 2024, T6303.30-39 (Hoey).

[1164] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [69] [MOH.0011.0086.0001 at 0016].

13.77. Although my present view is that there is likely to be considerable benefit to the forensic mental health system generally if Justice Health were to have overall management and governance responsibility for forensic mental health facilities across the State, given that there is a trial currently under way to examine that very question – and that time did not permit a thorough exploration of those issues in the context of this Special Commission – it would be premature for me to express a concluded view, or to make a recommendation about it in this Report.

13.78. Irrespective of the results of that trial, NSW Health must – as part of its overall planning processes – take steps to alleviate bed block in those facilities. Even if responsibility for medium security facilities were to remain with the LHDs there is likely to be significant benefit in Justice Health having, at least, central oversight of all forensic mental health patients and facilities across the State to facilitate patient flow through the system. Those matters should also be the subject of independent review as a matter of urgency.

13.79. Finally, it is convenient to say something here about the funding arrangements for Justice Health. While Justice Health's funding should be informed by the Statewide planning process that I have described elsewhere in this Report, there are some matters relating to it that I wish to highlight as they provide clear examples of the need to approach planning and funding in the way I have set out elsewhere.

13.80. First, as with the system as a whole – Justice Health's budget is determined by reference to a historical base figure, the origin of which is unknown. No assessment of whether Justice Health is currently (or has historically been) funded adequately to meet the needs of its patient population is undertaken when assessing the level of funding Justice Health is to receive each year.[1165] Whatever the source of the historical base figure might be, there is little to suggest that it now has (if it ever did have) any correlation to service need.[1166] In those circumstances, the use of that base as a starting point for the development of Justice Health's budget defies logic.

13.81. Secondly, there is a disconnect between historical funding models and the service needs of the population within the care of Justice Health.[1167] Those funding models do not adequately take account of service demand or the needs of the vulnerable population served by Justice Health, in part because those responsible for making these funding decisions fail to sufficiently engage with these issues.

13.82. Thirdly, although it was noted that Justice Health operates within its budget and has performed very well financially when compared with the rest of the system, it was also acknowledged that this fact says much more about the fiscal skills of Justice

[1165] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [13] [MOH.0011.0086.0001 at 0003]; Transcript of the Commission, 21 November 2024, T6608.27-6609.4 (D'Amato/Onley).

[1166] Transcript of the Commission, 19 November 2024, T6320.39-6321.19 (Hoey).

[1167] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [14] [MOH.0011.0086.0001 at 0003].

Health's management than about the adequacy of its funding envelope.[1168] As with any other public health organisation, that Justice Health has been successful in operating within its budget envelope should not (without much more analysis) be understood as meaning that it is resourced sufficiently to meet the healthcare needs of its patient population.[1169] I am satisfied that, in the case of Justice Health, this is **not** the case. I am also satisfied that those responsible for the management of Justice Health have made very clear to me that the funding they currently receive is insufficient to meet the health needs of its patient population.[1170]

13.83. Fourthly, a widening gap between Justice Health's service demand and service capacity (something that is also apparent across the system more broadly) suggests that it is not currently resourced to meet the healthcare needs of the population it serves.[1171] There are clear indicators to that effect. For example, Justice Health's underperformance against its self-imposed (and refreshingly insightful) KPIs relating to patients accessing care within clinically acceptable timeframes, and its clear advice to the Ministry of Health that the demand for dental services exceeds funding allocations.[1172] The Ministry of Health should not be in any doubt having had the benefit of hearing and reading Ms Hoey's evidence to this Special Commission that the current demand for Justice Health's services vastly exceeds that which can be provided with its current block funding,[1173] particularly in circumstances where no suggestion has been made to me that the divergence can be explained by inefficiencies of any kind.

13.84. In order to address those, and the many other, challenges it faces, Justice Health is engaging in a process to identify the health needs of those in custody to design service from the "bottom up", which begins with a detailed understanding of the health needs of those in its care in order to determine its funding needs – rather than one that begins with the budget and adapting services to the funds available.[1174] That approach recognises the importance of designing and planning a service that is targeted to meeting the health needs of those in its care. It is only once that is done that there can be a proper identification of the resources required to deliver that service – financial and human – and decisions can be made about what can and cannot be done within the constraints of finite public resources. That is precisely the kind of approach that I recommend be adopted across the system as a whole.

[1168] Transcript of the Commission, 22 November 2024, T6610.15-29 (D'Amato).

[1169] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [14] [MOH.0011.0086.0001 at 0003]; Transcript of the Commission, 19 November 2024, T6323.26-46 (Hoey).

[1170] C.F. Transcript of the Commission, 21 November 2024, T6610.1-13 (Daly).

[1171] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [38]-[41] [MOH.0011.0086.0001 at 0009-0010]; Transcript of the Commission, 19 November 2024, T6326.8-34 (Hoey).

[1172] Exhibit N.14, Letter from Professor Denis King OAM, Board Chair, Justice Health NSW (December 2024) [MOH.0010.0754.0001].

[1173] As I observed at the time: Transcript of the Commission, 21 November 2024, T6612.33-42.

[1174] Exhibit M.3, Statement of Wendy Hoey (13 November 2024), [14] [MOH.0011.0086.0001 at 0003].

Conclusion

13.85. Statewide Services are an important feature of the NSW public health system. They provide highly specialised care to those in need of it across the State, and they do it well. However, the are several improvements that can be made to enhance those services and their sustainability.

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.

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.

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.

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

14. Chapter

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Introduction

14.1. For over a century, many of the religious and charity sector entities now described as Affiliated Health Organisations have played an integral role in the delivery of healthcare to the people of NSW. Their ongoing importance to what is now the public health system is best illustrated through the formal status they enjoy under the *Health Services Act*.

14.2. Representatives of the following AHOs gave evidence before this Special Commission:

a. The Royal Society for the Welfare of Mothers and Babies (Tresillian);

b. Karitane;

c. Royal Rehab Group; and

d. St Vincent's Health Network.

14.3. Before turning to a consideration of the issues raised by that evidence, it is useful to briefly describe those organisations, and the services they provide.

Royal Society for the Welfare of Mothers and Babies (Tresillian)

14.4. Tresillian is Australia's largest not for profit early parenting service. It supports new parents with issues including breastfeeding and nutrition, sleep and settling, as well as perinatal mental health.[1175] Tresillian provides services across NSW.[1176]

14.5. Tresillian was established under statute in 1919 to provide early parenting services across NSW, and has been doing so in collaboration with the NSW Government since that time.[1177] The organisation's current by-laws were gazetted by the NSW Parliament in 2018.[1178]

14.6. Tresillian operates 20 inpatient beds at Nepean Hospital, 14 beds at Canterbury Hospital, 14 beds in a facility in Wollstonecraft, and four beds at Macksville Hospital. It also has family care centres, which operate as drop in day services, at Nepean Hospital, Canterbury Hospital and Wollstonecraft.[1179] It also operates day services in several regional locations, including Lismore, Coffs Harbour, Taree, Muswellbrook, Armidale, Griffith, Goulburn, Queanbeyan, Broken Hill, Dubbo, and Moruya.[1180] "Tresillian 2U" vans operate in regional locations, which contain mobile nurseries and

[1175] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [2] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024, T2049.28–34 (Mills).

[1176] Transcript of the Commission, 18 April 2024, T2050.28–34 (Mills).

[1177] *Royal Society for the Welfare of Mothers and Babies' Incorporation Act 1919* (NSW): Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001]; Transcript of the Commission, 18 April 2024, T2049.38–44 (Mills); Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001 at 0001].

[1178] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [3] [SCI.0008.0344.0001 at 0001]; Transcript of the Commission, 18 April 2024, T2050.6–12 (Mills).

[1179] Transcript of the Commission, 18 April 2024, T2050.43–2051.27 (Mills).

[1180] Transcript of the Commission, 18 April 2024, T2051.37–45 (Mills).

travel to five different small regional locations per week.[1181] Tresillian also operates telephone and virtual services in partnership with Karitane.

14.7. Tresillian's services are primarily funded through agreements with Sydney LHD.[1182] Under the 2023–24 agreement, Tresillian provided Statewide residential services, a virtual parenting service, day services, a parents' helpline, home visiting (including extended visits), and perinatal mental health services.[1183] The budget allocation was $14,535,000, covering services at Nepean Hospital, Canterbury Hospital, and Wollstonecraft, along with support for the parents' helpline and various ancillary services.[1184]

14.8. In addition, Tresillian entered into separate service agreements with Healthy North Coast PHN and Northern NSW LHD, Albury Wodonga Health, Murrumbidgee LHD, Western NSW LHD, Southern NSW LHD, Far West LHD, Hunter New England LHD, Mid North Coast LHD, Nepean Blue Mountains LHD, and the Ministry of Health.

14.9. Tresillian's service agreement with Sydney LHD is a one year agreement, which has historically rolled over each year.[1185] Its service agreements with regional LHDs and the Ministry of Health are renegotiated at the end of their fixed terms.[1186] However, as a matter of practice, funding has not been withdrawn for any Tresillian service under these agreements since 2015.[1187]

Karitane

14.10. Karitane has been operating since 1923.[1188] It is a registered charity through the Australian Charities and Not-for-profits Commission, and a company limited by guarantee operating under the governance of an independent Board of Directors.[1189]

14.11. Karitane provides Statewide and national child and family health services, including perinatal mental health, parenting support, and early intervention for families with children in the first 2000 days after birth (zero to five years).[1190] It operates 19 tertiary residential beds at Campbelltown Hospital, Randwick Parenting Centre, and Jade House, alongside a Statewide toddler clinic and services at Oran Park Integrated

[1181] Transcript of the Commission, 18 April 2024, T2072.16–32 (Mills).

[1182] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [24] [SCI.0008.0344.0001 at 0008].

[1183] Exhibit D.96, SLHD and Tresillian Family Care Centres, *Service Agreement 2023–24* (12 December 2023) [3.2] [SCI.0008.0113.0001 at 0014].

[1184] Exhibit D.96, SLHD and Tresillian Family Care Centres, *Service Agreement 2023–24* (12 December 2023) [4] [SCI.0008.0113.0001 at 0019]; Transcript of the Commission, 18 April 2024, T2058.3–20 (Mills).

[1185] Transcript of the Commission, 18 April 2024, T2059.40–46 (Mills).

[1186] Transcript of the Commission, 18 April 2024, T2058.42–2059.19, 2060.1–13 (Mills).

[1187] Transcript of the Commission, 18 April 2024, T2061.26–31 (Mills).

[1188] Transcript of the Commission, 18 April 2024, T2002.33–34 (O'Loughlin).

[1189] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [4]–[6] [SCI.0008.0343.0001 at 0001].

[1190] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [7] [SCI.0008.0343.0001 at 0001]; Transcript of the Commission, 18 April 2024, T2002.27–44 (O'Loughlin).

Care Hub.[1191] Karitane also offers nursing in child and family hubs at Wolli Creek, Shellharbour, and Newcastle, collaborating with Mission Australia, the Benevolent Society, and Barnardos to provide parenting support throughout NSW. These services deliver early intervention for families with complex care needs.[1192] It also provides virtual residential parenting services and virtual home visiting services, which are Statewide services operating through virtual means, such as phone calls, video calls, emails, and webinars.[1193]

14.12. Families are generally referred to Karitane through general practitioners, paediatricians, psychiatrists, psychologists, and child and family health services in the LHDs.[1194]

14.13. Karitane primarily provides its child and family health services to the public health system through service agreements with South Western Sydney LHD.[1195] Under those agreements, Karitane receives block funding for a financial year, with a range of agreed performance measures and KPI targets, which are reported on quarterly.

14.14. For example, the 2023–24 service agreement between Karitane and South Western Sydney LHD covers Karitane's residential unit beds at Campbelltown Hospital, the Randwick Parenting Centre, Jade House, the Statewide toddler clinic, and the Oran Park Integrated Care Hub.[1196] The budget allocation for these services was $8,024,980 (excluding Patient Fees, Karitane Donation Revenue, other "own source funding", and supplemental Ministry of Health Funding).[1197]

14.15. In addition, Karitane has grant funding agreements directly with the Ministry of Health for the provision of its virtual residential parenting services and virtual home visit services.[1198] The agreement relating to virtual residential parenting services is ongoing and has most recently been extended to 30 June 2025.[1199] Karitane also has a partnership agreement with South Eastern Sydney LHD for the provision of services at the Wolli Creek Hub.[1200]

[1191] Transcript of the Commission, 18 April 2024, T2005.27–45, 2008.33–35, 2010.4–2012.17 (O'Loughlin).

[1192] Transcript of the Commission, 18 April 2024, T2014.39–2015.1–4, 2015.43–47 (O'Loughlin).

[1193] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [9] [SCI.0008.0343.0001 at 0002]; Transcript of the Commission, 18 April 2024, T2004.34–44 (O'Loughlin).

[1194] Transcript of the Commission, 18 April 2024, T2004.7–17 (O'Loughlin).

[1195] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [8] [SCI.0008.0343.0001 at 0001].

[1196] D.80, SWSLHD and Karitane, *Service Agreement 2023–24* (5 April 2024) cl 3.2 [SCI.0008.0169.0001 at 0017].

[1197] D.80, SWSLHD and Karitane, *Service Agreement 2023–24* (5 April 2024) cl 4 [SCI.0008.0169.0001 at 0024].

[1198] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [9] [SCI.0008.0343.0001 at 0002]; Transcript of the Commission, 18 April 2024, T2014.18–25 (O'Loughlin).

[1199] Transcript of the Commission, 18 April 2024, T2013.14–19 (O'Loughlin).

[1200] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [10] [SCI.0008.0343.0001 at 0002].

Royal Rehab Group

14.16. The Royal Rehab Group provides specialist rehabilitation and disability services across various LHDs in NSW, including services for general rehabilitation patients, and patients with spinal cord injuries and traumatic brain injuries. It has been a provider of health services in NSW since 1899 and was founded as a result of philanthropy.[1201]

14.17. The Royal Rehab Group offers inpatient rehabilitation and community rehabilitation services, which include arranging necessary modifications to a patient's residence, connecting patients with multidisciplinary care providers in the community, and working with organisations on the patient's behalf, such as the National Disability Insurance Agency insurers.[1202] It also operates its community services, including the NSW Spinal Outreach Service,[1203] providing post hospital discharge care to spinal cord injury patients in every LHD across NSW.

14.18. The Royal Rehab Group operates a 37 bed private neurological rehabilitation hospital in Petersham, as well as a resort for people with spinal cord injury in Collaroy, which is partly funded by iCare and the National Disability Insurance Scheme.[1204] There are also seven residents with profound disabilities in long term housing at Weemala Extended Care Service, who are provided extended care services by the Royal Rehab Group, rather than divesting to the National Disability Insurance Agency, under a legacy agreement.[1205]

14.19. Its funding (in its capacity as an AHO) is managed through the Northern Sydney LHD. However, due to disagreement between the parties as to the adequacy of the funding provided for the services required, the most recent service agreement that was executed expired on 30 June 2012.[1206] In lieu of a written service agreement, the services and funding arrangements have, since that time, been based on history. These arrangements are managed through quarterly performance meetings, during which the executive staff of the Royal Rehab Group and the Northern Sydney LHD discuss whether KPIs are being met.[1207]

[1201] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [2], [5], [8] [SCI.0008.0341.0001 at 0001, 0002].

[1202] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [5] [SCI.0008.0341.0001 at 0001]; Transcript of the Commission, 18 April 2024, T2090.46–2091.10 (Mackay).

[1203] Transcript of the Commission, 18 April 2024, T2091.21–25 (Mackay).

[1204] Transcript of the Commission, 18 April 2024, T2087.29–42, 2091.27–33 (Mackay).

[1205] Transcript of the Commission, 18 April 2024, T2090.1–44 (Mackay).

[1206] Transcript of the Commission, 18 April 2024, T2101.6–31, 2102.26–2103.2 (Mackay); Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [13] [SCI.0008.0341.0001 at 0003].

[1207] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [13]–[14] [SCI.0008.0341.0001 at 0003].

14.20. For the 2023–24 financial year, the Royal Rehab Group's budget allocation received from the Northern Sydney LHD was $28,925,495.[1208] That figure included an "own source revenue" target of $4,179,768, with the result that the total funding provided by the Northern Sydney LHD for the 2023–24 financial year was $24,745,727.[1209]

St Vincent's Health Network

14.21. St Vincent's Health Australia is Australia's largest not for profit mission based health and aged care organisation, established by the Sisters of Charity in 1857.[1210] St Vincent's Health Australia has the longest standing community partnership with the State Government for the delivery of public healthcare in NSW.[1211]

14.22. St Vincent's Health Network (a wholly owned subsidiary of St Vincent's Health Australia) is a networked AHO in respect of two recognised establishments and services: St Vincent's Hospital Sydney, and Sacred Heart Health Service, Darlinghurst. As noted above, the networked AHO is known as the St Vincent's Health Network.[1212]

14.23. The services provided by the St Vincent's Health Network include:[1213]

a. delivering 2.5 per cent of the State's acute inpatient activity in addition to a comprehensive range of subacute and non-admitted medical and surgical services;

b. being the sole provider of heart and lung transplantation services and haematopoietic Stem Cell Transplantation for severe scleroderma;

c. being the designated provider of the following highly specialised services to patients across NSW: critical care services including extracorporeal membrane oxygenation (ECMO) and adult intensive care; transcatheter aortic valve implantation; human immuno virus reference laboratory; and bone marrow transplantation and laboratory;

d. being the only public hospital in NSW with a dedicated health service for those experiencing homelessness;

[1208] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [16] [SCI.0008.0341.0001 at 0003–0004].

[1209] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004]; D.35, Letter from Jacquie Ferguson to Matthew Mackay, attached budget for Royal Rehab for 2023–24, 17 October 2023 [SCI.0008.0027.0001].

[1210] Exhibit G.30, Statement of Christopher John Blake (6 June 2024) [7]–[8] [SVH.9999.0004.0001 at 0002]; Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [8] [SVH.9999.0002.0001 at 0002].

[1211] Transcript of the Commission, 12 June 2024, T3550.35 (Blake).

[1212] Exhibit G.30, Statement of Christopher John Blake (6 June 2024) [14] [SVH.9999.0004.0001 at 0002]. St Vincent's Hospital Sydney 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) [12] [SVH.9999.0002.0001 at 0002].

[1213] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [19] [SVH.9999.0002.0001 at 0003].

e. providing cardiology, neurology, mental health and alcohol and drug, diabetes outreach, haematology, rehabilitation, and pathology services to patients across the State, including in rural and regional areas via both virtual and outreach services, where the LHDs in those areas could not otherwise provide the services; and

f. providing inpatient, virtual and outreach services to patients across Murrumbidgee LHD through formalised referral pathways.

14.24. As a networked AHO, there is a high degree of integration between the St Vincent's Health Network and the wider public health system.[1214] It is seemingly uncontroversial that there are ongoing system benefits in those arrangements, as opposed to NSW Health attempting to replicate or duplicate the highly specialised and Statewide nature of many of the services offered by the St Vincent's Health Network.[1215]

14.25. As the only networked AHO, interactions between the St Vincent's Health Network and the Ministry of Health are similar to those that occur between the Ministry of Health and LHDs.[1216] Each financial year, there are service agreement negotiations which involve meetings between senior officials of the St Vincent's Health Network and the Ministry of Health.[1217] Funding generally reflects the level and mix of services purchased from the St Vincent's Health Network by the Ministry of Health. The St Vincent's Health Network also has the opportunity to submit purchasing requests for funding above the base purchased volume of services, in the same way as LHDs.[1218]

14.26. The St Vincent's Health Network is subject to quarterly performance review meetings with the Ministry of Health against the *NSW Health Performance Framework*, which is the same performance framework applicable to LHDs. Since March 2024, the St Vincent's Health Network has also commenced more detailed monthly financial reporting to NSW Health due to recent financial pressures.[1219]

14.27. For the 2023–24 financial year, the St Vincent's Health Network received a budget of $450,988,000 from the Ministry of Health to operate St Vincent's Hospital Sydney and Sacred Heart Health Service, Darlinghurst.[1220]

[1214] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [25] [SVH.9999.0002.0001 at 0005]; Exhibit G.103, Statement of Matthew Daly (6 June 2024) [28]–[31] [MOH.9999.1290.0001 at 0006].

[1215] Exhibit G.103, Statement of Matthew Daly (6 June 2024) [25] [SVH.9999.0002.0001 at 0005].

[1216] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [24] [SVH.9999.0002.0001 at 0005]; Exhibit G.104, Statement of Deb Willcox (6 June 2024) [28] [MOH.9999.1297.0001 at 0004].

[1217] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [28] [SVH.9999.0002.0001 at 0005].

[1218] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [29]–[30] [SVH.9999.0002.0001 at 0005]; Exhibit G.103, Statement of Matthew Daly (6 June 2024) [26] [MOH.9999.1290.0001 at 0005].

[1219] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [34]–[35] [SVH.9999.0002.0001 at 0006].

[1220] Exhibit G.29.9, AM-9 NSW Health and SVHNS, *Service Agreement 2023–24* (16 November 2023) [SVH.0009.0002.0096].

Funding Affiliated Health Organisations

14.28. The AHOs that gave evidence before this Special Commission were united in their belief that they are underfunded to deliver the services required of them. They all contended that the funding provided to them through their respective service agreements fell short of their actual cost of delivering the services contemplated by those agreements, often by a very substantial amount. Although the product of a Public Private Partnership rather than an AHO, I note here that St John of God claimed to have had a similar experience in so far as the funds proffered to it for the purposes of operating Hawksbury Hospital, and cited this as one of the principal reasons that it was not proposing to renew the agreement through which it did so.[1221]

Karitane

14.29. Karitane's position was that the funds received under its primary service agreement with South Western Sydney LHD was consistently insufficient to meet the cost of delivering the service volumes to be provided.[1222] Its relationship with that LHD has, at times, been very challenging.

14.30. To offset that shortfall in funding, Karitane has relied on the additional funding it receives from sources other than the LHD, including revenue from community and interstate programs, private health insurance, grants, and philanthropy.[1223] The funding shortfall has been the subject of much correspondence between the South Western Sydney LHD, the Ministry of Health, and the NSW Government.[1224]

14.31. While recourse to its alternate sources of funding have historically permitted Karitane to operate on a cost neutral basis, or otherwise with only small losses, the size of the funding shortfall has increased over time.[1225] As a result, Karitane has been required to reduce or discontinue some of its services due to funding deficits, for example, the closure of the Liverpool Parenting Centre in 2018.[1226]

14.32. Karitane has engaged in annual efficiency reviews and equivalent processes with South Western Sydney LHD since 2018. South Western Sydney LHD has communicated to Karitane that it would advocate to the Ministry of Health for

[1221] Transcript of the Commission, 12 June 2024, T3464.39–3465.3 (Edwards).

[1222] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [16] [SCI.0008.0343.0001 at 0002–0003]; Transcript of the Commission, 18 April 2024, T2021.10–14, 2023.18–34, 2037.13 (O'Loughlin).

[1223] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [17]–[18] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2025.25–2026.24 (O'Loughlin).

[1224] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [21] [SCI.0008.0343.0001 at 0004]; Exhibit D.82, Letter from Lee Carpenter and Grainne O'Loughlin to Deborah Willcox, Karitane Funding and Service Level Agreement with SWSLHD, 18 December 2023 [SCI.0008.0293.0001].

[1225] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [19] [SCI.0008.0343.0001 at 0003]; Exhibit D.81, SWSLD Service Funding Status for Service Agreement with Karitane 2015–2024 [SCI.0008.0165.0001].

[1226] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [20] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2041.12–30 (O'Loughlin).

additional funding for Karitane if those reviews identified no efficiency issues.[1227] Despite this communication, and multiple meetings directly with the Ministry of Health,[1228] as of April 2024 Karitane had received no additional funding commensurate with the cost of operating the services it was contracted to deliver under its service agreement.[1229] This ongoing funding uncertainty is problematic in light of Karitane's obligation not to trade while insolvent.[1230]

14.33. Karitane predicted that for the 2023–24 financial year, there would be a deficit of $1.7 million in its budget. This was a substantially higher deficit than in prior years and Karitane indicated that it would be difficult to offset either through efficiency savings or alternate sources of revenue.[1231] Karitane's 2023–24 service agreement with South Western Sydney LHD allocated a figure of just over $1 million in "own source funding". When that target is taken into account, the shortfall between the public funding received and the cost of delivering the services required was approximately $2.7 million.[1232]

14.34. Karitane has raised its concerns with respect to underfunding in the covering letter of the service agreement with South Western Sydney LHD for the 2023–24 financial year,[1233] and stated that the money budgeted for in that agreement did not cover the cost of providing the services required to be delivered.[1234] However, Karitane has been advised that the South Western Sydney LHD does not have funding within its own budget to bridge that gap.[1235]

14.35. Notwithstanding the deficiencies in its budget under the agreement with South Western Sydney LHD, Karitane gave evidence that the funding it receives from the Ministry of Health for its Statewide virtual services meets the full cost of providing that service. Significantly, the budgets set by the Ministry of Health do not require any contribution from Karitane's "own source funding", and Karitane has not experienced any shortfalls in its contracts with the Ministry of Health.[1236]

[1227] Transcript of the Commission, 18 April 2024, T2037.45–2038.9 (O'Loughlin).

[1228] Transcript of the Commission, 18 April 2024, T2038.30–2039.1 (O'Loughlin).

[1229] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [22]–[23] [SCI.0008.0343.0001 at 0004].

[1230] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [24] [SCI.0008.0343.0001 at 0004].

[1231] Exhibit D.121, Outline of Evidence for Grainne O'Loughlin (11 April 2024) [19] [SCI.0008.0343.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2023.23–2024.12 (O'Loughlin).

[1232] Transcript of the Commission, 18 April 2024, T2028.10–24, 2029.4–15 (O'Loughlin).

[1233] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [15] [SCI.0008.0343.0001 at 0002].

[1234] Transcript of the Commission, 18 April 2024, T2029.10–14 (O'Loughlin); Transcript of the Commission, 29 April 2024, T2550.38–2551.13 (Willcox).

[1235] Transcript of the Commission, 18 April 2024, T2039.16–32 (O'Loughlin).

[1236] Transcript of the Commission, 18 April 2024, T2045.29–2046.11 (O'Loughlin).

Tresillian

14.36. Tresillian has also experienced a consistent disparity between the budgets in its service agreements with Sydney LHD and the actual cost of delivering the services required under those agreements.[1237] There are no funding adjustments made by way of annual escalations to account for increases to the costs of goods and services, and repairs and maintenance.[1238] The indexation applied to its agreements has not kept pace with its actual annual growth in costs.[1239]

14.37. To make up for funding shortfalls, Tresillian has drawn on its "other funding buckets",[1240] including funding from grants, philanthropy and private health fund revenue,[1241] to maintain the level of services required of it pursuant to its service agreement.

Royal Rehab Group

14.38. As noted above, the Royal Rehab Group has not executed a service agreement with the Northern Sydney LHD since 2011–2012.[1242] That is because of ongoing disagreement between the parties as to "an equitable model of funding for the organisation in the provision of Statewide services".[1243] The Royal Rehab Group's position – like that of Karitane and Tresillian – is that the funding proffered by the Northern Sydney LHD is insufficient to meet the cost of providing the services that are required of it.[1244]

14.39. The Royal Rehab Group points to the fact that there has only been a limited uplift in its overall base funding, aside from indexation applied in line with public sector wage increases,[1245] and composite escalations for the expense budget and revenue budget.[1246] It was suggested to me that the full wage (composite) escalation costs, particularly the superannuation component of such costs, do not flow through to the Royal Rehab Group in the budget.[1247]

[1237] Transcript of the Commission, 18 April 2024, T2062.22–33, 2085.12–29 (Mills).

[1238] Transcript of the Commission, 18 April 2024, T2061.44–2062.39 (Mills).

[1239] Transcript of the Commission, 18 April 2024, T2062.44–2053.5 (Mills).

[1240] Transcript of the Commission, 18 April 2024, T2062.12–20 (Mills).

[1241] Transcript of the Commission, 18 April 2024, T2085.31–45 (Mills).

[1242] Transcript of the Commission, 18 April 2024, T2101.6–31 (Mackay); Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [13] [SCI.0008.0341.0001 at 0003].

[1243] Transcript of the Commission, 18 April 2024, T2102.26–2103.2 (Mackay); Transcript of the Commission, 29 April 2024, T2548.7–17 (Willcox); Transcript of the Commission, 22 April 2024, T2293.11–14 (Schembri).

[1244] Transcript of the Commission, 18 April 2024, T2103.10–23 (Mackay).

[1245] Exhibit D.123. Outline of Evidence for Matthew Mackay (11 April 2024) [20]–[21] [SCI.0008.0341.0001 at 0004]; Transcript of the Commission, 24 April 2024, T2419.22–30 (Middleton).

[1246] Transcript of the Commission, 18 April 2024, T2108.42–2109.7 (Mackay).

[1247] Transcript of the Commission, 18 April 2024, T2112.42–2113.42 (Mackay).

14.40. While the size of the shortfall between the funding that the Royal Rehab Group receives and its cost of providing services varies from year to year, it ranges from $2 to $4 million dollars annually.[1248] That shortfall affects its ability to keep its services running and to operate a Statewide Service.[1249]

14.41. Adjunct Professor Anthony Schembri AM, Chief Executive of Northern Sydney LHD, agreed that the Royal Rehab Group had made him aware of its belief that it is underfunded, and that this is the reason why it has refused to sign a service agreement.[1250] He also noted that similar representations had been made to the Minister for Health and that the Royal Rehab Group had met with the Ministry of Health in relation to those issues.[1251]

14.42. However, Adjunct Professor Schembri suggested that he did not have any data to support the claim that the Royal Rehab Group is underfunded.[1252] In December 2023, Adjunct Professor Schembri reinforced advice from the Ministry of Health that the best way forward was for the Royal Rehab Group to prepare a detailed business case outlining the gaps in funding, and verbally requested that it prepare a business case particularising its underfunding issues for his consideration.[1253] This was followed up with a written request in April 2024.[1254] It was suggested that the business case would enable a review of the model of care, the indirect and direct costs of services, the revenue model, opportunities for private insurance and compensable payments, and the gap between the current revenue and costs.[1255] Without this information, Adjunct Professor Schembri contended that the Northern Sydney LHD does not have “a true picture of the cost buckets for the service”.[1256]

14.43. NSW Health told me that, as at 18 February 2025, that business case had not been provided.[1257] While this, if it remains true at the time of this Report, is regrettable, it does not entirely explain the failure by Northern Sydney LHD and the Royal Rehab Group to enter into a service agreement over the past 12 years. Were a business case of the type now requested by Adjunct Professor Schembri any real answer to this impasse, it should have been requested more than a decade ago. As matters stand, I have little confidence that, if provided, a business case alone would result in

[1248] Transcript of the Commission, 18 April 2024, T2112.42–2113.8 (Mackay).

[1249] Transcript of the Commission, 18 April 2024, T2116.46–2117.4 (Mackay).

[1250] Transcript of the Commission, 22 April 2024, T2284.26–40 (Schembri).

[1251] Transcript of the Commission, 22 April 2024, T2285.26–34 (Schembri).

[1252] Transcript of the Commission, 22 April 2024, T2285.9–10 (Schembri).

[1253] Transcript of the Commission, 22 April 2024, T2285.26–34 (Schembri).

[1254] Transcript of the Commission, 22 April 2024, T2285.26–34 (Schembri); Exhibit D.90, Letter from Anthony Schembri to Matthew Mackay, 17 April 2024 [MOH.9999.1110.0001].

[1255] Transcript of the Commission, 22 April 2024, T2285.36–45 (Schembri).

[1256] Transcript of the Commission, 22 April 2024, T2286.9–14 (Schembri).

[1257] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.38] [MOH.0010.0758.0001 at 0110].

any significant increase in the level of funding to deliver the services contemplated by the Royal Rehab Group's most recent (unsigned) service agreement.

14.44. In circumstances where Adjunct Professor Schembri did not have all the information required to make an assessment of the true cost of the services required of the Royal Rehab Group (including details of its capital needs), he agreed that the Northern Sydney LHD's assessment of how much funding should be made available is currently based on a historical assessment with composite escalation for goods, services, salaries, and wages.[1258] At the time he gave evidence, Adjunct Professor Schembri agreed that providing the Royal Rehab Group with written details of the information the LHD required to consider a request for increased funding would be useful.[1259]

14.45. Ms Willcox gave evidence that she had been advised by Northern Sydney LHD that, having regard to an independent review of Royal Rehab's costings conducted in 2023 by Taylor Fry, there was no substantial gap between the service provided by the Royal Rehab Group and the funding it received from the LHD to deliver those services.[1260]

14.46. The Taylor Fry review is said to have considered the reasonableness of the Royal Rehab Group's cost allocation procedures and the accuracy of the cost reports it provided to the LHD.[1261] While it identified some divergence between reported and actual "in scope costs", the views expressed in it are highly qualified and not the subject of universal agreement by the Royal Rehab Group. In those circumstances, and given Adjunct Professor Schembri's evidence, it is not entirely clear how the view that there was "no material shortfall" in the funding provided to the Royal Rehab Group could have been properly formed by the person who expressed this opinion to Ms Willcox.

St Vincent's Health Network

14.47. The St Vincent's Health Network experienced material financial pressure in the 2023–24 financial year, leading to a budget shortfall.[1262] The budget shortfall reflected inflationary pressure and skills shortages requiring additional reliance on agency staff and increased workforce costs, a slower than anticipated return to efficient operating after the COVID response, and activity pressures due to increasing demand.[1263] There was also approximately $12 million in costs associated with decommissioning St Joseph's Hospital Auburn in 2023, which was borne solely by the St Vincent's Health Network.[1264]

[1258] Transcript of the Commission, 22 April 2024, T2292.29–2293.6 (Schembri).

[1259] Transcript of the Commission, 22 April 2024, T2287.29–35 (Schembri).

[1260] Transcript of the Commission, 29 April 2024, T2548.39–2549.4 (Willcox); Exhibit D.129, Draft Independent review of Royal Rehab cost estimates (Taylor Fry) (13 June 2023) [SCI.0008.0082.0001].

[1261] Exhibit D.129, Taylor Fry, *Draft Independent Review of Royal Rehab Cost Estimates* (13 June 2023) [SCI.0008.0082.0001].

[1262] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [63] [SVH.9999.0002.0001 at 0012].

[1263] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [64] [SVH.9999.0002.0001 at 0012].

[1264] Transcript of the Commission, 13 June 2024, T3600.21–3601.12 (McFadgen).

14.48. In August 2023, the St Vincent's Health Network was engaged in negotiations with the Ministry of Health in relation to the service agreement for the 2023–24 financial year. When seeking approval for its interim budget, the St Vincent's Health Network projected a budget deficit of $43.8 million.[1265] The St Vincent's Health Network proposed a plan to address the deficit through both efficiency initiatives and sustainable funding allocation from the Ministry of Health.[1266]

14.49. In November 2023, the St Vincent's Health Network again expressed concern about the ongoing sustainability of its provision of health services under the proposed service agreement, and advised the Health Secretary that it would have a material budget deficit for the 2023–24 financial year, with cash constraints becoming a key risk from early 2024.[1267] Relevantly, discrepancies between the modelled budget prepared by the St Vincent's Health Network during the budget delay in the early months of the 2023–24 financial year, and receipt of the service agreement in November 2023 (five months after the period during which the relevant services were to be delivered had actually commenced), meant that the St Vincent's Health Network had to realign and revise its budget, in part because some of the funding the St Vincent's Health Network had expected to receive was not forthcoming.[1268] This presented challenges to the St Vincent's Health Network's ability to stay within its budget allocation.[1269] The St Vincent's Health Network requested a formal review of its funding arrangements to ensure the ongoing sustainable provision of its services to NSW Health.[1270]

14.50. On 19 February 2024, the St Vincent's Health Network again wrote to the Ministry of Health advising of a projected negative cash flow position for the remainder of the 2023–24 financial year, culminating in a $60.2 million deficit.[1271] It noted that, without urgent support in addition to the existing 2023–24 service agreement, it would be unable to pay its staff and creditors in the fourth quarter of 2023–24.[1272] The St Vincent's Health Network identified a number of efficiency improvement initiatives under way to respond to the cost pressures within the hospital, which were expected to deliver an annualised $24 million in efficiency gains, and it sought supplementary funding of $60 million from NSW Health to address uncertainty in the forecast position

[1265] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [66] [SVH.9999.0002.0001 at 0012].

[1266] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [66] [SVH.9999.0002.0001 at 0012].

[1267] Exhibit G.48, Letter from Paul McClintock to Susan Pearce, 15 November 2023 [SVH.0002.0001.0280].

[1268] Transcript of the Commission, 13 June 2024, T3596.24–27 (McFadgen).

[1269] Transcript of the Commission, 13 June 2024, T3596.35–3597.11 (McFadgen).

[1270] Exhibit G.48, Letter from Paul McClintock to Susan Pearce, 15 November 2023 [SVH.0002.0001.0280].

[1271] Exhibit G.29.19, AM-19 Letter from Anna McFadgen, SVHN to Alfa D'Amato, Deputy Secretary, Financial Services, *St Vincent's Health Network Financial Support 2023–24* (19 February 2024) [SVH.9999.0002.0255 at 0256]; Transcript of the Commission, 13 June 2024, T3603.8–35 (McFadgen).

[1272] Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Alfa D'Amato, 19 February 2024 [SVH.9999.0002.0255 at 0256].

to the end of June 2024.[1273] This request assumed that the $24 million in efficiency savings would not be achieved within the 2023–24 budgetary period.[1274]

14.51. The St Vincent's Health Network was able to secure an additional one off subsidy of $30 million in February 2024 on condition that it implement a financial recovery plan, submit monthly performance reports, and recoup the amount of the subsidy through efficiency initiatives in the 2024–25 financial year.[1275] It was of the view that the subsidy would be inadequate to close the hole in its budget, noting that it had requested double the subsidised amount in its letter of 19 February 2024.[1276] It was also concerned that, accounting for the requirement to recoup the $30 million subsidy in the next financial year, the St Vincent's Health Network would have a deficit of approximately $100 million going into the 2024–25 financial year.[1277]

14.52. On 25 March 2024, the St Vincent's Health Network indicated to the Health Secretary that it was not able to execute its 2023–24 service agreement without a commitment from NSW Health to formally discuss its role within the State public health system and negotiate a longer term agreement.[1278] This reflected the St Vincent's Health Network's concerns in relation to a funding gap.[1279] In particular:

a. the St Vincent's Health Network was concerned that the amount of money that was to be delivered through the funding arrangement for the 2023–24 financial year would be insufficient to meet the costs of delivering the service required to be delivered under the agreement.[1280] This included the inflating capital maintenance and workforce costs and the St Vincent's Health Network's ability to deliver services in the longer term if the funding was not continuing at pace with this inflation;[1281] and

b. the St Vincent's Health Network was concerned about the ongoing uncertainty regarding its funding, which was preventing it from undertaking any long term planning or having any confidence with respect to its longer term role in the public health system.[1282] The St Vincent's Health Network feared that it would be forced to cease operating if it did not have sufficient funding, because the

[1273] Exhibit G.29.19, AM-19 Letter from Anna McFadgen to Alfa D'Amato, 19 February 2024 [SVH.9999.0002.0255 at 0257].

[1274] Transcript of the Commission, 13 June 2023, T3612.14–23 (McFadgen).

[1275] 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 Alfa D'Amato, 19 February 2024 [SVH.9999.0002.0255]; Exhibit G.29.20, AM-20 Letter from Susan Pearce to Anna McFadgen, 28 February 2024 [SVH.9999.0002.0259].

[1276] Transcript of the Commission, 13 June 2023, T3613.32–40 (McFadgen).

[1277] Transcript of the Commission, 13 June 2023, T3616.18–46 (McFadgen).

[1278] Transcript of the Commission, 12 June 2024, T3550.2–44 (Blake); Exhibit G.29.22, AM-22 Letter from Paul McClintock to Susan Pearce, 25 March 2024 [SVH.9999.0002.0262].

[1279] Transcript of the Commission, 12 June 2024, T3551.6–10 (Blake).

[1280] Transcript of the Commission, 12 June 2024, T3551.36 (Blake).

[1281] Transcript of the Commission, 12 June 2024, T3551.45–3552.9 (Blake).

[1282] Transcript of the Commission, 12 June 2024, T3550.35–44 (Blake).

Board would not be able to commit to continued operations of a hospital that could not pay its expenses.[1283]

14.53. The 2023–24 service agreement was ultimately executed, with a request that the longer term arrangements be planned and negotiated.[1284]

Particular matters impacting on the funding of Affiliated Health Organisations

14.54. While each of the AHOs that gave evidence identified a variety of reasons for what they perceive to be inadequate funding to cover the costs of delivering the services required under their respective service agreements, four key themes emerged.

The service agreement process

14.55. The current processes for negotiating service agreements with AHOs lacks transparency in terms of their budget allocations and there is limited support being provided for service planning by those organisations.

14.56. Despite the general position (with the exception of the St Vincent's Health Network) that LHDs were responsible for managing AHOs, there is a lack of clarity as to how budgets were set and whether, in truth, it is the relevant LHD or the Ministry of Health that has ultimately responsibility for them.[1285] For example:

a. while Karitane was of the view that it was the South Western Sydney LHD which **allocated** the funding under its service agreements,[1286] each of South Western Sydney LHD and the Ministry of Health advised Karitane that it was the other who **set** the budget;[1287] and

b. both the Ministry of Health and Northern Sydney LHD took the position that they were not responsible for facilitating increases to the Royal Rehab Group's funding,[1288] with the Royal Rehab Group being referred to the LHD by the Ministry for funding discussions and thereafter advised by the LHD that any increase in funding needed to come from the Ministry.[1289] To this end, the LHD offered support to the Royal Rehab Group in putting together a business case for presentation to the Ministry to seek more funding.[1290]

14.57. Uncertainty about who – at least in a practical sense – is responsible for determining the funding offered to AHOs is unsurprising in the context of a system

[1283] Transcript of the Commission, 12 June 2024, T3550.15–27, 3553.4 (Blake).

[1284] Transcript of the Commission, 12 June 2024, T3552.23–27 (Blake).

[1285] Transcript of the Commission, 18 April 2024, T2039.39–2040.10 (O'Loughlin), 2116.32–2117.15 (Mackay).

[1286] Transcript of the Commission, 18 April 2024, T2039.3–14 (O'Loughlin).

[1287] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [25] [SCI.0008.0343.0001 at 0004].

[1288] Transcript of the Commission, 18 April 2024, T2116.32–2117.15 (Mackay).

[1289] Transcript of the Commission, 18 April 2024, T2114.19–26, 2116.32–2117.15 (Mackay).

[1290] Transcript of the Commission, 18 April 2024, T2116.38–43 (Mackay); Exhibit D.90, Letter from Northern Sydney LHD to Royal Rehab Group (17 April 2024) [MOH.999.1110.0001].

where service agreements are being entered into with LHDs, that themselves are having to operate within a budget that is often insufficient to deliver the services **they** must provide under their own agreements with the Ministry of Health. While this explains the situation, it does not make it acceptable.

14.58. It means that there can be little in the way of genuine negotiation in relation to AHOs' yearly budget allocations. While there may be meetings between the LHD and the AHO, I am satisfied that those meetings do not involve substantive and meaningful engagement between the parties in relation to the levels of funding that will be made available in return for the services that are to be provided by the AHO in accordance with the service agreement.[1291] That, for more than a decade, the Royal Rehab Group and the Northern Sydney LHD have been unable to agree on the terms of a service agreement is a strong indication that there is little scope for an AHO to persuade an LHD that further funding is required to meet the costs of delivering the services required of it. The experience of other AHOs that gave evidence to this Special Commission is to similar effect. Accordingly, while it may be accepted that AHOs have the opportunity to "seek funding growth, routinely and on an *ad hoc* basis" from LHDs,[1292] it is doubtful that LHDs can substantively engage with those requests without further funding from the Ministry of Health.[1293]

14.59. In this way, the experience of the AHOs that gave evidence before this Special Commission mirrored the evidence given by LHDs in so far as their own funding negotiations with the Ministry of Health were concerned. As I have noted elsewhere in this Report, the funds provided to each of the LHDs are often insufficient for them to deliver the services required to meet the health needs of their populations.

14.60. While it is understandable that LHDs have sought to minimise the payments required to be made to AHOs under their service agreements and have held them strictly to those agreements in an attempt to operate within the confines of their own budgets, this approach is unacceptable if, in reality, the funds made available through those agreements do not reflect the cost of actually delivering the care required by them.

14.61. Dealing with AHOs in a way that results in them being paid less than is required to deliver the care contemplated under their respective agreements fails to recognise the fact that, while statutorily part of the public health system, they are also private entities with their own corporate obligations. The need to balance the district's budget and

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[1291] See, e.g., Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [15] [SCI.0008.0341.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2107.57–2108.11, 2117.17–28, 2125.7–29 (Mackay); Transcript of the Commission, 22 April 2024, T2283.23–2284.24 (Schembri).

[1292] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.38] [MOH.0010.0758.0001 at 0110].

[1293] Northern Sydney LHD's offer to support Royal Rehab in the preparation of a business case outlining the difference between Royal Rehab's costs in delivering services to the LHD, and the funding made available to it by the LHD for those services, was for the purpose of the LHD presenting that business case the Ministry of Health in order to facilitate the exploration of "potential ways forward" by Royal Rehab, the LHD, and the Ministry of Health: Exhibit D.90, Letter from Northern Sydney LHD to Royal Rehab Group (17 April 2024) [MOH.999.1110.0001].

avoid having to remove funding from another service or facility within the district is no answer to this.

14.62. The failure to properly grapple with the fact that AHOs are private entities and cannot be treated in the same manner as other components of NSW Health was also reflected in the manner in which LHDs, and the Ministry of Health generally, responded to the suggestion that AHOs were underfunded.

14.63. For example, in response to the Royal Rehab Group providing details of its funding shortfalls to Northern Sydney LHD,[1294] it was told that it was "being looked after" and was "lucky" to receive the funding it was allocated, because the LHD did not pass on the efficiency targets that LHDs are required to achieve.[1295] A similar sentiment underpinned the evidence of Matthew Daly, Deputy Secretary, System Sustainability Performance, Ministry of Health, who suggested that AHOs such as the Royal Rehab Group were "shielded" from the efficiency targets passed on from NSW Treasury to NSW Health by the LHD that funded them,[1296] and that this would require "the sacrifice of other LHD activity".[1297]

14.64. Similar sentiments were expressed by Lee Gregory, the then Acting Chief Executive of Nepean Blue Mountains LHD, in relation to the funding of St John of God to provide care through Hawksbury Hospital.[1298] While I accept that arrangements made under public private partnerships have a significantly different commercial character to those relating to AHOs, none of the above responses engage with the fundamental question of whether AHOs are receiving a level of funding that is adequate to cover the cost of delivering services that they are required to deliver under service agreements.

14.65. The short term nature of service agreements is also said to impact on the ability of AHOs to engage in long term planning.[1299] For example, the St Vincent's Health Network pointed to the example of a public hospital it operated in Victoria, which is funded through a 20 year agreement, with annual priorities set within the term of each financial year as well as an annual capital funding allocation.[1300] In saw clear advantages to longer term arrangements, principally being the level of confidence for long term planning. It also provided additional confidence for the Board of what is ultimately a non-government entity, and which has governance obligations relating to solvency.[1301]

[1294] Transcript of the Commission, 18 April 2024, T2112.42–2113.8 (Mackay).

[1295] Transcript of the Commission, 18 April 2024, T2113.20–24, 2114.7–17 (Mackay).

[1296] Transcript of the Commission, 29 April 2024, T2519.1–16 (Daly).

[1297] Transcript of the Commission, 29 April 2024, T2523.26–34 (Daly).

[1298] Transcript of the Commission, 12 June 2024, T3535.22–3542.31 (Gregory).

[1299] Transcript of the Commission, 18 April 2024, T2060.1–13 (Mills); Transcript of the Commission, 12 June 2024, T3549.41–47 (Blake); Transcript of the Commission, 13 June 2024, T3623.34–3624.3 (McFadgen).

[1300] Transcript of the Commission, 12 June 2024, T3548.4–35 (Blake).

[1301] Transcript of the Commission, 12 June 2024, T3548.32–42 (Blake).

14.66. In addition to the uncertainty created by short term funding, in some instances when service agreements are due for renewal, funding for AHOs has ceased until a new service agreement is entered into, notwithstanding services continue to be provided.[1302] NSW Health has told me that this does not reflect the "general practice" of LHDs and points to the payment of the Royal Rehab Group over the past 12 years, despite it having not executed a service agreement during this period, as evidence of that fact.[1303] However, Tresillian has given evidence of a different experience. It claimed to have been left to pay at least $2 million out of its own reserves to pay staff wages in circumstances where it continued to provide services during a period where it received no funding.[1304] Notwithstanding that funding may be ultimately received, the cessation of funding during that period puts unnecessary financial pressure on a not for profit organisation.

14.67. In seeking to explain this situation, NSW Health said that delays in payments to Tresillian have "at times related to the provision of services that were not recognised establishments or recognised services for the purposes of Schedule 3 of the *Health Services Act*".[1305] I will return below to the way in which NSW Health has approached the distinction between recognised services and those that have not been included in Schedule 3. For present purposes, it is sufficient to note that implicit in NSW Health's response is a recognition that "at times" delays in payments to Tresillian have related to services that are recognised under Schedule 3. It is difficult to conceive of any good reason why such a situation should arise.

14.68. One explanation for it may be that, notwithstanding that equivalent agreements between the LHD and Ministry of Health cover a financial year, they are regularly signed well into the year in respect of which they apply. However, none of that is within the control of an AHO and steps should be taken to ensure that the practice ceases. That such circumstances arise is yet another example of AHOs being approached by LHDs as if they were just another NSW Health entity, rather than the independent organisations that they are. Moving forward, the approach taken to engaging with AHOs must reflect that reality.

14.69. Having accepted whatever might have been proffered by LHDs, AHOs have often resorted to political lobbying or strategic media campaigns in an attempt to secure greater levels of funding for the services that they offer. While the evidence before this Special Commission suggests that action of this type has occasionally been

[1302] Exhibit D.122, Outline of Evidence for Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008–0009]; Transcript of the Commission, 18 April 2024, T2060.33–2061.10 (Mills).

[1303] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.41] [MOH.0010.0758.0001 at 0111–0112].

[1304] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008–0009]; Transcript of the Commission, 18 April 2024, T2060.33–2061.24 (Mills).

[1305] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.43] [MOH.0010.0758.0001 at 0112].

successful,[1306] it is an inequitable and wholly inefficient way of distributing the limited resources available to deliver the public health system and has the potential to undermine structured health system planning of the type I discuss elsewhere in this Report.

"Own source funding"

14.70. The budgets allocated to some AHOs include "own source funding" targets – being funds derived by those organisations from sources other than NSW Health agencies, such as philanthropy, private patient revenue, or grants. Other AHOs had to use those funding streams to supplement the shortfall in funding received pursuant to service agreements. Whichever scenario, it is clear that a significant amount of privately sourced funding has been used to ensure the sustainability and viability of public health services operated by AHOs.

14.71. For example, Karitane's 2023–24 service agreement with the South Western Sydney LHD allocated a figure of just over $1 million in "own source funding". This "own source funding" was to be derived from Karitane's alternate revenue streams, including philanthropy, grants and private health insurance, and, in Karitane's view, was a mechanism for propping up the services to be provided under the service agreement.[1307]

14.72. Similarly, the Royal Rehab Group's unsigned agreements with the Northern Sydney LHD also incorporated an amount of "own source funding", which was derived from patient fee revenue, and was deducted from the funding to be provided by the LHD for the services contemplated by those unsigned agreements.[1308] For the 2023–24 financial year, the Royal Rehab Group's "own source revenue" target was $4,179,768, and this related predominantly to patient payments, including from private health insurance and compensable motor vehicle insurance.[1309] According to the Royal Rehab Group, the allocated "own source funding" target was not the subject of discussion or negotiation and was predetermined by the LHD.[1310]

14.73. I note that the inclusion of "own source revenue" targets is consistent with the approach taken in service agreements between the Health Secretary and LHDs.

[1306] Transcript of the Commission, 18 April 2024, T2056.7–39 (Mills); Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [25] [SCI.0008.0344.0001 at 0008].

[1307] Transcript of the Commission, 18 April 2024, T2042.7–10 (O'Loughlin).

[1308] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004]; Exhibit D.35, Letter from Jacquie Ferguson to Matthew Mackay, attached budget for Royal Rehab for 2023–24, 17 October 2023 [SCI.0008.0027.0001]; Transcript of the Commission, 18 April 2024, T2126.16–24 (Mackay).

[1309] Transcript of the Commission, 22 April 2024, T2288.28–33 (Schembri).

[1310] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [17] [SCI.0008.0341.0001 at 0004].

14.74. Although not subject to "own source revenue" targets, Tresillian had to pull resources from its "other funding buckets",[1311] including funding from grants, philanthropy, and private health fund revenue[1312] to bridge the shortfall between the cost of delivering the services required of it and the funding provided to it for that purpose.

14.75. The St Vincent's Health Network has been required to subsidise service delivery as a result of the inadequacies in funding pursuant to its service agreement by accessing funding from philanthropic sources.[1313] However, this was difficult from a governance perspective, because its philanthropic funding is predominantly tied to research, education, ongoing professional development, and capital development projects, and is not available to supplement any part of the Network experiencing funding shortfalls.[1314]

14.76. There is a clear distinction to be drawn between "own source revenue" that is unrelated to the services provided pursuant to a services agreement (such as philanthropy, grants for other activities, and private patient fees received in connection with other services provided or facilities operated by the AHO), and patient fees received in relation to services provided in furtherance of the service agreement (for example, private health insurance payments or other external funding received in connection with patients accessing the services actually contemplated by the service agreement). To the extent that the AHO is fully funded to provide a service,[1315] it is perfectly reasonable that any patient fees or external payments received that directly relate to the provision of that service are accounted for when reckoning the amount that is to be paid to the AHO for providing that service.

14.77. However, there is no reasonable justification for requiring an AHO to utilise other "own source revenue" streams to meet the costs of delivering services under a service agreement that are otherwise underfunded (in the sense that the funding provided does not cover the cost of delivery). For example, there is no apparent reason why philanthropic funds donated to not for profit organisations should be used to subside the delivery of the public health system because the funding provided by NSW Health does not meet the cost of delivering certain services. It is one thing to direct that philanthropy into research, or to additional or other services that supplement the public health system but are not captured by a service agreement.[1316] It is quite another thing for those funds to be directed to meeting shortfalls in NSW Health's funding of what must have been identified as a necessary component of the public health system. While some entities within the public health system – for example the Sydney Children's Hospital – are themselves able to attract and deploy

[1311] Transcript of the Commission, 18 April 2024, T2062.12–20 (Mills).
[1312] Transcript of the Commission, 18 April 2024, T2085.31–45 (Mills).
[1313] Transcript of the Commission, 13 June 2024, T3592.41 (McFadgen).
[1314] Transcript of the Commission, 13 June 2024, T3594.2–13 (McFadgen).
[1315] Transcript of the Commission, 22 April 2024, T2288.45–47 (Schembri).
[1316] Transcript of the Commission, 29 April 2024, T2520.18–46 (Daly).

philanthropy in the context of their operations, I do not consider that this provides any proper basis for requiring that philanthropy received by AHOs be consumed in the delivery of those aspects of the public health system that they provide.

14.78. NSW Health has directed my attention to evidence given by Mr Daly to the effect that "it has been a longstanding feature of [AHOs] that they contribute charitable funding to supplement the services funded by Government"[1317] and expressed concern about the "limited visibility" NSW Health has of these organisations' charitable donations and other revenue streams.[1318]

14.79. I do not doubt that the practice alluded to by Mr Daly is longstanding. However, to the extent that the "supplementation" involves philanthropy subsidising services that are being delivered as part of the NSW public health system, that the practice has been longstanding does not make it right. In circumstances where the AHOs conduct research and provide an array of services that fall outside (and, in many respects, supplement) the public health system, there is no sound reason why the philanthropy they attract should be drawn away from those other important activities in order to subsidise core services that have been identified as comprising the public health system. Those core services are the sole responsibility of Government, supplemented by insurances and other moneys directly payable in connection with the provision of them.

14.80. Having regard to the views I have expressed above, the cited lack of transparency in relation to "own source revenue" generated by AHOs is only problematic to the extent that it relates to such payments as might be received from insurers or other sources directly in connection with the provision of those services that genuinely form part of the public health system.

14.81. It is concerning that an organisation as sophisticated as NSW Health is not able to determine the quantum of such payments by reference to the care actually delivered by AHOs operating within the public health system. To the extent that there are gaps in this knowledge base, they will be effectively and efficiently filled through the implementation of the recommendations I make elsewhere in this Report regarding the centralisation of all commercial arrangements with AHOs and the expansion of the SDPR project to capture all care delivered into the public health system by AHOs.

[1317] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.44] [MOH.0010.0758.0001 at 0112], citing Transcript of the Commission, 29 April 2024, T2520.18 (Daly).

[1318] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.45] [MOH.0010.0758.0001 at 0112–0113].

Activity based funding model

14.82. Consistently with the position of several LHDs, some AHOs highlighted the limitations of the ABF model to accurately capture the cost of delivering highly specialised and complex care.[1319]

14.83. In apparent recognition of the limitations of the ABF model in so far as it is applied to determining funding to AHOs, the Royal Rehab Group has historically received an annual "transitional grant".[1320] Even with the additional funding from transitional grants, the Royal Rehab Group has been required to use its "own source funding" to patch "holes" in service delivery that are not recognised or funded by the LHD.[1321]

14.84. What have been described to me as funding deficiencies stemming from ABF have also put pressure on the St Vincent's Health Network to change its model of care and work with other community services to secure alternative funding in order to continue providing public hospital services.[1322] Relevantly, due to the St Vincent's Health Network's concentration of complex patients requiring highly specialised services, the deficiencies of the ABF model are also said to be more concentrated and have made a significant contribution towards the Network's budgetary challenges.[1323]

14.85. Consistent with the observations I have made above, AHOs must be adequately funded to provide the services they are delivering into the public health system.

14.86. While problematic, I accept that it is open to NSW Health to approach the funding of its own entities in a manner that unevenly distributes the swings and roundabouts inherent in the ABF system among them. This cannot occur when NSW Health is dealing with AHOs. If the application of ABF results in an AHO receiving less than it is required to spend to deliver care to a disproportionately complex cohort of patients, supplementation must always be provided to the extent that it is required to avoid a funding shortfall. Unlike NSW Health, the AHOs do not have the same theoretical capacity to make up for such losses through gains associated with delivering care to more straightforward patients elsewhere in the wider public health system.

[1319] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [58]–[59], [62] [SVH.9999.0002.0001 at 0010–0011]; Transcript of the Commission, 18 April 2024, T2122.5–12 (Mackay); Transcript of the Commission, 13 June 2024, T3591.22–3592.1, 3589.41–3591.5, 3604.33–45 (McFadgen).

[1320] Transcript of the Commission, 18 April 2024, T2109.45–2110.43, 2111.27–30 (Mackay); Transcript of the Commission, 29 April 2024, T2548.7–17 (Willcox).

[1321] Transcript of the Commission, 18 April 2024, T2107.13–27 (Mackay).

[1322] Transcript of the Commission, 13 June 2024, T3592.32 (McFadgen).

[1323] Transcript of the Commission, 13 June 2024, T3591.37, 3605.1 (McFadgen).

Capital funding

14.87. Some AHOs highlighted problems associated with a lack of funding for capital investment and maintenance, which can create financial pressure for those organisations required to self-fund capital upgrades, maintenance, and replacements needed for the delivery of the services contemplated by their respective service agreements.

14.88. In this respect, the Royal Rehab Group identified the tension in current arrangements that expect it to operate as if it were a public facility, despite having to fund its own capital requirements while at the same time paying NSW Health for a wide range of services incidental to its operations, including technology service charges, training services, pathology, and payments to eHealth.[1324]

14.89. Similarly, the uncertainty of capital funding was of significant concern to the St Vincent's Health Network in light of substantial recurring capital costs for which it does not have the ability to plan long term. When representatives of the St Vincent's Health Network gave evidence in June 2024, much of its infrastructure had been maintained at its own cost but was reaching end of life and requiring investment similar to that received by other public facilities of a similar age and size.[1325]

14.90. The lack of capital infrastructure investment was a principal factor in the closure of St Joseph's Hospital in Auburn, which had been operated by the St Vincent's Health Network as a public hospital since 1882.[1326] The decision to decommission St Joseph's Hospital was made in June 2023 following a significant period of financial loss and concerns that the physical infrastructure could no longer support the level of contemporary care expected by patients and the community.[1327]

14.91. This lack of capital investment had continued under the St Vincent's Health Network's 2023–24 service agreement with the Ministry of Health, under which it was allocated a mere $105,000 in capital funding pursuant to NSW Health's asset replacement and refurbishment program. This amount was manifestly insufficient to maintain the infrastructure and equipment of St Vincent's Hospital Sydney in line with community expectations about the level of care that should be offered by the Network.[1328] Due to the limited capital funding received by the St Vincent's Health Network, it has needed to use operational funding to supplement its capital, including asset management and facilities maintenance.[1329] Unless that operational funding has been

[1324] Exhibit D.123, Outline of Evidence of Matthew Mackay (11 April 2024) [23] [SCI.0008.0341.0001 at 0005]; Transcript of the Commission, 18 April 2024, T2115.38–2116.4 (Mackay).

[1325] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [53] [SVH.9999.0002.0001 at 0009].

[1326] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [70], [75] [SVH.9999.0002.0001 at 0013, 0014].

[1327] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [71]–[74] [SVH.9999.0002.0001 at 0013–014].

[1328] Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [53] [SVH.9999.0002.0001 at 0008].

[1329] Transcript of the Commission, 13 June 2023, T3614.36–45 (McFadgen).

increased to recognise capital expenses necessarily incurred by the St Vincent's Health Network, its use for this purpose is obviously unsustainable.

14.92. For the St Vincent's Health Network, security of capital funding is critical to enable the planning of services in the longer term, and to allow planning of refurbishment and investment in assets.[1330] Without this security, there is a tendency towards a "break and fix" cycle, whereby capital investment only goes towards end of life equipment and infrastructure to prevent a discontinuation of services.[1331] The St Vincent's Health Network is subject to the same capital planning process applied to all LHDs and SHNs, which involves the consideration of any capital bids as part of the annual budget and prioritisation process within the Ministry of Health.[1332] However, it rightly perceives that it has not enjoyed the same level of success as NSW Health entities in bidding for capital funding. One need only look to the example of the St Vincent's Health Network's exclusion from the SDPR project for evidence of this reality.

14.93. I am entirely satisfied that the existing processes for AHOs to secure capital funding would benefit from improved transparency and certainty to promote longer term capital planning. Capital investment is an essential part of health service delivery and for AHOs, several of which operate facilities and equipment solely or primarily for the public health system, 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.

14.94. There are no doubt many ways that the challenges associated with the capital funding requirements of AHOs can be approached, ranging from periodic injections of capital funding to a recognition of ongoing capital funding costs in the level of remuneration offered for services provided under service agreements. While it is not my role to specify which approach should be taken in the case of any particular AHO, the simple fact is that these costs must be recognised in the funding provided to them by NSW Health.

Conclusion in relation to funding

14.95. As a general proposition, the notion that AHOs – which are, in substance, not for profit entities providing services on behalf of the public health system in NSW – should receive funding sufficient to cover the costs of delivering those services should not reasonably be open to debate. As a basal proposition, this much is accepted by

[1330] Transcript of the Commission, 12 June 2024, T3549.5–20 (Blake).

[1331] Transcript of the Commission, 12 June 2024, T3549.22–33 (Blake).

[1332] Exhibit G.104, Statement of Deborah Willcox (6 June 2024) [33] [MOH.9999.1297.0001 at 0005].

NSW Health.[1333] However, it emerged in the evidence that there is, frequently, a divergence of view as to what that amount is, and how it should be determined.[1334]

14.96. NSW Health has suggested that I should make no assumptions about the cost of delivering a particular service because it will depend very much on the way in which that service is configured, the remuneration and conditions offered to staff, and the terms of underlying supply contracts.[1335] As it is not my role to determine the fair cost of delivering any particular service, it is unnecessary for me to make any assumptions in that regard. However, it must also 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.

14.97. It is entirely possible – and perhaps probable – 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. Of course, if the divergence between these two figures becomes so great that NSW Health believes that stepping in and delivering the service itself to be the most viable and effective use of the public resources under its control, it should do so. Until that point is reached, the relevant AHO must be funded for the actual costs of delivering its services.

14.98. For example, an AHO may feel that, to attract and maintain its workforce in what is undoubtedly a highly competitive market, it must enter into an enterprise agreement that differs in some respect from the possibly outdated arrangements contemplated by the equivalent NSW Health award. One can readily see how this may result in an AHO paying more for its workforce than would NSW Health if it were the relevant employer. This cannot be ignored when determining what it will cost the AHO to deliver a particular service.

14.99. Continuing with this example, I accept that where the difference between the terms offered by an AHO to its workforce and the terms notionally available under the equivalent NSW Health award is so great that the former cannot be regarded as a reasonable or appropriate way for that organisation to be conducting its operations, the most appropriate response will be for NSW Health to itself deliver the service or work actively with the AHO to bring down its costs of delivering the service, while fully funding those costs during any transitional period.

[1333] Transcript of the Commission, 29 April 2024, T2550.11–16 (Willcox).

[1334] Transcript of the Commission, 29 April 2024, T2550.24–30 (Willcox).

[1335] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.36] [MOH.0010.0758.0001 at 0109]; see also Transcript of the Commission, 26 February 2025, T7123.5010 (Minns).

14.100. Similarly, 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. Just as the care delivered through LHDs is supplemented by periodic injections of capital funding, so to must the unavoidable capital costs of AHOs be recognised.

14.101. Ultimately, proffering insufficient funding to AHOs as a take it or leave it figure – and I recognise there is debate about the extent that this is occurring – is unacceptable. If it is occurring, it fails to recognise two important matters.

14.102. First, while AHOs are, by reason of their status under the *Health Services Act*, part of the public health system, they, unlike LHDs, remain independent organisations with their own legal obligations. Accordingly, if they do not receive funding sufficient to cover the cost of delivering the 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.

14.103. Secondly, AHOs are largely at the mercy of NSW Health. In many cases, the delivery of care in the public health system is central to their very existence and they have built infrastructure and a workforce around this reality such that they have little real choice but to accept whatever is proffered by NSW Health in their service agreements.

14.104. These two factors combine to place AHOs in a profoundly inferior bargaining position to the Ministry of Health or LHDs in their respective negotiations with them. There is a serious risk that this power imbalance will continue to operate to the detriment of AHOs 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 entered into with the Health Secretary would substantially overcome these problems.

14.105. This power imbalance – and my observations of the wholly unsatisfactory way in which disputes between AHOs and LHDs have been allowed to fester unresolved – also leads me to believe that a structured process through which such disputes can promptly be resolved is urgently required.

14.106. Any such process must incorporate an assessment – by a suitably independent party – of the extent to which funding offered to an AHO by NSW Health is sufficient to meet that organisation's costs 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 party 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.

14.107. NSW Health has suggested that the introduction of any such dispute resolution process would be inconsistent with the legislative framework under the *Health Services Act*, which provides that the amount of any subsidy paid to an AHO is to be determined by the Health Minister, citing ss 127(2) and 129 in support of this proposition.[1336] I do not accept that submission. I acknowledge that the Minister (or their delegate) must ultimately determine the subsidy to be paid to an AHO. Having a mechanism for an independent party to resolve a dispute about the cost to an AHO of delivering its services is not inconsistent with the Minister's power; the Minister could always decline to accept the views of the independent party. Of course, it would be a surprising exercise of power for a Minister (absent a very good reason) to decide that an AHO should be paid less than what an independent party had determined they were entitled to.

14.108. My recommendation on this issue makes clear that, once the fair cost of services to be delivered by an AHO under a proposed service agreement has been independently identified, it must remain open to either the AHO or the Minister (or her or his delegate) to elect **not** to enter into a service agreement for that service. In this way, an AHO that remains of the view that it cannot deliver a service at the identified cost without contravening its corporate obligations is not forced to do so. Similarly, and by way of answer to the concern raised by NSW Health, it would of course remain open to the Minister to elect not to procure the services or – as unpalatable as it would be – to offer less than the sum assessed as fair. If less than the assessed sum is to be offered, it is important that there be a greater level of transparency and accountability attaching to this fact.

Management and funding services delivered by Affiliated Health Organisations

14.109. There are different arrangements under which AHOs receive funding, including:

a. agreements directly with the Health Secretary, for instance, the grant funding agreement between the Health Secretary and Karitane in relation to their virtual residential parenting service,[1337] or the service agreement between the Health Secretary and Tresillian for similar virtual residential parenting services;[1338]

b. service agreements with each LHD in which the AHO provides services, for instance, the multiple agreements between Tresillian and each LHD in which it operates its Family Care Centres; and/or

[1336] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.34] [MOH.0010.0758.0001 at 0109].

[1337] Exhibit D.63, Signed Grant Agreement Virtual Parenting Residential Service between Karitane and the NSW Ministry of Health (16 June 2021) [SCI.0008.0048.0001_R].

[1338] Transcript of the Commission, 18 April 2024, T2055.09-25 (Mills).

c. a service agreement with the LHD in which the AHO is based and/or delivers the majority of its services, for instance, the agreement between Royal Rehab and Northern Sydney LHD.

14.110. In the 2023–24 financial year, Tresillian provided services pursuant to at least 11 LHDs through service agreements, as well as additional service agreements with the Health Secretary. A number of the LHD service agreements had been continued from previous financial years by way of complex deeds of variation negotiated between Tresillian and each LHD.[1339] There was added complexity in that the Ministry of Health funded a number of Tresillian regional centres, pursuant to a service agreement with the Health Secretary, while the specifics of service delivery were set out in separate service agreements with each LHD in which the Statewide Service was intended to operate.[1340]

14.111. The numerous split funding arrangements led to inconsistencies and issues around security of staff for Tresillian.[1341] It also increased the administrative burden on that organisation in dealing with multiple LHDs and the Ministry of Health.[1342] The administrative burden of that volume of service agreements was increased by their time limited nature. [1343]

14.112. As noted above, Karitane's principal service agreement is with the South Western Sydney LHD and, while its annual internal strategic planning process involved Karitane's Board of Directors consulting with NSW Health on strategic plans and reforms, this was limited to ensuring that the strategic priorities and reforms were aligned and was not considered by Karitane to be a collaborative process. Karitane also indicated that, where it identified a gap in service delivery and funding was available, it would open the required service. This type of expansion of services was not the subject of any centralised planning, though Karitane would consult with the relevant local LHDs and other stakeholders to ensure the services it was operating were symbiotic and did not duplicate existing services.[1344]

14.113. The St Vincent's Health Network, as a networked AHO, is in a somewhat different position to other AHOs given its greater level of integration within the Ministry of Health. It participates in the Ministry of Health's clinical service planning process in much the same way as do the LHDs, including participating in forums, committees, structures, and processes involved in clinical planning.[1345] The St Vincent's Health Network also had joint planning committees with its neighbouring LHDs and local PHNs. It meets regularly with these committees throughout the

[1339] Transcript of the Commission, 18 April 2024, T2053.32–36 (Mills).

[1340] Transcript of the Commission, 18 April 2024, T2053.38–2054.4, 2057.23–43, 2083.31–2084.15 (Mills).

[1341] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [26] [SCI.0008.0344.0001 at 0008–0009].

[1342] Transcript of the Commission, 18 April 2024, T2058.39 (Mills).

[1343] Transcript of the Commission, 18 April 2024, T2058.42–2059.19 (Mills).

[1344] Transcript of the Commission, 18 April 2024, T2044.32–41 (O'Loughlin).

[1345] Transcript of the Commission, 13 June 2024, T3567.32–3568.6, 3573.2 (McFadgen).

year and undertakes joint needs assessments and analyses to inform the provision of services to the collective catchment.[1346] The local Head of Strategy and Planning at the St Vincent's Health Network was also part of the Statewide planning network administered by the Ministry of Health, which had oversight of planning data that may impact the planning of LHDs.[1347]

14.114. Mr Mackay gave evidence that there were limitations within the current operational model in relation to the services performed by the Royal Rehab Group, whereby service planning and funding for spinal cord injury rehabilitation fell largely under the jurisdiction of one LHD, which did not provide sufficient resources for services to be distributed in areas of need across the State.[1348] He suggested that a hub and spoke model involving a Statewide spinal cord injury and rehabilitation service would create better outcomes for patients.[1349]

14.115. Karitane, Tresillian, and the St Vincent's Health Network agreed that there would be benefits to centralising decision making relating to service planning and funding within NSW Health. In particular, Karitane and Tresillian gave evidence that a centralised model would yield better results with respect to equitable, transparent, timely, and data driven resource allocation and funding, and would ensure the locations of AHO services met specific identified needs.[1350]

14.116. The St Vincent's Health Network agreed that there was significant benefit to increasing the level of central involvement in health planning, to enable coordination, cohesion and service provision planning, particularly in the context of scarce resources in the health system.[1351] Increasing the level of central involvement in this planning process presented greater opportunities for collaboration and the scaling of novel ideas and new models of care, as well as the identification of gaps in the services offered across the State.[1352] In the view of the St Vincent's Health Network, a system wide focus on prevention and diversion was an essential part of service planning, including in the identification of opportunities for system reform and where scarce resources may be best allocated.[1353]

[1346] Transcript of the Commission, 13 June 2024, T3568.17–32, 3569.38–44 (McFadgen).

[1347] Transcript of the Commission, 13 June 2024, T3569.19–28 (McFadgen).

[1348] Transcript of the Commission, 18 April 2024, T2117.33–2118.24 (Mackay).

[1349] Transcript of the Commission, 18 April 2024, T2118.18–24 (Mackay).

[1350] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [26] [SCI.0008.0343.0001 at 0005]; Transcript of the Commission, 18 April 2024, T2086.18–27 (Mills).

[1351] Transcript of the Commission, 13 June 2024, T3570.16–38 (McFadgen).

[1352] Transcript of the Commission, 13 June 2024, T2571.3–15 (McFadgen).

[1353] Transcript of the Commission, 13 June 2024, T3574.6–24 (McFadgen).

14.117. LHDs enjoy obvious advantages in being able to assess the needs of their respective communities more directly than Ministry of Health.[1354] They also have relationships with AHOs that are longstanding and important in the context of both the planning and delivery of services by those organisations. However, where a service is being delivered by an AHO, the Ministry of Health (with appropriate input from each of the LHDs as to the nature and extent of the particular services to be provided within their respective footprints through the planning process I have recommended elsewhere in this Report) should always have oversight of that service and be actively involved in its planning, which is not currently the case.[1355] The Ministry of Health's planning and financial oversight will be significantly enhanced if it is the Health Secretary that is entering into a service agreement with each of the AHOs.

14.118. In this respect, Ms Willcox saw "absolute efficiency and logic" in AHOs that provide services across a range of LHDs having a single service agreement with the Health Secretary, rather than through a particular LHD, or with each of the different LHDs where they operate services.[1356]

14.119. For those Statewide Services that are currently managed by a single LHD, there are benefits to be gained from centralised oversight with respect to population need and service gaps, as well as increased budgetary flexibility. I can see no reason why the same approach should not be applied to all AHOs, including those that might be delivering services confined to a single LHD.

14.120. Such an approach would support wider, strategic, system planning. At present, there is limited centralised or collaborative service planning relating to the services provided by AHOs. The evidence suggests that the expansion of services operated by AHOs, and the implementation of new measures to meet service gaps, is generally AHO led and based on their internal planning and strategy.[1357]

14.121. Both NSW Health and the Health Services Association NSW have alluded in their respective submissions to the importance of the close working relationships that have developed between AHOs and the LHDs into which they deliver care. I acknowledge that these relationships exist and are of value. Far from undermining these relationships, I think it is likely that the recommendations I make below could only serve to strengthen these relationships.

[1354] Transcript of the Commission, 29 April 2024, T2573.2–23 (Danos).

[1355] Transcript of the Commission, 18 April 2024, T2086.18–27 (Mills), 2118.26–47 (Mackay), 2126.32–36 (Mackay); Transcript of the Commission, 13 June 2024, T3570.16–38 (McFadgen); Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [26] [SCI.0008.0343.0001 at 0005].

[1356] Transcript of the Commission, 29 April 2024, T2551.15–24 (Willcox).

[1357] See, e.g., Transcript of the Commission, 18 April 2024, T2044.32–41 (O'Loughlin), 2055.42–2056.5 (Mills); Transcript of the Commission, 24 April 2024, T2419.35–2420.10 (Middleton).

Schedule 3 of the Health Services Act

14.122. Schedule 3, Column 2 of the *Health Services Act* has not kept up to date with the changing service offerings of the AHOs listed in Column 1, including with respect to services and establishments for which AHOs have received funding pursuant to service agreements with LHDs and the Ministry of Health. While this has had limited practical impact for some AHOs, others have been left with additional operational costs and liability risks, creating an apparent inconsistency in the treatment of AHOs within the public health system.

14.123. For Karitane, the recognised establishments and services in Schedule 3 Column 2 do not reflect the full range of its current service offerings pursuant to its service agreements, instead encapsulating only "[c]hild and family health services at Carramar, Fairfield, Liverpool and Randwick".[1358] That description does not recognise the services Karitane provides at Campbelltown Hospital and at the Oran Park Integrated Care Hub, nor the fact that Karitane is required to provide these services pursuant to its 2023–24 service agreement with South Western Sydney LHD. It also does not include the virtual residential parenting service or virtual home visit service funded directly by the Ministry of Health, nor any perinatal, infant and child mental health services that Karitane is also funded to provided.[1359] Karitane also has not operated a service in Liverpool since 2018, though this location remains on the Schedule.[1360]

14.124. Grainne O'Loughlin, Chief Executive Officer of Karitane, was not aware of any changes being made to Schedule 3 in relation to Karitane since she commenced in the role in 2014.[1361] This is despite the discrepancies being raised with NSW Health by both Karitane and the Health Services Association.[1362]

14.125. Tresillian's recognised establishments and services pursuant to Schedule 3 Column 2 are location based and include "Tresillian Family Care Centres at Belmore, Broken Hill, Coffs Harbour, Dubbo, Lismore, Penrith, Queanbeyan, Taree, Willoughby and Wollstonecraft".[1363] However, again, this list of recognised establishments and services is not consistent with each of the services Tresillian is presently funded to provide by either NSW Health or the LHDs. In the past, Tresillian has had some success in seeking amendments to Schedule 3, adding its Lismore Centre, and Broken Hill, Dubbo, Taree, Queanbeyan, and Coffs Harbour locations to Schedule 3, Column 2 in 2018 and 2020 respectively.[1364] This was achieved through email

[1358] *Health Services Act 1997* (NSW) sch 3.

[1359] Transcript of the Commission, 18 April 2024, T2017.39–44 (O'Loughlin).

[1360] Exhibit D.121, Outline of Evidence of Grainne O'Loughlin (11 April 2024) [12] [SCI.0008.0343.0001 at 0002].

[1361] Transcript of the Commission, 18 April 2024, T2017.46–2018.8 (O'Loughlin).

[1362] Transcript of the Commission, 18 April 2024, T2018.10–15 (O'Loughlin).

[1363] *Health Services Act 1997* (NSW) sch 3.

[1364] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [7] [SCI.0008.0344.0001 at 0003]; Exhibit D.100, Health Services Amendment (Royal Society for the Welfare of Mothers and Babies) Order 2020 under the *Health Services Act 1997* (NSW) (18 March

correspondence to the NSW Health legal branch attaching a copy of the relevant service agreements and seeking that the Schedule be updated accordingly.[1365]

14.126. However, in 2021, when Tresillian's service expanded to include seven further sites in line with its service agreement, the Ministry of Health refused to take such steps as are necessary to add these locations to Schedule 3,[1366] advising Tresillian that it would be required to make a business case to be assessed through the Prevention and Response to Violence, Abuse and Neglect Branch or the Health and Social Policy Unit of the Ministry of Health. This was the first occasion that such an approach had been adopted in relation to Schedule 3.[1367]

14.127. Tresillian has since sought to have Schedule 3 amended to accurately reflect its services that are delivered under service agreements with NSW Health agencies, without success. In February 2022, a proposal from Tresillian that its Column 2 services be amended to remove the locations of services and insert a more generic reference to "Tresillian Family Care Centres", in a similar way to the Column 2 descriptors for the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors and the Royal Rehab Group, was rejected.[1368] In December 2022, an alternate proposal that Column 2 for Tresillian be amended to include "Tresillian Family Care services in NSW conducted under written agreements with the NSW Ministry of Health, the Health Administration Corporation or a Local Health District" was also rejected.[1369]

14.128. Having regard to correspondence issued at the time by the then Minister for Health, it is apparent that the reasons for rejecting Tresillian's proposals were as follows:

a. in relation to the February 2022 proposal, that for services to be included in the Schedule, an AHO was required to have recurrent or ongoing funding (rather than time limited funding, such as the two year funding agreement for Tresillian's seven additional sites);[1370] and

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2020) [SCI.0008.0117.0001]; Exhibit D.101, Emails from Robert Mills to Melanie Shea, 9 January 2020–23 March 2020 [SCI.0008.0118.0001].

[1365] Transcript of the Commission, 18 April 2024, T2068.17–2069.7 (Mills).

[1366] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [7] [SCI.0008.0344.0001 at 0003].

[1367] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [8] [SCI.0008.0344.0001 at 0003]; Transcript of the Commission, 18 April 2024, T2071.7–38 (Mills).

[1368] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [9] [SCI.0008.0344.0001 at 0003]; Exhibit D.105, Letter from Brad Hazzard to Robert Mills, 28 February 2022 [SCI.0008.0123.0001].

[1369] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [12]–[13] [SCI.0008.0344.0001 at 0004–0005]; Exhibit D.109, Letter from Brad Hazzard to Mary Dowling, 20 December 2022 [SCI.0008.0127.0001].

[1370] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [11] [SCI.0008.0344.0001 at 0004]; Exhibit D.105, Letter from Brad Hazzard to Robert Mills, 28 February 2022 [SCI.0008.0123.0001]; Transcript of the Commission, 18 April 2024, T2073.29–2074.19 (Mills).

b. in relation to the December 2022 proposal, that there were "inherent issues" with the proposal,[1371] including that, if implemented, the amendment to the Schedule would create funding uncertainty for Tresillian's existing recognised services.[1372]

14.129. For completeness, I note that there are also a number of services identified in Schedule 3 that are no longer provided, including Karitane's Liverpool parenting centre and Tresillian's Willoughby centre. Neither is referred to in a service agreement or otherwise funded, despite their inclusion in Column 2.[1373]

14.130. In its closing submissions, NSW Health repeated to me its assertion that the inclusion of a service in Column 2 in some way carries with it an implication that the service cannot thereafter be withdrawn and will continue to receive recurrent funding.[1374] I cannot see any proper basis for this view.

14.131. The suggestion that, to be included in Column 2, services must receive recurrent funding does not sit comfortably with what has occurred in practice and is entirely unsupported by the statutory regime. In this respect, and as noted above, AHOs are largely funded pursuant to periodic service agreements, which carry no guarantee of future funding in themselves.[1375] Further, and significantly, s 129 of the *Health Services Act* contemplates that an AHO is not guaranteed ongoing funding in relation to any recognised establishment or service.[1376]

14.132. Maintaining the currency of Schedule 3 is not simply a matter of correctness and good order. There are material consequences for AHOs if their services are not accurately captured in Schedule 3. For example, the Ministry of Health's "Accounts and Audit Determination for Public Health Entities in NSW" requires that AHOs participate in the NSW Treasury Managed Fund insurance scheme (iCare) and not enter into other insurance contracts, unless otherwise approved by the Treasurer.[1377] The determination is generally included in service agreements as a "key condition" of the subsidy.[1378]

[1371] Exhibit D.109, Letter from Brad Hazzard to Mary Dowling, 20 December 2022 [SCI.0008.0127.0001].

[1372] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [13]–[14] [SCI.0008.0344.0001 at 0005]; Transcript of the Commission, 18 April 2024, T2077.46–2078.28 (Mills).

[1373] Transcript of the Commission, 18 April 2024, T2074.3–16 (Mills).

[1374] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.3] [MOH.0010.0758.0001 at 0095–0096].

[1375] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [11] [SCI.0008.0344.0001 at 0004]; Exhibit D.105, Letter from Brad Hazzard to Robert Mills, 28 February 2022 [SCI.0008.0123.0001]; Transcript of the Commission, 18 April 2024, T2074.47–2075.34, 2078.23–2079.6 (Mills).

[1376] The inclusion of the words "if any" in subsections (a) and (b) clearly contemplate that a decision may be made not to pay any subsidy in relation to a recognised establishment or service. That tells strongly against the notion that inclusion in Schedule 3 gives rise to a requirement to pay "recurrent funding".

[1377] Exhibit D.95, NSW Health, *Accounts & Audit Determination for Public Health Entities in NSW* (9 March 2020) [SCI.0008.0112.0001 at 0010]; Transcript of the Commission, 18 April 2024, T2065.19–46 (Mills).

[1378] Transcript of the Commission, 18 April 2024, T2065.6–17 (Mills); see, e.g., Exhibit D.80, SWSLHD and Karitane, *Service Agreement 2023–24* (5 April 2024) [1.1.4] [SCI.0008.0169.0001 at 0008]; Exhibit D.96, SLHD and Tresillian, *Service Agreement 2023–24* (12 December 2023) [1.1.4] [SCI.0008.0113.0001 at 0006].

14.133. Despite the requirements of the determination, in 2021, Tresillian was advised by the Ministry of Health that its iCare Certificate of Currency could not be amended to cover services or establishments that were not included in Schedule 3, even where those services and establishments were funded by NSW Health pursuant to a service agreement. The rationale for this advice was that, under the *Health Services Act*, an AHO is only recognised in respect of their services or institutions listed in Column 2 of the Schedule.[1379]

14.134. The Ministry of Health and iCare's position was confirmed in February 2022, and again in December 2022, when Minister Hazzard advised Tresillian that unified iCare coverage of its services would only be possible if all the services were listed in Column 2 of the Schedule.[1380] Minister Hazzard suggested that additional insurance costs in relation to the services not included in Column 2 of Schedule 3 were a matter "to raise with the relevant funding entities as part of funding negotiations about the cost of services".[1381]

14.135. The position adopted to date produces the unusual circumstance that some AHO operated hospital beds funded by NSW Health and located within public hospitals are not listed as recognised services in Column 2 of Schedule 3, nor subject to iCare insurance coverage.[1382] In practical terms, the AHO in that circumstance is not considered to be part of the public health system, as it does not fall within the scope of s 6 of the *Health Services Act*, yet was purporting to admit inpatients to a facility it operated within a public hospital.[1383] That is (to put it as mildly as I can) undesirable, and exposes the AHO to material risk if an adverse incident were to occur.[1384]

14.136. It also places an additional financial burden on AHOs in that situation.[1385] For example, Tresillian's iCare Certificate of Currency for 2023–24 expressly noted that Tresillian is only insured for its recognised establishments and services as listed in Schedule 3.[1386] Accordingly, it was required to pay separate workers compensation, public liability and property insurance for its NSW Health funded services that were

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[1379] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [8] [SCI.0008.0344.0001 at 0003]; Exhibit D.102, Email from Robert Mills to Olivia King, 25 June 2021–19 November 2021 [SCI.0008.0119.0001]; Transcript of the Commission, 18 April 2024, T2070.11–33 (Mills).

[1380] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [10], [16] [SCI.0008.0344.0001 at 0004, 0006]; Exhibit D.105, Letter from Brad Hazzard to Robert Mills, 28 February 2022 [SCI.0008.0123.0001].

[1381] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [16] [SCI.0008.0344.0001]; Exhibit D.109, Letter from Brad Hazzard to Mary Dowling, 20 December 2022 [SCI.0008.0127.0001]; Transcript of the Commission, 18 April 2024, T2079.8–20 (Mills).

[1382] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [22] [SCI.0008.0344.0001 at 0007]; Transcript of the Commission, 18 April 2024, T2075.36–46 (Mills).

[1383] Exhibit D.103, Email from Robert Mills to Anette Marley, 8 September 2022 [SCI.0008.0120.0001 at 0005].

[1384] Transcript of the Commission, 18 April 2024, T2075.36–2076.16 (Mills).

[1385] Although there was evidence that suggests that the experience of Affiliated Health Organisations in this respect is not uniform, and different approaches have been adopted in relation to different organisations: see, e.g., Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [21] [SCI.0008.0344.0001 at 0007]; Exhibit D.56, iCare, *Insurance for NSW – Certificate of Currency for NSW Health* [SCI.0008.0046.0001]; Transcript of the Commission, 18 April 2024, T2080.26–28 (Mills), 2018.33–39 (O'Loughlin).

[1386] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [21] [SCI.0008.0344.0001 at 0007]; Exhibit D.39, iCare, *Insurance for NSW – Certificate of Currency for NSW Health and Royal Society for the Welfare of Mothers and Babies* (27 June 2023) [SCI.0008.0002.0001]; Transcript of the Commission, 18 April 2024, T2080.6–24 (Mills).

not listed in Column 2 of the Schedule, totalling $80,397 in 2023.[1387] Tresillian had not received any additional funding in its service agreements to compensate for these additional insurance costs.[1388]

14.137. In May 2023, following a meeting between Tresillian and Minister Park, a NSW Health Services Association Working Group was established to enable direct liaison between NSW Health and Tresillian and the Health Services Association, on issues relating to Schedule 3 and other AHO related matters.[1389] At a meeting of that group in January 2024, Robert Mills, Chief Executive Officer of Tresillian, was advised that – from the perspective of the NSW Health Legal Branch – there were no concerns with adding Tresillian's services at Macksville Hospital and Campbelltown Hospital to Column 2 of Schedule 3, but rather it was a policy decision.[1390] To date, no changes to Schedule 3 have been made.

14.138. Schedule 3 should reflect an accurate description of the AHOs, and their recognised services and establishments. That Schedule should be kept up to date at all times.

14.139. This is not to suggest that there might not occasionally be services provided by an AHO that are not included in Column 2. For example, if an AHO were to succeed in a competitive tendering process for the provision of some discrete service and obtain a grant for the provision of that service, it is unlikely that it would be doing so in its capacity as an AHO. The terms upon which that discrete service is provided will emerge from the tender and be governed by the terms of the grant. However, where a service is being provided by an AHO pursuant to its service agreement with an LHD or, if my recommendation is accepted, the Health Secretary, it would be artificial and inappropriate for the Ministry of Health to decide – on "policy grounds" – to exclude that service (or some part of it) from Column 2. For so long as a service agreement requiring the provision of that service is in force, all services contemplated by it should be included in Column 2. If, in connection with the planning exercise I have referred to elsewhere in this Report, it is decided that the service is no longer required (or no longer to be obtained from the AHO), it can and should be removed from Column 2.

14.140. NSW Health has suggested in their closing submissions that regularly adjusting Schedule 3 in the manner contemplated by the above paragraph would require the invocation of some complex process of legislative amendment, the implication being that it would be in some way impractical for this to occur.[1391] I disagree. Section 62(2) of the *Health Services Act* makes clear that the Governor may, by order, make such

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[1387] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [20] [SCI.0008.0344.0001 at 0007]; Exhibit D.112, Various certificates of currency for Tresillian (issued variously by iCare, Gallagher Basset and Ansvar Insurance) (27 May 2023) [SCI.0008.0131.0001]; Transcript of the Commission, 18 April 2024, T2079.22–36 (Mills).

[1388] Transcript of the Commission, 18 April 2024, T2079.38–47 (Mills).

[1389] Transcript of the Commission, 18 April 2024, T2081.32–47 (Mills).

[1390] Exhibit D.122, Outline of Evidence of Robert Mills (11 April 2024) [19]; Transcript of the Commission, 18 April 2024, T2082.24–46 (Mills).

[1391] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [11.31]-[11.32] [MOH.0010.0758.0001 at 0107–0108].

amendments to Column 2 as may, from time to time, be required. It is obvious that adjustments to the services contemplated by annual service agreements warrant the exercise of that power and no sound policy basis has been identified by NSW Health for a refusal to do so.

14.141. Accordingly, immediate steps should be taken to review and update Schedule 3 of the *Health Services Act* to ensure that it accurately reflects each of the AHOs, and services and establishments delivered through their respective service agreements.

14.142. Concomitant with that approach, where a new service is established, there should be clear advice given by the Ministry of Health or LHD to the AHO as to whether that service is intended to form part of the organisation's recognised services (and thus be included in its service agreement), or whether, in delivering that service, the organisation is to provide those services otherwise than in its capacity as an AHO. Clear communication about those issues is imperative to enable the organisation to consider whether to provide the service on that basis and determine whether the funding to be provided for that service is sufficient to meet its costs of doing so.

Conclusion

14.143. Planning the services to be provided by each AHO (and where those services are to be provided) should form an integral part of the system wide service planning process.

14.144. AHOs have long been an important part of the NSW public health system and in some cases, they are the only provider of highly specialised services within it.

14.145. However, it must also be recognised that – although deemed to be a part of the NSW public health system in respect of their recognised facilities and services – they are independent organisations. That means that they cannot be approached in the same way as LHDs or SHNs. If an LHD or SHN exceeds its budget, it is not at risk of collapsing. The same cannot be said of AHOs.

14.146. It is for that reason critical that AHOs receive funding that covers their reasonable cost of delivering the services contemplated by their service agreement. I do not understand that to be a controversial proposition. Indeed, it would be extraordinary if an arm of the NSW Government considered that it was appropriate to pay a not for profit organisation an amount less than what it costs that organisation to deliver services to the public health system.

14.147. Yet I am told that is what has happened in several instances.

14.148. Acknowledging that there is live debate about that issue between some AHOs and the relevant LHD (and the Ministry of Health), the circumstances that give rise to that debate must be addressed. Part of that is to have AHOs deal directly with the Ministry of Health in relation to their funding arrangements, thus taking them out of the already stretched budgetary responsibility of LHDs. That does not mean that the close relationships between AHOs and the LHDs that host their services will be lost or diminished. Indeed, they may improve in circumstances where funding issues and discussions dealt with as between the AHO and the Ministry of Health.

14.149. Further, there must be a mechanism to resolve any lingering disagreement as to whether the funding offered is sufficient to meet the reasonable cost of delivering the service contemplated by the AHO's service agreement (or proposed service agreement). It is of no benefit to anyone to have debates about that question continue – in one case for more than a decade. Such a process would not interfere with the Minister's ultimate power to determine the level of subsidy to be made available to an AHO. It would, however, provide the Minister with a more complete picture than that which is currently available.

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.

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.

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:

The Single Digital Patient Record

Volume 2

15.1. As I have already noted, in 2008 the Garling Inquiry was confronted with a primarily paper based system for the recording of clinical notes within the NSW public health system. Commissioner Garling made several observations about the obvious shortcomings of that system including that:

a. it relies on a varied ability to decipher the handwriting of another busy clinician;[1392]

b. the type and form of data being recorded varied greatly between clinicians, wards and hospitals;[1393] and

c. there was an obvious risk that information would be missed;[1394]

d. most significantly, for present purposes, paper based patient records cannot be readily shared and, therefore, cannot be accessed (or contributed to) by all the clinicians who might provide care to a patient within the public health system.[1395]

15.2. Commissioner Garling described the fact that, as at 2008, there was no Statewide functioning system for recording and sharing clinical notes as "beyond my belief" and found it "unacceptable" that remedying this systemic deficiency was not, then, an immediate priority for NSW Health.[1396] He also found there to be a real need for a Statewide electronic medical record system that was fully compatible across the acute and community health sectors.[1397] Accordingly, he recommended that relevant electronic records generated in public hospitals be accessible to "general practitioners, specialists, allied health professionals and community health clinicians".[1398] A further recommendation provided a timeline for the implementation of this reform, as follows:[1399]

a. Stage 1: 12 months – Infrastructure;

b. Stage 2: 18 months – Electronic medical record and patient administration system;

c. Stage 3: 24 months – Human resources information system, business information strategy, medical imaging, intensive care, and hospital pharmacy system;

[1392] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.30] [SCI.0011.0760.0001 at 0052].

[1393] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.21] [SCI.0011.0760.0001 at 0046].

[1394] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.26], [14.34] [SCI.0011.0760.0001 at 0052, 0053].

[1395] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.51] [SCI.0011.0760.0001 at 0056].

[1396] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.73] [SCI.0011.0760.0001 at 0059–0060].

[1397] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [21.60] [SCI.0011.0760.0001 at 0371].

[1398] Exhibit N4.4, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.173] (Recommendation 50) [SCI.0011.0760.0001 at 0078].

[1399] Exhibit N4.3, *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) vol 2 [14.191] (Recommendation 51) [SCI.0011.0760.0001 at 0083].

d. Stage 4: 36 months – Community health system redevelopment, automated rostering, clinical documentation and medication management; and

e. Stage 5: 48 months - Statewide roll out of the electronic health record.

15.3. More than 16 years after those recommendations were made, there remains no Statewide electronic medical record system that captures and shares – even across all facilities operated by NSW Health – information relating to the treatment received by patients within the NSW public health system. The failure to have responded effectively, or with any expedition, to Commissioner Garling's recommendations on this issue simply beggars belief. This was a recommendation aimed right at the heart of patient safety. And yet, it was not progressed in any substantive way for well over a decade.

15.4. Having said this, I should also say that I am certain many within NSW Health share a similar view and would – had funding been made available to them to do so – have committed themselves to the implementation of a system of the type described by Commissioner Garling. Instead, such ambitions as they might have had in this area have been left to languish while vast sums have been directed into the construction of new and upgraded hospitals and the continued operation of smaller facilities that the Chief Executives of some LHDs believe should have been closed. Viewed in this way, it is difficult to see the absence of a Statewide electronic medical records system as anything other than a failure of Government.

15.5. The evidence received, and site visits conducted, by this Special Commission revealed a wide array of different and poorly integrated systems for recording clinical records:

a. a paper based system for recording medical notes is still in use at St Vincent's Hospital Sydney[1400] (part of St Vincent's Health Network);

b. Hawkesbury District Health Service – which until recently, was operated as part of the public health system in NSW by St John of God under a public private partnership arrangement – did not use electronic medical records, at least up to the point at which it ceased to be operated by St John of God.[1401]

c. I was told that Albury Wodonga Health, which I recognise is officially part of the Victorian health system, is also still using a paper based system for recording medical notes. While this may not be under the direct control of NSW Health, a significant amount of NSW money contributes to the funding of Albury Wodonga Health and a large number of patients who reside in southern NSW receive treatment in the facilities it operates. These same individuals routinely receive care through clinics and other facilities operated by NSW Health throughout southern

[1400] Transcript of the Commission, 13 June 2024, T3604.45–3605.6 (McFadgen).

[1401] Transcript of the Commission, 12 June 2024, T3493.5–19 (Edwards).

NSW. There has clearly been ample need and opportunity for NSW Health to work collaboratively with Albury Wodonga Health to find a solution to this issue;

d. where electronic medical record systems **are** being used in NSW Health facilities, they are by no means uniform or compatible. Different electronic medical record systems are currently used by different LHDs and SHNs.[1402] There are at least nine systems storing electronic medical records, 10 patient administration systems, and five pathology laboratory information management systems currently in use.[1403] While I have been told that there is some overlap in these systems, this has been largely explained by reference to the fact that at some point prior to the creation of the LHDs and SHNs, each Area Health Service commissioned its own electronic medical record system, which is still being used in each of the facilities that formerly fell under its control.

15.6. In practice, this means that medical records relating to treatment received by patients within the public health system are frequently not able to be viewed or contributed to by other clinicians who might subsequently be required to provide care to the same patients, even where that subsequent treatment is provided through a clinic or a public hospital in another part of the public health system (say, a facility operated by a different LHD, or an SHN or AHO).

15.7. Some attempt is made to share information about treatment provided to patients in public hospitals with those clinicians who are providing their primary care. This occurs primarily through the provision of discharge summaries. However, (as I have observed above) these discharge summaries are frequently delayed and often not received by the relevant clinician providing primary care to a patient. The quality of the information contained in discharge summaries is also highly variable. It has been suggested that discharge summaries are frequently prepared by the most junior members of the medical workforce within hospitals, and often by clinicians who have not actually provided care to the relevant patient. Important information – including changes to medication, the results of tests performed, and other information important to those providing primary care – is occasionally omitted from discharge summaries.[1404]

15.8. Clinical records created in connection with the provision of primary care are largely invisible to those providing care in the acute setting.

15.9. The only bidirectional source of medical information that bridges the divide between acute and primary care is that found in a patient's My Health Record. However, the evidence given to this Special Commission, and my discussion with clinicians during

[1402] Transcript of the Commission, 23 February 2024, T977.32–37, T978.3–8 (Bolevich).

[1403] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [31(a)(ii)] [MOH.0001.0433.0001 at 0014].

[1404] Transcript of the Commission, 18 March 2024, T1151.05–1152.22, 1195.28-1196.26 (Christmas); Transcript of the Commission, 19 March 2024, T1400.39–1401.29 (Mills); Transcript of the Commission, 22 March 2024, T1680.26–1681.05 (Bruce); Transcript of the Commission, 14 May 2024, T2705.44-2707.3 (Chua).

roundtables and in regional visits, makes clear that this system is unreliable, inefficient, and inadequate.[1405]

15.10. The serious problems created by the arrangements I have described above – viewed from the perspective of both efficiency and patient safety – are obvious. It is clear that ready access to a patient's full suite of medical information can only enhance clinical outcomes and reduce the wastage occasioned by duplication.[1406] Clinical outcomes can be compromised when important information is not accessible due to a lack of information system compatibility between services.[1407] As Adjunct Professor Michael Nicholl, the Chief Executive of the CEC, agreed, providing visibility of a patient's medical records to **all** people involved in delivering care to that patient, and an opportunity for the patient to view and correct anything in it which they know to be inaccurate, are "essential features of a good and safe system".[1408] Regrettably, these are not features of the current system.

15.11. In an attempt to address these problems, NSW Health has now embarked on the development and implementation of what it describes as the SDPR Project. A tender process for that project commenced in 2020, and global technology company EPIC Systems was awarded the project in late 2022. Evidence about this project was primarily provided to this Special Commission by Dr Zoran Bolevich, who, at the time he gave that evidence, was the Chief Executive of eHealth NSW and Chief Information Officer of NSW Health.[1409]

15.12. The stated purpose of the project is to transform the digital systems and workflows that NSW public healthcare workers use every day to deliver care, through the rollout of "a next generation, integrated patient administration system, electronic medical record, and laboratory information management system."[1410] Put another way, the aim of the SDPR is to deliver a Statewide, integrated clinical platform that will provide a holistic view of a patient's medical record at the point of care.[1411]

[1405] Transcript of the Commission, 29 November 2023, T264.25–39 (Lyons); Transcript of the Commission, 15 April 2024, T1761.38–1762.02 (Wilkinson); Transcript of the Commission, 14 May 2024, T2719.08–2720.06 (MacIsaac); Transcript of the Commission, 22 May 2024, T3131.36–3132.12 (Nott).

[1406] Transcript of the Commission, 23 February 2024, T981.17–31 (Bolevich); Transcript of the Commission, 19 April 2024, T2239.22–31 (Smith); Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [94] [MOH.9999.0008.0001 at 0033–0035]; Transcript of the Commission, 29 November 2023, T237.11–27 (Lyons); Transcript of the Commission, 28 November 2023, T185.42–186.3 (Willcox); Transcript of the Commission, 29 November 2023, T236.43–237.9 (Willcox).

[1407] See, for example, Transcript of the Commission, 18 March 2024, T1149.18–42 (Christmas); Transcript of the Commission, 16 April 2024, T1907.1–29 (Smith); Transcript of the Commission, 16 April 2024, T1813.45–1814.28 (Wood).

[1408] Transcript of the Commission, 16 April 2024, T1957.12–23 (Nicholl).

[1409] Dr Bolevich held those roles until June 2024, when he commenced a new role as the Chief Executive of the Australian Institute of Health and Welfare. The roles of Chief Executive of eHealth NSW and Chief Information Officer of NSW Health are currently held by Richard Taggart.

[1410] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [31(a)(i),(ii)] [MOH.0001.0433.0001 at 0014].

[1411] Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [93] [MOH.9999.0981.0001 at 0032–0033].

15.13. The SDPR will use a platform created by EPIC Systems. The Single Digital Patient Record Implementation Authority (SDPRIA) was established to work in partnership with LHDs, SHNs, eHealth NSW, NSW Health Pathology, shared services, Pillar agencies, the Ministry of Health, and Epic Systems to lead the implementation of the project.[1412]

15.14. As conceptualised, the information contained on the SDPR will initially include imaging records, readouts from bedside point of care machines, medication records, and discharge records.[1413] It is anticipated that the SDPR will also operate as a clinical workflow management tool, enabling clinicians to, among many other things, order tests, receive results, make observations, record progress notes, and capture patient histories.[1414] It may also be used to notify clinicians of a potential course of treatment based on the information logged on the system.[1415]

15.15. It is intended that the SDPR will operate across each LHD and SHN, with its rollout to commence across the Hunter New England LHD and Justice Health.[1416] However, even as conceptualised, the SDPR will not be rolled out in all public hospitals operated by NSW Health until some date in approximately 2028–2029.[1417]

15.16. While it has been said that there was strong engagement across the entire health system in relation to the project,[1418] it is not presently intended that the SDPR will cover even the entire public health system in NSW, and in two particular respects falls well short of what was recommended by Commissioner Garling.

15.17. First, neither the St Vincent's Health Network nor any other facility operated by an AHO is to be included in the rollout of the SDPR. No funding is to be provided to any AHO to facilitate their participation in the project.[1419] This is despite the St Vincent's Health Network submitting a *Strategic Asset Management Plan* to the Ministry of Health during the 2023–24 financial year to highlight their aligning capital priorities including the SDPR,[1420] and around the same time, requesting priority funding for

[1412] 'Single Digital Patient', *eHealth NSW* (Web Page, April 2025) <https://www.ehealth.nsw.gov.au/solutions/clinical-care/electronic-medical-records/sdpr>.

[1413] Transcript of the Commission, 23 February 2024, T978.18–26, 980.19–27 (Bolevich).

[1414] Transcript of the Commission, 23 February 2024, T978.34–42 (Bolevich).

[1415] Transcript of the Commission, 23 February 2024, T978.44–979.06 (Bolevich).

[1416] 'Single Digital Patient', *eHealth NSW* (Web Page, April 2025) <https://www.ehealth.nsw.gov.au/solutions/clinical-care/electronic-medical-records/sdpr>.

[1417] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [31(a)(iv)] [MOH.0001.0433.0001 at 0014]; 'Single Digital Patient', *eHealth NSW* (Web Page, April 2025) <https://www.ehealth.nsw.gov.au/solutions/clinical-care/electronic-medical-records/sdpr>.

[1418] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [31(a)(iii)] [MOH.0001.0433.0001 at 0014].

[1419] Transcript of the Commission, 13 June 2024, T3629.21–3634.7 (McFadgen); Exhibit G.29, Statement of Anna McFadgen (4 June 2024) [52] [SVH.9999.0002.0001].

[1420] Exhibit G.29.18, *AM-18 SVHA Board Paper – SVHNS Interim Budget FY23*/24 (31 August 2023) p 11 [SVH.9999.0002.0240 at 0252].

capital projects including the SDPR.[1421] The St Vincent's Health Network estimates it will cost $125 million to roll out the SDPR and an associated interim solution.[1422]

15.18. The facilities operated by the St Vincent's Health Network are an integral part of the NSW public health system. One is a large public hospital that serves the health needs of a substantial metropolitan catchment. Several highly complex procedures provided by the NSW public health system are available **only** at that Hospital. The nature of the services provided through St Vincent's Hospital Sydney and its location means that many of the patients who receive its care will likely receive care in other public hospitals across the State. There is no reason why the St Vincent's Health Network should be excluded from the roll out of the SDPR and funded to the extent necessary to facilitate this. In fact, to exclude care delivered to a patient through any particular facility that forms part of the public health system would undermine the core purpose of a **single** digital patient record.

15.19. Similar logic dictates that all other services delivered by AHOs as part of the public health system in NSW should be included, and the AHOs providing those services should be funded appropriately to enable this to occur. By way of example only, I note that excluding the Royal Rehab Group from the SDPR would have absurd consequences in the case of an individual who sustains a serious spinal injury and transitions from critical care in a large public hospital to rehabilitation in the Royal Rehab Group's facility at Ryde and, thereafter, to step down or episodic care in another public hospital closer to their home. If the Royal Rehab Group is not included in the roll out of the SDPR, clinicians who provide care to such patients in its facility at Ryde would not have access to clinical records relating to the initial care provided to that patient within the public health system and those who might be called upon to provide care after the patient leaves the Royal Rehab Group's facility will not be able to see the records relating to this important phase in the patient's treatment journey. Beyond the potential impact of this information gap on patient safety and system efficiency, the exclusion of a significant aspect of the care delivered to many of the people who sustain serious spinal injuries in NSW can only undermine the extent to which the Statewide spinal service can be effectively managed in the way I discuss elsewhere in this Report.

15.20. Secondly, as conceptualised, the SDPR will not interface with primary care providers. The importance of sharing clinical records between the primary and acute care settings was a consistent theme that emerged in the evidence. There can be no doubt of the benefits that could be realised if clinicians had access to a patient's complete record, irrespective of where the care detailed in those records

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[1421] Exhibit G.29.18*, AM-18 SVHA Board Paper – SVHNS Interim Budget FY23/24* (31 August 2023) p 11 [SVH.9999.0002.0240 at 0252].

[1422] Exhibit G.29.18, AM-*18 SVHA Board Paper – SVHNS Interim Budget FY23/24* (31 August 2023) p 11 [SVH.9999.0002.0240 at 0252].

is delivered.[1423] While integration of this type is said to be under active consideration,[1424] it is not an immediate priority.[1425]

15.21. Despite Commissioner Garling's clear recommendation, and the universally recognised benefits of sharing clinical data with all clinicians who might provide care to patients in NSW, the original business case for the SDPR did not envisage anything like this level of integration. The roll out of the SDPR to the primary care sector has not even been costed.[1426] As a result, the project is not currently funded to deliver anything more than the extension of the SDPR to facilities operated by NSW Health.[1427] No work has yet been done with major suppliers of medical record technology to facilitate the sharing of clinical information between the primary healthcare setting and the acute care setting.[1428] However, the SDPR platform is said to have robust and advanced integration compatibilities, which will allow for a good degree of interoperability to bridge information gaps between primary and acute providers.[1429]

15.22. I accept there are significant challenges associated with including all primary care providers in the SDPR project. Those challenges include the fact that most primary care providers (including general practices) are independent organisations with their own governance structures and legal obligations, giving rise to issues such as funding, governance, infrastructure, privacy, data governance, and cyber security. I also accept the complexity of integrating numerous existing electronic (and hardcopy) record systems that have varying compatibility.[1430] However, I have also been told that the vast majority of primary care providers in NSW use a very small number of clinical record products available on the market.[1431] Working towards the integration of the SDPR with one or more of these commonly used products would seem to be a logical way of getting a substantial degree of integration in the records maintained across the acute and primary care sectors.

[1423] See, for example, Transcript of the Commission, 29 November 2023, T263.2–265.31 (Lyons).

[1424] Transcript of the Commission, 23 February 2024, T983.2–984.7 (Bolevich); Transcript of the Commission, 19 March 2024, T1397.37–1400.32 (Neal/Mills); Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.3], [8.5] [MOH.0011.0099.0001 at 0010, 0011].

[1425] Transcript of the Commission, 28 November 2023, T185.23–188.12 (Lyons/Willcox)

[1426] Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.2] [MOH.0011.0099.0001 at 0010].

[1427] Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.1] [MOH.0011.0099.0001 at 0010].

[1428] Transcript of the Commission, 23 February 2024, T983.02–12 (Bolevich).

[1429] Transcript of the Commission, 23 February 2024, T981.33–44 (Bolevich).

[1430] Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.4] [MOH.0011.0099.0001 at 0010-0011].

[1431] Transcript of the Commission, 23 February 2024, T982.36–47 (Bolevich).

15.23. I also accept that the – a collaboration between NSW Health and the Commonwealth Government – has a role to play in facilitating electronic information sharing with general practitioners, including the sharing of information across multiple clinical settings.[1432] This collaboration between NSW Health and the Commonwealth has produced initiatives like the recently passed *Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Act 2025* (Cth), which mandates the automatic sharing of pathology and diagnostic imaging results with the My Health Record. This itself allows both patients and their healthcare providers to access health records from various care settings including primary care, public and private hospitals, and community health services.[1433] However, as noted above, the My Health Record system is extremely limited.

15.24. In my view, the extension of the SDPR to enable clinical information to be shared between the primary and acute care settings is vital, an issue of basic patient safety, and should be viewed as a priority for NSW Health.

15.25. That conclusion is supported by the following evidence provided by Dr Bolevich:[1434]

> *Q. It would be beneficial, wouldn't it, from a health point of view, for there to be a single point source of information in relation to a patient's medical records - that is, a single point of information which shows the treatment delivered and the observations made of the patient both in an acute setting and, say, in a primary care setting?*
>
> *A. That certainly is the Holy Grail of digital health and something that nationally, and even internationally, we're all striving towards. It often gets, then, bundled into this concept of interoperability in digital health, or lack of it, which is in other words ability of all of these different disparate systems to seamlessly share patient information.*
>
> *A lot of work is currently going into developing standards that will hopefully enable a more streamlined sharing of information between different systems, so even if we don't get to the Nirvana that you are describing, at least then we can ensure that those individual systems – primary care, hospital care, aged care – have an ability to seamlessly and safely and securely share certain defined core datasets in the interests of the patient.*

[1432] Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.6] [MOH.0011.0099.0001 at 0011].

[1433] Supplementary Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (6 March 2025) [8.7] [MOH.0011.0099.0001 at 0011].

[1434] Transcript of the Commission, 23 February 2024, T980.40–981.15 (Bolevich).

15.26. Further, it is not clear to me what, if any, attempt has been made to coordinate the SDPR project with whatever equivalent work may be under way in other states and territories, with a view to achieving some level of uniformity and data sharing. Given the significant cross border patient flows (especially between NSW, ACT, Vic, QLD and SA), uniformity would seem to be of obvious benefit to all of those systems and, more importantly, the patients who shuttle between them. Responsibility for that missed opportunity probably needs to be shared by all public health systems (as well as the Commonwealth). However, it should not have been beyond the states and territories to at least try to sort this out amongst themselves. If they have not yet done so, they should.

Conclusion

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.

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.

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.

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