



Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley



ISBN: 978-0-646-71545-2

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Published April 2025.

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New South Wales

Special Commission of Inquiry into Healthcare Funding

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

Your Excellency,

Special Commission of Inquiry into Healthcare Funding

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

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

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

Yours faithfully,

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

The Honourable Justice Richard Beasley
Commissioner

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

We pay our respects to Elders past and present.

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

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

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Chapter 1:

Overview

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Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Primary care

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

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

...

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

and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Aged care

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

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

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

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

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

First Nations healthcare

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

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

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

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

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

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

Affiliated Health Organisations (AHOs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statewide Services

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

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

- 1.92. There is no Statewide plan and strategy for paediatric services. Meanwhile, there is evidence of long delays for certain childhood interventions – as long as two to five years. I was told this was way beyond what could be considered clinically appropriate. Again, waitlists as long as this for paediatric services (which may bring lifelong benefits) are not compatible with the notion of universal healthcare.
- 1.93. Part of the NSW Health *First 2000 days Implementation Strategy 2020–25* has this as one of its goals:¹¹⁸

3.1 *Ensure that children identified as developmentally at risk receive early, integrated assessment and intervention services.*

- 1.94. Waitlists as long as two to five years are clearly not consistent with the goal of “early, integrated ... intervention services”.
- 1.95. In *Brighter Beginnings: The First 2000 Days of Life*, NSW Health claims that “[l]ate intervention [presumably across the spectrum of services referred to in this document] is estimated to cost \$15.2 billion/year through high intensity and crisis services.”¹¹⁹ It states that for every dollar invested in such interventions there is a “return on investment of \$13”.¹²⁰
- 1.96. The cost of \$15.2 billion per year represents the cost of not doing something (i.e. not intervening a clinically appropriate time). What funding is currently spent on early interventions is not known, but with a return on investment of \$13 for every \$1 spent (presumably a figure reached after comprehensive cost benefit analysis and modelling) it is obviously not enough in light of waitlists of two to five years in some LHDs for certain paediatric services. In saying that, I accept that part of the cause of these long waitlists is not merely funding, but relevant workforce availability problems (particularly in regional areas) also contribute to them.¹²¹

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

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

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

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

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

Justice Health and Forensic Mental Health Network

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

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

¹²³ But probably not.

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

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

Ambulance services

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

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

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

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

Planning and funding the NSW public health system

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Workforce and training

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

Award reform

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

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

Training and placements

- 1.131. In his evidence to this Special Commission, Professor Stephen Duckett AM, Chair of Health Performance Council, South Australia and Deputy Chancellor, Royal Melbourne Institute of Technology,¹⁵⁴ said this: “there’s been a **collapse** of workforce planning in this country”.¹⁵⁵ Unsurprisingly, this view is consistent with the opinion expressed in his book, *The Australian Health Care System*, where he described Australia (as with some other countries) as having a “poor track record” in planning the health workforce (with particular criticism of workforce planning for nursing).¹⁵⁶
- 1.132. A similar view was expressed by Professor Jeffrey Braithwaite, Director of Centre for Healthcare Resilience and Implementation Science, Founding Director of the Australian Institute of Health Innovation, Professor of Health Systems Research, Macquarie University, in his evidence when he said:¹⁵⁷

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Student placements

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

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

Data

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

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

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

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

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

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

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

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

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

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

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

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

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

Publicly available data

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

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

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

Operational matters

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

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

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

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

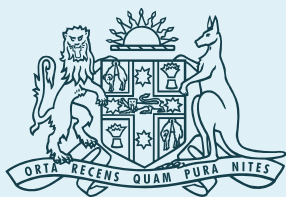
District Hospital) is the Northern Beaches Hospital. There has been significant public discourse in relation to that facility during this Special Commission. As matters transpired, those arrangements were the subject of parallel consideration by the NSW Government that has resulted in the introduction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

Conclusion

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

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

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



Chapter 2:

Key findings

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Introduction

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

Overview

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

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

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

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

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

Primary and aged care: Chapter 11

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

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

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

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

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

First Nations Healthcare: Chapter 12

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

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

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

Statewide Services: Chapter 13

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

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

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

Affiliated Health Organisations: Chapter 14

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

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

Single Digital Patient Record: Chapter 15

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

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

Planning: Chapter 16

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

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

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

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

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

Albury Wodonga Health: Chapter 17

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

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

Workforce: Chapter 18

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

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

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

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

the NSW public health system bidding against each other, which only results in increased cost to it.

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

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

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

Funding: Chapter 19

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

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

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

Procurement: Chapter 20

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

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

Innovation: Chapter 21

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

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



Chapter 3:

Schedule of Recommendations

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

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

Chapter 11: Primary care and aged care

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

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

Chapter 12: First Nations healthcare

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

Chapter 13: Statewide Services

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

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

Chapter 14: Affiliated Health Organisations

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

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

Chapter 15: Single Digital Patient Record

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

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

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

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

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

Chapter 14: The health workforce

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

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

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

Chapter 19: Funding

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

Chapter 20: Procurement

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

Chapter 21: Innovation

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

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

Chapter 22: Conclusion

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



Chapter 4:

Glossary

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

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

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

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



Chapter 5:

Dramatis personae

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Name	Role¹⁷⁷
Agar, Associate Professor Ashish	Ophthalmologist with subspeciality in glaucoma, South Eastern Sydney Local Health District Conjoint Associate Professor, School of Clinical Medicine, University of NSW
Alexander, Dr Shirley	Staff Specialist and Head of the Department of the Children's Hospital Institute of Sports Medicine and Weight Management, Sydney Children's Hospitals Network
Anderson, Professor Debra	Dean, Faculty of Health, University of Technology Sydney
Angelico, Daniel	Chief Executive Officer, College of Intensive Care Medicine of Australia and New Zealand
Arnold, Professor Mark	Chief Medical Officer, Western NSW Local Health District
Astill, Brad	Chief Executive, Far West Local Health District (Now Chief Executive, Nepean Blue Mountains Local Health District)
Awad, Dr Ramsey	Executive Director, Infrastructure, Planning and Sustainability, Hunter New England Local Health District
Ayers, Dr Serena	Network Director of Medical Services, Inland Network, Southern NSW Local Health District
Baird, Professor Kathleen	Head, School of Nursing and Midwifery, University of Technology Sydney
Bedford, Professor David	Professor, Business School, Accounting Discipline, University of Technology Sydney
Begbie, Dr Stephen	Executive Clinical Director, Hastings Macleay Clinical Network Medical Oncologist and General Physician

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

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

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

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

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

Name	Role¹⁷⁷
Dickinson, Michael	Chief Information Officer and Director of Digital Health, South Western Sydney Local Health District
Dixon, Elizabeth	Board Member, Murrumbidgee Local Health District Board Chair, Health Care and Quality Subcommittee
Dominish OAM, Jacqueline	Health Professional Workforce, NSW Health
Donoghue PSM, Tony	General Manager, Coolamon Shire Council
Ducat, Jacinta	Chief Information Officer, Southern NSW Local Health District
Duckett AM, Professor Stephen	Chair of Health Performance Council, South Australia Deputy Chancellor, Royal Melbourne Institute of Technology
Duroux, Kevin	Deputy Chief Executive Officer, Tamworth Aboriginal Medical Services, Aboriginal Corporation
Eagar AM, Adjunct Professor Kathy	Adjunct Professor, School of Clinical Medicine, Faculty of Medicine and Health, University of NSW
Edwards, Benjamin	Chief Operating Officer, St John of God Health Care
Edwards, Dian	Manager, Namatjira Haven Drug and Alcohol Healing Centre
Egan, Darryn	Team Leader, Penrith Community Mental Health Team, Nepean Blue Mountains Local Health District
Egan, Dominique	Director of Workplace Relations and Legal Counsel, Australian Medical Association NSW
Ewer, Karina	Chief Executive Officer, Berrigan Shire Council
Falzon, Kristine	Chief Executive Leadership Team, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)

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

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

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

Name	Role¹⁷⁷
Huckel Schneider, Associate Professor Carmen	Senior Advisor, Evidence Connect, Sax Institute Deputy Director, Leeder Centre for Health Policy, Economics and Data, University of Sydney
Hull AO, Kay	Chair, Palliative Care Enhancement Council
Ingram, Dr Matthew	Staff Specialist Emergency Medicine, Wyong Hospital, National Program Steering Committee, Accreditation Committee, and Trainee Review Panel Representative, Australian College of Emergency Medicine
Jackson MLC, The Honourable Rose	Minister for Mental Health
Janissen, Vanessa	Chief Executive, NSW Health Pathology
Jewitt, Joseph	Acting General Manager of Concord Repatriation General Hospital, Sydney Local Health District
Jones, Professor Debra	Head of Rural Clinical School, Broken Hill University Department of Rural Health, Sydney Nursing School, Faculty of Medicine and Health, University of Sydney
Kahawita, Apsara	Director of Finance and Corporate Services, Far West Local Health District
Kanhutu, Associate Professor Kudzai	Dean, Royal Australasian College of Physicians
Kastoun, Louis	Executive Director, Health and Stronger Communities Division, Policy and Budget Group, NSW Treasury
Kealy-Bateman, Dr Warren	Clinical Director Mental Health Drug and Alcohol, Dubbo and Regions, Western NSW Local Health District
Kennedy, Councillor Thomas	Mayor, Broken Hill City Council

Name	Role¹⁷⁷
Kerridge, Dr Ross	Senior Staff Specialist, Anaesthetics and Perioperative Medicine, John Hunter Hospital Conjoint Associate Professor, University of Newcastle
Knight, Anthony	Chair, Weilmoringle Community Working Party
Kokkinakos, Maria	Director Strategic Health Sourcing, Sydney Local Health District
Kolbe, Anthony	Board Member, Murrumbidgee Local Health Chair of Planning Resources and Performance, Board Subcommittee,
Koschel, Dr Alison	Executive Manager Populations, Access and Performance, Hunter New England and Central Coast Primary Health Network
Lawrence, Kevin	Executive Director Finance and Performance, Murrumbidgee Local Health District
Layer, Craig	Chief Operational Officer, Ungooroo Aboriginal Corporation
Layer, Taasha	Chief Executive Officer, Ungooroo Aboriginal Corporation
Lester, Cecil	Chief Executive Officer, Condobolin Aboriginal Health Service
Levesque, Adjunct Professor Jean-Frédéric	Deputy Secretary, Clinical Innovation and Research, Ministry of Health Chief Executive, Agency for Clinical Innovation
Lim, Professor Boon	Vice-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Lindner, Adrian	Interim Board Chair, Murrumbidgee Local Health District
Longbottom, Hayley	Chief Executive Leadership Team, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)

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

Name	Role¹⁷⁷
Marchioni, Dean	Registered Nurse, Cluster Manager, Narrandera/Leeton Cluster, Murrumbidgee Local Health District
Marsden, Councillor Jarrod	Mayor, Cobar Shire Council
Marshall PSM, Sonia	Chief Executive, South Western Sydney Local Health District
Mason, Carl	Chair, Collarenebri (“Colli”) Community Working Party
Mastersson, Nadia	Head, Prevention, Sax Institute
May AM, Professor Jennifer	Commissioner, Office of the National Rural Health Commissioner, Betty Fyffe Chair of Rural Health Director, Department of Rural Health, University of Newcastle
McCann OAM, Councillor David	Mayor, Coolamon Shire Council
McClintock, Dr Colin	Renal Physician, General Medicine Physician Board Member, Western NSW Local Health District
McCosker PSM, Tracey	Chief Executive, Hunter New England Local Health District
McCowen, Debbie	Chief Executive Officer, Armajun Aboriginal Health Service
McFadgen, Anna	Chief Executive Officer, St Vincent’s Health Network Sydney
McFarlane, Helen	Director, Mental Health, Drug and Alcohol and Regions, Western NSW Local Health District
McHughes, Doreen	Chair, Brewarrina Community Working Party
McLachlan, Scott	Chief Executive, Central Coast Local Health District
McNamara, Dr Martin	Chief Executive Officer, Sax Institute

Name	Role¹⁷⁷
McRae, Dr Michelle	Senior Director of Training, Australasian College of Dermatologists
Middleton, Professor James	Clinical Director, NSW State Spinal Cord Injury Service Professor of Rehabilitation Medicine, John Walsh Centre for Rehabilitation Research
Milat, Professor Andrew	Professor of Public Health, University of Sydney
Mills, Narelle	Interim Chief Executive Officer, Murrumbidgee Primary Health Network
Mills, Robert	Chief Executive Officer, Royal Society for the Welfare of Mothers and Babies (Tresillian)
Minns, Philip	Deputy Secretary, People, Culture and Governance, Ministry of Health
Misevska, Karolina	Business Manager, Sydney Local Health District
Mitchell PSM, Dr Jo	Director, Policy by Proxy
Morgan ASM, Dr Dominic	Chief Executive and Commissioner, NSW Ambulance
Morrison, Dr Tom	Neurosurgery Registrar, St Vincent's Hospital Sydney
Moyle, Dr Michelle	Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists, Director of Anaesthetic Department, St Vincent's Hospital Sydney
Murphy, Dr Karen	Acting Executive Director, Medical Services and Clinical Governance, Illawarra Shoalhaven Local Health District
Nankervis, Dr Richard	Chief Executive Officer, HNECC Limited / Hunter New England Central Coast Primary Health Network Founding Director on the Board of the Centre of Innovation in Regional Health
Nankivell, Jay	General Manager, Broken Hill City Council

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

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

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

Name	Role¹⁷⁷
Russell, Matthew	Director of Mental Health, Nepean Blue Mountains Local Health District
Rutledge AM, Pamela	Board Member, Nepean Blue Mountains Local Health District
Sam, Greg	Chief Executive Officer, Royal Flying Doctor Service, South Eastern Section
Samuelsson, Payden	Chief Executive Officer, Bullinah Aboriginal Health Service
Schembri AM, Adjunct Professor Anthony	Chief Executive, Northern Sydney Local Health District
Scott, Dr David	Physical and Gastroenterologist Visiting Medical Officer Chair of Medical Staff Council, Hunter New England Local Health District
Shenouda, Associate Professor Ayman	Immediate Past Chair and Current Rural Faculty Chair, Royal Australian College of General Practitioners General Practitioner, Wagga Wagga
Shillingsworth, Millie	Chair, Enngonia Community Working Party
Shortis, Brendan	Acting Nurse Manager, Community Health, Nepean Blue Mountains Local Health District
Simon, Isaac	Chief Executive Officer, Tobwabba Aboriginal Medical Service
Simpson, Professor Stephen	Academic Director, Charles Perkins Centre, School of Life and Environmental Sciences, University of Sydney
Slaven, John	Director of Finance and Performance, Mid North Coast Local Health District
Sloane, Luke	Deputy Secretary, Rural and Regional Health, Ministry of Health

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

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

Name	Role¹⁷⁷
Willcox AM, Deborah	Deputy Secretary, Health System Strategy and Patient Experience, Ministry of Health (Now Chief Executive, Sydney Local Health District)
Williams, Dr Robin	Chair, Western Health Alliance Ltd Board, General Practitioner, Molong
Wilson AO, Professor Andrew	Co-Director, Leeder Centre for Health Policy, Economics and Data, University of Sydney
Wilson, Tobi	Chief Executive, South Eastern Sydney Local Health District
Wolfenden, Professor Luke	School of Medicine and Public Health, University of Newcastle
Wong, Jill	District Director Integrated Care, Allied Health and Community Services, Mid North Coast Local Health District (Now Chief Executive, Mid North Coast Local Health District)
Wood, Debborah	Director, People and Community Services, Bogan Shire Council
Wood, Michael	Director of Clinical Governance, Nepean Blue Mountains Local Health District
Yik, Jerry	Head of Policy and Advocacy, Advanced Pharmacy Australia
Yoosuff, Associate Professor Alam	Board Director, Murrumbidgee Local Health District, Principal General Practitioner, Finley Regional Care, Board Director, Murrumbidgee Primary Health Network, Vice President, Rural Doctors Association NSW
Zacka, Mark	Executive Director, Clinical Governance and Patient Experience, Northern Sydney Local Health District

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

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

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

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

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

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

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

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

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

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



Chapter 6:

Staff of the Special Commission

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Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley



ISBN: 978-0-646-71545-2

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Published April 2025.

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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 Bidge! 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 were 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 Belleair. 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 on 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

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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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.

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

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 heads 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

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

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

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

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

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

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

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

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

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

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 overseas 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

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 politics¹⁵⁴ 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

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

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

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

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

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

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 xlv–xlvi, 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

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

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

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

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

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 primary focus by the health system on patient crisis rather than prevention and early treatment;²⁷¹
 - the fragmented and ill fitting nature of health services together with poor coordination between care pathways, particularly between primary and acute care;²⁷²
 - inadequate information flows and haphazard data collection, together with the slow uptake of technologies;²⁷³

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);

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

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

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

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;

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.

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

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

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

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

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:

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*;

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

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, ‘Ahptra 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

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](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

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 88 [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.

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

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 LHDs⁴⁸⁸ (eight covering the Sydney metropolitan region and seven covering rural and

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 into 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

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.

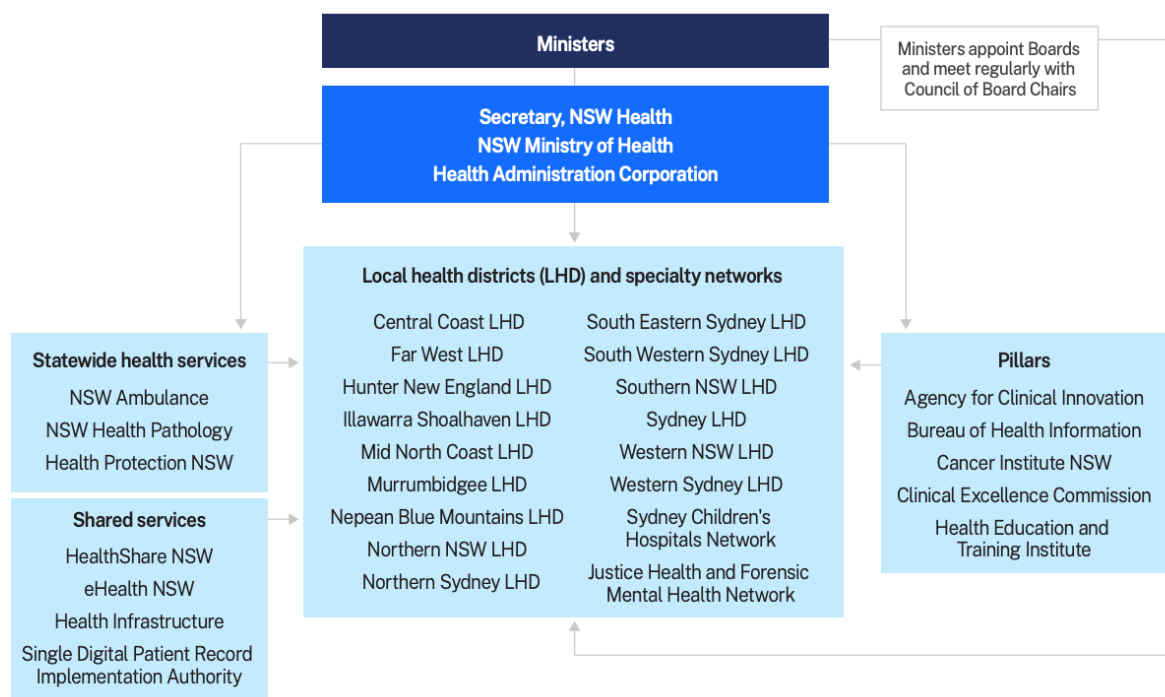


Figure 1: NSW Health organisational chart⁴⁹⁸

- 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 products⁵⁰⁵, 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

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.

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].

Ministry of Health organisational chart

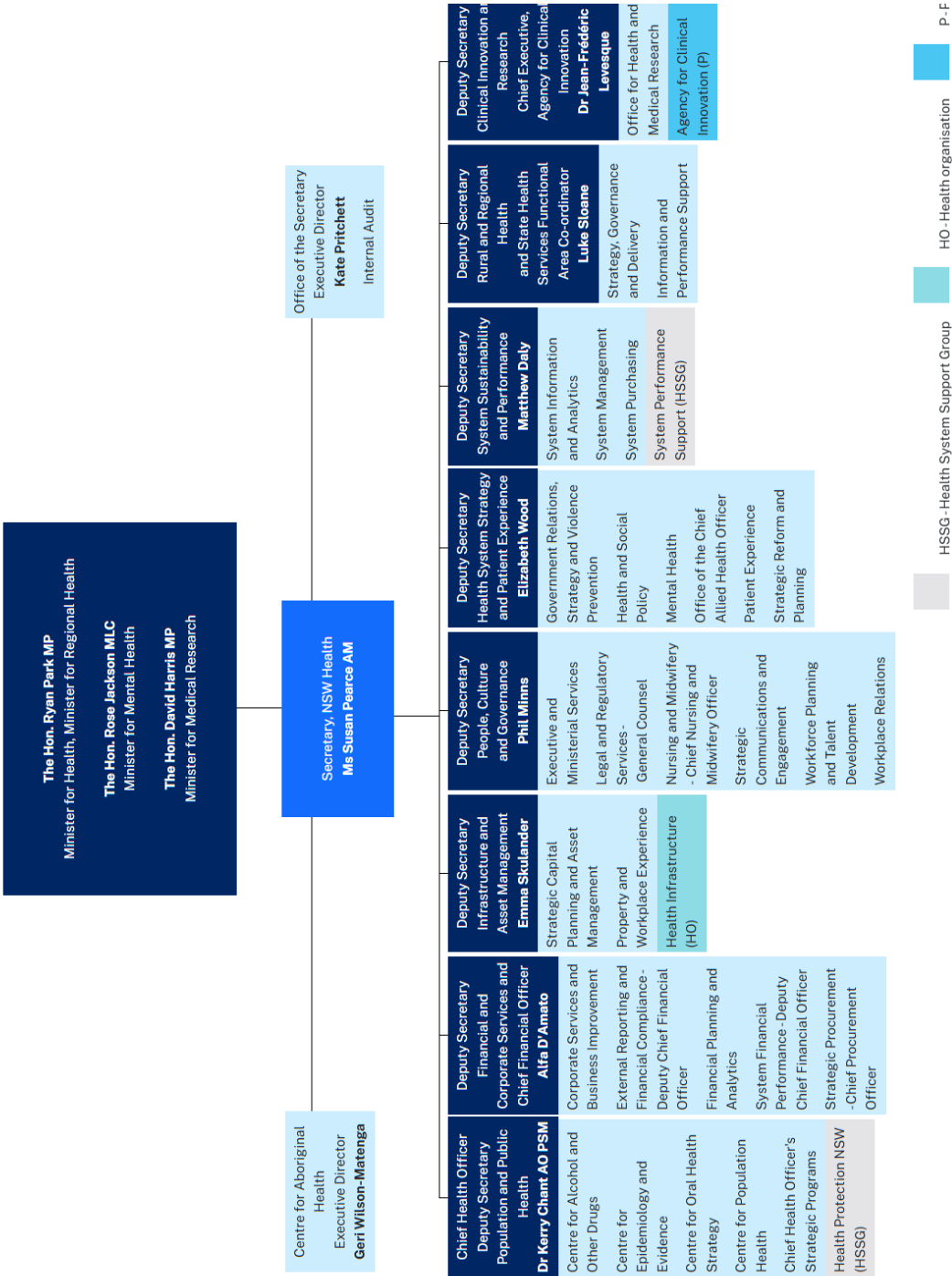


Figure 2: Ministry of Health organisational chart⁵²⁶

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.asp>> [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.

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

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

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

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

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;

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.

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

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

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 are 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

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

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

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;

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;

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;

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
- undertaking, commissioning or sponsoring cancer research, facilitating collaboration between cancer research bodies, and providing a system for expeditious ethics approval;
 - fostering evidence based best practice to cancer control including through development or endorsement of guidelines and protocols;
 - accrediting cancer prevention and screening programs;
 - reviewing, evaluating and making recommendations about cancer programs and proposed initiatives, and developing or commissioning innovative programs for cancer control;

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

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:
- 37 custodial centres for adult inmates;
 - seven youth justice centres;
 - 13,000 adult inmates; and
 - 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).

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

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.

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

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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.

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

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.0001.0016.0001 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].

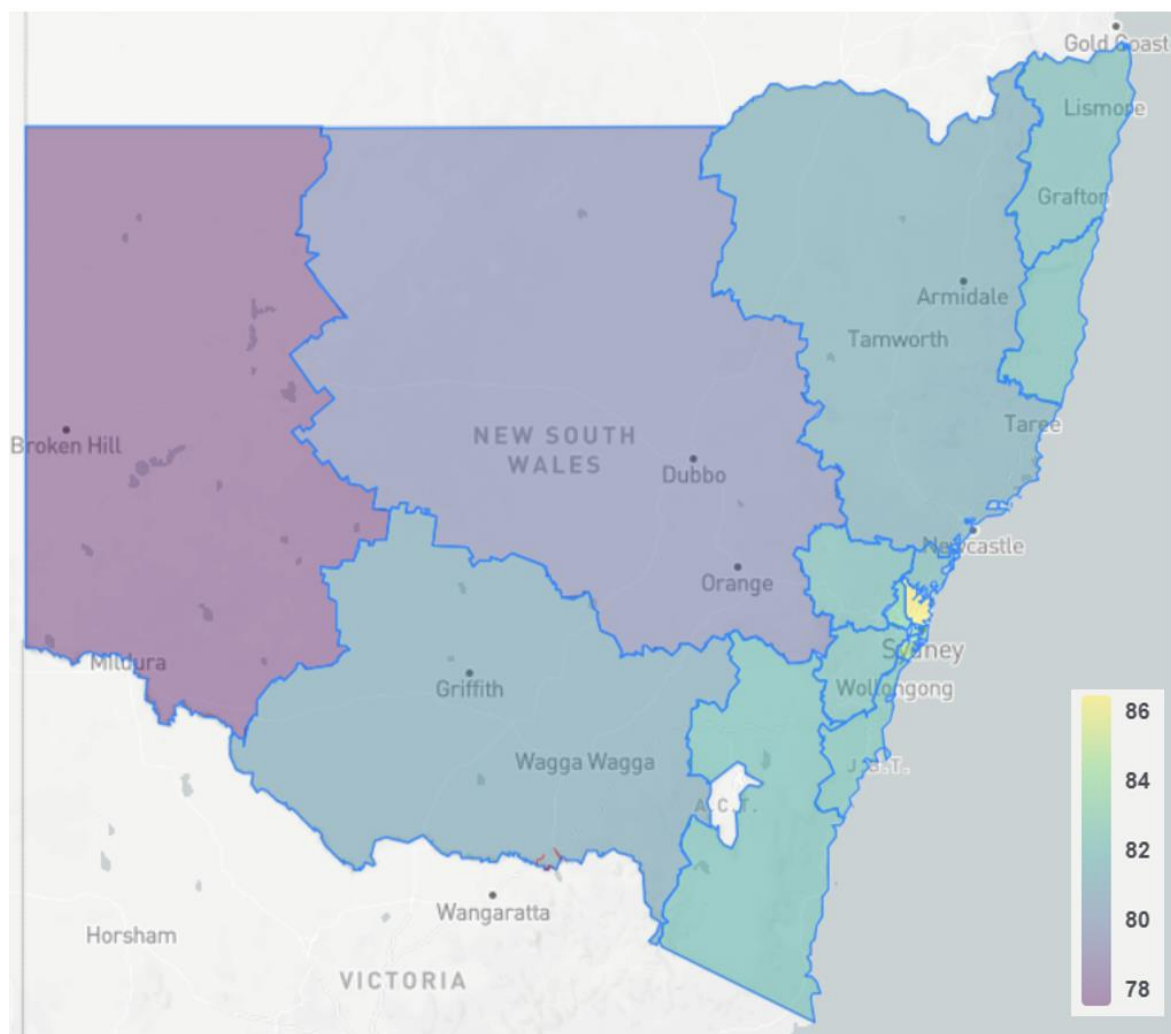


Figure 1: Life expectancy at birth for persons by LHD for 2022

- 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.

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

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

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].

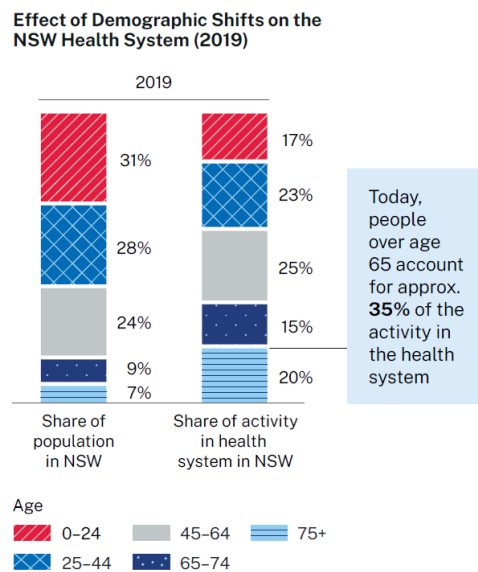


Figure 4: Effect of demographic shifts on the NSW health system (2019), NSW Health

- 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].

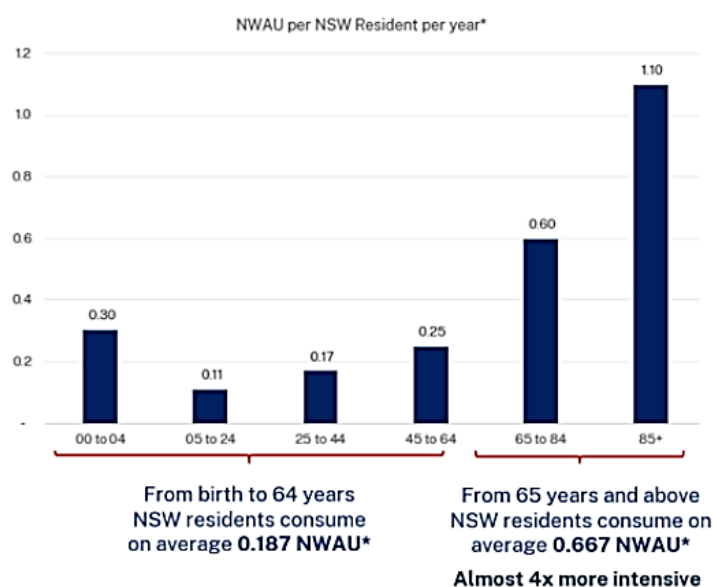


Figure 5: NWAU per NSW resident per year

- 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

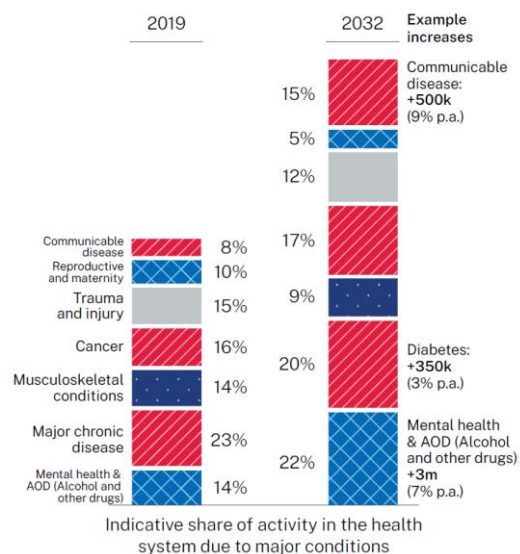


Figure 6: Indicative share of activity in the health system due to major conditions: 2019–2032, NSW Health

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.

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

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.

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-surgery⁷⁵³ 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 initiatives 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

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 preventable 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 services 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

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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

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 risen⁷⁷⁹ (although there has been a recent upturn in the number of graduates electing to pursue specialist training as a general

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 (Grotowski), 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 ageing⁷⁸¹ 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 NSW⁷⁸⁴ – 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

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 H.2.25, 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:
- 16.6 per cent of adults have diabetes;
 - 36 per cent of adults have high cholesterol;
 - 31 per cent of adults have high blood pressure;
 - 24 per cent of children are developmentally vulnerable in one or more domains in their first year of school; and
 - 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

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.

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:
- 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
 - 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
 - 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
 - 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

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.

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);*

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 delivery, 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

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).

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.

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

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 underserved 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

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

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.

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 health⁹²⁵ 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 planning⁹²⁷ 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 Secretary⁹²⁸ 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 SHNs⁹²⁹ 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.

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

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

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

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 Belleair).

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 Belleair 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 Belleair).

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 Bellea/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 Bellea/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,

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 Belleair/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

⁹⁹² Transcript of the Commission, 28 November 2024, T6766.1–39 (L Bellea).

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

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,

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 Bellebar), 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

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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 years¹⁰⁷¹ 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 compete 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 of 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
- acute review for children who have attended an Emergency Department to enable them to return home;
 - follow up care for children to enable them to be discharged earlier from hospital without requiring admission; and
 - 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
- 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

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 Prisoners¹¹⁴⁷ (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, there 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

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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, SWSLHD 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

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 It 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 revenue¹³¹² 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 subsidise 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 provide.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

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

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

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

- 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 Sydney¹⁴⁰⁰ (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

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.



Volume 2

April 2025



Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley



ISBN: 978-0-646-71545-2

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Published April 2025.

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Chapter 16:

The planning and delivery of health services in NSW

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Introduction

- 16.1. A robust health service planning function is critical to the delivery of healthcare in NSW.
- 16.2. The capability of NSW Health to design and implement a feasible and successful system wide approach to health service planning relies on decision making as to what the public health system is, and the boundaries of “the civil contract ... between taxpayers and the Government about what [public health services] might be received in a particular community”; particularly in the context of budgeting “constraints”.¹
- 16.3. The current approach to public health service and workforce planning in NSW does not involve this kind of Statewide vision; nor is it built upon a comprehensive understanding of population health needs from the bottom up. The Ministry of Health has itself identified the need for it to provide greater coordination of clinical services planning, and clearer guidance in the clinical services planning being undertaken by local planning teams within LHDs and SHNs. Work in this area is said to have commenced.²
- 16.4. The evidence supports the view that the Ministry of Health should embark upon a refocussed approach to service and workforce planning. To the extent any such work is under way, efforts towards it should be redoubled and adequately resourced so as to enable health services to be spread across the State in a manner that best responds to local population need and community expectations regarding service availability to the greatest extent possible within whatever funding envelope is available.

The current approach to service planning and its drivers

- 16.5. Healthcare service planning in NSW is presently devolved from the Ministry of Health to LHDs and SHNs, which have the primary responsibility for service planning in response to the health needs of their designated populations. This responsibility, in both the short and long term, includes:
 - a. undertaking detailed service planning and workforce planning to ensure a sound foundation for investment decisions, both capital and recurrent;
 - b. any planning considered necessary at the local level to respond to particular health issues, emergencies or service needs; and
 - c. developing plans to improve health outcomes in response to national, State and local health priority areas.³

¹ Transcript of the Commission, 16 April 2024, T2907.32-42 (Spittal).

² Exhibit D.10, Statement of Deborah Willcox (9 April 2024) [35]-[52], [98] [MOH.9999.0981.0001 at 0016-0022, 0038-0039]; Exhibit N.3.28, Statement of Scott McLachlan (9 December 2024) [7]-[10] [MOH.0011.0095.0001 at 0002]; Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [7.2]-[7.4] [SCI.0011.0814.0001 at 0021].

³ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.1.1] [MOH.0010.0256.0001 at 0066].

- 16.6. At least in theory, the Ministry of Health has responsibility for coordinating the planning of **system wide** services, workforce, population health, asset planning and portfolio management, and providing advice to the Minister, Minister for Regional Health, and the Minister for Mental Health on these matters.
- 16.7. The clinical service planning framework, and the way in which the responsibilities of the Ministry of Health, and the LHDs and SHNs, with respect to service planning are supposed to interact, are set out in a number of cascading policy documents that reflect a top-down approach to service planning.
- 16.8. At the top of the policy hierarchy are the policies developed at the NSW Health level, principally the *NSW Future Health Strategic Framework*, which “is the roadmap for the health system to achieve NSW Health’s vision” between 2022 and 2032.⁴ It includes six key strategic objectives relating to patient experience, safe care, population health, workforce, sustainability, and research and innovation.⁵ It is complemented by three other NSW Health wide strategic plans relating to regional health, health workforce, and Aboriginal health.⁶
- 16.9. On its face, the *NSW Future Health Strategic Framework* is intended to reflect “guiding, overarching strategies and objectives” that will then flow through into the plans generated by LHDs and SHNs, the service agreements, and arrangements for Statewide services.⁷ It is said to have been developed in consultation with the LHDs, as well as consumers and clinicians.⁸
- 16.10. Through its policies, as well as centralised planning approaches and service agreements, the Ministry of Health is supposed to guide the development of services and investments in the NSW public health system.⁹ The Ministry of Health is also supposed to monitor and review data to inform its planning around gaps in service provision and changes in population demographics.¹⁰

⁴ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.2] [MOH.0010.0256.0001 at 0067-0068].

⁵ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.2] [MOH.0010.0256.0001 at 0067-0068].

⁶ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.2.3]-[6.2.5] [MOH.0010.0256.0001 at 0068-0069].

⁷ Transcript of the Commission, 28 November 2023, T76.10-30 (Lyons).

⁸ Transcript of the Commission, 28 November 2023, T76.36-77.1 (Lyons).

⁹ Exhibit A.1. Joint Report of Dr Nigel Lyons, Dr Kerry Chant AO PSM, and Deborah Willcox AM (17 November 2023) [37] [MOH.9999.0001.0001 at 0005]; Transcript of the Commission, 28 November 2023, T75.45-76.24 (Lyons).

¹⁰ Transcript of the Commission, 28 November 2023, T77.5-13 (Chant).

- 16.11. The role of LHDs and SHNs is said to be to translate the Ministry of Health's strategy and directions into organisational plans developed at the LHD/SHN level,¹¹ which include:¹²
- a. Strategic Plans;
 - b. Health Care Services Plans;
 - c. Corporate Governance Plans;
 - d. Strategic Asset Management Plans/Asset Management Plans; and
 - e. Operations/Business plans at all management levels of the LHD or SHN.
- 16.12. Of the above organisational plans, the most comprehensive plan is the *Health Care Services Plan*. This plan is intended to include detail of priorities for a LHD or SHN over a five to 10 year horizon, with specific focus on those issues that affect the health of the catchment population and the delivery of services.¹³ As acknowledged by the Ministry of Health:¹⁴
- the value and quality of a Health Care Services Plan will depend on the quality of a number of separate, but interdependent foundation planning processes, which focus more specifically on areas such as health improvement, clinical services, clinical and non-clinical support services, assets, resource implications and sustainability (workforce, financial and environmental).*
- 16.13. LHDs and SHNs are also supposed to prepare more detailed local workforce plans that identify the numbers and types of staff required to meet service needs. To implement such plans, maintaining a long term planning horizon is important. Transitioning services within a facility or district will inevitably take time.¹⁵ Moreover, time and a clear articulation of short, medium, and long term planning is needed to enable the Ministry of Health and education and training agencies to facilitate the training of the numbers and types of health service staff required to deliver on those plans.¹⁶
- 16.14. At the bottom of the policy hierarchy are the facility plans, which are influenced by the nature of the service under consideration and the objectives of the particular planning exercise. These plans, accompanied by service agreements, are intended to provide "clear direction for the provision of health services to achieve

¹¹ Transcript of the Commission, 28 November 2023, T80.40-46 (Lyons).

¹² Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [MOH.0010.0256.0001].

¹³ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069].

¹⁴ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069].

¹⁵ Transcript of the Commission, 19 November 2024, T6332.23-42 (Wilson).

¹⁶ Exhibit H2.51, NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.4] [MOH.0010.0256.0001 at 0071].

measurable health improvements and outcomes and are undertaken within a broader framework of system wide goals, objectives and priorities”.¹⁷

- 16.15. A general observation can be made here. In nothing that follows or in the planning recommendation I ultimately make do I mean to suggest that LHDs and SHNs should not play a key role in the planning of service delivery to their populations. The NSW public sector is this State’s largest employer, and the NSW Health workforce is by far its largest component.¹⁸ That workforce is spread right around the metropolitan area of Sydney, and throughout the regions. Knowledge of health service needs is likely to be strongest at a local and regional level. There would be diminishing returns to such knowledge and to efficiency if an organisation as large as NSW Health had its core health service planning function situated centrally at the Ministry of Health. As discussed, the Ministry of Health will have a different role in the planning process.
- 16.16. From the perspective of the Ministry of Health, the devolved planning structure recognises that the LHDs (and likewise the SHNs) are “the best people to make a decision about what services should be provided”.¹⁹ This is because:²⁰

[d]ecisions that are made as close as possible to where patients receive their care or where communities receive a service are seen to be better decisions because people can be involved in those decisions, can understand them, be involved in processes that support the decision making, and understand who is making the decision again, and ask why. When the decision is made a long way away, that is more difficult to achieve ...

- 16.17. In this regard, LHDs will undoubtedly have a “greater understanding of the service configuration locally, the relationship to other service providers ... and for much of [their] care, it is around how [they] work in partnership with ... primary care, aged care sector or other non-government organisations”.²¹ As a result, when planning services for their communities, they are expected to use the Ministry of Health level policies as a framework for consideration. However, they are also required to make such adaptations as may be necessary to ensure that the services provided reflect the best allocation of available funds to meet the health needs of their respective communities.²²
- 16.18. While these policy documents appear to contemplate the Ministry of Health retaining Statewide oversight of the services offered at different locations, including the overall

¹⁷ Exhibit H2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.3] [MOH.0010.0256.0001 at 0070-0071].

¹⁸ Exhibit O.59, Public Service Commission, Workforce Profile Report (2023) pp 9-11 [SCI.0011.0889.0001 at 0009-0011].

¹⁹ Transcript of the Commission, 21 November 2024, T6543.27-32 (Portelli) and see T6542.39-6544.38 (Smith/Portelli).

²⁰ Transcript of the Commission, 28 November 2023, T70.1-19 (Lyons).

²¹ Transcript of the Commission, 28 November 2023, T70.28-34 (Chant).

²² Transcript of the Commission, 28 November 2023, T84.23-35 (Willcox).

equitability and accessibility of the various services, the evidence suggests that there is little in the way of oversight currently occurring, and the funding allocation provided to the LHDs and SHNs is largely untied, enabling those entities to enact and bring their clinical services plan to life and address what they perceive to be the needs of their population in a responsive manner.²³ In practice, the absence of well supported planning at every level means that decision making at the local level is often more reactive to immediate needs or crises than it is responsive to an evaluation of a community's evolving health needs over the medium to long term.

- 16.19. In addition to the policy framework outlined above, there are implementation processes and mechanisms that are also devolved from the Ministry of Health to LHDs and SHNs.
- 16.20. At the Ministry of Health level, I am told that there are planning teams that review populations – including demographics, ageing, housing, public transport, and “macro government measures” – that impact on that population and its needs. Precisely how these matters are currently brought to account in the planning being undertaken and implemented by LHDs and SHNs is not clear. It has also been suggested that planning undertaken at Ministry of Health level has regard to any specific needs of priority populations, for the purpose of “macro planning”.²⁴ However, it is, again, not clear how – if at all – this Ministry of Health level planning is influencing planning and decision making occurring within LHDs and SHNs.
- 16.21. With respect to equity, the Ministry of Health has told me that it strives for “the same outcomes” for all people in NSW, but acknowledges that achieving the same outcomes in relation to the same underlying health need requires different approaches in different contexts.²⁵ In the rural and regional setting, this is said to involve conducting “place making work”, which, according to the Ministry of Health, brings together relevant people within a community such as community leaders, local government, community members and non-government organisations, to “collectively make decisions around what sorts of health services they’re going to need now and into the future”.²⁶ The evidence reveals that this theoretical – and entirely appropriate – approach to planning is not reflected in the current reality of health service planning at either the Ministry of Health or LHD and SHN levels; in no small part because, to do it, adequate funds must be available and allocated to enable this task. As I observe elsewhere in this Report, current funding of LHDs and SHNs is insufficient to enable this to occur.

²³ Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).

²⁴ Transcript of the Commission, 28 November 2023, T159.17-31 (Willcox).

²⁵ Transcript of the Commission, 28 November 2023, T84.13-17 (Chant).

²⁶ Transcript of the Commission, 28 November 2023, T162.19-41 (Willcox).

- 16.22. At the LHD and SHN level, population health planning and clinical service planning is said to be informed by a range of inputs, including Australian Bureau of Statistics data and local government, which is then translated into plans outlining “where their services need to be developed, either location or complexity, to ... care for their population”. I am told that hospitals and other services will also generate operational plans on the basis of the overarching local and State level strategic plans to determine how they run their operational services in a way that is “supporting the population needs that are being described at a macro level”.²⁷ However, what this means in practice is, again, far from clear.
- 16.23. As I have noted above, the Ministry of Health, under the guidance of the Health Secretary, is presently working on strengthening its central service planning capability. However, to date this has occurred largely in the context of capital programs, not through the enhancement of more general health service planning,²⁸ where it is more urgently required.

Drivers of service planning

- 16.24. As I have alluded to above, the formal policy does not reflect the reality of the planning processes currently undertaken by the Ministry of Health, LHDs and SHNs, nor the effectiveness of those processes. Rather, I am persuaded that the reality of health service planning is currently very different from the cohesive approach suggested by the above policies.
- 16.25. The evidence comfortably establishes that the devolution of clinical service planning has led to an erosion of whatever planning capability that may have existed within both the Ministry of Health and LHDs and SHNs. Relevantly, the widespread disinvestment in planning resources within NSW Health and dissolution of its service planning branches following the devolution of planning functions to LHDs in 2010, as well as ongoing underinvestment in retaining planning skill at the LHD level, has fostered what I accept to be, at best, a “patchy” approach to service and workforce planning.²⁹
- 16.26. I wish to make clear that the underinvestment in planning that has occurred at the LHD and SHN level is almost certainly a product of the “constrained financial environment” in which they have been compelled operate. Where the funding provided to LHDs and SHNs is merely – and in some cases, not – sufficient to continue delivering the existing array of services, there are simply insufficient financial resources available to fund the place based planning that is so urgently required in LHDs and SHNs, let alone fund the transition of existing services in the manner required to implement the outcomes of that considered planning process.

²⁷ Transcript of the Commission, 28 November 2023, T159.33-160.9 (Willcox).

²⁸ Transcript of the Commission, 21 November 2024, T6575.21-37 (Daly).

²⁹ Transcript of the Commission, 21 November 2024, T6574.34-45 (Daly).

- 16.27. The devolved service planning structure also means that local needs analysis at the LHD and SHN level no longer drives, and cannot currently drive, service and workforce planning strategy at the Ministry of Health level. To the contrary, the limited collaboration between the Ministry of Health and LHDs and SHNs in relation to the implementation of the planning and policy documents means that all strategic decision making effectively sits at the local level.³⁰
- 16.28. In these circumstances, the drivers of service planning and delivery have strayed from the Ministry of Health's strategic plans towards other, more tangible, considerations at the LHD and SHN level; namely, the immediate need to continue delivering the current array of services in the context of a highly constrained budgetary environment and to react, where necessary, to emerging challenges.

Funding availability

- 16.29. The availability of funding is presently, and has historically been, a key driver in decision making and planning with respect to services that are delivered by LHDs and SHNs in NSW.
- 16.30. As I have outlined elsewhere in this Report, LHDs and SHNs are primarily funded pursuant to service agreements with the Health Secretary. This funding may take a number of different forms with respect to whether the funding is tied to activity, programs, or is available for those organisations to spend as they see fit. However, the Ministry of Health currently exercises limited oversight of them with respect to the deployment of their financial resources.
- 16.31. Many (if not most) LHDs and SHNs regularly exceed the budgets that are allocated to them in their annual service agreements with the Health Secretary.³¹ Although there is capacity for them to receive (and they regularly do receive) supplementary funding throughout the year, this suggests to me that the current base budgets of LHDs and SHNs are no longer sufficient to meet the demand placed on them to continue providing existing services. In these circumstances, there can be no expectation of budget availability for LHDs and SHNs to invest in the evolution of services in accordance with local population need and demand.
- 16.32. It is inevitable that LHDs and SHNs under these constraints will become overstretched if they attempt to deploy adequate funding towards essential planning activities while simultaneously continuing to meet demand generated by existing services. Yet, in the absence of any clear planning about service need more broadly, including how that service need may already be met in surrounding LHDs or other locations, LHDs, SHNs and the public health system more broadly are forced to continue to attempt to deliver a wide range of services from multiple locations (despite

³⁰ Transcript of the Commission, 19 November 2024, T6355.43-6356.7 (Cox); Transcript of the Commission, 14 October 2024, T5614.18-28 (Griffiths).

³¹ See, for example, Transcript of the Commission, 16 April 2024, T2961.46-2962.17 (Spittal).

limited demand and cost inefficiencies)³² and have insufficient financial headroom to engage in necessary planning activities or transition services to reflect the outcomes of that planning.

- 16.33. While LHDs and SHNs can receive program based funding from the Ministry of Health in a fashion that directs them to spend funding in a certain manner, this manner of driving decision making is rarely done in a way that is strategic, and instead focusses on the resolution of discrete problems.³³
- 16.34. Further, while LHDs and SHNs are subject to a list of standardised KPIs in implementing their services,³⁴ these KPIs are largely disconnected from any planning activity in the sense that they are not crafted to measure achievement of whatever objectives an LHD or SHN may be seeking to achieve through the implementation of its plans. Rather, in a practical sense, these KPIs create unnecessary burdens on reporting requirements and can incentivise LHDs and SHNs to divert their funding towards particular services.³⁵ This can come at the expense of community based services not generally subject to reporting obligations, or a KPI.³⁶
- 16.35. Ultimately, while it will always be necessary to operate within a budgetary envelope, in the absence of structured service planning that commences with an identification of the health needs of the community, and the services required to meet those needs, it is not possible to reach an informed and objective view as to the adequacy of that budgetary envelope or how best it should be deployed.

Historical considerations

- 16.36. Similarly to funding availability, historical service mix has largely underpinned the growth of the public health system, with a focus on maintaining existing services, and creating new services *ad hoc* when population need, political motive or funding availability arise.
- 16.37. The “starting position” for many LHDs and SHNs is the funding of existing services, which they have committed to fund and the community expects them to continue to provide. This can make divesting from services very challenging.³⁷ In this way, these historical “precedents” effectively limit the discretion of LHDs and SHNs with respect to the services they can fund and deliver within their allocated budgets.³⁸ Accordingly,

³² Transcript of the Commission, 15 October 2024, T5706.41-5707.2 (Minns).

³³ Transcript of the Commission, 23 May 2024, T3366.1-12 (Astill).

³⁴ Transcript of the Commission, 28 November 2023, T96.11-21 (Lyons).

³⁵ Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).

³⁶ Transcript of the Commission, 21 November 2024, T6547.25-6548.39 (Daly/Smith).

³⁷ Transcript of the Commission, 19 November 2024, T6330.3-15 (Wilson).

³⁸ Transcript of the Commission, 19 November 2024, T6332.11-21 (Wilson), T6334.4-14 (Collins).

funding of new services or altering the locations of services based on community need largely relies on LHD and SHN efficiency offsets or other reductions to costs.³⁹

- 16.38. The tendency for the budgets of LHDs and SHNs to be set in accordance with historical funding and service precedents is the product of several different challenges with divesting, adding or changing services in a reactive, rather than planned, manner. The care delivered can be dictated to some extent by the staff, including clinicians, working within a facility and their particular skill set.⁴⁰ Further, in the absence of a longer term plan outlining service priorities, LHDs and SHNs cannot always respond appropriately when opportunities for beneficial service change present themselves.⁴¹ Given that changes in service delivery will inevitably affect workforce needs and mix, change management must occur progressively.
- 16.39. The retention of services for historical reasons (until change can progressively be made to re-adjust priorities) also means that any increased costs associated with providing those services spreads the available funding even thinner across the array of services within the LHD or SHN.⁴²
- 16.40. Most importantly, that service delivery is a product of history rather than a careful forward looking planning process impedes healthcare delivery from keeping pace with vast shifts in community demographics and the burden of disease.⁴³ For example, I was told that Cooma Hospital and Health Service was “suffering” from the lack of “any kind of lead or governance program or plan to move it forward”, when planning conversations to meet its current demographic should have started 10 years prior.⁴⁴ On the basis of evidence received and information gleaned from roundtables conducted in health facilities across the State, I am confident that this problem is not isolated to Cooma Hospital and Health Service. In all LHDs, the current funding and approach to planning has not allowed “sensible reinvestment or evolution of the ways in which [LHDs are] investing to improve health outcomes for [their] community”.⁴⁵

Workforce considerations

- 16.41. The availability and presence of a workforce to deliver the services offered and prioritised by an LHD or SHN also influences service planning.
- 16.42. For instance, while there may be certain services that a LHD or SHN would prioritise if the required workforce were available, workforce shortages and maldistribution

³⁹ Transcript of the Commission, 19 November 2024, T6330.3-15 (Wilson).

⁴⁰ Transcript of the Commission, 19 November 2024, T6331.28-47 (Wilson).

⁴¹ Transcript of the Commission, 19 November 2024, T6332.23-42 (Wilson).

⁴² Transcript of the Commission, 19 November 2024, T6332.44-6333.11 (Wilson).

⁴³ Transcript of the Commission, 16 May 2024, T2973.30-2974.3 (Spittal).

⁴⁴ Transcript of the Commission, 15 August 2024, T4954.31-44 (Clarke).

⁴⁵ Transcript of the Commission, 16 May 2024, T2974.17-34 (Spittal).

mean that they are unable to attract and retain a workforce in the short term to staff those services.⁴⁶

- 16.43. On the other hand, where a workforce is available to deliver services that are not necessarily a priority for the population need within a certain community, the mere presence of that workforce alone can drive service planning. For example, Jude Constable, then Acting Chief Executive of Central Coast LHD, gave evidence, which I accept, that she had observed occasions in rural health districts where clinicians who lived in the district and had highly specialised skills, were funded and supported by the district to offer specialised services that need not otherwise be located within that district. When those clinicians then left the district, the community expected the specialised service to continue, which became highly political and challenging for the district to manage.⁴⁷ Once again, information provided during roundtables I attended suggests that these examples were by no means isolated.
- 16.44. The emphasis on workforce availability (rather than population need) as a driver of service planning reflects the deficiencies in the current workforce planning processes, as well as the limited integration of workforce and service planning. In particular, NSW has not “done a very good job of predicting ahead of time how many doctors [it will] need, [and] how many nurses [it will] need”, nor facilitating collaboration between educational institutions and medical colleges for the delivery of that workforce.⁴⁸
- 16.45. This, at least in part, reflects the fact that that under the current framework there is insufficient coordination of the many entities with input into, and influence over, the potential planning approach and its outcomes, including the Commonwealth and State Governments, administrators of training placements, medical specialty colleges, and universities.⁴⁹
- 16.46. I discuss elsewhere in this Report the extent to which properly coordinated planning might assist in overcoming workforce challenges that impact on the delivery of care across the State. In making those observations, I do not intend to dismiss the role of metropolitan based clinicians in contributing to the delivery of care in regional, rural, and remote areas where – as part of that planning exercise – it is determined that this is the most efficient and effective way for the public health system to deliver that care. This may occur in many ways; clinicians might, in a more structured way than currently occurs, deliver “fly in fly out” clinics, or utilise technology to deliver care in collaboration with local clinicians. Far from detracting from efforts to establish local services in those regions, there are examples across the system of where that

⁴⁶ Transcript of the Commission, 19 November 2024, T6339.32-6340.5 (Constable).

⁴⁷ Transcript of the Commission, 19 November 2024, T6340.17-35 (Constable).

⁴⁸ Transcript of the Commission, 20 November 2024, T6448.28-6449.15 (Braithwaite).

⁴⁹ Transcript of the Commission, 20 November 2024, T6502.27-44 (Duckett).

approach has resulted (in time) in a local service being stood up and carried on by local clinicians.

- 16.47. A system wide approach to planning should also recognise, and seek to harness, the potential benefits to rural and regional based clinicians of a greater level of involvement in the delivery of clinics and care at the metropolitan facilities. For example, such planning might facilitate a structured affiliation between a regionally based specialist and relevant department of a large metropolitan hospital, providing that clinician with professional support and development opportunities through (for example) participation in multidisciplinary team and departmental meetings.

Facility focussed

- 16.48. The service agreements of LHDs and SHNs are the primary mechanism for the distribution of their budgets. Because LHDs and SHNs have traditionally delivered facility based services, planning processes have had a tendency to be driven by the needs of capital processes, infrastructure and prioritisation of limited capital funds.⁵⁰ This “bricks and mortar” approach is problematic. The “real planning need or the needs of [a] community [have] nothing to do with a facility” and instead demand the provision of services in a community in a different way, for example through extended general practice or extended scope of practice for nurses and midwives, and allied health practitioners.⁵¹ The latter kind of planning does not fit easily into the traditional planning process.⁵²
- 16.49. The Ministry of Health has acknowledged that the focus on “delivering bigger and larger hospitals with more beds” should be realigned to a focus on the needs of the community, which may take the focus of health service planning “out of hospital”.⁵³ As was frankly acknowledged by the Health Secretary:⁵⁴

if we continue to solely focus on bricks and mortar as a proxy for health service delivery, we're not going to progress beyond that. It is important to us that we are able to focus on the broad suite of healthcare, including health promotion and prevention.

- 16.50. That facility, bricks and mortar, focussed approach also has a significant influence on capital planning and expenditure. Public discourse is replete with examples of community representatives (including elected representatives at all levels of government) advocating for new or upgraded facilities in their regions. That discourse can (and often does) result in political commitments to deliver what the community wants.

⁵⁰ Transcript of the Commission, 16 May 2024, T2958.2-19, T2972.11-32 (Spittal).

⁵¹ Transcript of the Commission, 16 May 2024, T2973.6-22 (Spittal).

⁵² Transcript of the Commission, 16 May 2024, T2973.15-19 (Spittal).

⁵³ Transcript of the Commission, 28 May 2023, T107.2-16 (Lyons).

⁵⁴ Transcript of the Commission, 26 February 2025, T7048.22-26 (Pearce).

- 16.51. In making that observation, I should not be understood to be suggesting that those communities do not genuinely believe they **need** those facilities in their regions. Nor should I be understood as seeking to downplay the importance of community consultation and engagement in the planning and designing of public health services; to the contrary, I consider it to be an essential feature of good planning. However, there can often be a divergence between what a community considers it needs (or wants), and what those charged with the delivery of the public health system assess as being required to promote, protect and maintain the health of that population.
- 16.52. That approach can also perpetuate the view that high quality care can only be delivered within the four walls of a modern hospital. That is no longer the case, and that is to the great benefit of society.
- 16.53. What approach, then, should be taken to capital planning?
- 16.54. That topic (like many others that were raised during the course of this Special Commission) could be the subject of a standalone inquiry. However, as a starting point, there is no good reason why capital planning – by which I mean planning for new facilities or significant upgrades to existing facilities – ought not be driven by the same concepts that inform the system wide service planning process that I recommend should be adopted.
- 16.55. That process should start with an assessment of the health needs of the population, which can then inform a proper assessment of the services that are required to meet those needs. An assessment of what facilities are available (or should be constructed) to deliver those services is an integral aspect of that process. It is through that process that a capital program that supports the system to deliver the services that are needed, where they are needed, can be developed.
- 16.56. That is not an entirely new concept. In the fourth *Report of the Royal Commission on Public Charities* delivered in 1899, a recommendation was made that a “favourable report as to the necessity for the establishment of any new hospital should be conditions precedent to the granting of government assistance to either build or maintain that hospital”.⁵⁵ That recommendation – made 125 years ago – highlights the centrality of **need** in the assessment of public health system capital projects.
- 16.57. In drawing attention to that recommendation, I do not suggest that current capital funding processes do not include appropriate assessments, including in relation to the benefits they may deliver. However, given that it is accepted (at least by the Ministry of Health) that the time has come for a shift away from a “bricks and mortar” approach, and the prevalence of facilities within the system that would be closed in order to divert resources to better meet the needs of the community if the relevant Chief Executive were able to do so; there is a need to restore the centrality (if not

⁵⁵ *Royal Commission on Public Charities* (Fourth Report, April 1899) 1iv.

primacy) of population **need** to the assessment of health system capital works. Few would disagree with the basic (and, I admit, oversimplified) proposition that if constructing a new facility does not represent the best use of public funds to address the health needs of the population, the rationale for its construction is likely insufficient to justify the massive expenditure of public resources that comes with it.

- 16.58. No one who has read this far into this Report should consider that I am advocating for the mass closure of public hospitals and facilities across the State. I am not. However, I am of the view that there is a critical need to align capital planning over the long term with detailed and robust Statewide service planning to best use what I have been repeatedly told are finite public resources to meet the needs of the population across the State. Having regard to what I have seen, and what I have been told, it is not apparent to me that is always the case.
- 16.59. That needs based approach must be central throughout the lifecycle of significant capital projects within the NSW public health system; from conception to delivery.
- 16.60. A shift in focus will present greater opportunity for “more investment in community based services”.⁵⁶ It would also allow the reallocation of capital currently being used to build resources in circumstances where the building and operating costs of those facilities are going to present a “real challenge” for the NSW Health budget into the future.⁵⁷
- 16.61. Facility focussed planning, which seeks to continuously upgrade the services available in facilities, particularly those in rural and remote locations, has also forced LHDs and SHNs to invest in facility based maintenance and upgrades rather than appropriate patient transport that could connect patients to a broader network of available healthcare.
- 16.62. In a State as large as NSW and with the hospital system that it has, it is inevitable that there will be a wide range of clinics, procedures, and other services that are only able to be delivered at larger facilities, whether that be larger facilities in regional centres or, in some cases, only in metropolitan areas. There has always been a need to move patients around the State to enable them to receive the care that they require and – as the requirements of patient safety and the costs of delivering health expand – this need will only increase. Underpinning this uncontroversial observation is an acceptance of the proposition that universal healthcare does not require that every service be available at every location, but rather that all services are properly accessible to all patients who require them, wherever they might be located. In this context, accessible and effective patient transport is critical to delivering on the promise of universal healthcare, as is proper centralised oversight of local planning activities.

⁵⁶ Transcript of the Commission, 28 November 2023, T107.2-16 (Lyons).

⁵⁷ Transcript of the Commission, 28 November 2023, T107.37-44 (Lyons).

- 16.63. At present, in addition to LHD patient transport vehicles conducting interhospital transfers, HealthShare NSW's Patient Transport Service is available to non-emergency patients who require transport to, or from, a health facility such as a hospital, rehabilitation unit or aged care facility and are assessed as medically unsuitable for community, public or private transport by a medical practitioner or registered nurse. Transports are available within greater metropolitan Sydney (including the Central Coast, Illawarra Shoalhaven and Hunter New England areas), and in other parts of NSW, non-emergency patient transport is managed locally.⁵⁸ There is also the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS), which has associated eligibility criteria and conditions.⁵⁹
- 16.64. Notwithstanding the existence of these programs, there remain accessibility issues for patients in regional, rural, and remote areas.⁶⁰ HealthShare's Patient Transport Service either does not operate in those areas or, if it does operate, it applies increased costs for travelling the large distances required.⁶¹ There is also limited community knowledge of, and capability to apply for, air transport services.⁶²
- 16.65. The gaps in patient transport extend to interhospital transfers, returning patients home after they have received hospital treatment,⁶³ medical retrieval, and transport to and from outpatient services.⁶⁴ As the Health Secretary acknowledged, "access to care for people in rural and remote locations is" – and should properly remain – "a key area of focus" for the Ministry of Health.⁶⁵
- 16.66. As a result of accessibility issues, patients may forego the care they need,⁶⁶ or rely on other community services,⁶⁷ such as ACCHOs,⁶⁸ to provide non-emergency transport. Similarly, where there are no other transport options available, ambulances can be forced to assume the role of non-emergency patient transport, at the expense of attending and completing emergency jobs.⁶⁹ It is not acceptable for community services to bear the costs of transporting patients long distances where they are not funded to do so, nor should LHDs permit the use of ambulances for patient transport that could appropriately utilise a LHD patient transport vehicle,⁷⁰ unless entirely

⁵⁸ Exhibit B.11. Statement of Carmen Rechbauer (12 February 2024) [77]-[80] [MOH.9999.0009.0001 at 0023].

⁵⁹ Exhibit A.49. NSW Regional Health Strategic Plan 2022-2032 (February 2023) p 34 [MOH.0001.0372.0000 at 0034].

⁶⁰ Transcript of the Commission, 22 May 2024, T3137.15-18 (Bottrell); Transcript of the Commission, 16 August 2024, T5109.23-34 (Bennett); Transcript of the Commission, 23 May 2024, T3318.22-30 (Kahawita).

⁶¹ Exhibit K.44, Statement of Tony Gilbertson (9 September 2024) [22]-[23] [MOH.0011.0065.0001 at 0005].

⁶² Transcript of the Commission, 22 May 2024, T3136.5-22 (Nott).

⁶³ Transcript of the Commission, 15 August 2024, T4997.5-19 (Cawthorne).

⁶⁴ Transcript of the Commission, 14 May 2024, T2747.18-38 (Mason).

⁶⁵ Transcript of the Commission, 26 February 2025, T7088.6-8 (Pearce).

⁶⁶ Transcript of the Commission, 22 May 2024, T3135.16-33 (Nott).

⁶⁷ Transcript of the Commission, 23 May 2024, T3318.22-30 (Kahawita).

⁶⁸ Transcript of the Commission, 14 May 2024, T2739.14-22 (Hampton).

⁶⁹ Transcript of the Commission, 19 November 2024, T6369.17-26, T6370.38-46 (Morgan).

⁷⁰ Transcript of the Commission, 16 August 2024, T5109.23-34 (Bennett).

satisfied that doing so will not compromise in any material way the ability of NSW Ambulance to respond adequately to an emergent situation.

- 16.67. Patient transport must be part of the system wide service planning process to effectively connect patients to the care they need. It is an integral part of any service plan that aims to deploy resources and services in an efficient and effective way across the State, whilst delivering accessible care to the people of NSW.

Political considerations

- 16.68. It has been suggested that every Chief Executive of an LHD likely has a list of services that they would like to cease providing so as to reinvest the moneys liberated into services that would provide better benefit to their particular communities.⁷¹ I have no doubt that this is the case, and it is well borne out by evidence gathered through hearings and roundtables.
- 16.69. It is said that disinvestment of this type “is really, really hard and it requires an enormous amount of will and political acumen to actually secure... not just through the medical politics but also the community politics and then macro politics”, particularly within rural areas.⁷² NSW Health has sought to emphasise that “the challenge posed in making disinvestment decisions cannot be overstated”.⁷³
- 16.70. These obstacles are not new. They were identified in the *Garling Report*⁷⁴ and little appears to have changed since that report was written.
- 16.71. The conversation about what the public health system **should** be, and the services that **should** be provided within it, has an inherently political dimension. It is perhaps inevitable, then, that political drivers and decisions will influence the public health system and the way in which services are planned and delivered. However, that influence should be used responsibly and in a manner that is properly informed by the process and objectives of system wide planning. I have been given examples across the State of political motivations influencing decisions to maintain services that are viewed by those responsible for service planning as unnecessary and a poor use of finite resources. I have also been given examples of services having been established in response to advocacy from a local Member of Parliament (or aspiring Member of Parliament), that may not reflect the needs of the community, or appropriate resource distribution.

⁷¹ Transcript of the Commission, 21 November 2024, T6560.29-6561.9 (Daly).

⁷² Transcript of the Commission, 21 November 2024, T6560.29-6561.21 (Daly).

⁷³ Submissions of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [7.18] [SCI.0011.0814.0001 at 0026-0027].

⁷⁴ Exhibit N4.5, Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals: Volume 3 (27 December 2008) [26.133]-[26.159] [SCI.0011.0762.0001 at 0075-79].

- 16.72. The effect of political influence in service planning and delivery is most often seen in decisions (or the lack thereof) to make changes to the services that are delivered (including closing a service) in a particular community or location. What might be seen as opportunistic resistance to service changes that do not pay proper regard to the assessment of the community need and the service planning that has been performed to meet that need, will likely compromise the ability of a detailed, Statewide planning exercise to meet its ultimate objective – to promote, protect and maintain the health of the **entire** population. As a consequence, and regardless of the actual health needs of a community, there is often a lack of political will to cease inefficient and uneconomic services. There is an expectation that this necessary evolution of the public health system will be highly resisted and difficult to work through within the affected communities.⁷⁵
- 16.73. Where I have suggested that there is a lack of political will, what I am really pointing to is an absence of political support – ideally bipartisan – for the difficult, but critically important, rationing decisions made by LHDs and SHNs regarding the best and most efficient use of the limited funds made available to them to deliver healthcare to their respective communities.
- 16.74. These challenges are exacerbated by the fact that the political and public discourse about the state of the NSW public health system (sometimes, and often unfairly, described as being in “crisis”) is largely framed around a set of narrow metrics, which of themselves say little about the overall performance and strength of the system; such as Emergency Department waiting times and elective surgery waiting lists. Statistics of those kinds can inform an assessment of demand on the system, but in isolation they do not paint a complete picture. Put bluntly, publication of what might be viewed as adverse statistics and their wider circulation in the press will likely provoke a political response. Where that reporting is narrow, it will inevitably result in funding being driven into the areas that have been the subject of that reporting, diverting those funds away from whatever might have been contemplated by such planning as has taken place.
- 16.75. This lack of support for those with responsibility for planning and managing the wider system is highly problematic, particularly where such decisions are made in the context of consistently strained budgets. It deprives LHDs and SHNs of the practical ability to redistribute the moneys liberated through disinvestment of inefficient or unnecessary services into alternative services that are acutely needed to meet the evolving health needs of a particular community.⁷⁶

⁷⁵ Transcript of the Commission, 16 May 2024, T2974.17-34 (Spittal).

⁷⁶ Transcript of the Commission, 16 May 2024, T2974.5-39 (Spittal).

- 16.76. Elected representatives, political parties, and bureaucrats are not working together across the political divide (effectively, or at all) to explore real and genuine ways to realign the health system. Part of that realignment must include planning with communities and providing them with the information needed to enable them to understand that changes to services can and likely will produce better health outcomes for them. Changes of those kinds cannot reasonably be said to amount to “taking something away” from a community, which is, unfortunately, how service changes are often viewed. That must change, before it is too late.⁷⁷
- 16.77. The political cycle, by which governments realign their priorities or are replaced, can also impact funding, particularly program funding, according to what the government of the day views as a priority. This has occasionally forced LHDs and SHNs, as publicly funded organisations, to “pivot” towards the Government’s priorities at any given time, though this can be costly, time consuming,⁷⁸ and at odds with their assessment of the evolving health needs of their respective communities.
- 16.78. Regrettably, these forces continue to obstruct the necessary evolution of the public health system and, accordingly, its capacity to best meet the changing health needs of communities within NSW. While it might be unrealistic to think that these obstructions can be removed entirely, it is possible for the public health system to operate in a manner that reduces the impact that they have.
- 16.79. As I note below, what is required is a far greater level of genuine community engagement and transparency around decision making. It is understandable that a community will fall prey to political posturing around disinvestment in a service where there is no proper understanding of the decision making process that lies behind that proposal or, particularly, the benefits that are to be obtained by that community through the redeployment of the liberated resources. This lack of understanding will inevitably be a feature of any system that lacks transparency and makes decisions **for** rather than **with** the community it is intending to serve.
- 16.80. While some may be reluctant to increase the level of transparency around health service planning – as this must, appropriately, bring with it a higher level of accountability for delivering on the objectives identified though that planning – it is necessary for there to be adequate community engagement in the planning process. This will ultimately provide the Ministry of Health, LHDs and SHNs with a greater level of insulation from the political obstacles I have referred to above.

⁷⁷ Transcript of the Commission, 16 May 2024, T2975.26-44 (Spittal).

⁷⁸ Transcript of the Commission, 20 March 2024, T1509.6-18 (Lawrence).

The importance of place based planning

- 16.81. The absence – at least at a practical level – of strong system wide planning has fostered the organic development of services in response to other drivers, such as funding and workforce availability, political considerations, and historical service commitments (to which I refer above). This method of growth has been ineffective in promoting patient safety and fiscal responsibility,⁷⁹ and has culminated in a public health system that is increasingly being stretched unsustainably in an attempt to deliver as many services, in as many locations, as possible. No doubt this fact has contributed to the perception within certain areas of the public health system that funding and workforce shortages have driven the system to a “crisis” point.
- 16.82. In large part, this reflects the under resourced and devolved nature of the current service planning framework and the resultant loss of planning capability within both the Ministry of Health and LHDs and SHNs.
- 16.83. As discussed earlier in this Chapter, at the LHD and SHN level, service planning has taken on a facility centric view, while a lack of genuine coordination of services with surrounding districts has limited the potential for truly networked or system wide planning. Planning of this type is seen – and treated – as the business of NSW Health and executed accordingly. At the Ministry of Health level, a very broad principle based service planning strategy provides little guidance to LHDs and SHNs in their distribution and prioritisation of services.
- 16.84. In these circumstances, there is a clear need to approach system wide service planning in NSW in a way that better combines the local knowledge and assessment of LHDs and SHNs in relation to their population health needs, a more genuine collaboration with (and information sharing between) LHDs, SHNs and other providers of healthcare within their catchments, and overarching system wide coordination delivered through the Ministry of Health. Greater central involvement in planning is essential, including with respect to identifying the optimal and equitable distribution of services across the State. It is vital if the NSW public health system is to operate, truly, as **one system**.
- 16.85. The evidence clearly establishes that the approach to place based planning should involve the following steps:
- a. identification of the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of healthcare in the relevant region;
 - b. identification of other entities, including LHDs, that are already (or are capable of) delivering services meet the identified needs;

⁷⁹ Transcript of the Commission, 19 November 2024, T6343.19-24 (Mains).

- c. identification of gaps or areas of need that are not being met;
 - d. identification of which of those gaps the public health system “should” fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community and all other providers of healthcare within the relevant place; and
 - e. ongoing collaboration with the community and other providers of health services to:
 - i. determine how emerging gaps are to be filled and what funding is available to enable that to occur;
 - ii. generate a strategy that is forward looking and has a reasonable planning horizon; and
 - iii. incorporate regular and genuinely collaborative monitoring processes to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.
- 16.86. In developing robust place based service planning, the steps outlined above reflect a need to base planning decisions on informed conclusions about a population’s health needs, whether the public health system should be responsible for meeting those needs, and, if so, how those needs can be met in the optimal and most equitable manner.
- 16.87. Each of these steps, and the reason for their respective importance, is outlined below.

Identification of the health needs of the relevant community

- 16.88. The first step in this process must be the identification of the health needs of the local community. It is important that this be the first step in the planning process, because unless community needs are identified, there will potentially be large gaps in service provision, including gaps that are invisible to service planners.⁸⁰ It also recognises that the health needs of a community should be the core consideration in place based planning, and “the infrastructure requirements or the service provider requirements to meet that need are secondary to the core purpose of planning”.⁸¹
- 16.89. The identification of need, for the purpose of service planning, should involve population needs analysis, demand analysis, and analysis of socio-demographic factors,⁸² as well as genuine community engagement.⁸³ In recognising that LHDs are but “a single organisation in a health ecosystem”,⁸⁴ it should also involve engagement

⁸⁰ Transcript of the Commission, 12 December 2024, T6992.37-6994.33 (Wilson/Huckel Schneider).

⁸¹ Transcript of the Commission, 16 April 2024, T2958.2-19 (Spittal).

⁸² Transcript of the Commission, 19 November 2024, T6341.25-41 (Mains).

⁸³ Transcript of the Commission, 15 May 2024, T2893.5-7 (Hawthorn).

⁸⁴ Transcript of the Commission, 18 September 2024, T5341.16-17 (Maisey).

with other local organisations delivering services, in both the primary care and acute care sector,⁸⁵ to determine both the quantitative and qualitative needs of the community.⁸⁶ This is essential to understanding the entire patient journey, not just their experience in a hospital,⁸⁷ and overcoming the “hyper-fragmentation” of healthcare.⁸⁸ I pause here to observe that this collaborative approach to health service planning would also appear to be one of the central aspirations underpinning the *Addendum to the NHRA*.⁸⁹

- 16.90. The “needs identification” step of the process will inevitably be best informed by a ground up approach, whereby LHDs and SHNs with intimate knowledge of their local communities and the associated health matrix can feed information into the planning process while also utilising information flowing down from the Ministry of Health, which has a broader understanding of service availability across the State. LHDs can also distil and indicate where regional health needs differ from the needs of specific communities within a region.⁹⁰ In this regard, in deciding whether a particular location has a need for a particular service, there is a requirement to “marry the local knowledge and understanding as well as the technical support ... from [M]inistry to make those sorts of decisions”.⁹¹
- 16.91. Without first identifying health and service needs, there cannot be any valuable exercise in prioritisation or rationing with respect to the services that can feasibly be delivered within a LHD or SHN’s budget envelope.⁹² In other words, the needs of the community must inevitably form the basis of all subsequent service planning decisions. This is far more productive than attempting to design services to suit funding arrangements.⁹³

Identification of what services the public health system “should” deliver and where

- 16.92. The next step is determining what services should in fact be delivered by the public health system in order to meet the identified need. This involves a broader consideration of what the public health system is and what it can deliver in an economic and safe way.⁹⁴

⁸⁵ Transcript of the Commission, 14 May 2024, T2681.3-13 (Chua).

⁸⁶ Transcript of the Commission, 18 September 2024, T5341.15-24 (Maisey).

⁸⁷ Transcript of the Commission, 22 March 2024, T1691.35-41 (Ludford).

⁸⁸ Transcript of the Commission, 15 August 2024, T4899.9-28 (Gow).

⁸⁹ Exhibit A.28, *Addendum to the National Health Reform Agreement 2020–2025* (2020) [SCI.0001.0024.0001].

⁹⁰ Transcript of the Commission, 15 May 2024, T2884.23-40 (Hawthorn).

⁹¹ Transcript of the Commission, 20 November 2024, T6489.15-18 (Duckett).

⁹² Transcript of the Commission, 19 November 2024, T6334.34-6335.7 (Collins).

⁹³ Transcript of the Commission, 18 September 2024, T5342.11-28 (Maisey).

⁹⁴ Transcript of the Commission, 20 November 2024, T6440.8-31 (Braithwaite).

- 16.93. There is a finite budgetary envelope allocated to NSW Health, and it is not possible for the public health system to deliver every health service within every LHD and SHN. However, “[d]ifferent people have different expectations of what health services should be provided, where, and by whom”.⁹⁵
- 16.94. Accordingly, there is a need for NSW Health to consider, first, what services fall within the ambit of the “public health system”, and, secondly, how the public health system can operate to offer those in scope services to the people of NSW in an optimal and equitable way. This must be done as part of an open collaboration with community and other providers of healthcare to that community. As I have said elsewhere in this Report, NSW Health needs to recognise the important distinction between doing things **with** people and doing things **to** people. Health service planning must be approached on the former basis.
- 16.95. With respect to the determination of what the public health system is at its core, and what services it should offer at a Statewide level, it has been suggested that NSW Health should give consideration to whether the public health system should bear the significant costs spent on certain highly specialised and low volume procedures in all current locations, and/or the delivery of low value care.⁹⁶ While it is not for me to determine or comment on issues of this nature, while potentially politically unpopular, they are decisions that must be made and communicated to guide the prioritisation of services and long term planning decisions.
- 16.96. Perhaps more importantly, in circumstances where it is likely to continue receiving a similar proportion of the State budget to that which it does now, NSW Health must determine the scope of the public health system, including whether it needs to meet “every health need locally”,⁹⁷ and, if not, how services can best be distributed in a safe, economic and equitable way to remote, rural, regional and metropolitan communities.
- 16.97. At present, it is said that there is a community expectation that the people of NSW “can receive every health service they need within 20 minutes of their home address”.⁹⁸ It is also said that there is an expectation that services that have been provided within a LHD historically will not be withdrawn or ceased, regardless of whether they are providing efficient and safe outcomes.⁹⁹ This has stemmed from the organic growth of services in response to changing community needs and, in a reality

⁹⁵ Transcript of the Commission, 16 August 2024, T5040.29-32 (Clout).

⁹⁶ Transcript of the Commission, 14 November 2024, T6042.41-6043.34 (Begbie); Transcript of the Commission, 29 November 2023, T237.46-238.47 (Lyons).

⁹⁷ Transcript of the Commission, 19 November 2024, T6339.18-19 (Constable).

⁹⁸ Transcript of the Commission, 19 November 2024, T6338.29-39 (Constable).

⁹⁹ Transcript of the Commission, 28 August 2024, T5143.20-43 (May).

where health needs are infinite, a failure to “draw the line on what [the public health system’s] role is and what other people’s roles are”.¹⁰⁰

- 16.98. The challenges presented by community expectations of public healthcare that are unlimited and unrestricted were articulated by Mr Spittal, who gave evidence that Western NSW LHD was operating seven Emergency Departments that were fully staffed 24/7, yet saw fewer than 1,000 patients per year. In his view, the utility of these services for the community was “really low” and meant that the higher volume Emergency Departments within the LHD struggled with staffing. However, without “substantial political push”, he considered that it would not be possible to close those Emergency Departments and reinvest the money in interventions of which the community had a greater need, and would result in a reduction in Emergency Department presentation.¹⁰¹
- 16.99. It is not sustainable for the public health system to fund and provide high cost and low utility services by virtue of community expectation alone. Rather, robust service planning should reflect population need by prioritising and allocating funding to the services of greatest importance to the community, and defunding or de-implementing inefficient services. This process is essential in recognising the current trend that NSW Health “won’t be able to fund all of the care that’s going to be needed” into the future,¹⁰² and any attempt do so will result in the strained and under resourced delivery of care within an ever more thinly spread budgetary envelope.¹⁰³
- 16.100. The system wide service planning process outlined above would not support the evolution of a service within an LHD just “because [they] happen[ed] to have a clinician that had the expertise” to perform a specialty service, because this may not reflect quality, safety or value for money in service delivery.¹⁰⁴ To the contrary, this approach to service delivery may inadvertently deprioritise services that are of community benefit, or perpetuate the thinning of an LHD’s budget, thereby compromising service delivery.¹⁰⁵
- 16.101. As noted above, in reaching a decision as to the scope of the public health system, including what it should offer and where LHDs and the Ministry of Health must have “open and transparent dialogue” with the people of the relevant locality, as well as clinicians, in relation to their shared vision for the public health system and how this might be reflected in place based service and workforce planning.¹⁰⁶ While these will undoubtedly be difficult conversations, the implementation of a coordinated, system

¹⁰⁰ Transcript of the Commission, 21 November 2024, T6542.5-16 (Portelli).

¹⁰¹ Transcript of the Commission, 16 April 2024, T2975.1-24 (Spittal).

¹⁰² Transcript of the Commission, 20 November 2024, T6431.11-14 (Braithwaite).

¹⁰³ Transcript of the Commission, 20 November 2024, T6440.8-31 (Braithwaite).

¹⁰⁴ Transcript of the Commission, 19 November 2024, T6340.17-35 (Constable), see also T6342.39-45 (Mains).

¹⁰⁵ Transcript of the Commission, 19 November 2024, T6343.44-6344.7 (Mains).

¹⁰⁶ Transcript of the Commission, 16 April 2024, T2981.31-32 (Spittal).

wide plan for staffing and funding the public health system requires “understanding between governments, organisations like [LHDs], others involved in the delivery of health services and the community at large about what [to] expect in terms of the kind of services that might be available”.¹⁰⁷ These discussions cannot take place **after** a decision about the shape or scale of health services in any particular locality has been made by an LHD and/or the Ministry of Health.

- 16.102. The conversation with the community must include an explanation of the financial constraints of the public health system, the identified health needs of the community, and the rationing or “trade offs”¹⁰⁸ that have to be made to deliver services that harmonise both patient safety, workforce sustainability, and economic efficiency.¹⁰⁹ This may include conversations about the value of existing services, for example “the value of an Emergency Department that sees triage five patients largely [sic], a thousand a year, compared to all of that money going into something else”.¹¹⁰ It will also inevitably cover any planning assessment that has been made as to:¹¹¹

what services are needed for a community to have access to; which of those can appropriately be provided as close as possible to where people live, i.e., in their community; which of those services [an LHD] can staff to, to ensure that the staff that are there are appropriate to provide safe and high quality services; and which ones it is going to be far better, just from the point of view of patient safety and quality, for someone to have a process of travelling to, or being provided in a different locality, so that specialist care can be provided when it is needed.

- 16.103. This will, in turn, support LHDs and the communities they serve in transparent and consistent processes in prioritising particular services and workforce strategies in line with both population need and the broader service planning framework,¹¹² while also disinvesting in services that are not required.
- 16.104. Noting the challenges associated with withdrawing a service over time from one area because it is being provided in another area, a transparent and centrally supported planning process around that decision making at the State level would assist in signposting to the community that certain decisions relate to the strategic plan of the State, rather than the individual decision of an LHD Chief Executive.¹¹³

¹⁰⁷ Transcript of the Commission, 16 April 2024, T2907.15-30 (Spittal).

¹⁰⁸ Transcript of the Commission, 28 August 2024, T5144.17-19 (May).

¹⁰⁹ Transcript of the Commission, 20 November 2024 T6484.1-12 (Duckett); Transcript of the Commission, 16 April 2024, T2979.21-36 (Spittal).

¹¹⁰ Transcript of the Commission, 16 April 2024, T2981.45-2982.2 (Spittal).

¹¹¹ Transcript of the Commission, 16 August 2024, T5040.36-5041.26 (Clout).

¹¹² Transcript of the Commission, 19 November 2024, T6354.5-7 (Cox).

¹¹³ Transcript of the Commission, 19 November 2024, T6348.39-6349.20 (Wilson).

Identification of services being delivered by others

- 16.105. Complementary to place based planning is an understanding that “health services don’t exist in isolation” and planning for any one health service must also consider the broader network of health services that is available and interconnected.¹¹⁴ Accordingly, linked to the consideration of what the public health system should offer within a particular community or district is the consideration of which other entities, including other LHDs, are already (or are capable of) delivering required services to the public health system.
- 16.106. NSW Health receives a finite budget and it is generally not economically efficient nor beneficial for patient safety to duplicate all services across multiple LHDs.¹¹⁵ While the duplication of services between LHDs may be necessary with respect to some services, for example, services that must be delivered to a patient on a regular basis (e.g., renal dialysis)¹¹⁶ or where there is a high population demand, there are also several costly services operated by multiple LHDs with strained resourcing.
- 16.107. Thinking around this issue should not be confined to the range of high complexity, low volume services that are already concentrated within the supra-LHD service portfolio of the Ministry of Health.¹¹⁷ For example, there was evidence that in the Central Coast LHD, specialised services such as neurosurgery and cardiac surgery are not available. The decision not to deliver those services, despite the likely desire of some clinicians to bring those services within the LHD, was based on the fact that those services are readily available to the population at John Hunter and Royal North Shore Hospitals, and to bring those services within the district and make them operational, effective, safe, and efficient would create significant workforce and training challenges.¹¹⁸ Therefore, since the population need can be comfortably met outside the district, there is no need to bring these services into it.
- 16.108. However, decisions of this type cannot be made in an *ad hoc* manner. Instead, they must be informed by a system wide approach to service planning.

¹¹⁴ Transcript of the Commission, 15 May 2024, T2894.12-17 (Hawthorn); see also Transcript of the Commission, 16 April 2024, T2980.34-2981.8 (Spittal).

¹¹⁵ Transcript of the Commission, 18 September 2024, T5290.47-5291.8 (Wong).

¹¹⁶ Transcript of the Commission, 23 May 2024, T3334.5-17 (Astill).

¹¹⁷ Transcript of the Commission, 19 November 2024, T6338.29-43 (Constable); Transcript of the Commission, 28 November 2023, T81.15-82.3 (Lyons).

¹¹⁸ Transcript of the Commission, 19 November 2024, T6339.12-23 (Constable).

- 16.109. Appreciating that this is reflective of the existing approach to supra-LHD or Statewide services,¹¹⁹ LHDs with responsibility for operating such services have the benefit of receiving appropriate funding for the scale of the services and projected activity.¹²⁰ Similarly, LHDs relieved of operating such services have the capacity to divert the conserved budgetary resources into other programs based on local community need, while simply retaining the capacity to stabilise a patient and “get them to the right service as safely and efficiently and as quickly as possible”.¹²¹
- 16.110. In addition to high complexity and specialised services, this supra-LHD approach should be applied to other types of services that would be more efficiently consolidated, rather than duplicated between LHDs.¹²²
- 16.111. In addition to the above mentioned economic and efficiency gains that would accompany a more deliberate distribution of services across the State, from a patient safety perspective this type of overarching planning guidance is reflective of a recognition that, within the public health system:¹²³
- all places can't do all things, and so [for] these high acuity, low occurrence procedures... whether it be cardiology, whether it be trauma, whether it be mental health, whether it be obstetrics, ... patients do better in centres that are consolidated with people that are doing high volumes ...*
- 16.112. Accordingly, it is preferable for patients in terms of both efficiency and quality to limit certain types of services and procedures to a location where they are regularly performed.¹²⁴ This requires patients to understand that “it’s better to travel and get very, very good care than get care next door that’s substandard ... because they’re just not doing enough of those procedures”.¹²⁵ It also requires a community to be sufficiently involved in the planning process to have a proper understanding of the benefits delivered – say, through the development of needed services not currently being delivered – through what might, in isolation, be viewed as adverse decisions. In these circumstances, LHDs would continue to have a responsibility to ensure, through consultation with the Ministry of Health, that people living within their catchments have access to the basic services that those communities **should** have available to them, whether within the district or at a location outside the district but sufficiently proximate.

¹¹⁹ Transcript of the Commission, 28 November 2023, T81.15-82.3 (Lyons).

¹²⁰ Transcript of the Commission, 20 November 2024, T6440.42-6441.19 (Braithwaite).

¹²¹ Transcript of the Commission, 20 November 2024, T6483.2-14 (Duckett).

¹²² Transcript of the Commission, 15 May 2024, T2896.14-32 (Hawthorn).

¹²³ Transcript of the Commission, 19 November 2024, T6348.17-23 (Morgan).

¹²⁴ Transcript of the Commission, 28 November 2023, T82.8-26 (Lyons); Transcript of the Commission, 20 November 2024, T6440.8-40 (Braithwaite); Transcript of the Commission, 18 September 2024, T5343.9-27 (Maisey).

¹²⁵ Transcript of the Commission, 20 November 2024, T6441.41-46 (Braithwaite).

- 16.113. In order for this type of consolidation of services to be feasible, the Ministry of Health needs to share with LHDs central information about the “[S]tatewide blueprint” for service delivery, to give context to the service delivery planning.¹²⁶ Without such information, LHDs can only plan with an understanding of their direct context, which can lead to duplication and competition between districts for the resources (including workforce) required to implement services that may be better shared or networked between them.¹²⁷ Further, decisions as to the appropriate locations and types of services to be consolidated, on the basis of the needs assessments undertaken at the district level, would be best made at the Ministry of Health level.
- 16.114. As I have already observed, I appreciate that decisions to withdraw a service from one area or facility – because it is being provided in another area or facility – are inherently political and challenging from both a community and clinician perspective, including where these decisions relate to services other than highly specialised services.¹²⁸ However, in my view, greater consultation and transparency around the evidence underpinning decisions to withdraw or relocate a service outside of a district, accompanied by an explanation of the resulting benefit, including to better service community need, can only be of significant benefit in navigating those political challenges.¹²⁹ It is not possible to offer this kind of transparency without first having an evidence informed Statewide planning approach through the Ministry of Health that centralises particular services in a cost effective way,¹³⁰ or, in the case of non-specialised services, that articulates the rationing decisions made by LHDs and the advantages of the chosen approach.¹³¹
- 16.115. As part of that process, services (including specialist services) should then be distributed across NSW consistently with service planning that has identified, by reference to population need, the optimal location for those services.¹³² For example, through that planning process, the optimal (and sustainable) method of delivering a specialist service may be to locate it in a regional centre. From that regional centre, in a hub and spoke type model, clinicians could provide services to patients in more rural and remote areas (including from adjacent LHDs). That may involve those clinicians travelling to rural and remote facilities to deliver clinics or perform procedures. Alternatively, patients – supported by a comprehensive patient travel service – may travel to the regional centre to receive care before being decanted to a facility close to their homes to continue their treatment, recovery or rehabilitation

¹²⁶ Transcript of the Commission, 15 October 2024, T5707.31-40 (Minns).

¹²⁷ Transcript of the Commission, 15 October 2024, T5706.41-5707.2 (Minns).

¹²⁸ Transcript of the Commission, 20 November 2024, T6441.11-23 (Braithwaite).

¹²⁹ Transcript of the Commission, 20 November 2024, T6441.25-46 (Braithwaite).

¹³⁰ Transcript of the Commission, 20 November 2024, T6442.13-29 (Braithwaite).

¹³¹ Transcript of the Commission, 20 November 2024, T6485.9-28 (Duckett).

¹³² Transcript of the Commission, 20 November 2024, T6443.19-38 (Braithwaite).

through a genuine collaboration between the local facility and those clinicians who deliver the care in the regional centre.

- 16.116. As part of that approach, there may be opportunities to use technology. For example, some clinics and consultations may be appropriately delivered remotely in a way that limits the need for clinicians, and importantly patients, to travel long distances. It should not be assumed (as many do) that care delivered in this way is necessarily inferior to traditional arrangements where clinician and patient are co-located. I saw many examples of remotely delivered services that involved a collaboration between local clinicians and specialist clinicians located elsewhere, which were arguably a superior method of delivering care. That is particularly so in circumstances where those methods facilitate ready access to care that would not otherwise have been available to that patient without the need for them to travel vast distances. However, any assessment of whether it is appropriate and safe to deliver care in this way must always be clinically informed, and evidence based.

Identify gaps or areas of need that are not being met

- 16.117. The final step underpinning the development of an effective service delivery and workforce plan is the analysis of the local population need, as compared to the services the public health system is willing and able to deliver, and the subsequent identification of the areas of need that are not presently met, or capable of being met.
- 16.118. In identifying service gaps, NSW Health should consider the impact of both infrastructure and workforce on service delivery, in addition to the services themselves. The extent to which population need is, or can be, met by services external to LHDs (including private market based solutions) will also be relevant.¹³³
- 16.119. At the conclusion of that process, NSW Health will be equipped to embark on a process of service planning that is cognisant of local community need, the services offered by the public health system that are capable of meeting that need, the private enterprise already satisfactorily meeting that need, the potential for community need to be appropriately met outside the locality of the LHD, and any remaining service gaps that need to be filled. In some cases, it may be appropriate for NSW Health to provide support for external providers of health services or even step in to fill gaps, however, it might also be sufficient for it to pass relevant information about the identified area of need to another organisation under a “joined up” planning approach overseen by the Ministry of Health.¹³⁴ Identification of the appropriate course will be dictated by the particular circumstances.

¹³³ Transcript of the Commission, 15 May 2024, T2891.2-37 (Hawthorn).

¹³⁴ Transcript of the Commission, 15 May 2024, T2891.2-37 (Hawthorn).

Consultation must be thorough and genuine

- 16.120. Throughout this Report – and particularly where I recommend a change to the way health services are planned and delivered by NSW Health – I refer to the importance of community and stakeholder consultation. Having regard to the centrality of effective community consultation to the planning process I have recommended NSW Health adopt, I feel it is important to elaborate on what I consider good and effective community consultation requires.
- 16.121. First, and foremost, community engagement around health services planning must be a genuinely consultative process. Telling the community what has been decided after a planning decision has been made is not consultation.¹³⁵ To think otherwise would be to overlook the fact that one of the key objectives of effective community consultation is the gathering of information to ensure that a significant decision is made on a properly informed basis.
- 16.122. Good community consultation also requires a high degree of frankness and transparency around the subject matter of the decision. It is largely pointless to seek input from the community about health service planning decisions where those being consulted lack a proper understanding of the context in which the relevant decisions are being made or the potential outcomes in relation to which their views are being sought. While these decisions will at times be challenging and will frequently provoke an unhappy response from sections of the community who see a service they utilise is potentially under threat, they must nevertheless take place.
- 16.123. Effective community consultation not only enhances the quality of the decisions ultimately made, but also enables the community served by the public health system to better understand the challenges faced by those charged with responsibility for its administration, and that their views and needs have been considered when determining how those challenges are to be met.
- 16.124. Like good health planning, effective community consultation must be an ongoing and dynamic process. An annual meeting where community members are invited to share their views followed by 12 months of disengagement would not be effective community consultation. The same can be said of engagement with community representatives such as local government. Ticking off the once a year meeting with local government representatives within an LHD's catchment would not amount to effective community consultation.

¹³⁵ Cf Transcript of the Commission, 18 March 2024, T1244.8-1244.30 (Cornwell McKean/Ewer).

- 16.125. Having said all of that, how health planners and those responsible for the management of LHDs should go about consulting with their communities regarding the planning and delivery of public health services will be inherently place based and cannot readily be reduced to a formulaic series of steps to be rolled out at every LHD or community.
- 16.126. To be effective, consultation cannot be a one off question and answer session or voluntary survey. Rather, good community consultation will spring from carefully developed and genuine relationships of trust and respect. Careful consideration will need to be given to how these services can best be deployed in individual communities. However, several general observations can be made.
- 16.127. There are organisations within every community that should almost always be key collaborators with NSW Health when it comes to health services planning. Local councils – particularly in regional, rural and remote communities – should be actively engaged with by LHDs. By this, I mean much more than an annual meeting or get together. Local councils will ordinarily have connections with their communities that LHDs cannot – and should not try to – replicate. Local councils in rural and remote areas will themselves often be engaged in the delivery or support of primary and aged care in their communities. Most importantly, elected councillors and those employed by local councils will almost always live within their communities and – through their daily interaction with community members – will have a very keen sense of what that community wants and needs by way of healthcare; they often bear the brunt of community dissatisfaction with health planning decisions.¹³⁶
- 16.128. In that sense, local councils should be seen as far more than a mere source of information about their communities. Ongoing collaboration with local councils will enable LHDs to engage with the communities they represent in a meaningful way. Information about communities can be gathered and communities better informed about health planning and decisions while they are happening. This ongoing collaboration will also serve as a valuable source of feedback, enabling those involved in health planning to assess the extent to which their objectives are being achieved in what will inevitably be a dynamic environment.
- 16.129. Similar comments apply to ACCHOs, a genuine joint service planning process will go a long way towards – if not require – ongoing and meaningful consultation with the communities those organisations serve.
- 16.130. No doubt there will be other community organisations that are capable of providing a conduit between health planners and the communities they service through which genuine community consultation can be facilitated. Identifying them will be a core function of good health planning.

¹³⁶ Transcript of the Commission, 22 May 2024, T3224.15-27 (Marsden).

- 16.131. In making the above observations, I have not overlooked the existing Local Health Advisory Councils that already exist across the State. Looking at their terms of reference, it is clear they are intended to create a conduit through which community consultation can occur. Without wanting to downplay the excellent work that those councils no doubt do, the evidence suggests to me that they are frequently very facility centric organisations and fall well short of the level of community consultation and engagement required for good and collaborative health service planning.
- 16.132. However, the evidence before this Special Commission overwhelmingly supports a conclusion that current consultation by NSW Health with the communities served by the public health system regularly falls short of the process I have described above and is frequently ineffective.¹³⁷

The importance of “data” to system planning and service delivery

- 16.133. There are vast amounts of data within the health system.¹³⁸ Some is collected and harnessed well. For example, the Ministry of Health’s access to comprehensive data relating to workforce issues and financial performance of the system enables it to engage in detailed analysis of those matters. As much has been demonstrated in the assistance provided to this Special Commission through the preparation of reports and summaries.
- 16.134. However, there are barriers to collection and sharing of data – both across NSW Health agencies, and across the wider healthcare system – in other areas that mean that its power is not fully realised. For example (as discussed above), clinical data is currently captured in a range of disparate systems across NSW Health and the healthcare system more broadly.¹³⁹ The siloed nature of the various data systems, including those used across NSW Health agencies, creates gaps in understanding health outcomes, thereby hindering the ability to measure allocative efficiency, preventing clinicians from being more proactive in administering optimal care, and resulting in increased clinical risk.¹⁴⁰

¹³⁷ Transcript of the Commission, 28 August 2024, T5143.33-5145.2 (May); Transcript of the Commission, 18 March 2024, T1206.18-40, T1207.2-22 (Shenouda); Transcript of the Commission, 18 March 2024, T1238.7-13, T1239.14-1241.6, T1241.26-44, T1242.3-22, T1244.8-30, T1274.19-34 (Cornwell/McKean/Ewer); Transcript of the Commission, 19 March 2024, T1348.46-1350.7 (Field); Transcript of the Commission, 21 March 2024, T1548.29-1549.14, T1554.24-1555.10 (Dixon/Kolbe); Transcript of the Commission, 13 May 2024, T2663.9-2665.6 (Tory); Transcript of the Commission, 14 May 2024, T2764.16-36 (Gordon); Transcript of the Commission, 15 May 2024, T2887.39-2889.26 (Hawthorn); Transcript of the Commission, 22 May 2024, T3154.26-3155.6, 3156.2-9, 3157.29-40 (Bottrell); Transcript of the Commission, 16 August 2024, T5106.5-36, 5107.6-43 (Bennett); Transcript of the Commission, 16 August 2024, T5036.19-5038.33, T5040.29-5041 (Clout); Transcript of the Commission, 16 August 2024, T5051.3-5052.22, 5054.5-5055.10 (Hoskins/Clout); Transcript of the Commission, 15 August 2024, T4972.6-28 (Stapleton); Transcript of the Commission, 17 September 2024, T5204.18-38 (Slaven); Transcript of the Commission, 19 September 2024, T5400.16-38 (McCosker); Transcript of the Commission, 20 September 2024, T5537.7-5541.22 (Cohen).

¹³⁸ Transcript of the Commission, 26 February 2025, T7038.41-43 (Pearce).

¹³⁹ Exhibit D.9, Statement of Sharon Smith (9 April 2024) [15] [MOH.9999.0980.0001 at 0004-0005]; Transcript of the Commission, 16 April 2024, T1895.14-1896.44 (Smith).

¹⁴⁰ See for example, Transcript of the Commission, 15 April 2024, T1812.9-1814.37 (Wood).

- 16.135. In December 2022, the Strengthening Medicare Taskforce recommended implementing better connections in “health data across all parts of the health system, underpinned by robust national governance and legislative frameworks, regulation of clinical software and improved technology”.¹⁴¹ Consistently with that recommendation, NSW Health has acknowledged that a “secure, end-to-end view of patient information and interactions would greatly contribute to safe, high quality and efficient care giving”.¹⁴² To this end, NSW Health has implemented various digital projects and reforms targeted at improving data collection and integration, including the SDPR project.¹⁴³
- 16.136. There is no doubt that the introduction of the SDPR will result in several benefits and enhancements across the system, including efficiencies,¹⁴⁴ reduction of unnecessary interventions and clinical errors,¹⁴⁵ reduction of gaps and duplications in care,¹⁴⁶ better care experiences for patients,¹⁴⁷ and better access for them to their medical records and information.¹⁴⁸ It will also be a vital tool in health service planning.
- 16.137. System wide data is critical to effective service planning and delivery. It is evident that some enhancements to that capability can, and should, be pursued. For example, while elective surgery waitlists and Emergency Department waiting times are recorded, collated and analysed, data concerning other waiting lists – such as for outpatient clinic appointments¹⁴⁹ – do not appear to be approached in a similar way at a system level. Without robust data of that kind, there is a real risk that concepts of “demand” will continue to be assessed through the overly narrow lens of historical “activity”, rather than a reflection of present and emerging community need.
- 16.138. In addition to enhancing the planning function, capturing a wider range of data sets will enable a refreshed suite of KPIs that are better aligned to measuring whether the relevant agency is meeting the needs the community, its population or, in the case of an LHD, achieving its primary purposes to provide relief to sick and injured persons through the provision of care and treatment, and to protect, promote and maintain the health of the population for which it is responsible.¹⁵⁰

¹⁴¹ Exhibit A.61, Strengthening Medicare Taskforce Report (December 2022) pp 8-9 [SCI.0001.0053.0001 at 0008-0009].

¹⁴² Exhibit B.23.23, Future Health: Guiding the next decade of health care in NSW 2022-2032 (15 February 2024) p 54 [MOH.0001.0320.0001 at 0054].

¹⁴³ For a detailed list of completed and ongoing projects by eHealth NSW since 2018, see Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [26]-[31] [MOH.0001.0433.0001 at 0005-0020].

¹⁴⁴ Transcript of the Commission, 19 April 2024, T2239.22-31 (Smith).

¹⁴⁵ Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) [94] [MOH.9999.0008.0001 at 0033-0035].

¹⁴⁶ Transcript of the Commission, 29 November 2023, T237.11-27 (Lyons).

¹⁴⁷ Transcript of the Commission, 28 November 2023, T185.42-186.3 (Willcox).

¹⁴⁸ Transcript of the Commission, 29 November 2023, T236.43-237.9 (Willcox).

¹⁴⁹ See, for example, Transcript of the Commission, 21 November 2024, T6548.13-6551.3 (Smith/Portelli).

¹⁵⁰ *Health Services Act 1997* (NSW) s 9.

Developing a health service planning strategy

- 16.139. The identification and prioritisation of health needs, as per the above process, will support the development of a robust and comprehensive health service planning strategy that identifies exactly how those needs are to be met by the patchwork of services available, and that is the product of a collaboration between the community, LHDs, SHNs, other providers of health services, and the Ministry of Health. Relevantly, the identification of service need, and prioritisation of services to meet that need, at the LHD level will inform the overarching Statewide strategy for service delivery at the Ministry of Health level.
- 16.140. In this process, the first step is for LHDs and SHNs to identify gaps in the care required to adequately meet the health needs of their respective communities and embark upon a process of meaningful collaboration with the Ministry of Health and other providers of health services with a view to determining how those gaps might be filled, and how much funding is required and available to enable that to occur. This should involve the Ministry of Health taking a system oversight role, in which LHDs and SHNs present:¹⁵¹
- a. the actual health needs of that particular community, including any identified gaps in service delivery;
 - b. the services that the LHD or SHN believes, having prioritised spending within a limited budget envelope, will best meet the needs of that community, including any existing services that do not fall within that category; and
 - c. a projection of what it will cost to deliver the priority services.
- 16.141. On the basis of that information, the LHD or SHN can make a proposal to the Ministry of Health as to the way in which the highest priority services will fit within its budgetary envelope. Alternatively, if the Ministry of Health wants the LHD or SHN to provide something additional, the LHD or SHN can place the burden back on the Ministry of Health to either provide additional funding or advise it which services can be withdrawn, either because they are outside the scope of the public health system, or because they are already adequately offered by other entities providing public health services.¹⁵² In this way, both local and Statewide planning processes can feed into funding decisions.¹⁵³
- 16.142. In order for this approach to be successful, there is a clear need to rebuild planning capability at both an LHD and SHN and Ministry of Health level, and generate structures that foster genuine collaboration between the districts and networks and the Ministry of Health in relation to service planning. Further, while the Ministry of

¹⁵¹ Transcript of the Commission, 21 November 2024, T6537.5-6538.9 (Smith/Portelli).

¹⁵³ Transcript of the Commission, 19 November 2024, T6340.37-6342.26 (Constable/Mains).

Health should take on an oversight role, this should not extend to dictating to LHDs and SHNs the way in which they are to go about delivering their services. This is a matter for local decision making.¹⁵⁴ However, where the Ministry of Health is required to drive the development and maintenance of services that are necessary to service the population needs of more than one district, the Ministry of Health could drive that service delivery through purchasing and activity targets or specific initiatives.¹⁵⁵

- 16.143. Once the LHDs, SHNs and Ministry of Health have determined the most efficient and equitable way in which the districts and networks can provide essential public health services to both local and Statewide populations within a finite budget allocation, this decision making should form the basis of a Ministry of Health level health service planning strategy that is forward looking in nature, and has a reasonable planning horizon.
- 16.144. It is necessary for a longer term strategic process to underpin the decisions made about service provision as between the LHD or SHN and Ministry of Health, because it is not possible to change the shape of existing services within the State within a short period of time. However, over a longer planning horizon of approximately 10 years, it is possible to develop services that are consistent with both existing and anticipated need, as well as enable sufficient time for the necessary consultation and feedback from clinicians and the community.¹⁵⁶
- 16.145. Key to the delivery of any services through this planning approach will be a properly functioning patient transport service. In this respect, I am not merely referring to the transportation of patients during episodes of care, but also, where required, transporting patients to the location at which care is to be provided. It is likely that transportation of this type will increasingly become an important feature of the delivery of equitable and accessible care to rural and remote communities.
- 16.146. In particular, there is likely to be benefit in a built in hub and spoke model for both services and patient transport, whereby patients can access services centrally before being decanted back to either regional facilities for ongoing treatment, or their homes, as appropriate. The Chief Executive of NSW Ambulance, Dr Dominic Morgan, gave evidence that some jurisdictions had successfully implemented this kind of model by housing patient transport vehicles in large regional centres for the purpose of picking up and dropping off patients from small rural communities.¹⁵⁷ Such a model would support greater consolidation of certain services without compromising equity of access to those services for communities in rural and remote locations. It would, however, require a well planned and funded patient transport service that could

¹⁵⁴ Transcript of the Commission, 21 November 2024, T6542.39-6544.38 (Smith/Portelli).

¹⁵⁵ Transcript of the Commission, 21 November 2024, T6589.31-6590.28 (D'Amato/Portelli).

¹⁵⁶ Transcript of the Commission, 19 November 2024, T6352.5-32 (Wilson).

¹⁵⁷ Transcript of the Commission, 19 November 2024, T6369.1-11 (Morgan).

accommodate both the retrieval and decanting of non-emergency patients requiring public health services.

- 16.147. This approach to service planning will also need to involve an integration of workforce planning with service planning to ensure the availability of the appropriate range and levels of clinical staff necessary to provide services.¹⁵⁸ This requires a collaborative approach between universities, specialist medical colleges and the Workforce Planning Branch of NSW Health to identify and implement the relevant training pathways. There was consensus in the evidence that this planning should not be siloed in the Workforce Planning Branch and that HETI should take on a greater role in facilitating training placements to ensure the composition and location of the NSW Health workforce is consistent with the service planning pipeline.¹⁵⁹
- 16.148. Once developed, the strategy should incorporate regular and genuinely collaborative processes of monitoring and evaluating progress to ensure that the plan is delivering on its intended objectives and enables adjustment to be made where required. This is important for continuous improvement in service planning.¹⁶⁰

The importance of adequate funding

- 16.149. As has been highlighted by NSW Health, the important planning process I have outlined above will require dedicated funding, both at Ministry of Health level and within LHDs and SHNs. It is clear that the existing funding envelope available to NSW Health cannot also accommodate the costs associated with this planning exercise. Further funding will be required, together with the quarantining of that funding within the budgets of relevant NSW Health agencies for planning activities. If not quarantined, any further funding provided for that planning function may be consumed by the ever present need to address growing and unmet health needs within the communities they serve.

Transparency and accountability

- 16.150. As I have observed above, for the above planning process to be effective and insulate itself (to the greatest extent practicable) from political forces, it must be transparent. Those leading the planning process must also be accountable for delivering on its objectives.
- 16.151. There are no commercial sensitivities that realistically attach to the planning and delivery of what is ultimately the **public** health system. Members of the public are entitled to understand decisions that are made in relation to the rationing of the

¹⁵⁸ Transcript of the Commission, 15 August 2024, T4964.20-47 (Stapleton); Transcript of the Commission, 16 August 2024, T5048.33-35 (Clout).

¹⁵⁹ Transcript of the Commission, 14 October 2024, T5618.28-5620.14, T5650.25-5651.5, T5653.6-45 (Griffiths/Dominish).

¹⁶⁰ Exhibit H.2.51. NSW Health Corporate Governance and Accountability Compendium (May 2024) [6.3.1] [MOH.0010.0256.0001 at 0069-0070].

financial resources made available for the delivery of that system. They have a right to be informed of the extent to which the objectives pursued through those rationing decisions have been achieved. Without transparency and accountability of this kind, NSW Health will not enjoy the trust of the public, and political forces will continue to sway decision making in a manner that has the capacity to compromise its ability to best meet the health needs of the community with the finite resources available.

- 16.152. LHDs and SHNs should share with the communities they serve the outcome of the needs analysis which underpins service planning. This should be done in a clear and open way. Communities must understand what the LHD or SHN believes to be their specific health needs and the services required to meet those needs, for example, the proportion of the community suffering from diabetes and the clinics and other services – including primary and specialist care and allied health support – required to address that need.
- 16.153. By sharing this information in an open and digestible form, an opportunity is created for the community, or other care providers, to identify hidden need or reflect on the particular way in which care should be delivered to address that hidden need. This information is critically important from a planning perspective as it informs decision making around what services should be provided to that community, and how they are provided. This process will inevitably involve difficult decisions about how to prioritise the distribution of a limited budgetary envelope. Those decisions, and the rationale behind them, must be delivered to the community in a frank and transparent manner.
- 16.154. To that end, this process will frequently identify a far greater level of need than is able to be met by the health services available within the immediate community and its surrounds. As awkward and difficult as open discussions around this reality can be,¹⁶¹ it is critically important that they take place. The Ministry of Health, LHDs, and SHNs must ensure that community, clinicians, and other providers of care understand, and are meaningfully engaged in, the decision making processes about whether, and if so how, these health needs are going to be provided for within the public health system or elsewhere.
- 16.155. Importantly, the LHD or SHNs should identify the intended outcomes of the planning process in terms that enable it – and the community it serves – to objectively monitor the extent to which those outcomes are being achieved.

¹⁶¹ Transcript of the Commission, 26 February 2025, T7055.11-45 (Minns).

- 16.156. Publicly available planning documents should spell out (in clear language) the identified health needs of the community, the services that it is anticipated will be required to meet those health needs, and how (and by whom) it is intended that those services will be provided. These documents should also be explicit about what members of the community requiring those services should expect in terms of accessibility (including transportation arrangements, where necessary) and waiting times (the metrics around which will inevitably be informed by appropriate clinical evidence). For the avoidance of doubt, this form of information must extend well beyond what the community is to expect in terms of wait times for ambulance services, care delivered in Emergency Departments, or for elective surgery. It should include (but by no means be limited to) wait times for obtaining access to specialist outpatient care delivered through the public health system.
- 16.157. Finally, the extent to which these identified outcomes are being achieved must be measured and reported upon. Transparency of this type will inevitably result in the identification of areas where NSW Health is failing to deliver on the outcomes sought to be achieved through the planning process I describe above. However, transparency is essential to maintaining the trust of both clinicians and the community, and promoting further collaboration between all relevant stakeholders, in an attempt to address the highlighted challenges. Ultimately, a mature public health system should not be afraid to publicly confront its shortcomings.

Key performance indicators

- 16.158. Views will likely differ as to whether outcomes that are sought to be achieved through the planning process that I have described should inform the KPIs incorporated into the service agreements of the LHDs and SHNs.¹⁶² To the extent that they reflect important health objectives to be delivered through the funds provided under those agreements, they should be.
- 16.159. A review of the KPIs contained in the various service agreements in evidence before this Special Commission suggests that they are not currently doing this. KPIs are voluminous and largely *pro forma* across each of the service agreements, by which I mean the overwhelming number of those indicators being measured are neither bespoke to the particular circumstances of each LHD and SHN, nor linked to intended outcomes of any planning that has been undertaken (other than, perhaps, in the most general of ways).

¹⁶² An approach which has been embraced by Justice Health: see, for example, Transcript of the Commission, 19 November 2024, T6321.23-6323.4 (Hoey).

- 16.160. This Special Commission heard evidence that measuring outcomes in real time (other than adverse events) is challenging, but there is strong evidence that many process indicators correlate with program outcomes and benefits.¹⁶³ There is also a shift towards developing indicators that measure patient outcomes in areas such as mental health and renal supportive care.¹⁶⁴ It is also necessary to acknowledge that some of the KPIs that are used must be matched to the national indicators against which the State's performance will be measured.¹⁶⁵
- 16.161. I was told by LHD Board members that the current list of KPIs is long and mostly volume based, and while they find some of them useful for monitoring performance, they would like to see an evolution towards other indicators that reflect value based healthcare.¹⁶⁶ One Chief Executive observed that there are more than 100 KPIs in the service agreements, mostly measuring inputs and outputs, and in her view there should be a better combination of input, output, outcome, lead and lag indicators.¹⁶⁷ There can be tension between the efficiency improvement program and meeting the KPI targets.¹⁶⁸ Particular challenges were noted with some quality indicators in facilities that have very small patient volumes, as one incident will automatically exceed the performance threshold.¹⁶⁹
- 16.162. KPIs that target the outcomes sought to be achieved through proper service planning are likely to be more productive of allocative efficiency than many of the generic KPIs that are currently a feature of these documents. Whether or not they are reflected in KPIs, the progress towards these outcomes must be measured and shared – ideally through independent reporting by the BHI.
- 16.163. Whatever approach is ultimately taken, the current suite of KPIs in service agreements and statements of service should be reviewed with a view to reducing the total number and improving the balance between the five types of indicators – input, output, outcome, lead and lag indicators. They should also be adapted to more meaningfully assess the extent to which the LHD or SHN is achieving the outcomes of its service planning and fulfilling its core function – including to protect, promote and maintain the health of the population.

¹⁶³ Transcript of the Commission, 28 November 2023, T92.9-42 (Chant), T97.10-40 (Willcox/Lyons).

¹⁶⁴ Transcript of the Commission, 30 November 2023, T301.42-302.5 (Willcox).

¹⁶⁵ Transcript of the Commission, 16 April 2024, T1895.3-12, T1916.1-8 (Smith).

¹⁶⁶ See for example, Transcript of the Commission, 21 March 2024, T1544.38-1545.33 (Dixon/Kolbe).

¹⁶⁷ Transcript of the Commission, 18 September 2024, T5333.33-5335.9 (Maisey).

¹⁶⁸ Transcript of the Commission, 18 September 2024, T5365.31-5363.34 (Maisey); Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [128] [MOH.0011.0064.0001 at 0026].

¹⁶⁹ Transcript of the Commission, 23 May 2024, T3366.38-3367.4 (Astill).

Conclusion

- 16.164. As should now be clear, I consider that a system wide approach to service planning is critical to the future of the NSW public health system. It is through that process that a proper assessment of the resources that are needed – and where they are needed – to meet the health needs of the population can be made.
- 16.165. That assessment, in turn, provides the foundation for other important aspects of system planning – including workforce distribution and need (both in the medium and long term), and the levels of funding that will be required to sustain that system. In the context of a public system that will never have unlimited resources, that approach is key to ensuring the optimal distribution of the resources (human and financial) that the system has at its disposal.

Recommendation 21: NSW Health must implement a transparent, committed, and collaborative approach to system wide service planning that is coordinated and overseen by the Ministry of Health.

- 16.166. The local identification of health needs and the general perspective of LHDs and SHNs should remain a central feature of this process, but there is now a need for greater system wide planning, coordinated through the Ministry of Health, and a far greater level of engagement of community and other providers of health services at every stage in the planning process.
- 16.167. I have been told that in response to the great many reviews and inquiries into the public health system in NSW that the pendulum between centralised and devolved responsibility has consistently swung back and forth. In recommending that a system wide planning process be implemented, I am not suggesting that the significant benefits of devolution should be abandoned. Rather, the purpose of the system informed approach to planning that I recommend is to ensure that local knowledge is informed by a broader understanding of the system as a whole, which will in turn provide a strong platform for the deployment of available resources (human, financial or otherwise) in the most efficient and effective manner. With this in mind, it is critical that those tasked with implementation of any of the recommendations that I make in this Report are alive to the risks associated with allowing the pendulum to swing too far back towards central control in order to avoid repeating past mistakes.

Recommendation 22: That system wide service planning process must involve at least:

- a. a substantive and detailed identification of
 - i. the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of healthcare within the relevant place;
 - ii. those other entities, including other LHDs and providers outside of the NSW public health system, that are already (or are capable of) delivering services to meet the identified needs;
 - iii. any service gaps, or other areas of need within the community that are not currently being met by available services;
 - iv. which of those gaps the public health system *should* fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of healthcare within the relevant place;
- b. a system wide approach, coordinated within the Ministry of Health, to determining what services are to be provided through the NSW public health system to ensure that the identified health needs of the relevant population are met in an accessible but sustainable way, recognising that not all services can or should be provided everywhere;
- c. ongoing and genuine collaboration with the community and other providers of health services to:
 - i. determine how emerging service gaps, and areas of need, are to be addressed;
 - ii. identify all available funding streams, for example through collaborative commissioning models and the like;
 - iii. generate an evolving strategy which is forward looking and covers short, medium and long term planning horizons; and
 - iv. incorporate a genuinely collaborative and transparent processes of monitoring, to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.

Recommendation 23: Capital planning (i.e., planning for new facilities or significant upgrades to existing facilities) must be an integral part of that system wide service planning process and be aligned to its objectives. Decisions to construct new, or make significant upgrades to existing, facilities must reflect an assessment of the health needs of the population, and the most efficient and effective way of meeting them.

Recommendation 24: System wide, coordinated planning of that kind needs to be accompanied by a transparent articulation of the planning process, the health needs of the community identified through that process, the way in which those health needs are to be met and, to the extent that they are not, this also needs to be clearly articulated and an explanation provided of the rationale for this decision. It is essential that the extent to which those objectives are being achieved is reported upon in a frank and transparent way, supported by expanded reporting by the Bureau of Health Information.

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



Chapter 17:

Albury Wodonga Health

2016-2017 Financial Year

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Introduction

- 17.1. In November 2024, this Special Commission travelled to Albury to meet with executives and clinicians of Albury Wodonga Health, the cross border health service that is the subject of an intergovernmental agreement between the states of NSW and Victoria.
- 17.2. Albury Wodonga Health serves the cross border cities of Wodonga and Albury, and currently has a catchment population of approximately 300,000 people. It was established in 2011, and, as part of the Victorian health system, its relevance to this Special Commission is that it is jointly funded by both the Department of Health, Victoria (Victoria Health) and the Ministry of Health. The workforce is also distributed about evenly between the NSW Health workforce, and that of Victoria Health.
- 17.3. In addition to meeting with the management and clinicians of Albury Wodonga Health at the Albury Hospital, this Special Commission held meetings with the following:
 - a. Dr Amanda Cohn MLC, the NSW Greens spokesperson for Health (who also provided the Special Commission with a written submission);
 - b. Justin Clancy MP, the Member for Albury (who also provided a written submission);
 - c. Albury Wodonga Aboriginal Health Service;
 - d. the Border Medical Association and Better Border Health; and
 - e. the Murray Primary Health Network.
- 17.4. During these meetings, a number of issues common to other regional visits were discussed. These included:
 - a. underinvestment in preventable health;
 - b. a lack of adequate access to primary health services;
 - c. an increasing number of patients presenting to the Emergency Department of Albury Hospital;
 - d. inadequate public dental services;
 - e. under resourcing and underfunding of mental health services; and
 - f. a backlog of elderly patients admitted to public hospital wards who are ready for discharge to an aged care facility.
- 17.5. While these issues are important, and germane to other regional and rural locations visited, there was one matter unique to our Albury site visit, yet raised by everyone we spoke to there – the proposed redevelopment of the Albury Hospital.

Planning recommendation and infrastructure

- 17.6. The 2021 *Clinical Services Plan* for Albury Wodonga Health dated February 2021¹⁷⁰ records that:
- a. utilisation of medical and surgical bed stock is close to 100 per cent. This means that Albury Wodonga Health has near constant access block, cannot flow patients through the health service and is unable to admit all patients from the Emergency Department that need inpatient support;¹⁷¹
 - b. in the calendar year 2019, Albury and Wodonga Hospitals admitted 39,000 patients and had 71,312 Emergency Department presentations;¹⁷²
 - c. Albury Wodonga Health serves a larger population than its peer Victorian regional health services, except Barwon and Bendigo Health. Relative to other similar sized health services, Albury Wodonga Health maintains a high level of activity in presentations, despite current capacity constraints;¹⁷³
 - d. the catchment population of Albury Wodonga Health (including primary, regional and specialist catchments) is growing, but also ageing. Residents aged 65 and over are projected to account for 82 per cent of the increase across its catchment population¹⁷⁴
 - e. by 2040, Albury Wodonga Health will need to be able to support the following projected annual service demands across its catchments:¹⁷⁵
 - i. up to 150,000 emergency presentations;
 - ii. up to 80,000 total admissions;
 - iii. approximately 40,000 surgeries;
 - iv. 3,200 intensive care patients
 - v. 1,900 births
 - vi. 5,700 paediatric admissions;
 - f. this Services Plan sets out the necessary actions for Albury Wodonga Health to achieve its ambitions as one of Victoria's largest regional health services. A key theme of the major recommendations is the consolidation of acute and sub-acute services to a single site to ensure safety and efficiency;¹⁷⁶

¹⁷⁰ Which is the *Clinical Services Plan* on the Albury Wodonga Health website as at March 2025.

¹⁷¹ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 6 [SCI.0011.0854.0001 at 0006].

¹⁷² Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 7 [SCI.0011.0854.0001 at 0007].

¹⁷³ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 8 [SCI.0011.0854.0001 at 0008].

¹⁷⁴ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 9 [SCI.0011.0854.0001 at 0009].

¹⁷⁵ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 10 [SCI.0011.0854.0001 at 0010].

¹⁷⁶ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 11 [SCI.0011.0854.0001 at 0011].

- g. the total population of the three catchments (primary, regional and specialist) is set to increase by about 36,000 people to 315,000 by 2036. This includes around:¹⁷⁷
 - i. 118,000 in primary catchment (+26,000);
 - ii. 64,000 in the regional catchment (+2,000);
 - iii. 133,000 in the specialist catchment (+8,000);
 - h. factors suggest that current population projections for Albury Wodonga Health catchments (particularly the primary catchment) may be underestimations, particularly in relation to movements (migration) to the area;¹⁷⁸ and
 - i. there are higher rates of smoking, obesity, and diabetes in the Albury Wodonga Health catchment than state averages in Victoria or NSW.¹⁷⁹
- 17.7. Perhaps because of all these factors, participants in this Special Commission's meetings and roundtables expressed a desire for a hospital large enough to cater for future demands.
- 17.8. In October 2022, the then NSW Premier Dominic Perrottet, and the then Victorian Premier Daniel Andrews, announced funding for the redevelopment of the Albury Hospital. \$225 million was committed by both governments, in addition to \$108 million that was said to have been already invested by the NSW and Commonwealth governments. The proposed redevelopment was said to cover the "first three stages of a five-point master plan developed by Albury Wodonga Health".¹⁸⁰
- 17.9. Nobody who engaged with this Special Commission concerning this "brownfield" redevelopment of Albury Hospital expressed genuine enthusiasm about the project. The divergence of views shared with me can best be characterised as a debate between one camp that believes that an insufficient funding envelope for a partial redevelopment is better than nothing, and another camp that fears that accepting the insufficient funds now will result in an inadequate redevelopment and – in practical terms – remove the prospect of future adequate funding being made available. The discussion points and assertions made about the proposed redevelopment can be summarised as follows:
- a. the redevelopment does not sufficiently (or at all) take into account population growth or population health demographics;

¹⁷⁷ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 19 [SCI.0011.0854.0001 at 0019].

¹⁷⁸ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 20 [SCI.0011.0854.0001 at 0020].

¹⁷⁹ Exhibit O.65, *2021 Clinical Services Plan: Albury Wodonga Health* (February 2021) p 22 [SCI.0011.0854.0001 at 0022].

¹⁸⁰ Exhibit O.66, Rosa Ritchie and Anna Chisholm, 'Victoria and NSW Governments Commit to \$558m Redevelopment of Albury Base Hospital', *ABC News* (online, 27 October 2022) <<https://www.abc.net.au/news/2022-10-27/albury-base-hospital-wodonga-funding-victoria-nsw-government/101583566>> [SCI.0011.0853.0001 at 0002].

- b. the redevelopment will do little (if anything) to alleviate bed shortages (including intensive care unit beds) at Albury Hospital;
 - c. the proposed funding amount for the redevelopment is “arbitrary”, and not based on either the 2021 *Clinical Services Plan* or any proper (or any) analysis of the health needs, including future needs, of the catchment population;
 - d. if the redevelopment truly is just a part of a “staged development”, there is no guarantee of funding for those further stages;
 - e. to the suggestion that the 2021 *Clinical Services Plan* has not been “accepted” fully by NSW Health or the Victoria Health (or they have somehow developed their own clinical services plan), there has been an attempt to “reverse engineer” the funding announcement into something that looks like it was based on a services plan, but is not;
 - f. what is proposed will not alleviate the need to keep the Wodonga Hospital Emergency Department open beyond 2028, thus persisting with a “two site” facility that local clinicians feel is undesirable for a range of reasons;
 - g. Albury Hospital currently has a bed shortage (in November 2024) of 70 beds per day. Patients are being placed in overflow areas, which exposes them to clinical risk. The redevelopment will only just meet the current bed shortages, but not provide for future anticipated growth; and
 - h. individuals involved in a value management exercise associated with the redevelopment – a process aimed at determining how to generate the greatest value from a budgetary envelope that is insufficient to deliver the project as originally conceptualised – suggested to me that they have been required to retain a multimillion dollar carpark while removing more important clinical aspects of the original proposal, on the basis that one or other of the Premiers had referred to the enhancement of parking facilities when announcing the funding.
- 17.10. While these matters have not been fully tested, and it would therefore not be appropriate for me to make definitive findings about them, I am greatly concerned by the possibility that the proposed redevelopment of the Albury Hospital would proceed if it is true that, as now proposed, it has limited regard to any of the following:
- a. the 2021 Clinical Services Plan;
 - b. future growth projections for the population catchment; and
 - c. a careful, detailed analysis of what the current health care services needs are for the specific catchment population, in conjunction with a careful detailed analysis of the likely future healthcare needs for that population at least out to the time of the lifetime of the development (a 20 year period for NSW Health Infrastructure).

- 17.11. It is the final matter that concerns me most. It relates back to what has been said (and recommended) elsewhere in this Report concerning health service planning.
- 17.12. Without needing to make an express finding about this project, it is not optimal practice for any health infrastructure (let alone an investment of over half a billion dollars) to be conceived and designed around a particular sum of money that happens to be available. That, instead, is an optimal way of risking the wastage of precious public funds. The money said to be available (or made available) for health infrastructure cannot and should not drive service delivery. Rather, any infrastructure spend should be based on what the health service needs of the catchment population are and will be, which themselves will be based on a variety of factors such as (but not limited to) population growth, ageing profile, and various socioeconomic factors. I expect to some extent these were matters considered in the 2021 *Clinical Services Plan*.
- 17.13. There is not much I have seen that suggests that the proposed redevelopment of the Albury Hospital was based on this kind of analysis. Further, there is little to suggest that the proposed redevelopment of Albury Hospital has had meaningful regard to the views of the medical and other clinical workforce of Albury Wodonga Health, of management, or of the community. While those views are not determinative of any particular outcome, there must be meaningful engagement with them. In this instance, that appears to be either absent or, at best, insufficient.



Chapter 18:

The health workforce

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Introduction

- 18.1. The NSW public health system's most important asset is its workforce. Put simply, that system could not function without a high quality, engaged, and well supported workforce that is present in the places where it is needed to meet the healthcare needs of the population.¹⁸¹
- 18.2. It is not surprising that some of the most prominent themes that emerged in the evidence related to (directly or indirectly) workforce challenges. For example, during site visits and in public hearings, I heard much about workforce shortages in rural and regional areas generally, as well as shortages in particular clinical cohorts and practice disciplines. In some areas, this has necessitated the engagement of an expansive contingent workforce of locums and agency staff to fill rosters. Some of the workforce issues being experienced in NSW are not unique to it, and are also being felt in health systems in other parts of Australia and across the world.¹⁸²
- 18.3. The causes of the current workforce challenges facing NSW Health are multifaceted. Some reflect societal change – such as shifts in how and where people want to work – which will take time to address. Others are what might be described as system issues relating to how NSW Health plans, engages, and deploys its workforce.
- 18.4. A significant issue that emerged in the evidence was that most of the awards and other instruments setting the terms and conditions of employment or engagement for NSW Health workers do not reflect contemporary work practices.¹⁸³ Relatedly, there presently exists a disparity in the rate of pay between NSW and other Australian jurisdictions for some of the health workforce.¹⁸⁴ That disparity was also cited as being a factor in some of the difficulties experienced in recruiting and retaining a permanent workforce, particularly in some specialties and regions.¹⁸⁵
- 18.5. Although all members of the NSW Health Service are employed by the NSW Government in service of the Crown, and the employer functions in respect of them are vested in the Health Secretary, in practice, many of those employer functions are devolved to LHDs and other public health organisations. With some exceptions, the functions of service planning, establishing and funding positions, recruitment, and

¹⁸¹ Exhibit B.23.23, NSW Health, Future Health: Guiding the next decade of health care in NSW 2022-2032 (Report Summary, May 2022) [MOH.0001.0320.0001 at 0012]; Exhibit L.13.2, NSW Health, NSW Health Workforce Plan 2022-2032 (Report, 23 June 2022) [MOH.9999.3112.0001].

¹⁸² See, for example, Transcript of the Commission, 21 March 2024, T1648.43-1649.3 (Bruce); Transcript of the Commission, 22 March 2024, T1710.1-44 (Ludford); Transcript of the Commission, 23 May 2024, T3295.47-3297.3 (Wenham); Transcript of the Commission, 15 August 2024, T4979.8-4980.8 (Cawthorn); Transcript of the Commission, 23 July 2024, T3913.39-47 (Cross).

¹⁸³ Transcript of the Commission, 5 August 2024 T4648.3-25 (Collins).

¹⁸⁴ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 32-35 [MOH.0010.0377.0001 at 0032-0035].

¹⁸⁵ An example of the impact of that disparity can be seen in the widely reported industrial action taken by psychiatrists, which included many clinicians resigning or threatening to resign from staff specialist positions. That matter was before the Industrial Relations Commission when this Report was written. More generally, see also, Transcript of the Commission, T3295.47-3297.3 (Wenham); Exhibit K53B, Statement of Stewart Dowrick (12 September 2024) [42] [MOH.0011.0069.0001 at 0011-0012]; Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [147]-[151] [MOH.0011.0064.0001 at 0029-0030]; Transcript of the Commission, 18 September 2024, T5359.43-5360.5 (Maisey).

management of staff (including in relation to complaints and grievances) are all performed at the local level.

- 18.6. This means that despite the Ministry of Health having a substantial “warehouse” of data showing trends and distributions of workers across the system with reasonable granularity,¹⁸⁶ complemented by service utilisation and demand data, it is largely up to local decision makers to determine how, if at all, that data is deployed within their zone of operations. Those decisions are not usefully guided by the various strategic documents and KPIs developed at the Ministry of Health level, which are too high level (and, in the case of the KPIs, frequently irrelevant) to shape local behaviour in a practical way.
- 18.7. These observations are not to deny or diminish the importance of local input into workforce planning, or the parties’ input into terms and conditions of workers’ employment or engagement. There is an obvious need for those matters to be informed by the knowledge and experience of those closest to the ground, who deal with the consequences of decisions about service delivery and working conditions daily. Equally, however, given the nature of the challenges and issues facing the system, the time has come for the Ministry of Health to take a more central role in that process. Greater coordination at a system level will support the most effective deployment of the workforce to meet the needs of the NSW population, having regard to the resources (financial and human) at the disposal of the system.
- 18.8. A further difficulty arises in that, within the NSW industrial relations framework, awards have historically been made and varied at the initiative of the parties (i.e., employers and employee organisations), commonly by consent. At least in recent times, the Industrial Relations Commission has had little involvement in setting the terms and conditions provided by awards outside of arbitrated disputes, which have usually involved narrow issues and not provided an occasion for broader award review. However, because it is almost inevitably overlaid with disputes about money, and tends naturally to become focussed on a small number of key issues that reflect prevailing industrial concerns, the fact that there was (save for limited instances) widespread agreement that the awards are out of date suggests that industrial bargaining has not been conducive to the reform needed to modernise awards and industrial instruments to reflect modern working practices.
- 18.9. Finally, training pathways – which fill and direct the health workforce pipeline – are poorly coordinated and have been left largely under the control of a wide range of different organisations, which are often unaware of particular workforce needs (in terms of both volume and distribution). Such organisations (including, universities and specialist medical colleges) also have a very limited ability to harness or direct the resources needed to ensure reliable training pathways, with the consequence that

¹⁸⁶ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [MOH.0011.0022.0001]; Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [MOH.0010.0377.0001].

training opportunities are concentrated in areas where these resources are plentiful and easy to corral, making them very metrocentric. This has significant influence on the ultimate distribution of the workforce generated by these pathways and thereby contributes to maldistribution.

- 18.10. In examining those challenges, it should not be overlooked that the health workforce in NSW is comprised of dedicated and highly skilled people, who every day work to provide high quality care to the people of NSW. There is, though, a need now to take steps to ensure that the public health system will have the benefit of such a workforce long into the future.

The NSW Health workforce

- 18.11. As of June 2024, the NSW Health workforce comprised over 165,000 employees by headcount, comprising approximately 140,000 FTE.¹⁸⁷ The composition of that workforce is set out in figure 1.

Number of full time equivalent staff employed in the NSW public health system

	June 2024
Medical	15,824.3
Nursing	56,549.3
Allied health	13,372.2
Other professions and paraprofessionals	3,328.1
Scientific and technical clinical support	6,591.0
Oral health practitioners and therapists	1,377.7
Ambulance officers	6,389.6
Sub-total clinical staff	103,432.1
Corporate services	6,708.1
Clinical support	22,060.7
Hotel services	9,202.0
Maintenance and trades	854.3
Other	504.1
Other staff	39,329.1
Total	142,761

Figure 1: Number of FTE staff employed in the NSW Public Health system, as of June 2024¹⁸⁸

¹⁸⁷ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [6] [MOH.0011.0022.0001 at 0003].

¹⁸⁸ Exhibit N3.27, NSW Health Annual Report 2023-24 (October 2024) [SCI.0011.0717.0001 at 0079].

- 18.12. The NSW Health workforce constitutes over one third of the entire NSW public sector workforce,¹⁸⁹ and annual workforce related costs account for approximately 61 per cent of NSW Health's overall annual expenditure.¹⁹⁰
- 18.13. Clinical staff account for more than two thirds of the total NSW Health workforce, and fall into four categories:
- a. medical – constituting approximately 11 per cent of the total NSW Health workforce by FTE;
 - b. nursing and midwifery – constituting approximately 40 per cent of the total by FTE;
 - c. allied health – constituting approximately 10 per cent of the total by FTE; and
 - d. other clinical, including professional and paraprofessional support staff, scientific and technical clinical support staff, oral health practitioners, support workers and ambulance staff – constituting approximately 13 per cent of the total by FTE.¹⁹¹
- 18.14. The medical workforce is made up of:
- a. Junior Medical Officers, comprising:
 - i. prevocational trainees, being medical officers (doctors) who have not obtained a position in an accredited vocational training program for a medical specialty, generally in their first year (referred to as “intern” or “PGY1”) and second year (referred to as “resident” or “PGY2”); and
 - ii. registrars, being medical officers who are training in an accredited vocational training program or have had at least three years' public hospital experience (the latter, if they are not training in an accredited program, are sometimes referred to as “unaccredited registrars”);
 - b. Career Medical Officers, being non-specialist doctors who are not appointed in or occupying Junior Medical Officer positions; and
 - c. specialists, being doctors who have completed an accredited vocational training program and obtained fellowship of the relevant specialist medical college. Specialists may be employed, in which case they are referred to as staff specialists, or engaged as Visiting Medical Officers.
- 18.15. In 2024, approximately 78.6 per cent of the NSW Health workforce was employed on a permanent basis.¹⁹² However, a substantial proportion of the medical workforce

¹⁸⁹ When measured by FTE positions.

¹⁹⁰ Exhibit N3.27 NSW Health Annual Report 2023-24, October 2024 [SCI.0011.0717.0001 at 0160]. Calculated as employee related expenses (\$18,901,233,000) as a percentage of total expenses excluding loss (\$31,206,107,000) (60.57 per cent). See also Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [61] [MOH.0011.0025.0001 at 0010].

¹⁹¹ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 6 [MOH.0010.0377.0001 at 0006].

¹⁹² Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 12] p 26 [MOH.0010.0377.0001 at 0026].

was engaged as Visiting Medical Officers or locums, as opposed to permanent employees.¹⁹³

Treasury Group	Permanent	Temporary	Casual/Agency
Medical	26.0%	69.9%	4.2%
Nursing	84.8%	7.5%	7.7%
Allied Health	82.1%	16.2%	1.6%
Other Prof. & Paraprofessionals & Support Staff	80.6%	8.4%	13.4%
Scientific & Technical Clinical Support Staff	87.7%	9.2%	3.1%
Oral Health Practitioners & Support Workers	86.7%	12.5%	0.8%
Ambulance Staff	99.3%	0.4%	0.3%
Corporate Services & Hospital Support	84.6%	12.6%	2.8%
Hotel Services	85.1%	4.6%	10.3%
Maintenance & Trades	98.1%	1.5%	0.4%
Other Staff	54.0%	40.5%	5.5%
Total	78.6%	15.9%	5.5%

Source: Corporate Analytics Data Warehouse extracts

Figure 2: Employment composition of the health workforce by profession in June 2024¹⁹⁴

- 18.16. In recent times, considerable attention has been drawn to the use of medical locums within the NSW public health system. In 2023–2024, medical locums represented approximately 4 per cent of the overall medical workforce (668.7 FTE), at a total cost of approximately \$270 million.¹⁹⁵ However, there was a substantial disparity between locum usage in metropolitan areas, where medical locums comprised 1.35 per cent of the medical workforce, and in rural and regional areas, where locums constituted 9.26 per cent of the medical workforce.¹⁹⁶ There is also a wide variance in the use of medical locums between LHDs.¹⁹⁷

¹⁹³ Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [110] [MOH.0011.0025.0001 at 0018].

¹⁹⁴ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 12] p 26 [MOH.0010.0377.0001 at 0026].

¹⁹⁵ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 25 [MOH.0010.0377.0001 at 0025].

¹⁹⁶ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 24 [MOH.0010.0377.0001 at 0024].

¹⁹⁷ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 10] p 25 [MOH.0010.0377.0001 at 0025].

- 18.17. Similarly, the use of agency nurses and midwives has also been the subject of attention. Agency use peaked in June 2021, during the COVID-19 pandemic, at a total expense of \$63.1 million. By 2023, this had reduced to an average of 481.6 FTE of agency nurses engaged across NSW Health. The use of agency nurses has predominantly been in rural and regional LHDs, with the exception of Sydney LHD. Figure 3 below shows the change in expenditure on agency nursing per year for each LHD and SHN.¹⁹⁸

LHD	2021	2022	2023
SLHD	19,627,192	13,670,207	8,372,602
MLHD	10,902,536	9,422,349	7,214,043
HNELHD	7,132,966	5,504,229	5,578,456
NSLHD	4,927,949	3,770,381	4,827,396
SNSWLHD	5,402,530	4,655,036	4,644,262
WSLHD	3,875,325	4,556,115	4,585,053
MNCLHD	1,373,628	3,106,891	4,566,733
FWLHD	1,508,486	1,638,809	4,254,801
WNSWLHD	2,718,186	3,437,529	3,603,452
NNSWLHD	910,969	2,856,466	2,076,364
SESLHD	1,524,469	1,128,145	1,608,112
JHFMHN	-	636,863	1,385,706
NBMLHD	1,158,455	695,975	1,002,687
SWSLHD	1,498,623	1,646,074	897,810
ISLHD	39,312	607,205	565,951
CCLHD	-	44,787	353,105
SCHN	556,914	496,731	316,730
Total	63,157,540	57,873,792	55,853,263

Source: Corporate Analytics Data Warehouse extracts

Note: Expense includes salaries only.

Figure 3: Agency nursing expense by LHD and SHN from June 2021 to June 2023

- 18.18. NSW Health recognises 23 allied health professional groups, which cover diverse fields including art therapy and music therapy, audiology, counselling, exercise physiology, genetic counselling, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, psychology, radiation therapy, speech pathology and social work.¹⁹⁹

¹⁹⁸ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 10] p 20 [MOH.0010.0377.0001 at 0020].

¹⁹⁹ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [112c] [MOH.0011.0022.0001 at 0035]; A full list of the 23 recognised allied health professional groups is in Exhibit H.2.28, NSW Health, *Allied Health Workforce Macro Trends Report* (Report, May 2022) p 8 [MOH.0003.0234.0001 at 0010].

Trends in the NSW Health workforce: 2019–2024

18.19. Between 2019 and 2024, the overall NSW Health workforce grew at a relatively consistent rate.²⁰⁰

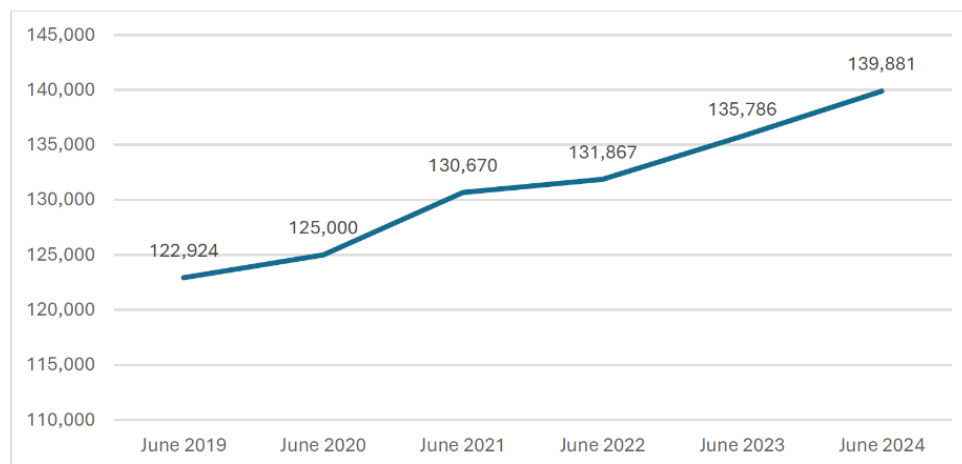


Figure 4: Growth in the NSW Health workforce by FTE 2019–2024

18.20. Rural and regional LHDs recorded higher growth than metropolitan districts in that period, but the overall distribution of the workforce has remained broadly the same.²⁰¹

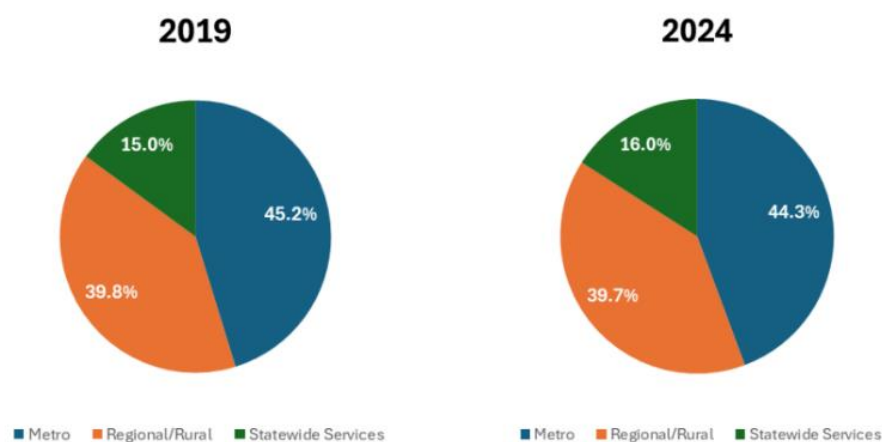


Figure 5: Distribution of the health workforce in 2019 and 2024²⁰²

²⁰⁰ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Figure 2] p 7 [MOH.0010.0377.0001 at 0007].

²⁰¹ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 7 [MOH.0010.0377.0001 at 0007].

²⁰² Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Figure 3] p 9 [MOH.0010.0377.0001 at 0009].

- 18.21. Between 2018–2019 and 2023–2024, the medical workforce grew by approximately 2,000 FTE, and the number of Visiting Medical Officers engaged (by headcount) grew by 590.²⁰³ Across that period, the proportional expenditure between permanent staff and Visiting Medical Officers remained largely consistent.

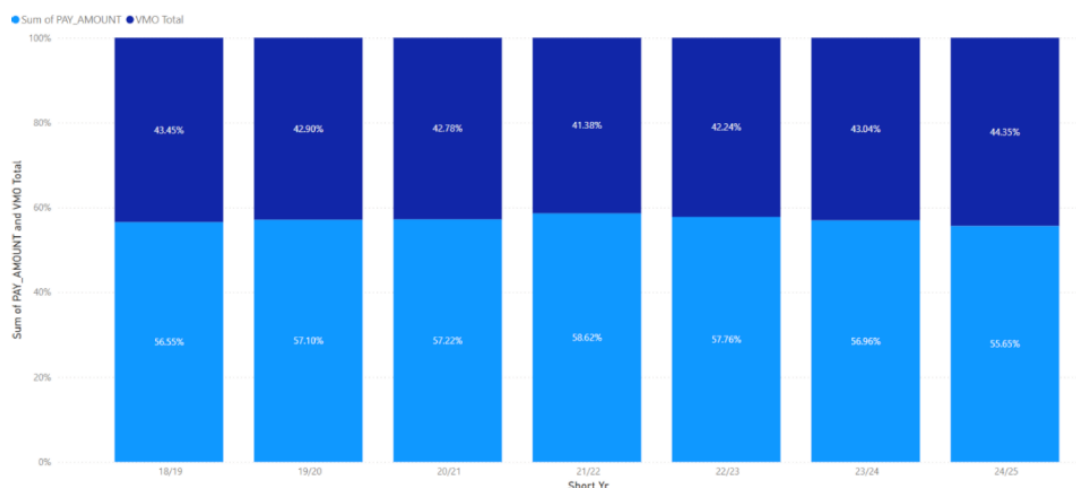


Figure 6: Proportion of spend on Visiting Medical Officers and staff specialists 2018–19 to 2024–25²⁰⁴

- 18.22. Over that same period, the use of medical locums increased significantly, particularly in rural and regional areas, where their use rose by approximately 50 per cent.²⁰⁵ However, once again there were variances between the rate of locum usage in rural and regional LHDs and metropolitan LHDs, with some regional LHDs being heavily reliant on a medical locum workforce.

²⁰³ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 3], [Figure 14] pp 10, 28 [MOH.0010.0377.0001 at 0010, 0028].

²⁰⁴ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 21 [MOH.0010.0377.0001 at 0021].

²⁰⁵ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 24–25 [MOH.0010.0377.0001 at 0024–0025]; Transcript of the Commission, 6 August 2024 T4769.4–20 (Griffiths).

Financial Year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
SCHN	0.00%	0.00%	0.00%	0.18%	0.00%	0.00%
SLHD	0.02%	0.07%	0.18%	0.32%	1.10%	0.61%
SESLHD	0.49%	0.55%	0.56%	0.63%	0.76%	0.83%
NSLHD	0.36%	0.33%	0.44%	0.39%	0.79%	1.11%
WSLHD	0.43%	1.10%	1.81%	2.45%	2.69%	2.68%
SWSLHD	1.62%	1.86%	2.05%	2.23%	2.01%	2.10%
Metropolitan total	0.54%	0.73%	0.94%	1.14%	1.36%	1.35%
MNDLHD	13.26%	11.43%	9.88%	8.35%	12.06%	11.43%
FWLHD	27.43%	27.89%	27.51%	29.83%	34.94%	41.49%
MLHD	17.57%	17.81%	15.51%	13.14%	16.98%	16.44%
CCLHD	1.64%	1.75%	0.96%	1.13%	2.29%	3.81%
ISLHD	7.03%	5.21%	4.02%	3.46%	4.21%	4.54%
NBMLHD	1.04%	0.89%	1.22%	1.66%	2.17%	2.48%
WNSWLHD	13.76%	12.02%	13.10%	12.55%	15.03%	18.46%
HNELHD	3.02%	3.24%	3.04%	3.13%	4.08%	4.96%
SNSWLHD	60.10%	58.30%	61.91%	65.73%	63.57%	67.66%
NNSWLHD	14.39%	15.77%	14.20%	12.86%	16.56%	17.76%
Rural/Regional total	7.63%	7.21%	6.75%	6.63%	8.33%	9.26%
NSWHP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NSWA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
eHealth NSW	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
JHFMHN	2.59%	0.15%	0.15%	1.10%	1.88%	3.38%
HealthShare NSW	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Statewide Services total	0.38%	0.02%	0.02%	0.17%	0.29%	0.52%
Overall	3.14%	3.08%	3.05%	3.15%	3.93%	4.31%

Figure 7: Medical locums as a proportion of the medical workforce by LHD/Statewide Service 2018–19 to 2023–24²⁰⁶

- 18.23. Consistent with the increase in the use of medical locums in that period, medical locum expenditure rose from approximately \$132 million in 2018–19 to approximately \$270 million in 2023–24. Although those amounts are significant, and the increase over that period saw total locum expenditure more than double, NSW Health's expenditure on medical locums represented approximately 1.5 per cent of its total payroll cost in 2023–24.²⁰⁷
- 18.24. In 2023–24, \$18,901,233,000 was spent by NSW Health on employee related expenses,²⁰⁸ and \$240,440,710 was spent on locum medical staff.²⁰⁹
- 18.25. The use of agency nurses peaked in 2021 at 591.8 FTE, declining to 481.6 FTE in 2023. Once again, the use of agency nurses and associated expenditure varies across the State although, somewhat counterintuitively given the nature of workforce challenges across NSW, the highest user of agency staff has been the Sydney LHD.

²⁰⁶ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 10] p 25 [MOH.0010.0377.0001 at 0025].

²⁰⁷ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 25 [MOH.0010.0377.0001 at 0025]; Transcript of the Commission, 6 August 2024, T4768.14-4769.20 (Griffiths).

²⁰⁸ Exhibit N3.27, NSW Health Annual Report 2023-24 (October 2024) p 152 [SCI.0011.0717.0001 at 0160]. See also Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [61] [MOH.0011.0025.0001 at 0010].

²⁰⁹ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 25 [MOH.0010.0377.0001 at 0025].

Reflective of the decrease in use of agency staff across that period, total expenditure fell from approximately \$63 million in 2021 to \$55 million in 2023.²¹⁰

- 18.26. The use of “premium labour” (i.e., agency staff) in allied health professions has been far more limited compared with nursing and midwifery, and medicine.²¹¹
- 18.27. NSW Health has enjoyed relatively stable retention rates across its workforce groups, together with low attrition and turnover rates, and compares well on those measures against the rest of the public sector.²¹²

Treasury Group	June 19	June 20	June 21	June 22	June 23	June 24
Allied Health	93.6%	94.9%	93.5%	91.9%	92.0%	92.7%
Ambulance Staff	96.9%	97.3%	95.1%	94.4%	95.1%	93.2%
Corporate Services & Hospital Support	93.0%	94.3%	93.3%	90.1%	90.5%	92.1%
Hotel Services	92.0%	93.6%	92.4%	89.1%	89.2%	90.5%
Maintenance & Trades	92.4%	95.0%	92.6%	89.0%	88.9%	89.0%
Medical	95.1%	96.3%	94.8%	95.4%	94.9%	94.4%
Nursing	93.7%	95.3%	94.0%	92.2%	92.6%	93.6%
Oral Health Practitioners & Support Workers	95.3%	94.7%	92.5%	91.6%	90.4%	93.2%
Other Professional & Paraprofessionals & Support Staff	92.9%	93.3%	92.1%	89.7%	90.4%	90.3%
Other Staff	92.2%	95.0%	91.4%	86.1%	90.8%	89.8%
Scientific & Technical Clinical Support Staff	93.4%	94.4%	93.8%	91.5%	91.2%	92.3%
NSW Health total	93.5%	94.9%	93.6%	91.6%	91.9%	92.8%

Source: Corporate Analytics Data Warehouse extracts

Figure 8: NSW permanent retention rates by Treasury Group – June 2019 to June 2024²¹³

The nature and extent of workforce shortages and maldistribution

- 18.28. A consistent theme that emerged in the evidence related to workforce shortages and maldistribution across some specialities and disciplines. In some respects, those issues are interrelated, and the challenges that arise because of them have a similar consequence. Jacqui Cross, Chief Nursing and Midwifery Officer, NSW Health, gave evidence that “there is a maldistribution” of graduate nurses which creates the challenge of attracting graduates to positions in rural and regional areas.²¹⁴ I was similarly told of challenges to recruiting and retaining allied health professionals to roles within the public health system, particularly in regional, rural and remote areas.

²¹⁰ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 8] p 20 [MOH.0010.0377.0001 at 0020].

²¹¹ Transcript of the Commission, 14 October 2024, T5640.20-25 (Dominish).

²¹² Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 30-31 [MOH.0010.0377.0001 at 0030-0031]; Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [28] [MOH.0011.0022.0001 at 0010]; Transcript of the Commission, 6 August 2024, T4772.8-4773.26 (Griffiths).

²¹³ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Table 15] p 30 [MOH.0010.0377.0001 at 0030].

²¹⁴ Transcript of the Commission, 23 July 2024, T3919.27-31 (Cross).

The medical workforce

- 18.29. Although there has been growth in the size of the medical workforce, it has nevertheless suffered from shortages in some areas (including the workforce pipeline) as well as significant maldistribution.
- 18.30. In 2024, approximately 8 per cent of intern positions (94.5 out of 1,153.5) were unfilled after candidates were allocated across all recruitment pathways.²¹⁵ Sixty-six of those unfilled positions were in rural or regional NSW.²¹⁶ As at June 2024, there were 168 PGY1 and PGY2 vacancies, again disproportionately seen in rural and regional locations.²¹⁷ Concurrently with those shortfalls, Ministry of Health modelling projects a need for an additional 165 to 212 medical graduates per annum above current levels.²¹⁸
- 18.31. Challenges in relation to the registrar or vocational training workforce have largely been assessed by the Ministry of Health in two ways. The first involves comparing the number of applicants with the number of available training positions for a given specialist training program. That analysis indicates there are overall shortages of applicants in some specialties – such as psychiatry and emergency medicine training.²¹⁹ The second involves modelling the number of trainees required to meet projected demand for specialists in the relevant specialty.²²⁰ That modelling was last undertaken in 2021.²²¹ The results of that modelling (albeit expressed in a relatively high level form)²²² indicate “significant” career opportunities in psychiatry, diagnostic radiology, ophthalmology, rehabilitation medicine, as well as neurosurgery.²²³ Those “significant career opportunities” correspond with a relatively high number of additional trainees needed each year to meet projected demand.
- 18.32. A shortfall in applications for internship positions or for vocational training positions – at least in relation to some specialties – is likely to impact the future workforce. It is from those pathways that the future medical workforce (including specialists) develops, and extensive or prolonged shortage in those pipelines has the very real potential to lead to future shortages in that workforce.

²¹⁵ Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [79], [83] [MOH.0011.0020.0001 at 0016].

²¹⁶ Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [83] [MOH.0011.0020.0001 at 0016].

²¹⁷ Exhibit L.2, Statement of Justine Harris (2 October 2024) [8] [MOH.0011.0077.0001 at 0002].

²¹⁸ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].

²¹⁹ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].

²²⁰ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [47] [MOH.0011.0022.0001 at 0015].

²²¹ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [46] [MOH.0011.0022.0001 at 0015]. However, the data set appears to be from 2019, at least in some instances: See, for example, Exhibit H.1.115, NSW Health, *Psychiatry Workforce modelling factsheet* [SCI.0011.0273.0001].

²²² NSW Health ‘Medical Workforce Modelling’, NSW Health (Web Page, 5 July 2023) <<https://www.health.nsw.gov.au/workforce/modelling/Pages/medical-modelling.aspx>> (accessed 10 December 2024).

²²³ NSW Health ‘Medical Workforce Modelling’, NSW Health (Web Page, 5 July 2023) <<https://www.health.nsw.gov.au/workforce/modelling/Pages/medical-modelling.aspx>> (accessed 10 December 2024).

- 18.33. There have also been shortages of specialists to fill existing positions in several specialities, including psychiatry, emergency medicine, radiology, and anaesthesia, as well as general practice.²²⁴
- 18.34. Many, but not all, of those shortages are seen in rural and regional NSW.²²⁵ The underlying causes of workforce shortages in rural and regional NSW are multifactorial but include:
- a. a perception (which may be mistaken) within the medical profession that work in rural and regional areas is less interesting and professionally satisfying while being more onerous (including in relation to on call obligations);²²⁶
 - b. at least a perception of a lack of professional and social support in rural and regional areas, especially for those clinicians who trained in metropolitan areas;²²⁷
 - c. insufficient financial incentives for metropolitan based clinicians to relocate to rural or regional areas;²²⁸ and
 - d. limited employment opportunities for spouses and partners of clinicians, a lack of suitable accommodation, childcare and other services in rural and regional areas.²²⁹

Nurses and midwives

- 18.35. There are significant shortages of midwives and enrolled nurses across the State, and (as with the medical workforce) a maldistribution of the nursing and midwifery workforce between metropolitan and rural and regional areas.²³⁰

²²⁴ Exhibit L.2, Statement of Justine Harris (2 October 2024) [10] [MOH.0011.0077.0001 at 0002]. A common theme in relation to psychiatry, radiology and anaesthesia is that the public sector experiences significant competition from the private sector, which pays substantially more: See, for example, Transcript of the Commission, 18 September 2024, T5320.8-13 (Wong); Transcript of the Commission, 7 August 2024, T4796.39-44 (Minns).

²²⁵ See, for example, Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [11] [SCI.0011.0249.0001 at 0002]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [6], [27] [MOH.0011.0031.0001 at 0003, 0008]; Exhibit H.7.8, Statement of Dr Michelle McRae (17 July 2024) [9] [SCI.0011.0257.0001 at 0002]; See also Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [18] [MOH.0011.0024.0001 at 0005] (referring to shortages in 14 of 64 medical specialties in regional areas).

²²⁶ See, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [20] [MOH.0011.0019.0001 at 0005]; Exhibit L.2, Statement of Justine Harris (2 October 2024) [11(b)-(c)] [MOH.0011.0077.0001 at 0003]; Exhibit L.9, Statement of Dr Natalie Rainger (28 July 2024) [18] [SCI.0011.0286.0001 at 0003].

²²⁷ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [17] [MOH.0011.0024.0001 at 0004-0005]; Exhibit L.2, Statement of Justine Harris (2 October 2024) [11(d)] [MOH.0011.0077.0001 at 0003]; Exhibit L.3, Statement of Luke Sloane (3 October 2024) [7] [MOH.0011.0079.0001 at 0002].

²²⁸ See, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [22] [MOH.0011.0019.0001 at 0006].

²²⁹ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [17] [MOH.0011.0024.0001 at 0004-0005]; Exhibit H.7.8, Statement of Dr Michelle McRae (17 July 2024) [25] [SCI.0011.0257.0001 at 0004]; Exhibit L.16, Statement of Andrew Holland (1 October 2024) [28] [SCI.0011.0469.0001 at 0005].

²³⁰ Transcript of the Commission, 14 October 2024, T5569.22-5570.1, T5572.20-26 (Griffiths/Dominish); Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [43]-[44] [MOH.0011.0007.0001 at 0008]; Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [48] [MOH.0011.0022.0001 at 0015]; Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [5]-[11] [MOH.0011.0056.0001 at 0001-0003]; Exhibit H.5.28, Statement of Jonathan Morris [8] [MOH.0011.0028.0001 at 0002]; Exhibit K.40, Statement of Tracey McCosker PSM (13 September 2024) [81]-[86] [MOH.0011.0062.0001 at 0021-0022]; Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [157] [MOH.0011.0064.0001 at 0032-0033]; Exhibit I.30, Statement of Margaret Bennett (6 August 2024) [102] [MOH.0011.0041.0001 at 0022]; Transcript of the Commission, 14 October 2024 T5596.20-43 (Griffiths); Exhibit H.5.26, Statement of Hayley Scuriaga (18 July 2024) [22] [MOH.0011.0027.0001 at 0005].

- 18.36. The shortages in the nursing and midwifery workforce in some rural and regional LHDs correlate with difficulties in attracting students for clinical placements and applicants for graduate positions,²³¹ notwithstanding the range of incentives, scholarships, and cadetship programs aimed at increasing the attractiveness of rural and regional work.²³² Those shortages are also reflected with a greater use of agency nurses in those areas.²³³
- 18.37. There was some contest in the evidence as to whether there are general shortages (as opposed to maldistribution) among registered nurses. The Ministry of Health suggests that there is a sufficient supply of graduate registered nurses to meet demand, although they are maldistributed across the system.²³⁴ However, the NSW Nurses and Midwives Association (NSWNMA) has received feedback from its members of a generalised experience of shortages even among registered nurses. That feedback is based in part on observations of vacancies in nursing positions.²³⁵
- 18.38. The divergence in views on that issue serves to highlight the limited use that is presently made of vacancy data. It is not presently a data set that is systematically monitored by the Ministry of Health, and currently sits only at the LHD level.²³⁶ There is force in the observation that there are some limitations in using vacancy data as a measure of staffing levels within NSW Health, as the fact that there is a vacancy does not mean that the position is unfilled or that there are staff shortages as a consequence of it. In many instances, those vacant positions will be filled using agency staff or overtime.²³⁷
- 18.39. However, in my view, there is nevertheless value in data that analyses “aged vacancies” – i.e., vacancies in respect of permanent positions that have been advertised but unfilled for some time. Data of that kind is likely to assist in identifying and quantifying the extent (and duration) of a shortage within the permanent workforce at a facility or across a region. The Ministry of Health should take steps to capture and consider data of that kind as part of an enhanced system level planning process into the future.

²³¹ Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [14] [MOH.0011.0056.0001 at 0003-0004]; Exhibit H5.16, Statement of Jacqueline Blackshaw (11 July 2024) [9]-[17] [MOH.0011.0016.0001 at 0003-0005].

²³² Exhibit H5.21, Statement of Richard Griffiths (16 July 2024) [34] [MOH.0011.0022.0001 at 0012]; Exhibit H5.10, Statement of Jacqui Cross (8 July 2024) [46] [MOH.0011.0007.0001 at 0009].

²³³ Although there are some limitations in the data in this respect, as it is presented as raw figures rather than, for example, agency nursing FTE or expenditure relative to FTE of or expenditure on employed nurses: Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 20-21 [MOH.0010.0377.0001 at 0020-0021].

²³⁴ Transcript of the Commission, 23 July 2024, T3919.27-31 (Cross).

²³⁵ Transcript of the Commission, 14 October 2024, T5570.42-5571.6 (Whaites).

²³⁶ Exhibit H.5.21.2, Supplementary Statement of Richard Griffiths (2 August 2024) [4]-[11] [MOH.0011.0039.0001 at 0001-0003].

²³⁷ Exhibit H.5.21.2, Supplementary Statement of Richard Griffiths (2 August 2024) [4]-[11] [MOH.0011.0039.0001 at 0001-0003]; Transcript of the Commission, 6 August 2024, T4786.46-4788.28 (Griffiths); Transcript of the Commission, 7 August 2024 T4818.21-4819.21 (Minns).

Allied health

- 18.40. The Ministry of Health conducted workforce modelling for 22 allied health disciplines in 2021.²³⁸ That modelling indicated that some allied health disciplines were experiencing significant shortages compared with service demand, including, for example, radiation therapy, sonography, pharmacy, psychology, podiatry and occupational therapy.²³⁹ Maldistribution of the allied health workforce is also a significant issue in most disciplines.²⁴⁰
- 18.41. The reasons for those shortfalls and workforce maldistribution in the allied health workforce are, again, complex but include:
- a. competition from the private sector and NDIS providers, which typically pay more and offer more flexibility;²⁴¹
 - b. at least a perception of reduced career development or progression opportunities, particularly in rural and regional areas;²⁴² and
 - c. insufficient supervisors to supervise complete clinical placements for those under training.²⁴³

Recruitment and retention initiatives

- 18.42. There have been several initiatives implemented to address the various workforce challenges across the system. They were conveniently summarised by Mr Griffiths in his statement of 16 July 2024, which I gratefully adopt. Those incentives include:
- a. The Rural Health Workforce Incentive Scheme, which enables participating NSW Health organisations to offer incentives and benefits above award entitlements to attract, recruit, and retain health workers in positions with hard-to-fill and critical vacancies at regional, rural, and remote locations.
 - b. Tertiary Health Study Subsidies, which are targeted to university students by supporting new entrants to health careers. They are available across fifteen workforce groups, and provide those students with a financial subsidy in return for

²³⁸ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [46] [MOH.0011.0022.0001 at 0015]; NSW Health 'Medical Workforce Modelling', NSW Health (Web Page, 5 July 2023) <<https://www.health.nsw.gov.au/workforce/modelling/Pages/allied-health.aspx>> (accessed 10 December 2024).

²³⁹ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [49] [MOH.0011.0022.0001 at 0016]; Transcript of the Commission, 14 October 2024, T5636.25-31 (Griffiths); Transcript of the Commission, 14 October 2024, T5642.15-18 (Dominish); Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [7]-[8] [SCI.0011.0155.0001 at 0002]; Exhibit H.7.5, Statement of Professor Lil Vrklevski (16 July 2024) [21]-[22] [SCI.0011.0198.0001 at 0005]; Exhibit L.13, Statement of Jerry Yik and Dr Jonathan Penm (26 September 2024) p 17 [SCI.0011.0459.0001 at 0017].

²⁴⁰ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [18] [MOH.0011.0024.0001 at 0004-0005]; Exhibit H.5.16, Statement of Jacqueline Blackshaw (11 July 2024) [21] [MOH.0011.0016.0001 at 0006]; Exhibit H.5.17, Statement of Emma-Kate Dewhurst (10 July 2024) [11] [MOH.0011.0018.0001 at 0003]; Transcript of the Commission, 23 July 2024, T3933.10-12 (Dewhurst).

²⁴¹ Exhibit H.5.17, Statement of Emma-Kate Dewhurst (10 July 2024) [36] [MOH.0011.0018.0001 at 0008-0009]; Transcript of the Commission, 23 July 2024 T3935.25-3936.31 (Dewhurst/Griffiths).

²⁴² Exhibit H.5.16, Statement of Jacqueline Blackshaw (11 July 2024) [21] [MOH.0011.0016.0001 at 0006].

²⁴³ Transcript of the Commission, 14 October 2024, T5636.46 – 5637.2 (Griffiths); Transcript of the Commission, 14 October 2024, T5649.39-46 (Newton-John).

- a commitment to work for NSW Health for a nominated period on completion of their studies.
- c. Rural Undergraduate Scholarships, that provide financial support to undergraduate nursing and midwifery students living in rural NSW
 - d. Nursing and Midwifery Undergraduate Clinical Placement Grants, that provide financial support to nursing and midwifery students attending clinical placements in a NSW public health facility over 150km from the student's university.
 - e. NSW Health Aboriginal Nursing and Midwifery Undergraduate Scholarships for Aboriginal and/or Torres Strait Islander students undertaking a Bachelor of Nursing or Bachelor of Midwifery.
 - f. NSW Health Aboriginal Enrolled Nurse to RN Scholarships for Aboriginal and/or Torres Strait Islander students who hold a Diploma of Nursing qualification and are undertaking a Bachelor of Nursing.
 - g. Diploma of Nursing Rural Travel Support Incentive for associated travel and accommodation costs related to Diploma of Nursing studies.
 - h. Rural postgraduate midwifery student scholarships are offered to support a "Grow Your Own" strategy for midwifery. They are allocated to small rural maternity units to support the employment of a midwifery student, in addition to their existing full-time equivalent workforce profile.
 - i. Rural Allied Health Undergraduate Scholarships, for students from rural backgrounds undertaking 'entry level' studies in allied health leading to a degree qualifying the student to practice.
 - j. Rural Allied Health Clinical Placement Grants to subsidise travel and accommodation costs associated with rural clinical placements.
 - k. Aboriginal Rural Allied Health University Student Scholarships, that provide financial assistance to Aboriginal allied health students with a rural background residing in regional or rural areas
 - l. Rural Allied Health Assistant Scholarships, that provide financial assistance for individuals from a rural area to complete an Allied Health Assistant qualification at TAFE NSW.
 - m. Supporting Entry into University Medicine or Dentistry Program Scholarships, that provide financial support to prospective students from NSW rural communities who are pursuing a career in medicine or dentistry to sit the Graduate Medical School Admissions Test (GAMSAT) or University Clinical Aptitude Test (UCAT).
 - n. Getting Started in Medicine Scholarships, for First Year Students pursuing a career in medicine from NSW rural communities to assist with relocation and study commencement costs.

- o. NSW Rural Resident Medical Officer Cadetship Program for NSW, that is open to medical students interested in undertaking a career in rural NSW by providing them with financial support during their final two or three years of undergraduate study in return for the completion of two of their first three postgraduate years in a rural hospital.
- p. Financial subsidies are also made available to current NSW Health professionals to support ongoing professional development, including:
 - i. NSW Rural Allied Health Postgraduate Scholarships, that provide assistance to clinicians in rural public health services to pursue postgraduate study.
 - ii. Rural Allied Health Generalist Program (Level 1) Scholarships, that provides financial assistance to complete the Level 1 Allied Health Rural Generalist Program through James Cook University.
 - iii. Allied Health Rural Graduate Diploma of Rural Generalist Practice (Level 2) Scholarships, that provide financial assistance for NSW Health allied health professionals currently working in a rural area to complete the Graduate Diploma of Rural Generalist Practice through James Cook University
 - iv. Rural Generalist Scholarships, that provide financial support to doctors undertaking advanced skills training as part of the NSW Rural Generalist Trainee program. That program aims to produce doctors who are General Practitioners with advanced skills able to deliver services to rural communities.

The employment and engagement of the NSW Health workforce

- 18.43. The primary ways in which the NSW Health workforce is engaged are as:
- a. employees;
 - b. visiting practitioners (for example, the engagement of specialist doctors as Visiting Medical Officers); or
 - c. through agencies (for example, as locum doctors or agency nurses).

Employees

- 18.44. Most staff who are employed in NSW Health agencies are employed in the “NSW Health Service”.²⁴⁴
- 18.45. Staff employed in the NSW Health Service are employed by the Government of NSW in the service of the Crown, as LHDs and Statutory Health Corporations cannot employ staff.²⁴⁵ As a consequence, their employer is the State of NSW.²⁴⁶

²⁴⁴ *Health Services Act 1997* (NSW) ss 115(1), 116(1).

²⁴⁵ *Health Services Act 1997* (NSW) ss 22(2), 45(2), 115(1).

²⁴⁶ For the purposes of the *Crown Proceedings Act 1988* (NSW) s 5(1).

- 18.46. As noted elsewhere, the Health Secretary exercises employer functions in relation to staff employed in the NSW Health Service, apart from Chief Executives and senior executives of LHDs and SHNs, for whom the employer functions are exercised by the Board and the Chief Executive, respectively.²⁴⁷ In exercising those functions, the Health Secretary has the power to fix the salary, wages, and conditions of employment of staff employed in the NSW Health Service in so far as they are not fixed by or under any other law.²⁴⁸
- 18.47. Those functions can be, and to a large extent have been, delegated.²⁴⁹ As a consequence, most of the day to day functions associated with employment are exercised by the LHDs and other public health organisations.²⁵⁰ Outside of specific initiatives, the Ministry of Health's workforce role is largely confined to matters of policy and strategy, setting terms and conditions of employment, and taking carriage of industrial negotiations and matters.²⁵¹
- 18.48. While all employees in the NSW Health Service are employed under contracts of employment, their terms and conditions of employment are principally those set out in awards. Some employees receive additional or different terms and conditions of employment set out in determinations approved by the Ministry of Health. A small number have been employed under what has been described as "unauthorised" or "non-standard" arrangements. Those arrangements have been agreed at a local level for a particular cohort, and include terms that are inconsistent with wider awards or determinations.²⁵²
- 18.49. Some employees within the NSW health system, principally within roles in the Ministry of Health, are employed in the NSW public service rather than the NSW Health Service, and are subject to different employment arrangements.²⁵³

²⁴⁷ *Health Services Act 1997* (NSW) ss 116(3), 3A, 3B, 3C, 3D.

²⁴⁸ *Health Services Act 1997* (NSW) s 116A(1).

²⁴⁹ *Health Administration Act 1982* (NSW) s 21(1); Exhibit H.1, NSW Health, *Combined Delegations Manual* [MOH.9999.0817.0001].

²⁵⁰ There are exceptions – including, for example, in relation to the recruitment of medical interns and graduate nurses: see, for example, Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [10] [MOH.0011.0017.0001 at 0002]; Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [40] [MOH.0011.0007.0001 at 0008].

²⁵¹ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [7]-[8] [MOH.0011.0024.0001 at 0002]; Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [25] [MOH.0011.0025.0001 at 0004].

²⁵² Exhibit H5.23.2. Supplementary Statement of Melissa Collins, 3 August 2024, pp 1-10 [MOH.0011.0038.0001 at 0001-0010].

²⁵³ Under the *Government Sector Employment Act 2013* (NSW) rather than the *Health Services Act 1997* (NSW): Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [19] [MOH.0011.0025.0001 at 0003].

Visiting practitioners

- 18.50. Visiting practitioners are medical practitioners or dentists appointed by a public health organisation to practise at a particular public hospital or other health service in accordance with specified terms.²⁵⁴ They are recognised within the *Health Services Act* and are appointed under a “service contract”.²⁵⁵
- 18.51. The *Health Services Act* recognises two main types of remunerated service contracts for Visiting Medical Officers: a “fee for service” contract, which provides for the practitioner to be paid per service they provide, and a “sessional” contract, which provides for the practitioner to be paid per “session” of service at an hourly rate.²⁵⁶
- 18.52. The arrangements for the engagement of visiting practitioners compared with employees in the NSW Health Service differ in two material ways. The first is that they are not employees, and therefore are not subject to the terms and conditions of employment set out in awards or the provisions of the *Industrial Relations Act 1996* (NSW). The second is that their legal relationship is with the particular public health organisation (for example, the relevant LHDs), and not with the NSW Government or the Crown. However, the terms of those service contracts are nevertheless subject to regulation under the *Health Services Act* in two main respects:
- a. first, it provides that the Minister may approve a set of conditions recommended by the Australian Medical Association (NSW) Limited (AMA NSW) for inclusion in service contracts of a particular class (fee for service contracts and sessional contracts being discrete classes).²⁵⁷ If the Minister does this, all remunerated service contracts of that particular class must contain those approved terms, and must not contain any inconsistent terms;²⁵⁸ and
 - b. secondly, it provides a process for arbitration on application by the Minister or the AMA NSW, to be conducted by an arbitrator appointed by the Minister administering the *Industrial Relations Act*, to determine the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable in respect of medical services provided by Visiting Medical Officers under fee for service contracts or sessional contracts (or both).²⁵⁹ A determination made by the arbitrator is, in substance, contractually binding, and any inconsistent contractual terms are of no effect.²⁶⁰ Following recent

²⁵⁴ *Health Services Act 1997* (NSW) s 76.

²⁵⁵ *Health Services Act 1997* (NSW) s 78.

²⁵⁶ *Health Services Act 1997* (NSW) ss 82, 83.

²⁵⁷ *Health Services Act 1997* (NSW) s 87(1).

²⁵⁸ *Health Services Act 1997* (NSW) ss 87(2), 88(1)-(2).

²⁵⁹ *Health Services Act 1997* (NSW) s 91(1).

²⁶⁰ *Health Services Act 1997* (NSW) s 98.

amendments to the *Health Services Act*, the arbitrator must be a Judicial Member of the Industrial Relations Commission.²⁶¹

- 18.53. There are two determinations presently in force in relation to Visiting Medical Officers: one relating to sessional contracts²⁶² and the other relating to fee for service contracts.²⁶³ They are now 10 years old, although there have been periodic increases to the rates of remuneration set out in them.²⁶⁴

Locums and agency staff

- 18.54. Although locum medical officers are commonly sourced through an agency, they are engaged as casual or temporary employees, and are frequently paid higher rates than other employees.²⁶⁵ While there is a Ministry of Health Policy Directive setting out indicative rates to be paid to non-specialist locums, it is outdated and not followed in practice.²⁶⁶
- 18.55. Agency nurses are engaged directly by LHDs and SHNs when required, under contracts with agencies.²⁶⁷ NSW Health is in the process of establishing a Whole of Health Nursing Agency Panel with a Statewide contract for agency nurses and midwives.²⁶⁸

Key NSW Health workforce stakeholders

- 18.56. There are several key stakeholders that have a role and interest in matters related to the health workforce.

Health Education and Training Institute

- 18.57. The role of HETI is to provide leadership to LHDs, SHNs and other public health organisations and training providers on the development and delivery of education

²⁶¹ *Industrial Relations Amendment Act 2025* (NSW) sch 1 items 1.3(1), 1.4 regarding *Health Services Act 1997* (NSW) s 90; *Health Services Regulation 2018* (NSW) reg 34.

²⁶² Exhibit H.4.18, Public Hospitals (Visiting Medical Officers - Sessional Contracts) Determination 2014 [MOH.0010.0100.0001].

²⁶³ Exhibit H.4.19, Public Hospitals (Visiting Medical Officers - Fee-for-Service Contracts) Determination 2014 [MOH.0010.0090.0001].

²⁶⁴ Exhibit H.5.23.2, Supplementary Statement of Melissa Collins (3 August 2024) [4], [9] [MOH.0011.0038.0001 at 0001, 0003]; Exhibit H.3.44, NSW Health, *Remuneration Rates for Fee-for-Service Visiting Medical Officers* (IB2021_054) (4 November 2021) [MOH.9999.1034.0001]; Exhibit H.4.23, NSW Health, *Remuneration Rates for Sessional Visiting Medical Officers* (IB2024_001) (10 January 2024) [MOH.9999.1038.0001].

²⁶⁵ Exhibit H.3.31, NSW Health, *Employment and Management of Locum Medical Officers by NSW Public Health Organisations* (PD2019_006) (1 February 2019) [MOH.9999.0074.0001].

²⁶⁶ Exhibit H.4.29, NSW Health, *Remuneration Rates for Non-Specialist Medical Staff - Short Term/Casual (Locum)* (PD2012_046) (10 August 2012) [MOH.0010.0321.0001]; Exhibit H.5.20, Statement of Dr Rebecca Nogajski (16 July 2024) [16(b)] [MOH.0011.0021.0001 at 0004].

²⁶⁷ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [72] [MOH.0011.0022.0001 at 0021].

²⁶⁸ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [75]-[78] [MOH.0011.0022.0001 at 0022].

and training across the NSW public health system.²⁶⁹ It is predominantly funded by the Ministry of Health.²⁷⁰

18.58. HETI has several critical roles in relation to the wider health workforce, including:

- a. the recruitment of medical interns, allocating those interns to positions throughout the NSW health system, and accrediting the prevocational training programs delivered to interns and other prevocational trainees at the local level.²⁷¹ While HETI generally determines the allocation of candidates to intern positions, it does not determine the number or distribution of the available intern positions or how interns rotate through networks once in a position. Responsibility for those matters rests with the relevant LHD, SHN or AHO;²⁷²
- b. support for vocational training networks relating to basic physician training (part of the physician specialty training), psychiatry, paediatric physician, emergency medicine, radiology, advanced general medicine, and medical administration.²⁷³ Those networks were established centrally by NSW Health, and each typically includes at least one rural or regional hospital as well as metropolitan hospitals,²⁷⁴ and a central governance structure.²⁷⁵ While HETI provides support for these governance structures and positions, it is not directly involved or responsible for decisions concerning the day to day operation of the vocational training networks,²⁷⁶ the establishment and distribution of vocational training positions,²⁷⁷ the extent to which trainees rotate through the networks (although this function is supported administratively),²⁷⁸ the recruitment of vocational trainees,²⁷⁹ or

²⁶⁹ Exhibit H.1.17.1, NSW Health, *Determination of Functions of Statutory Health Corporation (HETI)* (13 September 2017) cl 1 [SCI.0001.0060.0001 at 0001].

²⁷⁰ Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [5] [MOH.0011.0012.0001 at 0001]. Its expense budget has decreased by about \$5.5 million in the period 2020 to 2024: Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [6] [MOH.0011.0012.0001 at 0002].

²⁷¹ Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [56]-[60] [MOH.0011.0012.0001 at 0012-0013]; Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [10] [MOH.0011.0017.0001 at 0002].

²⁷² Transcript of the Commission, 22 July 2024, T3795.44-45 (Burnand). Although all facilities that offer intern positions must be accredited by the Health Education Training Institute's Prevocational Accreditation Committee: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [33]-[36] [MOH.0011.0017.0001 at 0006-0007]; Transcript of the Commission, 22 July 2024, T3802.19-26 (Burnand).

²⁷³ Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [47] [MOH.0011.0017.0001 at 0008].

²⁷⁴ Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [38]-[44] [MOH.0011.0017.0001 at 0007-0008].

²⁷⁵ Including a State Training Council and, in most cases, network governance committees that manage the local delivery of training: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [48] [MOH.0011.0017.0001 at 0008]. Each network also has Network Directors and Education Support Officers (and, in some cases, other network-related positions), which are generally funded by the Ministry of Health: Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [50]-[51] [MOH.0011.0017.0001 at 0008-0009].

²⁷⁶ Exhibit H.5.15, Statement of Dr Josephine Burnand (11 July 2024) [45]-[46] [MOH.0011.0017.0001 at 0008]; Transcript of the Commission, 22 July 2024, T3813.3-22 (Burnand).

²⁷⁷ Transcript of the Commission, 22 July 2024, T3809.37-44 (Burnand).

²⁷⁸ Transcript of the Commission, 22 July 2024, T3809.37-44, T3811.41-3812.12 (Burnand).

²⁷⁹ Transcript of the Commission, 22 July 2024, T3809.37-44 (Burnand). With the apparent exception of the Psychiatry network: Transcript of the Commission, 24 July 2024, T4034.33-42 (Virgona).

accreditation of specialist training positions or locations (which is the responsibility of the specialist medical training colleges);²⁸⁰ and

- c. administration of the ClinConnect system used to manage clinical placements for students across NSW Health in the sense of making that system available and maintaining it from a technical perspective.²⁸¹ However, the negotiation, establishment, allocation and management of clinical placements are conducted at the local level between universities and the relevant local organisation.²⁸²

Nursing and Midwifery Office

- 18.59. The Nursing and Midwifery Office is part of the Ministry of Health, led by the Chief Nursing and Midwifery Officer.²⁸³ In addition to providing advice in relation to professional and policy issues relating to nursing and midwifery, the Office coordinates the recruitment of graduate nurses and midwives within the NSW health system through a centralised recruitment program and an initial allocation of candidates to facilities based on preferences.²⁸⁴ However, local organisations undertake their own interviews, selection and onboarding of candidates, and determine available positions.²⁸⁵

Universities

- 18.60. As the primary source of the future health workforce, universities are an important feature of the workforce landscape.
- 18.61. Universities and the NSW public health system interact in several ways, but most relationships are established and operate at the local level. For example, there are several rural clinical schools and regional training hubs throughout NSW, which involve partnerships between universities and LHDs that facilitate students undertaking part or all of their studies and clinical placements in rural or regional locations.²⁸⁶ Those clinical placements are generally based on agreements between LHDs and universities, with students being allocated to places at the local level.²⁸⁷ In

²⁸⁰ Transcript of the Commission, 22 July 2024, T3809.46-3810.1 (Burnand).

²⁸¹ Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [51]-[52] [MOH.0011.0012.0001 at 0012]; Transcript of the Commission, 22 July 2024, T3791.7-3792.15 (Solman).

²⁸² Exhibit H.5.11, Statement of Annette Solman (9 July 2024) [54]-[55] [MOH.0011.0012.0001 at 0012]; Transcript of the Commission, 23 July 2024, T3917.38-3918.23 (Cross).

²⁸³ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [5] [MOH.0011.0007.0001 at 0001].

²⁸⁴ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [5]-[6], [40] [MOH.0011.0007.0001 at 0001-0002, 0008]; Transcript of the Commission, 23 July 2024, T3917.38-3918.23 (Cross).

²⁸⁵ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [40] [MOH.0011.0007.0001 at 0008].

²⁸⁶ Transcript of the Commission, 19 March 2024, T1360.23-28, T1361.18-37 (Stephenson); Transcript of the Commission, 20 March 2024, T1441.20-1442.40 (MacKenzie); Transcript of the Commission, 22 May 2024, T3161.42-3162.9 (Jones); Transcript of the Commission, 30 July 2024, T4231.39-4232.22 (Fielding).

²⁸⁷ See, for example, Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [7]-[8] [MOH.0011.0013.0001 at 0002]; Transcript of the Commission, 23 July 2024, T3895.15-33 (Hockey).

cases of limited supply, the nature of these arrangements can lead to competition for students as between LHDs and for placements as between universities.²⁸⁸

- 18.62. Similarly, the establishment of conjoint professorial appointments or research collaborations between universities and particular facilities or LHDs can assist in attracting clinical staff,²⁸⁹ but these are not presently organised in a systematic or coordinated way.

Registration authorities

- 18.63. Health practitioners in Australia are subject to a regulatory scheme established under uniform national laws. In NSW, that scheme is established by the *Health Practitioner Regulation National Law 2009* (NSW), which restricts individuals holding themselves out as being registered or qualified to practise as a health practitioner, or using certain “protected titles” (including, for example, “medical practitioner”, “nurse”, “midwife”, “paramedic”, “pharmacist” and “psychologist”) unless they are registered with a National Board.²⁹⁰
- 18.64. The National Boards each develop registration standards, codes (for example, codes of conduct) and guidelines for their respective professions.²⁹¹ In NSW, non-compliance with an applicable code can result in disciplinary action.

Specialist medical colleges and the Australian Medical Council

- 18.65. A medical practitioner who wishes to hold themselves out as a specialist in Australia must obtain specialist registration with the Medical Board of Australia.²⁹² Leaving aside international medical graduates, the only pathway to obtaining specialist registration in Australia is to obtain (or be assessed as eligible to obtain) fellowship of a specialist medical college.²⁹³
- 18.66. Programs of study to acquire fellowship are accredited by the Australian Medical Council.²⁹⁴ In practice, international medical graduates wishing to obtain specialist registration are also assessed by the relevant college, except for those whose

²⁸⁸ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003]; Transcript of the Commission, 23 July 2024, T3914.38-46 (Cross).

²⁸⁹ Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [14]-[15] [MOH.0011.0013.0001 at 0004]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [34(a)(v)] [MOH.0011.0031.0001 at 0011].

²⁹⁰ *Health Practitioner Regulation National Law 2009* (NSW) regs 31, 113-119; *Health Services Regulation 2018* (NSW) reg 4. The National Boards are supported administratively by the Australian Health Practitioner Regulation Agency: *Health Practitioner Regulation National Law 2009* (NSW) s 25.

²⁹¹ *Health Practitioner Regulation National Law 2009* (NSW) ss 38-39.

²⁹² *Health Practitioner Regulation National Law 2009* (NSW) s 115.

²⁹³ *Health Practitioner Regulation National Law 2009* (NSW) ss 57(1)(a), 58; See, for example, Transcript of the Commission, 18 October 2024 T5960.25-29, T5964.38-46 (Page); Transcript of the Commission, 18 October 2024, T6002.8-20 (Lim).

²⁹⁴ *Health Practitioner Regulation National Law 2009* (NSW) s 5 (definition of “approved program of study”), s 47(3), s 47(6); Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) pp 19-20 [MOH.0010.0053.0001 at 0019-0020].

qualifications are on the “Expedited Specialist” pathway (which include certain qualifications obtained in the United Kingdom, Ireland and Canada).²⁹⁵

- 18.67. There are 16 Australian Medical Council accredited specialist medical colleges in Australia, several of which also cover New Zealand.²⁹⁶
- 18.68. Each of the colleges sets the curriculum for its training program and determines the requirements that must be completed by a trainee to attain fellowship.²⁹⁷ Each of the colleges also conducts its own accreditation process to determine whether training at a particular facility or in a particular position will be recognised for the purposes of its training program. This is not a function recognised by statute or in any other formal way, and, to date, has been relatively unregulated. However, the accreditation processes applied by the colleges may be considered by the Australian Medical Council as part of its consideration of whether to accredit or reaccredit a college’s training program.²⁹⁸
- 18.69. Each college has developed its own approach to the accreditation of training positions or facilities.²⁹⁹ However, there are some similarities between them. A notable similarity is that each of the colleges – with greater or lesser rigidity – imposes requirements as to the maximum number of trainees who can be supported per supervisor at a facility (in effect, a ratio).³⁰⁰
- 18.70. Another is that, while agreeing that their accreditation standards should be “outcomes based” and “evidence informed”³⁰¹, several colleges viewed the function of their accreditation standards as including setting broader professional or workplace standards for those working in the relevant specialty.³⁰² This might be thought to be reflected in some of the colleges’ accreditation standards that deal with matters such as adequate office space, administrative support, and the appointment processes for senior clinical staff.³⁰³

²⁹⁵ Exhibit H2.53, Medical Board of Australia, *Draft Revised Registration Standard: Specialist Registration* (3 June 2024) pp 2-3 [MOH.0010.0054.0001 at 0002-0003].

²⁹⁶ Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) p 20 [MOH.0010.0053.0001 at 0020].

²⁹⁷ Transcript of the Commission, 18 October 2024, T5958.37-5960.29 (Burnand/Lim/Page).

²⁹⁸ Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) pp 20-21, 24 [MOH.0010.0053.0001 at 0020-0021, 0024].

²⁹⁹ By way of a simple example, colleges differ in relation to whether they accredit training sites (facilities) or positions; Transcript of the Commission, 18 October 2024, T5976.12-14 (Haq); Transcript of the Commission, 18 October 2024, T6007.18-27, T6009.4-11 (Burnand/Page).

³⁰⁰ Exhibit H.1.5.1, RANZCR, *Accreditation Standards for Education, Training and Supervision of Clinical Radiology Trainees* (December 2018) p 20 [COR.0002.0006.0001 at 0022]; Transcript of the Commission, 31 July 2024, T4314.23-41 (Angelico).

³⁰¹ Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) p 38 [MOH.0010.0053.0001 at 0038]; Transcript of the Commission, 24 July 2024, T3990.10-19 (Page); Transcript of the Commission, 25 July 2024, T4152.1-34 (Findley); Transcript of the Commission, 31 July 2024, T4338.26-4339.8 (Angelico).

³⁰² Transcript of the Commission, 24 July 2024, T3954.32-41 (Page).

³⁰³ See, for example, Exhibit H.1.53.2, ANZCA, *Handbook for Accreditation* pp 13-19 [ACA.0001.0007.0001 at 0013-0019].

- 18.71. Colleges have, from time to time, withdrawn or downgraded the accreditation of certain facilities. The consequence of withdrawing accreditation is that the college will no longer recognise training undertaken by a doctor at that facility, or in that position, as contributing towards that doctor satisfying its training requirements. Such a circumstance can have substantial practical consequences for facilities and trainees.³⁰⁴ There have been occasions when colleges have withdrawn, downgraded, or threatened to withdraw or downgrade a facility's accreditation because of what might be regarded (without diminishing their importance) as cultural issues in the relevant department, including allegations of workplace bullying and harassment.³⁰⁵
- 18.72. One concern that has been raised about the accreditation of specialist training is that colleges' accreditation decisions might occasionally have been influenced by industrial considerations.³⁰⁶ Although the evidence before this Special Commission does not indicate that such an approach is widespread, some colleges acknowledged accreditation could be used as a "lever" to achieve certain outcomes desired by the college.³⁰⁷
- 18.73. Different arrangements apply between the colleges as to whether they are involved in the recruitment and selection of trainees or whether these processes were left to local organisations.³⁰⁸ Those colleges that are involved in recruitment and selection considered this to be valuable because it allowed them to bring their Fellows' expertise to bear on those processes and allows for a more efficient process for interviewees.³⁰⁹
- 18.74. However, apart from influencing the maximum number of trainees who may be engaged at a given site and their training conditions, colleges have a limited capacity to influence the number and distribution of trainees in NSW.³¹⁰ They do not determine the number or distribution of trainee positions: the establishment of a position is a discrete and additional step to the college's accreditation of sites or positions in which training is delivered.³¹¹ While most colleges have, to varying degrees, implemented initiatives aimed at increasing rural training (including through Commonwealth Specialist Training Program and Flexible Approach to Training in Expanded Settings

³⁰⁴ See, for example, Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [104] [MOH.0011.0020.0001 at 0020]; Exhibit H.5.27, Statement of Mark Spittal (17 July 2024) [16]-[21] [MOH.0011.0023.0001 at 0004]; Transcript of the Commission, 30 July 2024, T4214.20-31 (Fielding); Transcript of the Commission, 30 July 2024, T4295.23-41 (Chan).

³⁰⁵ See, for example, Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [43] [MOH.0011.0031.0001 at 0014]; Exhibit H.5.31.8, Letter from Dr Estall and Dr Lisa Sullivan to Dr Louise Nardone regarding Accreditation of Central Coast Cancer Centre for Radiation Oncology (15 February 2023) pp 1-2 [MOH.0010.0218.0001 at 0001-0002].

³⁰⁶ Exhibit H.5.30, Statement of Graeme Loy (25 July 2024) [7] [MOH.0011.0030.0001 at 0002].

³⁰⁷ Transcript of the Commission, 25 July 2024, T4112.37-4113.11 (Haq).

³⁰⁸ Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [121] [MOH.0011.0020.0001 at 0023-0024].

³⁰⁹ Transcript of the Commission, 30 July 2024, T4208.21-36 (Fielding); Transcript of the Commission, 24 July 2024, T4035.10-27 (Virgona).

³¹⁰ Transcript of the Commission, 24 July 2024, T3968.13-16 (Page); Transcript of the Commission, 30 July 2024, T4213.28-35 (Clota).

³¹¹ Transcript of the Commission, 23 July 2024, T3871.3-20 (Nogajski).

funding),³¹² all of the college representatives who gave evidence expressed a view that their colleges had no or inadequate access to data about service demands and workforce planning needs, which constrained their ability to contribute meaningfully to solving shortage and distribution problems.³¹³

- 18.75. The roles and responsibilities of colleges, particularly in accreditation, have recently been the subject of a report by the National Health Practitioner Ombudsman.³¹⁴ That report included 23 recommendations, most of which are directed at improving the fairness and transparency of the colleges' accreditation processes including setting accreditation standards, assessing whether accreditation should be granted, monitoring, non-compliance, and dealing with grievances about accreditation decisions.³¹⁵ All jurisdictional Health Ministers have supported these recommendations,³¹⁶ and the Australian Medical Council has been directed to work with jurisdictions and the colleges to implement them.³¹⁷ Most of the college representatives who gave evidence said their colleges also endorsed the National Health Practitioner Ombudsman's recommendations.³¹⁸

Industrial organisations:

- 18.76. Industrial organisations are, obviously, key stakeholders in matters relating to the large and diverse workforce. The key industrial organisations relevant to the NSW health system are:
- a. the AMA NSW (representing Visiting Medical Officers);
 - b. the Australian Paramedics Association (NSW) (representing some paramedics);
 - c. the Australian Salaried Medical Officers Federation (NSW) (ASMOF, representing employed doctors);

³¹² Transcript of the Commission, 24 July 2024, T3967.12-3970.21 (Moyle/Page); Transcript of the Commission, 25 July 2024, T4086.15-22 (Haq); Transcript of the Commission, 30 July 2024, T4236.33-45 (Fielding).

³¹³ Transcript of the Commission, 24 July 2024, T4015.32-38 (Moyle); Transcript of the Commission, 24 July 2024, T4038.3-29, T4056.16-35 (Virgona); Transcript of the Commission, 25 July 2024, T4097.36-42 (Kanhutu/Haq); Transcript of the Commission, 30 July 2024, T4209.33-43 (Fielding); Transcript of the Commission, 31 July 2024, T4323.10-33 (Angelico). Each would prefer, and could make use of, access to more data about these matters: Transcript of the Commission, 25 July 2024, T4172.20-36 (Findley); Transcript of the Commission, 31 July 2024, T4323.35-41 (Angelico); Transcript of the Commission, 18 October 2024, T5986.42-5987.1 (Haq); Transcript of the Commission, 18 October 2024, T5991.1-4 (Fielding).

³¹⁴ Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) [MOH.0010.0053.0001].

³¹⁵ Exhibit H.2.39, National Health Practitioner Ombudsman, *Processes for progress – Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation* (October 2023) pp 5-7 [MOH.0010.0053.0001 at 0005-0007].

³¹⁶ Exhibit H.2.42, Health Ministers Meeting, Communique (10 November 2023) p 1 [MOH.0010.0302.0001 at 0001].

³¹⁷ Exhibit H.3.49, Ministerial Policy Direction 2023-1: Medical college accreditation of training sites (1 September 2023) p 1 [MOH.0010.0063.0001 at 0001].

³¹⁸ Transcript of the Commission, 25 July 2024, T4095.37-4096.4 (Haq/Kanhutu); Transcript of the Commission, 25 July 2024, T4162.13-37 (Findley); Transcript of the Commission, 30 July 2024, T4201.28-39 (Fielding); Transcript of the Commission, 31 July 2024, T4324.33-40, T4338.20-24 (Angelico).

- d. the Health Services Union (HSU, representing a wide range of health workers but notably allied health professionals and non-clinical staff working in hospitals, as well as some paramedics); and
 - e. the NSWNMA (representing nurses and midwives).
- 18.77. Industrial organisations are typically parties to awards covering employees who are or are eligible to be their members.

External complaints agencies

- 18.78. The *National Law* establishes a scheme for dealing with health, performance and conduct issues involving registered (and formerly registered) health practitioners.³¹⁹ Among other things, the scheme provides for complaints about health practitioners to be made to the relevant Council for the profession or the Health Care Complaints Commission,³²⁰ and then dealt with by a variety of means including proceedings in the Civil and Administrative Tribunal, which can result in the suspension or cancellation of a practitioner's registration.

Workforce planning and establishment

The current framework

- 18.79. The current framework for service planning, workforce planning, and the establishment of clinical positions has several core features.
- 18.80. First, clinical service planning – that is, determining what health services will be supplied and with what resources – is conducted at the local level.³²¹ While the Ministry of Health conducts supply and demand modelling and makes it available to local organisations to inform their service planning,³²² it is ultimately a matter for the local organisation as to whether and how it uses that modelling to inform its service planning.
- 18.81. Secondly, as observed above, workforce planning and establishment – that is, planning and establishing positions for clinical workers – is also conducted at the local level (apart from some specific Ministry of Health led programs). Again, the Ministry of Health makes modelling available to local organisations to inform these processes, but the function of workforce planning and establishment is almost entirely devolved to local organisations.
- 18.82. Thirdly, while service and workforce planning generally occur at a local level, the Ministry of Health has visibility of a substantial amount of data relevant to the

³¹⁹ *Health Practitioner Regulation National Law 2009* (NSW) Pt 8.

³²⁰ Which is governed by separate but overlapping legislation: *Health Care Complaints Act 1993* (NSW).

³²¹ Exhibit L.6, Statement of Philip Minns (8 October 2024) [10] [MOH.0011.0082.0001 at 0003]; Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [112] [MOH.0011.0083.0001 at 0025].

³²² Transcript of the Commission, 25 July 2024, T4119.44 – 4120.5 (Dominish); Transcript of the Commission, 7 August 2024, T4824.9-38 (Minns).

workforce across the system.³²³ In contrast, local organisations do not appear to perform, or always have the capacity to perform, detailed and sophisticated analysis of that data at least to the same extent that the Ministry of Health does.³²⁴ In any event, their focus is naturally local, rather than adopting a system wide perspective in their planning activities.³²⁵

- 18.83. Fourthly, the Ministry of Health provides limited practical or operational direction to local organisations about service planning or workforce planning and establishment.³²⁶ The Ministry of Health provides strategic guidance, for example in the *Workforce Plan*,³²⁷ but this is a very high level document that does not provide any significant operational direction. The Ministry of Health also holds meetings with local organisations from time to time to discuss concerning trends in the data monitored by the Ministry of Health,³²⁸ but these appear to be *ad hoc*.
- 18.84. Relatedly, the service agreements between the Health Secretary and local organisations do not impose any obligations relating to the use of supply and demand modelling to inform their service or workforce planning. The agreements address service delivery obliquely and in limited fields that are mostly uninformative as to the effectiveness of the organisation's service planning for meeting population demands (for example, time to see Emergency Department presentations). To the extent that KPIs address workforce matters, they do so generally in narrow and formulaic ways focussed mostly on culture (for example, "People Matter Employee Survey" results) and workforce participation (for example, an Aboriginal workforce participation target).
- 18.85. However, the Ministry of Health does, from time to time, engage in direct interventions in relation to workforce issues. For example, in response to the 2019 NSW bushfires, the Ministry of Health established a unit that actively deploys staff (mostly nursing and allied health) to areas of high demand. This unit has recently had funding approved to expand to 400 FTE over the next three years and the Ministry of Health plans to expand it further.³²⁹ As noted above, the Ministry of Health has also established a whole of health agency nursing panel and is exploring establishing an "internal" agency for medical locums.³³⁰ Those are welcome initiatives, which should be pursued and embedded at a system level. In this respect, an internal locum agency would likely go some way to eliminating the untenable circumstance of LHDs,

³²³ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [146] [MOH.0011.0022.0001 at 0044-0045]; Transcript of the Commission, 6 August 2024, T4776.21-30 (Griffiths).

³²⁴ Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [23]-[24] [SCI.0011.0249.0001 at 0005].

³²⁵ Transcript of the Commission, 15 October 2024, T5706.41-5707.13 (Minns).

³²⁶ Transcript of the Commission, 6 August 2024, T4761.24-38 (Griffiths).

³²⁷ Exhibit L.13.2, NSW Health, *NSW Health Workforce Plan 2022-2032* [MOH.9999.3112.0001]; See also, Exhibit H.2.36, NSW Health, *Workforce Plan 2022-2032: A supplementary guide* [MOH.0010.0275.0001].

³²⁸ Transcript of the Commission, 6 August 2024, T4766.9-4767.30 (Griffiths).

³²⁹ Transcript of the Commission, 6 August 2024, T4762.38-4763.18, T4763.43-4765.10 (Griffiths).

³³⁰ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [62]-[73] [MOH.0011.0083.0001 at 0015-0017]. An "internal" locum agency would go some way to eliminating the untenable circumstance of NSW Health agencies bidding against each other to secure the services of a clinicians.

or individual facilities, “bidding” against each other to secure medical locums, and to manage costs.³³¹

- 18.86. Each of those initiatives has had a measure of success in addressing the underlying challenge, and is demonstrative of the benefit that can be gained from the Ministry of Health having more direct involvement in workforce planning and deployment across the system. However, they are initiatives that are reactive rather than a product of a proactive approach to workforce issues at a system level or long term strategic planning.
- 18.87. Finally, in contrast to the data sharing that occurs between the Ministry of Health and local organisations, there are inconsistencies in the approach to data sharing that occurs with other stakeholders including universities, specialist medical colleges and industrial organisations. Stakeholders have access to publicly available data sources, including data made available by NSW Health through the Bureau of Health Information, and some high level workforce modelling outputs published on NSW Health’s website. But aside from those modelling outputs, this data is not typically collated, correlated or otherwise analysed as the Ministry of Health does.³³² That must change.
- 18.88. The often contentious nature of the relationship between the Ministry of Health and several of these stakeholders – especially the industrial organisations – significantly undermines the extent to which they can collaborate to overcome what are often entrenched workforce challenges. The sharing of information with these organisations by the Ministry of Health is critical if these relationships are to change in a way that maximises the benefit that each can bring to what is ultimately a public health system.
- 18.89. The Ministry of Health must overcome its fear that any information shared – particularly that relating to challenging aspects of the public health system or difficult decisions that must be made in the prioritisation of the limited resources available – will be weaponised against it by stakeholders, including industrial organisations.³³³ Stakeholders entrusted with this wider range of information must use it responsibly. Sharing information in that way might draw attention to aspects of the system that are under stress, or are not meeting targets. However, that is not a reason to refrain from sharing information about the system in a transparent manner. A mature and high performing health system must embrace those areas in which it knows that it is failing or under strain, and work collaboratively with all relevant stakeholders to remedy that situation.

³³¹ Exhibit H5.21. Statement of Richard Griffiths (16 July 2024) pp 20-21 [MOH.0011.0022.0001 at 0020-0021]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [32] [MOH.0011.0031.0001 at 0010].

³³² Transcript of the Commission, 22 July 2024, T3758.22-3759.12 (Halse).

³³³ Transcript of the Commission, 6 August 2024, T4788.12-4789.1 (Griffiths); Transcript of the Commission, 6 August 2024, T4815.31-41 (Minns).

The need for a system wide approach to workforce planning

- 18.90. Currently, there is no system wide approach to workforce planning, in the sense that the clinical workforce is not established or structured by reference to a detailed assessment of population needs or the supply of clinicians across the system. That is not surprising given the highly devolved approach that has been adopted in relation to service and workforce planning functions, which does not include substantive involvement from the Ministry of Health, notwithstanding that the Ministry of Health is the only one with visibility across the system and the capability to model system wide supply and demand.
- 18.91. The need for a system wide approach to workforce planning and engagement has increased in recent times as the effects of “pressure” on the health budget, workforce shortages, and maldistribution have become more acute.
- 18.92. Difficult choices must be made as to what services are made available, where, and in what form if the system is to be sustainable into the future. As discussed elsewhere in this Report, the advantage of a system wide perspective in responding to that new environment is that it provides an opportunity to maximise the efficient delivery of health services across the State by ensuring the most effective deployment of its workforce and budget to achieve that aim.
- 18.93. It is essential that the Ministry of Health has a key role in that process given that it, and it alone, has oversight over large amounts of workforce data and the ability to analyse and interpret that data at a system level. It also effectively controls the funding allocated to local organisations to fund their workforce needs. Those two matters alone make clear that the Ministry of Health must play a lead role in system wide planning of this kind if it is to be effective.
- 18.94. Greater coordination at a system level would also provide opportunities to address inefficiencies. For example:
- a. some rural and regional LHDs have undertaken programs to recruit doctors, nurses and midwives from overseas, with some success. These initiatives have largely involved each developing its own processes, engaging its own recruitment agencies, offering its own incentives to attract candidates, and taking responsibility for the associated administrative work, including sponsorship documentation.³³⁴ However, some LHDs have not been able to afford the costs of conducting international recruitment or have not managed to achieve success on this front for other reasons.³³⁵ A more coordinated approach to workforce planning and

³³⁴ Exhibit K.36, Statement of Jennifer Richter (5 September 2024) [8]-[12] [MOH.0011.0056.0001 at 0002-0003]; Exhibit H.5.26, Statement of Hayley Sciuriaga (18 July 2024) [12] [MOH.0011.0027.0001 at 0003]; Exhibit H.5.28, Statement of Jonathan Morris (19 July 2024) [15d] [MOH.0011.0028.0001 at 0004]; Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [31] [MOH.0011.0031.0001 at 0010].

³³⁵ Exhibit H.5.14, Statement of Barbara Crawford (11 July 2024) [26] [MOH.0011.0015.0001 at 0005]; Exhibit H.5.25, Statement of Melissa Pickering (18 July 2024) [22]-[23] [MOH.0011.0026.0001 at 0004].

structuring may provide an opportunity to develop a centralised process for international recruitment, which would result in system wide benefits;

- b. while there are centralised recruitment processes for graduate nurses and midwives and medical interns, there are no such processes for allied health professionals or medical trainees in many specialty training programs.³³⁶ This means that candidates are required to put in multiple applications, and local organisations are required to conduct duplicative recruitment processes, despite the fact that it may be the same (or largely the same) cohort of applicants applying for the same set of available positions;³³⁷
 - c. there is no central coordinating function in relation to clinical placements, which can lead to competition between universities for those placements;³³⁸
 - d. a more structured approach to the deployment of the workforce to areas of need – including across LHD and SHN boundaries – can be developed. There are many examples of clinicians providing critical services in more than one LHD, however, they have largely grown organically and in many cases exist through the continuing goodwill of individual clinicians. Given the significant maldistribution of the workforce, the system as a whole would undoubtedly benefit from a structured approach to workforce planning that aligns with the clinical services planning process that I discuss elsewhere in this Report. In doing so, flexible models that enable clinicians to be deployed (even for short periods) to areas of need across LHD and SHN boundaries should be explored and implemented;
 - e. as observed above, the current structures have given rise to the untenable situation of parts of the system competing with one another for agency nurses and locums. That results in parts of the NSW public health system bidding against each other, which only results in increased cost to it. An example of the benefits of a system wide approach is the Ministry of Health's agency staff initiatives, which appear likely to result in significant benefits.
- 18.95. The need for a system wide approach to workforce planning does not mean that the benefits of devolution are to be discarded. To the contrary, local perspective and input remain critical to effective planning. Those benefits must be retained and harnessed. But there does need to be a consistent level of operational oversight and coordination from the Ministry of Health to ensure that workforce planning (including in relation to the future workforce pipeline) and engagement supports a long term sustainable

³³⁶ Transcript of the Commission, 14 October 2024, T5645.18-23 (Dominish); cf Transcript of the Commission, 22 July 2024, T3827.10-3828.5 (Twigg).

³³⁷ Transcript of the Commission, 16 October 2024, T5787.32-5789.23 (Yik/Penm); Transcript of the Commission, 24 July 2024, T3976.12-23, T3978.10-3982.47 (Page/Moyle).

³³⁸ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003].

system. It must be a collaboration in which the Ministry of Health provides support, advice and direction, rather than a wholesale takeover of all workforce functions.³³⁹

- 18.96. NSW Health recognised in its written submissions that, over time, the highly devolved approach to clinical services and workforce planning has resulted in there being a “a missing middle” function related to service planning and configuration.³⁴⁰ That “missing middle” function was described by Mr Minns³⁴¹ by reference to Defence style capability planning, as follows:³⁴²

Throughout the long period of capital investment since 2011, there has been a very limited application of a Defence style capability lens where whole of health system strategic objectives would operate to influence specific localised decisions while also drawing the linkages between strategy, service delivery planning and capability, redesigned models of care, sustainable financial resources and workforce availability – both immediately and after deployment of pipeline building strategies. The statement of Mr Richard Griffiths prepared to address workforce solutions, makes this point under the heading “identifying current in demand service areas”.

This missing middle function existed prior to the 2011 governance changes to the NSW public health system. Recreating this missing middle function cannot be done in a way that removes the involvement of clinicians, staff and communities in local planning for individual service plans. Rather, what needs to happen is that this local engagement occurs in a coherent overarching context provided by a system level design of networked service delivery.

The aim of this different approach to health system capability planning would be to ensure that we are indeed making investment and planning decisions based on the direction of the Future Health Strategy, and in workforce terms, we are assessing workforce challenges, constraints and reform opportunities at the earliest point in health system capability planning.

³³⁹ Transcript of the Commission, 14 October 2024, T5614.18-33 (Griffiths).

³⁴⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.3] [MOH.0010.0758.0001 at 0062-0063].

³⁴¹ Exhibit L.6, Statement of Philip Minns (8 October 2024) [10] [MOH.0011.0082.0001 at 0003].

³⁴² Exhibit L.6, Statement of Philip Minns (8 October 2024) [13]-[15] [MOH.0011.0082.0001 at 0003-0004].

18.97. The changes in 2011 referred to in that extract involved the then Director-General of NSW Health “adopt[ing] a fundamental principle of a commitment to devolution and localism” which moved the function of clinical service planning from the Ministry of Health to the local organisation level, limiting “broader Statewide oversight of service design and alignment”.³⁴³

18.98. Mr Griffiths reflected on the issue in this way:³⁴⁴

At present, NSW Health focusses too strongly on adapting models of care to the current workforce and the way it currently works, rather than building workforce for delivery of new models of care. Our service planning structure tends to replicate what has previously been done, and then workforce is retrofitted.

In my view, NSW Health needs to move away from looking at networking opportunities after developing individual service plans and instead start with a system level networked approach to service. How we identify what workforce is needed and where and how to supply the identified workforce needs greater central oversight to facilitate system visibility and more contemporary service planning. We need to conduct workforce planning not by looking at workforce as a limiting factor but to design Clinical Services Plans in a more connected way between LHDs and consider the new models of care available and the workforce that might be created to deliver them. Although Ministry of Health has expectations that the LHDs will demonstrate networking in their Clinical Services Plans, greater centralisation of this function would ensure that we standardise models of care, capture innovation opportunities and look at supply of workforce to meet these opportunities, rather than determining that existing workforce prevents these opportunities from being considered.

18.99. The views expressed by Mr Minns and Mr Griffiths highlight the benefits that can be achieved through a system wide approach to workforce planning and service configuration.

18.100. As noted above, the benefit of devolution must be retained as local knowledge and input will be essential to an effective planning process. However, the time has come to make use of those benefits to build and maintain a strong and sustainable workforce across the system.

³⁴³ Exhibit L.6, Statement of Philip Minns (8 October 2024) [12] [MOH.0011.0082.0001 at 0003].

³⁴⁴ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [111]-[112] [MOH.0011.0083.0001 at 0025].

- 18.101. As much appears to be accepted by NSW Health. In its written submissions, it stated that it already has “significant efforts under way in respect of system wide workforce planning”, although it accepts that there are “opportunities to further centralise its current workforce planning activities and to improve the connectivity between Ministry of Health and [LHDs]”.³⁴⁵ That work should be progressed as a priority.
- 18.102. NSW Health identified a series of “potential challenges” in implementing a centralised workforce planning function.³⁴⁶
- 18.103. One of those challenges relates to the time and resources in the manual collation of necessary data.³⁴⁷ I accept that, as a direct consequence of the current systems that are in place across NSW Health, and the methods of data collection that are currently used, there is likely to be a degree of effort (perhaps significant effort) to collate the data necessary to support a robust centralised workforce planning function within the Ministry of Health. However, that is a function of the systems that have been implemented within NSW Health. It is within NSW Health’s ability to make necessary changes to those systems, to (as NSW Health put it) “alleviate” that challenge.³⁴⁸ In any event, that collating data of that kind will likely require significant effort, is no reason to not do so.
- 18.104. Another of the challenges identified by NSW Health related to its ability to influence external factors.³⁴⁹ It goes without saying that NSW Health cannot “control” external bodies or societal trends (including in relation to work preferences). It can, however, utilise its position as the largest public health system in the country to influence outcomes, in part through effective and meaningful collaboration with stakeholders and other jurisdictions.
- 18.105. In any event, one of the significant benefits of a centralised workforce planning function that leverages the oversight and expertise within the Ministry of Health is that it will provide NSW Health with the ability to better observe the impact of the actions or policies of external stakeholders and societal changes on its workforce (including its future workforce pipeline), and to plan and implement a response to them.
- 18.106. It would not be productive for me to dictate a particular structure or approach that should be adopted to implement the centralised workforce planning function. The Ministry of Health (in particular the Workforce Planning and Talent Development Branch) together with local organisations are best placed to determine those matters.

³⁴⁵ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.2] [MOH.0010.0758.0001 at 0062].

³⁴⁶ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.18-10.23] [MOH.0010.0758.0001 at 0067-0068].

³⁴⁷ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.18-10.21] [MOH.0010.0758.0001 at 0067].

³⁴⁸ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.18] [MOH.0010.0758.0001 at 0067].

³⁴⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.22-10.23] [MOH.0010.0758.0001 at 0067-0068].

It is evident that some work has already begun to achieve those aims.³⁵⁰ More, however, is required.

18.107. As part of a centralised approach to workforce planning, the following matters should be considered by the Ministry of Health:

- a. Whether there is scope to rationalise and target existing workforce incentives, which are largely *ad hoc*.³⁵¹
- b. Whether a centralisation of recruitment processes will provide benefits to the system, and the workforce, including by creating significant efficiencies and improving the capacity of the system to match workforce supply with system and population need.
- c. Whether in engaging a medical workforce, terms and conditions should include an obligation for practitioners to support service delivery in rural and regional locations, including by attending those locations to deliver clinics or conduct procedures from time to time, providing virtual care into those locations, and/or providing remote supervision to trainees in a rural or regional location (all with appropriate compensation).³⁵²
- d. The maximisation of opportunities to expose students and junior practitioners to fields in which there are workforce shortages, for example psychiatry and general practice, as well as supporting opportunities for more training to be undertaken in rural and regional locations wherever possible.³⁵³

The role of the Health Education and Training Institute

18.108. There is considerable scope to enhance the planning, establishment and allocation of clinical placements for university students and vocational training positions for registrars, which will likely deliver significant benefits to the system. In this respect, NSW Health accepted that there was at least a need for a “consideration of greater centralised coordination” between its agencies and external stakeholders.³⁵⁴ Something more than a “consideration” of such an approach is required.

³⁵⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.2] [MOH.0010.0758.0001 at 0062]. In designing those structures account can be taken of the unique circumstances of some NSW Health agencies in relation to workforce planning activities – for example, NSW Ambulance: Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.5] [MOH.0010.0758.0001 at 0063].

³⁵¹ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [37] [MOH.0011.0083.0001 at 0008].

³⁵² Transcript of the Commission, 30 July 2024, T4233.17-28 (Fielding).

³⁵³ Exhibit H.5.12, Statement of Professor Peter Hockey (10 July 2024) [13], [16] [MOH.0011.0013.0001 at 0003, 0004].

³⁵⁴ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.25] [MOH.0010.0758.0001 at 0069].

18.109. As part of a system wide approach to workforce planning, there should be greater strategic coordination and planning related to clinical placements and vocational training. HETI is well placed to take a leading role in that process, and to perform that function going forward.

Student placements

18.110. Placements in all disciplines are established by agreements between individual universities and local organisations. While HETI administers a central computer based system (ClinConnect) that facilitates the “booking” of students into placements,³⁵⁵ there is no central coordination of where placements are established or how students are allocated to them.

18.111. This approach creates some obvious problems, including that:

- a. either universities or local organisations end up competing with each other depending on whether demand for placements exceeds supply in the relevant local area or the reverse;³⁵⁶
- b. the matching of students with placements is largely manual rather than allocated in the nature of, for example, the medical intern program;
- c. because the matching of supply and demand occurs locally and is largely based on relationships, there may be a supply of students at one university and a demand for students at a local organisation that are never matched with one another because there is no central coordination or visibility;
- d. there is a duplication of administrative work because of the need for both universities and local organisations to make and administer multiple arrangements with one another, with variable terms;³⁵⁷ and
- e. there is no central monitoring or direction as to the number of clinical placements that should be established or where they should be established in order to match demand for placements, or future service requirements.³⁵⁸

18.112. As a result, NSW Health is not able to obtain the benefit that may flow from a more coordinated approach to the allocation of university placements and recruitment of those being placed into identified areas of need at the time of their likely graduation.

³⁵⁵ Transcript of the Commission, 22 July 2024, T3792.7-15 (Solman).

³⁵⁶ Exhibit H.5.10, Statement of Jacqui Cross (8 July 2024) [16] [MOH.0011.0007.0001 at 0003].

³⁵⁷ Transcript of the Commission, 14 October 2024, T5608.3-11 (Griffiths).

³⁵⁸ An important point given that it is uncontroversial that the prospect of encouraging clinicians to move to or stay in rural or regional locations improves with more time spent in those locations earlier in their careers: Transcript of the Commission, 25 July 2024, T4085.43-T4086.10 (Haq); Transcript of the Commission, 15 May 2024, T2856.9-20, T2856.42-2857.5 (Arnold); Transcript of the Commission, 22 July 2024, T3824.23-28 (Twigg); Transcript of the Commission, 15 October 2024, T5675.37-5679.14 (Morrison); Exhibit L.14, Statement of Dr Matthew Ingram (27 September 2024) [18] [SCI.0011.0461.0001 at 0003].

- 18.113. Those matters indicate that a more strategic, whole of system approach to allocating clinical placements that aligns (so far as possible) with projected future demand for clinicians in the relevant field, is necessary.
- 18.114. In the absence of that type of approach, local organisations can feel that they are “passive recipients of universities having students wanting to come” to them, rather than through the identification of future workforce needs and then attempting to “pull students in” to meet that need.³⁵⁹
- 18.115. Any intervention in the current frameworks relating to clinical placements must recognise that:
- a. there are long standing and well developed relationships between certain universities and certain local organisations that both have value and would be challenging to untangle;³⁶⁰
 - b. the capacity for a particular local organisation to take students on clinical placements depends largely on the availability of their employees to supervise those students,³⁶¹ which makes it important for the Ministry of Health to undertake a more centralised role in close collaboration with local organisations.³⁶² This collaboration would, of course, include ensuring that both placements and the supervision of them are adequately funded. Achieving this within a devolved system may require those members of the workforce distributed throughout the system who are responsible for coordinating and delivering education to be funded through HETI so as to insulate them from the constant pressure imposed upon LHDs to harness “efficiency” in the core business of delivering care. The use of measures such as a divergence between a growth in activity and FTE growth as measures of inefficiency highlight the need for such an approach; and
 - c. there are real financial barriers to students participating in placements away from home, described as “placement poverty”.³⁶³ This issue is particularly acute in the present environment of high living costs. Its impact on students should not be underestimated.
- 18.116. However, those challenges are not insurmountable, and there was acceptance that there was a role for the Ministry of Health in ensuring there was appropriate capacity

³⁵⁹ Transcript of the Commission, 23 July 2024, T3896.17-22 (Hockey); Transcript of the Commission, 23 July 2024, T3936.35-41 (Dewhurst).

³⁶⁰ Transcript of the Commission, 14 October 2024, T5622.35-46 (Baird); Transcript of the Commission, 14 October 2024, T5623.3-12 (Dominish); Transcript of the Commission, 14 October 2024, T5651.7-5652.4 (Anderson).

³⁶¹ Transcript of the Commission, 14 October 2024, T5600.5-39 (Griffiths/Cross).

³⁶² Transcript of the Commission, 14 October 2024, T5614.14-T5615.2 (Griffiths).

³⁶³ Transcript of the Commission, 14 October 2024, T5610.29-38 (Griffiths); Transcript of the Commission, 14 October 2024, T5625.25-32 (Whaites); Transcript of the Commission, 14 October 2024, T5659.29-32 (Griffiths); Transcript of the Commission, 16 October 2024, T5796.21-30 (Yik/Penn).

in the system to accept clinical placements and to manage those placements.³⁶⁴ Indeed, the fact that the capacity to accept student placements goes hand in hand with the availability of clinicians within the system to supervise those students only serves to reinforce the desirability of a more coordinated approach to student placements for the same good reasons why it is desirable to implement a more coordinated approach to workforce planning generally.

18.117. Such an approach would also facilitate the implementation of a recruitment program that is akin to graduate recruitment programs in other contexts. That is, a recruitment program could be undertaken to secure a future workforce while candidates are undergoing training and completing clinical placements. Mr Griffiths described such a model, and its benefits, in the context of the allied health workforce as follows:

10. *Under a standardised program, there would be additional ways in which health students, particularly allied health students, can be incentivised into early career employment within NSW Health. This could include conditional letters of offers of employment which are provided prior to Australian Health Practitioner Regulation Agency registration. This would speed up the on boarding process and reduce risk of losing preferred candidates to the private and NDIS sectors.*
11. *Another option could be re-establishing graduate programs with a more structured pipeline and regional rotation. Such programs would require a strategy to be developed centrally, to mitigate the financial risk of having a certain amount of graduates when we are unable to precisely forecast demand.*
12. *A standardised new graduate program could be established in a number of ways. One way could be via a centralised annual recruitment process to identify existing positions from each LHD/Specialty Health Network that could be converted to a new graduate position for specific allied health professions which are time limited (for example, one or two year contracts) so there is a steady stream of allied health graduates into the system. Once their contract expires, they could apply for ongoing permanent roles.³⁶⁵*

18.118. In identifying a “potential challenge” in adopting such an approach, NSW Health submitted that an early recruitment program of that kind may “not always be practicable” given public sector recruitment requirements.³⁶⁶ It also appeared to be

³⁶⁴ Transcript of the Commission, 23 July 2024, T3898.20-40 (Hockey); noting that some discussions to that effect are already happening in the allied health space: Transcript of the Commission, 14 October 2024, T5606.20-27, T5608.3-34 (Griffiths); Transcript of the Commission, 14 October 2024, T5608.36-5609.32 (Cross).

³⁶⁵ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [10-12] [MOH.0011.0083.0001 at 0002].

³⁶⁶ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.39] [MOH.0010.0758.0001 at 0073].

concerned Counsel Assisting was suggesting an approach that would not involve an appropriate or competitive recruitment process.³⁶⁷

- 18.119. I did not understand any part of the submission of Counsel Assisting on this issue to suggest that I recommend an approach that would be inconsistent with existing public sector recruitment requirements or would not otherwise involve a robust recruitment process. Rather, what was proposed was an adoption of the approach identified by Mr Griffiths. In any event, it would be entirely futile for me to recommend an approach to recruitment that could never be implemented as it was inconsistent with the requirements of the NSW public service. I do not intend to do so.
- 18.120. To be clear, in recommending that NSW Health pursue opportunities to engage in recruitment of clinical staff at an earlier stage – i.e., before they have completed their training – my intention is to simply recommend that, where it is appropriate to do so, a robust and appropriate recruitment process occurs at an earlier stage than it does at present.
- 18.121. Again, it would not be desirable for me to prescribe what form that role should take, or how it ought to be delivered. Such an approach could be established in a number of ways. Those within the Ministry of Health are best placed to determine how that might be done in order to give the system the best chance of harnessing the benefits of it that were described by Mr Griffiths in his evidence.
- 18.122. However, it is apparent that the coordination of clinical placements is a function that is best located within HETI, working in close collaboration with Ministry of Health and the LHDs and SHNs. That function should involve, at the very least:
- a. regular and systematic collaboration with local organisations and universities with a view to establish clinical placements in a way that best meets the future workforce pipeline requirements of the system and (if it can be accommodated within that objective) student demand. This function should be informed by input from the universities as to their student placement needs, data gathered and modelling generated within the Ministry of Health as to system needs, and the availability of appropriate supervision structures. It should also be informed by a recognition that embedding placements in rural and regional locations for as long as practicable is most likely to facilitate the development of a future rural and regional workforce, but also that such placements will require investment to support students whose financial situations would otherwise prevent their participation; and
 - b. a more active role in allocating students to available placements. This could take the form of a preference matching approach like the one taken with medical interns but should in any event have future workforce needs at its core.

³⁶⁷ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.39] [MOH.0010.0758.0001 at 0073].

18.123. Whatever approach is adopted, it must avoid a situation where students are forced into “placement poverty”. To this end, the Ministry of Health and the LHDs and SHNs should facilitate employment opportunities for those who are participating in placements, wherever possible. This is to offset the risk of placement poverty and, as importantly, to maximise the prospect that those participating in the placement program will become embedded within the particular section of the health workforce where they will be most needed upon graduation. This may also require a high degree of collaboration by training organisations, which should be encouraged to structure the delivery of their respective courses in a manner that facilitates paid employment opportunities that align with placements to maximise the benefit obtained by both students and the wider health system.

Training networks

18.124. There are several benefits to the existing vocational training networks, including that they:

- a. assist trainees by providing a complete pathway to meet all the requirements of their training program, rather than requiring the trainee to self-manage their training pathway, which may include having to apply for discrete positions to collate the necessary experience. This is important in overcoming potential bottlenecks in the progression through training programs;³⁶⁸
- b. provide trainees with exposure to different types of facilities, supervisors and working conditions;³⁶⁹
- c. are governed under an overarching structure of experts with oversight of the whole training pathway. This provides an opportunity for the network governing bodies to shape the locations where trainees gather the requisite experience by grouping them into rotations which the trainees are required to complete;³⁷⁰
- d. reduce the administrative burden on individual sites and local organisations, and support consistency, including by allowing for more centralised recruitment and the sharing of educational resources;³⁷¹ and
- e. can assist in attracting trainees to rural and regional sites.³⁷²

18.125. However, they have their limitations.

³⁶⁸ Such bottlenecks have been experienced in anaesthesia, whilst the networked structure has enabled such bottlenecks in radiology training to be resolved: Transcript of the Commission, 24 July 2024, T3957.46-3958.3 (Page); Transcript of the Commission, 30 July 2024, T4255.41-4256.42 (MacPherson); Transcript of the Commission, 18 October 2024, T5957.46-5958.9 (Burnand); Exhibit L.2, Statement of Dr Justine Harris (2 October 2024) [81]-[85] [MOH.0011.0077.0001 at 0016].

³⁶⁹ Transcript of the Commission, 25 July 2024, T4085.13-4087.29 (Haq/Kanhutu).

³⁷⁰ Transcript of the Commission, 30 July 2024, T4254.12-41 (MacPherson).

³⁷¹ Transcript of the Commission, 24 July 2024, T3981.7-47 (Moyle); Transcript of the Commission, 25 July 2024, T4087.31-4088.7 (Kanhutu); Transcript of the Commission, 25 July 2024, T4149.39-45 (Findley).

³⁷² Transcript of the Commission, 25 July 2024, T4087.31-4088.7 (Kanhutu).

- 18.126. The existing networks relate to a limited number of specialties. The main (and perhaps only) reason for this appears to be a lack of funding to expand them.³⁷³ In this respect, Dr Josephine Burnand, Acting Medical Director, HETI, gave evidence that:³⁷⁴

There's certainly an opportunity to expand not only that work within the existing vocational training pathways that we currently oversight, but potentially additional specialist training pathways, particularly when there are workforce issues. And not only where there are workforce issues, but also potentially where there are issues of trainees along that pathway meeting particular training requirements ... some of those bottlenecks that occur in order to meet the college requirements for the training.

- 18.127. The existing training networks have a “metropolitan centric” focus.³⁷⁵ This is partly symptomatic of a broader metrocentric approach to accreditation and training, which has seen the bulk of training concentrated in metropolitan areas.³⁷⁶ But it is also a discrete network problem. For example, the Central Coast LHD considers that it has minimal influence over the allocation of specialist trainees within networks because this allocation is centralised and conducted in a metrocentric way.³⁷⁷ This is consistent with the perception by at least some college representatives that HETI (along with other parts of the wider system) is metropolitan focussed.³⁷⁸

- 18.128. The existing networks are also presently focussed on education and training, rather than planning. In this respect, HETI and the Ministry of Health currently play no established coordinating role in determining where training positions are required to build the necessary workforce. This leads to a lack of “longitudinal and system coordination”.³⁷⁹ The immediate benefits in that coordination were described by Dr Justine Harris, Chief Medical Workforce Advisor, NSW Health, as follows:³⁸⁰

if the vocational training pathways, ones that are HETI governed and the ones that ideally would be sitting under there, were overlaid with the workforce plan, I think that would be the best scenario to respond to the state's needs and the community needs.

³⁷³ Exhibit H.5.19, Statement of Dr Linda MacPherson (12 July 2024) [165] [MOH.0011.0020.0001 at 0032]; Transcript of the Commission, 30 July 2024, T4256.44-4257.5 (MacPherson); Exhibit L.2, Statement of Dr Justine Harris (2 October 2024) [26] [MOH.0011.0077.0001 at 0006]; Transcript of the Commission, 18 October 2024, T5979.11-26 (Harris).

³⁷⁴ Transcript of the Commission, 18 October 2024, T5957.46-5958.9 (Burnand).

³⁷⁵ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [59] [MOH.0011.0022.0001 at 0019]; Transcript of the Commission, 30 July 2024, T4248.31-43 (MacPherson); Transcript of the Commission, 18 October 2024, T5974.36-5975.6 (Newton).

³⁷⁶ Transcript of the Commission, 25 July 2024, T4103.41-46 (Kanhutu); Transcript of the Commission, 30 July 2024, T4224.23-33 (Fielding); Exhibit L.10, Statement of Dr Sanjay Hettige (31 July 2024) [8] [SCI.0011.0287.0001 at 0002].

³⁷⁷ Exhibit H.5.31, Statement of Professor Steevie Chan (29 July 2024) [26] [MOH.0011.0031.0001 at 0007-0008].

³⁷⁸ Transcript of the Commission, 18 October 2024, T5989.7-24 (Fielding).

³⁷⁹ Transcript of the Commission, 18 October 2024, T5984.29-5985.27 (Harris); Transcript of the Commission, 18 October 2024, T5987.18-19 (Kanhutu).

³⁸⁰ Transcript of the Commission, 18 October 2024, T5980.21-25 (Harris).

18.129. There are, of course, challenges in any expansion of the vocational training networks and its related functions to address these deficiencies. These include:

- a. the need to accommodate each college's accreditation requirements. This will require the Ministry of Health, HETI and the colleges to work together to develop mutually acceptable solutions. There may be innovative ways of doing this. For example, the Australian and New Zealand College of Anaesthetists has a system of "satellite" facilities that are not accredited themselves but operate under another facility's accreditation to deliver particular training requirements.³⁸¹ Several colleges are also increasing flexibility in supervision requirements by allowing for some volume of remote, virtual supervision;³⁸² Standardisation of some accreditation requirements with the colleges should also be explored;
- b. the need to provide sufficient "protected time" for supervisors to enable them to deliver training effectively.³⁸³ This is a general problem but may be particularly acute in rural or remote facilities;
- c. the need to have appropriate structural supports in place for trainees required to live and work away from home for some or all of their training programs, including accommodation and social supports;³⁸⁴
- d. the need for adequate funding for the development of new training networks, including for network director and educator roles, and for the enhanced coordinating role in terms of workforce planning. This will probably require some "centralised, quarantined funding"³⁸⁵ otherwise there is a real risk that through notional "efficiency" measures, positions such as those will not be retained; and
- e. the need to keep in mind colleges' national/binational jurisdictions, and trying to minimise "change fatigue" for colleges that have gone through other recent reviews impacting on their operations.³⁸⁶

18.130. As is obvious, pursuing that change will necessarily involve a collaboration with the specialist medical colleges.

³⁸¹ Transcript of the Commission, 24 July 2024, T3964.9-18 (Moyle).

³⁸² Transcript of the Commission, 30 July 2024, T4236.33-45 (Fielding).

³⁸³ Transcript of the Commission, 18 October 2024, T5977.9-15 (Haq).

³⁸⁴ Transcript of the Commission, 18 October 2024, T5996.25-42 (Kanhutu); Transcript of the Commission, 18 October 2024, T6003.4-8 (Page).

³⁸⁵ Transcript of the Commission, 18 October 2024, T5993.9-18 (Harris).

³⁸⁶ Transcript of the Commission, 18 October 2024, T6005.5-19 (Haq); Transcript of the Commission, 18 October 2024, T6010.9-27 (Newton/Kanhutu).

- 18.131. However, none of these challenges is an insurmountable obstacle to expanding HETI's role in relation to training networks. At least some will be addressed through collaboration with the specialist colleges and local organisations,³⁸⁷ and the continued use of the colleges' specialist expertise including in the governance and planning of those networks (which should include appropriate data sharing).
- 18.132. On the other hand, there are likely to be significant benefits from the expansion of the networks. The training system plays a central role in shaping the medical workforce of the future. There are good reasons to think that intervention in training pathways – including by expanding rural and regional training opportunities, relieving bottlenecks and seeking to structure the delivery of training to reflect future service and workforce needs – will help to produce a more evenly distributed medical workforce in the future. A medical workforce that is more appropriately distributed in terms of specialties and locations will better meet the needs of the population and will support long term system sustainability.

Funding the expansion of the Health Education and Training Institute

- 18.133. NSW Health identified a series of “potential challenges” that are created by the proposed changes to the role of HETI that I have identified.³⁸⁸
- 18.134. The first was that there would be “significant work involved” in implementing some of the changes that I have proposed.³⁸⁹ As much may be accepted, but I do not understand NSW Health to be suggesting that change should not be pursued because it would require “significant work” or involve a “significant undertaking”. As I have observed elsewhere, that change requires significant effort or work is not a reason for it to be delayed or abandoned.
- 18.135. Related to that “potential challenge”, NSW Health noted in its written submissions that “[f]unding appropriate to the approach that is adopted would need to be provided to support” any change to current approaches, or expansion of the role of HETI.³⁹⁰ I agree. It would be unreasonable (and foolhardy) to expect HETI to perform a greater role without being adequately resourced to do so. That would only set it up for failure.
- 18.136. To reap the system wide benefits of greater coordination of clinical placements and vocational training through HETI, it must be appropriately and adequately resourced to perform that role. In doing so, there should be quarantined funding for those roles (perhaps in the form of clinical educators) within HETI that are the interface between

³⁸⁷ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.40] [MOH.0010.0758.0001 at 0073].

³⁸⁸ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.37-10.40] [MOH.0010.0758.0001 at 0072-0073].

³⁸⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.37-10.38] [MOH.0010.0758.0001 at 0072].

³⁹⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.26] [MOH.0010.0758.0001 at 0069].

universities, students and local organisations to ensure that local organisations are appropriately supported to deliver high quality and effective student placements over the medium to long term.³⁹¹ Such roles must be protected from broad brush “efficiency” programs. To the extent that NSW Health requires additional funding to, in turn, adequately fund HETI to perform that function, that should occur.

Engaging the workforce

18.137. The general framework in which the health workforce is engaged is set out above. In this section of the Report, aspects of those arrangements as they relate to employees and Visiting Medical Officers, and potential enhancements to them, are explored in more detail.

Employees

18.138. In practice, there are three main sources of terms and conditions of employment for NSW Health Service employees:

- a. awards made under the *Industrial Relations Act*.³⁹² Such an award is an industrial instrument that provides conditions of employment for employees to whom it relates (generally determined by classifications specified in the award). It has statutory force in that it is enforceable against employers bound by the award by employees and industrial organisations concerned in the relevant industry;³⁹³
- b. determinations made by the Health Secretary or a delegate. These may relate to cohorts of employees or to individuals.³⁹⁴ A prominent example is the *Staff Specialists Determination 2015*,³⁹⁵ which sets out entitlements of staff specialists relating to matters including rights of private practice, training, education and study leave and abnormal working hours, which are not dealt with in the *Staff Specialists (State) Award*. Unlike awards, determinations do not have statutory force, although they may be enforceable if they are incorporated into employees’ employment contracts. Not all employees have conditions of employment set by determinations; many are only subject to awards; and
- c. contracts of employment. These usually do not go beyond the terms of applicable awards or determinations. However, they may impose some additional obligations on employees, for example to comply with Ministry of Health Policy Directives such as the code of conduct.

³⁹¹ Transcript of the Commission, 14 October 2024, T5642.22-34, T5653.6-5654.22 (Dominish/Anderson); Transcript of the Commission, 22 July 2024, T3748.37-3749.11 (Halse).

³⁹² *Industrial Relations Act 1996* (NSW) s 10.

³⁹³ *Industrial Relations Act 1996* (NSW) s 12.

³⁹⁴ Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [37]-[40] [MOH.0011.0024.0001 at 0006].

³⁹⁵ Exhibit H.4.17, Staff Specialists Determination 2015 [MOH.9999.0081.0001].

- 18.139. In the NSW Health Service context, the framework is extensive and complex. There are currently 43 awards that apply, comprising over 300 unique classifications, and involving 11 industrial organisations.³⁹⁶ Over 500 determinations have been approved since 2005,³⁹⁷ with at least 25 relating to general cohorts of employees (as opposed to individuals or small, discrete groups).³⁹⁸ There are also 60 workplace relations policies.³⁹⁹
- 18.140. Awards in NSW generally have limited “nominal terms” of between 12 months and three years, although they continue in force until rescinded by the Industrial Relations Commission.⁴⁰⁰ In practice, most awards are replaced at the end of their nominal term by consent. Often, these contain minimal substantive changes, if any, with the main change being to update rates of remuneration. These awards generally contain “no extra claims” clauses, which prevent parties from making claims for additional or reduced conditions of employment during the nominal term.
- 18.141. The Industrial Relations Commission is required to review each award at least once every three years, with the purpose of the review being “to modernise awards, to consolidate awards relating to the same industry and to rescind obsolete awards”.⁴⁰¹ However, at least in recent years, it has not engaged in a substantive review of awards on a regular or systematic basis.⁴⁰² For example, while it appears that at least some awards were reviewed in 2021 and 2022,⁴⁰³ these reviews appear to have focussed on particular issues raised by parties rather than conducting a wholesale review for the purposes of determining whether modernisation or consolidation should occur.

³⁹⁶ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [50] [MOH.0011.0024.0001 at 0018]; Exhibit H.4.30, NSW Health, *Schedule of awards and determinations applicable to NSW Health employees* [MOH.0010.0300.0001]. Thirty-six of the awards are under the auspices of the Health Services Union alone: Transcript of the Commission, 17 October 2024, T5898.1-8 (Collins).

³⁹⁷ Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [40] [MOH.0011.0024.0001 at 0006].

³⁹⁸ Exhibit H.4.30, NSW Health, *Schedule of awards and determinations applicable to NSW Health employees* [MOH.0010.0300.0001].

³⁹⁹ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [50] [MOH.0011.0024.0001 at 0018].

⁴⁰⁰ *Industrial Relations Act 1996* (NSW) s 16(1)-(2).

⁴⁰¹ *Industrial Relations Act 1996* (NSW) s 19(1)-(2).

⁴⁰² Exhibit L.5, Statement of Melissa Collins (4 October 2024) [32] [MOH.0011.0081.0001 at 0008].

⁴⁰³ Miscellaneous Workers Home Care Industry (State) Award [2022] NSWIRComm 1024; Re Motels, Accommodation and Resorts, &c. (State) Award [2021] NSWIRComm 1056; Shop Employees (State) Award [2022] NSWIRComm 1012; Crown Employees (Department of Industry) Land Information Officers Award [2021] NSWIRComm 1096; Sydney Cricket and Sports Ground Trust (Maintenance Staff) Enterprise Award 2018 [2021] NSWIRComm 1075; Marine Charter Vessels (State) Award [2022] NSWIRComm 1009; Crown Employees (Botanic Gardens and Centennial Parklands Building and Mechanical Services Employees) Award 2016 [2021] NSWIRComm 1083; Health Employees' Conditions of Employment (State) Award 2018 (Infectious Cleaning Allowance) [2021] NSWIRComm 1049.

- 18.142. This may be because of a 1998 decision of a Full Bench of the Industrial Relations Commission,⁴⁰⁴ which took a narrow view of the s 19 review process, including that it:
- a. was not to be used for the purpose of ensuring that in substance an award met the needs of employers and employees in the circumstances of the relevant industry or enterprise;⁴⁰⁵
 - b. was not a mechanism for employers or employees to overcome the effects of a previous decision of the Commission or an earlier bargain;⁴⁰⁶
 - c. did not, at least generally, allow the Commission to insert new conditions into an award, even ones the Commission might think should be contained in a “modern” award of that kind;⁴⁰⁷ and
 - d. was to be driven by the parties in the same way as other litigation, such that, for example, the review was to be determined based on material put before it by the parties and not by the Commission “embark[ing] upon a wide ranging investigation into the operation of a particular award or industry”.⁴⁰⁸
- 18.143. Consequently, most of the awards applying to employees in the NSW Health Service have not been reviewed substantively for many years. Many terms of those awards date back decades. Even awards that have seen recent substantive updates, such as the *NSW Ambulance Paramedics (State) Award*, have been updated in a piecemeal way which has not avoided uncertainty and disputation about their meaning.⁴⁰⁹
- 18.144. Similarly, it has been many years since the Industrial Relations Commission gave detailed consideration to the nature of the work performed by most health professionals and its value for the purposes of assessing whether their remuneration and conditions were appropriate. These assessments typically occur in “work value” cases, which are claims (generally made by industrial organisations) for increased wages and conditions because of an increase in the value of the work performed by the relevant employees. For example, the last “work value” assessment in relation to staff specialists was in 2006.⁴¹⁰ Similarly, the last work value assessment in relation to most allied health professionals occurred between 2001 and 2007.⁴¹¹

⁴⁰⁴ Principles for Review of Awards – State Decision 1998 [1998] NSWIRComm 661; (1998) 85 IR 38.

⁴⁰⁵ (1998) 85 IR 38 at 44.

⁴⁰⁶ (1998) 85 IR 38 at 45.

⁴⁰⁷ (1998) 85 IR 38 at 45-46.

⁴⁰⁸ (1998) 85 IR 38 at 56.

⁴⁰⁹ See, for example, *Australian Paramedics Association (NSW) v Health Secretary in respect of New South Wales Ambulance (Virtual Clinical Care Centre Clinicians)* [2024] NSWIRComm 1066.

⁴¹⁰ *Re Staff Specialists (State) Award* [2006] NSWIRComm 124; (2006) 152 IR 405.

⁴¹¹ *Re Health and Community Employees Psychologists (State) Award* [2001] NSWIRComm 302; (2001) 109 IR 458; *Re Health Employees Pharmacists (State) Award* [2003] NSWIRComm 453; (2003) 132 IR 244; *Health Employees Medical Radiation Scientists (State) Award* [2006] NSWIRComm 34; *NSW Health Service Health Professionals (State) Award* [2007] NSWIRComm 300; (2007) 171 IR 8.

Visiting Medical Officers

- 18.145. The terms and conditions relating to the engagement of Visiting Medical Officers are largely set by the *Visiting Medical Officer Determinations* that were produced by arbitrations conducted under the *Health Services Act*. They resemble awards, but have contractual force, albeit that they override any inconsistent contractual provisions.⁴¹² The Ministry of Health has also published “model contracts” containing some terms and conditions that are additional to those set out in the *Visiting Medical Officer Determinations*. There is a policy directive that specifies when each type of contract (sessional or fee for service) should be used.⁴¹³
- 18.146. As noted above, the extant *Visiting Medical Officer Determinations* have not been updated since 2014, although rates of pay have been increased from time to time.

The need for greater flexibility

- 18.147. Mr Spittal gave evidence about the challenges faced by the LHD in recruiting for part time allied health positions. He explained that both Western NSW LHD and the various non-government organisations that operate within it – such as Marathon Health, Livebetter and the Royal Flying Doctors Service – struggle to recruit for allied health roles in the range of 0.2 FTE “because it’s not enough to make an income from”.⁴¹⁴ Equivalent challenges are likely to be faced by LHDs and non-government organisations across the State.
- 18.148. He explained that Western NSW LHD was now working in partnership with various non-government organisations in the area to effectively create full time roles by combining different part time roles under a single employer model.⁴¹⁵

So we are exploring... how we might have a single employer model. So one of the agencies - and in different towns it could be a different agency, sometimes it could be [Western NSW LHD], sometimes it could be the NGO - how we actually work out how we pool our respective needs and that contribution towards salaries to do that.

- 18.149. Although conceptually similar, these arrangements are not part of the single employer arrangements piloted in the Murrumbidgee LHD to support the training of general practitioners.
- 18.150. Under the model referred to by Mr Spittal, an allied health professional would be retained by a single organisation – say an LHD – but work, say, one day per week in

⁴¹² *Health Services Act 1997* (NSW) s 98.

⁴¹³ Exhibit H.3.21, NSW Health, *Visiting Practitioner Appointments in the NSW Public Health System* (PD2016_052) [15.3] [MOH.0011.0004.0001 at 0027].

⁴¹⁴ Transcript of the Commission, 16 May 2024, T2958.21-47 (Spittal).

⁴¹⁵ Transcript of the Commission, 16 May 2024, T2959.1-7 (Spittal). See also Transcript of the Commission, 23 May 2024, T3366.14-36 (Astill).

an LHD facility, one day per week in another LHD facility, and the balance of the week in facilities run by one or more non-government organisations. Under this model, all financial arrangements relating to that individual's salary are made as between the participating organisations and not through separate fractional employment arrangements held by the allied health professional.

- 18.151. Mr Spittal acknowledged that there were logistical barriers to the implementation of this model, particularly where the awards, remuneration rates, and conditions of employment vary between the prospective employers and would need to be “harmonised”. This will be particularly challenging where a participating non-government organisation operates on a small scale and is unable to compete with the remuneration provided for under the applicable NSW Health award (and potentially able to be matched by larger non-government organisations).⁴¹⁶
- 18.152. These challenges should not be allowed to stand in the way of any arrangement which has the real capacity to overcome or ameliorate recruitment and retention challenges which compromise the actual implementation of good service planning. In fact, meaningful collaboration, of the type I believe to be central to good service planning, is likely to be where opportunities for arrangements like those described by Mr Spittal are identified. A suitably flexible approach to workforce planning and engagement will be required if NSW Health is to capitalise on opportunities like this across multiple rural and regional localities.
- 18.153. The need to accommodate flexible arrangements of this type should be recognised in award reform and, to the extent necessary, workforce recruitment and engagement processes within NSW Health must be moulded to encourage and enable them to occur.
- 18.154. I wish to make clear that nothing I have said above in relation to the sensible arrangements referred to by Mr Spittal should be seen as limiting or prescribing the way in which local workforce challenges should be addressed. Flexibility is central to the success of the collaborative and place based approach to service planning that I discuss elsewhere in this Report. Those involved in that process at a local level should have the freedom to deploy resources – both human and financial – in the way that is most likely to achieve the objectives of that planning exercise. In some cases, that may be through arrangements of the type described by Mr Spittal, in others it may involve the workforce of a non-government organisation or primary care provider being supplemented with LHD clinicians if that reflects the most efficient way of delivering a necessary service to a particular community. In every case, the unique circumstances of a location or community will need to be assessed and accommodated.

⁴¹⁶ Transcript of the Commission, 16 May 2024, T2959.8-12, T2960.18-2961.1 (Spittal).

The need for reform

18.155. There was general consensus (except in relation to the *Public Health System Nurses' and Midwives' (State) Award*⁴¹⁷) that NSW Health awards and the *Vising Medical Officer Determinations* were outdated and no longer fit for purpose.⁴¹⁸ However, the reasons for this view varied. For example:

- a. Mr Minns said that many industrial instruments “are outdated, ambiguous, and do not reflect current service delivery models”.⁴¹⁹ He gave the examples of allowances such as the infectious cleaning and nauseous linen allowances in the *Health Employees' Conditions of Employment (State) Award*, which have given rise to frequent disputes because of uncertainty about their scope;⁴²⁰
- b. Ms Collins considered that awards were “outdated, ambiguous, overly prescriptive and can place limits on the ability to engage and retain an agile and contemporary workforce”.⁴²¹ She gave the example of the *Public Hospital Medical Officers (State) Award*, which applies to Junior Medical Officers, as being premised on Monday to Friday daywork in metropolitan facilities, which does not reflect the present reality of their work which is increasingly 24/7, and involves rotations to rural and regional facilities;⁴²²
- c. similarly, Ms Collins agreed that, because it does not allow expressly for shift work or work outside of 7am to 6pm Monday to Friday (except for emergency physicians and certain “averaging” arrangements), the *Staff Specialists Award* does not accommodate the realities of 24/7 service delivery in many specialties.⁴²³ This is a problem exacerbated by the fact that the *Staff Specialists Award* is a “salaried award”, which provides a fixed annual salary for all staff specialists without separate or variable payments for on call and recall or overtime.
- d. Dr Nicholas Spooner, President of ASMOF and Director of Emergency Medicine at Wyong Hospital, described the *Staff Specialists Award* as being “out of date in regard to remuneration and other conditions”, including by paying staff specialists less than other jurisdictions, not remunerating staff specialists separately (or adequately) for on call work or overtime, not including training, education and

⁴¹⁷ Transcript of the Commission, 17 October 2024, T5868.39-5870.27 (Candish).

⁴¹⁸ Transcript of the Commission, 17 October 2024, T5868.39-5871.3 (Hayes/Egan/Holland/Collins).

⁴¹⁹ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [51] [MOH.0011.0024.0001 at 0018].

⁴²⁰ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [52] [MOH.0011.0024.0001 at 0018]; See also Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [58]-[59] [MOH.0011.0024.0001 at 0009-0010].

⁴²¹ Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [54] [MOH.0011.0024.0001 at 0009]; See also Exhibit L.5, Statement of Melissa Collins (4 October 2024) [4], [29a] [MOH.0011.0081.0001 at 0001, 0006-0007].

⁴²² Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [55] [MOH.0011.0024.0001 at 0009].

⁴²³ Transcript of the Commission, 5 August 2024, T4634.13-4635.11 (Collins); Transcript of the Commission, 17 October 2024, T5911.6-17 (Collins).

study leave arrangements in the award (only in a determination), and not dealing with minimum “safe staffing” levels;⁴²⁴

- e. college witnesses raised the need for protected supervision and, for psychiatrists, clinical support time;⁴²⁵
- f. Dominique Egan, Director of Workplace Relations and Legal Counsel at the AMA NSW, described the *Vising Medical Officer Determinations* as outdated, principally because they (in conjunction with the Ministry of Health’s informal determinations) do not provide competitive remuneration with other jurisdictions or the private sector, and they do not adequately compensate for on call arrangements, after hours or weekend work, or remote or virtual service provision;⁴²⁶ and
- g. Gerard Hayes AM, Secretary of the HSU, saw the awards covering the HSU’s members as being “out of date and uncompetitive with the industrial instruments in other Australian states”, in need of consolidation, and not reflecting “modern, flexible ways of working”.⁴²⁷ Examples of outdated features of the awards from Mr Hayes’ perspective included obsolete allowances (such as an “incinerator allowance”) and the absence from awards of some qualifications and roles that now form part of the workforce.⁴²⁸

18.156. Several examples of outdated features of awards relating to allied health practitioners were also highlighted in the evidence. For example, Jill Harris, Director of Radiation Therapy at Westmead and Blacktown Hospitals, pointed to the fact that the award applying to radiation therapists (the *Health Employees’ Medical Radiation Scientists (State) Award*) has not been updated to recognise the fact that the tertiary qualification for radiation therapists has changed from a three year to a four year program.⁴²⁹ The *Health and Community Employees Psychologists (State) Award* has not been updated to take account of changes in the education and registration requirements for psychologists (including an increase in the standard minimum length of a university degree from four years to five years).⁴³⁰ There is also a general sense that allied health awards typically lack appropriate career progression options.⁴³¹

⁴²⁴ Exhibit H.7.6, Statement of Dr Nicholas Spooner (17 July 2024) [28]-[41] [SCI.0011.0249.0001 at 0006-0008]; See also Transcript of the Commission, 23 July 2024, T3853.23-30 (Spooner). Similar views were expressed by other witnesses: see Transcript of the Commission, 17 October 2024, T5874.41-46 (Holland); Transcript of the Commission, 24 July 2024, T4012.31-4013.17 (Moyle); Transcript of the Commission, 24 July 2024, T4051.4-47 (Virgona).

⁴²⁵ Transcript of the Commission, 18 October 2024, T5977.9-15 (Haq); Transcript of the Commission, 24 July 2024, T4051.9-19 (Virgona).

⁴²⁶ Exhibit H.7.13, Statement of Dominique Egan (25 July 2024) [50]-[72] [SCI.0011.0283.0001 at 0010-0014].

⁴²⁷ Exhibit L.15, Statement of Gerard Hayes (30 September 2024) [14]-[22] [SCI.0011.0464.0001 at 0003-0005].

⁴²⁸ Transcript of the Commission, 17 October 2024, T5871.38-44, 5872.21-38 (Hayes). Ms Collins agreed that consolidation of the HSU awards is desirable: Transcript of the Commission, 17 October 2024, T5872.40-5873.7 (Collins).

⁴²⁹ Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [9]-[13] [SCI.0011.0155.0001 at 0002-0003].

⁴³⁰ Exhibit H.7.5, Statement of Associate Professor Lil Vrklevski (16 July 2024) [8]-[9] [SCI.0011.0198.0001 at 0002].

⁴³¹ See, for example, Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [22] [SCI.0011.0155.0001 at 0005]; Exhibit H.7.5, Statement of Associate Professor Lil Vrklevski (16 July 2024) [10]-[11] [SCI.0011.0198.0001 at 0002]; Exhibit L.13, Statement of Jerry Yik and Dr Jonathan Penm (26 September 2024) p 15 [SCI.0011.0459.0001 at 0015].

18.157. These issues with award arrangements have manifested in various ways. One is industrial disputation about the meaning of award provisions. Others include:

- a. industrial action, which has occurred in a public way throughout the course of this Special Commission across several health professions, with a dominant focus on wages;
- b. the use of uni-lateral determinations by the Ministry of Health to fill gaps in the conditions provided for by awards;⁴³²
- c. the spread of “unauthorised non-standard arrangements”, a euphemistic description of payments made, or conditions afforded to employees in excess of those provided for under the award or determinations and not approved by anyone holding a valid delegation to do so;⁴³³ and
- d. difficulties experienced by “border” LHDs, such as Northern NSW LHD and Southern NSW LHD, in attracting and retaining staff because of a pay disparity with other jurisdictions.⁴³⁴

18.158. A consequence of the variety of views about the deficiencies in the current award framework is that different stakeholders have different perceptions of what “award reform” should encompass. For example, the Ministry of Health tends to view award reform predominantly as a process of simplification, consolidation and increasing flexibility for the employer to accommodate what it sees as its service delivery needs.⁴³⁵ On the other hand, industrial organisations tend to view award reform predominantly as involving increased remuneration and improved conditions to appropriately compensate for what their members see as the pressure points in their daily work.⁴³⁶

18.159. Some of these perspectives will overlap: for example, the changes required to accommodate the employer’s changing service delivery needs can be expected to reflect the realities of the work employees actually perform in their roles. But it is in the nature of any industrial environment that interests will diverge at some point. Any award reform process will need to navigate this industrial reality.

18.160. There were also different views as to what form an “award reform” process might take. Some industrial organisations advocated for, in effect, starting again with a blank sheet of paper,⁴³⁷ while the NSWNMA was not in favour of wholesale reform of

⁴³² Exhibit H.7.1, Statement of Jill Harris (12 July 2024) [9]-[13] [SCI.0011.0155.0001 at 0002-0003].

⁴³³ Exhibit H.5.22, Statement of Philip Minns (17 July 2024) [54] [MOH.0011.0024.0001 at 0019]; Exhibit H.5.23.2, Supplementary Statement of Melissa Collins (3 August 2024) [MOH.0011.0038.0001]; See also, for example, Exhibit H.5.18, Statement of Dr Karen Murphy (12 July 2024) [25] [MOH.0011.0019.0001 at 0007].

⁴³⁴ Transcript of the Commission, 19 September 2024, T5416.25-5417.38 (McCosker); Transcript of the Commission, 15 August 2024, T4985.8-23, 4986.23-31 (Ayers).

⁴³⁵ Exhibit L.5, Statement of Melissa Collins (4 October 2024) [60]-[61] [MOH.0011.0081.0001 at 0014].

⁴³⁶ Exhibit L.5, Statement of Melissa Collins (4 October 2024) [62]-[63] [MOH.0011.0081.0001 at 0014].

⁴³⁷ Exhibit L.12, Statement of Dr Nicholas Spooner (20 September 2024) [30] [SCI.0011.0448.0001 at 0006]; Exhibit L.15, Statement of Gerard Hayes AM (30 September 2024) [19] [SCI.0011.0464.0001 at 0005].

the *Nurses and Midwives Award* at all.⁴³⁸ The AMA NSW and the Ministry of Health appear to favour a “middle ground” in which parts of the existing instruments are maintained.⁴³⁹

18.161. All parties wished to preserve the role of bargaining in seeking to achieve award reforms but could also see at least a prospective role for the Industrial Relations Commission in the process.⁴⁴⁰ Several stakeholders, agreed that a legislated “sunset date” for any award reform process would be appropriate.⁴⁴¹

18.162. Many awards, on their face, are overly long, not drafted in plain language, are frequently ambiguous, and replete with inconsistencies and incoherences (both internally and with other awards dealing with similar professions).⁴⁴² The number of awards dealing with allied health professions lacks any rational explanation except for history. In this respect, in a recent decision approving (by consent) increased remuneration in several HSU awards, Justice Taylor, President of the Industrial Relations Commission, made the following pertinent observation:⁴⁴³

Finally, I commend the parties for their commitment to reforming these awards and to reducing the number of professional awards. There is real scope to simplify awards in this sector and to standardise conditions for similar workers, to the mutual advantage of the parties. ... The Commission stands ready to assist the parties in that endeavour.

18.163. There is also a lack of an obvious rationale for having several determinations that set terms and conditions of employment for the same cohorts covered by awards but outside of the award structure. While that approach may have been taken to provide for those terms and conditions without then attaining statutory force through inclusion in awards, some (like training, education and study leave rights in the *Staff Specialists Determination*) have become sufficiently engrained that they are regarded as minimum conditions for staff specialists and thus they should be considered for inclusion in the *Staff Specialists Award*. These issues, though formal in nature, are important because awards should be capable of being readily understood and applied by employees, industrial representatives, and local organisations without substantial industrial knowledge and experience.

⁴³⁸ Transcript of the Commission, 17 October 2024, T5910.4-17 (Candish).

⁴³⁹ Transcript of the Commission, 17 October 2024, T5910.23-28 (Egan); Transcript of the Commission, 17 October 2024, T5910.38-5911.32 (Collins).

⁴⁴⁰ Transcript of the Commission, 17 October 2024, T5902.4-41 (Hayes and Minns); Transcript of the Commission, 17 October 2024, T5910.9-17 (Candish); Transcript of the Commission, 17 October 2024, T5910.32-34 (Holland).

⁴⁴¹ Transcript of the Commission, 22 July 2024, T3755.31-38 (Halse); Transcript of the Commission, 5 August 2024, T4605.23-29 (Egan); Transcript of the Commission, 7 August 2024, T4802.7-27 (Collins).

⁴⁴² As a further example of a lack of coherence and consistency between awards, see *Health Services Union NSW v Secretary, NSW Ministry of Health in respect of NSW Health Pathology and Sydney Children's Hospitals Network (Technical Officers and Hospital Scientists Dispute)* [2024] NSWIRComm 1057.

⁴⁴³ *Re Health and Community Employees Psychologists (State) Award 2024 and other Health Awards* [2024] NSWIRComm 15 at [7].

- 18.164. In addition to these issues of form, as set out above, there are important issues of substance with many awards, including their ability to reflect current work practices and changes in qualifications and registration requirements among allied health professions. They also include a lack of appropriate opportunities for career progression in some cohorts.
- 18.165. The picture that clearly emerged in the evidence on this topic is that there is an urgent need for a broad project of award reform in respect of NSW Health awards. Recent history suggests that if that does not occur, NSW Health, and the industrial organisations and their members, will likely continue to be engaged in a rolling series of negotiations and disputes.
- 18.166. The various issues that were identified with the current industrial instruments can only sensibly be addressed by a wholesale review of the relevant awards in form and in substance. While the NSWNMA resisted the idea that the *Nurses and Midwives Award* requires wholesale reform – it may be that it is an example of an award that is more current than others – in my view, there is no good reason to exclude it from a wider review and reform project. Its drafting follows a similar form and structure to other NSW Health awards, which warrants at least consideration as to whether it should be modernised. Further, there will be a need to consider relativities between NSW Health awards, such that any changes to other awards may impact on the appropriate pay and conditions under the *Nurses and Midwives Award*.
- 18.167. A significant issue raised in the evidence, and by clinicians around the State, was the adequacy of remuneration for health professionals in NSW. Comparisons were regularly made between the remuneration offered in NSW, and that offered in other jurisdictions.
- 18.168. There are some complexities in drawing direct comparisons between remuneration offered in NSW with that offered in other jurisdictions, due to the way allowances and other benefits are accounted for. However, when a comparison of base rates is made, it is evident that the salary range for staff specialists is the lowest of all Australian states and territories.
- 18.169. As illustrated in Figure 9, even accounting for the difficulties in making “like for like” comparisons with other jurisdictions, the rates of staff specialist remuneration are uncompetitive with other jurisdictions.⁴⁴⁴

⁴⁴⁴ Transcript of the Commission, 7 August 2024, T4648.3-10 (Collins).

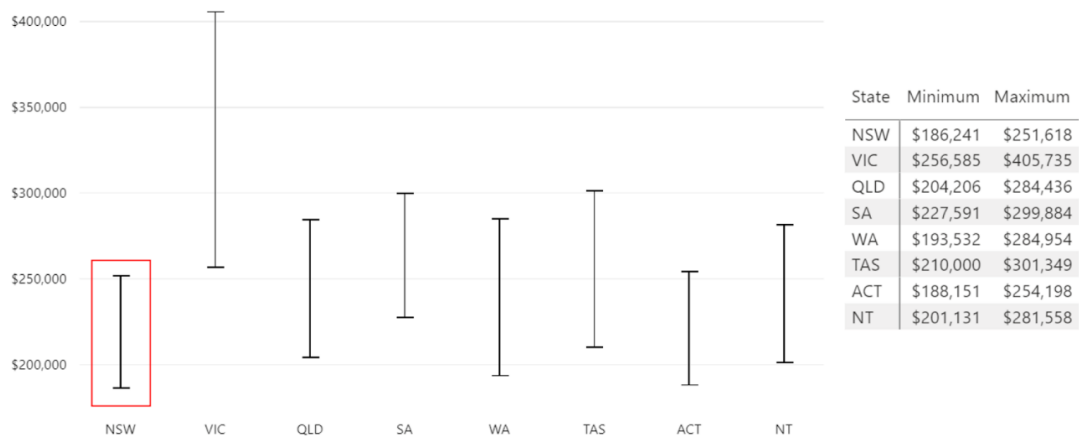


Figure 9: Staff specialist base pay with interstate comparison⁴⁴⁵

- 18.170. When base rates of pay are considered, the salary range for Junior Medical Officers starts the lowest but increases to around the middle of the range. Similarly, the salary range for nurses and midwives starts the second lowest but increases to around the middle of the range. Allied health professionals at all levels are paid around the middle of the range for all states and territories.⁴⁴⁶
- 18.171. When considering disparity between base levels of remuneration between jurisdictions it is, of course, necessary to recognise that the differences that have arisen are the product of different government policies. In the NSW context, they include the long standing wages “cap”. But they also include policy decisions taken by other governments over that same period.
- 18.172. Whether parity is ultimately to be achieved or not, there can be no genuine controversy that the pay and conditions of health professionals in NSW should be appropriate to the work performed. In seeking to identify what appropriate pay and conditions are in any circumstance, the following key considerations arise:
- first, that health professionals in NSW should be fairly and reasonably compensated for the value of their work to the system. This will require an assessment of the nature of their work, the skill and responsibility involved, and the contribution it makes to the system, including any changes in those qualities since the last “work value” assessment. The contribution a profession makes to the system should be viewed broadly, not as limited to questions of productivity, efficiency or savings. It should also be recognised that the value of contributions to the system may differ, and therefore that differences in pay and conditions may be justified. This concept is not adequately embodied in any of the current NSW Health awards and – at least in the eyes of the

⁴⁴⁵ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) [Figure 17] p 33 [MOH.0010.0377.0001 at 0033].

⁴⁴⁶ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [30] [MOH.0011.0022.0001 at 0010]; Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) pp 32-35 [MOH.0010.0377.0001 at 0032-0035].

health workforce - was fundamentally undermined by the arbitrary cap imposed on public sector wage increases;

- b. secondly, the impact that any current or changed pay and conditions may have on attraction and retention. These matters should be the subject of detailed quantitative and qualitative analysis. To the extent there is no demonstrable system wide impact, but a demonstrable impact in certain areas or for certain pockets of employees, then again, consideration should be given to differential remuneration structures or conditions for those employees; and
- c. thirdly, the fiscal or economic impact of increasing pay and conditions. Again, any asserted impacts of this kind should be demonstrated by evidence, including economic modelling where appropriate, not by mere assertion.

Mechanisms for reform

18.173. During this Special Commission, there were several ongoing industrial processes in relation to the NSW Health workforce:

- a. the HSU and the Ministry of Health are holding discussions, which commenced in about early 2024, with the aim of consolidating the 36 HSU awards into a small number of “streams”;⁴⁴⁷
- b. in November 2024, by the consent of the Health Secretary and the HSU, the Industrial Relations Commission made orders, the effect of which was to approve amendments to several awards, including a 3.5 per cent increase to salaries effective from 1 July 2024;⁴⁴⁸
- c. since at least August 2024, the Health Secretary (NSW Ambulance) and the HSU have been in dispute over issues including an alleged ongoing failure to maintain “full roster maintenance” with respect to NSW Ambulance.⁴⁴⁹ As at the time of writing, the dispute remained on foot before the Industrial Relations Commission;⁴⁵⁰
- d. the NSWNMA and NSW Health have engaged in an ongoing industrial dispute over pay and conditions for public sector nurses; however, agreement has not been reached. Negotiations have been ongoing since at least 10 May 2024.⁴⁵¹ On

⁴⁴⁷ Transcript of the Commission, 7 August 2024, T4801.31-37 (Collins). However, it is anticipated that rates of pay will likely become a sticking point in these negotiations: Transcript of the Commission, 7 August 2024, T4801.39-4802.5 (Collins); Transcript of the Commission, 17 October 2024, T5902.43-5903.10 (Hayes), T5903.18-42 (Minns).

⁴⁴⁸ *Re Health and Community Employees Psychologists (State) Award 2024 and other Health Awards* [2024] NSWIRComm 15 (Taylor J, President); *Re Operational Ambulance Managers (State) Award 2024* [2024] NSWIRComm 17 (Taylor J, President), at [1].

⁴⁴⁹ *Health Secretary (NSW Ambulance) v Health Services Union NSW & Anor* [2024] NSWIRComm 12 (Chin J, Vice President), at [1]; *Health Secretary (NSW Ambulance) v Health Services Union NSW & Anor (No 2)* [2024] NSWIRComm 18 (Chin J, Vice President), at [1]-[3].

⁴⁵⁰ *Health Secretary (NSW Ambulance) v Health Services Union NSW & Anor* [2024] NSWIRComm 12 (Chin J, Vice President), at [22].

⁴⁵¹ *Health Secretary, Ministry of Health v NSW Nurses and Midwives' Association* [2024] NSWIRComm 3 (Chin J, Vice President), at [1].

18 September 2024, proceedings commenced in the Industrial Relations Commission.⁴⁵² The Industrial Relations Commission recommended, among other things, that the parties to the dispute enter discussions immediately on the basis that the Health Secretary would agree to a 3 per cent interim increase in salaries.⁴⁵³ While that interim increase was effected in late 2024,⁴⁵⁴ those discussions did not result in the resolution of the underlying dispute, and accordingly it was programmed for arbitration.⁴⁵⁵ As at the time of writing, it appears that the arbitration process remains on foot;

- e. the AMA NSW has been preparing to commence an arbitration in relation to the *Visiting Medical Officer Determinations*;⁴⁵⁶ and
- f. ASMOF and the Ministry of Health have been engaged in ongoing “mutual gains bargaining”, which commenced on 15 December 2023.⁴⁵⁷ At the time of writing this Report, that process has not resulted in agreement between the parties.⁴⁵⁸ Relatedly, ASMOF made a claim for a new award in respect of the psychiatry workforce (to be called the *Psychiatry Staff Specialises Attraction and Retention (State) Interim Award 2025*), including a claim for interim relief in the nature of a payment of an allowance. The Industrial Relations Commission commenced arbitration in respect of the claim for that allowance, which was heard in March 2025. At the time of writing this Report, that process was at risk of stalling as a result of concurrent industrial action by the wider medical workforce.⁴⁵⁹

18.174. It was not the function of this Special Commission, nor would it have been appropriate, to engage in a consideration of the merits of those (and other) industrial matters. However, it is clear the lengthy ongoing engagement in relation to many of the industrial instruments that apply to the health workforce is in large part a product of their complexity, and highlights the challenges in achieving substantive award reform through bargaining processes.

18.175. The issue of remuneration levels also looms large in many of those ongoing processes. Despite the removal of the “wages cap”, the Ministry of Health remains

⁴⁵² Transcript of the Commission, 17 October 2024, T5892.43-5893.5 (Minns); Transcript of the Commission, 17 October 2024, T5878.18-5879.9 (Candish); See *New South Wales Nurses and Midwives' Association v State of NSW* [2024] NSWSC 636.

⁴⁵³ *Health Secretary, NSW Ministry of Health v New South Wales Nurses and Midwives Association* [2024] NSWIRComm 4 (Taylor J, President).

⁴⁵⁴ *Health Secretary, NSW Ministry of Health v New South Wales Nurses and Midwives Association (No 2)* [2024] NSWIRComm 9 (Taylor J, President), at [3].

⁴⁵⁵ *Health Secretary, NSW Ministry of Health v New South Wales Nurses and Midwives Association (No 3)* [2024] NSWIRComm 16 (Taylor J, President), at [2].

⁴⁵⁶ Transcript of the Commission, 5 August 2024, T4604.9-16 (Egan).

⁴⁵⁷ *Industrial Relations Act 1996 (NSW)* ch 2A.

⁴⁵⁸ Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [89]-[98] [MOH.0011.0025.0001 at 0015-0016]; Transcript of the Commission, 17 October 2024, T5892.43-5893.5 (Minns), T5911.6-17 (Collins).

⁴⁵⁹ See generally: *Health Secretary, Ministry of Health v Australian Salaried Medical Officers Federation (New South Wales)* [2025] NSWIRComm 4; *Health Secretary, Ministry of Health v Australian Salaried Medical Officers' Federation (New South Wales)* [2025] NSWIRComm 5.

bound by a NSW Government wages policy.⁴⁶⁰ The current wages policy has the practical effect of capping the amount of any annual increase in total employee remuneration that may be offered by NSW Government agencies without identifying savings or efficiency improvements.⁴⁶¹

- 18.176. This means that any increases in employee remuneration above limits set out in the wages policy, or above what can be justified by savings or efficiency improvements, cannot be agreed to by the Ministry of Health ⁴⁶² and must instead be arbitrated in the Industrial Relations Commission. Conversely, industrial organisations are, understandably, not prepared to agree to substantial changes to the structure or flexibility of work allowed for by awards without what they perceive as a *quid pro quo* in the form of monetary compensation.
- 18.177. Thus, there are barriers to the bargaining process, by itself, achieving the necessary extent of award reform. As an example, the (as of the time of writing) current proceedings between the Health Secretary and ASMOF in the Industrial Relations Commission, together with industrial action, in my view clearly demonstrate that current processes are unlikely to result in the kind of reform that is now required. As set out above, I have been told that the problems with the awards extend well beyond the remuneration provided for in them. However, the current process – and the understandable focus on remuneration levels – seems unlikely to produce the wholesale reform that is required.
- 18.178. The prospect that the parties themselves will reach agreement on all aspects of the awards that need modernisation seems remote, at least in the short to medium term. Accordingly, if there is to be prompt and meaningful reform, there must be a process that results in a wholesale review and modernisation of those awards that (almost) everyone agrees are significantly out of date and no longer fit for purpose. That is not likely to occur within current structures, which are substantially driven by the parties. That is not to diminish the importance of the parties' contributions to that outcome, which will be essential. Nor is it a criticism of the parties. Instead, it reflects the inherent difficulties in achieving significant and substantive "award reform" through negotiation by parties that, naturally, have different perspectives and, at least in some respects, interests.
- 18.179. There have been models by which award reform has been pursued in other jurisdictions. One such example is the award modernisation process that occurred in the federal jurisdiction in 2008 and 2009. It was a legislated process under Part 10A of the *Workplace Relations Act 1996* (Cth), which involved the Australian Industrial

⁴⁶⁰ Exhibit H.3.58, *NSW Government Fair Pay and Bargaining Policy 2023* [MOH.0010.0143.0001]; Exhibit H.5.23, Statement of Melissa Collins (17 July 2024) [42]-[43] [MOH.0011.0025.0001 at 0007].

⁴⁶¹ Exhibit H.3.58, *NSW Government Fair Pay and Bargaining Policy 2023*, cl 3 [MOH.0010.0143.0001 at 0004].

⁴⁶² Unless the Expenditure Review Committee of Cabinet were to give approval.

Relations Commission making a single, coherent set of “modern awards” to replace many pre-reform awards and other instruments.

18.180. Section 576A(2) of the *Workplace Relations Act* specified certain objects that were to be met by the modernised awards, which it is worth setting out in full:

(2) *Modern awards:*

- (a) *must be simple to understand and easy to apply, and must reduce the regulatory burden on business; and*
- (b) *together with any legislated employment standards, must provide a fair minimum safety net of enforceable terms and conditions of employment for employees; and*
- (c) *must be economically sustainable, and promote flexible modern work practices and the efficient and productive performance of work; and*
- (d) *must be in a form that is appropriate for a fair and productive workplace relations system that promotes collective enterprise bargaining but does not provide for statutory individual employment agreements; and*
- (e) *must result in a certain, stable and sustainable modern award system for Australia.*

18.181. Section 576B(2) of the *Workplace Relations Act* also set out certain matters that the Commission was required to have regard to in performing its award modernisation function, including:

- (a) *promoting the creation of jobs, high levels of productivity, low inflation, high levels of employment and labour force participation, national and international competitiveness, the development of skills and a fair labour market;*
- (b) *protecting the position in the labour market of young people, employees with a disability and employees to whom training arrangements apply;*
- (c) *the needs of the low-paid;*
- (d) *the desirability of reducing the number of awards operating in the workplace relations system;*
- (e) *the need to help prevent and eliminate discrimination on the grounds of race, colour, sex, sexual preference, age, physical or mental disability, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction or social origin, and to*

promote the principle of equal remuneration for work of equal value;

- (f) the need to assist employees to balance their work and family responsibilities effectively, and to improve retention and participation of employees in the workforce;*
- (g) the safety, health and welfare of employees;*
- (h) relevant rates of pay in [predecessor instruments];*
- (i) minimum wage decisions of the [relevant decision-maker];*
- (j) the representation rights ... of organisations and transitionally registered associations.*

18.182. The modernisation process was triggered by an “award modernisation request” made by the Minister for Employment and Workplace Relations, which set out details of the process to be followed and its timeframe (subject to an overall legislated time limit of two years).⁴⁶³

18.183. The process followed by the Australian Industrial Relations Commission in practice was, broadly, to:

- a. establish a timetable for dealing with each relevant industry or occupation, including a list of priority industries and occupations that were dealt with first, in consultation with relevant peak organisations and industrial parties;
- b. address a number of general issues, including the drafting of standard clauses, which would apply across all modern awards, again in consultation and having regard to submissions from relevant peak organisations and industrial parties;⁴⁶⁴ and
- c. for each relevant industry or occupation:
 - i. invite initial submissions and proposed draft modern awards from the relevant industrial parties;
 - ii. publish an “exposure draft” modern award, developed by the Commission based on the parties’ drafts and submissions, for comment; and
 - iii. finalise the modern award based on the parties’ submissions about the exposure drafts.

18.184. One key distinction between the federal award modernisation process and the needs of a reform project that have emerged in the evidence is that it was an object of the federal process to neither disadvantage employees nor increase costs for

⁴⁶³ See, for example, The Hon. Julia Gillard MP, Request under section 576C(1) – Award Modernisation – Consolidated Version (9 November 2009).

⁴⁶⁴ *Award Modernisation* [2008] AIRCFB 1000.

employers.⁴⁶⁵ In other words, it was a “pure” process of consolidation and modernisation, without incorporating a substantive review of whether the resulting terms and conditions were fair and reasonable. A process of that kind will not address many of the matters that now cause the relevant awards to be out of date. A more comprehensive process is required here.

- 18.185. An award modernisation process also occurred in Queensland between 2014 and 2016, that dealt with all Queensland public sector awards.⁴⁶⁶ The Queensland process was conducted under the auspices of the Queensland Industrial Relations Commission. Unlike the federal process, it permitted consideration of the substantive fairness and reasonableness of the terms and conditions in the relevant awards. Although it experienced significant delays, which later gave rise to some difficulties – it should not be assumed that the same would occur in the present context, and in any event should not be seen as a reason to avoid such a process in this State.⁴⁶⁷
- 18.186. The time has come for wholesale award reform and modernisation in relation to the healthcare workforce. Awards and determinations that do not reflect current working practices should not be maintained. The process of award reform and modernisation should include a consideration of whether the terms and conditions contained in them are reasonable.
- 18.187. The obvious forum for a process to modernise the industrial awards and instruments that apply to the health workforce is the Industrial Relations Commission. It is a specialist court and tribunal, comprising judges and commissioners with substantial industrial knowledge, skill and experience. It already has a wide jurisdiction with respect to NSW Health awards and NSW Health Service employees, and (following recent legislative amendment)⁴⁶⁸ to Visiting Medical Officers.
- 18.188. It also has an existing award modernisation function under s 19 of the *Industrial Relations Act*. However, the narrow construction that has been given to those provisions to date means that if (what most regard as the necessary) wholesale award reform is to be carried out in the Industrial Relations Commission (which it should be), legislative amendment will likely be required to trigger that process and ensure that it is one that is not constrained by the construction given to s 19 of the *Industrial Relations Act* to date.
- 18.189. That legislative amendment should also include a process for regular substantive reviews of those instruments by the Industrial Relations Commission that is similarly uninhibited by the narrow way in which s 19 of the *Industrial Relations Act* has been

⁴⁶⁵ The Hon. Julia Gillard MP, Request under section 576C(1) – Award Modernisation – Consolidated Version (9 November 2009) cl 2.

⁴⁶⁶ *Industrial Relations Act 1999* (Qld) pt 8; The Hon. Grace Grace MP, Request under section 140CA(1) – Award Modernisation – Consolidated Request arising from Variation Notice (6 June 2016).

⁴⁶⁷ See, for example, Queensland Services, *Industrial Union of Employees v Moreton Bay Regional Council* [2022] ICQ 23.

⁴⁶⁸ Health Services Amendment (Visiting Medical Officers) Regulation 2024.

construed. In my view, such a process will limit the risk that those industrial instruments fail to keep pace with changes in the health system that affect the way in which its workforce performs their respective roles. If that is not done, the benefits of the award modernisation process will not be maintained into the future.

- 18.190. NSW Health submitted that existing processes provide a framework in which award reform is achievable.⁴⁶⁹ As a general statement, that might be right. However, recent experience – a prime example being the dispute between the Health Secretary and ASMOF that was playing out as this Report was being written – demonstrates that the availability of those processes has not facilitated the modernisation or reform of those awards to the extent that (almost) all agree is required.⁴⁷⁰
- 18.191. In its written submissions, NSW Health identified several factors that have “hampered” award reform in the current legislative context. It then went on to submit that as a result of those factors, a legislative amendment “would not address the barriers to much needed award reform”.⁴⁷¹
- 18.192. It is not clear to me why those barriers – which all rise in the context of inter parties processes – would remain if the Industrial Relations Commission exercised its powers in s 19 of the *Industrial Relations Act* in a way that was uninhibited by the narrow construction that has been applied to those powers, and in doing so, undertook a wholesale review and modernisation of relevant awards.
- 18.193. What is now needed is for the Industrial Relations Commission to undertake a full review and modernisation (including a consideration of whether terms and conditions are reasonable) of the awards that apply to the health workforce. If there is some doubt about whether the process available in s 19 of the *Industrial Relations Act* – constrained by the narrow construction of those powers that have previously been applied to it – would permit that to occur,⁴⁷² such legislative change as is necessary to give the Industrial Relations Commission the ability to do so should be made.
- 18.194. It will be a matter for the Industrial Relations Commission as to how it conducts that process, and it would not be appropriate for me seek to dictate how that should occur. However, NSW Health’s observation that such processes in other jurisdictions have been lengthy ought not give rise to any concern as to the utility of the process that I

⁴⁶⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.45-10.49] [MOH.0010.0758.0001 at 0075-0076].

⁴⁷⁰ Including for the very reasons identified by NSW Health in its written submissions: Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.50] [MOH.0010.0758.0001 at 0076].

⁴⁷¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.50-10.51] [MOH.0010.0758.0001 at 0076].

⁴⁷² It is unclear whether that was the intent of NSW Health’s submission. There is some tension in NSW Health’s submission that the current processes provide an appropriate avenue for award reform on the one hand (see Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.45-10.49] [MOH.0010.0758.0001 at 0075-0076]), but that triggering the Industrial Relations Commission’s powers under s 19 of the Industrial Relations Commission would not achieve that result and overcome those barriers that arise in ordinary inter-parties processes, including bargaining (see Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.50-10.51] [MOH.0010.0758.0001 at 0076-0077]).

recommend, nor is it a reason not to pursue the changes that are necessary to give effect to it.⁴⁷³ While delays may have been experienced in another jurisdiction when a similar process was undertaken, it is a very safe assumption to make that the Industrial Relations Commission will approach and conduct any such process as quickly and as efficiently as possible. I did not take NSW Health to have made a contrary suggestion.

Workforce management

- 18.195. Reflective of the importance of the workforce to any operation, particularly one as large as the NSW public health system, NSW Health has a wide range of policy directives, guidelines and similar documents directed to workforce management and engagement.
- 18.196. Throughout the work of this Special Commission, several issues in relation to how NSW Health engages with its workforce were raised. Three warrant attention in this Report.

Consultation between management and the clinical workforce

- 18.197. As was highlighted by Commissioner Garling, effective consultation between health system management and clinicians is an integral part of a highly performing health system.⁴⁷⁴
- 18.198. To promote effective consultation, several structures were created to provide the opportunity and forum for that consultation to take place: Medical Staff Councils, Executive Medical Staff Councils, and Clinical Councils.
- 18.199. In this respect, the Chief Executives of LHDs and Statutory Health Corporations (including the SHNs) have power under the *Health Services Act* to establish “such committees and councils as he or she considers appropriate to assist [the LHD or Statutory Health Corporation] in the exercise of its functions”.⁴⁷⁵ The Health Secretary also has power under the *Health Services Act* to make Model By-Laws for or with respect to (among other things) the appointment and functions of the councils and committees of an LHD or Statutory Health Corporations.⁴⁷⁶
- 18.200. The Health Secretary has exercised that power, with the most recent Model By-Laws having been made on 17 September 2021.⁴⁷⁷ The Model By-Laws do not have

⁴⁷³ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.52] [MOH.0010.0758.0001 at 0077-78].

⁴⁷⁴ Exhibit N4.2, *Special Commission of Inquiry Acute Care Services in NSW Public Hospitals* (Final Report, 27 November 2008) Overview, [1.73]–[1.74] [SCI.0011.0756.0001 at 0015].

⁴⁷⁵ *Health Services Act* (NSW) ss 29B, 54.

⁴⁷⁶ *Health Services Act* (NSW) ss 39(1)(g), 60(1)(h).

⁴⁷⁷ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* [SCI.0001.0002.0001]; see NSW Government Gazette, 17 September 2021.

binding force in themselves but, in practice, they have been adopted by LHDs and Statutory Health Corporations.⁴⁷⁸

18.201. Among other things, the Model By-Laws provide for the local organisation 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”.⁴⁷⁹ The Model By-Laws describes the objectives of those structures as being to:⁴⁸⁰

- 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.

18.202. The Model By-Laws also provide for the establishment and operations of these structures. In relation to Medical Staff Councils, these provisions include:

- 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;⁴⁸¹
- b. the Medical Staff Councils are to be comprised of (leaving aside NSW Health Pathology) all visiting practitioners, staff specialists, career medical officers and dentists appointed to the organisation or the hospital or hospitals the Council represents;⁴⁸²
- c. sufficient Medical Staff Councils should be established to ensure that all visiting practitioners, staff specialists, career medical officers and dentists of the LHD are members;⁴⁸³
- 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 the 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 or part thereof);⁴⁸⁴ and
- e. the function of the Medical Staff Executive Council is to provide advice to the Chief Executive and the Board of the LHD on medical matters, and nominate medical

⁴⁷⁸ See, e.g., Exhibit H.5.32, Statement of Dr Teresa Anderson AM (30 July 2024) [9] [MOH.0011.0034.0001 at 0002].

⁴⁷⁹ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 21 [SCI.0001.0002.0001 at 0006].

⁴⁸⁰ Exhibit H.2.57, *Model By-laws* at cl 22 [SCI.0001.0002.0001 at 0006-0007].

⁴⁸¹ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 24(1) [SCI.0001.0002.0001 at 0007].

⁴⁸² Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 24(2)(a) [SCI.0001.0002.0001 at 0007].

⁴⁸³ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 24(3) [SCI.0001.0002.0001 at 0007].

⁴⁸⁴ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 25 [SCI.0001.0002.0001 at 0008].

practitioners for consideration as members of the Board: cl 26. The constitution and procedure provisions for LHD Boards in Schedule 4A of the *Health Services Act* include that the Chair of the Medical Staff Executive Council for the LHD (or, if there is only one Medical Staff Council, its Chair) is to be an invited attendee at Board meetings.⁴⁸⁵

- 18.203. The Model By-Laws describe the objective of Hospital Clinical Councils as being to “provide a structure for consultation with, and involvement of, clinical staff in management decisions impacting public hospitals and related community services”.⁴⁸⁶ Hospital Clinical Councils are comprised of representatives of nursing and midwifery and allied health staff, as well as medical staff and the general manager of the relevant hospital.
- 18.204. Similarly, the Model By-Laws provide for 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, with the function of providing advice to the Board and Chief Executive on “clinical matters affecting the organisation”.⁴⁸⁷
- 18.205. While the creation and composition of those structures are clearly laid out in the Model By-Laws, there is a difference in the way in which the objectives and functions of some of them are identified.
- 18.206. For example, other than the general description of the objectives of the Council structures as a whole, the Model By-Laws do not set out the objectives or functions for Medical Staff Councils. Perhaps something about their function and purpose can be inferred from the fact that the Medical Staff Executive Councils (or the Medical Staff Council if there is only one) are to provide advice to the Chief Executive and Board on “medical matters”.⁴⁸⁸ However, it is not entirely clear whether the role of the Medical Staff Council is to have similar advisory functions.
- 18.207. Further, what is to fall within the scope of “medical matters” is almost boundless. On one view, it is confined to matters relating to the treatment of patients. On another, it could be said to encompass every aspect of hospital operations given the function and purpose of the public health system as a whole. It is a phrase that is so ambiguous in its content that it is, effectively, meaningless. Alternatively, it means everything. When viewed in the context of the description of the general functions of Medical Staff Councils set out in clause 25 of the Model By-Laws,⁴⁸⁹ its ambiguity is only heightened.

⁴⁸⁵ *Health Services Act 1997* (NSW) sch 4A, cl 18(1)(b).

⁴⁸⁶ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cls 33 and 37 [SCI.0001.0002.0001 at 0007].

⁴⁸⁷ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 43 and 44 [SCI.0001.0002.0001 at 0015-0016].

⁴⁸⁸ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 26(a) [SCI.0001.0002.0001 at 0008].

⁴⁸⁹ Exhibit H.2.57, NSW Health, *Model By-Laws for LHDs and SHNs* cl 25 [SCI.0001.0002.0001 at 0008].

- 18.208. The difficulties that arise from those features of the Model By-Laws can have real impact. Some of the consequences of the way in which the structures are currently identified in the Model By-Laws were seen in the events that occurred at Concord Repatriation General Hospital between late 2022 and mid-2024.⁴⁹⁰
- 18.209. I do not consider it necessary to make findings about those matters in this Report, and in particular which parties bear responsibility for them. However, as Counsel Assisting pointed out, it was an unsatisfactory state of affairs for the relationship between the clinicians comprising the Hospital's Medical Staff Council and Hospital and District executives to deteriorate to the point that they did.
- 18.210. Until a vote of no confidence in the Chief Executive was passed, the Ministry of Health seems to have been unaware of the issues that had arisen at that hospital.⁴⁹¹ That is not satisfactory. While I accept that there are some limits to how much those within the Ministry can be expected to know about what is occurring within the workforce of a particular LHD and or facility, what occurred at Concord in that period was not the norm.
- 18.211. In any event, a significant feature of those events was the disagreement that developed between the Chair of the Concord Repatriation General Hospital Medical Staff Council, Associate Professor Winston Cheung, Chair, Concord Hospital Medical Staff Council, and executive management as to the proper role of the Medical Staff Council.
- 18.212. Associate Professor Cheung viewed the function of the Medical Staff Council as including a role to advise on "just about everything [that] has an effect on medical matters – so education, research, quality and safety",⁴⁹² and as having an advocacy role.⁴⁹³ To his mind, its role included the ability to establish subcommittees dealing with matters such as workforce culture and industrial relations.⁴⁹⁴ That understanding was ultimately reflected in a set of draft terms of reference for the Medical Staff Council that he prepared and circulated.⁴⁹⁵
- 18.213. The executive management of the LHD took a different view of the ambit of the role of the Medical Staff Council. In their view, the draft terms of reference that had been prepared by Associate Professor Cheung exceeded the proper function of

⁴⁹⁰ See, for example, Exhibit H.5.3, Statement of Dr Andrew Hallahan (6 June 2024) [MOH.9999.1294.0001]; Exhibit H.5.32, Statement of Dr Teresa Anderson AM (30 July 2024) [MOH.0011.0034.0001]; Exhibit H.7.4, Statement of Dr Lloyd Ridley (14 July 2024) [SCI.0011.0195.0001]; Exhibit H.7.12, Statement of Clinical Associate Professor Winston Cheung (16 July 2024) [SCI.0012.0174.0001]; Transcript of the Commission, 30 July 2024 – 2 August 2024, 6 August 2024 T4297ff.

⁴⁹¹ Transcript of the Commission, 7 August 2024, T4846.28-4847.23 (Minns).

⁴⁹² Transcript of the Commission, 31 July 2024, T4361.41-43 (Cheung).

⁴⁹³ Transcript of the Commission, 31 July 2024, T4367.47-T4368.1 (Cheung).

⁴⁹⁴ As listed at Exhibit H.5.32.6, Concord Repatriation General Hospital Medical Staff Council - Terms of Reference (Draft, 25 May 2022) [MOH.0010.0403.0001 at 0006].

⁴⁹⁵ Exhibit H.5.32.6, Concord Repatriation General Hospital Medical Staff Council - Terms of Reference (Draft, 25 May 2022) [MOH.0010.0403.0001]; Exhibit H.7.12.14, Concord Repatriation General Hospital Medical Staff Council – (Proposed) Terms of Reference (3 March 2023) [SCI.0012.0041.0001].

the Medical Staff Council, and amounted to an attempt to “usurp” the functions of the Board or executive.⁴⁹⁶

- 18.214. The disagreement as to the role and function of the Medical Staff Council included the then Chief Executive of the LHD handing a letter to Associate Professor Cheung during a meeting, which set out (at length) the LHD’s concerns about the proposed terms of reference for the Medical Staff Council that incorporated Associate Professor Cheung’s views as to its role, directed him to withdraw that proposal and prepare a proposal in line with the executive’s interpretation, and “remind[ed]” him about the *NSW Health Code of Conduct* in that context.⁴⁹⁷
- 18.215. It was, as Counsel Assisting put it, an unfortunate series of events reflective of the breakdown in the relationship between at least some of the medical workforce at Concord Repatriation General Hospital and management.⁴⁹⁸
- 18.216. What made it all the more unfortunate was that, on the issue of the role of the Medical Staff Council as an advisory body, there was agreement that the Council had a role in providing advice about the very things set out in Associate Professor Cheung’s proposed terms of reference, such as: the efficient and economic operation of the hospital, standards of care and services, health needs, strategies to ensure balance in provision, and adequate arrangements for effective communication.⁴⁹⁹
- 18.217. The underlying concern of management, however, seems to have been that through the terms of reference, the Medical Staff Council was attempting to elevate itself above an advisory role. Quite how that could ever have occurred remains unclear to me. What is clear to me, however, is that a great deal of tension resulted from there being no clear identification of the role and functions of the Medical Staff Council in the Model By-Laws. That, in turn, created the environment in which the dispute arose and then escalated.
- 18.218. The importance of genuine engagement between management and clinicians cannot be overstated.⁵⁰⁰ The Medical Staff Council (and other councils provided for in the Model By-Laws) provides a mechanism for that to occur and for management to harness the benefits of the collective experience and expertise of its clinicians in

⁴⁹⁶ Exhibit H.5.3, Statement of Dr Andrew Hallahan (6 June 2024) [30] [MOH.9999.1294.0001 at 0007]; Exhibit H.5.32, Statement of Dr Teresa Anderson AM (30 July 2024) [130] [MOH.0011.0034.0001 at 0025]; Transcript of the Commission, 1 August 2024, T4434.44-4439.23 (Hallahan); Transcript of the Commission, 6 August 2024, T4702.9-4705.9 (Anderson); Exhibit H.7.12.15, Letter from Dr Teresa Anderson AM to Associate Professor Winston Cheung (21 April 2023) [SCI.0012.0079.0001].

⁴⁹⁷ Exhibit H.7.12.15, Letter from Dr Teresa Anderson AM to Associate Professor Winston Cheung (21 April 2023) [SCI.0012.0079.0001].

⁴⁹⁸ Outline of Submissions by Counsel Assisting to the Special Commission of Inquiry into Healthcare Funding (20 December 2024) [747]-[749] [SUBM.0001.0012.0001 at 0239-0240].

⁴⁹⁹ Transcript of the Commission, 1 August 2024, T4443.11-4444.44 (Hallahan); Transcript of the Commission, 6 August 2024, T4704.22-42, T4705.44-4706.4 (Anderson).

⁵⁰⁰ Transcript of the Commission, 23 July 2024, T3889.41-3890.8, T3892.13-3893.20 (Nogajski); Transcript of the Commission, 2 August 2024, T4525.34-4526.4 (Richards); Transcript of the Commission, 5 August 2024 T4585.37-4586.7 (Loy); Transcript of the Commission, 5 August 2024, T4601.11-33 (Egan); Transcript of the Commission, 6 August 2024, T4733.20-27 (Anderson).

matters affecting the delivery of care at their hospitals.⁵⁰¹ If Medical Staff Councils (and the other councils) are to achieve that aim, they must provide an effective means of consultation and engagement at the facility and district or network level.

- 18.219. There are many examples of Medical Staff Councils that are functional and effective.⁵⁰² However, as was the case at Concord Repatriation General Hospital, there are situations in which the relationship between a Medical Staff Council and management is not as effective as it might be, or (at worst) is dysfunctional.⁵⁰³
- 18.220. In order to strengthen those processes, and to enable both clinicians and management to benefit from them to the maximum extent possible, the Council structures set out in the Model By-Laws should be reviewed. The role and purpose of each Council should be clearly identified, and they should be complementary of each other. Following that review, the Model By-Laws should be amended to clearly articulate the purpose and role of each of the Councils, and how they relate or interact with each other.
- 18.221. In its written submissions, NSW Health identified some steps that are being undertaken to provide Chief Executives with data that identifies trends and areas of concerns within units that sit within their organisation.⁵⁰⁴ To the extent that the provision of data will inform and support management to identify areas of concern within its workforce, and engage in meaningful consultation to address them at an earlier stage, that is a positive development.
- 18.222. However, that work does not, in my view, mean that the existing structures for consultation should not be reviewed and enhanced. NSW Health submitted that absent legislative amendment, any changes proposed to the Model By-Laws would need to account with the *Health Services Act*.⁵⁰⁵ It is somewhat unclear to me whether that submission was intended to suggest that legislative amendment would be required to permit the Health Secretary to review and amend the Model By-Laws to clarify the role of each Council and how they interact with each other,⁵⁰⁶ and NSW Health did not identify any particular provision that requires amendment (or the nature of that amendment) to permit that to occur.
- 18.223. In my view, neither s 39, s 60 nor schedule 4A of the *Health Services Act* constrain the Health Secretary in reviewing those aspects of the Model By-Laws and amending them as necessary to clearly identify the role and function of each Council. If I am wrong about that, whatever legislative amendment that is required to permit the

⁵⁰¹ Transcript of the Commission, 15 October 2024, T5727.25-29 (Minns).

⁵⁰² Exhibit H.5.6, Statement of Professor Michael Hensley (7 June 2024) [16] [MOH.9999.1295.0001 at 0004-0005].

⁵⁰³ Transcript of the Commission, 7 August 2024, T4841.30-4842.07 (Minns); Transcript of the Commission, 5 August 2024, T4595.27-4596.19 (Egan).

⁵⁰⁴ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.55-10.57] [MOH.0010.0758.0001 at 0078-0079].

⁵⁰⁵ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.58-10.62] [MOH.0010.0758.0001 at 0079-0080].

⁵⁰⁶ Or whether that submission was directed to invitations to attend board meetings, which is discussed below.

review and amendment of the Model By-Laws in relation to the Council structures is required should be made.

- 18.224. Counsel Assisting also submitted that, as an enhancement to better engagement, the standing invitation to attend Board meetings should be extended to the Chairs of all Staff Councils, not only the Chair of the Executive Medical Staff Council. There is force in NSW Health's observation that, if such a recommendation were adopted, an amendment to cl 18 of sch 4A to the *Health Services Act* would be required to make such a standing invitation mandatory. However, that change requires legislative amendment is not, as a general proposition, a reason why it ought not be pursued.
- 18.225. In my view, having the Chairs of each Council observe Board meetings can only enhance the discourse between management and clinicians. It will enable those clinicians to directly report back to their respective Councils on matters affecting the district. While I do not accept that there will be any substantive "practical difficulties" created by a situation where there are more attendees than Board members, I accept (as NSW Health submitted) that the circumstances of each LHD and Statutory Health Corporation are different, including as to the number of Council Chairs and the quality of their consultation processes and structures.
- 18.226. Accordingly, I will not recommend that a standing invitation to the Chairs of all Councils to attend Board meetings be made mandatory. However, I remain of the view that some steps should be taken to enhance collaboration between boards, executive management, and clinicians, in addition to the review and amendment of the Model By-Laws. Such steps should include:
- a. each Board extending invitations to the Chairs of all councils to attend Board meetings;⁵⁰⁷
 - b. if the circumstances and needs of the relevant LHD or Statutory Health Corporation are such that doing so would be inappropriate, inefficient, or would not otherwise enhance consultation between the Board, management and clinicians, a Board need not extend those invitations, however, the reasons why that decision has been made should be recorded in the minutes; and
 - c. where a Board has determined not to extend an invitation to Council Chairs to attend Board meetings, they should implement a procedure whereby the Board shall receive reports from the Chair of each of the Councils within their district or corporation on a regular basis (no less than once per quarter) as to matters that fall within the remit of their respective Councils.

⁵⁰⁷ In accordance with their powers to invite any person to attend board meetings pursuant to cl 18(4) of schedule 4A to the *Health Services Act*.

Complaints and grievances

18.227. NSW Health has a suite of policies relating to the management of workplace complaints and grievances. They include:

- a. *Complaints Management* (PD2020_013);⁵⁰⁸
- b. *Managing Misconduct* (PD2018_031);⁵⁰⁹
- c. *Managing Complaints and Concerns about Clinicians* (PD2018_032);⁵¹⁰
- d. *Resolving Workplace Grievances* (PD2016_046);⁵¹¹
- e. *Prevention and Management of Bullying in NSW Health* (PD2021_030);⁵¹²
- f. *Prevention and Management of Unacceptable Behaviours in NSW Health* (PD2021_031);⁵¹³
- g. *Incident Management* (PD2020_047);⁵¹⁴ and
- h. *Public Interest Disclosures* (PD2023_026).⁵¹⁵

18.228. It is a complex framework and it is not surprising there is evidence of delays, inconsistencies, and departures from these policies by those in local organisations which are tasked with trying to implement them.⁵¹⁶ For example, while the *Managing Complaints and Concerns about Clinicians* policy directive contemplates that investigations conducted under that policy will “ideally” be completed within 12 weeks,⁵¹⁷ the average length of time taken to complete investigations as reported to the AMA NSW by two Medical Defence Organisations was eight months.⁵¹⁸ This causes understandable frustration and stress for those clinicians subject to investigations.

18.229. It is undoubtedly true that workplace complaints and grievances may be complex and require time consuming investigations from time to time. There may also be good reasons to have discrete policies dealing with, for example, reporting and managing clinical incidents compared with misconduct.

⁵⁰⁸ Exhibit D.1.78, NSW Health, PD2020_013 Complaints Management (24 April 2020) [MOH.9999.0837.0001].

⁵⁰⁹ Exhibit B.23.119, NSW Health, PD2018_031 Managing Misconduct (7 September 2018) [MOH.0001.0391.0001].

⁵¹⁰ Exhibit H.3.28, NSW Health, PD2018_032 Managing Complaints and Concerns about Clinicians (7 September 2018) [MOH.9999.0933.0001].

⁵¹¹ Exhibit H.3.18, NSW Health, PD2016_046 Resolving Workplace Grievances (18 October 2016) [MOH.0002.0047.0001].

⁵¹² Exhibit H.3.42, NSW Health, PD2021_030 Prevention and Management of Bullying in NSW Health (3 August 2021) [MOH.0002.0087.0001].

⁵¹³ Referred to in Exhibit H.5.4, Statement of Nathan Rudd (6 June 2024) [7] [MOH.9999.2145.0001 at 0002].

⁵¹⁴ Exhibit D.1.34, NSW Health, PD2020_047 Incident Management (14 December 2020) [MOH.9999.0803.0001].

⁵¹⁵ Exhibit B.23.118, NSW Health, PD2023_026 Public Interest Disclosures (3 October 2023) [MOH.0001.0151.0001].

⁵¹⁶ Exhibit H.7.13, Statement of Dominique Egan (25 July 2024) [97]-[98] [SCI.0011.0283.0001 at 0019].

⁵¹⁷ Exhibit H.3.28, NSW Health PD2018_032 Managing Complaints and Concerns about Clinicians (7 September 2018) cl 5.1 [MOH.9999.0933.0001 at 0021].

⁵¹⁸ Exhibit H.7.13, Statement of Dominique Egan (25 July 2024) [98] [SCI.0011.0283.0001 at 0019].

- 18.230. However, the need for such an extensive and overlapping set of policies dealing with complaints and grievances as presently exists above is less clear. That complex web of policies combines with a lack of sufficient central support within the Ministry of Health to provide advice to local organisations about managing grievances or complaints, or to monitor the time taken by local organisations to conduct complaints and grievance processes.
- 18.231. In those circumstances, it is evident that the complaints and grievance policies would benefit from wholesale review and simplification. Pleasingly, NSW Health accepted the benefits in doing so, and some work in this respect is under way,⁵¹⁹ although more needs to be done.
- 18.232. As part of that wholesale review, the complaints and grievance process should be enhanced by the establishment of central support for NSW Health agencies in dealing with such matters, central monitoring of the time taken to finalise them – particularly in relation to those that extend beyond targets for completion – and the creation of a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.
- 18.233. In relation to the creation of an avenue of review external to the local organisation, NSW Health submitted such an approach has “potential significant practical consequences”, and was one that would likely involve a significant volume of work.⁵²⁰ Instead, NSW Health submitted that it was “prepared to consider including a right of internal review” as part of its review of workplace complaints and grievance policies.⁵²¹
- 18.234. I am not persuaded that the potential challenges identified by NSW Health outweigh the significant advantages that flow from the creation of an avenue of review that is external to the local organisation. I accept that the establishment of such a process will likely involve work to ensure that (in so far as is possible) it is as effective and efficient as it can be. However, as I have observed elsewhere, that change requires significant effort is not a persuasive (or valid) reason to maintain the *status quo* – particularly in a system the size of NSW Health.
- 18.235. Even if I were to assume that the “consideration” of an internal avenue of review of the kind described in NSW Health’s submissions ultimately resulted in its implementation, it has the significant vice that it sits within the same organisation in which the relevant complaint or grievance has been made and considered. That such a review is to be undertaken by an appropriate officer independent of the original process does not overcome that difficulty. It will not overcome the impression (real or

⁵¹⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.64-10.73] [MOH.0010.0758.0001 at 0081-0085].

⁵²⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.74-10.75] [MOH.0010.0758.0001 at 0085].

⁵²¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.76] [MOH.0010.0758.0001 at 0085].

perceived, it does not matter which) that the complaint or grievance is being dealt with “in house”. That is the very point of a process that is external to the local organisation.

- 18.236. NSW Health also submitted that, in circumstances where it is common for persons engaged in the NSW health system to have worked across multiple organisations, appointing a person “external to the local organisation” may not ensure impartiality or independence.⁵²² That submission only serves to highlight the limitations of an internal avenue of review. If a person external to the organisation is not considered to be impartial or independent because they may have worked in it in the past, it is not clear how that perception can be overcome by an internal review process of the kind contemplated in NSW Health’s submissions.
- 18.237. As should be clear by now, in making recommendations, I have been cautious about being too prescriptive as to models or structures that should be adopted. I am acutely aware that, even after some 18 months as Commissioner of this Special Commission, there are nuances in the system and its structures that are only capable of being fully appreciated by those with a long tenure in it.
- 18.238. However, in this instance, a clear and logical place for the external review function to sit is within Ministry of Health. To adapt the language of NSW Health’s written submissions, the external review function can be performed by an appropriate officer within the Ministry of Health, independent from the original process and external to the local organisation. It may be that, if NSW Health’s concerns about the volume of external review requests materialise, positions within the Ministry of Health to perform that function will need to be established, and it naturally follows that the Ministry of Health will need to be adequately resourced to do so. If additional resourcing is required for the Ministry of Health to perform that function, it should be provided.

Wellbeing

- 18.239. The health and wellbeing of the NSW Health workforce (like any other) is critical to the performance of the system, and are strong influences on workplace culture. Happy and healthy workers can be expected to take less leave, to be more productive, and are likely to remain within the system for longer. A workplace known for a culture of promoting the wellbeing of its staff will also be more attractive to prospective employees.⁵²³
- 18.240. There are high levels of fatigue, stress, and burnout across the NSW Health workforce.⁵²⁴ “Burnout” in this context means something much more than just

⁵²² Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.75] [MOH.0010.0758.0001 at 0085].

⁵²³ Transcript of the Commission, 23 July 2024, T3882.27-43 (Nogajski); Transcript of the Commission, 23 July 2024, T3897.16-31 (Hockey).

⁵²⁴ Exhibit H.2.28, NSW Health, *Allied Health Macro Workforce Trends Report* (May 2022) p 13 [MOH.0003.0234.0001 at 0015]; Exhibit H.5.29, Statement of Sarah Whitney (22 July 2024) [17]-[18] [MOH.0015.0001.0001 at 0006]; Exhibit H.6.1, Statement of the

fatigue.⁵²⁵ It was described by Dr Bethan Richards, Chief Medical Wellness Officer, Sydney LHD, as follows:⁵²⁶

So when you look at the domains of burnout, it's got three domains. The first one's emotional exhaustion; the second one is depersonalisation or cynicism; and the third one is around professional efficiency or your efficiency of practice.

What does it sort of translate to in a real-world environment? If your body is under extreme stress, so occupational distress, for prolonged periods of time and that is not successfully managed, you will become emotionally exhausted, your coping mechanisms in that way, because you don't have a lot to give to others, tend to be to detach.

So in medicine, that may manifest as seeing patients as the next problem walking through the door; they're a bed number, not a named human being in front of you. And so you try and conserve your own energy by, you know, reducing compassionate care.

That can also lead to, you know, negativity and cynicism and things, and obviously reduced activity or performance, and in medical staff, at least, it's interesting, that's the last thing that goes.

18.241. In the 2023 “People Matter Employee Survey”, only 51 per cent of respondents across NSW Health as a whole gave a favourable response to questions about their wellbeing.⁵²⁷ However, given its nature, the “People Matter” survey should not be seen to be an adequate or comprehensive measure of staff wellbeing within the health context.

18.242. While the pandemic undoubtedly contributed to those features of the workforce, that high rates of burnout persist within the system, and that only half of respondents gave favourable responses to questions about their wellbeing, should be seen by all of those with an interest in maintaining a strong and effective health workforce as troubling. It is something that must be addressed in a meaningful way, and as a matter of priority. While NSW Health has a range of wellbeing initiatives,⁵²⁸ it is not immediately apparent how, if at all, their success is monitored.

Royal Australian College of Physicians (12 July 2024) p 20 [SCI.0011.0185.0001 at 0020]; Exhibit L.23.1, Deloitte, *Medical Workforce Pressures in New South Wales* (February 2023) p 11 [SCI.0011.0490.0001 at 0011]; Exhibit L.16, Statement of Andrew Holland (1 October 2024) [19] [SCI.0011.0469.0001 at 0003-0004]; Exhibit L.17, Statement of Dr Behny Samadi (30 September 2024) [23]-[25] [SCI.0011.0465.0001 at 0005-0006]; Transcript of the Commission, 25 July 2024, T4106.24-4107.5 (Kanhutu); Transcript of the Commission, 2 August 2024, T4526.21-31, T4539.47-4540.20 (Richards).

⁵²⁵ Transcript of the Commission, 2 August 2024, T4539.3-7 (Richards).

⁵²⁶ Transcript of the Commission, 2 August 2024, T4539.10-33 (Richards).

⁵²⁷ Exhibit H5.24, Rian Thompson, *Workforce Data Report* p 36 [MOH.0010.0377.0001 at 0036]; Exhibit H7.12.55, *NSW People Matter Employee Survey 2023 – Health portfolio 2023* p 13 [SCI.0012.0003.0001 at 0013].

⁵²⁸ Exhibit L.7, Statement of Richard Griffiths (8 October 2024) [98]-[103] [MOH.0011.0083.0001 at 0022-0024].

- 18.243. One initiative that has seen measurable success has been the creation of a Chief Medical Wellness Officer within the Sydney LHD. Dr Richards, who occupies that position, is a Senior Staff Specialist at the Royal Prince Alfred Hospital who performs the Chief Medical Wellness Officer role part time.⁵²⁹ When she commenced in that role in 2019, it was the first of its kind in Australia, although equivalent roles have been established internationally.⁵³⁰
- 18.244. In her evidence before this Special Commission, Dr Richards described a range of initiatives within the Sydney LHD to improve the wellbeing of medical staff, with a particular focus on prevention and early detection.⁵³¹ Those initiatives covered a range of matters that influence wellbeing, including nutrition, fatigue, stress associated with grievance and adverse events processes, mental health issues, and leadership support.
- 18.245. Significantly, Dr Richards' team also collects data to monitor staff wellness, in a more granular way than the "People Matter" survey.⁵³²
- 18.246. The investment made in the wellbeing of medical staff by the Sydney LHD has demonstrated early returns. Data gathered by Dr Richards' team shows a reduction in levels of burnout and distress and an increase in levels of self-compassion, resilience and self-care behaviours, together with improvements in quality and safety outcomes.⁵³³ Perhaps unsurprisingly, Sydney LHD recorded some of the better wellbeing scores in the most recent "People Matter" survey.⁵³⁴
- 18.247. Given the extent of burnout across the system and what I regard to be low levels of staff wellbeing recorded in the latest "People Matter" survey, more detailed data on those matters should be routinely collected across the system. That will then provide the basis for targeted initiatives (which may differ in different locations) to support and enhance the wellbeing of the workforce and reduce staff distress, including that which is occasioned by burnout.
- 18.248. In addition, information of that kind will be relevant to wider system planning. It will provide a basis on which a consideration can be made of whether services being delivered through the LHD or SHN (including in relation to volume) are viable having regard to the impact that delivering them has on the existing workforce.
- 18.249. In identifying "potential challenges" to such an approach, NSW Health submitted that the success of the Chief Medical Wellness Officer initiative in the Sydney LHD was, at least in part, because it evolved locally, that it was difficult for NSW Health (which

⁵²⁹ Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [3] [MOH.9999.2147.0001 at 0001].

⁵³⁰ Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [5] [MOH.9999.2147.0001 at 0002].

⁵³¹ Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [6]-[9] [MOH.9999.2147.0001 at 0002-0003].

⁵³² Transcript of the Commission, 2 August 2024, T4527.1-4529.20 (Richards).

⁵³³ Exhibit H.5.5, Statement of Dr Bethan Richards (7 June 2024) [10] [MOH.9999.2147.0001 at 0003].

⁵³⁴ Exhibit H.5.24, Rian Thompson, *Workforce Data Report* (Report, 17 July 2024) p 36 [MOH.0010.0377.0001 at 0036].

I take to be a reference to the Ministry of Health) to drive local cultural change, and that attempts to impose requirements in a “top-down fashion” can be met with resistance.⁵³⁵

- 18.250. I do not consider that any of those “potential challenges” are likely to ultimately materialise or create any insurmountable difficulties in collecting the kind of data discussed above. In my view, it is inconceivable that there could be any meaningful (or reasonable) resistance to the collection and collation of informative data that would provide both local organisations and the Ministry of Health with a basis to assess and improve the wellbeing of its workforce.
- 18.251. Further, while the success of the Chief Medical Wellness Officer initiative was, no doubt, in part because it evolved locally in response to local needs, there is no good reason why the significant benefits from that initiative cannot be adapted to other locations. For example, the precise data sets that are to be collected to provide a basis for a meaningful and targeted consideration of staff wellbeing across the system should account for local circumstances and nuances. However, the data that is collected (acknowledging that a range of data is already collected across the system in relation to matters affecting the workforce⁵³⁶) should at least include similar data sets to those collected in the Sydney LHD.

Conclusion

- 18.252. The health workforce is NSW Health’s greatest asset. It is the key to a strong and sustainable system into the future.
- 18.253. It is therefore critical, that in adopting the system wide approach to planning that I consider to be essential to the long term strength of the system, that a similar approach is taken to the development and deployment of its workforce. That requires that – together with the LHDs and SHNs – the Ministry of Health must take a greater role in workforce planning. It also requires a more structured approach to training across the workforce to gain the benefit of NSW Health’s position as the largest public health system in Australia.
- 18.254. All of that, however, will be compromised if industrial instruments remain out of date, and do not reflect current practices within the system. Despite what I accept have been genuine efforts by all of those involved to resolve those issues through a process of bargaining, for the most part that has not happened. It is now time for an award modernisation process to occur – one that is undertaken free from the context of an industrial dispute.

⁵³⁵ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.86-10.88] [MOH.0010.0758.0001 at 0088].

⁵³⁶ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [10.80-10.85] [MOH.0010.0758.0001 at 0086-0087].

Recommendation 26: As part of the system wide approach to service planning, NSW Health should:

- a. establish a central workforce planning function, located within the Ministry of Health, which collaborates regularly and systematically with local organisations to direct the clinical workforce establishment across the NSW health system with the objective of guiding the deployment of the human resources available within the system in a way that best meets the needs of the NSW population as a whole; and
- b. once that function is established, prioritise a thorough, evidence based, review of specific initiatives that should be implemented to help address current workforce shortages and maldistributions.

Recommendation 27: The Health Education and Training Institute's role should be expanded, with appropriate funding, to include:

- a. coordinating the allocation of students to clinical placements within NSW Health facilities and services in collaboration with universities and relevant NSW Health agencies;
- b. devising and overseeing a graduate recruitment program that capitalises on the clinical placements offered within the public health system and facilitates the early recruitment of those who have held such placements immediately upon graduation and into areas of need; and
- c. establishing and delivering specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations, with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need, and focussing upon maximising opportunities for training and recruitment in rural and regional locations.

Recommendation 28: There should be an award reform process conducted by the Industrial Relations Commission of New South Wales incorporating at least the following features:

- a. a legislated set of objectives to be achieved by the process, which include:
 - i. simplifying and, where appropriate, consolidating the current range of awards, determinations and other instruments setting terms and conditions of employment or engagement for NSW Health workers, to provide a consistent and coherent framework of terms and conditions that is easy to understand and apply;
 - ii. updating instruments so that they reflect the current and expected future service delivery and workforce needs of the NSW health system and current and expected future working conditions;
 - iii. providing fair and reasonable terms and conditions of employment or engagement for workers across the NSW health system, including having regard to the value of their work to system, the impact of those terms and conditions on attraction and retention, and their fiscal and economic impacts; and
- b. a reasonable but expeditious timeframe in which the process is to be completed; and
- c. an extension of the process to Visiting Medical Officers and the Visiting Medical Officer Determinations.

Recommendation 29: To the extent that legislative amendment is necessary for the Industrial Relations Commission of New South Wales to be able to complete the award modernisation process contemplated by Recommendation 28 other than in the context of an industrial dispute (and unconstrained any prior construction given to s 19 of the *Industrial Relations Act*), that amendment should be made urgently.

Recommendation 30: The Model By-Laws made under ss 39 and 60 of the *Health Services Act* should be reviewed and amended with a view to clearly identifying the role and functions each Council and committee established by them and ensuring that they:

- a. provide an effective and robust forum for consultation and feedback between clinicians and management; and
- b. are complementary of each other.

Recommendation 31: Steps should be taken to enhance collaboration between boards, executive management and clinicians, in addition to the review and amendment of the Model By-Laws. Such steps should include:

- a. each Board extending invitations to the Chairs of all councils to attend Board meetings;
- b. if the circumstances and needs of the organisation are such that doing so would be inappropriate, inefficient or would not otherwise enhance consultation between the Board, management and clinicians, a Board need not extend those invitations, however, the reasons why that decision has been made should be recorded in the minutes; and
- c. where a Board has determined not to extend an invitation to Council Chairs to attend Board meetings, they should implement a procedure whereby the Board shall receive reports from the Chair of each of the Councils within their district or corporation on a regular basis (at least quarterly) as to matters that fall within the remit of their respective Councils.

Recommendation 32: The Ministry of Health should review its processes for dealing with workplace complaints and grievances, including:

- a. simplifying and, where appropriate, consolidating its policy directives and guidelines relating to complaints, grievances, incidents, and workplace behaviour;
- b. establishing a central contact within the Ministry of Health for local organisations to seek advice about conducting those processes;
- c. establishing a process for monitoring the time taken by local organisations to conduct those processes; and
- d. establishing a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.

Recommendation 33: There should be a routine collection and collation of a granular data set directed to the wellbeing of the workforce (like that which the has been collected by the Chief Wellness Officer in the Sydney LHD) with a view to supporting and improving the wellbeing of the workforce within local organisations and across the system more generally.



Chapter 19:

Funding healthcare in NSW

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Introduction

- 19.1. As observed in the Overview, this Special Commission was, fundamentally, an inquiry into the funding of healthcare in NSW.
- 19.2. Although the Terms of Reference were exceptionally broad and covered a great many topics and themes, a consideration of each of them inevitably raised issues of funding. For example, any consideration of how prevailing workforce challenges may be addressed, how training programs may be strengthened and improved to provide a sustainable health workforce in NSW, or how health services are planned, necessarily includes a consideration of the resourcing available to effect necessary change and sustain it into the future. While resourcing in that context is not limited to funding, but includes human and capital resources, the ability to obtain and retain those levels of resources within the NSW public health system is obviously affected by the level of funding available.
- 19.3. It is perhaps unsurprising, then, that the funding of health services – whether in the primary, community, or acute care settings – is a topic that generates significant interest and commentary. The levels of funding available, or how it is deployed, is a regular topic of public and political discourse.
- 19.4. As will be explored in this Chapter, the budget allocated to the NSW public health system is comprised of amounts appropriated from the Consolidated Fund (i.e., State Government funding), contributions received from the Commonwealth Government pursuant to the *Addendum to the NHRA* or other grants, and revenue from other sources, including patient fees.⁵³⁷
- 19.5. The question of whether the NSW public health system is “adequately” funded, or put another way “underfunded”, is one that has arisen at various times. For example, facilities or services that are under pressure to meet or keep up with demand are sometimes said to be “underfunded”. Similarly, the uncontroversial fact that if there were additional funding within the system as a whole, it could be put to good use and produce good health outcomes, is relied on to suggest that the system as a whole is “underfunded”. However, approaching the question of funding in that way is almost always too simplistic. Fundamentally, the question of whether a service, facility or even a system as a whole is “underfunded” begs the question – underfunded to do what?
- 19.6. Accordingly, it can be seen the question of whether the system as a whole is “underfunded” is complex and cannot be answered solely by reference to demand indicators. It requires consideration of what the NSW public health system should be, including the nature of the services that should be available, where those services should be offered, and the timeframes in which patients can expect to be treated. The answers to those questions will necessarily vary between different services, but must

⁵³⁷ Exhibit D.4, Statement of Adjunct Professor Alfa D’Amato (9 April 2024) [13] [MOH.9999.0763.0001 at 0003].

be formulated through the lens of what can reasonably be expected of a public health system responsible for delivering care to the entire population.

- 19.7. However, it is only once that system is identified and designed that the necessary funding levels, and optimal models, can be identified. Tracey Maisey, Chief Executive of Northern NSW LHD, aptly captured those concepts in the following passage of her evidence:⁵³⁸

I think the mistake that you can fall into is taking an approach of who's paying the money... in my experience, if you put the patient in the centre of that conversation and say actually, "What does this individual need?", in terms of supporting them on their healthcare journey and having a variety of those stakeholders that are described sitting there to have those conversations, and then you look at a care arrangement or a service delivery arrangement that meets the needs of those consumers and then you look at how that's going to be funded. That's a far more productive discussion than trying to work out the funding arrangements and then designing the services to suit the funding. You have to be a bit - that does require people to be flexible, have a will and intent to try something new. It does require a review of policy and regulation and all those things, so sometimes that can take time.

- 19.8. Additionally, Mr Spittal stated:⁵³⁹

... the tendency of the New South Wales health system has been to plan for the services that we provide, and particularly to plan for the infrastructure required for those services, be it our hospitals or whatever else. Our aspiration, and I believe the correct aspiration of the New South Wales health system, or the Commonwealth Government health systems, would be to plan for the needs, the health needs of a community as the core thing that it does through place-based planning, and the infrastructure requirements or the service provider requirements to meet that need are secondary to the core purpose of planning. As I said right at the beginning, current legislation does not drive the system towards that goal when, in my view, clearly it should.

- 19.9. In my view, approaching the planning, funding and delivery of healthcare in any other way allows the size of the available funding envelope (which is likely always to be limited) and existing funding models to be the "tail that wags the dog".

⁵³⁸ Transcript of the Commission, 18 September 2024, T5342.11–28 (Maisey). Some of the concepts raised by Ms Maisey in this answer are explored further elsewhere in this Report.

⁵³⁹ Transcript of the Commission, 16 May 2024, T2958.5–19 (Spittal).

- 19.10. Of course, this approach will not resolve all challenges in funding the NSW public health system. Available funding is not – and is unlikely to ever be – unlimited. Throughout the work of this Special Commission and its visits to each of the LHDs, I was shown many examples of worthwhile initiatives and programs, and heard of models of care and treatments that, if funded or made available to patients, would produce good health outcomes. Viewed from the perspective of the patient in need of that care, it could hardly be said that funding those initiatives would not represent a worthwhile and proper use of public funds.
- 19.11. However, there will always be tension between the ideals of providing the highest quality care and treatment to all patients in the context of limited (or “constrained”) government budgets. There is little reason to think that tension will reduce in the near future as the development of new treatments and models of care accelerates. Although the fundamental assumption on which I proceed is that a universal healthcare system remains an ideal shared by both the Commonwealth and state and territory governments,⁵⁴⁰ it does not follow that government should provide as much funding to the NSW public health system as it can absorb. The reality in which that assumption sits is that the funding that can be devoted to public health services in NSW is not unlimited.
- 19.12. While it may be accepted, then, that the community is entitled to expect and receive high quality care when in need of it, it must be recognised that such care is to be delivered in the context of limited public resources – a significant proportion of which is already allocated to health.
- 19.13. In this respect, the observations of Commissioner Garling that there needed to be an identification as to how the system would “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” are just as relevant (and perhaps more so) today.⁵⁴¹
- 19.14. The difficulty in having those discussions, making those assessments, and then implementing necessary change (including service changes) is not lost on me. Local populations can have long and genuine connections to local services or facilities. That is understandable given that, of all the public services provided by government, healthcare affects all members of the population directly and personally. There may be resistance to change. That resistance to change will invariably persist even in circumstances where, following detailed analysis, consideration and assessment, service changes may be in the wider interest of those communities and the system as

⁵⁴⁰ One that is consistent with the approach taken by NSW Health to the delivery of services: Transcript of the Commission, 26 February 2025, T7066.12–36 (Pearce). It is also one that is consistent with the agreement of all governments that Australia’s health system should “provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country”: Exhibit A.25, National Healthcare Agreement (2012) p 2 [SCI.0001.0021.0001 at 0002].

⁵⁴¹ Exhibit N4.3, Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Final Report, 27 December 2008) vol 1, [2.56] [SCI.0011.0758.0001 at 0074].

a whole. It may manifest through media commentary or interventions by elected representatives (or those aspiring to be elected representatives). Such is the way of public services. No recommendation of a Special Commission such as this will be able to overcome those challenges.

- 19.15. However, that change is difficult is not a valid reason to avoid or delay making it where it is required. Giving effect to necessary change to secure the long term sustainability of the NSW public health system will require strong leadership – not only of those within the system (as discussed above) but by our elected representatives. The Ministry of Health and those responsible for the delivery of care across the State should be supported to make difficult decisions that are in the system’s interest.
- 19.16. None of that is to say that additional investment in public health services is not required. For example, it is almost inevitable that adopting the recommendations in this Report will require additional funding to be allocated to enable NSW Health to continue to meet patient demand for acute services while also expanding and enhancing its services in other areas and to (importantly) undertake the system wide planning recommended. Whatever funding is provided for that purpose should be quarantined to provide the headroom necessary for that work to be done without draining already stretched resources and to guard against the prospect that it may be used to meet the cost of service delivery.
- 19.17. The benefits to be realised from the Recommendations set out in this Report will take time to materialise, and the system will not be able to implement the change needed unless a long term commitment from the Government to see it through is made.

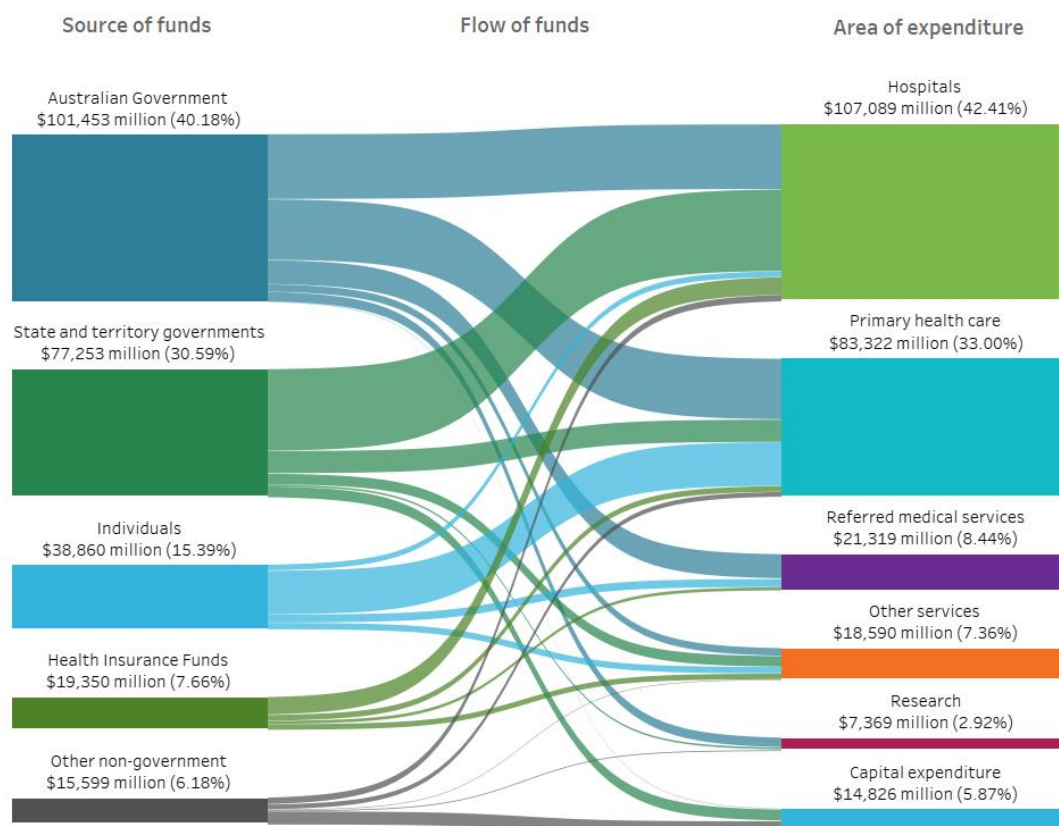
Funding flows

- 19.18. Although healthcare funding is primarily viewed through the lens of government expenditure (including in this Report), it must be remembered that it is ultimately the taxpayer that funds public health through revenue raised by taxation or private expenditure, whether that be by way of direct payment to the healthcare provider, private health insurance premiums, or philanthropy as illustrated in Figure 1.⁵⁴² Those taxpayer funds ultimately pass through a series of channels to the healthcare sector.

⁵⁴² See, eg, Stephen Duckett, *The Australian Healthcare System* (Oxford University Press, 6th ed, 2022) p 58.

Broad health spending flows, 2022-23

Select year:
2022-23



Notes

1. This analysis excludes spending on the medical expenses tax rebate.
2. Health spending is in current prices.

Source: AIHW Health Expenditure Database.
<http://www.aihw.gov.au>

Figure 1: AIHW Broad Health Spending Flows 2022–23.

- 19.19. The circuitous flow of funds adds further complexity to an already fragmented system. As Professor Lenert Bruce, Executive Director Medical Services, Murrumbidgee LHD, observed when giving evidence:⁵⁴³

And remember, the patient is just unwell. They don't understand State, federal, different funding models and we just make it too complex. Even for healthcare providers, the system is just too complex.

and further:

... in the end, Australia funds it. Whether or not it comes from either the State or federal government, it doesn't matter; the Australian taxpayer is funding it.

- 19.20. That no one level of government has sole responsibility for funding, management, planning, or delivery of public healthcare in Australia also leads to debates between governments. As but one example of the areas in which those debates can arise – several witnesses maintained the view that primary care was not NSW Health's "responsibility" or within its "remit" having regard to what was said to be the Commonwealth's responsibility as set out in the *Addendum to the NHRA*.⁵⁴⁴ That position was also advanced in the NSW Health's final submissions.⁵⁴⁵
- 19.21. The error of those views is explored elsewhere in this Report. However, in circumstances where – whichever level of government is notionally the source of funding – healthcare is ultimately funded by the taxpayer, patients (and the clinicians who treat them) have little interest in debates of those kinds. Understandably, their prime concern is obtaining appropriate care in a timely and seamless way, irrespective of where the funding comes from.⁵⁴⁶ Associate Professor Shannon Nott, Chief Medical Officer and Executive General Manager – Health and Clinical Services, Royal Flying Doctor Service, succinctly described those concerns as follows:⁵⁴⁷

For our communities and the work that we do across communities with Royal Flying Doctor Service, it is very clear to us also that community members do not want to be drawn into the politics, is this a State, federal or a local problem; the reality is that people want and deserve to have access to care in a way that actually meets their healthcare need.

⁵⁴³ Transcript of the Commission, 21 March 2024, T1667.1–36 (Bruce).

⁵⁴⁴ See, eg, Exhibit E.47, Statement of Mark Spittal (30 April 2024) [18] [MOH.9999.1202.0001 at 0005]; Transcript of the Commission, 20 March 2024, T1506.11–1507.8 (Lawrence); Transcript of the Commission, 29 April 2024, T2494.24–2495.1 (Daly), 2540.14–30 (Willcox); Transcript of the Commission, 21 November 2024, T6542.18–37 (Daly).

⁵⁴⁵ See generally Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) s 9 [SCI.0011.0814.0001 at 0041–0061].

⁵⁴⁶ See, eg, Transcript of the Commission, 29 November 2023, T204.46–205.4 (Chant), Transcript of the Commission, 15 May 2024, T2875.8–23 (Arnold).

⁵⁴⁷ Transcript of the Commission, 22 May 2024, T3107.12–18 (Nott).

- 19.22. NSW Health submitted that this Special Commission “might sympathise” with concerns of that kind.⁵⁴⁸ I do. I would expect that any person interested in the equitable delivery of healthcare in Australia would not only sympathise with those concerns, but embrace the notion that debates between governments as to how services should be funded, planned, or delivered ought not to impact on any patient’s ability to receive timely access to the care they need. No patient is well served by governments pointing at each other across a void while they experience difficulties in accessing the care they need within a reasonable time.
- 19.23. That such debates continue to arise in the context of now long standing national agreements that outline the commitments from Commonwealth and state and territory governments is perplexing. Some of those commitments are explored in this Chapter. While the fragmented nature of the broader system inevitably poses challenges, the national agreements clearly set out how those challenges are to be addressed and overcome. While it may not be possible to eliminate the scope for such debates to arise entirely,⁵⁴⁹ as was ultimately accepted by NSW Health, those challenges should be able to be addressed.⁵⁵⁰

How much does NSW spend on health?

NSW spending on health

- 19.24. Over the last decade, spending on health has consistently represented the largest proportion of the NSW budget by any service area.⁵⁵¹ For example, the 2024–25 NSW Budget provided for \$31.122 billion expenses on health, representing 25.5 per cent of total general government expenses.

⁵⁴⁸ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [6.16] [SCI.0011.0814.0001 at 0015–0016].

⁵⁴⁹ See Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [6.16] [SCI.0011.0814.0001 at 0015–0016].

⁵⁵⁰ Transcript of the Commission, 26 February 2025, T7128.19–7129.38 (Cheney SC).

⁵⁵¹ Exhibit N3.32, NSW Budget Statement 2014–15 (Budget Paper No 2, June 2014) p 5.16 [SCI.0011.0741.0001 at 0106]; Exhibit N3.33, NSW Budget Statement 2015–16 (Budget Paper No 1, June 2015) p 5.20 [SCI.0011.0722.0001 at 0078]; Exhibit N3.34, NSW Budget Statement 2016–17 (Budget Paper No 1, June 2016) p 5.17 [SCI.0011.0723.0001 at 0057]; Exhibit N3.35, NSW Budget Statement 2017–18 (Budget Paper No 1, June 2017) p 6.12 [SCI.0011.0724.0001 at 0079]; Exhibit N3.36, NSW Budget Statement 2018–19 (Budget Paper No 1, June 2018) p 6.11 [SCI.0011.0730.0001 at 0088]; Exhibit N3.37, NSW Budget Statement 2019–20 (Budget Paper No 1, June 2019) p 5.16 [SCI.0011.0725.0001 at 0075]; Exhibit N3.38, NSW Budget Statement 2020–21 (Budget Paper No 1, November 2020) p 5.19 [SCI.0011.0726.0001 at 0100]; Exhibit N3.39, NSW Budget Statement 2021–22 (Budget Paper No 1, June 2021) p A1.12 [SCI.0011.0727.0001 at 0112]; Exhibit N3.40, NSW Budget Statement 2022–23 (Budget Paper No 1, June 2022) p A1.12 [SCI.0011.0728.0001 at 0121]; Exhibit N3.41, NSW Budget Statement 2023–24 (Budget Paper No 1, September 2023) p A1.12 [SCI.0011.0729.0001 at 0110].

19.25. As is illustrated in Figure 11, compared to other states, total spending on health in NSW is the largest in the nation – which might be expected given that the NSW public health system is the largest in Australia. On a per capita basis, NSW spending on public hospital services sits just below the national average, as shown in Figure 12.

Financial Year	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
2022–23	\$ millions	28,208	24,058	19,822	11,834	6,382	2,429	1,970	1,383	96,085
2021–22	\$ millions	29,092	22,673	18,815	11,414	5,840	2,177	1,953	1,412	93,377
2020–21	\$ millions	26,269	20,931	17,869	10,542	5,397	2,059	1,811	1,745	86,623
2019–20	\$ millions	25,331	19,583	17,430	9,626	5,394	1,943	1,774	1,625	82,705
2018–19	\$ millions	24,750	18,910	16,589	9,548	5,302	1,785	1,656	1,247	79,789
2017–18	\$ millions	23,737	18,106	15,866	9,323	4,845	1,763	1,744	1,122	76,507
2016–17	\$ millions	23,013	17,540	15,168	9,406	4,579	1,686	1,716	1,284	74,391
2015–16	\$ millions	22,652	16,595	14,474	10,130	4,669	1,578	1,710	1,050	72,858
2014–15	\$ millions	22,119	15,703	10,749	9,717	4,527	1,504	1,288	967	66,573

Figure 2: Total Real Recurrent Expenditure on Public Hospital Services.⁵⁵²

Financial Year	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
2022–23	\$	3,424	3,563	3,679	4,187	3,472	4,249	4,274	5,530	3,649
2021–22	\$	3,593	3,429	3,569	4,130	3,231	3,821	4,308	5,664	3,616
2020–21	\$	3,245	3,157	3,442	3,862	2,996	3,664	4,044	7,041	3,370
2019–20	\$	3,130	2,942	3,392	3,577	2,941	3,511	4,030	6,601	3,225
2018–19	\$	3,092	2,885	3,281	3,618	2,915	3,289	3,845	5,073	3,155
2017–18	\$	3,004	2,813	3,192	3,581	2,791	3,317	4,151	4,546	3,079
2016–17	\$	2,952	2,775	3,103	3,654	2,662	3,229	4,197	5,217	3,039
2015–16	\$	2,952	2,703	3,012	3,968	2,736	3,061	4,286	4,303	3,031
2014–15	\$	2,907	2,615	2,264	3,834	2,672	2,926	3,286	3,982	2,804

Figure 3: Real Recurrent Expenditure Per Capita on Public Hospital Services.⁵⁵³

⁵⁵² Extracted from Productivity Commission, Report on Government Services 2025 (Report, 11 February 2025) Table 12A.1 (Public Hospital Data Tables).

⁵⁵³ Extracted from Productivity Commission, Report on Government Services 2025 (Report, 11 February 2025) Table 12A.2 (Public Hospital Data Tables).

Trends in health spending

19.26. NSW Government expenditure on health has been on a consistent upward trend, conveniently depicted in Figure 13, prepared by NSW Treasury.⁵⁵⁴

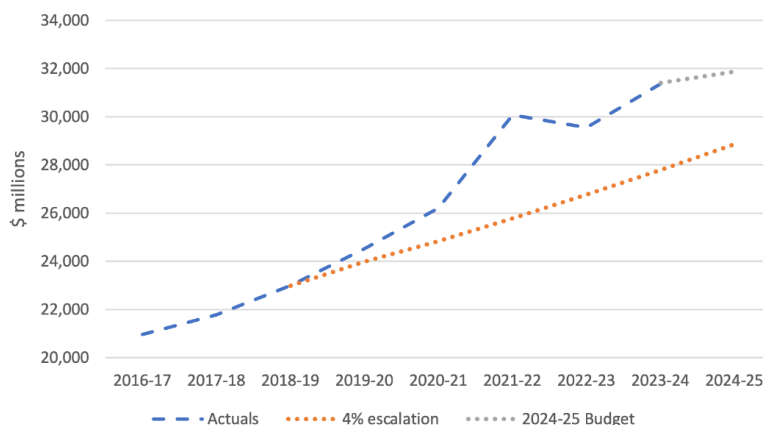


Figure 4: NSW Health actual expenditure (2016–17 to 2023–24) and budget (2024–25).

19.27. That upward trend has been a long standing one, with health spending in Australia growing faster than the rest of the economy since the mid-1980s.⁵⁵⁵

19.28. At the State level, the 2021–22 NSW Intergenerational Report *Towards 2061 – For the Future* projected that NSW Government spending on health will not only continue to consume the largest share of State Government expenditure moving forward, but will also grow faster than any other service area. The contrast with other sectors of government spending over this timeframe is illustrated in Figure 14. On those projections, NSW Government spending on health is expected to grow at an average rate of 5.4 per cent per year, rising to 38 per cent of recurrent NSW Government expenditure by 2061.⁵⁵⁶

⁵⁵⁴ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [Chart 1] [TRY.0001.0001.0001 at 0004].

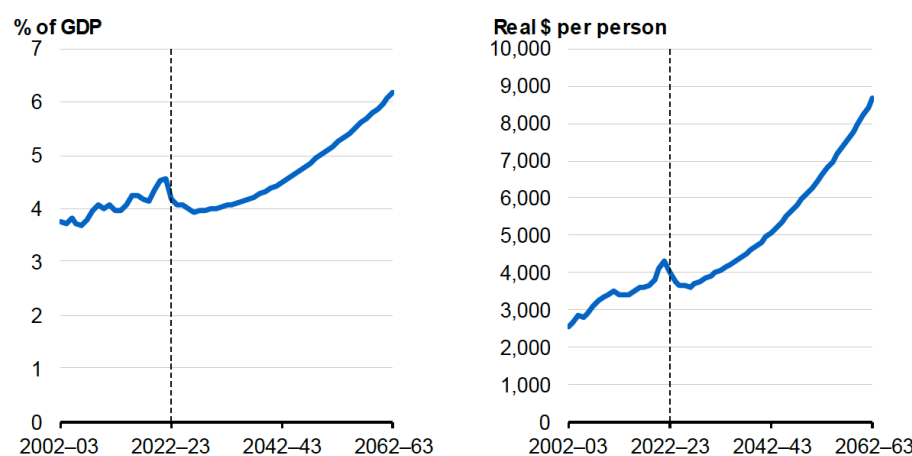
⁵⁵⁵ Exhibit A.22, 2021 Intergenerational Report: Australia over the next 40 years (Report, June 2021) pp 94–102 [SCI.0001.0018.0001 at 0112–0120].

⁵⁵⁶ Exhibit A.20, 2021–22 Intergenerational Report: Towards 2061 – Planning for the Future (Report, 7 June 2021) 72–74 [SCI.0001.0016.0001 at 0074–0076]; Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.36]–[2.37] [TRY.0001.0001.0001 at 0007–0008].



Figure 5: Service area share of total recurrent expenses of NSW Government.⁵⁵⁷

- 19.29. Commonwealth Government spending on health is also expected to rise significantly over that same period. The Commonwealth Government's intergenerational report, *Australia's Future to 2063*, projects that total spending on healthcare will rise from 4.2 per cent of Gross Domestic Product (GDP) in 2022–23 to 6.2 per cent of GDP in 2062–63. Overall expenditure per person is projected to almost double over that time.⁵⁵⁸



Note: Real dollars per person refers to 2022–23 prices.

Figure 6: Commonwealth Government health spending as a share of GDP and real Commonwealth Government health spending per person.⁵⁵⁹

⁵⁵⁷ Exhibit A.20, 2021-22 Intergenerational Report: Towards 2061 – Planning for the Future (Report, 7 June 2021) chart 4.1, p 72 [SCI.0001.0016.0001 at 0072]; Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) chart 3 [TRY.0001.0001.0001 at 0008].

⁵⁵⁸ Exhibit A.21, Intergenerational Report 2023: Australia's Future to 2063 (Report, 2023) [7.1] [SCI.0001.0017.0001 at 0168–0171].

⁵⁵⁹ Exhibit A.21, Intergenerational Report 2023: Australia's Future to 2063 (Report, 2023) charts 7.7 and 7.8 [SCI.0001.0017.0001 at 0170].

- 19.30. Consistent with the position observed at the State level, Commonwealth Government spending on health will consume the largest proportion of Commonwealth Government expenditure in any service category, outstripping defence and education by a considerable margin. It is also the fastest growing component of Commonwealth Government expenditure. If spending on aged care and the NDIS are also taken into account, total spending is projected to exceed 10 per cent of GDP by 2062–63.

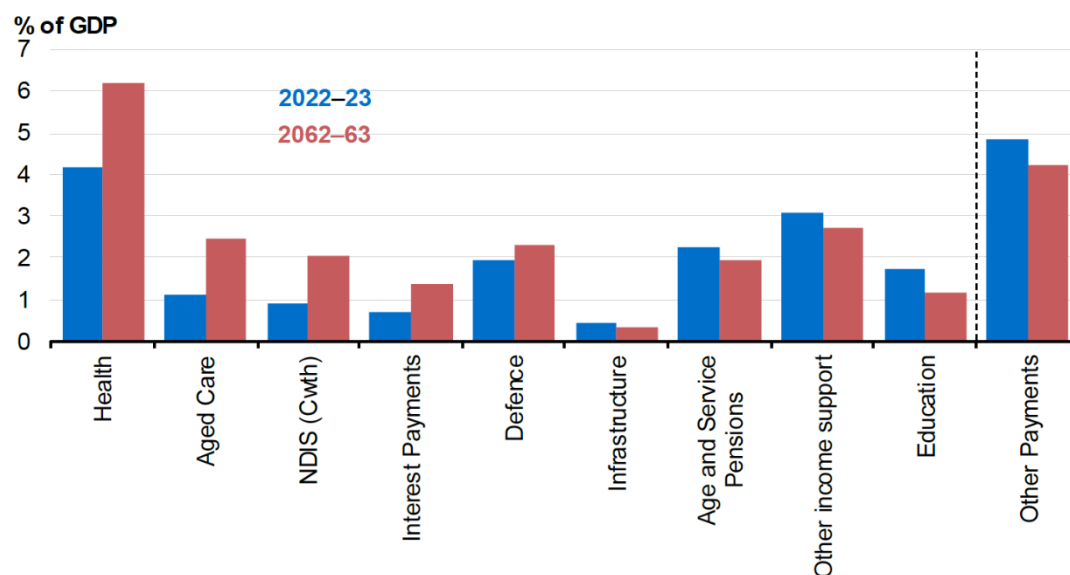


Figure 7: Commonwealth Government payments by major category.⁵⁶⁰

- 19.31. The causes of the projected growth in government expenditures of any kind are complex and multifactorial.
- 19.32. However, there are several key drivers of the projected growth in health spending that are common to Commonwealth and State Government projections. Factors such as an ageing population that lives longer in years of both good and ill health, increasing rates of chronic disease, and an expectation from within the community that they will have access to high quality care, all drive spending increases. In addition to those demographic features, pressure on government expenditure will also be felt from the continual (and in some instances, rapid) advancements in technology and development of new models of care.⁵⁶¹

⁵⁶⁰ Exhibit A.21, Intergenerational Report 2023: Australia's Future to 2063 (Report, 2023) chart 7.5 [SCI.0001.0017.0001 at 0167].

Exhibit A.20, 2021–22 Intergenerational Report: Towards 2061 – Planning for the Future (Report, 7 June 2021) pp 15–18, [1.1]–[1.2], [4.2], [6.3] [SCI.0001.0016.0001 at 0015–0018, 0026–0030, 0074–0079, 0108–0113]; Exhibit A.21, Intergenerational Report 2023: Australia's Future to 2063 (Report, 2023) pp viii–xi, 6–8, [7.1] [SCI.0001.0017.0001 at 0010–0013, 0026–0028, 0168–0171]; Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.36]–[2.37] [TRY.0001.0001.0001 at 0007].

The national framework

- 19.33. When engaging in a consideration of healthcare funding in NSW, it is necessary to have regard to both national level arrangements, and the manner in which the NSW Government funds healthcare through the NSW budget.
- 19.34. The current national arrangements followed a series of reforms implemented during the 2000s, including through the Intergovernmental Agreement on Federal Financial Relations (entered into in November 2008) and the National Health and Hospitals Network Agreement (entered into in April 2010).

The National Healthcare Agreement

- 19.35. The National Healthcare Agreement (entered into in 2011) defined the objectives, outcomes and performance indicators and sought to outline the roles and responsibilities that guide the Commonwealth and the states and territories in delivering services across the health sectors.⁵⁶²
- 19.36. It encompassed the collective aspirations of the Commonwealth, state, and territory governments in relation to prevention, primary and community care, hospital and related care, and aged care.⁵⁶³ In doing so, it recorded the commitment of all governments to “improve health outcomes for all Australians and ensure the sustainability of the Australian health system.”⁵⁶⁴
- 19.37. The National Healthcare Agreement set out the agreement of all governments that Australia’s health system should:
- a. be shaped around the health needs of patients, their families and communities;
 - b. focus on the prevention of disease and injury, the maintenance of health and not just the treatment of illness;
 - c. support an integrated approach to health promotion, the prevention of illness and injury and the diagnosis and treatment of illness across the continuum of care; and
 - d. provide all Australians with timely access to quality health services based on their needs, regardless of where they live.⁵⁶⁵
- 19.38. The National Healthcare Agreement also recorded the shared responsibility of the Commonwealth and the states and territories to fund public hospitals, public health activities, mental health services, subacute care, Aboriginal and Torres Strait Islander

⁵⁶² Exhibit A.25, National Healthcare Agreement (2012) [SCI.0001.0021.0001].

⁵⁶³ Exhibit A.25, National Healthcare Agreement (2012) cl 10 [SCI.0001.0021.0001 at 0003].

⁵⁶⁴ Exhibit A.25, National Healthcare Agreement (2012) cl 12 [SCI.0001.0021.0001 at 0003].

⁵⁶⁵ Exhibit A.25, National Healthcare Agreement (2012) cl 4 [SCI.0001.0021.0001 at 0002].

health services, health research, health workforce training, emergency response, and blood and blood products.⁵⁶⁶

19.39. In addition to those shared funding responsibilities:

- a. the states and territories were obliged to fund community health, capital infrastructure and service planning, ambulance services, food and safety regulation, environmental health, and disability services;⁵⁶⁷ and
- b. the Commonwealth was obliged to fund access to private medical care, access to pharmaceuticals, access to private health insurance, education of health professionals, health services for eligible veterans, residential, community and flexible aged care services, the purchase of vaccines under national immunisation arrangements, and community controlled Aboriginal and Torres Strait Islander primary healthcare.⁵⁶⁸

19.40. The National Healthcare Agreement also identified the respective responsibilities of the states and territories beyond direct funding obligations as including:

- a. providing public patients with access to all services provided to private patients in public hospitals;
- b. service planning, capital works and adequate infrastructure for public hospitals and community health facilities to meet future needs;
- c. the funding of patient assistance, travel schemes and ensuring that public patients are aware of how to access those schemes;
- d. ensuring that eligible persons who have elected to be treated as private patients have done so on the basis of informed consent;
- e. providing and funding pharmaceuticals for public and private patients and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Agreements are in place);
- f. maintaining a public patients hospital charter and an independent complaints body and ensuring that patients are aware of how to access these provisions;
- g. providing public health, community health, public dental; delivering vaccines purchased by the Commonwealth under national immunisation arrangements; and health promotion programs; and
- h. continuing to provide an agreed national minimum data set; and providing clinical training programs for undergraduates and specialists.⁵⁶⁹

⁵⁶⁶ Exhibit A.25, National Healthcare Agreement (2012) cl 24 [SCI.0001.0021.0001 at 0006].

⁵⁶⁷ Exhibit A.25, National Healthcare Agreement (2012) cl 26 [SCI.0001.0021.0001 at 0007].

⁵⁶⁸ Exhibit A.25, National Healthcare Agreement (2012) cl 29 [SCI.0001.0021.0001 at 0008-0009].

⁵⁶⁹ Exhibit A.25, National Healthcare Agreement (2012) cl 27 [SCI.0001.0021.0001 at 0008].

- 19.41. The obligations of the Commonwealth under the National Healthcare Agreement also included the obligation to:
- a. ensure equitable and timely access to affordable primary health services, predominantly through general practice;
 - b. assist in reducing pressure on hospital Emergency Departments through the provision of funding for primary health services;
 - c. ensure equitable and timely access to affordable specialist services; provide reliable, timely and affordable access to safe, cost-effective and high quality medicines;
 - d. ensure that there are sufficient affordable aged care services so that people needing this care can access it when it is required, regardless of geographic location;
 - e. regulate the private health insurance industry and subsidise access to private health insurance; facilitate access by Aboriginal and Torres Strait Islander people to mainstream health services to help close the health equity gap;
 - f. provide data to the states and territories on a quarterly basis concerning private health insurance coverage levels, the MBS and the PBS by specified geographic area;
 - g. continue to provide data for an agreed national minimum data set;
 - h. purchase vaccines for the delivery by states and territories through national immunisation agreements; and
 - i. provide vocational training programs for general practitioners.

The National Health Reform Agreement

- 19.42. The NHRA set the parties' commitments in relation to public hospital funding, public and private hospital performance reporting, local governance of elements of the health system, and policy and planning for primary healthcare. Following the Royal Commission into Aged Care Quality and Safety, it was amended to provide for the subsequent rearrangement of governmental responsibilities for aged care.
- 19.43. It was first entered into in August 2011, and has been the subject of subsequent amendments. The current iteration is reflected in the *Addendum to the NHRA*.⁵⁷⁰
- 19.44. The *Mid-Term Review of the 2020–2025 Addendum to the NHRA* resulted in 45 recommendations, which include proposals for reforms and initiatives to enable the

⁵⁷⁰ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) [SCI.0001.0024.0001]. The Addendum had the effect of amending the National Health Reform Agreement for the period 1 July 2020 to 30 June 2025: cl 1(d).

health system to address current and future challenges, including in relation to funding models.⁵⁷¹

- 19.45. Following this review, National Cabinet endorsed several objectives that are to be explored through the negotiations for the next iteration of the NHRA, including:⁵⁷²
- a. increasing Commonwealth contributions to public hospital services to 45 per cent over a maximum of a 10 year period from 1 July 2025, with an interim target of 42.5 per cent before 2030;
 - b. replacing the 6.5 per cent national funding cap with a more generous approach that applies a cumulative cap over the period 2025–2030, and includes a first year “catch-up” growth premium; and
 - c. commencing the renegotiation of the *Addendum to the NHRA* to embed long term, system wide structural health reforms, including considering the *Mid-Term Review of the Addendum to the NHRA* findings.
- 19.46. At the time of this Report, those negotiations have not been concluded.⁵⁷³
- 19.47. The preliminaries to the current *Addendum to the NHRA* set out a range of matters relating to the roles of the Commonwealth and state and territory governments. Importantly, they include:⁵⁷⁴
- a. the “shared intention...to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system”; and
 - b. a recognition that “the responsibility for health is shared between the Commonwealth and the states” and that they have a responsibility to ensure that systems work together effectively and efficiently to produce best outcomes for people”.
- 19.48. The shared nature of the responsibility for health across governments is reflected throughout the *Addendum to the NHRA*, including through a series of system wide objectives, roles and responsibilities, and implementation measures.⁵⁷⁵ The details of how those objectives are to be achieved and the roles and responsibilities of the Commonwealth and state and territory governments are to be performed are set out

⁵⁷¹ Exhibit N3.17, Rosemary Huxtable, Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 (Report, 24 October 2023) [SCI.0011.0585.0001].

⁵⁷² Exhibit N3.44, National Health Funding Body Annual Report 2023–24 (Report, 20 September 2024) p 19 [SCI.0011.0745.0001 at 0029].

⁵⁷³ See Federal Financial Relations 2024–2025 (Budget Paper No 3, 14 May 2024) p 29: “Negotiations of the 2025–2030 NHRA Addendum to embed the funding changes endorsed by National Cabinet are ongoing, as such, the National Health Reform funding estimates are based on the current 2020–2025 NHRA Addendum.”

⁵⁷⁴ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls 1(a), 1(c) [SCI.0001.0024.0001 at 0005].

⁵⁷⁵ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls 5–28 [SCI.0001.0024.0001 at 0006–0013].

in the schedules to the *Addendum to the NHRA*. Those schedules deal with the following topics:

- a. Schedule A - the “sustainability” (i.e., funding) of “public hospital services”;
- b. Schedule B – the National Bodies, namely the Independent Health Pricing Authority, the Administrator of the National Health Funding Body, the Australian Commission on Safety and Quality in Health Care, and the Australian Institute of Health and Welfare;
- c. Schedule C – “Long Term Health Reform Principles”, which sets out a series of commitments for “shared action” between Commonwealth and state and territory Governments (some aspects of which will be explored below);
- d. Schedule D – “Transparency and Performance”, which deals with system performance reporting and analysis;
- e. Schedule E – deals with local governance issues, including the role of Local Health Networks (LHDs in NSW);
- f. Schedule F – deals with the interfaces between health systems; and
- g. Schedule G – sets out a series of “Business Rules” that service providers are required to operate under.

19.49. Some aspects of those schedules are explored below and elsewhere in this Report.

Funding arrangements under the NHRA

19.50. Schedule A to the *Addendum to the NHRA* sets out the national funding arrangements for public hospital services. In particular, it identifies the three principal methods by which the Commonwealth contributes to the funding of public hospital services, namely:

- a. activity based funding;
- b. block funding; and
- c. public health funding.

19.51. Services that are eligible to attract Commonwealth funding (whether by way of ABF, or by block funding) are described as being “in scope”. In a broad sense, the range of “in scope” activities include:⁵⁷⁶

- a. all admitted services, including Hospital in the Home programs;
- b. all Emergency Department services provided by a recognised Emergency Department service; and

⁵⁷⁶ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.17 [SCI.0001.0024.0001 at 0017].

- c. other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service.
- 19.52. The Independent Health and Aged Care Pricing Authority is responsible for maintaining and publishing a list of services that are “in scope” and eligible for Commonwealth funding.⁵⁷⁷ The states and territories and the Commonwealth may also enter into bilateral agreements that determine the scope of activities that will attract Commonwealth funding.⁵⁷⁸
- 19.53. Hospitals and services may be funded through a mix of ABF, block funding and public health funding in accordance with the *Addendum to the NHRA*,⁵⁷⁹ as depicted in the following diagram (related to 2023–24 year).⁵⁸⁰

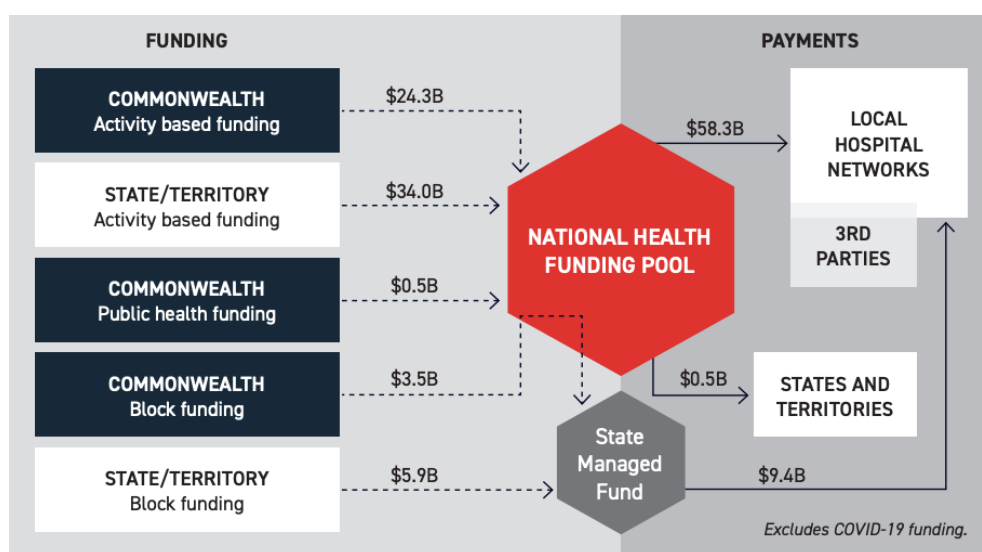


Figure 8: 2023-24 public hospital funding payment flows.

- 19.54. Although it has been the ambition that the Commonwealth contribution towards the funding of public hospital services would increase, it has, in fact, declined from a high in 2019–20 to a projected 37.8 per cent for 2024–25.⁵⁸¹

⁵⁷⁷ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls A.18–A.24 [SCI.0001.0024.0001 at 0017].

⁵⁷⁸ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls A.25–A.28 [SCI.0001.0024.0001 at 0018].

⁵⁷⁹ Exhibit A.44, IHACPA, Understanding the NEP and NEC Determinations 2023–24 (Report, March 2023) p 5 [SCI.0001.0040.0001 at 0005].

⁵⁸⁰ Exhibit N3.44, National Health Funding Body Annual Report 2023–24 (Report, 20 September 2024) p 22 [SCI.0011.0745.0001 at 0032]; Exhibit D.4, Statement of Adjunct Professor Alfa D’Amato (9 April 2024) [33] [MOH.9999.0763.0001 at 0008].

⁵⁸¹ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.39], chart 4 [TRY.0001.0001.0001 at 0009]; Transcript of the Commission, 18 November 2024, T6282.1–6 (Kastoun/D’Amato).

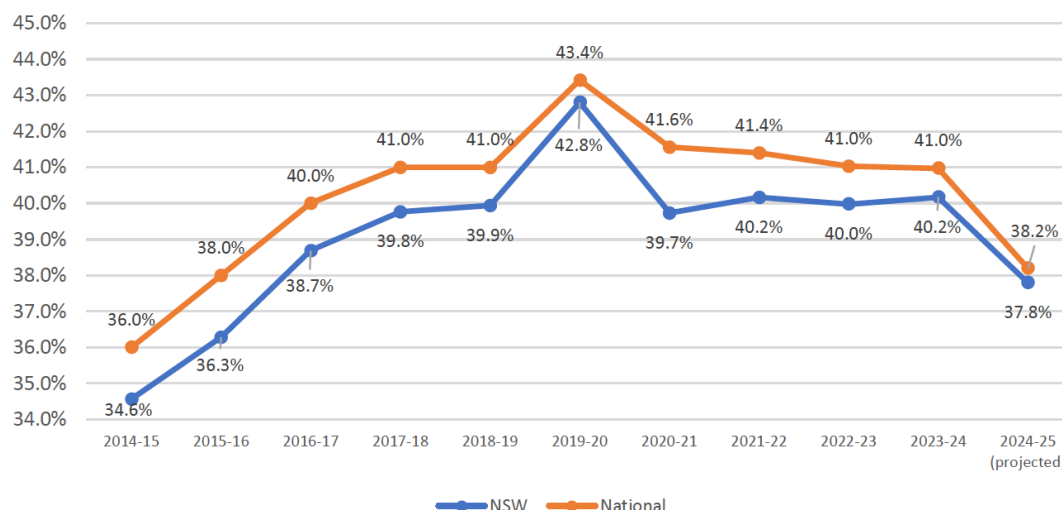


Figure 9: Commonwealth contribution rates for NSW and all states and territories (national) from 2014-2015 to 2024-2025.

- 19.55. As noted above, however, negotiations in relation to the next iteration of the NHRA include the objective of increasing the value of the Commonwealth contributions.

Activity based funding

- 19.56. ABF is the primary mechanism by which the Commonwealth's contribution to funding public hospital services is to be determined. It is applied in all cases except where its use would be neither practicable nor appropriate.⁵⁸² Conceptually, it is "a way of funding hospitals for the number and mix of patients they treat" and is said to "account for some patients being more complex and resource intensive to treat than others".⁵⁸³
- 19.57. The model is a complex one, with many inputs.⁵⁸⁴ However, at a general level, the Commonwealth Government is required to fund 45 per cent of the "efficient growth of ABF service delivery", subject to the operation of the national funding cap.⁵⁸⁵ The effect of the national funding cap is that growth in the Commonwealth's total funding contribution is capped at 6.5 per cent per year.⁵⁸⁶ "Efficient growth" consists of "the national efficient price for any changes in the volume of services provided" and "the growth in the national efficient price of providing the existing volume of services".⁵⁸⁷

⁵⁸² Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.3 [SCI.0001.0024.0001 at 0014].

⁵⁸³ Exhibit H2.51, NSW Health, Corporate Governance & Accountability Compendium (May 2024) [7.2.2] [MOH.0010.0256.0001 at 0078].

⁵⁸⁴ See, for example, Confidential Exhibit 33, NSW Health, NSW Activity Based Funding and Activity Based Management Compendium 2023-24 [MOH.0100.0295.0001].

⁵⁸⁵ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.6 [SCI.0001.0024.0001 at 0015].

⁵⁸⁶ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020), cl A.5 [SCI.0001.0024.0001 at 0015].

⁵⁸⁷ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.6 [SCI.0001.0024.0001 at 0015].

19.58. The *Addendum to the NHRA* provides that the Commonwealth Government's contribution to services funded on an activity basis is determined by adding:⁵⁸⁸

- (a) *previous year amount – the Commonwealth's contribution rate for the relevant state in the previous year, multiplied by the volume of weighted ABF Services provided in the previous year, multiplied by the National Efficient Price in the previous year;*
- (b) *price adjustment – the volume of weighted services provided in the previous year, multiplied by the change in the national efficient price relative to the previous year, multiplied by 45 per cent; and*
- (c) *volume adjustment – the net change in volume of weighted services provided in the relevant state (relative to the volume of weighted ABF Services provided in the previous year), multiplied by the national efficient price, multiplied by 45 per cent.*

19.59. The ABF model will improve every year, informed by previous years' cost and activity data.⁵⁸⁹ Actual activity data is provided by each jurisdiction to the National Health Funding Body annually, with activity and funding reconciled at the conclusion of each financial year.⁵⁹⁰ Based on this data and the National Efficient Price (NEP), the Commonwealth contribution for ABF is paid into the National Health Funding Pool.⁵⁹¹

19.60. This Special Commission heard evidence that the ABF model has allowed for greater technical efficiencies, as it calls for the collection of activity data which, when analysed, enables providers to better understand the elements contributing to cost of care.⁵⁹²

19.61. Under the ABF model, public health services in NSW are funded based on a National Weighted Activity Unit and the level of activity as set out in their service agreements.⁵⁹³

19.62. Price adjustments are applied to accurately account for the complexity of treatment. These adjustments may relate to the remoteness of the patient (in terms of their place of residence or place of treatment) or their Indigenous status.⁵⁹⁴

⁵⁸⁸ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.34 [SCI.0001.0024.0001 at 0019].

⁵⁸⁹ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.41 [SCI.0001.0024.0001 at 0020].

⁵⁹⁰ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [11] [MOH.9999.0001.0001 at 0002–0003].

⁵⁹¹ Transcript of the Commission, 30 November 2023, T295.37–47 (D'Amato).

⁵⁹² Transcript of the Commission, 30 November 2023, T311.7–35 (Willcox).

⁵⁹³ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [18] [MOH.0011.0091.0001 at 0004].

⁵⁹⁴ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [13] [MOH.9999.0001.0001 at 0003]; see also Transcript of the Commission, 30 November 2023, T311.47–312.27 (D'Amato).

- 19.63. ABF is based on classifications (e.g., acute, subacute, mental health, non-admitted), to ensure that services can be described in a homogenous way and funded according to prices set by IHACPA.⁵⁹⁵ IHACPA provides the following explanation:⁵⁹⁶

The NEP [national efficient price] is based on the average cost of an admitted acute episode of care provided in public hospitals during a financial year. Each episode of patient care is allocated a national weighted activity unit (NWAU).

The NWAU is a measure of hospital activity expressed as a common unit. It is a point of relativity for the pricing of public hospital services, which are weighted for clinical complexity. The ‘average’ hospital service is worth one NWAU. More complex and expensive activities are worth multiple NWAUs, and simpler and less expensive activities are worth fractions of an NWAU.

- 19.64. For the purposes of determining the Commonwealth’s funding contribution, the price of each public hospital service is calculated by multiplying the NWAU allocated to that service by the NEP.

Block funding

- 19.65. Block funding is provided to support:⁵⁹⁷
- a. public hospital functions other than patient services;
 - b. public patient services that are not appropriately funded through ABF (including small rural hospitals); and
 - c. services or functions that are not yet able to be described in terms of ‘activity’, such as teaching, training and research.
- 19.66. Where services eligible for Commonwealth funding are more appropriately funded through block grants, the Commonwealth funds 45 per cent of growth in the efficient cost of providing those services or performing those functions. Block funding is paid at the National Efficient Cost, determined annually by IHACPA, “taking account of changes in utilisation, the scope of services provided and the cost of those services, to ensure the Local Hospital Network has the appropriate capacity to deliver the relevant block funded services and functions”.⁵⁹⁸

⁵⁹⁵ Transcript of the Commission, 30 November 2023, T290.17–24 (D’Amato).

⁵⁹⁶ Exhibit A.44, IHACPA, Understanding the NEP and NEC Determinations 2023–24 (Report, March 2023) p 4 [SCI.0001.0040.0001 at 0004].

⁵⁹⁷ Exhibit A.44, IHACPA, Understanding the NEP and NEC Determinations 2023–24 (Report, March 2023) p 5 [SCI.0001.0040.0001 at 0005].

⁵⁹⁸ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls A.7, A.49, A.55 [SCI.0001.0024.0001 at 0015, 0022, and 0023].

- 19.67. The amount of the Commonwealth's contribution by way of block funding is the total of the previous year's payment, plus 45 per cent of the growth in the efficient cost of providing the services.⁵⁹⁹ Block funding is also subject to the 6.5 per cent cap.
- 19.68. IHACPA, in consultation with jurisdictions, maintains the criteria for block funding and identifies whether hospital services and functions are eligible for block funding or a mix of block and ABF.⁶⁰⁰

Public health funding

- 19.69. The Commonwealth provides "public health activity funding" to the states and territories, and the states have "full discretion" over the application of that funding in achieving the outcomes set out in the *Addendum to the NHRA*.⁶⁰¹

The responsibility of the State to pay for public hospital services

- 19.70. In addition to the Commonwealth Government's responsibility to contribute to the cost of public health services, the states and territories are required to determine the amount they will pay for public hospital services (in the sense of the amount they will allocate to their respective health systems for those services), and fund the balance of the cost of those services that is over and above the amount of the Commonwealth's contribution.⁶⁰²

Other sources of Commonwealth funding

Bi-lateral/multi-lateral agreements

- 19.71. The *Addendum to the NHRA* contemplates that state and territory governments may enter into agreements with the Commonwealth pursuant to which the Commonwealth provides funding that would not otherwise flow under that agreement.
- 19.72. The *Bilateral Schedule on Mental Health and Suicide Prevention*⁶⁰³ between the Commonwealth and NSW is one such example. It provides for funding arrangements for specified mental health and suicide prevention services in NSW, until the finalisation of the *National Mental Health and Suicide Prevention Agreement*, at which time the Schedule will be transferred to the National Agreement.⁶⁰⁴

⁵⁹⁹ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.50 [SCI.0001.0024.0001 at 0022].

⁶⁰⁰ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl A.51 [SCI.0001.0024.0001 at 0022].

⁶⁰¹ Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls A.14–A.15 [SCI.0001.0024.0001 at 0017].

⁶⁰² Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cls A.89–A.95 [SCI.0001.0024.0001 at 0028].

⁶⁰³ Bilateral Schedule on Mental Health and Suicide Prevention between the Commonwealth and New South Wales (7 March 2022). The Schedule falls under the Federation Funding Agreement - Health, until the National Mental Health and Suicide Prevention Agreement is finalised: cl 1.

⁶⁰⁴ Bilateral Schedule on Mental Health and Suicide Prevention between the Commonwealth and New South Wales (7 March 2022).

Other Commonwealth grants

- 19.73. The Commonwealth Government's contribution towards public hospital services through the *Addendum to the NHRA* is not the only source of Commonwealth funding received by NSW that is available to be allocated to the NSW public health system.
- 19.74. Significantly, the Commonwealth Grants Commission distributes the revenue raised by the Commonwealth from the GST among the states and territories.⁶⁰⁵
- 19.75. For the purposes of this Report, it is not necessary to examine the processes undertaken by the Commonwealth Grants Commission. However, it is relevant to observe that the allocation process makes adjustments having regard to the fact that the states and territories have different capacities to raise revenue. Those differences are then taken into account in assessing a state's ability to pay for a standard set of services (which include public hospital services).⁶⁰⁶
- 19.76. In assessing a state's ability to pay for those standard services, "payments for specific purposes" received from the Commonwealth – such as those made under the *Addendum to the NHRA* – are accounted for, such that:⁶⁰⁷

"[t]o the extent that a state receives above average per capita amounts of PSPs, less GST is required to equalise its fiscal capacity. Conversely, if a state receives below average amounts of PSPs, it requires more GST."

- 19.77. Therefore, the more a state receives from a specific purpose payment (such as funding under the *Addendum to the NHRA*), that state will "need" less of a share of GST revenue to pay for that standard set of services.⁶⁰⁸
- 19.78. As a result, it cannot be assumed that increases in funding received from the Commonwealth pursuant to the *Addendum to the NHRA* (for example, through an increase in activity, or an expansion of "in scope" services) will result in corresponding increases to the overall funding envelope that flows to NSW from the Commonwealth. However, I recognise that – from the perspective of NSW Health – moneys received by the State through the operation of the *Addendum to the NHRA* have the advantage that they are almost certain to be deployed in the delivery of the public health system.

⁶⁰⁵ See, eg, Exhibit M.20, Stephen Duckett, Commonwealth-State Financial Arrangements in Health Care (Report, 13 September 2023) [21] ff [SCI.0011.0500.0001 at 0004 ff].

⁶⁰⁶ Exhibit M.20, Stephen Duckett, Commonwealth-State Financial Arrangements in Health Care (Report, 13 September 2023) [42] [SCI.0011.0500.0001 at 0007].

⁶⁰⁷ Commonwealth Grants Commission, Report on GST Revenue Sharing Relativities: 2020 Review (Report, 28 February 2020) vol 1, p 15; Exhibit M.20, Stephen Duckett, Commonwealth-State Financial Arrangements in Health Care (Report, 13 September 2023) [47] [SCI.0011.0500.0001 at 0008].

Exhibit M.20, Stephen Duckett, Commonwealth-State Financial Arrangements in Health Care (Report, 13 September 2023) [49] [SCI.0011.0500.0001 at 0008]; Transcript of the Commission, 20 November 2024, T6492.32–45, T6493.21–34 (Duckett).

Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme

- 19.79. The MBS operates by “paying a specified benefit (in the form of a rebate) for a health or medical service for which a claim is submitted”.⁶⁰⁹ Medicare benefits are paid in relation to eligible services provided by private practitioners to an eligible person. Services provided in a public hospital may attract a Medicare benefit if the patient elects to be treated as a private patient,⁶¹⁰ or if provided by a public service following the grant a s 19(2) exemption (of which NSW Health has received several, as I note above).⁶¹¹ The operation of the MBS is governed the *Health Insurance Act*, and the Commonwealth Minister for Health and Aged Care maintains overall responsibility for Medicare.⁶¹²
- 19.80. The PBS is a Commonwealth Government program that subsidises the cost of approved medicines.⁶¹³ Under the PBS, a co-payment is made by patients towards the cost of each PBS medicine and the Australian Government typically covers the remainder, subject to the PBS Safety Net scheme, which provides individuals and families with free further prescription medicines where they have spent the equivalent of their Safety Net threshold during the calendar year.⁶¹⁴

The role of the national bodies under the NHRA

Independent Health and Aged Care Pricing Authority

- 19.81. IHACPA was established under the *National Health Reform Act 2011* (Cth).
- 19.82. Since its creation in 2011, IHACPA has had the following main functions in relation to healthcare pricing and costing and the funding of public hospitals:⁶¹⁵
- determining the NEP and the National Efficient Cost;
 - determining adjustments to the NEP to reflect legitimate and unavoidable variations in the cost of delivering health services;
 - except where otherwise agreed between the Commonwealth and a state or territory, determining the public hospital functions that are to be funded in the state or territory by the Commonwealth; and

⁶⁰⁹ Amanda Biggs, ‘Medicare: A Quick Guide’ (Research Paper, Parliamentary Library, Parliament of Australia, 12 July 2016) pp 1–2.

⁶¹⁰ Amanda Biggs, ‘Medicare: A Quick Guide’ (Research Paper, Parliamentary Library, Parliament of Australia, 12 July 2016) p 1.

⁶¹¹ That being an exemption from the prohibition on the payment of a Medicare benefit on services rendered by a state granted by the federal Health Minister pursuant to s 19(2) of the *Health Insurance Act 1973* (Cth).

⁶¹² Amanda Biggs, ‘Medicare: A Quick Guide’ (Research Paper, Parliamentary Library, Parliament of Australia, 12 July 2016) pp 1–2; *Health Insurance Act 1973* (Cth) pt II.

⁶¹³ It is noted NSW has not yet entered a Pharmaceutical Reform Agreement with the Commonwealth.

⁶¹⁴ Rebecca Storen, Rosalind Hewett and Emma Vines, ‘The Pharmaceutical Benefits Scheme: A Quick Guide’ (Research Paper, Parliamentary Library, Parliament of Australia, 23 February 2022) p 2.

⁶¹⁵ *National Health Reform Act 2011* (Cth) s131 (1)(a)-(f); Exhibit N3.45, Response of IHACPA to request for information from the Special Commission of Inquiry into Healthcare Funding (11 December 2024) pp 2–3 [SCI.0011.0748.0001 at 0001–0002].

- d. developing and specifying classification and data collection systems that are relevant to fulfilling these functions.
- 19.83. Since 2022, IHACPA has also taken on the role of providing advice on (but not determining) the costing and pricing of aged care services to the Commonwealth Minister for Health and Aged Care.⁶¹⁶
- 19.84. IHACPA is required to annually publish, among other reports and papers relating to its functions, a National Efficient Price Determination and a National Efficient Cost Determination (Determinations).⁶¹⁷ In developing the Determinations, IHACPA engages in a detailed consultation process.⁶¹⁸
- 19.85. The National Efficient Price Determination includes the scope of public hospital services eligible for Commonwealth funding on an activity basis as per the *General List of In-Scope Public Hospital Services*.⁶¹⁹ The Determinations are published in March each year, ahead of their implementation from 1 July that year.⁶²⁰
- 19.86. The Determinations assist in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost or price of providing these services, as outlined in the *Addendum to the NHRA*.⁶²¹

The National Health Funding Pool and the National Health Funding Body

- 19.87. The Office of the Administrator of the National Health Funding Pool and the National Health Funding Body were established in 2011 under the *National Health Reform Act*.⁶²²
- 19.88. The National Health Funding Body's primary purpose is to support the obligations and responsibilities of the Administrator through best practice administration of public hospital funding.⁶²³
- 19.89. The National Health Funding Pool refers to the combined State Pool Accounts for each state and territory, being the bank accounts opened under the laws of the states

⁶¹⁶ *National Health Reform Act 2011* (Cth) s131A; Exhibit A.28, Addendum to the National Health Reform Agreement 2020–2025 (2020) cl B.23 [SCI.0001.0024.0001 at 0044].

⁶¹⁷ Exhibit N3.45, Response of IHACPA to request for information from the Special Commission of Inquiry into Healthcare Funding (11 December 2024) pp 3–4 [SCI.0011.0748.0001 at 0002–0003].

⁶¹⁸ Exhibit N3.45, Response of IHACPA to request for information from the Special Commission of Inquiry into Healthcare Funding (11 December 2024) p 4 [SCI.0011.0748.0001 at 0003].

⁶¹⁹ Exhibit A.44, IHACPA, Understanding the NEP and NEC Determinations 2023–24 (Report, March 2023) p 5 [SCI.0001.0040.0001 at 0005].

⁶²⁰ Exhibit N3.45, Response of IHACPA to request for information from the Special Commission of Inquiry into Healthcare Funding (11 December 2024) p 4 [SCI.0011.0748.0001 at 0003].

Exhibit A.44, IHACPA, Understanding the NEP and NEC Determinations 2023–24 (Report, March 2023) pp 4, 5 [SCI.0001.0040.0001 at 0004–0005].

⁶²² *National Health Reform Act 2011* (Cth) ss 231, 251. Comparable legislation in each State and Territory also provides the establishment of Administrator: see, eg, *Health Services Act 1997* (NSW) s 126i; sch 6A, pt 2, s 2(1).

⁶²³ Exhibit N.3.44, National Health Funding Body Annual Report 2023–24 (20 September 2024), p 8 [SCI.0011.0745.0001 at 0018].

and territories as State Pool Accounts for the purposes of the *Addendum to the NHRA*.⁶²⁴

- 19.90. The Administrator of the National Health Funding Pool is an independent statutory office holder who oversees the administration of the National Funding Pool, including calculating and advising the Treasurer of the Commonwealth of the amounts required to be paid by the Commonwealth into each State Pool Account of the National Health Funding Pool under the *Addendum to the NHRA* (including advice on any reconciliation of those amounts based on subsequent actual service delivery).⁶²⁵
- 19.91. In doing so, the Administrator uses IHACPA's *National Efficient Cost Determination* and *NEP Determination*, and public hospital activity from the states and territories, as the basis for calculation of the Commonwealth contribution to public hospital funding in each state and territory.

The NSW Health budget

- 19.92. The size of the budget allocated to NSW Health is, quintessentially, a matter for government. Like all portfolios, the needs of the NSW public health system fall to be considered against the competing demands of all service categories in the annual State budget process.
- 19.93. The State budget process commences in about November of each year, and involves portfolio Ministers preparing budget submissions, which set out the funding requirements and priorities for the year ahead. Those submissions are ultimately considered by the Cabinet Committee on Expenditure Review (otherwise referred to as the Expenditure Review Committee or ERC) in about May as part of the process of considering and prioritising funding requirements for the upcoming budget year, and into the future.⁶²⁶
- 19.94. The budget submissions prepared by Ministry of Health ordinarily include an analysis of the expenditure base for the forthcoming year, and the extent to which budgeted expenditure growth is sufficient to meet service demand, together with the identification of new policy proposals and an analysis of overall system performance, risks and pressures.⁶²⁷ The content of budget submissions may also be informed by

⁶²⁴ *National Health Reform Act 2011* (Cth) s 5; *Health Services Act 1997* (NSW) s 126I; sch 6A, pt 1, s 1; pt 3, s 9.

⁶²⁵ *National Health Reform Act 2011* (Cth) s 238; *Health Services Act 1997* (NSW) s 126I; sch 6A, pt 2, s 8; Exhibit N3.45, Response of IHACPA to request for information from the Special Commission of Inquiry into Healthcare Funding (11 December 2024) p 3 [SCI.0011.0748.0001 at 0002].

⁶²⁶ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [39]–[43] [MOH.0011.0091.0001 at 0010–0011]. See also the description of the annual budget process at Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2024) [2.7]–[2.11] [TRY.0001.0001.0001 at 0004].

⁶²⁷ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [43] [MOH.0011.0091.0001 at 0010]; Transcript of the Commission, 18 November 2024 T6248.9–27 (Cornelius).

directions from government, so as to align new policy measures with government priorities or advance proposals that are supported by savings measures.⁶²⁸

- 19.95. Treasury then prepares advice for government and, in doing so, proposes a “base” funding requirement for the year ahead.⁶²⁹
- 19.96. Treasury also provides advice to Government on the level of funding required to support services that are critical to maintain current service outcomes,⁶³⁰ and on the merit of new policy proposals or service enhancements, including as to how these proposals align with the NSW Government’s broader priorities and fiscal capacity.⁶³¹
- 19.97. A convenient summary of the yearly State budget process is set out in Figure 19, a timeline prepared by NSW Health to assist this Special Commission:⁶³²

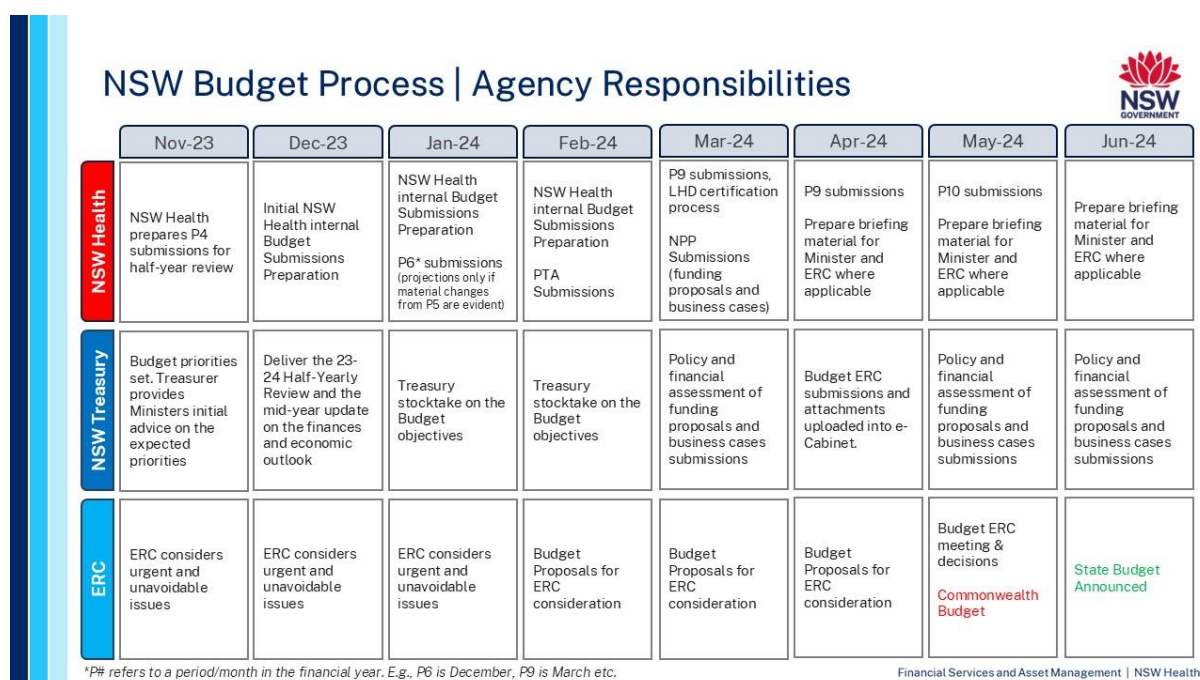


Figure 10: NSW budget process – agency responsibilities.

- 19.98. The Ministry of Health is responsible for the preparation of the NSW Health budget submission. That process commences in about November and culminates with the submission being provided to Treasury the following February/March.⁶³³ Obviously enough, in setting the overall State budget, the ERC considers budget submissions

⁶²⁸ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2024) [2.7]–[2.11] [TRY.0001.0001.0001 at 0004].

⁶²⁹ Transcript of the Commission, 18 November 2024, T6248.20–27 (Cornelius).

⁶³⁰ Transcript of the Commission, 18 November 2024, T6260.45–6261.4 (Cornelius).

⁶³¹ Transcript of the Commission, 18 November 2024, T6261.6–14 (Cornelius).

⁶³² Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [48] [MOH.0011.0091.0001 at 0012].

⁶³³ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2024) [2.7]–[2.11] [TRY.0001.0001.0001 at 0004].

and proposals from each of the portfolios and must consider competing demands for funding. Fundamentally, the allocation of the State budget and the amounts allocated to respective portfolios and service areas is a matter for the government of the day.⁶³⁴

- 19.99. Any attempt in a Report such as this to summarise the process of setting the annual budget for NSW Health risks oversimplification.⁶³⁵ That is inevitable given that the process is one that involves several stages and processes across the period from about November to May each year.
- 19.100. However, there were several general concepts that emerged in the evidence and that highlight aspects of the current approach that warrant change. They include the use of a “base” level of funding from which the budget is built each year.
- 19.101. In setting the budget for NSW Health each year, what is described as the “base” reflects an annualised budget, to which adjustment is then made for specific initiatives, activity growth and escalations, and takes into account savings initiatives and any ceasing activities.⁶³⁶
- 19.102. An annual escalation rate is applied to that “base”. The annual escalation rate for NSW Health is initially set at 4 per cent, before adjustments are made for matters such as such as inflation, emerging priorities, and any particular policy decisions (such that the escalation rate that is ultimately applied may differ from the 4 per cent starting point).⁶³⁷ The 4 per cent escalation rate comprises 2.5 per cent for cost growth and 1.5 per cent for service growth (a feature of the process unique to NSW Health).⁶³⁸ It is significant that the 1.5 per cent service growth component of the escalation rate was set in 2019 and, significantly, was described by a witness from NSW Treasury as not being “overly scientific”.⁶³⁹
- 19.103. In addition to the “base”, as adjusted through the application of the ultimate escalation rate in any given year, an allocation for capital works based on identified projects is also made, together with some funding for specific programs.⁶⁴⁰

⁶³⁴ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [20] [MOH.9999.0001.0001 at 0003]; Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [44]–[47] [MOH.0011.0091.0001 at 0011].

⁶³⁵ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (7 November 2023) [6.18] [SCI.0002.0001.0001 at 0016].

⁶³⁶ Exhibit A.53, Joint Report of Alfa D’Amato and Deb Willcox (27 November 2023) [11] [MOH.9999.0005.0001 at 0003]; Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [26] [MOH.9999.0001.0001 at 0004]; Transcript of the Commission, 18 November 2024, T6250.6–9 (Cornelius).

⁶³⁷ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2024) [2.1]–[2.6] [TRY.0001.0001.0001 at 0003-0004].

⁶³⁸ Transcript of the Commission, 18 November 2024, T6269.38–45 (Kastoun).

⁶³⁹ Transcript of the Commission, 18 November 2024, T6269.27–36 (Kastoun/Cornelius).

⁶⁴⁰ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [28] [MOH.9999.0001.0001 at 0004].

- 19.104. While NSW Health is expected to operate within its allocated budget, it is open to the Ministry to seek additional funding throughout the year in accordance with relevant Treasury policy.⁶⁴¹
- 19.105. Significantly, it emerged in the evidence that the historical origins of the “base” figure – including the size and shape of the health system that it was at least conceptually supposed to have supported – are unknown by those within the Ministry of Health responsible for the preparation of budget submissions, and those within Treasury currently charged with considering and making recommendations in relation to them.⁶⁴²
- 19.106. In circumstances where no one can identify the origin of the base from which the NSW Health budget has been (and is being) set, in my view, the base cannot be said to reflect an assessment of the level of funding required to deliver a public health system that meets the current and emerging health needs of the population, or what is required to “promote, protect and maintain” the health of the population. True it is that there is a consideration of matters such as cost growth and forecasted activity growth in the budgetary process.⁶⁴³ However, those are matters that inform a consideration of what it would cost to operate the public health system to continue for another year in its existing form.⁶⁴⁴ They say little (if anything) meaningful about the cost of delivering a public health system that is best placed to meet the health needs of the population.
- 19.107. Further, as discussed below, while the environment pre-pandemic was relatively stable such that the system was able to deliver and drive efficiencies simultaneously, which were then reinvested to undertake more activity, the post-pandemic environment is such that it is now unlikely that the “base” on which NSW Health’s budget is set remains a reliable foundation or starting point.⁶⁴⁵
- 19.108. An alternate view of the annual budget process may be that it reflects the need to allocate (or ration) a limited pool of funding that is available in the State budget across various priorities, rather than on the basis of an assessment of the funding required to deliver a system that meets the needs of the population. If this has always been the approach, the fact that the origins of the “base” are not known, and that aspects of the escalation rate are “not overly scientific”, is perhaps not as surprising as first thought. In circumstances where public funds are limited and there are competing demands on them, Commissioner Garling’s observation that the NSW public health system cannot expect to attract an ever increasing proportion of the State budget

⁶⁴¹ Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [49] [MOH.0011.0091.0001 at 0012].

⁶⁴² Transcript of the Commission, 18 November 2024, T6250.24–46 (Kastoun/Cornelius).

⁶⁴³ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (7 November 2023) [6.19] [SCI.0002.0001.0001 at 0016]

⁶⁴⁴ Assessed through the lens of some fairly narrow performance parameters such as Emergency Department wait times and wait times for elective surgery: Transcript of the Commission, 18 November 2024, T6261.16ff (Kastoun/Cornelius).

⁶⁴⁵ Exhibit M.6, Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [77]–[78] [MOH.0011.0091.0001 at 0024]; Transcript of the Commission, 18 November 2024, T6257.22–6258.28 (Kastoun/D’Amato); Transcript of the Commission, 20 November 2024, T6523.42–6524.3 (Daly); Transcript of the Commission, 21 November 2024, T6523.42–6524.18 (D’Amato).

rings loud.⁶⁴⁶ Such is the nature of public service. However, the process of setting NSW Health’s budget was not described to me in those terms. Nor was it described to me as being one that had an assumption that the proportion of the State budget allocated to NSW Health will fall within a relatively small range or not exceed a particular percentage.

- 19.109. Several witnesses accepted the general proposition that, in order to determine the level of funding required to deliver a public health system that meets the needs of the population, it was first necessary to gain a detailed understanding of: what those needs are, the services that are available (both within NSW Health and from other providers) to meet those needs, and what (if any) additional services are needed. It is only once those matters are identified that an informed assessment of the funding required to deliver that system can be made.⁶⁴⁷ As discussed further below, that analysis is best performed as part of the system wide planning process that I recommend must now be undertaken.
- 19.110. It is clear that in the post-pandemic era, there is no longer sufficient “headroom” in the NSW Health budget to fund additional activity or new initiatives within the existing budget envelope. NSW Health accepts that there are those “limitations” in the existing funding model.⁶⁴⁸ However, beyond mere “limitations”, it is clear to me that it can no longer be assumed that the current annual budgetary process is one that delivers to NSW Health a budget that reflects the cost of delivering a public health system that meets the current health needs of the population.

Setting the budgets of NSW Health agencies

- 19.111. Amounts that are ultimately appropriated from the Consolidated Fund each year in respect of NSW Health are distributed to the Minister in the annual appropriations legislation and paid to the Ministry of Health.⁶⁴⁹ The Minister then determines the amount (if any) that will be paid from that which is appropriated from the Consolidated Fund to a public health organisation. As part of that process, as system manager, the Ministry of Health makes recommendations concerning the allocation of the overall budget allocated to the health portfolio.⁶⁵⁰

⁶⁴⁶ Exhibit N4.5, Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Final Report, 27 November 2008) vol 3, p 890 [25.58] [SCI.0011.0762.0001 at 0022].

⁶⁴⁷ See, for example, Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [18] [MOH.0011.0086.0001 at 0005-0006].

⁶⁴⁸ Exhibit M.6, Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [77]–[79] [MOH.0011.0091.0001 at 0024].

⁶⁴⁹ See, for example, *Appropriation Act 2023* (NSW) s 11; Exhibit D.4, Statement of Alfa D’Amato (9 April 2024) [16], [32] [MOH.9999.0763.0001 at 0004, 0008].

⁶⁵⁰ Exhibit D.4, Statement of Alfa D’Amato (9 April 2024) [32] [MOH.9999.0763.0001 at 0008]; *Health Services Act 1997* (NSW) s 122(1)(e).

Local Health Districts

19.112. In determining the amount to be paid to each LHD, the Minister must have regard to the following matters:⁶⁵¹

- a. the size and health needs of the resident population of the LHD;
- b. the health services provided to patients from outside the LHD;
- c. the net receipts and expenditures of the LHD for the financial year;
- d. probable capital maintenance and expenditure requirements for the financial year;
- e. the NHRA (which in now reflected the *Addendum to the NHRA*); and
- f. such other matters as are prescribed by the regulations or as the Minister thinks fit.

19.113. However, the extent to which these factors substantively inform the current process of budget allocation to the LHDs through their annual service agreements is somewhat unclear.

19.114. The Ministry of Health and the LHDs operate as if in a “purchaser/provider relationship”, with a budget allocated to these organisations through the annual service agreements. It is through those agreements that the Ministry of Health “purchases” activity and services (that attract ABF contributions) and provides block or other funding, which is the mechanism by which LHDs budgets are allocated.⁶⁵²

19.115. The annual process is conveniently summarised in Figure 20:⁶⁵³

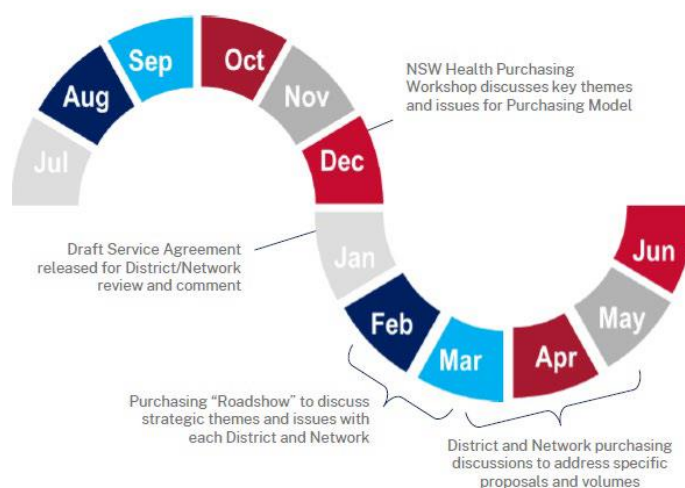


Figure 11: Summary of service agreement process.

⁶⁵¹ *Health Services Act 1997* (NSW) s 127(1), (2A).

⁶⁵² Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [30]–[31] [MOH.9999.0001.0001 at 0004]; Exhibit H2.51, NSW Health, Corporate Governance & Accountability Compendium (May 2024) [7.3] [MOH.0010.0256.0001 at 0080].

⁶⁵³ Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [33] [MOH.9999.0005.0001 at 0006].

- 19.116. The process that ultimately culminates in the service agreements being finalised begins in around October, with the Ministry of Health reviewing the current year's service agreements.⁶⁵⁴ That review process also involves meetings with each of the LHDs.⁶⁵⁵ Following that review, the System Purchasing Branch within the Ministry of Health commences the annual "purchasing process" in December through a series of workshops with the LHDs, SHNs, Pillars and Statewide Services.⁶⁵⁶ Through those workshops, the Ministry of Health provides the LHDs (and other public health organisations) with information and wider context that may affect the terms of the forthcoming service agreement.⁶⁵⁷ Following those workshops, the Ministry finalises the purchasing model to be applied in the purchasing process.⁶⁵⁸
- 19.117. Early in the calendar year, a "Purchasing Roadshow" is held with each public health organisation, including the LHDs.⁶⁵⁹ The purpose of those "Roadshows" is said to be to explore key elements of the service agreements for the forthcoming year, including activity targets, service mix, funding models, strategic priorities, policy proposals, and KPIs.⁶⁶⁰ The budgets for LHDs are then finalised, with funding allocated by reference to a mix of funding streams, such as: ABF (acute admitted, Emergency Department, non-admitted, subacute admitted and non-admitted); small rural hospitals; block funded hospitals and services; and teaching, training and research.⁶⁶¹ That should ordinarily conclude in about June.⁶⁶²
- 19.118. The Roadshow process was described at various times as enabling a level of negotiation between public health organisations and the Ministry of Health as to funding levels and priorities.⁶⁶³ Others observed that, in the context of an overall constrained financial environment, discussions during these Roadshows often did not create a truly negotiated outcome or result in LHDs achieving funding for their priorities.⁶⁶⁴

⁶⁵⁴ Transcript of the Commission, 21 November 2024, T6508.28–34 (Daly).

⁶⁵⁵ Transcript of the Commission, 21 November 2024, T6509.6–28 (Portelli).

⁶⁵⁶ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [29], [32]–[33] [MOH.0011.0089.0001 at 0006–0008]; Transcript of the Commission, 21 November 2024, T6513.20–25 (Portelli).

⁶⁵⁷ Transcript of the Commission, 21 November 2024, T6527.42–47 (D'Amato).

⁶⁵⁸ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [32]–[33] [MOH.0011.0089.0001 at 0008]; Transcript of the Commission, 21 November 2024, T6513.10–14 (Portelli), T6527.13–18 (Carr).

⁶⁵⁹ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [34] [MOH.0011.0089.0001 at 0008].

⁶⁶⁰ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [34]–[35] [MOH.0011.0089.0001 at 0008].

⁶⁶¹ Exhibit H2.51, NSW Health, Corporate Governance & Accountability Compendium (May 2024) [7.2.4] [MOH.0010.0256.0001 at 0079].

⁶⁶² Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [33] [MOH.9999.0005.0001 at 0006].

⁶⁶³ Transcript of the Commission, 22 April 2024, T2305.33–41, T2306.10–18, T2308.18–29 (McLachlan); Transcript of the Commission, 22 April 2024, T2274.35–2275.36 (Schembri); Transcript of the Commission, 5 August 2024, T4590.12–4591.15 (Loy).

⁶⁶⁴ Transcript of the Commission, 12 June 2024, T3540.19–27 (Gregory); Transcript of the Commission, 23 May 2024, T3383.5–24 (Astill); Transcript of the Commission, 19 September 2024, T5436.8–23 (McCosker).

- 19.119. There were several service agreements in evidence that were executed well into the year in respect of which they applied.⁶⁶⁵ Some of that delay is likely attributable to recent delays in the delivery of the State budget. However, it is inherently undesirable – from a governance perspective – that the agreements that form the basis of budget allocations and performance monitoring are executed well into (or in unusual circumstances, shortly after) the period during which the relevant services are to be provided.
- 19.120. The starting point for the allocation of the budget to an LHD in the “purchaser/provider” model is the previous financial year’s activity targets.⁶⁶⁶ Growth, in terms of equity, ageing population, and total population size, is also considered. In this respect, in determining the levels of activity and mix of services to be “purchased”, data relating to system performance and service utilisation is then applied.⁶⁶⁷ A series of “equity adjusters” are then applied and are intended to account for particular demographic and socio-economic features of the relevant segment of the population.⁶⁶⁸ Factors specific to a particular LHD, such as new builds, Statewide Services, or highly specialised services, are also considered.⁶⁶⁹

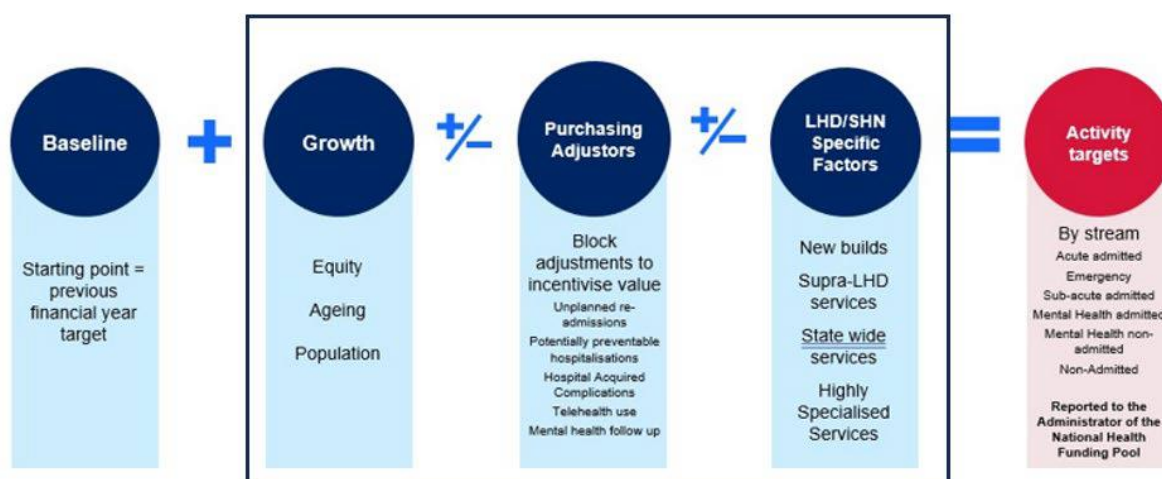


Figure 12: Summary of budget development process.

⁶⁶⁵ See, eg, Exhibit B.23.129, NSW Health and HealthShare NSW, Statement of Service 2023–24 (9 February 2024) [MOH.9999.0010.0001]; Exhibit B.23.181, NSW Health and SNSWLHD, Service Agreement 2023–24 (26 October 2023) [MOH.0001.0456.0001]; Exhibit D.1.20, NSW Health and NBMLHD, Service Agreement 2023–24 (31 October 2023) [MOH.9999.0794.0001].

⁶⁶⁶ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [30] [MOH.9999.0001.0001 at 0004].

⁶⁶⁷ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [10]–[11] [MOH.0011.0089.0001 at 0003].

⁶⁶⁸ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [13] [MOH.0011.0089.0001 at 0003].

⁶⁶⁹ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [30] [MOH.9999.0001.0001 at 0004]; Exhibit A.53, Joint Report of Alfa D’Amato and Deb Willcox (27 November 2023) [37] [MOH.9999.0005.0001 at 0007].

- 19.121. Pausing here, the equity adjusters were described by Counsel Assisting in their written submissions as being “opaque”.⁶⁷⁰ NSW Health took issue with that description and submitted that (even though there was evidence from executives and Board members of some LHDs that they did not understand the application of the equity adjusters) I should infer that they have a rational basis.⁶⁷¹ That submission is not really to the point.
- 19.122. Fundamentally, a budget process that does not enable executives or Board members of LHDs (some of whom had extensive business and accounting experience)⁶⁷² to readily understand how the budget has been prepared is a process that loudly calls for improvement. That is particularly so when it is recalled that it is the function of an LHD Board to approve the annual service agreement, and to provide strategic oversight of and monitor their LHD’s financial and operational performance.⁶⁷³ LHD Boards cannot reasonably discharge those functions unless given a budget that is capable of being readily understood.
- 19.123. In her evidence, the Health Secretary accepted that there was an opportunity to better explain how budgets were put together, and it is apparent that there are steps in train to ensure that occurs in the next cycle.⁶⁷⁴ Whatever funding model is adopted into the future, it should be considered to be an essential element of it that the budgets allocated to the LHDs (and indeed any other public health organisations) are capable of being understood by those charged with the responsibility of their management.
- 19.124. Approximately 70 per cent of the total State health budget is allocated through ABF, around 20 per cent through block funding, with the remainder made up of grants related to specific programs.⁶⁷⁵
- 19.125. In NSW, 100 hospitals are eligible for ABF.⁶⁷⁶ To be eligible for this funding type, a hospital must have more than 3,500 NWAU per annum in a rural hospital, or more than 1,800 admitted patient NWAU per annum in metropolitan hospital.⁶⁷⁷ In funding LHDs on an activity basis, the Ministry “purchases” that activity at the State Efficient

⁶⁷⁰ Outline of Submissions by Counsel Assisting the Special Commission of Inquiry into Healthcare Funding (20 December 2024) [309].

⁶⁷¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [6.22] [SCI.0011.0814.0001 at 0018].

⁶⁷² Transcript of the Commission, 20 September 2024 T5547.35–5555.3 (Treseder/Carter/Cohen). See also Transcript of the Commission, 23 May 2024 T3383.5–22 (Astill); Transcript of the Commission, 18 September 2024, T5335.18–43, T5336.37–5337.10, T5340.8–28 (Maisey).

⁶⁷³ See *Health Services Act*, ss 32(1)(d), 32(1)(g).

⁶⁷⁴ Transcript of the Commission, 26 February 2025, T7082.36–7083.46 (Pearce).

⁶⁷⁵ Transcript of the Commission, 28 November 2023, T138.14–25 (Lyons).

⁶⁷⁶ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [14] (MOH.9999.0001.0001 at 0003).

⁶⁷⁷ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [14] (MOH.9999.0001.0001 at 0003).

Price.⁶⁷⁸ The State Efficient Price is issued to reflect the average cost of providing the weighted unit of care – i.e., the NWAU – within NSW.⁶⁷⁹

- 19.126. There are 110 small rural hospitals that are block funded, because their volume is too low to attract ABF.⁶⁸⁰ These hospitals are funded on a block basis in accordance with the small hospitals funding model.⁶⁸¹ There are a further 17 facilities in the State that are also block funded, including specialist standalone mental health facilities and standalone major city hospitals providing specialist services.⁶⁸² These include the Sydney Eye Hospital, for example, which has a limited range of patients.⁶⁸³
- 19.127. LHDs (like all public health organisations) can also submit funding requests for new services or expansions of existing services beyond the base amount at any stage, or for budget supplementation.⁶⁸⁴

Specialty Health Networks

- 19.128. The SCHN is funded in a manner relevantly similar to LHDs, through a combination of purchased activity and block funding.⁶⁸⁵
- 19.129. Justice Health is block funded in circumstances where health services provided to those in custody are not eligible to receive a Commonwealth funding contribution pursuant to the *Addendum to the NHRA* or MBS.⁶⁸⁶ As with LHDs, Justice Health's budget is set by reference to a historical base, together with growth funding. Once again, the origin of the base is unknown. That approach does not enable a considered assessment to be made as to whether the 'base' budget is sufficient to enable Justice Health to deliver the services required of it under the *Crimes (Administration of Sentences) Act 1999* (NSW) and its service agreement.⁶⁸⁷

Affiliated Health Organisations

- 19.130. In determining the amount to be paid to an AHO from money appropriated from the Consolidated Fund, the Minister may have regard to such matters as the Minister thinks fit.⁶⁸⁸ The Minister may delegate the function of determining the amount of subsidy to

⁶⁷⁸ Exhibit H2.51, NSW Health, Corporate Governance & Accountability Compendium (May 2024) [7.2.2] [MOH.0010.0256.0001 at 0078]; Transcript of the Commission, 28 November 2023 T151.14–20 (Lyons).

⁶⁷⁹ Transcript of the Commission, 28 November 2023 T151.14–20 (Lyons).

⁶⁸⁰ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [15] [MOH.9999.0001.0001 at 0003].

⁶⁸¹ Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [98] [MOH.9999.0005.0001 at 0018–0019].

⁶⁸² Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [17] [MOH.9999.0001.0001 at 0003].

⁶⁸³ Transcript of the Commission, 28 November 2023 T137.21–31 (Lyons).

⁶⁸⁴ Exhibit M.4, Statement of Matthew Daly, Joe Portelli and Sharon Smith (14 November 2024) [39]–[40] [MOH.0011.0089.0001 at 0009].

⁶⁸⁵ Exhibit G.20, NSW Health and Sydney Children's Hospitals Network, Service Agreement 2023–24 (20 October 2023) pp 13, 16 [SCI.0010.0002.0001 at 0014, 0017].

⁶⁸⁶ Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [7]–[8], [12] [MOH.0011.0086.0001 at 0002–0003]; see *Crimes (Administration of Sentences) Act 1999* (NSW), s 236A.

⁶⁸⁷ Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [12] [MOH.0011.0086.0001 at 0003].

⁶⁸⁸ *Health Services Act 1997* (NSW) s 127(2).

be paid to any AHO in relation to its recognised services or establishments.⁶⁸⁹ In practice, this is what occurs.

Shared services

19.131. The Health Secretary issues statements of service to each of HealthShare NSW, eHealth NSW and NSW Health Pathology.⁶⁹⁰ Those organisations operate on a cost recovery model including through internal charges to the LHDs and SHNs.⁶⁹¹ NSW Health shared services' budgets are determined as part of the annual budget cycle and are prepared by reference to considerations specific to the service, such as charges they levy to other NSW Health entities.⁶⁹²

19.132. I note this model seems unlikely to promote technical efficiency, as those ultimately meeting the cost of delivering shared services have limited or no control over the way in which those services are procured or delivered by HealthShare or eHealth. LHDs regularly expressed concern to me about the competitiveness of the charges issued for shared services delivered by HealthShare and eHealth.⁶⁹³

NSW Ambulance

19.133. NSW Ambulance enters into a service agreement, pursuant to which it receives block funding.⁶⁹⁴ Its budget reflects a base level of funding that is adjusted annually to account for escalations, including in the cost of delivering services, but does not include adjustments that take into account the increased demand for ambulance services, or, as discussed elsewhere in this Report, the changed nature of services provided by paramedics.⁶⁹⁵

The Pillars

19.134. The Pillar organisations enter into performance agreements with the Health Secretary.⁶⁹⁶ They are similar to the service agreements entered into by the LHDs, but as those organisations do not provide clinical services, they do not include a section concerning purchased volumes and services.⁶⁹⁷ These organisations operate

⁶⁸⁹ *Health Services Act 1997 (NSW)* s 129.

⁶⁹⁰ Exhibit D.4, Statement of Alfa D'Amato (9 April 2024) [36], [40] [MOH.9999.0763.0001 at 0009–0010].

⁶⁹¹ Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [38] [MOH.9999.0005.0001 at 0007–0008].

⁶⁹² Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [38] [MOH.9999.0005.0001 at 0007–0008].

⁶⁹³ See, eg, Transcript of the Commission, 21 February 2024, T747.3–15 (Anderson); Transcript of the Commission, 22 February 2024, T783.19–47; T791.37–47 (Clancy); Transcript of the Commission, 22 February 2024, T808.24–47 (Marshall); Transcript of the Commission, 20 March 2024, T1479.1–1481.4 (Lawrence).

⁶⁹⁴ Exhibit D.4, Statement of Alfa D'Amato (9 April 2024) [36], [40] [MOH.9999.0763.0001 at 0009–0010]; Transcript of the Commission, 18 November 2024, T6363.38–47, T6392.16–18 (Morgan).

⁶⁹⁵ Transcript of the Commission, 18 November 2024, T6392.4–18, T6365.18–29 (Morgan).

⁶⁹⁶ Exhibit D.4, Statement of Alfa D'Amato (9 April 2024) [36] [MOH.9999.0763.0001 at 0009].

⁶⁹⁷ Exhibit D.4, Statement of Alfa D'Amato (9 April 2024) [39] [MOH.9999.0763.0001 at 0010].

on a salaries and wages and goods and services budget, in which escalations for wages are consistent with applicable industrial agreements.⁶⁹⁸

Benefits and limitations of current funding models

19.135. I have addressed above some of the limitations in the current approach to setting the NSW Health budget. There were, however, several others identified in the evidence, as well as some several benefits.

19.136. The *Mid-Term Review of the Addendum to the NHRA* made a series of recommendations for improvements or adjustments to existing models. For example, the review recommended:

- a. the creation of a funding pathway to support prevention, innovation, or any of the long term reforms;⁶⁹⁹
- b. the development of bundled and blended payment models under the Addendum to the NHRA;⁷⁰⁰
- c. an increase in the Commonwealth's contribution to 45 per cent of nationally efficient public hospital activity and reframing the existing 6.5 per cent national funding cap;⁷⁰¹ and
- d. a further review of the calculation of the NEP to reduce calculation complexity.⁷⁰²

19.137. As will be seen below, the focus of those recommendations is consistent with some of the limitations in the current funding models that have been identified in the evidence. Given that the *Mid-Term Review of the Addendum to the NHRA* supported the continued use of the activity based and block funding methodologies,⁷⁰³ any consideration of how healthcare funding models used within NSW can be improved to overcome those limitations should pragmatically assume these methods will remain central to funding arrangements as between the Commonwealth and NSW into the future.

19.138. However, there is an urgent need to review the extent to which these arrangements are mirrored in the funding by the Ministry of Health of the LHDs and SHNs. The evidence adduced in this Special Commission suggests that replicating these models

⁶⁹⁸ Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [42] [MOH.9999.0005.0001 at 0008].

⁶⁹⁹ Exhibit N3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) pp 7–8, 11 [SCI.0011.0585.0001 at 0012–0013, 0016].

⁷⁰⁰ Exhibit N3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) p 8 [SCI.0011.0585.0001 at 0013].

⁷⁰¹ Exhibit N3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) p 9 [SCI.0011.0585.0001 at 0014].

⁷⁰² Exhibit N3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) p 8 [SCI.0011.0585.0001 at 0013].

⁷⁰³ Exhibit N3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Report, 24 October 2023) pp 8, 10 [SCI.0011.0585.0001 at 0013, 0015].

is, at this level, no longer capable (if it ever was) of delivering such organisations the funding they require to meet the evolving health needs of their respective populations.

The benefits

- 19.139. Most of the benefits of the current funding models – and in particular the centrality of ABF to that model – identified in the evidence relate to the promotion of technical efficiency and transparency.⁷⁰⁴ In this respect, through the implementation and adherence to those models, the NSW public health system has become, by world standards, highly technically efficient.⁷⁰⁵ Accordingly, while the system should always aim for further improvement, there are arguably limited material gains in technical efficiency to be achieved in the immediate future.⁷⁰⁶
- 19.140. The existing funding models have also enabled the system to collect valuable data on the activity performed across the system. Given the importance of data, ancillary benefits of that kind that flow from existing funding models are significant.⁷⁰⁷

The limitations

- 19.141. Several limitations in the current funding models were identified, some of which include the way in which those models are applied in setting the budgets of NSW Health agencies. Set out below are some of those that have been identified in the evidence. There were several others that were also identified, and that are relevant to the overall consideration of this issue, but which are not necessary to explore here for the purpose of the analysis.⁷⁰⁸

Allocative efficiency

- 19.142. While existing funding models are recognised as supporting technical efficiency, the broad consensus that emerges from the evidence is that they do not drive allocative efficiency, focussing on activity throughput rather than health outcomes.⁷⁰⁹ Those limitations were effectively summarised by Mr Spittal in the following way⁷¹⁰:

⁷⁰⁴ Exhibit A.53, Joint Report of Alfa D'Amato and Deb Willcox (27 November 2023) [93] [MOH.9999.0005.0001 at 0012]; Transcript of the Commission, 30 November 2023, T310.29–311.35 (D'Amato); Exhibit E.47, Statement of Mark Spittal (30 April 2024) [103] [MOH.9999.1202.0001 at 0020–0021]; Transcript of the Commission, 20 November 2024, T6478.25–6479.8 (Duckett).

⁷⁰⁵ Transcript of the Commission, 10 December 2024, T6826.6–21 (Eagar).

⁷⁰⁶ Transcript of the Commission, 10 December 2024, T6826.26–45 (Eagar). Cf Transcript of the Commission, 18 November 2024, T6286.22–37 (Cornelius).

⁷⁰⁷ See, eg, Transcript of the Commission, 30 November 2023 T310.29–311.35 (D'Amato); Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [80] [MOH.0011.0091.0001 at 0024].

⁷⁰⁸ See, eg, Transcript of the Commission, 20 November 2024, T6523.42–6524.7 (Daly/D'Amato); Transcript of the Commission, 10 December 2024, T6808.20–6809.7, T6848.14–28 (Eagar).

⁷⁰⁹ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [156] [MOH.9999.0001.0001 at 0024]; Transcript of the Commission, 29 November 2023, T227.16–27 (Lyons); Transcript of the Commission, 30 November 2023, T278.33–40 (Willcox).

⁷¹⁰ Exhibit E.47, Statement of Mark Spittal (30 April 2024) [104]–[105] [MOH.9999.1202.0001 at 0021].

The critical deficiency in the model, however, is that it does not equally balance the public policy tensions between compassion, social justice and the efficient stewardship (productive efficiency) of taxpayer resources. The current focus is almost solely on productive efficiency at the expense of both allocative efficiency (investing in the interventions that deliver the greatest benefit) and considerations of social equity (distributive justice).

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

- 19.143. Similarly, Anna McFadgen, Chief Executive Officer, St Vincent's Hospital Sydney, described the limitation of the funding model as it relates to driving allocative efficiency as follows⁷¹¹:

... activity based funding, by its nature, is designed to incentivise activity, right, throughput, as opposed to a bundle of care, if you will. So I think there's an opportunity through some different funding models – block funding, bundled care, however you kind of want to term it – that you could provide to a health service and LHD, a network, for more flexible use, which would then enable that health service to either deliver care where it's appropriate to do so in a hospital setting, but actually also potentially deliver care in other settings, which, as I say, is more cost effective... you know, we've certainly explored those sorts of models, I think there's much more opportunity to do that.

- 19.144. Stewart Dowrick, then Chief Executive of the Mid North Coast LHD, also expressed the view that there was a need to craft funding models to promote activity that addresses the socio-economic factors affecting health outcomes (i.e., the social determinants of health). In this respect, he gave evidence that:⁷¹²

The ABF model, as a mechanism for funding LHDs based on type and volumes of services provided, is primarily a hospital acute service model and does not effectively address the financial burden imposed on LHDs as a consequence of broader socio-economic factors impacting healthcare and importantly health outcomes. The inflexible application of ABF in NSW Health does not always ensure that LHDs

⁷¹¹ Transcript of the Commission, 13 June 2024, T3624.28–42 (McFadgen).

⁷¹² Exhibit K.49, Statement of Stewart Dowrick (12 September 2024) [17] [MOH.0011.0069.0001 at 0005].

are funded adequately to support innovation and meet community needs. The ABF model needs to accommodate the application of some discretion to ensure that LHDs with considerable population disadvantage, such as MNCLHD, receive an appropriate share of the State health budget.

19.145. Other witnesses expressed similar views.⁷¹³ These critiques of the ABF funding model would appear from the evidence to be both fair and accurate.

Support for innovation

19.146. It has been suggested that the current funding model – including the ABF component of that model – does not support the development of innovative models of care, in circumstances where those models are not immediately recognised as being “in scope” and thus eligible to attract a Commonwealth funding contribution.⁷¹⁴

19.147. There are funding streams under the *Addendum to the NHRA* that support innovation outside of ABF.⁷¹⁵ However, the limitation referred to in the evidence is perhaps more immediate in circumstances where care is to be delivered outside of the hospital environment and may not be what would have been considered as a traditional hospital service.⁷¹⁶ Care of that kind is not immediately compatible with the premise of ABF.

19.148. Of course, there is nothing preventing LHDs or SHNs from developing and implementing innovative models of care, even if they do not immediately attract a funding contribution from the Commonwealth.⁷¹⁷ Indeed, they should do so while pursuing a Commonwealth funding contribution towards the delivery of those models, where appropriate.⁷¹⁸ As Adjunct Professor Jean-Frédéric Levesque, Deputy Secretary for Clinical Innovation and Research and Chief Executive of the Agency for Clinical Innovation, rightly said:⁷¹⁹

What we don't want is for a new model not to be adopted because implementing it would reduce the activity that is actually the way to generate reimbursement in healthcare. That's a well-known issue

⁷¹³ See, eg, Exhibit K.34, Statement of Tracey Maisey (9 September 2024) [130]–[131] [MOH.0011.0064.0001 at 0026]; Transcript of the Commission, 10 December 2024, T6823.39–43, T6826.6–21 (Eagar).

⁷¹⁴ Transcript of the Commission, 28 November 2023, T133.11–28 (Willcox); Transcript of the Commission, 29 November 2023, T241.2–35 (Lyons).

⁷¹⁵ Transcript of the Commission, 26 February 2024, T1131.7–14 (Levesque).

⁷¹⁶ See, eg, Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [201] [MOH.9999.0001.0001 at 0028]; Transcript of the Commission, 29 November 2023, T241.37–242.9 (Willcox); Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [87], [113] [MOH.0001.0435.0001 at 0034, 0041].

⁷¹⁷ Transcript of the Commission, 26 February 2024, T1131.7–14 (Levesque).

⁷¹⁸ Transcript of the Commission, 18 November 2024, T6264.32–41 (Cornelius).

⁷¹⁹ Transcript of the Commission, 26 February 2024, T1106.47–1107.6 (Levesque). However, it appears that the focus on activity generation that flows from the existing model, including activity targets given to LHDs, is having that practical effect: see, eg, Exhibit K.40, Statement of Tracey McCosker (13 September 2024) [50] [MOH.0011.0062.0001 at 0013]; Transcript of the Commission, 19 September 2024, T5442.11–17 (McCosker); Transcript of the Commission, 19 November 2024, T6392.33–6393.1 (Wilson).

around the world, and therefore it's something we need to address through those negotiations with the Commonwealth and the health reform agenda.

19.149. However, it is within the power of the Ministry of Health to address this issue. It only becomes a problem if the Ministry of Health slavishly adopts the Commonwealth's approach to the ABF model when making its own funding decisions; it does not have to do so. Innovative models of care can be funded by the Ministry of Health in a way that does not require the recognition of Commonwealth defined activity.

Promoting or incentivising preventive care

19.150. For similar reasons to those related to the implementation of innovative models of care, it has been suggested by NSW Health, PHNs and clinicians alike that existing funding models do not support or incentivise the delivery of preventive care within the NSW public health system.⁷²⁰ I agree.

The ability of the model to capture the cost of complex care and rural and regional services

19.151. Another criticism of the current funding model is that the funding that flows through it does not reasonably reflect the cost of delivering complex care, or care in rural and regional locations.⁷²¹

19.152. For example, in July 2024, NSW Health conducted a review of the Small Hospitals Funding Model.⁷²² That review found that the current approach to funding small hospitals is not sufficiently responsive to changes in structural costs like patient transport and workforce, inflation, and capital funding and asset management in small hospital settings,⁷²³ and that funding for rural LHDs does not adequately support the implementation of innovative models of care.⁷²⁴ Any future review of the funding models must also address those shortcomings.

⁷²⁰ See, eg, Transcript of the Commission, 28 November 2023, T128.20–27, 33–34 (Chant); Transcript of the Commission, 29 November 2023, T226.40–227.14 (Lyons); Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [124] [MLH.0001.0016.0001 at 0025]; Transcript of the Commission, 22 March 2024, T1725.3–25, T1726.21–39 (Ludford); Transcript of the Commission, 13 June 2024, T3642.40–47 (Preddy); Transcript of the Commission, 19 September 2024, T5383.30–5384.22 (Grotowski); Exhibit I.43, Statement of Andrew Gow (14 August 2024) [19] [SCI.0011.0379.0001 at 0004].

⁷²¹ Transcript of the Commission, 30 November 2023, T322.42–324.2 (D'Amato); Transcript of the Commission, 20 March 2024, T1487.42–1488.21 (Lawrence); Exhibit F.1, Statement of Bradley David Astill (8 May 2024) [63] [MOH.9999.1258.0001 at 0010]; Exhibit K.40, Statement of Tracey McCosker (13 September 2024) [48]–[49] [MOH.0011.0062.0001 at 0012]; Transcript of the Commission, 18 September 2024, T5338.41–5339.11 (Maisey); Transcript of the Commission, 19 November 2024, T6396.2–11, T6396.22–6397.20 (Collins); Transcript of the Commission, 21 November 2024, T6580.15–21 (D'Amato); Transcript of the Commission, 10 December 2024, T6805.28–6806.30 (Eagar).

⁷²² Exhibit M.9, NSW Health, Small Hospitals Funding Model Review (Report, July 2024) [MOH.0100.0294.0001].

⁷²³ Exhibit M.9, NSW Health, Small Hospitals Funding Model Review (Report, July 2024) pp 18–22 [MOH.0100.0294.0001 at 0019–0023].

⁷²⁴ Exhibit M.9, NSW Health, Small Hospitals Funding Model Review (Report, July 2024) pp 27–28 [MOH.0100.0294.0001 at 0028–0029].

- 19.153. The review also found that the Commonwealth's funding contribution has not kept pace with the increasing costs of providing care in small hospitals⁷²⁵ and aged care in MPSs.⁷²⁶
- 19.154. Further, in many parts of the State, the cost of delivering care exceeds the State Efficient Price. The model of purchasing activity at the State Efficient Price was adopted "to drive the best, most optimal amount of volume of activity" with the resources available,⁷²⁷ and it was described as "one of the levers to support people looking for new ways and innovative ways to deliver services, maintain their quality at the highest possible level, and keep that sustained, but look for more efficient and effective ways of delivering care".⁷²⁸
- 19.155. In an attempt to address that reality, and the fact that some LHDs do not have the benefit of the "swings and roundabouts" of being able to provide care in some locations below that price that offsets those locations that cost more,⁷²⁹ certain adjusters are applied.⁷³⁰ However, the evidence suggests that the various adjusters applied are not meeting the rising cost of delivering services in some parts of the State, or offsetting other limitations of the funding model.⁷³¹

Short term budget cycles

- 19.156. The annual budget cycle can create challenges for effective long term planning.⁷³²
- 19.157. While, in the past, when the budgetary environment was more stable, NSW Health agencies could project likely future funding flows (including growth) with some reliability, in the current environment their ability to do so is compromised.⁷³³ In this respect, longer budget cycles are said to support robust service design and planning, support the development, implementation and assessment of new or innovative models of care, and support workforce planning.⁷³⁴

⁷²⁵ Exhibit M.9, NSW Health, Small Hospitals Funding Model Review (Report, July 2024) p 22 [MOH.0100.0294.0001 at 0023].

⁷²⁶ Exhibit M.9, NSW Health, Small Hospitals Funding Model Review (Report, July 2024) p 24 [MOH.0100.0294.0001 at 0025].

⁷²⁷ Transcript of the Commission, 28 November 2023, T151.26–28 (Lyons).

⁷²⁸ Transcript of the Commission, 28 November 2023, T152.18–23 (Lyons).

⁷²⁹ Transcript of the Commission, 20 November 2024, T6480.28–47, T6487.3–21 (Duckett).

⁷³⁰ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [20] [MOH.0011.0091.0001 at 0004–0005].

⁷³¹ See, eg, Exhibit K.49, Statement of Stewart Dowrick (12 September 2024) [17]–[18] [MOH.0011.0069.0001 at 0005]; Transcript of the Commission, 21 November 2024 T6568.32–37 (D'Amato).

⁷³² See, eg, Transcript of the Commission, 20 March 2024, T1507.15–1508.44 (Lawrence); Transcript of the Commission, 23 May 2024, T3236.13–3264.25 (Files/Pearce); Exhibit N1.1, Sax Institute, Resource Management in NSW Health (Expert Report No 1, 29 November 2024) [36] [SCI.0011.0607.0001 at 0009].

⁷³³ See, eg, Transcript of the Commission, 23 May 2024, T3236.13–3264.25 (Files/Pearce).

⁷³⁴ Transcript of the Commission, 23 May 2024, T3263.36–3264.2 (Pearce).

- 19.158. In apparent recognition of the challenges associated with short term budget cycles, consideration is currently being given to longer term arrangements that focus on improving health outcomes to complement the annual cycles that flow from the arrangements under the *Addendum to the NHRA*.⁷³⁵

No allowance for increase in demand built into the funding model applied to NSW Ambulance

- 19.159. Dr Dominic Morgan ASM, Commissioner and Chief Executive, NSW Ambulance, described the challenges of the current funding model that is applied to NSW Ambulance as follows:⁷³⁶

... through the service agreement process and the roadshows, because we're block funded and therefore only deal with escalation and the CPI, we don't actually even discuss demand at all because there's no way of dealing with the demand. And so therefore it doesn't feature in our service agreement despite that we will absolutely go up at the same percentage as everybody else.

- 19.160. A further challenge of the existing model applied to NSW Ambulance was described by Dr Morgan as being that “block funding with ever increasing demand and that only being met by *ad hoc* political announcements lends us to a situation of really disproportionate FTE growth to demand growth”, which – as a funding model – is not fit for purpose.⁷³⁷
- 19.161. I am comfortably satisfied that the approach currently taken to the funding of NSW Ambulance does not adequately recognise the highly sophisticated role now played by that service or the way it interlinks with the wider public health system.
- 19.162. The role of NSW Ambulance in delivering the service mix offered by LHDs and SHNs must be addressed as part of the health service planning I discuss elsewhere in this Report. For example, the ability to locate what was described to me as “a mobile intensive care unit” in particular locations should clearly feature in decision making around the distribution of Emergency Departments across the State. It may be that in some locations an accessible primary care service, supported by an enhanced ambulance presence, would better meet the health needs of a community than an existing Emergency Department in a manner that does not compromise – and perhaps even enhances – outcomes for patients requiring genuine emergency care in that community. It is not the role of this Special Commission to express any concluded view in relation to this example. However, it highlights the need to adopt a

⁷³⁵ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [79] [MOH.0011.0091.0001 at 0024]; Transcript of the Commission, 30 November 2023, T305.7–10 (D'Amato).

⁷³⁶ Transcript of the Commission, 18 November 2024, T6392.4–18 (Morgan).

⁷³⁷ Transcript of the Commission, 18 November 2024, T6365.18–29, T6366.8–22 (Morgan); Exhibit M.30, NSW Ambulance data table and graph of percentage change for the number of Ambulance Officer FTE and Emergency Incidents by Financial Year (2010/11–2023/24) [SCI.0011.0587.0001].

more sophisticated approach to the funding of the NSW Ambulance service to ensure that it is adequately resourced to deliver whatever services are ultimately identified through this planning process.

Is the NSW public health system “underfunded”?

- 19.163. The NSW Health budget, including the budgets of LHDs, SHNs and individual services, is under significant pressure;⁷³⁸ despite the overall size of the health budget, the evidence clearly demonstrates this. Whatever may have been the case prior to the pandemic, it is clear that in the “post-pandemic environment” it can no longer be assumed that the funding envelope available to NSW Health is (or will, in the future, be) sufficient to meet the existing demands placed on it; whether they be in relation to service demand, or those associated with the costs of delivering the current suite of services.
- 19.164. As outlined above, prior to the pandemic, the budgetary environment was relatively stable and had generally been predicated on relatively consistent growth of about 4–5 per cent, together with funding to support new policies.⁷³⁹ That model was utilised to “provide greater funding certainty and improve the sustainability of growth”. Despite a spike in growth during the pandemic, from the 2023–24 financial year, the growth rate going forward was anticipated to be much lower.⁷⁴⁰
- 19.165. The confluence of factors presently impacting on the public health system – many of which are out of the system’s direct control – have produced what was described by many (in the most neutral of ways) as a “constrained financial environment”. In this respect, the joint statement of Adjunct Professor D’Amato, Steven Carr, Deputy Chief Financial Officer, Ministry of Health, and Neville Onley, Director Activity Based Management Taskforce, NSW Health, describes the difference in the pre and post pandemic environment in the following way:⁷⁴¹

The existing model functioned relatively well in allocating funding for the delivery of public health services across NSW in a stable growth environment, where there was sufficient funding for additional activity or new initiatives through the purchasing process and new policy proposals.

⁷³⁸ Transcript of the Commission, 15 April 2024, T1836.12–30 (Russell); Transcript of the Commission, 22 April 2024, T2270.43–2271.14 (Schembri); Transcript of the Commission, 29 April 2024, T2523.13–15 (Daly); Transcript of the Commission, 16 August 2024, T5073.38–5074.14 (Bennett); Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [51]–[54] [MOH.0011.0091.0001 at 0012–0015]; Statement of Alfa D’Amato to the Industrial Relations Commission of NSW (19 February 2025) [54]–[57] [MOH.0100.0781.0001 at 0011–0012].

⁷³⁹ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [22] [MOH.9999.0001.0001 at 0002].

⁷⁴⁰ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox (17 November 2023) [23]–[25], [69] [MOH.9999.0001.0001 at 0003, 0013];

⁷⁴¹ Exhibit M.6, Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [77]–[78] [MOH.0011.0091.0001 at 0024].

However, this is not the case in the post COVID-19 environment with limited growth funding available and challenges with attraction and retention of workforce, escalation of costs for goods and services and the bringing online of a large number of new facilities through the capital program

- 19.166. As a result, it cannot now be assumed that the “base” on which the funding model is built reflects a reliable starting point – that is particularly so given that, as outlined above, its origin was not able to be identified to me by any relevant witness from Treasury or the Ministry.⁷⁴² In this respect, Adjunct Professor D’Amato succinctly explained the impact of the prevailing circumstances as follows⁷⁴³:

...we need to make a distinction from what happened after COVID, because I think COVID kind of created more challenges.

Before COVID, in a relatively, you know, stable environment, when wages or even, you know, CPI was relatively under control, we were able to deliver and drive efficiencies at the same time. So those efficiencies were reinvested to do more activity, but that was the key, the stability in the economic and fiscal environment.

Now, we are in a different situation, and I think that’s where the challenge is at the moment. I don’t know whether we’re ready to set the new base at this stage.

- 19.167. The reduction in the growth funding applied to the base,⁷⁴⁴ and the fact that the cost of providing health services has grown at a rate that exceeds the growth applied to the base,⁷⁴⁵ makes it unsurprising that the system is subject to budgetary pressures. As a consequence, public health organisations (in particular LHDs and SHNs) do not have the same levels of headroom within their budgets to develop and expand services that may have existed in the past.⁷⁴⁶ This lack of financial headroom is also a significant impediment to an appropriately considered process of evolution within public health organisations.
- 19.168. There are other features of a public health system that add to the complexity of those issues. Even if the overall funding envelope available were to increase significantly, reasonable arguments could be made for yet further investment. As much is demonstrated by the fact that over the last decade, some LHDs have seen their

⁷⁴² Transcript of the Commission, 18 November 2024, T6257.22–6258.28 (Kastoun/D’Amato); Transcript of the Commission, 20 November 2024, T6523.42–6524.3 (Daly); Transcript of the Commission, 21 November 2024, T6523.42–6524.18 (D’Amato).

⁷⁴³ Transcript of the Commission, 21 November 2024, T6524.5–18 (D’Amato).

⁷⁴⁴ Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [77]–[82] [MOH.0011.0091.0001 at 0024–0025].

⁷⁴⁵ Transcript of the Commission, 21 November 2024, T6523.42–6524.5 (Daly/D’Amato).

⁷⁴⁶ Transcript of the Commission, 21 November 2024, T6597.40–6598.13 (Portelli).

expense budgets increase by over 100 per cent,⁷⁴⁷ yet many compelling examples of the use to which additional funding could be put emerged in the evidence.⁷⁴⁸ It is not an exaggeration to say that the public health system has the capacity to absorb any increase in funding it may be given.⁷⁴⁹

- 19.169. However, the health budget cannot be viewed in isolation. Although the health portfolio is a vital and important aspect of Government services, it is only one aspect of government spending that must be balanced against many others.⁷⁵⁰ Unless there is to be a significant expansion in the taxation or revenue base (which is unlikely), the challenge associated with resolving competing demands on a finite budget will remain ever present.
- 19.170. It is in that context that the question of whether the overall levels of funding available for healthcare is “adequate” or “sufficient” must be considered. To respond to such a question by pointing to the fact that, if more funding were allocated, it could undoubtedly be put to good use within the system, does not address the substance of the issue at hand.
- 19.171. Some people (but not many) have suggested that the present level of funding is adequate.⁷⁵¹ The ability of NSW Health agencies to (at least until recently) generally operate within their budgets is sometimes cited as supporting that view.⁷⁵² However, the ability of an agency to operate within its budget is a blunt (and here probably unreliable) measure of whether the level of funding allocated to that agency is “enough” or “sufficient” to enable it to fulfil its function and purpose. It says much more about the financial management of the entity than the capacity of that entity to produce any particular outcome through the application of the available funding.⁷⁵³
- 19.172. Others would conclude that the current funding envelope is insufficient. Individual clinicians point to their inability to obtain funding for a particular service, or for additional staff to support a service, as indications of the inadequacy of funding available. They view the inability to attract funding as reflective of an insufficiency of funding within the wider system generally.

⁷⁴⁷ See, eg, Exhibit M.6, Joint Statement of Neville Onley, Alfa D’Amato and Steven Carr (14 November 2024) [57] [MOH.0011.0091.0001 at 0017].

⁷⁴⁸ See, for example, Exhibit M.3, Statement of Wendy Hoey PSM (13 November 2024) [41], [51] [MOH.0011.0086.0001 at 0010, 0012].

⁷⁴⁹ Transcript of the Commission, 19 November 2024, T6409.44–47 (Mains).

⁷⁵⁰ See, eg, Transcript of the Commission, 18 November 2024 T6254.39–6256.21 (Kastoun).

⁷⁵¹ Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.30] [TRY.0001.0001.0001 at 0007]; Transcript of the Commission, 22 November 2024, T6609.28–6610.29 (Daly/D’Amato)

⁷⁵² Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.31] [TRY.0001.0001.0001 at 0007].

⁷⁵³ Transcript of the Commission, 21 November 2024, T6610.15–29 (D’Amato).

19.173. Within some parts of the system, a conclusion can readily be drawn that the funding available is (at least currently) insufficient. For example:

- a. the funding available to many of the LHDs and AHOs does not enable them to deliver the services necessary to meet the needs of their populations, and maintain infrastructure;⁷⁵⁴
- b. LHDs have experienced significant budgetary challenges when opening and operating new facilities in circumstances where the ongoing funding made available to them does not meet the cost of doing so;⁷⁵⁵ and
- c. Justice Health does not presently attract the level of funding it requires to meet the demand for its services, with “patients waiting longer than clinically recommended, across all services waitlists”.⁷⁵⁶

19.174. A comparison of the expense budgets of the LHDs and SHNs (after supplementation) against their actual expenditure suggests that (at least in that period) the expense budget allocations were insufficient to cover the actual costs incurred by each of them in delivering services contemplated by their respective service agreements.

⁷⁵⁴ See, eg, Exhibit I.26, Statement of Elizabeth Hoskins (2 August 2024) [20] [MOH.0011.0035.0001 at 0005]; Transcript of the Commission, 16 April 2024, T2961.46–2962.17 (Spittal); Transcript of the Commission, 18 April 2024, T2023.18–2024.9 (O’Loughlin) (Karitane); Transcript of the Commission, 16 August 2024, T5066-5070 (Hoskins/Clout/Bennett).

⁷⁵⁵ See, eg, Transcript of the Commission, 18 September 2024, T5355.45–5358.42 (Maisey).

⁷⁵⁶ Exhibit M.3, Statement of Wendy Hoey (13 November 2024) [14] [MOH.0011.0086.0001 at 0003].

NSW Health Entity Expense Budgets – Variance to Latest Approved Budget (2023–24)				
Local Health Districts, Specialty Health Networks and Health Administration Corporation				
\$000	Budget	Actual	Variance (%)	Variance
Local Health Districts and Specialty Health Networks				
Central Coast LHD	1,111,477	1,136,482	2.2%	25,005
Far West LHD	163,089	167,134	2.5%	4,045
Hunter New England LHD	2,987,548	3,065,905	2.6%	78,357
Illawarra Shoalhaven LHD	1,249,598	1,307,012	4.6%	57,414
Mid North Coast LHD	881,378	930,901	5.6%	49,523
Murrumbidgee LHD	852,318	909,254	6.7%	56,936
Nepean Blue Mountains LHD	1,147,294	1,211,307	5.6%	64,013
Northern NSW LHD	1,156,273	1,237,227	7.0%	80,954
Northern Sydney LHD	2,211,003	2,248,587	1.7%	37,584
South Eastern Sydney LHD	2,317,914	2,378,434	2.6%	60,520
South Western Sydney LHD	2,590,489	2,648,125	2.2%	57,636
Southern NSW LHD	562,085	621,303	10.5%	59,218
Sydney LHD	2,357,528	2,454,184	4.1%	96,656
Western NSW LHD	1,232,184	1,283,978	4.2%	51,794
Western Sydney LHD	2,480,778	2,555,709	3.0%	74,931
Sydney Children's Hospital Network	1,111,446	1,152,368	3.7%	40,922
Justice Health and Forensic Mental Health Network	339,116	340,099	0.3%	983
	24,751,518	25,648,009	3.6%	896,491
Health Administration Corporation	4,855,613	5,075,926	4.5%	220,313
TOTAL				1,116,804
Local Health Districts, Specialty Health Networks and Health Administration Corporation				

Figure 13: NSW Health Entity Expense Budgets – Variance to Latest Approved Budget (2023–24).⁷⁵⁷

- 19.175. While own source revenues and additional payments from the Ministry of Health (over and above the supplemented budget) are, in many instances, likely to have affected the overall result, the fact that actual expenditures of the LHDs and SHNs exceeded their supplemented expense budgets (in some cases by significant sums) supports the views expressed by several Chief Executives and Board members that (as a general proposition), LHDs and SHNs are not provided with sufficient levels of funding to deliver the services contemplated by their service agreements, maintain their capital infrastructure, and develop and expand services to meet the needs of their populations.
- 19.176. That lack of “headroom” across the budgets of LHDs and SHNs affects their ability to assess the health needs of their populations and design and deliver services to meet those needs, while managing high levels of demand for acute care services. Meaningful collaboration with other stakeholders – of the type that is central to the delivery of a good and efficient public health system – requires resourcing, both human and financial. The availability of that resourcing will be critical to the successful

⁷⁵⁷ Extracted from 2023–24 Financial Statements of Health Entities

implementation of the system wide planning process that I recommend elsewhere in this Report.

- 19.177. Ultimately, whether the funding envelope available to the NSW public health system as a whole is sufficient is a more nuanced question. It is not one that can be addressed by pointing to the things that could be done if more funding were available. In this respect, Adjunct Professor D'Amato, when asked to express a view as to whether the current level of funding available to NSW Health was adequate,⁷⁵⁸ gave evidence that (my emphasis):⁷⁵⁹

*Okay, I feel that it's a bit **difficult for me to make a call whether we're adequately funded. We do the best we can with what has been allocated to us** and we always try to do our best for our patients and our workforce. Ultimately, that's what we do.*

*Admittedly, I think we've done relatively well compared to the other states and other territories, and perhaps also internationally, but I do think that **we're now stepping into a different environment and it is challenging. It is challenging to maintain the level of performance** and it is challenging because, in my opinion, **we need to start thinking more about medium and long term outcomes, investment in prevention**, which before – we probably tried to get there, just before COVID, as we were working with other policies, Treasury policies, with outcome budgeting and then, all of a sudden, we interrupted the whole process.*

*I think there was an evolution in our ABF moving towards more of an outcome framework. We had investment in value based healthcare, but during COVID, obviously, all of these had been paused. So for me to answer your question, **I feel that it's a bit premature. I think we need to acknowledge that the environment's changed now.***

- 19.178. There are some important observations that can be made about this answer. The first is that in respect to the comment that “we do the best we can with what has been allocated to us”, as a general proposition (applying to NSW Health as a whole, as well as to LHDs, SHNs, and AHOs and other entities) I accept that. The second is, that while couched in perfectly appropriate restraint, by a senior public servant who is genuinely trying to help me and whose evidence I unhesitatingly accept, there is I think a real hint being given to me that in the “different environment” we are now in, and with a need to think (and act) more towards achieving “medium and long term outcomes”, the system is probably underfunded. It is an answer that aligns well with my view that a considered assessment of whether the funding available to the public

⁷⁵⁸ As suggested by Treasury: see Exhibit M.1, Submission of NSW Treasury to the Special Commission of Inquiry into Healthcare Funding (11 November 2023) [2.30] [TRY.0001.0001.0001 at 0007].

⁷⁵⁹ Transcript of the Commission, 18 November 2024, T6291.19–43 (D'Amato).

health system as a whole is “adequate” or “sufficient” inherently depends on an identification of the nature and extent of the services that the system should be delivering, including where those services are to be delivered. As I have said on several occasions now, in conducting that assessment, it is necessary to repeat that NSW Health does not, and will not have, an unlimited stream of funding available to it. Even after the completion of the system wide planning process that I have recommended, it is inevitable difficult decisions will need to be made about how the limited pool of public funds are to be rationed in order to best meet the needs of the population will need to be made.

19.179. All of that only serves to highlight the critical importance of a system wide, strategic approach to service design and planning in ensuring (in so far as is possible) that the resources available are most effectively and efficiently deployed. If that is not done, I do not think it is a stretch to say that the future ability of the system to meet the needs of the population, and its long term sustainability, are at risk.⁷⁶⁰

19.180. What I am proposing is not an entirely new concept, nor should it be considered unduly radical. Like many issues that have arisen during the course of this Special Commission, these ideas have been the subject of consideration by earlier reviews of the health system. As but one example, Commissioner Garling concluded in 2008 that:⁷⁶¹

... there needs to be a complete state-wide review undertaken by NSW Health which involves:

- (a) the identification of a set of criteria, which relate to at least, patient safety, necessary workforce skills, and the volume and quality of services regarded as an appropriate critical mass for the services provided across NSW in public hospitals;*
- (b) a determination of whether each hospital, having regard to its location, the available workforce determined on a long term basis, the size of the population which it services, the alternative locations within an appropriate distance (measured by time or distance) and the age and state of repair of the facilities and equipment, is (or can become) a location for the delivery of safe patient care;*
- (c) a clear delineation of the role of each hospital – what it can and can't do;*

⁷⁶⁰ Exhibit M.6, Joint Statement of Neville Onley, Alfa D'Amato and Steven Carr (14 November 2024) [52] [MOH.0011.0091.0001 at 0012-0013].

⁷⁶¹ Exhibit N4.5, Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Final Report, 27 November 2008) vol 3, [26.96] [SCI.0011.0762.0001 at 0070].

- (d) *clear communication of the role of a local hospital to its community, and community understanding of the limitations of the local hospital;*
- (e) *re-allocation of specialist medical services to hospitals in NSW best placed to deliver those services; and*
- (f) *the consideration of the availability of an efficient transport and retrieval system state-wide to transport patients to the hospital best placed to provide the medical service required, and return the patient to their original locations.*

19.181. Several of those concepts still find themselves at the core of some of the recommendations I have made.

19.182. Ultimately, the funding model should not be the tail that wags the dog. Rather, the funding models that are adopted by the Government to fund the NSW public health system and by the Ministry to fund the public health organisations (and the system more widely) should be those that best support the delivery of the public health system that the Government (through NSW Health) aspires to provide.⁷⁶²

Conclusion

19.183. It can no longer be assumed that the current approach to funding NSW Health – whether by government in setting the overall budget, or by the Ministry of Health in setting the budgets of the public health organisations (in particular the LHDs and SHNs) delivers a level of funding that is required to meet the health needs of the population, or is the optimal model to fund those services into the future.

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

19.184. It is only by engaging in those processes that a considered assessment can be made of whether the present funding envelope is “adequate”, or whether additional funding is needed, and if so, how much. At present that assessment cannot reliably be made in circumstances where the origins of the current starting point (i.e., the “base”) are elusive, and a comprehensive, system wide, analysis of population health needs and the services and facilities needed to meet them, has not been undertaken.

⁷⁶² Transcript of the Commission, 12 December 2024, T6969.32–6971.9 (Wilson).

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Introduction

- 20.1. Procurement within any organisation the size of NSW Health is inevitably complex.
- 20.2. Those complexities are heightened in the context of government procurement and the expenditure of public funds. In this respect, NSW Health's procurement activities are subject to a range of legislative requirements, NSW Government level policies and oversight by the central NSW Procurement Board, and are governed by a wide range of policies, guidelines and procedures.
- 20.3. As might be expected, those activities are extensive, and are spread across the entire system, from Ministry of Health to local facility level.⁷⁶³ In the 2023–24 financial year, NSW Health spent approximately \$8.86 billion on goods and services, representing approximately 28 per cent of NSW Health's total expenditure.⁷⁶⁴
- 20.4. Although (as NSW Health recognised) there are improvements that can be made, there are many aspects of its approach to procurement that currently work well and provide good support for the wider system. Some of those strengths were demonstrated during the pandemic, even if those events themselves highlighted areas for improvement.⁷⁶⁵
- 20.5. In that context, the key themes that emerged in the evidence did not relate to the system's capacity to respond to events of urgency and scale, nor to the general day to day processes of procurement, although no doubt those areas will benefit from a continued process of improvement and enhancement. Rather, the key issues arise at a higher level: for example, how the system regards, evaluates and puts into practice the concepts of value, and how it measures and monitors procurement outcomes, including as against those concepts.
- 20.6. As is explored in this chapter, "value" is a prominent theme in NSW Government and NSW Health procurement strategies and frameworks.
- 20.7. It is uncontroversial that delivering the highest value healthcare for the money expended should be a priority in any procurement process; a concept that is sometimes described as "value based healthcare". However, as NSW Health rightly submitted, in the overall context of the NSW Government Procurement Framework, the concept of "value for money" is broader than value based healthcare. Accordingly, it must be remembered in any consideration of NSW Health's approach to procurement that, in the wider

⁷⁶³ This section of the Report addresses NSW Health's procurement of goods and services, as opposed to workforce (such as the engagement of locums and agency nurses). The latter is considered elsewhere in the Report.

⁷⁶⁴ Exhibit N.3.27, NSW Health Annual Report 2023-24 (October 2024) p 152 [SCI.0011.0717.0001 at 0160].

⁷⁶⁵ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [28], [58]-[59] [MOH.0001.0434.0001 at 0006, 0020]; Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].

government context, a range of criteria beyond monetary value must be incorporated into procurement plans and tender evaluation processes.⁷⁶⁶

- 20.8. Ultimately, as NSW Health accepted, there are several ways in which NSW Health's procurement processes can be improved and strengthened to better meet those objectives, including through actions to:⁷⁶⁷
- a. improve the incorporation of value based criteria into procurement plans and tender evaluation processes;
 - b. introduce a common set of evaluation criteria specifically related to clinical outcomes into NSW Health procedures as a starting point for personnel to draw upon; and
 - c. reinforce value based healthcare principles in procurement by further training offered by Ministry's Strategic Procurement Branch.

Roles and responsibilities in relation to procurement activities

- 20.9. In the paragraphs that follow, a general summary of the roles and responsibilities of various agencies (within NSW Health and across government more broadly) relating to NSW Health's procurement activities are set out.

NSW Procurement Board

- 20.10. The procurement of goods and services by or on behalf of a NSW Government agency (which includes NSW Health)⁷⁶⁸ is subject to Part 11 of the *Public Works and Procurement Act 1912* (NSW).⁷⁶⁹
- 20.11. The *Public Works and Procurement Act* established the NSW Procurement Board,⁷⁷⁰ whose functions include the development and implementation of policies for, and the oversight of, the procurement of goods and services by and for government agencies.⁷⁷¹
- 20.12. Government agencies are obliged to comply with any directions or policies issued by the Board, the terms of any accreditation granted to them, and "the principles of probity and fairness".⁷⁷² A government agency "is also to ensure it obtains value for

⁷⁶⁶ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.9] [SCI.0011.0814.0001 at 0116-0117]; See, for example, Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001]; Exhibit B.23.18, NSW Government, *Small and Medium Enterprise and Regional Procurement Policy* [MOH.0001.0417.0001].

⁷⁶⁷ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.10] [SCI.0011.0814.0001 at 0117].

⁷⁶⁸ *Public Works and Procurement Act 1912* (NSW) s 162.

⁷⁶⁹ *Public Works and Procurement Act 1912* (NSW) s 163.

⁷⁷⁰ *Public Works and Procurement Act 1912* (NSW) s 164.

⁷⁷¹ *Public Works and Procurement Act 1912* (NSW) s 172.

⁷⁷² Which are not defined: *Public Works and Procurement Act 1912* (NSW) s 176(1).

money in the exercise of its functions in relation to the procurement of goods and services”.⁷⁷³

- 20.13. The NSW Procurement Board established accreditation programs pursuant to the *Public Works and Procurement Act*.⁷⁷⁴ Under the goods and services accreditation program, the Board accredits an agency to conduct procurement for itself or other government agencies. It may also authorise a government agency to carry out specified procurement of goods and services without accreditation. The goods and services accreditation program has two levels of accreditation. Level 1 accredited agencies may independently conduct procurement activities up to a maximum contract value based on whether the risk profile of the procurement is low, medium, or high risk. Level 2 accredited agencies may independently conduct procurement activities in line with approved budgets, financial delegations and procurement delegations.⁷⁷⁵ The Health Administration Corporation holds a “Level 2” accreditation,⁷⁷⁶ which means it is authorised to procure goods and services of any value without reference to the Board.⁷⁷⁷
- 20.14. The NSW Procurement Board has also issued a range of mandatory directions and policies in accordance with the *Public Works and Procurement Act*,⁷⁷⁸ as well as a range of non-binding guidelines, which are summarised in the NSW Government *Procurement Policy Framework*.⁷⁷⁹ They relate to such matters as:
- a. non-discrimination, and general use of open approaches to market for procurement;⁷⁸⁰
 - b. prioritising procurement from small and medium enterprises and regional businesses,⁷⁸¹ including specific targets relating to ICT and digital procurement;⁷⁸²

⁷⁷³ Public Works and Procurement Act 1912 (NSW) s 176(3).

⁷⁷⁴ *Public Works and Procurement Act 1912* (NSW) s 174; Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) pp 6, 43-45, 144 [MOH.0001.0132.0001 at 0006, 0043-0045, 0144]. Those directions are in addition to various legislative obligations that apply directly to procurement activities, such as those that arise under the *Modern Slavery Act 2018* (NSW).

⁷⁷⁵ Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) pp 142, 144 [MOH.0001.0132.0001 at 0142, 0144]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [35] [MOH.0001.0434.0001 at 0008].

⁷⁷⁶ Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0125-0126]; Exhibit B.23.15, Audit Office of NSW, *Ensuring Contract Management Capability in Government – HealthShare NSW* (31 October 2019) p 1 [MOH.0001.0013.0001 at 0005]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [17]-[19] [MOH.0001.0434.0001 at 0004].

⁷⁷⁷ Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 144 [MOH.0001.0132.0001 at 0144].

⁷⁷⁸ Contraventions of certain Board directions or policies are enforceable: *Public Works and Procurement Act 1912* (NSW) ss 176D-176F.

⁷⁷⁹ Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001].

⁷⁸⁰ Exhibit B.23.95, NSW Procurement Board, *Procurement (Enforceable Procurement Provisions) Direction 2019* [MOH.0001.0121.0001].

⁷⁸¹ Exhibit B.23.18, NSW Government, *Small and Medium Enterprise and Regional Procurement Policy* (July 2021) [MOH.0001.0417.0001].

⁷⁸² Exhibit B.23.19, NSW Government, *ICT/Digital SME procurement commitments* (19 December 2022) [MOH.0001.0334.0001].

- c. payment terms for small businesses;⁷⁸³
 - d. prioritising procurement from Aboriginal businesses;⁷⁸⁴
 - e. environmental sustainability;⁷⁸⁵
 - f. dealing with unsolicited proposals;⁷⁸⁶ and
 - g. a mandated contracting framework for ICT procurement.⁷⁸⁷
- 20.15. NSW Health's procurement activities are also subject to several other legislative obligations, such as those that arise under the *Modern Slavery Act 2018* (NSW).

Health Administration Corporation

- 20.16. Although the Health Administration Corporation holds the accreditation to undertake procurement for NSW Health, that function is largely exercised through HealthShare, as well as eHealth in relation to ICT procurements, for procurements that have a value of up to \$30 million, and/or recurrent yearly payments in aggregate up to \$30 million in the case of eHealth.⁷⁸⁸ Procurement of goods or services exceeding those thresholds must be approved by the Chief Procurement Officer.⁷⁸⁹

HealthShare

- 20.17. The predecessor of HealthShare – Health Support Services – was established in 2007 to provide shared services for NSW Health entities, including linen, food, payroll, warehousing, procurement and recruitment services, as well as some ICT services.⁷⁹⁰
- 20.18. In 2012, Health Support Services was renamed HealthShare NSW, and created as an “administrative unit” of a “division” of the Health Administration Corporation.⁷⁹¹ HealthShare became the vehicle through which the Health Secretary provided those

⁷⁸³ Exhibit B.23.20, NSW Government, *Small Business Shorter Payment Terms Policy* (July 2021) [MOH.0001.0416.0001].

⁷⁸⁴ Exhibit B.23.21, NSW Government, *Aboriginal Procurement Policy* (January 2021) [MOH.0001.0277.0001].

⁷⁸⁵ Exhibit B.23.22, NSW Government, *NSW Government Resource Efficiency Policy* (2019) [MOH.0001.0324.0001].

⁷⁸⁶ Exhibit B.23.96, NSW Department of Premier and Cabinet, *Unsolicited Proposals* (C-2017-05) (22 December 2017) [MOH.0001.0428.0001]; Exhibit B.23.97, NSW Government, *Unsolicited Proposals Guide for Submission and Assessment* (May 2022) [MOH.0001.0427.0001].

⁷⁸⁷ Exhibit B.23.99, NSW Procurement Board, *Mandated use of ICT Purchasing Framework* (PBD-2021-02) (1 July 2021) [MOH.0001.0341.0001].

⁷⁸⁸ Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0215-0216]; Exhibit D.1.57, NSW Health, *eHealth NSW Delegations Manual* – Version: 3.0 (May 2019) pp 15, 16, 19 [MOH.9999.0819.0001 at 0015, 0016, 0019].

⁷⁸⁹ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [75a] [MOH.0001.0434.0001 at 0026].

⁷⁹⁰ See, for example, Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (2011) p 27 [MOH.0001.0309.0001 at 0029].

⁷⁹¹ Exhibit B.23.37, *Delegation of functions of the HealthShare NSW Board* (29 November 2012) recital B [MOH.0001.0308.0001 at 0001].

shared services under s 126B of the *Health Services Act*, with its governance overseen by the HealthShare Board.⁷⁹² That structure remains in place today.

- 20.19. Since 10 November 2008, public health organisations have been directed by the Minister to acquire all procurement, contract management and contract negotiation services from HealthShare (and its predecessor, Health Support Services).⁷⁹³ That direction is binding on public health organisations other than AHOs, which can elect whether to acquire those services from HealthShare.⁷⁹⁴
- 20.20. HealthShare is funded primarily on this “cost recovery” model through intrahealth service charges, together with a recurrent subsidy.⁷⁹⁵
- 20.21. Relevantly, public health entities⁷⁹⁶ pay a “recovery charge” to HealthShare for its services, unless otherwise approved by the Health Secretary.⁷⁹⁷ Procurement contract and tendering services are charged at a fixed price,⁷⁹⁸ while a volume based charge is applied to the acquisition of goods through the centralised “Onelink” warehouse.⁷⁹⁹ Those volume based charges include components for the item itself, warehousing operations, and freight cost.⁸⁰⁰
- 20.22. HealthShare’s procurement related activities fall into the following general categories:⁸⁰¹
 - a. Leading the process for establishing and renewing of whole of NSW Health and whole of NSW Government (health related) arrangements for purchasing goods and services.⁸⁰² HealthShare’s responsibilities include developing a procurement plan; preparing tender documentation (assuming, as is usual, that the procurement is to be by way of an approach to market); preparing evaluation criteria and an evaluation plan; conducting the tender and evaluation process; and preparing and finalising the contract, in accordance with the NSW Health Procurement Policy and Procedures and other relevant policies and

⁷⁹² Health Services Act 1997 (NSW) s 126C.

⁷⁹³ Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) [MOH.0001.0404.0001]; See also, Exhibit B.23.35, NSW Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 26 cl 4.1(a)(i)(2) [MOH.0001.0278.0001 at 0027].

⁷⁹⁴ *Health Services Act 1997* (NSW) ss 126G, 126H (2).

⁷⁹⁵ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [25] [MOH.9999.0009.0001 at 0009].

⁷⁹⁶ Exhibit D.95, NSW Ministry of Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 30 [SCI.0008.0112.0001 at 0031]. A public health entity means a public health organisation and the divisions of the Health Administration Corporation.

⁷⁹⁷ Exhibit D.95, NSW Ministry of Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 27 cl 4.1(c) [SCI.0008.0112.0001 at 0028]. The recovery charge will be paid by the Ministry of Health on behalf of the public health organisation.

⁷⁹⁸ See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [36] [MOH.0001.0260.0001 at 0013-0014].

⁷⁹⁹ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28] [MOH.9999.0009.0001 at 0009].

⁸⁰⁰ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28(b)] [MOH.9999.0009.0001 at 0009].

⁸⁰¹ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31] [MOH.9999.0009.0001 at 0011].

⁸⁰² Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [42] [MOH.9999.0009.0001 at 0014].

procedures.⁸⁰³ The result of those processes is generally a “Standing Offer Arrangement” between the relevant supplier and the Health Administration Corporation, which sets out the terms and conditions on which contracts may be formed between the supplier and individual NSW Health entities.⁸⁰⁴

- b. Conducting procurements referred to it by other NSW Health entities that are outside their authority.⁸⁰⁵ That process is a similar process to establishing a whole of NSW Government or whole of NSW Health contract, but the result is a single contract between the supplier and the relevant NSW Health entity, rather than the Health Administration Corporation.⁸⁰⁶
- c. Contract management and administration of whole of NSW Health and whole of NSW Government (health related) contracts.⁸⁰⁷
- d. Procuring, warehousing, and delivering of a wide range of medical and surgical consumables used in NSW Health facilities through the “Onelink” warehouse – a centralised warehouse from which HealthShare then distributes consumables.⁸⁰⁸ In doing so, HealthShare procures three million different medical and surgical consumables worth about \$200 million annually and delivers these across 400 sites every day.⁸⁰⁹ HealthShare also maintains a product catalogue and various supply chain information systems for use by NSW Health entities.⁸¹⁰
- e. Providing assistance and advice to other NSW Health staff, particularly at the local level, regarding procurement matters.⁸¹¹
- f. The development of procurement strategy and reform, including category strategies as described above.⁸¹²

eHealth

20.23. eHealth was established on 1 July 2014 as another “unit” within the Health Administration Corporation.⁸¹³ It was established to centralise ICT services for NSW Health, which at that time were spread between what were the then Area Health Services and Health Support Services, as well as the Ministry of Health.⁸¹⁴ Its current

⁸⁰³ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [61]-[67] [MOH.9999.0009.0001 at 0017-0021].

⁸⁰⁴ See, for example, Exhibit B.23.40, Template Standing Offer Agreement (13 December 2022) [MOH.0001.0367.0001].

⁸⁰⁵ Generally, procurement valued in excess of \$250,000 and outside a whole of NSW Government or whole of NSW Health contract: Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [61]-[67] [MOH.9999.0009.0001 at 0011, 0017-0021].

⁸⁰⁶ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)] [MOH.9999.0009.0001 at 0011].

⁸⁰⁷ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49]-[56] [MOH.9999.0009.0001 at 0015-0016].

⁸⁰⁸ Transcript of the Commission, 23 February 2024, T895.36-896.14, T921.33-923.6 (Rechbauer).

⁸⁰⁹ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [34] [MOH.9999.0009.0001 at 0012].

⁸¹⁰ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31f] [MOH.9999.0009.0001 at 0011].

⁸¹¹ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [35]-[36] [MOH.9999.0009.0001 at 0012].

⁸¹² Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [86]-[102] [MOH.9999.0009.0001 at 0024-0029].

⁸¹³ Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) recital A [MOH.0001.0312.0001 at 0001].

⁸¹⁴ Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (2011) p 24 [MOH.0001.0001.0309.0001 at 0026].

functions include planning, strategy development, project development, support and maintenance of ICT for NSW Health, as well as the provision of network and storage facilities, and ICT hardware and software.⁸¹⁵

- 20.24. Similar to HealthShare, NSW Health entities (other than AHOs) are obliged to acquire ICT goods and services that are offered by eHealth.⁸¹⁶ Those goods and services extend to most ICT infrastructure (including NSW Government data centres and the cloud), corporate/business systems (such as incident management, payroll, recruitment and finance systems), cyber security services, communications platforms (including email and video conferencing), clinical systems (such as electronic patient medical records, imaging, pharmacy and ambulance systems), and virtual care systems.⁸¹⁷
- 20.25. eHealth's ordinary operations are funded in a similar way to HealthShare: partly through recurrent funding from the Ministry of Health, but primarily through service charges levied on NSW Health entities for using its services, either on a fixed or consumption basis.⁸¹⁸ Statewide programs and projects may receive separate capital funding.⁸¹⁹
- 20.26. In performing its functions, eHealth:
 - a. negotiates and manages whole of NSW Health contracts for ICT goods and services, by establishing "Master" or "Head" agreements with suppliers pursuant to which NSW Health entities may then contract;⁸²⁰
 - b. negotiates contracts on behalf of NSW Health entities for ICT goods and services outside whole of NSW Health and whole of NSW Government contracts and above their financial authority, which (in accordance with the NSW Health Procurement Policy) is \$150,000;⁸²¹ and
 - c. is involved in the development of strategies and reforms relating to ICT in NSW Health.⁸²²
- 20.27. It is also required to approve any laptop or desktop purchases within NSW Health of any value, for standardisation reasons.⁸²³

⁸¹⁵ Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) [2] [MOH.0001.0312.0001 at 0001].

⁸¹⁶ Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) cl 3 [MOH.0001.0404.0001]; Exhibit B.23.35, NSW Ministry of Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 26 cl 4.1(a)(iii) [MOH.0001.0278.0001 at 0027].

⁸¹⁷ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [10], [53] [MOH.0001.0433.0001 at 0002 and 0026-0027].

⁸¹⁸ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [15]-[17] [MOH.0001.0433.0001 at 0003].

⁸¹⁹ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [17(a)], [18] [MOH.0001.0433.0001 at 0003, 0004].

⁸²⁰ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [46]-[48] [MOH.0001.0433.0001 at 0024].

⁸²¹ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [42(b)] [MOH.0001.0433.0001 at 0022].

⁸²² Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [26]-[32] [MOH.0001.0433.0001 at 0005-0020].

⁸²³ Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [43] [MOH.0001.0433.0001 at 0022-0023].

Ministry of Health

- 20.28. Aside from procurement activities it may undertake for its own purposes, the Ministry of Health has what has been described as a “strategic” role in relation to procurement.⁸²⁴ That role broadly reflects the Ministry of Health’s function as “system manager”.⁸²⁵
- 20.29. The Ministry of Health is responsible for developing and overseeing the general framework of policies, procedures and guidelines applying to procurement across NSW Health. The most notable of these are the *NSW Health (Goods and Services) Procurement Policy*⁸²⁶ and *NSW Health Procurement Procedures (Goods and Services)*.⁸²⁷ A wide range of separate, specific policies also bear on the procurement function.⁸²⁸ Public health organisations are required to comply with the NSW Health Procurement Policy and Procedures as a condition of the financial subsidies they receive.⁸²⁹
- 20.30. The Ministry of Health’s Strategic Procurement Branch has a lead role in the implementation of the procurement related elements of the *Future Health Plan*.⁸³⁰ It also has responsibility for overseeing the current “Procurement Reform Program”.⁸³¹
- 20.31. The Chief Procurement Officer has a range of responsibilities that are particularly focussed on procurement activities that are outside the ordinary course and, as noted above, include approving procurement at or over \$30 million in value and procurement plans and evaluation plans, and establishing whole of NSW Health contracts, as well as granting exemptions to existing procurement requirements.⁸³²
- 20.32. The Ministry of Health also oversees compliance with procurement requirements and functions by other entities within the system.⁸³³ The main way in which this occurs is

⁸²⁴ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22] [MOH.0001.0434.0001 at 0004-0005].

⁸²⁵ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [9]-[10], [20] [MOH.0001.0434.0001 at 0002-0003, 0004].

⁸²⁶ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) [MOH.0001.0037.0001].

⁸²⁷ Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) [MOH.0001.0366.0001].

⁸²⁸ Some examples include: Exhibit B.23.28, NSW Health, *Disclosure of Contract Information* (PD2018_021) (26 June 2018) [MOH.0001.0148.0001]; Exhibit B.23.29, NSW Health, *Conflicts of Interest and Gifts and Benefits* (PD2015_045) (27 October 2015) [MOH.0001.0145.0001]; Exhibit B.23.30, NSW Health Code of Conduct (PD2015_049) (16 December 2015) [MOH.0001.0359.0001]; Exhibit B.23.31, NSW Health, *Corrupt Conduct - Reporting to the Independent Commission Against Corruption (ICAC)* (PD2016_029) (5 July 2016) [MOH.0001.0298.0001]; Exhibit B.23.32, NSW Health, *Procurement Cards within NSW Health* (PD2022_038) (2 September 2022) [MOH.0001.0149.0001]; Exhibit B.23.43, NSW Health, *Asset Management* (PD2022_044) (19 September 2022) [MOH.0001.0150.0001]; Exhibit B.23.46, NSW Health, *Uniforms Policy* (PD2019_012) (22 March 2019) [MOH.0001.0369.0001]; NSW Health, *Early Response to High Consequence Infectious Disease* (PD2023_008), referred to in Exhibit B.5, Statement of Michael Gendy (31 January 2024) [53(e)] [MOH.0001.0434.0001 at 0018].

⁸²⁹ See, for example, Exhibit B.23.100, NSW Ministry of Health Financial Requirements and Conditions of Subsidy (Government Grants) for the year ending 30 June 2023 (21 June 2022) p 24 cl 3.5 [MOH.0001.0318.0001 at 0025].

⁸³⁰ Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of healthcare in NSW 2022-2023* (May 2022) [MOH.0001.0320.0001]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [29] [MOH.0001.0434.0001 at 0006].

⁸³¹ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30]-[31] [MOH.0001.0434.0001 at 0006-0007].

⁸³² Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp ii, 5,6,14,15, 30 [MOH.0001.0037.0001 at 0003, 0009, 0010, 0018, 0019, 0034]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [75b] [MOH.0001.0434.0001 at 0026].

⁸³³ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22f], [35] [MOH.0001.0434.0001 at 0005, 0008].

through the setting and monitoring of KPIs relating to procurement in the service agreements between the Health Secretary and LHDs, SHNs and AHOs, and Statements of Service with HealthShare, eHealth, NSW Health Pathology and Health Infrastructure.⁸³⁴ Those KPIs are focussed on cost savings (for example, “annual procurement savings target achieved”), standardisation (for example, “reducing free text orders catalogue compliance”, “reducing off-contract spend” and “use of Whole of Health contracts”), and environmental sustainability (for example, reducing the use of certain chemicals and diverting waste from landfill).⁸³⁵

Pillar organisations

- 20.33. The ACI and the CEC also play a role, albeit an *ad hoc* one, in procurement processes.
- 20.34. There is likely to be significant system benefits if those agencies were to have a systematic role in the procurement processes. By the very nature of their function, they have valuable system and clinical knowledge that could be brought to bear in the procurement processes in a way that will promote value based procurement principles. The current *ad hoc* role they perform should be formalised so that those undertaking procurement have clear guidance as to when the input of those agencies should be sought.

Agency for Clinical Innovation

- 20.35. The ACI and the Office of Health and Medical Research (OHMR) have a significant role to play in identifying, assessing, developing and implementing clinical and technical innovations within NSW Health.⁸³⁶
- 20.36. At present, no clear role for the ACI in NSW Health’s procurement processes is identified, outside of implementing clinical innovations sponsored by it.
- 20.37. In this respect:
- a. its role in tender evaluation processes is largely *ad hoc* and it generally depends on whether the members of the technical evaluation committee for the tender elect to involve it;⁸³⁷
 - b. as Adjunct Professor Levesque explained,⁸³⁸ the ACI does not undertake monitoring of the effects of clinical products procured via Statewide contracts in a

⁸³⁴ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [51]-[55] [MOH.0001.0434.0001.0017-0019].

⁸³⁵ See, for example, Exhibit B.23.181, Southern NSW Local Health District Service Agreement 2023-24 (26 October 2023) p 27 [MOH.0001.0456.0001 at 0028].

⁸³⁶ See, for example, Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [66]-[85]. [MOH.0001.0435.0001 at 0021-0033].

⁸³⁷ Transcript of the Commission, 23 February 2024, T905.22-907.20 (Rechbauer); Transcript of the Commission, 26 February 2024 T1133.5-1134.40 (Levesque).

systematic way, nor does it oversee it. However, changes in some outcome measures may appear incidentally in data gathered for other purposes, such as work undertaken in relation to clinical variation and measures in place through clinical registries;⁸³⁹

- c. none of the “deliverables” set out in the ACI’s Service Agreement relate (at least expressly) to involvement it may have in the procurement of goods and services, other than a reporting requirement relating to its own procurement;⁸⁴⁰
- d. the ACI’s two most recent strategic plans do not identify any strategic or systematic function in respect of procurement, beyond the *ad hoc* role it may occasionally take (referred to above),⁸⁴¹ nor is the ACI referred to in the NSW Health Procurement Policy or Procedures; and
- e. Adjunct Professor Levesque’s statement of evidence, which was tendered in this Special Commission and comprehensively described the ACI’s important role in relation to clinical innovations and models of care, used the word “procurement” only once, in the context of saying: “[p]rocurement practices can prevent local innovations from being taken to a stage where they are commercially viable.”⁸⁴²

Clinical Excellence Commission

- 20.38. Similar to the position of the ACI, aside from regular meetings with HealthShare concerning supply chain issues (introduced in the wake of COVID-19), the CEC’s involvement in procurement processes is also largely *ad hoc*.⁸⁴³ Like the ACI, the CEC does not have a regular or routine role in procurement processes, and there does not appear to be any policy or procedure requiring tender evaluation committees considering tenders for the supply of clinical goods or services to seek input from it, nor does it have a “standing” membership of those committees.⁸⁴⁴
- 20.39. However, the CEC can become involved in procurement activities from time to time, including by:
- a. leading responses to urgent, system level medicine, medical device, chemical and equipment shortages (including because of supply chain disruptions) to ensure clinical quality and safety;⁸⁴⁵ and

⁸³⁹ Transcript of the Commission, 26 February 2024, T1135.5-26 (Levesque).

⁸⁴⁰ Exhibit B.23.49, Agency for Clinical Innovation, *Performance Agreement 2023-24* (31 October 2023) [MOH.0001.0284.0001 at 0001].

⁸⁴¹ See, for example, Exhibit B.23.56, Agency for Clinical Innovation, *Strategic Plan 2019-22* [MOH.0001.0281.0001]; Exhibit B.23.50, Agency for Clinical Innovation, *Strategic Plan 2023-2026* [MOH.0001.0350.0001 at 0020].

⁸⁴² Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [112f] [MOH.0001.0435.0001 at 0040].

⁸⁴³ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [63] [MOH.0001.0434.0001 at 0021].

⁸⁴⁴ Transcript of the Commission, 23 February 2024, T907.12-15 (Rechbauer).

⁸⁴⁵ Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [23]-[30] [MOH.0001.0262.0001 at 0006].

- b. participating in Statewide procurement projects, such as the NSW Medicines Formulary, the SDPR and medical device reforms.⁸⁴⁶

Local organisations

- 20.40. A significant amount of the procurement activity in NSW Health occurs at the local organisational level, where most goods and services used across NSW Health are acquired.
- 20.41. Local organisations can conduct some procurement activities themselves, although once particular thresholds and conditions are met, they must be referred to HealthShare or eHealth, the effect of which is that:
- a. if the goods or services (excluding professional services) to be procured are valued at \$10,000 or less, the local organisation may procure them from any supplier, provided they meet all applicable quality, safety, security, and regulatory requirements, and their cost is reasonable and consistent with normal market rates;⁸⁴⁷
 - b. if the goods or services to be procured are valued at more than \$10,000 and are available under a whole of NSW Health or whole of NSW Government contract, or a whole of NSW Government prequalification scheme or procurement list (essentially, a list of suppliers approved to supply particular goods or services to NSW Government agencies), the local organisation must use that arrangement (unless a procurement connected policy exemption or exemption granted by the Chief Procurement Office has been granted);⁸⁴⁸ and
 - c. if the goods or services to be procured are not available under a whole of NSW Government or whole of NSW Health contract, or a whole of NSW Government prequalification scheme (including the ICT Services Scheme) or procurement list, the following apply:
 - i. if the goods or services to be procured are valued at more than \$10,000 up to \$30,000, the local organisation may procure the goods or services itself, by obtaining one written quote. NSW Health agencies must still meet applicable quality, safety, security, and regulatory requirements, and also check for any additional local arrangements;⁸⁴⁹

⁸⁴⁶ Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [31]-[33], [38]-[65] [MOH.0001.0262.0001 at 0007-0012].

⁸⁴⁷ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 9 cl 4.5 [MOH.0001.0037.0001 at 0013].

⁸⁴⁸ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 10 cls 5.1, 5.2 [MOH.0001.0037.0001 at 0014].

⁸⁴⁹ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp 13-14 cl 6.1.1 [MOH.0001.0037.0001 at 0017-0018].

- ii. if the goods or services are valued at more than \$30,000 up to \$250,000 (\$150,000 in the case of ICT goods or services), the local organisation may procure the goods or services itself, generally by an approach to market.⁸⁵⁰ The nature of the approach to market required, and other requirements for the procurement (including whether a procurement plan and an evaluation plan are required, and the extent of the approach to market documentation required), depend on the outcome of a risk assessment conducted using the NSW Health “risk assessment tool”,⁸⁵¹ and
- iii. if goods or services are valued at more than \$250,000 (\$150,000 in the case of ICT goods or services), the local organisation must refer the procurement to HealthShare or eHealth as described above.⁸⁵²

20.42. The systems used by local organisations to undertake procurement activities are varied. Some local organisations have developed their own guidelines or manuals in an effort to make the processes easier to follow.⁸⁵³ Most local organisations have their own internal procurement teams, which carry out some procurement tasks themselves and otherwise provide support to staff with that responsibility at the facility level.⁸⁵⁴ They also have their own delegations for procurement activities.⁸⁵⁵ The staff with delegations to perform procurement at the local level include clinical staff such as nurse unit managers, nurse practitioners and clinical educators.⁸⁵⁶

⁸⁵⁰ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14 cl 6.1.2 [MOH.0001.0037.0001 at 0018].

⁸⁵¹ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14-22 cls 6.1.2, 6.2 - 6.18 [MOH.0001.0037.0001 at 0018-0026].

⁸⁵² Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14 cl 6.1.2 [MOH.0001.0037.0001 at 0018].

⁸⁵³ See for example, Exhibit B.23.145, Illawarra Shoalhaven Local Health District, *ISLHD Purchasing Manual* [MOH.0001.0446.0001]; Exhibit B.23.146, Illawarra Shoalhaven Local Health District, *Purchasing Matrix* [MOH.0001.0447.0001]; Exhibit B.23.163, South Western Sydney Local Health District, *SWSLHD Major Procurement Requirements and Guidelines: Tenders, Expressions of Interest, Contracts and State Contract Equipment Purchases* (10 May 2017) [MOH.0001.0270.0001]; Exhibit B.23.179, Southern NSW Local Health District, *Southern NSW LHD Procurement Guide* (September 2023) [MOH.0001.0457.0001]; See also, Exhibit B.1, Statement of Margot Mains (29 January 2024) [28] [MOH.0001.0260.0001 at 0011].

⁸⁵⁴ See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [29]-[31] [MOH.0001.0260.0001 at 0012]; Exhibit B.4, Statement of Dr Teresa Anderson (31 January 2024) [21]-[22] [MOH.0001.0258.0001 at 0007-0008]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [19]-[20] [MOH.0001.0261.0001 at 0006]; Exhibit B.8, Statement of Mark Spittal (6 February 2024) [28]-[29] [MOH.0001.0263.0001 at 0007]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [21] [MOH.9999.0007.0001 at 0007-0008]; See also, Exhibit B.23.121, South Western Sydney Local Health District, *Procurement Team Structure* (undated) [MOH.0001.0399.0001].

⁸⁵⁵ See, for example, Exhibit B.23.109, Illawarra Shoalhaven Local Health District, *Delegations Framework* (February 2021) [MOH.0001.0337.0001]; Exhibit B.23.114, Sydney Local Health District, *Delegations of Authority Manual* (28 June 2021) [MOH.0001.0412.0001]; Exhibit B.23.161, South Western Sydney Local Health District, *Delegations Manual* (September 2023) [MOH.0001.0268.0001]; Exhibit B.23.180, Southern NSW Local Health District, *Delegations of Authority Manual* (28 November 2023) [MOH.0001.0453.0001]; See also, Exhibit B.8, Statement of Mark Spittal (6 February 2024) [31] [MOH.0001.0263.0001 at 0007].

⁸⁵⁶ See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [25] [SCI.0003.0001.0009 at 0012-0013]; Transcript of the Commission, 19 February 2024, T416.19-30 (Tastula).

- 20.43. Considering the range, complexity, and multilayered nature of the policies, processes, and systems governing the procurement within NSW Health, even with the launch of the “Procurement Academy” training modules for procurement staff and currently available user support mechanisms, it is perhaps understandable that staff at the local facility level often experience uncertainty, confusion, and frustration when attempting to procure non-routine items, such as medical consumables.⁸⁵⁷ It is also not surprising that inconsistencies have arisen in procurement timeframes or outcomes in different places.⁸⁵⁸ It would be undoubtedly frustrating for a clinician in one facility to see their colleagues in a different facility procuring the same item more quickly or efficiently.⁸⁵⁹
- 20.44. Complexity is inevitable in procurement that occurs within a system that is the size and scope NSW Health, particularly when those activities occur within a wider government context that also introduces a range of legislative and NSW Government requirements. It might also be that NSW Health’s procurement reforms, including the “SmartChain” platform described below, will, over time, help with streamlining and simplification. But there are undoubted benefits in NSW Health continuing to:
- a. consolidate its procurement policies, processes and systems where practicable;
 - b. provide clear, practical guidance to staff at all levels of the system (and not just procurement staff) as to the steps they need to take to procure different kinds of goods and services; and
 - c. ensure that assistance is readily available if staff experience difficulties.

Recent and ongoing procurement reforms

- 20.45. The consideration of NSW Health’s procurement framework by this Special Commission has occurred in a context where NSW Health has been conducting a “reform” of that framework, the purpose of which is to deliver the change required to manage procurement more effectively, and to support value based healthcare across the system.⁸⁶⁰

⁸⁵⁷ See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [12]-[25] [SCI.0003.0001.0009 at 0010-0013]; Transcript of the Commission 19 February 2024, T416.32-417.7 (Tastula); Transcript of the Commission, 23 February 2024, T991.17-26 (Gendy).

⁸⁵⁸ See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [21], [24] [SCI.0003.0001.0009 at 0012].

⁸⁵⁹ See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [24] [SCI.0003.0001.0009 at 0012]; Transcript of the Commission, 19 February 2024, T409.13-28, T410.30-411.14 (Tastula); Exhibit B.1, Statement of Margot Mains (29 January 2024) [73] [MOH.0001.0260.0001 at 0021]; Exhibit B.4, Statement of Dr Teresa Anderson (31 January 2024) [120] [MOH.0001.0258.0001 at 0031].

⁸⁶⁰ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [93], [96] [MOH.0001.0434.0001 at 0031, 0034].

20.46. That reform program involves four “workstreams”:

- a. Operating Model: This workstream involves the implementation of a new “Operating Model”,⁸⁶¹ which includes investment in additional staffing in contract implementation and management roles across HealthShare, eHealth and NSW Health Pathology, as well as the clarification of roles and responsibilities of existing procurement staff, a new Contract Management Framework, and new procurement “dashboards” for procurement spending, as well as updates to the “risk assessment tool”;⁸⁶²
- b. NSW Medicines Formulary: A “holistic framework governing the procurement and usage of pharmaceuticals” across NSW public hospital inpatients and NSW Ambulance.⁸⁶³ It involves a consolidation of 27 different formularies and 60 different governance groups for reviewing formulary submissions into one, with one peak governing body, as well as reduction of medicines in the formulary by more than two thirds;⁸⁶⁴
- c. DeliverEASE: This is a reform focussed on the medical consumables supply chain. In addition to simplifying the ordering process, DeliverEASE improves inventory management,⁸⁶⁵ and standardises storeroom layouts across NSW Health facilities;⁸⁶⁶ and
- d. SmartChain: The aim of SmartChain is to create a single, Statewide, end to end procurement platform for all procurement and supply chain activities in NSW Health, including pricing, ordering, and inventory monitoring.⁸⁶⁷ SmartChain will include five modules. One of those – “Traceability”, a tracking system for implantable and prosthetic products and devices used for patients⁸⁶⁸ – has been rolled out.⁸⁶⁹

⁸⁶² Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)], [95(b)] [MOH.0001.0434.0001 at 0006, 0021, 0034]; See also, Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].

⁸⁶³ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(b)], [64(b)] [MOH.0001.0434.0001 at 0006, 0022]; Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [38]-[65] [MOH.0001.0262.0001 at 0007-0012].

⁸⁶⁴ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [95(a)(iii)]-[95(a)(iv)] [MOH.0001.0434.0001 at 0033].

⁸⁶⁵ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(c)], [64(c)] [MOH.0001.0434.0001 at 0006, 0022]; See also, Exhibit B.1, Statement of Margot Mains (29 January 2024) [69] [MOH.0001.0260.0001 at 0020]; Transcript of the Commission, 1 February 2024, T667.31-668.10 (Chimento).

⁸⁶⁶ Transcript of the Commission, 23 February 2024, T993.36-994.16 (Gendy); Transcript of the Commission, 21 February 2024, T668.12-28 (Chimento).

⁸⁶⁷ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30d], [64e], [65] [MOH.0001.0434.0001 at 007, 0022].

⁸⁶⁸ See, for example, Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [114] [MOH.9999.0009.0001 at 0031]; Transcript of the Commission, 21 February 2024, T669.8-671.26 (Chimento).

⁸⁶⁹ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [66] [MOH.0001.0434.0001 at 0023].

Value based procurement

Conceptions of value

20.47. As noted above, one of the five objectives of procurement identified in the NSW Government *Procurement Policy Framework* – and the one that is “the overarching consideration for government procurement” – is “value for money”.⁸⁷⁰ The Framework describes “value for money” in the following way:⁸⁷¹

Value for money is not necessarily the lowest price, nor the highest quality good or service. It requires a balanced assessment of a range of financial and non-financial factors, such as: quality, cost, fitness for purpose, capability, capacity, risk, total cost of ownership or other relevant factors.

20.48. NSW Health translates the concept of value for money into a health setting through the concept of value based healthcare.⁸⁷² This is reflected in one of the “key objectives” in the *Future Health Plan*, which is to “[d]rive value-based healthcare that prioritises outcomes and collaboration”.⁸⁷³ “Value-based healthcare” is said to mean:

*continually striving to deliver care that improves the health outcomes that matter to patients, patient experiences of receiving care, clinician experiences of providing care as well as the effectiveness and efficiency of care.*⁸⁷⁴

20.49. This is said to require a shift in focus away from those matters that incentivise gains in technical efficiency, that are inherent in volume or activity based funding, towards “care that focuses on outcomes”.⁸⁷⁵

20.50. The definition of value based healthcare in the *Future Health Plan* incorporates outcomes and experiences (of both patients and clinicians). That is consistent with the ACI’s approach to value based healthcare set out in its *Value-based surgery: Clinical practice guide*.⁸⁷⁶

⁸⁷⁰ Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0132.0001 at 0009].

⁸⁷¹ Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0132.0001 at 0009].

⁸⁷² Exhibit B.5, Statement of Michael Gendy (31 January 2024) [40] [MOH.0001.0434.0001 at 0009-0010].

⁸⁷³ Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) p 16 [MOH.0001.0320.0001 at 0016].

⁸⁷⁴ Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) pp 16 [MOH.0001.0320.0001 at 0016].

⁸⁷⁵ Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) p 16 [MOH.0001.0320.0001 at 0016].

⁸⁷⁶ Exhibit B.23.64, Agency for Clinical Innovation, *Value-based surgery: Clinical practice guide* (November 2023) p 4 [MOH.0001.0282.0001 at 0007]; See also, Exhibit B.59, NSW Health, *Leading Better Value Care* (December 2019) p 3 [SCI.0003.0021.0001 at 0003].

In NSW, value-based healthcare means continually striving to deliver care that improves:

- *health outcomes that matter to patients*
- *the experience of receiving care*
- *experiences of providing care*
- *effectiveness and efficiency of care.*

Value-based healthcare requires a collaborative approach to ensure best outcomes for patients and the best value for the system.

- 20.51. Dr Teresa Anderson, then Chief Executive of Sydney LHD, described value based health outcomes in a similar way: ⁸⁷⁷

So this is really about making sure that we get value out of the contracts, not just in terms of savings, financial savings, but improved outcomes for our patients and the experience of our staff, helping to streamline the processes for our staff.

- 20.52. Other definitions of value based healthcare focus primarily on “outcomes”. For example:

- a. the NSW Health Procurement Procedures refer to value based healthcare as taking “an outcomes-based approach”,⁸⁷⁸
- b. Alira Health, in a report titled *Value-Based Procurement in Australia* commissioned for the Medical Technology Association of Australia (MTAA) – which advocates for a value based approach to procurement – defined value based healthcare as “the improved health outcomes for patients versus the total costs of delivering care”, and value based procurement as having a corresponding meaning,⁸⁷⁹
- c. Paul Dale, Director, Policy of the MTAA, described value based healthcare as “delivering the outcomes that matter to patients as efficiently as possible”, although he also referred to the experience of the patient;⁸⁸⁰

⁸⁷⁷ Transcript of the Commission, 21 February 2024, T726.46-727.4 (Anderson).

⁸⁷⁸ Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) p 37 cl 6.13.2 [MOH.0001.0366.0001 at 0037].

⁸⁷⁹ Exhibit B.18, Alira Health, *Value-Based Procurement in Australia* p 6 [SCI.0003.0001.0048 at 0053].

⁸⁸⁰ Transcript of the Commission, 20 February 2024, T612.11-18 (Dale).

- d. Carmen Rechbauer, then Chief Executive of HealthShare NSW, ultimately described the concept as requiring consideration not just of price but of “all other aspects that go into being able to provide safe products for patients”;⁸⁸¹ and
- e. Michael Gendy, Chief Procurement Officer, Ministry of Health, described value based healthcare as follows:⁸⁸²

Value based health care for me is all about patient outcomes and the primary focus of that is the outcomes that we can achieve for our patients. Everything that we do is all for our patients.

- 20.53. Mr Gendy emphasised that value was not synonymous with “price”.⁸⁸³ However, he saw value as interacting with economic efficiency. For example, procurement reforms with the effect of reducing cost and freeing up staff would, in turn, allow money and staff time to be redirected to better achieving patient outcomes.⁸⁸⁴ Similarly, Mr Dale’s view was that, while value based healthcare must be patient centric, “there’s an efficiency component as well, so delivering the maximum outcome for the resources that you are using”.⁸⁸⁵
- 20.54. What these conceptions of value based healthcare have in common is the aim of delivering the most valuable healthcare for a given cost. There is a general consensus that this should be the underlying intent of procurement activities (and probably any expenditure) in the health system. The aim should not merely be to achieve the lowest price for the type of good or service to be acquired.
- 20.55. Identifying what represents value in that context, or formulating robust processes for identifying it, is less straightforward. Although there is a consensus that value based healthcare must involve, at some level, or be linked to, achieving good patient outcomes, what amounts to “good” patient outcomes is not always the subject of clear or easy identification.
- 20.56. It appears to be accepted that the concept should not be limited to an objectively successful clinical outcome but may also encompass, for example, whether the provision of care achieved what the patient wanted to achieve from it, and whether the patient is happy with how they were treated. Quantifying value should also involve consideration of the position of the broader system; including the interests of clinicians, and the wider system impacts of resource allocations.

⁸⁸¹ Transcript of the Commission, 23 February 2024, T916.10-16 (Rechbauer).

⁸⁸² Transcript of the Commission, 23 February 2024, T1002.11-14 (Gendy).

⁸⁸³ Transcript of the Commission, 23 February 2024, T1002.16-23 (Gendy).

⁸⁸⁴ Transcript of the Commission, 23 February 2024, T1002.16-1003.14 (Gendy).

⁸⁸⁵ Transcript of the Commission, 20 February 2024, T612.18-20 (Dale).

- 20.57. Accordingly, the concept of value in healthcare should involve a consideration of value not just to an individual patient and those with a direct stake in their care, but to other stakeholders in the system including clinicians and the broader community.
- 20.58. It would be futile for me to attempt to formulate a definition of value that should be applied to all procurement activities across NSW Health. In each case, what must be considered in the assessment of value will turn on the particular good or service, its use, and the context in which the procurement occurs. What is important, though, is that there is a systematic approach to identifying and assessing value in the context of procurement activities that seek to support the notion of value based healthcare.
- 20.59. That is not presently occurring, or at least not in a systemic and regular way, across NSW Health's procurement activities.

Embedding an assessment of value in procurement activities

- 20.60. Despite an extensive range of policies, procedures, guidelines, frameworks, and similar documents relating to procurement, none describes how value is to be assessed and achieved in any given procurement process.
- 20.61. The main way in which value appears to be assessed in NSW Health's procurement processes is through the criteria applied in evaluating tenders. These criteria are set out in a procurement plan. They may, depending on the subject matter of the tender, include value related criteria such as the extent to which the product or service will achieve certain patient outcomes. Expertise is brought to bear on these criteria during the tender evaluation process through clinicians or other subject matter experts participating as members of the tender evaluation committee, or by providing feedback to contract managers or clinical product managers who are expected to pass on that feedback.⁸⁸⁶
- 20.62. However, there does not appear to be any documented method or system by which value related criteria are to be determined and incorporated into a procurement plan or tender evaluation process. For example, Ms Rechbauer was not aware of whether there was any formal process by which tender evaluation committees weighted value based considerations such as patient outcomes,⁸⁸⁷ nor whether such considerations were recorded or communicated, but said the brief produced for her approval – as one of the individuals with responsibility for signing off the award of a contract – would not include that level of detail.⁸⁸⁸ In its written submissions, NSW Health accepted – as is clear from the evidence – that there were “opportunities to improve in this area”.⁸⁸⁹

⁸⁸⁶ Transcript of the Commission, 23 February 2024, T901.13-904.42 (Rechbauer), T1007.15-1009.35, T1013.35-38 (Gendy).

⁸⁸⁷ Transcript of the Commission, 23 February 2024, T910.3-911.9 (Rechbauer).

⁸⁸⁸ Transcript of the Commission, 23 February 2024, T910.3-911.9 (Rechbauer).

⁸⁸⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.8] [SCI.0011.0814.0001 at 0116].

- 20.63. Further, the incorporation of clinical feedback into the evaluation of tenders is heavily dependent on whether clinicians have provided feedback to the relevant category managers or clinical product managers which was then passed on and taken into account in the tender evaluation process;⁸⁹⁰ and whether clinicians happened to be available and selected as LHD representatives on tender evaluation committees.⁸⁹¹ While clinicians at the LHD level may be involved in tender processes, they do not ordinarily have input into the negotiation of a contract, which can lead to problems later.⁸⁹²
- 20.64. In its written submissions addressing this issue, NSW Health accepted that there is an “opportunity” to better document the importance of engaging clinical expertise throughout the lifecycle of a procurement process, not only at the planning stages, but during the product specification and negotiation phases.⁸⁹³ Once again, I agree.
- 20.65. As noted above, whether the ACI or CEC becomes involved in a particular tender process is *ad hoc*, and seemingly up to the individual tender evaluation committee to decide.⁸⁹⁴ In its written submissions, NSW Health recognise this as:⁸⁹⁵
- an area of future opportunity, whereby HealthShare NSW can work with Ministry, Agency for Clinical Innovation and Clinical Excellence Commission to test how value-based healthcare can better be integrated into procurement processes from end to end.*
- 20.66. The current approach to value in NSW Health procurement processes might result in some tenders being conducted in a way that supports and promotes value based healthcare. But the absence of a documented and systematic approach to the consideration of value based measures and factors means there are currently no processes, plans or structures in place to ensure that this occurs consistently.
- 20.67. Those difficulties do not only arise in the context of tenders. No specific guidance is given on how to assess concepts of value when procuring lower value goods or services on PCards or VCards,⁸⁹⁶ or when local organisations procure goods or services on established whole of NSW Government or whole of NSW Health contracts. It is obviously desirable to balance the need to include value based

⁸⁹⁰ Transcript of the Commission, 23 February 2024, T902.41-904.42 (Rechbauer).

⁸⁹¹ Transcript of the Commission, 23 February 2024, T904.44-907.40 (Rechbauer).

⁸⁹² Transcript of the Commission, 21 February 2024, T702.7-35 (Kokkinakos), T727.21-728.13 (Anderson).

⁸⁹³ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.11] [SCI.0011.0814.0001 at 0117-0118].

⁸⁹⁴ Transcript of the Commission, 23 February 2024, T906.35-907.20 (Rechbauer).

⁸⁹⁵ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.12] [SCI.0011.0814.0001 at 0118].

⁸⁹⁶ See Exhibit B.23.32, *PD2022_038 Procurement Cards within NSW Health* (2 September 2022) p 6 [MOH.0001.0298.0001 at 0009]: Procurement Cards (PCards) are a credit card issued by the Card Issuer (generally a bank, building society or credit union) which is used by Cardholders (as government officers) to engage in transactions relating to the purchase of goods and services on behalf of the GSF agency; and Virtual Cards (VCards) are a credit card that is not issued as a physical card, rather a 16-digit number provided to a supplier for use in card-not-present transactions. The VCard card is not linked to a Cardholder but is established in the GSF agency's name (with one or many users).

considerations into procurement activities, and the need for much of it to occur at the local level as quickly and efficiently as possible. However, currently, there does not appear to have been any substantive attempt to strike that balance for procurement activities that do not involve a tender process.

- 20.68. There are also limited structures for supplier engagement and feedback that might support a more detailed assessment of value. In this respect, suppliers report receiving limited guidance from NSW Health for advancing value based product offerings.⁸⁹⁷ Attempts to do so have been met, both in HealthShare and at the LHD level, with a continued “strong focus” on achieving the lowest price or cost.⁸⁹⁸
- 20.69. Two primary pathways by which a supplier could bring to the attention of NSW Health an advance or development in medical technology that could benefit NSW patients were identified by Mr Gendy. They are: by a representative of the supplier raising it with a clinician within the system, or during the process of “refreshing” standing offer agreements, which enables new technologies to be added through the supplier panel.⁸⁹⁹ Both are somewhat *ad hoc*, although the proposed “supplier forums” (if pursued) appear likely to promote better dialogue between NSW Health representatives and suppliers in relation to future procurement activities and offerings.⁹⁰⁰
- 20.70. That HealthShare has not (to date) engaged in a process of systematically embedding value based healthcare into its procurement processes is likely to have been at least partly a function of the fact that the KPIs set out in its Statement of Service do not require it to do so in any substantive way. While one of the “achievement statements” in its *2023–24 Statement of Service* is that “[s]uccessful [value-based healthcare] initiatives are scaled and applied at a local and State level”, only one of the three “actions” directed to that achievement relates to procurement, which requires HealthShare to:⁹⁰¹

[c]omplete a refresh of all Procurement category strategies with input from across the system including identification of opportunities to drive better value and eliminate inefficiencies.

- 20.71. Further, while the *2024–25 Statement of Service* for HealthShare refers to the *Future Health Strategic Framework*, it does not include any statements of achievement or delivery actions that refer to value.⁹⁰²

⁸⁹⁷ Exhibit B.16, Statement of Paul Dale (14 February 2024) [4.1]-[4.3] [SCI.0003.0001.0022 at 0024-0025].

⁸⁹⁸ Exhibit B.16, Statement of Paul Dale (14 February 2024) [2.1.1.1] [SCI.0003.0001.0022 at 0023]; Transcript of the Commission, 20 February 2024, T617.30-618.39 (Dale).

⁸⁹⁹ Transcript of the Commission, 23 February 2024, T1015.1-35 (Gendy).

⁹⁰⁰ Transcript of the Commission, 23 February 2024, T913.6-20 (Rechbauer), 1014.12-37 (Gendy).

⁹⁰¹ Exhibit B.23.129, *HealthShare NSW Statement of Service 2023-24* (9 February 2024) p 19 cl 6.1.1.1.20 [MOH.9999.0010.0001 at 0020].

⁹⁰² Exhibit O.67, *HealthShare NSW Statement of Service 2024-25* (9 August 2024) [SCI.0011.0895.0001].

- 20.72. There are some local initiatives in some LHDs that seek to build value based healthcare into their local procurement processes. For example, South Western Sydney LHD has established a Strategic Advisory Procurement Board, which is tasked with advising and decision making on “strategic and value based procurement of goods and services including redevelopment activity, asset replacement, and ICT”.⁹⁰³ One of the matters that the Board must consider for a procurement proposal is “healthcare centred solutions with clinical engagement and evaluation”.⁹⁰⁴ That is sought to be achieved through the Board being required to consider not only the financial cost of a proposed procurement activity, but also whether it will achieve value, which is assessed by reference to the nature of the good or service in question.⁹⁰⁵ The Board has at least two members with a clinical background,⁹⁰⁶ and category managers generally consult with relevant clinical staff before presenting a proposal.⁹⁰⁷
- 20.73. However, the extent to which the Strategic Advisory Procurement Board is effective in implementing value based healthcare in South Western Sydney LHD’s procurement processes is not entirely clear, and it is apparent that its activities are heavily focussed on limiting costs and achieving savings and efficiencies.⁹⁰⁸ It is understandable, in the environment of intense budgetary pressure that prevails within NSW Health, that local procurement activities will be heavily influenced by financial savings and efficiencies, even in circumstances where effort is made to incorporate value based healthcare.
- 20.74. That only serves to highlight the need for the Ministry of Health and HealthShare to communicate clearly what the concept value based healthcare entails, and how it should be measured and assessed, to those with responsibility for procurement across the system, from facility and service levels up. Those principles must be embedded in a systematic manner throughout every level of procurement processes within NSW Health, rather than by local organisations adopting their own approach. That is not to say that what constitutes value will not be informed by local considerations and needs. But if there is to be a consistent, system wide approach to procurement (and healthcare spending generally) that supports the pursuit of value based healthcare, there must be clear guidance on what that means, and how it is to be assessed and measured.

⁹⁰³ Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 6 [MOH.0001.0423.0001 at 0002].

⁹⁰⁴ Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 7 [MOH.0001.0423.0001 at 0002].

⁹⁰⁵ Transcript of the Commission, 22 February 2024, T802.46-803.41 (Marshall).

⁹⁰⁶ Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 2 [MOH.0001.0423.0001 at 0001].

⁹⁰⁷ Transcript of the Commission, 22 February 2024, T801.23-34 (Marshall).

⁹⁰⁸ Transcript of the Commission, 22 February 2024, T774.10-33 (Clancy).

- 20.75. That is squarely within the remit of the Ministry of Health as system manager to drive forward. It has been done in other contexts. The ACI's *Value-based surgery: Clinical practice guide* describes a process for implementing value based care in surgical practice, including matters such as consultation requirements.⁹⁰⁹

Equity in procurement

- 20.76. The means by which equity in procurement – both in the sense of health equity and equity in the participation in the procurement process – is to be achieved across NSW Health agencies is somewhat unclear. For example:
- a. there are no substantive references to equity in the NSW Health Procurement Policy or Procedures;⁹¹⁰
 - b. there is no specific reference to procurement in the *Regional Health Strategic Plan*, except in the context of environmental sustainability;⁹¹¹
 - c. aside from referring to the general objectives in the *Future Health Plan* and *Regional Health Plan*, the only express reference to equity with any specified action in HealthShare's *2023–24 Statement of Service* is in the context of measuring “timely and equitable access” to services, for which the only specified action is developing and implementing dashboards for the Patient Transport Service (that is, nothing to do with procurement);⁹¹²
 - d. little has changed in its *2024–25 Statement of Service*, in which the only reference to equity is the context of influencing the redesign of services to achieve health equity among the First Nations population;⁹¹³ and
 - e. equity is not a concept that appears at all in HealthShare's most recent strategic plan.⁹¹⁴
- 20.77. This is not to say that NSW Health does not take the concept of equity seriously.
- 20.78. A key objective in the *Future Health Plan* is to “[s]trengthen equitable outcomes and access for rural, regional and priority populations”.⁹¹⁵ Similarly, NSW Health's *NSW Regional Health Strategic Plan 2022–2032* is dedicated to NSW Health's vision for

⁹⁰⁹ Exhibit B.23.64, NSW Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023) [MOH.0001.0282.0001].

⁹¹⁰ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp 20–21 cl 6.14 [MOH.0001.0037.0001 at 0024–0025]; Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) p 46 cl 6.17.4 [MOH.0001.0366.0001 at 0046].

⁹¹¹ Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) pp 63, 67 [MOH.0001.0372.0001 at 0063, 0067].

⁹¹² Exhibit B.23.129, HealthShare NSW, *Statement of Service 2023–24* (9 February 2024) p 17 cl 2.1.1.1.10 [MOH.9999.0010.0001 at 0018].

⁹¹³ Exhibit O.67, *HealthShare NSW Statement of Service 2024–25* (9 August 2024) p 5 [SCI.0011.0895.0001 at 0006].

⁹¹⁴ Exhibit B.23.38, HealthShare NSW, *Strategic Plan 2020–2024* (13 October 2020) [MOH.0001.0328.0001].

⁹¹⁵ Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022–2032* (May 2022) p 8 [MOH.0001.0320.0001 at 0008].

“[a] sustainable, equitable and integrated health system delivering outcomes that matter most to patients and the community in regional, rural and remote NSW”.⁹¹⁶ There have also been several initiatives that promote equity of access to services across the State, including virtual health care.⁹¹⁷ The recent NSW Medicines Formulary project also had as one of its aims equity of access to medicines for all patients in NSW.

- 20.79. There are also several initiatives (including at the State level) directed to equitable participation in procurement processes by Aboriginal businesses (i.e., one that has at least 50 per cent Aboriginal ownership).⁹¹⁸ Consistent with that approach, NSW Health has developed its own *Aboriginal Procurement Participation Strategy*,⁹¹⁹ and HealthShare has, (for some time) included a requirement for Aboriginal Participation Plans in relation to all goods and services over a certain threshold.⁹²⁰ Similarly, the *NSW Government Small and Medium Enterprise and Regional Procurement Policy* seeks to increase procurement opportunities for small and medium enterprises, including those in the regions, across NSW Government procurement activities.⁹²¹ All of those State level policies must be adhered to by NSW Health in its procurement activities.⁹²²
- 20.80. However, equity – whether of access to health services or in the procurement processes itself – is not a concept that seems to have been systematically embedded across the breadth of NSW Health’s procurement processes. As much was seemingly accepted by NSW Health in its written submissions, when it accepted that there was “scope” for further analysis of the use of its purchasing power to better achieve equity in the system.⁹²³
- 20.81. One reason why that has not occurred to date is that it has been seemingly assumed that increasing centralisation of procurement will inevitably lead to greater equity. In this respect, Mr Gendy gave evidence that:⁹²⁴

Centralised procurement also enables greater savings to be achieved by harnessing system purchasing power to obtain whole of health volume discounts from suppliers, which enables equitable procurement across geographic areas.

⁹¹⁶ Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) p 14 [MOH.0001.0372.0001 at 0014].

⁹¹⁷ See, for example, Exhibit B.23.67, NSW Health, *NSW Virtual Care Strategy 2021-2026* (February 2022) [MOH.0001.0371.0001].

⁹¹⁸ Exhibit B.23.21, *NSW Government Aboriginal Procurement Policy* p 2 (January 2021) [MOH.0001.0277.0001 at 0004].

⁹¹⁹ Exhibit B.23.115, *NSW Health Aboriginal Procurement Participation Strategy* (March 2022) [MOH.0001.0276.0001]

⁹²⁰ Exhibit B.23.115, *NSW Health Aboriginal Procurement Participation Strategy* (March 2022), p 4 [MOH.0001.0276.0001 at 0006].

⁹²¹ Exhibit B.23.18, *NSW Government Small and Medium Enterprise and Regional Procurement Policy* p 6 [MOH.0001.0417.0001 at 0006].

⁹²² Exhibit B.5, Statement of Michael Gendy (31 January 2024), [46], [78], [79] [MOH.0001.0434.0001 at 0012, 0027-0028].

⁹²³ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.15] [SCI.0011.0814.0001 at 0119].

⁹²⁴ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [87] [MOH.0001.0434.0001 at 0030].

- 20.82. Similarly, Ms Rechbauer referred (albeit in the context of other shared services) to increasing “service equity across metropolitan and regional LHDs” by increasing centralisation and standardisation of those services.⁹²⁵ She was insistent when giving evidence that Statewide contracts achieve “the best price for the State” and thereby “maximise equity across the system over time”.⁹²⁶
- 20.83. The proposition that Statewide or whole of health contracts result in the best price across the system appears to be based on the logic that the State (represented by HealthShare) has greater purchasing power, and therefore greater negotiating power, than individual LHDs or other local organisations negotiating separately.⁹²⁷
- 20.84. There is a natural attraction to that proposition. But it is not apparent that the underlying premise holds in the context of the wider public health system in this State, or that it has been meaningfully tested. For example, there is a view held by some metropolitan LHDs that they could achieve lower prices for some products and services if they were at liberty to procure them directly.⁹²⁸ Mr Gendy said that if an LHD approached him with evidence that it was worse off under a Statewide contract, then he would “look at how we can adjust that”, although his view remained that the system as a whole would be better off because of the Statewide contract.⁹²⁹ Similarly, Ms Rechbauer’s evidence was that there may be occasions on which a supplier is permitted to offer a lower price to a particular local organisation under a Statewide contract, but this would need to come through HealthShare, and would be determined by HealthShare on an *ad hoc* basis having regard to “how that will impact the system”.⁹³⁰ The extent to which this actually occurs, or how it is determined whether or to what extent differential pricing “will impact the system”, is not apparent.
- 20.85. There are also aspects of the current approach that might be said to leave rural and regional LHDs in a worse position. For example, in relation to goods supplied through the Onelink warehouse, non-metropolitan LHDs bear the cost of transporting goods from the warehouse to their facilities.⁹³¹ There is evidence that some suppliers are unwilling or unable (at least in a timely way) to supply to rural and remote facilities

⁹²⁵ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [125]-[126] [MOH.9999.0009.0001 at 0034].

⁹²⁶ Transcript of the Commission, 23 February 2024, T894.10-33 (Rechbauer).

⁹²⁷ See, for example, Transcript of the Commission, 23 February 2024, T894.45-895.11 (Rechbauer).

⁹²⁸ See, for example, Exhibit B.4, Statement of Dr Teresa Anderson AM (31 January 2024) [114] [MOH.0001.0258.0001 at 0030]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [46] [MOH.0001.0261.0001 at 0011]; Transcript of the Commission, 21 February 2024, T746.46-747.26 (Anderson); Transcript of the Commission, 22 February 2024, T781.44-782.44 (Clancy), T813.38-815.14 (Marshall).

⁹²⁹ Transcript of the Commission, 23 February 2024, T1006.41-1007.13 (Gendy).

⁹³⁰ Transcript of the Commission, 22 February 2024, T887.4-889.16 (Rechbauer); Transcript of the Commission, 23 February 2024, T895.13-30 (Rechbauer).

⁹³¹ See, for example, Exhibit B.8, Statement of Mark Spittal (6 February 2024) [69]-[71] [MOH.0001.0263.0001 at 0015-0016]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [55] [MOH.9999.0007.0001 at 0016]; Transcript of the Commission, 23 February 2024, T896.44-897.30 (Rechbauer).

despite being under Statewide contracts.⁹³² In these circumstances, Statewide contracts do not appear to be achieving equity.

- 20.86. It may be that Statewide contracts with a uniform pricing structure are, in fact, the best available means of achieving equity in procurement at a system wide level. There may also be other benefits to standardisation that can only be achieved by such an arrangement. While there will inevitably be “swings and roundabouts”, the overall benefit to the system might justify such an approach. But these matters cannot be assumed. Having regard to the size of the procurement activities conducted across NSW Health, they must be tested and monitored through careful modelling and analysis. Through such modelling and analysis of its procurement strategies, NSW Health should be in a position to properly assess whether its approach has promoted equity across the system.
- 20.87. Ultimately, the principal object of centralised procurement should be to ensure that NSW Health achieves the best value for money spent. Only through careful modelling will it be possible for HealthShare to determine which arrangement will deliver greatest value to the entire system. If that arrangement results in rural and remote LHDs paying more for a particular item, or incurring significant freight costs in having goods delivered from a centralised warehouse, it may be that equity can only be achieved through adjustments to the funding provided to those LHDs, rather than seeking to equalise pricing through procurement in a manner that risks system wide value.

Measuring the effectiveness of procurement

- 20.88. Any gains that may be made through improvements in processes, including through embedded principles of value, are at risk of being lost unless there are robust processes to monitor performance, and manage suppliers. These post procurement processes of monitoring and evaluation – often referred to as being within the realm of “contract management” – are “a crucial part of the procurement lifecycle”.⁹³³
- 20.89. That contract management function is generally conducted by the entity with responsibility for the contract. This means whole of NSW Government contracts relevant to NSW Health, or whole of NSW Health contracts are managed by HealthShare, except those relating to ICT, which are managed by eHealth.⁹³⁴ HealthShare also has a role in managing contracts for which it tenders on behalf of a

⁹³² Exhibit B.8, Statement of Mark Spittal (6 February 2024) [71] [MOH.0001.0263.0001 at 0016]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [53] [MOH.9999.0007.0001 at 0015].

⁹³³ Transcript of the Commission, 23 February 2024, T1013.3-4 (Gendy).

⁹³⁴ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49] [MOH.9999.0009.0001 at 0015]; Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [69] [MOH.0001.0433.0001 at 0029]; Transcript of the Commission, 23 February 2024, T1010.36-1011.5 (Gendy).

local organisation (generally contracts exceeding \$250,000 in value).⁹³⁵ Local contracts are otherwise managed by the relevant local organisation.

- 20.90. An immediate difficulty is that those responsibilities of HealthShare and eHealth are not clearly formalised or outlined. Neither the HealthShare Board's delegation of functions⁹³⁶ nor eHealth's determination of functions⁹³⁷ refers expressly to contract management as one of their functions or responsibilities. It is not a concept that appears in either organisation's most recent strategic plans except, in eHealth's case, for a high level reference to seeking to achieve "a more adaptive approach to vendor management".⁹³⁸ At least on their face, none of HealthShare's "Procurement and Supply Chain KPIs" in its most recent Statement of Service measure its effectiveness in contract management,⁹³⁹ and there is no specific reference to contract management at all.⁹⁴⁰ The section of the NSW Health Procurement Policy dealing with contract management is mostly addressed to local agencies, with little reference to HealthShare or eHealth.⁹⁴¹
- 20.91. However, the NSW Health Procurement Procedures contemplate HealthShare and eHealth being involved in contract management, and set out detailed procedures that those responsible for contract management are supposed to follow (including monitoring performance).⁹⁴² Given a core function of those organisations is procurement, their role in the critical areas of contract and supplier performance management should be clearly set out in their Statements of Service and reflected in measurable KPIs, not a procedural document.
- 20.92. In any event, the evidence supports a conclusion that the "contract management" functions of HealthShare and eHealth need to be strengthened. In this respect, while HealthShare has regular meetings with suppliers,⁹⁴³ there is presently no substantive system wide monitoring of the extent to which suppliers are complying with KPIs in their respective contracts.⁹⁴⁴ Instead, issues with suppliers generally make their way to HealthShare only when raised from the local organisation or facility level, which

⁹³⁵ Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [119] [MOH.9999.0009.0001 at 0011, 0032]; Transcript of the Commission, 22 February 2024, T880.15-23 (Rechbauer).

⁹³⁶ Exhibit B.23.37, Delegation of Functions of the Healthcare Board (29 November 2012) [MOH.0001.0308.0001].

⁹³⁷ Exhibit B.23.124, Instrument of Establishment – eHealth NSW (2 June 2023) [MOH.0001.0312.0001].

⁹³⁸ Exhibit B.23.66, NSW Health, *eHealth Strategy for NSW Health 2016-2026* p 12 [MOH.0001.0254.0001 at 0016]; See also, Exhibit B.23.38, HealthShare NSW, *Strategic Plan 2020-2024* (13 October 2020) [MOH.0001.0328.0001].

⁹³⁹ Exhibit O.67, HealthShare NSW, *Statement of Service 2024-25* (9 August 2024) p 13 [SCI.0011.0895.0001 at 0014].

⁹⁴⁰ Exhibit O.67, HealthShare NSW, *Statement of Service 2024-25* (9 August 2024) [SCI.0011.0895.0001].

⁹⁴¹ Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) cl 7 [MOH.0001.0037.0001 at 0026-0031].

⁹⁴² Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) pp 51-67 s 7 [MOH.0001.0366.0001 at 0051-0067].

⁹⁴³ See, for example, Transcript of the Commission, 23 February 2024, T902.11-19 (Rechbauer).

⁹⁴⁴ Transcript of the Commission, 23 February 2024, T902.41-904.42 (Rechbauer), T1011.20-22 (Gendy).

generally occurs only when the problem has become serious.⁹⁴⁵ Even in those circumstances, HealthShare’s responsiveness is perceived as being variable.⁹⁴⁶

- 20.93. To the extent there is monitoring of supplier KPIs by HealthShare, those with responsibility for procurement at the local level do not receive adequate feedback or have adequate visibility of data about the performance of Statewide suppliers, or even, at least in some cases, what their KPIs are.⁹⁴⁷ That significantly limits their ability to identify instances of poor performance, the effects of which are borne by the local organisation.⁹⁴⁸
- 20.94. There is also no clear process or method for evaluating whether the procurement actually achieved value. While, as set out above, notions of value are considered as part of tender evaluations,⁹⁴⁹ there does not appear to be any clear approach or method by which an assessment is made as to whether that value was ultimately delivered. Ms Rechbauer did not know whether there was any process for monitoring particular outcomes that may have been important in the decision making for a procurement activity, or whether local organisations were instructed to do so.⁹⁵⁰ Similarly, Mr Gendy said that he was not involved in monitoring the effectiveness of procurement in achieving patient outcomes, including those outcomes that may have been featured in the tender evaluation process.⁹⁵¹
- 20.95. The NSW Health Procurement Procedures, which provide the most detailed guidance to local organisations about their contract management responsibilities, do not refer expressly to monitoring whether a contract has actually achieved value in any relevant sense. What they require is that contract managers monitor and review “contractual performance measures”.⁹⁵²
- 20.96. In October 2019, the NSW Auditor-General reported to Parliament in October 2019 that, among other things, HealthShare “is not applying the capability needed to effectively manage high-value (over \$250,000) goods and services contracts”, and was not complying with the directions given to it by the Ministry of Health in relation

⁹⁴⁵ See, for example, Transcript of the Commission, 20 February 2024, T640.18-26 (Misevska), 775.39-47 (Clancy); See also, Transcript of the Commission, 23 February 2024, T920.41-921.31, T938.34-939.29 (Rechbauer), T1011.7-13 (Gendy).

⁹⁴⁶ See, for example, Transcript of the Commission, 21 February 2024, T757.36-758.4, T769.42-770.5 (Swingler), T715.26-32 (Kokkinakos); cf Transcript of the Commission, 22 February 2024, T777.15-21 (Clancy).

⁹⁴⁷ See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [88] [MOH.0001.0260.0001 at 0025]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [52] [MOH.0001.0261.0001 at 0012]; Transcript of the Commission, 20 February 2024, T588.10-21 (Vinton); Transcript of the Commission, 21 February 2024, T660.40-661.8, T672.18-673.25 (Chiumento); cf Transcript of the Commission, 22 February 2024, T777.5-13 (Clancy).

⁹⁴⁸ See, for example, Transcript of the Commission, 21 February 2024, T672.18-673.25 (Chiumento), T732.47-733.16, T743.45-744.21 (Anderson).

⁹⁴⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.22] [SCI.0011.0814.0001 at 0121].

⁹⁵⁰ Transcript of the Commission, 23 February 2024, T920.22-39 (Rechbauer).

⁹⁵¹ Transcript of the Commission, 23 February 2024, T1010.18-22 (Gendy).

⁹⁵² Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) pp 61-62 cl 7.6.1 [MOH.0001.0366.0001 at 0061-0062].

to contract management for over 80 per cent of the contracts it managed.⁹⁵³ The Auditor-General specifically found that “HealthShare’s contract management practices are limited by inadequate performance monitoring”, noting that HealthShare had advised it did “not have the capacity to closely manage individual contract performance, and even if it did, it does not have the information to do so”.⁹⁵⁴ The Auditor-General also noted HealthShare’s advice that its contract management approach “primarily involves HealthShare contract managers relying on information they receive from contract users and suppliers”.⁹⁵⁵

- 20.97. The Procurement Reform Program was in part a response to the NSW Auditor-General’s report to Parliament in October 2019 and was implemented with a view to having a material impact on the contract management issues identified by the Auditor-General.⁹⁵⁶ In doing so, one of the actions taken was to implement the new “Operating Model”, which included a new framework for contract management that included funding 76 additional full time equivalent (FTE) staff over two years across LHDs, HealthShare, eHealth and NSW Health Pathology to perform contract management.⁹⁵⁷ Appropriate levels of resourcing are clearly critical. However, it does not follow that an increase in FTE will result in improved contract management across the system unless there are clear and effective structures and procedures for that to occur.

⁹⁵³ Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) p 2 [MOH.0001.0013.0001 at 0006].

⁹⁵⁴ Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].

⁹⁵⁵ Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].

⁹⁵⁶ Transcript of the Commission, 23 February 2024, T960.9-961.18 (Rechbauer).

⁹⁵⁷ Transcript of the Commission, 23 February 2024, T960.9-961.18 (Rechbauer), T1012.43-1013.4 (Gendy); Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)] [MOH.0001.0434.0001 at 0006, 0021-0022].

Conclusion

20.98. NSW Health has done much to improve its procurement processes in recent times. Those improvements have resulted in significant benefits to the system. However, there is more that can – and should – be done, to embed concepts of value into those processes. Not only with that approach result in enhancements to the procurement process, it is likely to deliver wider system benefits.

Recommendation 35: NSW Health should develop and implement a systematic approach to embedding value based healthcare in its procurement processes, including developing and implementing clear and specific processes for:

- a. determining the components of value that are to be pursued in a particular procurement process;
- b. evaluating different options for procurement, including tenders, against each of those components of value;
- c. formalising and clarifying the role of CEC and the ACI in the procurement function, including by identifying the circumstances when and how those agencies should be involved in procurement activities;
- d. consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts, in procurement processes.

20.99. I note that in its written submissions NSW Health observed that a recommendation to that effect was consistent with one of the Strategic Procurement Branch's actions identified in the *Future Health Report*.⁹⁵⁸ I take that submission to mean that Strategic Procurement Branch will work with HealthShare NSW, eHealth NSW, the ACI, and the CEC to develop and then disseminate principles of value based procurement across the system, and suppliers and industry, in order to promote value based procurement across the system.⁹⁵⁹ That is a welcome development that should not only be pursued, but formalised in relevant NSW Health policy.

⁹⁵⁸ Exhibit B.5, Statement of Michael Gendy (31 January 2024) [48(h)] [MOH.0001.0434.0001 at 0016].

⁹⁵⁹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.4] [SCI.0011.0814.0001 at 0115].

Recommendation 36: NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers at a system wide level, including developing and implementing clear and specific processes for:

- a. formulating clear and measurable KPIs, including with reference to value based criteria applied in the procurement process;
- b. monitoring those KPIs, including designating clear lines of responsibility for performing that monitoring; and
- c. obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.



Chapter 21:

Innovation

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Introduction

- 21.1. Innovation has been a constant and important feature of healthcare systems across the world.
- 21.2. The constant pursuit of medical innovation – from the development of cutting edge technologies to the implementation of breakthrough treatment methods (including new drugs) and the implementation of enhanced clinical practices – has been essential to the significant improvements in patient outcomes that have been achieved over time. What were once life threatening conditions are now manageable with relatively little intervention, and life expectancy rates have consistently risen as a result. Innovation has also driven efficiencies in the delivery of care that are essential to the sustainability of the public health system.
- 21.3. However, the concept of “innovation” is likely to mean different things to different people. What might be seen as innovative to some could be seen as a natural development or enhancement of existing approaches by others. The ACI describes innovation in the healthcare context as “new technologies or treatment, renewal or transformation of clinical practice, or the introduction of new ways of working”.⁹⁶⁰
- 21.4. With developments in medical research and technology emerging at an ever increasing rate – a pace that is likely to increase with advances in technology – how the NSW public health system develops, assesses, harnesses and ultimately deploys innovations will be increasingly important. Whatever the future may hold for the healthcare sector, the NSW public health system must be ready to adapt to what may be significant developments in technology, treatments, and clinical practice for the benefit of the system and those it cares for.

Types of innovation

- 21.5. The Terms of Reference identified three main types of innovation to be considered during this Special Commission; those being clinical innovations, workforce innovations, and funding innovations. In many respects, they are interrelated. For example, a clinical innovation may be founded on a technical innovation and may in turn drive the development of a new model of care. Workforce innovations and changes to scope of practice may be required to implement and harness the benefit of clinical innovations, and new funding models may be necessary to scale new models of care across the system.

⁹⁶⁰ Exhibit B.23.50, Agency for Clinical Innovation, *Strategy 2023–2026*, p 3 [MOH.0001.0350.0001 at 0003].

Clinical innovations

- 21.6. Generally, clinical innovations encompass new techniques, methods, processes, or treatments that are administered to patients,⁹⁶¹ and include new therapeutics, new models of care, and technical innovations.

New therapeutics

- 21.7. Some examples of new and advanced therapeutics that have been developed, including in NSW, are:⁹⁶²
- a. bacteriophage therapy for patients with drug resistant infections, which use viruses to specifically target pathogenic bacteria;
 - b. gene therapies, a form of personalised medicine (i.e., a treatment that is designed and customised to the unique needs and circumstances of a particular patient) that modifies a person's genes to treat disease, administered through viral vector delivery; and
 - c. immune effector cell therapies for the treatment of blood cancers. These involve harvesting and reinfusing a patient's own blood cells after they have been modified so that they target and kill cancer cells.

New models of care

- 21.8. A model of care refers to the way health services are arranged and delivered, both generally or across a specific patient cohort.⁹⁶³ Models of care provide guidance to clinicians, which can enhance efficiencies and reduce unwarranted clinical variation; however, few are mandated by specific policy directives in such a way that they bind clinicians to adopt a particular course of action.⁹⁶⁴
- 21.9. The development of new models of care may involve changes in the providers of that care (or how they work together to provide care), processes, timeframes, or care settings.⁹⁶⁵ They are developed through a combination of research, data, and analysis of clinician and consumer experience.⁹⁶⁶ The ACI works with clinicians and managers to standardise existing models of care, and develop new models of care, across health facilities.⁹⁶⁷

⁹⁶¹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [61] [MOH.0001.0435.0001 at 0018].

⁹⁶² Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [64] [MOH.0001.0435.0001 at 0019–0020]; Exhibit N3.10, Statement of Olivia Hibbitt (18 June 2024) [13] [MOH.0006.0008.0001 at 0003].

⁹⁶³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [44] [MOH.0001.0435.0001 at 0013].

⁹⁶⁴ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [45] [MOH.0001.0435.0001 at 0013]; Transcript of the Commission, 26 February 2024, T1051.32–38 (Levesque).

⁹⁶⁵ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [44] [MOH.0001.0435.0001 at 0013].

⁹⁶⁶ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [45] [MOH.0001.0435.0001 at 0013]; Transcript of the Commission, 26 February 2024, T1050.33–1051.26 (Levesque).

⁹⁶⁷ Transcript of the Commission, 26 February 2024, T1051.40–1052.8 (Levesque). For example, current models of care in use or under development through the Agency for Clinical Innovation include the Emergency Care Assessment and Treatment program and

21.10. An example of this work is the “alternate models of care” initiative, which seeks to identify models of care that support and enhance efficiency in the delivery of healthcare and measures to reduce low value diagnostic tests and surgical procedures.⁹⁶⁸ Another is the significant development in virtual and digitally enabled care following the height of the COVID-19 pandemic that support timely management of patients, including those in rural, regional, and remote areas.⁹⁶⁹ Several LHDs have developed tailored virtual solutions for their communities to provide services to patients who might otherwise have limited access, and to provide professional support to staff in rural and remote facilities.⁹⁷⁰ Those can extend to prehospital care, “hospital in the home”, remote monitoring, and rehabilitation at home. The benefits of these new models are evidence based.⁹⁷¹

Technical innovations

21.11. Technical innovations are those that emerge through the development of new health technologies and are “interventions that substantially change the way care is delivered”; such as new tests, medical devices, or therapies.⁹⁷² They generally involve new or improved products or processes with technological features that differ significantly from what was previously available.⁹⁷³ Some examples of recent technical innovations that have been deployed across the NSW public health system include implantable medical devices (such as transcatheter aortic valve implantation) and point of care testing equipment used for pathology assays in facilities without on-site laboratory facilities.⁹⁷⁴

Workforce innovations

21.12. Examples of workforce innovations include measures to enhance greater workforce flexibility,⁹⁷⁵ recruitment and retention strategies,⁹⁷⁶ programs to create rural training

models for spinal cord injury, menopause and rehabilitation: Exhibit N3.12, Supplementary Statement of Jean-Frédéric Levesque (19 June 2024) [21]–[28] [MOH.0006.0038.0001 at 0005–0006].

⁹⁶⁸ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [53]–[56] [MOH.0001.0435.0001 at 0015–0016]; Exhibit B.23.63, NSW Health, *In brief – Alternate models of providing health care* (15 August 2023) p 4 [MOH.0001.0287.0001 at 0005]; Exhibit B.23.64, Agency for Clinical Innovation, *Value-based surgery: Clinical practice guide* (November 2023) pp 4–8 [MOH.0001.0282.0001 at 0007–0008].

⁹⁶⁹ Transcript of the Commission, 26 February 2024, T1073.46–1074.34 (Levesque).

⁹⁷⁰ Transcript of the Commission, 22 March 2024, T1712.16–37 (Ludford); Transcript of the Commission, 16 May 2024, T2963.35–2964.7 (Spittal).

⁹⁷¹ Exhibit B.23.63, NSW Health, *In brief – Alternate models of providing health care* (15 August 2023) pp 1–11 [MOH.0001.0287.0001 at 0001–0011]; Transcript of the Commission, 14 October 2024, T5669.38–5670.16 (Dominish).

⁹⁷² Exhibit N3.10, Statement of Olivia Hibbitt (18 June 2024) [5] [MOH.0006.0008.0001 at 0002].

⁹⁷³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [61] [MOH.0001.0435.0001 at 0018].

⁹⁷⁴ Exhibit B.10, Statement of Vanessa Janissen (8 February 2024) p 20 [MOH.9999.0008.0001 at 0020]; Transcript of the Commission, 19 November 2024, T6347.25–43 (Wilson). See also Exhibit B.23.68, NSW Health, *New Health Technologies and Specialised Services* (Guideline No GL2022_012, 28 October 2022) p 14 [MOH.9999.0888.0001 at 0017].

⁹⁷⁵ Exhibit H.2.36, NSW Health, *NSW Health Workforce Plan 2022-2032: A supplementary guide*, p 19 [MOH.0010.0275.0001 at 0019].

⁹⁷⁶ Exhibit H.2.36, NSW Health, *NSW Health Workforce Plan 2022-2032: A supplementary guide*, p 23 [MOH.0010.0275.0001 at 0023].

opportunities,⁹⁷⁷ and measures to support clinicians to practise at the top of their scope or, in some cases, to an expanded scope of practice. They may also include programs that support health practitioners relocate to regional and rural locations and facilitating their integration into a new community,⁹⁷⁸ as well as support staff to remain where they are needed through measures such as NSW Health Key Worker Accommodation program.⁹⁷⁹

- 21.13. The NSW Rural Generalist Single Employer Pathway is an example of a successful workforce innovation.⁹⁸⁰ That model seeks to incentivise junior doctors to pursue training in rural general practice by enabling them to train as rural generalists in primary care and hospital settings while employed in an LHD for up to four years.⁹⁸¹ One of the attractions of that model is that it gives junior doctors certainty of location, income, and working conditions, and they are able to maintain employee entitlements while gaining a wide range of experience and early exposure to rural general practice.⁹⁸² Following the success of the pilot that was conducted in the Murrumbidgee LHD, it has now been expanded to 80 training places per year in rural and regional areas.⁹⁸³
- 21.14. A clinician's scope of practice is the professional role and services that they are considered to be trained, qualified and competent to perform.⁹⁸⁴ Ensuring that (where appropriate and safe to do so) clinicians operate to the top of their scope of practice (i.e., the professional activities for which they are educated, competent, authorised and accountable) has been recognised as being one measure that can have benefits in responding to the some of the workforce challenges – including maldistribution and shortages – across the State.⁹⁸⁵ Workforce innovations that relate to scope of practice can include practitioners undertaking additional training to attain an expanded, extended or advanced scope of practice (terms that tend to be used interchangeably), for example:

⁹⁷⁷ Exhibit H.5.21, Statement of Richard Griffiths (16 July 2024) [86]–[89] [MOH.0011.0022.0001 at 0024–0027].

⁹⁷⁸ Transcript of the Commission, 19 March 2024, T1361.39–1364.24 (Stephenson).

⁹⁷⁹ Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 25 [MOH.0001.0372.0001 at 0025].

⁹⁸⁰ Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [147]–[151] [MLH.0001.0016.0001 at 0030].

⁹⁸¹ Exhibit M.8, NSW Health, *Regional Health Strategic Plan 2022–2032 - Progress Snapshot 2022–23* (November 2023) p 25 [MOH.0100.0297.0001 at 0027].

⁹⁸² Exhibit C.33.1, Statement of Jill Ludford (12 March 2024) [147]–[149] [MLH.0001.0016.0001 at 0030].

⁹⁸³ Exhibit L.3, Statement of Luke Sloane (3 October 2024) [53]–[55] [MOH.0011.0079.0001 at 0009–0010].

⁹⁸⁴ Exhibit H.2.26., Australian Government, *National Medical Workforce Strategy 2021–2031* (2021) p 85 [SCI.0011.0388.0001 at 0095]; Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 70 [MOH.0001.0372.0001 at 0070].

⁹⁸⁵ Transcript of the Commission, 15 August 2024, T4904.18–34 (Gordon); Transcript of the Commission, 28 August 2024, T5123.12–5124.29, 5130.5–37, 5152.29–33 (May); Transcript of the Commission, 17 September 2024, T5172.11–30 (Scott); Transcript of the Commission, 19 September 2024, T5383.2–14 (Grotowski).

- a. general practitioners may undertake additional training in fields such as anaesthesia or obstetrics.⁹⁸⁶ Further, new trainees, or trainees that have completed components of the general practitioner training pathway, may pursue a career as a rural generalist through the NSW Rural Generalist Single Employer Pathway;⁹⁸⁷
 - b. nurses may obtain endorsement as a nurse practitioner with an expanded scope of practice that includes the authority to prescribe some medications, request diagnostic investigations,⁹⁸⁸ and perform endoscopies;⁹⁸⁹ and
 - c. allied health practitioners can undertake further training in their respective fields to expand their scope of practice. For example, extended care paramedics are able to provide treatment to patients in the community to avoid the need for hospitalisation.⁹⁹⁰
- 21.15. While there is, of course, a need to ensure quality and safety of care in exploring any such initiatives,⁹⁹¹ and acknowledging that there are divergent views across the system in relation to this topic, in my view there is a clear need to explore scope of practice initiatives in a systematic and targeted way as part of a system wide response to current or emerging workforce supply shortages.⁹⁹²
- 21.16. Changes to the workforce mix (supported by flexible funding models) can also drive innovation in models of care, and deliver substantial benefits in efficiency, safety, and health outcomes. An excellent example was given by Jerry Yik, Head of Policy and Advocacy, Advanced Pharmacy Australia, and Dr Jonathan Penm, Vice Chair NSW Branch Committee, Advanced Pharmacy Australia and Associate Professor and NHMRC Emerging Leadership Fellow, University of Sydney, School of Pharmacy, who described the benefits to be derived from what, in relative terms, would be a modest increase in the pharmacy workforce.⁹⁹³ Greater utilisation of pharmacists in

⁹⁸⁶ Exhibit H.1.92, Royal Australian College of General Practitioners, *Australian General Practice Training Program Guide* (2024) pp 11–12

⁹⁸⁷ See, e.g., Exhibit C.33.1, Statement of Ms Jill Ludford (12 March 2024) [147]–[151] [MLH.0001.0016.0001 at 0030]; Transcript of the Commission, 18 March 2024, T1159.22–1160.11 (Christmas).

⁹⁸⁸ Exhibit H.3.47, *NSW Health Nurse Practitioners* (Policy Directive No PD2022_057, 6 December 2022) pp i, 3 [MOH.0010.0031.0001 at 0002, 0006]; Transcript of the Commission, 22 March 2024, T1663.44–1666.7 (Bruce)

⁹⁸⁹ Transcript of the Commission, 22 March 2024, T1665.12–42 (Bruce).

⁹⁹⁰ Exhibit B.23.23, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, 31 May 2022) p 41 [SCI.0001.0010.0001 at 0041]; Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) p 59 [MOH.0001.0372.0001 at 0059].

⁹⁹¹ Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022–2032* (February 2023) pp 18–19 [MOH.0001.0372.0001 at 0018–0019].

⁹⁹² Exhibit H.2.36, NSW Health, *NSW Health Workforce Plan 2022–2032: A supplementary guide*, pp 19, 22 [MOH.0010.0275.0001 at 0019, 0022]; Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 113 [SCI.0011.0585.0001 at 0118].

⁹⁹³ Unlike other aspects of the workforce, there is currently not a shortage of workforce supply to support a greater utilisation of pharmacists in the hospital setting.

the acute care setting, working collaboratively with the medical workforce in delivering care, has been demonstrated to:⁹⁹⁴

...[reduce] the burden upon medical staff and clinical resourcing dedicated to medication charting, and [increase] the through put of patients since medications are already reviewed and accurately charted prior to admission and available to the admitting medical or surgical team ... these collaborative approaches to care, provides an opportunity for education and credentialed pharmacists can educate junior medical staff regards to safe prescribing practices.

- 21.17. Ample evidence of the benefits of that model (including in delivering better patient outcomes) can be found in medical literature and the experience of patients receiving care in hospitals in Victoria and Queensland, where those models of care are routinely utilised.⁹⁹⁵ At present, those benefits are not being realised in NSW, in part due to a lack of planning and appropriate funding.
- 21.18. As Dr Penm observed (drawing on his experience within the public health system and as an educator of the future pharmacy workforce at the University of Sydney, School of Pharmacy):⁹⁹⁶

We have lots of people wanting to work in hospital. We just don't have enough positions for them to have. And then those that are in there, the pay structure doesn't reward them for their contribution. When you're talking about the restructuring, we often get those requests that say this hospital is implementing a new service, implementing more emergency department beds, implementing more wards. They will tell us how amazing those new facilities are, the new doctors they will hire for it, the new nurses they will hire for it. But in the pharmacy, we go, "So, are we getting anything?" "No". Pharmacy is generally not considered when it comes to new services and we've just been taking that load on and on and on and we've just got to this point now that our ratios just seem vastly lower than other states.

- 21.19. That is but one example of the significant benefit that can be achieved through (in the context of the wider system) modest changes to the workforce mix and workflows to drive the development of models of care for the benefit of the system as a whole.

⁹⁹⁴ Exhibit L.13, Statement of Jerry Yik and Dr Jonathan Penm (September 2024), p 11 [SCI.0011.0459.0001 at 0011].

⁹⁹⁵ Transcript of the Commission, 16 October 2024, T5766-5787 (Yik/Penm).

⁹⁹⁶ Transcript of the Commission, 16 October 2024, T5771.22-37 (Penm).

Funding innovations

- 21.20. Funding innovations can include new funding models or approaches, including those designed to better support and incentivise the delivery of care that meets the needs of the population and supports the sustainability of the system as a whole.
- 21.21. New funding models can also support the delivery of value across the system. For example, funding models that incentivise the delivery of outcomes, rather than those that reward volume (outputs), can support the delivery of value by reducing the cost of outcomes achieved, or improving outcomes without necessarily increasing expenditure. That approach can also enhance patient involvement in decision making, encourage providers to improve quality and safety, optimise resource allocation, reduce health inequalities, and drive reform.⁹⁹⁷
- 21.22. There are some examples of similar approaches being pursued in other jurisdictions, including:⁹⁹⁸
- a. Denmark revised its activity based funding (ABF) model with a view to removing low value care;
 - b. in the United States, some providers have 40 per cent of their revenue managed under value based care contracts;
 - c. in Norway, bundled payment contracts have been introduced for dialysis, some high cost treatment programs, and hip replacement surgery; and
 - d. the National Health Service of England has introduced a “best practice tariffs” scheme, which rewards providers who deliver high quality care through defined care pathways, with the aim of reducing unwarranted clinical variation across the system for certain conditions.
- 21.23. The collaborative commissioning initiative is an example of a new approach to funding that has been used in NSW. Collaborative commissioning involves pooling State, Commonwealth, and other resources (as relevant), and using those pooled resources to commission services that are targeted to meet the specific needs of a given community.⁹⁹⁹ Those initiatives are primarily driven by LHDs and PHNs (in consultation with other stakeholders) and focus on identified needs within the relevant community.¹⁰⁰⁰ That model is an example of an initiative that seeks to overcome the fragmented nature of the healthcare funding and delivery in Australia.

⁹⁹⁷ Exhibit M.21, PwC, *Funding for value* (2018) p 5 [SCI.0011.0588.0001 at 0005].

⁹⁹⁸ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 144 [SCI.0011.0585.0001 at 0149].

⁹⁹⁹ Transcript of the Commission, 26 February 2024, T1102.37–1103.4 (Levesque); Transcript of the Commission, 19 March 2024, T1384.39–1386.43 (Mills/Neal); Transcript of the Commission, 22 April 2024, T2294.38–2296.35 (Schembri).

¹⁰⁰⁰ Transcript of the Commission, 19 March 2024, T1384.39–T1386.43 (Mills/Neal); Transcript of the Commission, 22 April 2024, T2294.38–2296.35 (Schembri).

Research

21.24. Research is a key component of innovation across the wider health system. It covers more than medical research, and spans basic science, clinical, health services, policy and population health research.¹⁰⁰¹ Reflective of its significance, one of the six strategic outcomes identified in the *Future Health Report* is that “[r]esearch and innovation, and digital advances, inform service delivery”.¹⁰⁰² Accordingly, it can be seen that research is key, not only to innovation generally through the development of interventions and treatments, but to health system development.

21.25. Health research takes several forms, including:

- a. translational research, which explores how the findings of biomedical, health services, and population health research findings may be “translated” into clinical practice;¹⁰⁰³
- b. clinical trials, which play an important role in the development of new treatments but also provide opportunities to patients to access new treatments and for the professional development of clinicians;¹⁰⁰⁴
- c. intervention research, which assesses methods to improve service delivery and health outcomes; and
- d. implementation and evaluation research, which explores the qualitative and quantitative effects of health programs that have been introduced.¹⁰⁰⁵

21.26. Given the breadth of research that occurs within the NSW public health system, and the health sector more broadly, it is unsurprising that it is part of the core business of many NSW Health agencies, including LHDs, that have a statutory function to undertake research that is relevant to health service provision.¹⁰⁰⁶ The CEC, ACI and Bureau of Health Information also have significant research functions,¹⁰⁰⁷ as does the Cancer Institute NSW.¹⁰⁰⁸

¹⁰⁰¹ Exhibit B.23.51, NSW Health, *NSW Health and Medical Research Strategic Review 2012*, p 64 [MOH.0001.0358.0001 at 0082].

¹⁰⁰² Exhibit B.23.23, *Future Health: Guiding the Next Decade of Care in NSW 2022–2032* (Report, 31 May 2022) p 13 [MOH.0001.0320.0001 at 0013].

¹⁰⁰³ Exhibit B.23.51, NSW Health, *NSW Health and Medical Research Strategic Review 2012*, p 4 [MOH.0001.0358.0001 at 0022].

¹⁰⁰⁴ Exhibit K.46, Statement of Chris Levi (13 September 2024) [9] [MOH.0011.0070.0001 at 0002].

¹⁰⁰⁵ Exhibit B.23.51, NSW Health, *NSW Health and Medical Research Strategic Review 2012*, p 16 [MOH.0001.0358.0001 at 0034].

¹⁰⁰⁶ *Health Services Act 1997* (NSW) s 10(m).

¹⁰⁰⁷ Exhibit B.23.76, Clinical Excellence Commission Determination of Functions [SCI.0003.0001.0001 at 0385]; Exhibit B.023.048, Agency for Clinical Innovation Determination of Functions [MOH.0001.0345.0001]; Exhibit B.027, Bureau of Health Information Determination of Function [SCI.0001.0063.0001]. Exhibit B.24, *Determination of Functions – Clinical Excellence Commission* (13 July 2012) [SCI.0003.0001.0385]; Exhibit B.23.48, *Determination of Functions – Agency for Clinical Innovation* (21 August 2023) [MOH.0001.345.0001]; Exhibit D.26, *Determination of Functions – Bureau of Health Information* (27 June 2018) [SCI.0008.0033.0001].

¹⁰⁰⁸ *Cancer Institute (NSW) Act 2003* (NSW) s 12.

Oversight of research in NSW

- 21.27. In February 2023, the ACI and OHMR were integrated into the Division of Clinical Innovation and Research in the Ministry of Health (although they were not amalgamated).¹⁰⁰⁹ The objectives of this change included enhanced visibility of research and innovation across the system, and better alignment of work and investment across the continuum of research, discovery and implementation.¹⁰¹⁰
- 21.28. The Division includes the Critical Intelligence Unit and has responsibility for creating, fostering, disseminating, translating and using research.¹⁰¹¹
- 21.29. The OHMR administers research grant programs; provides a policy framework to support research governance and infrastructure; and facilitates engagement with universities, research institutes, industry and government stakeholders.¹⁰¹² In doing so, the OHMR facilitates several research grants, including the Translational Research Grants Scheme, to fund projects that have the potential to swiftly convert findings into treatments, for the benefit of NSW patients. Other grants include the Early-Mid Career Grants, PhD Scholarships and 'Omics' research, which facilitates access to state of the art technologies, as well as grants supporting research into spinal cord injury and treatment, schizophrenia research, and motor neurone disease.¹⁰¹³
- 21.30. The OHMR also:
- supports research infrastructure by providing a research ethics and governance management system, enhancing the research workforce through training programs for early to mid-career researchers, and supporting clinical trials;¹⁰¹⁴
 - collaborates with Pillar organisations, LHDs and SHNs as well as primary care providers and the private sector to translate research into clinical practice;¹⁰¹⁵ and
 - facilitates engagement with universities, research institutes, industry, and government stakeholders.¹⁰¹⁶

¹⁰⁰⁹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [4] [MOH.0001.0435.0001 at 0001–0002].

¹⁰¹⁰ Transcript of the Commission, 26 February 2024, T1020.30–1021.3 (Levesque).

¹⁰¹¹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [6]–[8], [32] [MOH.0001.0435.0001 at 0002, 0008–0009]; Exhibit H.2.51, NSW Health, *Corporate Governance & Accountability Compendium* (May 2024) [1.1.4] [MOH.0001.0297.0001 at 0011].

¹⁰¹² Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [9]–[14] [MOH.0001.0435.0001 at 0002–0004]; Transcript of the Commission, 26 February 2024, T1024.38–1025.18 (Levesque).

¹⁰¹³ Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003–0004].

¹⁰¹⁴ Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [12] [MOH.0001.0435.0001 at 0002–0003].

¹⁰¹⁵ Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [12] [MOH.0001.0435.0001 at 0002–0003].

¹⁰¹⁶ Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003–0004].

Funding of research in NSW

- 21.31. In 2023–2024, the OHMR oversaw a budget of \$104.7 million.¹⁰¹⁷ Of that amount, \$44.5 million was allocated to independent medical research institutes, and the remainder (other than amounts staff salaries and wages) was spread across the following initiatives:¹⁰¹⁸
- a. Cardiovascular Research Capacity Program to build capability in this field (\$15 million);
 - b. the Medical Devices Fund, which gives competitive grants to promising proposals so they can be accelerated to a commercialisation stage. This is complemented by a commercialisation training program to help ensure success (\$9.5 million);
 - c. the Translational Research Grants Scheme, which funds innovative health services research by LHDs for initiatives with the potential to be translated quickly into benefits for patients and to be scaled up (\$5 million);¹⁰¹⁹
 - d. research into schizophrenia, Motor Neurone Disease, spinal cord injury and treatment, “omics” technologies, and paediatric precision medicine; and
 - e. early to mid career researcher grants and PhD scholarships.
- 21.32. The two primary sources of funding for medical research institutes are Commonwealth Government programs: the National Health and Medical Research Council (NHMRC) and the Medical Research Future Fund (MRFF).¹⁰²⁰ Researchers employed in LHDs may obtain funding to support their research through the competitive grants processes administered by these bodies.¹⁰²¹ The PBS also funds some research.¹⁰²²
- 21.33. The OHMR established the “clinicaltrialsNSW” initiative to build capacity, capability and collaboration across the State, and, as part of that initiative, access to funding from the MRFF has been obtained that has enhanced clinical trial access in rural, regional and remote areas.¹⁰²³ There are also opportunities to run clinical trials in NSW for therapies that have been developed overseas, and to access funding from an international sponsor of those trials to do so.¹⁰²⁴

¹⁰¹⁷ Exhibit B.3, Statement of Jean–Frédéric Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003–0004].

¹⁰¹⁸ Exhibit B.3, Statement of Jean–Frédéric Levesque (30 January 2024) [14] [MOH.0001.0435.0001 at 0003–0004]; Transcript of the Commission, 26 February 2024, T1027.6–1028.47 (Levesque).

¹⁰¹⁹ Transcript of the Commission, 28 November 2023, T112.10–32 (Chant).

¹⁰²⁰ Transcript of the Commission, 26 February 2024, T1030.31–39 (Levesque).

¹⁰²¹ Exhibit K.46, Statement of Chris Levi (13 September 2024) [7] [MOH.0011.0070.0001 at 0002]; Exhibit N3.8, Statement of Ian Alexander (17 June 2024) [13] [MOH.0006.0024.0001 at 0004].

¹⁰²² Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [6] [MOH.0006.0024.0001 at 0002].

¹⁰²³ Exhibit K.46, Statement of Chris Levi (13 September 2024) [10]–[15] [MOH.0011.0070.0001 at 0003].

¹⁰²⁴ Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [14] [MOH.0006.0024.0001 at 0005].

- 21.34. The NHMRC and the MRFF grants are generally inadequate to cover the cost of taking advanced therapeutics to clinical trial and, as a result, researchers frequently engage with the commercial sector or seek venture capital to meet any shortfall.¹⁰²⁵ Some medical research institutes have established industry partnerships (including with organisations in the biomedical, medical device and pharmaceutical industries) to support their research activities,¹⁰²⁶ and philanthropy is another source of research funding.¹⁰²⁷

Current approaches to identifying and implementing innovation within the public health system

- 21.35. The current approach to the identification of innovations within the NSW public health system at a system level involves the following structures and processes:
- the Critical Intelligence Unit in the Division of Clinical Innovation and Research identifies new models of care and initiatives through literature searches of key medical journals, which are then reviewed by a clinical panel to identify those with the potential for high system impact;¹⁰²⁸ and
 - there are regular meetings of the ACI's International Expert Advisory Group, and the OHMR engages with a network of research leaders who have strong national and international links for advice on emerging trends;¹⁰²⁹
 - the Specialty Service and Technology Evaluation Unit in the Ministry of Health also undertakes horizon scanning for emerging health technologies that are expected to reach the market within one to three years;¹⁰³⁰ and
 - innovations are identified to address specific health system issues through targeted reviews and stakeholder engagement to develop solutions, for example, to tackle surgical wait times, manage end of life care, and deliver CAR-T cell therapies.¹⁰³¹

¹⁰²⁵ Exhibit N.3.8, Statement of Ian Alexander (17 June 2024) [13] [MOH.0006.0024.0001 at 0004].

¹⁰²⁶ Exhibit K.046, Statement of Chris Levi (13 September 2024) [38]–[41] [MOH.0011.0070.0001 at 0001, 0010].

¹⁰²⁷ Exhibit B.23.51, NSW Health, *NSW Health and Medical Research Strategic Review 2012*, pp 48–49 [MOH.0001.0358.0001 at 0066–0067].

¹⁰²⁸ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [66] [MOH.0001.0435.0001 at 0021].

¹⁰²⁹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [66] [MOH.0001.0435.0001 at 0022].

¹⁰³⁰ Exhibit N3.10, Statement of Olivia Hibbitt (18 June 2024) [5]–[10] [MOH.0006.0008.0001 at 0002–0003].

¹⁰³¹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [69] [MOH.0001.0435.0001 at 0023].

21.36. Innovations can also be identified in a more organic way. For example, clinicians across the system are a valuable source of information about emerging innovations in their respective fields of expertise, including those that they have a role in developing and implementing at the local level.¹⁰³² The process by which those matters come to the attention of the ACI and the OHMR is somewhat *ad hoc*, in the sense that if they are not drawn to their attention, they will not necessarily have visibility of them. Innovations of those kinds can be identified, including, for example, through the participation of clinicians in the ACI networks.¹⁰³³ However, as discussed further below, there are opportunities to better harness this valuable source of knowledge, and coordinate the development of such innovations, for the benefit of the system as a whole.

Prioritising innovations for implementation

21.37. One of the ACI's core functions is to support and promote innovations that aim to improve the effectiveness and efficiency of healthcare.¹⁰³⁴ The successful identification, and where appropriate, adoption of innovations of that kind are central to the long term sustainability of the system.

21.38. In pursuing that aim, the ACI's Division of Clinical Innovation and Research (as it was then known prior to an internal restructure in 2024)¹⁰³⁵ is developing a more rigorous process by which innovations are assessed and prioritised before significant investments are made in advancing them.¹⁰³⁶ That process, once developed, will also include a system for prioritising "game changing" innovations – that is, those that are anticipated to have profound impacts on how care is delivered – and a mechanism to identify and implement such system changes as are necessary to harness the full potential of such innovations.¹⁰³⁷ That work is clearly necessary, and should be progressed as a priority.

21.39. However, while a more robust approach to what might be considered to be significant and "game changing" innovations is both necessary and appropriate, there is also a need to adopt a similarly thorough approach to the identification, assessment, prioritisation, and implementation of innovations that target the current burden of disease and public health issues and trends that are prevalent within the community. There is a risk that groundbreaking innovations that, by their nature, will benefit a smaller patient cohort may receive disproportionate attention and support compared to those with the potential to

¹⁰³² Exhibit N3.10, Statement of Olivia Hibbitt (18 June 2024) [9], [11]–[12] [MOH.0006.0008.0001 at 0002–0003].

¹⁰³³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [70]–[71] [MOH.0001.0435.0001 at 0023–0026].

¹⁰³⁴ Exhibit B.23.50, Agency for Clinical Innovation, *Strategy 2023–2026*, p 3 [MOH.0001.0350.0001 at 0003].

¹⁰³⁵ '2024: A focus on ACI', *Agency for Clinical Innovation* (Web Page) <<https://aci.health.nsw.gov.au/focus-2024/our-strategy>>.

¹⁰³⁶ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [110] [MOH.0001.0435.0001 at 0038–0039].

¹⁰³⁷ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [110] [MOH.0001.0435.0001 at 0038–0039].

enhance health outcomes for more of the population, thereby yielding greater overall economic benefits and improving the health of many more people.

- 21.40. That is not to say that innovations that are likely to benefit smaller patient cohorts are not important and should not be pursued. As the evidence demonstrated, innovation at the State and local levels may be informed by a range of considerations, with some being more prominent in some settings than in others. For example, as observed by NSW Health in their submissions, those factors South Western Sydney LHD, include service planning, health outcomes, patient experience, and economic efficiencies. Each may involve both short and long term outcomes.¹⁰³⁸
- 21.41. However, in my view, there needs to be greater emphasis on the development of innovations aimed at prevention and addressing the rise and impact of chronic disease across the system. The recent announcement of targeted funding from the Commonwealth Government towards research in this area, together with the Prevention Research Support Program, is long overdue; it only a start.¹⁰³⁹ This development does not remove the need for a more coordinated approach at the system level to those matters.
- 21.42. That may require an expansion of the role of the ACI's Division of Clinical Innovation and Research to bring the identification, assessment, and adoption of innovations in relation to preventive care within its remit.¹⁰⁴⁰ However, ultimately how that coordinated approach is to be implemented is best determined by the Ministry of Health, together with the ACI and the OHMR. Whatever model is adopted, it should be clearly described so that it can be readily identified and understood by those with an interest in innovation in those areas, whether from within the system or outside (including independent research institutes). That approach should also include strengthening and clearly identifying the pathways and processes for the ACI and the CEC to work together in relation to innovations that are likely to produce benefits in terms of risk reduction.¹⁰⁴¹

¹⁰³⁸ Exhibit N.3.9, Statement of Matthew Jennings (18 June 2024) [37] [MOH.0006.0018.0001 at 0011]; Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.40]–[13.41] [MOH.0010.0758.0001 at 0135].

¹⁰³⁹ 'Preventive and Public Health Research initiative', *Australian Government* (Web Page, 5 June 2024) <https://www.health.gov.au/our-work/mrff-preventive-and-public-health-research-initiative>; Exhibit N.1.3, Sax Institute, *Expert Report 3 - Building capabilities to drive health system improvements* (Report, 29 November 2024) [38] [SCI.0011.0605.0001 at 0010]. [46] [SCI.0011.0605.0001 at 0011], cited in Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.52]–[13.53] [MOH.0010.0758.0001 at 0138].

¹⁰⁴⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.51] [MOH.0010.0758.0001 at 0138].

¹⁰⁴¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.55] [MOH.0010.0758.0001 at 0139].

Designing and implementing new models of care

- 21.43. The ACI has created a framework to assist health services to develop models of care, which covers identifying an issue or opportunity, defining what needs to change, designing a solution, implementing the new model, and sustaining it into the future.¹⁰⁴² An updated version of this framework titled, *Principles of developing models of care*, is in development.¹⁰⁴³ That framework is supplemented by an implementation guide that outlines the steps involved in planning and assessing what is needed and operationalising the solutions developed.¹⁰⁴⁴
- 21.44. The ACI Redesign School trains frontline staff to develop innovative solutions and provides transferrable skills that can be used for future initiatives,¹⁰⁴⁵ and the ACI implementation team supports clinicians and managers to ensure solutions are effective and sustainable.¹⁰⁴⁶

Scaling innovations across NSW

- 21.45. The Innovation Executive Strategic Committee brings together executive leads of innovation from LHDs and SHNs to foster strategic collaborations that drive innovation for the system reform agenda.¹⁰⁴⁷ The committee's roles are to identify priorities, address barriers, adapt and disseminate best practices, and undertake transformative initiatives.¹⁰⁴⁸
- 21.46. The Innovation Exchange is a website platform maintained by the ACI to support collaboration and sharing innovations that have emerged or been developed at the local level, and which may be suitable for piloting at new sites or scaling for wider system application.¹⁰⁴⁹ However, quite how effective that platform is as a method of identifying and communicating innovations that have been developed within the system is somewhat unclear. While the significant number of page views might suggest that it is regularly used, that statistic does not inform a considered assessment of how effective that platform has been in furthering and promoting

¹⁰⁴² Exhibit B.23.167, Agency for Clinical Innovation, *Understanding the process to develop a Model of Care – An ACI Framework* (May 2013) [MOH.0001.0283.0001].

¹⁰⁴³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [47] [MOH.0001.0435.0001 at 0013]; Exhibit N3.12, Supplementary Statement of Jean-Frédéric Levesque (19 June 2024) [19] [MOH.0006.0038.0001 at 0004].

¹⁰⁴⁴ Exhibit B.23.58, Agency for Clinical Innovation, *Implementation Guide: Putting a model into practice* (August 2015) [MOH.0001.0348.0001].

¹⁰⁴⁵ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [68] [MOH.0001.0435.0001 at 0022].

¹⁰⁴⁶ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [78] [MOH.0001.0435.0001 at 0030].

¹⁰⁴⁷ Exhibit N3.12.3, Agency for Clinical Innovation, *Terms of Reference – Innovation Executive Strategic Committee (LHDs/SHNs)* (July 2023) [MOH.0006.0041.0001].

¹⁰⁴⁸ Exhibit N.3.12.3, Agency for Clinical Innovation, *Terms of Reference – Innovation Executive Strategic Committee (LHDs/SHNs)* (July 2023) [MOH.0006.0041.0001].

¹⁰⁴⁹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [68] [MOH.0001.0435.0001 at 0022–0023].

innovation across the system, including as to the uptake of initiatives that are recorded on it.¹⁰⁵⁰

- 21.47. There are undoubtedly benefits that the Innovation Exchange brings, including in providing access to information about new models of care that have been developed, and which might then result in other clinicians adopting similar approaches rather than needing to develop their own solutions.¹⁰⁵¹
- 21.48. However, the means by which innovations that have wider system benefit are identified and then shared through that platform relies heavily on the initiative of clinicians and management at the local level to explore the content of that site. Even accepting, as I do, that the NSW Health workforce is dedicated to the constant pursuit of improvement, there is ample evidence of the workload pressures that presently persist. Accordingly, there is scope to enhance the method by which innovations that have been developed at the local level are identified and then disseminated across the wider system.

Managing the introduction of high cost innovations

- 21.49. The *New Health Technologies and Specialised Services Guideline* defines the processes for analysis of new health technologies and specialised services at a local level as well as those nominated for Statewide adoption.¹⁰⁵² As with the preceding guideline,¹⁰⁵³ adoption is only considered for innovations that are likely to be low volume with a volume/quality outcome relationship that will support concentration at a limited number of sites for safe, effective and efficient service delivery.¹⁰⁵⁴ Assessments are undertaken by the New Technology and Specialised Services Committee, an expert advisory group that facilitates planning and prioritisation of specialised services.¹⁰⁵⁵ NSW has also led the development of a national framework for assessment, funding and implementation of high cost, highly specialised therapies and services.¹⁰⁵⁶

¹⁰⁵⁰ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.56] [MOH.0010.0758.0001 at 0139].

¹⁰⁵¹ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.56] [MOH.0010.0758.0001 at 0139].

¹⁰⁵² Exhibit N4.7, NSW Health, *New Health Technologies and Specialised Services* (Guideline No GL2024_008, 24 June 2024) [MOH.0100.0022.0001].

¹⁰⁵³ Exhibit B.23.68, NSW Health, *New Health Technologies and Specialised Services* (Guideline No GL2022_012, 28 October 2022) pp 10–11 [MOH.9999.0888.0001 at 0013–0014]; Transcript of the Commission, 26 February 2024, T1080.11–1081.08 (Levesque).

¹⁰⁵⁴ Exhibit N4.7, NSW Health, *New Health Technologies and Specialised Services* (Guideline No GL2024_008, 24 June 2024) p 6 [MOH.0100.0022.0001 at 0009].

¹⁰⁵⁵ Exhibit N4.7, NSW Health, *New Health Technologies and Specialised Services* (Guideline No GL2024_008, 24 June 2024) p 7 [MOH.0100.0022.0001 at 0010].

¹⁰⁵⁶ Exhibit N.3.10.3, Agency for Clinical Innovation, *Framework for the assessment, funding and implementation of high cost, highly specialised therapies and services* (April 2024) [MOH.0006.0007.0001].

- 21.50. The Specialty Service and Technology Evaluation Unit provides a support and oversight role for new health technologies adopted at a Statewide level as well as supra-LHD specialised services.¹⁰⁵⁷

Evaluation of innovations after implementation

- 21.51. The ACI has a dedicated evaluation team and a framework that describes the health economics approach to evaluating innovations.¹⁰⁵⁸ The method of economic analysis used depends on the type of innovation being reviewed, including whether it is low or high cost and the volume of patients for which it applies.¹⁰⁵⁹ The NSW Treasury guideline is also used for economic evaluation where projects involve significant investment.¹⁰⁶⁰
- 21.52. The ACI aims to review models of care every five years to ensure they reflect current evidence, and new models are evaluated after about three years (earlier if a higher level of investment is involved).¹⁰⁶¹ It also conducts reviews of projects undertaken through the redesign school to assess whether they have become embedded.¹⁰⁶²

Some challenges in driving innovation

- 21.53. As can be seen from the above analysis, the approach to driving innovation across the system suffers from a lack of coordination in some areas. For example, adoption and adaptation of models of care designed or endorsed by the ACI is variable, with the result that there may be multiple models in use across the State based on clinician preferences and other factors.¹⁰⁶³
- 21.54. In an effort to address some of those challenges, the ACI has identified the following priority challenges for 2023 to 2026:¹⁰⁶⁴
- a. integrating patient care at the interfaces between different types of care providers with innovations that streamline patient journeys and promote connectivity between providers;

¹⁰⁵⁷ Exhibit N3.10, Statement of Olivia Hibbitt (18 June 2024) [4]–[7] [MOH.0006.0008.0001 at 0001–0002].

¹⁰⁵⁸ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [99] [MOH.0001.0435.0001 at 0036]; Exhibit B.23.74, Agency for Clinical Innovation, *Understanding the Use of Health Economics – An ACI Framework* (May 2013) [MOH.0001.0349.0001].

¹⁰⁵⁹ Exhibit B.23.74, Agency for Clinical Innovation, *Understanding the Use of Health Economics – An ACI Framework* (May 2013) p 10 [MOH.0001.0349.0001 at 0012].

¹⁰⁶⁰ Transcript of the Commission, 26 February 2024, T1053.13–22 (Levesque); Exhibit B.23.45, NSW Treasury, *NSW Government Guide to Cost Benefit Analysis* (Policy No TPG23-08, 27 February 2023) [MOH.0001.0325.0001].

¹⁰⁶¹ Transcript of the Commission, 26 February 2024, T1052.43–1053.22 (Levesque).

¹⁰⁶² Transcript of the Commission, 26 February 2024, T1082.12–25 (Levesque).

¹⁰⁶³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [112] [MOH.0001.0435.0001 at 0039]; Transcript of the Commission, 26 February 2024, T1118.26–1121.23 (Levesque).

¹⁰⁶⁴ Exhibit B.23.50, Agency for Clinical Innovation, *Strategy 2023–2026*, p 6 [MOH.0001.0350.0001 at 0006].

- b. reducing unwarranted clinical variation and promoting high value care, through data analytics that identify variations in care delivery and innovations to address variation;
 - c. redesigning healthcare to facilitate uptake of new technologies, therapies and clinical processes, by ensuring systems are prepared for emerging technologies and that there are pathways for rapid assessment, adoption and implementation of innovations;
 - d. implementing virtual care and digitally enabled models to enhance care delivery;
 - e. supporting equity by identifying unmet need and disparities in access and outcomes across vulnerable groups and areas that innovative models of care can address;
 - f. delivering person centred and culturally appropriate care; and
 - g. fostering financial and environmental sustainability in the identification, design and implementation of clinical innovations.
- 21.55. In addition to a general lack of coordination, implementing innovations within the system faces several other challenges outlined below.

Funding

- 21.56. As noted elsewhere in this Report, there are limitations in current funding models and approaches that impact on efforts to drive and implement innovations across the system. For example, it has been suggested that ABF can limit the capacity for local innovation that may produce wider system benefits if pursued. There may also be concerns that adopting a new model will have a negative financial impact in an ABF context because it will result in reduced activity and, therefore, will generate lesser reimbursement.¹⁰⁶⁵
- 21.57. Those limitations in current funding models sit in a context where, unlike some other jurisdictions, NSW does not have an “innovation fund” (or its equivalent) that is capable of being drawn upon to support innovation across the system.¹⁰⁶⁶ An example of such a fund is the \$2 billion fund that was established in 2020¹⁰⁶⁷ by the State of Victoria to stimulate industry investment in life sciences.¹⁰⁶⁸

¹⁰⁶⁵ Transcript of the Commission, 26 February 2024, T1106.32–1107.6 (Levesque).

¹⁰⁶⁶ Transcript of the Commission, 26 February 2024, T1105.32–1106.27 (Levesque).

¹⁰⁶⁷ ‘Breakthrough Fund To Boost Research And Innovation’, *Premier of Victoria* (online, 26 November 2020) <<https://www.premier.vic.gov.au/breakthrough-fund-boost-research-and-innovation>>

¹⁰⁶⁸ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [112] [MOH.0001.0435.0001 at 0041].

- 21.58. Unless enough resources are committed to embed implementation of an innovation into the system, it is unlikely the benefits will be sustained. That is because change in clinician behaviour and for the relevant processes to be integrated and become business as usual takes time.¹⁰⁶⁹ As a consequence, the ACI takes a cautious approach to the number of initiatives it rolls out Statewide at any one time.¹⁰⁷⁰ That can result in some promising programs not being scaled for wider application due to the time that it will take to implement them, particularly in circumstances where an LHD does not see a particular innovation as a priority for their population.¹⁰⁷¹

Culture

- 21.59. Relatedly, the receptiveness of clinicians and patients to new technologies or other innovations, including in relation to the method of care delivery, can also create barriers to their successful implementation.¹⁰⁷² Communities and clinical groups may resist new models of care, including those that include roles being performed by some care providers that have previously been performed by others. Challenges of those kinds are not easy to overcome, and there will be some who will never accept change; however, stakeholder engagement is essential to provide reassurance that the process is safe and may improve access to care and the quality of care received.¹⁰⁷³

Unintended consequences

- 21.60. The implementation of new diagnostic and therapeutic innovations can also lead to unintended consequences. For example, new tests and investigation techniques can be associated with over-investigation,¹⁰⁷⁴ together with over-diagnosis, over-treatment and over-monitoring, a situation that tends to be exacerbated in specialties and geographical locations where there is an oversupply of practitioners.

¹⁰⁶⁹ Transcript of the Commission, 26 February 2024, T1108.47–1109.8 (Levesque).

¹⁰⁷⁰ Transcript of the Commission, 26 February 2024, T1109.10–38 (Levesque).

¹⁰⁷¹ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [87]–[95] [MOH.0001.0435.0001 at 0034–0035]; Transcript of the Commission, 26 February 2024, T1104.32–1105.26 (Levesque).

¹⁰⁷² Transcript of the Commission, 26 February 2024, T1115.4–14 (Levesque); Exhibit EB.001, Murdi Paaki Regional Assembly and University of Sydney, *Engagement Model* [SCI.0009.0050.0001]; Exhibit B.23.167, Agency for Clinical Innovation, *Understanding the process to develop a Model of Care – An ACI Framework* (May 2013) p 9 [MOH.0001.0283.0001 at 0011].

¹⁰⁷³ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [112] [MOH.0001.0435.0001 at 0040]; Transcript of the Commission, 26 February 2024, T1059.17–39 (Levesque).

¹⁰⁷⁴ Exhibit A.31, Australian Government, *National Preventive Health Strategy 2021–2030* (12 December 2021) p 20 [SCI.0001.0027.0001 at 0020].

- 21.61. In addition, innovations that are adopted based on evidence of net benefit for one cohort may ultimately be used for a broader group of patients for whom there may be no additional benefit relative to the previous therapeutic option, yet a significant increase in cost. This can occur with both procedures and medications. Unwarranted clinical variation may also be associated with “indication creep” of this nature.¹⁰⁷⁵ Reducing unwarranted clinical variation is complex and multifaceted, requiring robust measurement of variation, consideration of available evidence, identification of levers for change, and effective change management.¹⁰⁷⁶
- 21.62. A Positive Cost Effectiveness Analysis/Cost Utility Analysis for an innovation may be predicated on a corresponding reduction in the use of a pre-existing therapeutic option, but unless adequate controls are put in place to ensure those reductions are realised, there may simply be a shift in the case mix to include new patients, or an increase in other procedures to fill the gap created.
- 21.63. The benefits anticipated from an innovation may be based in part on it replacing an outdated technology or practice, but this needs to be managed to ensure it occurs. A far greater focus is needed on enhancing system efficiencies in the delivery of care, disinvesting in low value care and reducing futile care.¹⁰⁷⁷ That is particularly so given that it is recognised that only 60 per cent of care delivered by health systems is “gold standard”, 30 per cent being some form of waste, and 10 per cent being harmful. Professor Jeffery Braithwaite, Director of Centre for Healthcare Resilience and Implementation Science,¹⁰⁷⁸ referred to those concepts in his evidence, as follows:¹⁰⁷⁹

MR BRAITHWAITE... So stay at the population level for a bit with me. If we start there, then we know some top-line numbers about the population. Some 60 per cent of the care that's delivered to them is in line with level 1 evidence or guidelines. That's the gold standard type way we should deliver care to the population.

MR MUSTON: Just can I ask you about that. Gold standard, does that effectively mean not only care that is delivered well and effectively but care that was genuinely required to be delivered to a particular individual?

A. It's a great question. So it's the care that has a randomised trial to suggest that that will be beneficial for the patient, it will deliver good outcomes, or it's the care that is delivered by the

¹⁰⁷⁵ Exhibit B.23.168, Jean-Frédéric Levesque and Kim Sutherland, 'Unwarranted clinical variation in health care: Definitions and proposal of an analytic framework' (2020) 26 *Journal of Evaluation in Clinical Practice* 687, p 692 [MOH.0001.0273.0001 at 0006].

¹⁰⁷⁶ Exhibit B.3, Statement of Jean-Frédéric Levesque (30 January 2024) [113] [MOH.0001.0435.0001 at 0042].

¹⁰⁷⁷ Exhibit A.1, Joint Report of Nigel Lyons, Kerry Chant and Deb Willcox AM (17 November 2023) [152]–[154] [MOH.9999.0001.0001 at 0023].

¹⁰⁷⁸ Professor Jeffrey Braithwaite is the Director of Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University.

¹⁰⁷⁹ Transcript of the Commission, 20 November 2024, T6417.20–6419.35 (Braithwaite).

guidelines that expert clinicians say is the way care should be delivered for that condition. So about 60 per cent is in line with level 1 evidence or consensus-based guidelines, those two elements.

Often the level 1 care is enshrined in the guidelines. So that gives scope for more care to be delivered in line with the guidelines and level 1 evidence.

..

The second number is 30 per cent. Thirty per cent of care is deemed at some level to be some sort of waste or not delivering good outcomes to patients, and that attracts people, including the Commission no doubt, because that's an area where we can be more efficient or make savings
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Q. That's what we heard described as low value care?

A. Low value care is one way of describing it, and there's a few things to do with the way the system's set up that inhibit us from - inhibit us from being efficient.

Q. Without wanting to pick on any particular example, are you able to, just to make it tangible for us, give an example of something that might fall into that 30 per cent?

A. A patient might move through the system very fast, we've taken some tests and the test results never get seen because the patient's now discharged. Or there's a lot of bureaucracy. You've got to go through lots of screens or lots of paperwork to deliver care. That's not adding value. It's necessary perhaps, but it's not actually directly adding value.

...

THE COMMISSIONER: Is care that's provided but provided at a time where it's past the time that was clinically appropriate for that care an example of something in the 30 per cent?

A. Yes, yes.

...

MR MUSTON: We're about to hear about the 10 per cent, hopefully, if my maths is right?

A. The 10 per cent is harm. So 10 per cent - one in 10 inpatient admissions has some level of harm. A lot of it is not consequential for the patient, but there's a proportion which is significant.

- 21.64. Although reducing unwarranted clinical variation and disinvesting in low value care are described as priorities across the system, there appears to be little central guidance or support for managing resistance to changes of this nature. I have been told of examples where, despite clear evidence that a procedure offered no (or at best, negligible) clinical benefit – and thus falling well within the broad concept of low value care – it nevertheless took considerable time for practitioners to change their methods.¹⁰⁸⁰ In part, that is likely because – as Professor Braithwaite observed – at a system level, “we’re not very good in New South Wales or any modern health system in really measuring what long-term benefit or gain was produced” by certain procedures or in interventions.¹⁰⁸¹
- 21.65. Relatedly, clinicians are frequently confronted with a circumstance in which an intervention that will not produce any benefit to the patient (i.e., one of low value) is available, but they do not feel empowered to refuse demands for it by patients and families.¹⁰⁸² For example, it is uncontroversial that a significant proportion of health expenditure occurs close to the end of a person’s life, often in the context of high levels of comorbidity such that it is death rather than life that is being prolonged, and often at great expense.¹⁰⁸³ However, clinicians experience pressure from families and other staff to provide every possible intervention for patients, and it is confronting to have conversations that question the appropriateness of this.¹⁰⁸⁴
- 21.66. There may also be insufficient appreciation of the increased costs that will flow through the system that can result from introduction of an innovation. For example, while it may be recognised that a new screening program could result in more procedures, there may not necessarily be the same appreciation of the increased burden on anatomical pathology resources when those procedures result in many more biopsies being taken. Strategies are also needed to manage the response to the makers and early adopters of innovative technologies, who may stimulate media and community interest with a view to influencing decision making. There need to be robust mechanisms in place to identify and manage conflicts of interest that may arise.

¹⁰⁸⁰ Transcript of the Commission, 15 April 2024, T1786.3-43 (Zacka).

¹⁰⁸¹ Transcript of the Commission, 20 November 2024, T6429.7-41 (Braithwaite)

¹⁰⁸² Transcript of the Commission, 14 November 2024, T6065.33–6066.47 (Hislop), T6067.5–47 (Begbie/Hodge).

¹⁰⁸³ Transcript of the Commission, 14 November 2024, T6024.16–36 (Hislop).

¹⁰⁸⁴ Transcript of the Commission, 14 November 2024, T6024.16–46 (Hislop).

- 21.67. None of those unintended consequences are easily overcome, and nor should the risk that they arise be seen as a reason why innovation ought not be pursued or implemented. However, they highlight the need for robust structures and processes to address them to the maximum extent possible in order to embed innovation into the system as effectively and efficiently as possible. Otherwise, their benefits may never fully be realised.
- 21.68. **Mid-Term Review of the Addendum to the NHRA**
- 21.69. The *Mid-Term Review of the Addendum to the NHRA* found there was a generally held view that the *Addendum to the NHRA* had not realised its aspiration to take a system wide approach and drive innovation and integration.¹⁰⁸⁵ In fact, the ABF model was seen as discouraging innovation, by financially penalising initiatives like new models of care deemed out of scope for the Commonwealth funding contribution, even if they reduce in scope activity.¹⁰⁸⁶
- 21.70. The Commonwealth established a \$100 million Health Innovation Fund for states and territories to trial innovative initiatives that support preventive health and better use of health data.¹⁰⁸⁷ However, it is one off funding that does not support full implementation of programs, and as a result investment in innovations is often tactical and not maintained after the pilot project.¹⁰⁸⁸
- 21.71. The *Mid-Term Review of the Addendum to the NHRA* recommended a standalone agency to drive innovation and reform based on system performance data indicating where there are innovation opportunities.¹⁰⁸⁹ A National Innovation and Reform Agency would be responsible for identifying emerging system pressures, and would be authorised to develop and advise on long term system reforms and innovation.¹⁰⁹⁰ It would work with all jurisdictions and the national bodies to ensure national buy in and priority setting, and have strong reporting lines through the Health Chief Executives Forum to Health Ministers.¹⁰⁹¹

¹⁰⁸⁵ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 1 [SCI.0011.0585.0001 at 0006].

¹⁰⁸⁶ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 29, 75 [SCI.0011.0585.0001 at 0034, 0080].

¹⁰⁸⁷ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 98–99 [SCI.0011.0585.0001 at 0103–0104].

¹⁰⁸⁸ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 36 [SCI.0011.0585.0001 at 0041].

¹⁰⁸⁹ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 3, 100 [SCI.0011.0585.0001 at 0008, 0105].

¹⁰⁹⁰ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 6, 11 [SCI.0011.0585.0001 at 0011, 0016].

¹⁰⁹¹ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 11, 101 [SCI.0011.0585.0001 at 0016, 0106].

- 21.72. A National Innovation and Reform Agency would also have skills and experience in system policy and financing, and expertise in developing models of care, change management and research and data analysis.¹⁰⁹² It would develop innovations to be trialled, be a knowledge exchange hub to facilitate uptake of proven ideas, and advise on whole of system ambitious outcomes and benchmarks to advance reform objectives.¹⁰⁹³
- 21.73. To support the operation National Innovation and Reform Agency, the need for a dedicated fund was identified as critical. An Innovation Fund would provide a source of funding for short term activities while work is undertaken with jurisdictions and national bodies to develop options for implementing successful innovations and reforms at scale.¹⁰⁹⁴ This would include a “Funding Innovation Pathway” that identifies at the outset how initiatives like optimal models of care with innovative funding mechanisms will be scaled up if they meet evaluation milestones.¹⁰⁹⁵
- 21.74. The *Mid-Term Review of the Addendum to the NHRA* also emphasised the need for funding reform, with any new NHRA that includes financing mechanisms to drive innovation and focus on value based care, payment for outcomes, and enabling digital and data enabled delivery models.¹⁰⁹⁶
- 21.75. If the next iteration of the NHRA were to adopt the recommendations relating to innovation identified in the *Mid-Term Review of the Addendum to the NHRA*, the role of the ACI will likely need to be adapted to align with those initiatives. It is encouraging that the ACI has already developed processes to ensure that its future efforts align with the expected outcomes of the *Mid-Term Review of the Addendum to the NHRA*.¹⁰⁹⁷

¹⁰⁹² Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 101 [SCI.0011.0585.0001 at 0106].

¹⁰⁹³ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 101 [SCI.0011.0585.0001 at 0106].

¹⁰⁹⁴ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 11 [SCI.0011.0585.0001 at 0016].

¹⁰⁹⁵ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) pp 7–8, 11 [SCI.0011.0585.0001 at 0012–0013, 0016].

¹⁰⁹⁶ Exhibit N.3.17, Rosemary Huxtable, *Mid-Term Review of the National health Reform Agreement Addendum 2020–2025* (Final Report, 24 October 2023) p 79 [SCI.0011.0585.0001 at 0084].

¹⁰⁹⁷ Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [13.59] [MOH.0010.0758.0001 at 0140].

The horizon

- 21.76. As observed above, there is little doubt that the current rate at which advances are made in medical technology and understanding will result in rapid developments into the future (including the very near future). Advances in artificial intelligence are already enhancing many health related modalities such as:¹⁰⁹⁸
- a. diagnostic platforms (pathology and radiology);
 - b. programs that predict patient deterioration and clinical risks; and
 - c. research and development including drug discoveries.
- 21.77. The role of artificial intelligence will only continue to grow. One can readily see how artificial intelligence might soon play a greater role in (among many other things), the monitoring and self-management of some chronic disease, the delivery of primary care generally, and the prediction of both disease progression and treatment success. There is also little doubt that artificial intelligence will be used to optimise the efficiency of auxiliary activities, such as certain administrative tasks, to maximise the time that clinicians have to perform clinical work, effecting positive health outcomes. The increased adoption, integration and use of artificial intelligence will also have cost outcomes, likely comprising an initial investment cost and ongoing integration and operation costs, which are hopefully offset by efficiency gains over time, together with the aforementioned gains to clinical activities.
- 21.78. However, precisely how, and to what extent, these still (rapidly) developing advances might ultimately impact the health system is not yet known, and is unlikely to be known for some time. At the very least, there are several layers of clinical, ethical, technological, and regulatory uncertainty that will take time to develop and resolve. Given the nascent stage of its implementation, and the degree of uncertainty that currently exists around its use, the role of artificial intelligence in healthcare ultimately falls beyond the scope of this Report.
- 21.79. Aside from artificial intelligence, change is also being felt through the development of personalised medicine; that is, the customisation of treatments to the unique needs and circumstances of a particular patient. The further development of treatments of those kinds will likely result in significant changes in how care is designed and delivered.¹⁰⁹⁹
- 21.80. There will be innovations, including those that have not yet been conceived of, that have the potential to consume significant resources – financial and otherwise – in their development, assessment, and implementation. There can be little doubt that the significant advances that have been made through those innovations have the capacity to support better patient outcomes. However, in the context of a public health system with a limited budget, it must be acknowledged that it is far from certain that (even with

¹⁰⁹⁸ Transcript of the Commission, 26 February 2024, T1123.14–1129.46 (Levesque).

¹⁰⁹⁹ Transcript of the Commission, 26 February 2024, T1136.1–33 (Levesque).

significant further funding) the public health system will be able to support the adoption of all innovations that might become available for those who would benefit from them. Accordingly, a coordinated approach to the identification of those innovations, one that is based on a clearly articulated set of principles and priorities, is needed. If that is not done, there is a real risk that those innovations that ought to be pursued within the context of a public health system will not be harnessed to their full extent.

- 21.81. I do not suggest that NSW has failed to achieve success in developing and implementing innovations, or that the system ought not encourage and support others outside of the system to pursue their development. As noted above, NSW Health has taken a proactive role in the advancement of clinical technologies such as bacteriophage and viral vector delivery for management of genetic diseases. However, it remains unclear how the State proposes to identify, assess, and then fund the future innovations (which are likely to come with significant costs) that have the potential to change the way healthcare is delivered.

Conclusion

- 21.82. The health system has always been in constant pursuit of innovation. Whether in the form of treatments, procedures, models of care, or service structures and planning. The health system of today looks very different to that of even a few decades ago. That must continue if the system is to remain viable in the long term.
- 21.83. Having regard to the rate of technological advances, including the rapid development of artificial intelligence – it seems almost certain that the pace of innovation of healthcare will increase at breakneck speed.
- 21.84. NSW Health and the people of NSW stand to benefit from those developments, but only if they can be harnessed in an efficient and effective way within the context of a public system with finite resources.

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

Recommendation 38: In setting research priorities, the Division of Clinical Innovation and Research should ensure that:

- a. Funding of research should be driven by community needs and priorities;
- b. Investment in innovation and research that aligns with capacity to improve health outcomes and include innovations that support prevention and/or are likely to have system management benefits;
- c. Support for translational research is enhanced, to enable the system to harness the benefits of innovations and prioritise those for wider implementation
- d. Investment in innovation should be evidence based with controlled introduction and ongoing monitoring to prevent indication creep or indiscriminate use, and to ensure costs are properly reflected and anticipated savings are realised.

Recommendation 39: There must be strong leadership (at the Ministry of Health and executive management levels) that empowers clinical and non-clinical staff to reduce unwarranted clinical practice variation, withhold low value care, and prevent over investigation, over diagnosis, and over treatment.



Chapter 22:

Conclusion and final comments

Conclusion

- 22.1. I feel it is important that I repeat two closing observations that I made in the Overview.
- 22.2. The first is that there is a risk in any Special Commission of Inquiry like this to neglect to emphasise what goes right in the health system, because the focus is on examining whether there should be any recommended change. Although I am not the only one to say this, the NSW public health system is a very good one. It comprises doctors, nurses, other clinicians, and workers who are well trained, highly skilled, and dedicated. It is well managed. The money allocated to the NSW public health system by a combination of the NSW and Commonwealth Governments is generally not wasted. Likewise, the LHDs and SHNs do not waste their budgetary allocation. It is not, and is unlikely to be in the near future, entirely mistake or incident free, but any person experiencing an illness or injury who attends a NSW public hospital, facility or service, is very likely to receive treatment and care comparable to the best that is provided in any other developed country.
- 22.3. The second point of emphasis is that, having now read along with my colleagues so many reports, reviews, and so much medical literature, economic literature, and sundry other published work dating back decades and up to the present, it is astonishing to me that we have the national system that we do. The failure to reform Medicare and the funding models for primary care, and to ensure adequate and timely primary care to all Australians, is close to (but not quite) beyond my comprehension. The failure to embed prevention in all its forms into the health system despite repeated and evidence based recommendations to do so is beyond my comprehension. So, too, is how we have allowed NSW public hospitals to have so many patients in wards for extended periods of time beyond any need for acute care to be provided to them, many of whom are elderly Australians who could and should be cared for in aged care facilities, specialist disability accommodation, or supported independent living arrangements for National Disability Insurance Scheme participants.
- 22.4. If I, generously, take as a starting point the recommendations made by the National Health and Hospitals Reform Commission in 2009, it is 16 years past the date from which the Commonwealth and the states, including NSW, should have been working together and collaborating to ensure gaps in primary and aged care did not emerge, and to embed and fund preventive health services. Based on all I have seen in the last 18 months, the long term health reforms outlined in the NHRA, and its aspirations for “shared intentions” and to “work in partnership” towards a “nationally unified and locally controlled health system”, are just words on paper.
- 22.5. I have been told by NSW Health that implementing many of the recommendations that I have made in this Report will involve a significant amount of work. I accept that is the case. However, the fact that change will require hard work is not a reason to maintain the *status quo*.

- 22.6. It would be naïve to think that NSW Health can successfully implement, embed, and sustain the system wide planning processes that I have recommended – along with the other recommendations made in this Report – without being adequately funded to do so. Unless NSW Health receives the funding necessary to properly respond to the recommendations I have made, there is a very real risk that their benefits will not be harnessed. If that were to occur, it would represent yet another lost opportunity to make the change necessary to address the challenges confronting the system that are explored in this Report. It would be deeply regrettable if the next Commissioner of an inquiry into the public health system were to be confronted (as I have on many occasions) with the same issues, themes and problems that continue to persist, despite them having been considered by many past inquiries. The Australian (and NSW) health public system is not short of evidenced based, recommended reforms. For too long though it has been short of action on those proposed reforms, and the long sighted funding and resourcing to implement them.
- 22.7. There is a significant amount of work to be done, and system change takes time. Although NSW Health should advance that work urgently, I accept it is not a short term project. NSW Health cannot be expected to “find” the funding for that work from its already stretched budget. It must receive a new funding stream, and one that is quarantined from other budgetary pressures to be used for that purpose.

Recommendation 40: NSW Health must be funded adequately to implement, embed, and sustain into the future the recommendations made in this Report. That funding should be ongoing, in addition to NSW Health’s existing budget allocation, and quarantined for those purposes.

Recommendation 41: The Health Secretary should provide a report to the Minister as to the progress in implementing these recommendations at six monthly intervals following the delivery of this Report.

Final comments

- 22.8. A Special Commission of Inquiry is an inquiry into the truth of something – in this case, into the truth concerning the many Terms of Reference. It is not a contested court proceeding, and I was appointed as a Commissioner, not as a judge. This has many advantages in a process like truth finding. It meant that I, and the staff of this Special Commission, were able to work with a range of experts, and not merely read or hear evidence from them. It meant I was able to sit down and talk to participants in the health system to discuss concerns, ideas, and relevant issues, not merely have them pointed towards a witness box. It meant that I was able to collaborate with the Counsel and solicitor teams of this Special Commission to consider issues, evidence, as well as possible key findings and recommendations. The legal team was not engaged by me to convince me about any particular conclusion I should reach on the matters we looked into. Instead, we worked together, and with many others, to shed light on those issues, reach preliminary views, and then final ones. The Report that follows, then, is not the result of my sole determination following an adversarial process. Rather, as can be seen from the many people referred to above (and listed in the appendices) this Report is the work of many.
- 22.9. As part of this process, Counsel Assisting drafted a comprehensive Outline of Submission in December 2024, that ran to almost 400 pages. Those submissions included a series of findings and recommendations that they submitted were open to me to make if I were minded to do so. Those submissions were provided to a large number of parties, including, of course, NSW Health. The submissions were in large part the product of the collaborative, investigative process I have referred to.
- 22.10. In February 2025, NSW Health (and a number of other interested parties) provided me with its written response to Counsel Assisting's submissions. Those submissions, and the final oral addresses that followed, were helpful in shedding further light on the issues, and finalising my views.
- 22.11. This Report is the product of this long process. Given the collaborative method of working over the last 18 months, it should surprise no one that I have accepted many of the submissions made by Counsel Assisting. That, however, does not change this final matter: whatever the merits or otherwise of the Report that follows, the sole responsibility for it is mine.



Chapter 23:

Acknowledgements

- 23.1. I am greatly indebted to all the people who gave their time to contribute to the work of this Special Commission. A large group of people and entities went to great efforts to engage (in person and in writing) with this Special Commission's work, and their willingness to give generously of their time as well as pass on the benefits of their knowledge and experience is greatly appreciated.
- 23.2. The names of witnesses who gave evidence, or persons who gave this Special Commission the benefit of their views in meetings, conferences, and roundtables, are set out in the appendices to this Report. Their contribution was invaluable.
- 23.3. I acknowledge also the important contribution made by the management and clinicians of various Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services visited by this Special Commission across the State. I was grateful that they shared their experiences and insights with me. There is a significant way to go before all First Nations people will feel that government services of all kinds, including healthcare, adequately and appropriately serve their needs. More must be done, and it is my hope that, with their assistance, the recommendations I have made will play a small part in realising that objective.
- 23.4. The Health Services Union, the Australian Salaried Medical Officers' Federation, the NSW Nurses and Midwives' Association, and the Australian Medical Association (NSW) all made valuable and helpful contributions to this Special Commission through their submissions, in conferences, and in oral evidence from their leaders and members. The same can be said of the medical colleges, and a number of tertiary institutions, non-government organisations, professional bodies, and other entities involved in the healthcare sector more widely, including research institutes.
- 23.5. A large number of health system experts and health economists assisted this Special Commission. The names of those who contributed to the Expert Panel are set out in an appendix to this Report, including those experts who gave oral evidence (as well as participating in meetings and roundtables). Particular thanks, however, are due to the Sax Institute, which was commissioned by this Special Commission to prepare three expert reports (the authors of which are noted elsewhere) that were of great assistance.
- 23.6. This Special Commission's work, which was frequently on the road and required a great deal of organisation, could not have run as effortlessly and as smoothly as it did without the leading contribution of Andrew Monk as Executive Director, and Rosie Castle as Senior Inquiry Coordinator. They have my thanks. I extend my thanks also to all those persons who provided support and administrative services to this Special Commission.
- 23.7. I must also thank icourts, who managed far more documents and statements than was good for any of us across the duration of this Special Commission in a seamless way, and whose provision of real time transcripts and streaming services was faultless.

- 23.8. The maturity, calmness, and professional leadership of Patrick Mullane, who was the Legal Director of this Special Commission, was indispensable.
- 23.9. The names of the many talented solicitors who worked on this Special Commission are listed elsewhere. It would put me in an invidious position to mention only a few in these Acknowledgments. Suffice to say that all greatly exceeded the requirements of their positions.
- 23.10. I am also very grateful to all five members of this Special Commission's Counsel team. Dan Fuller, Ian Fraser, and Tamsin Waterhouse were led by Ed Muston SC and Ross Glover, of whom it would be impossible to overstate their leadership, commitment, and insight. I am grateful to have had the opportunity to work with them and all the people I have mentioned in an attempt to serve the public interest.
- 23.11. Finally, I began the Overview of this Report with an acknowledgement of and thanks to NSW Health for its cooperative approach to this Special Commission. I extend that thanks to NSW Health's legal advisors, including its Counsel team.



Volume 3

April 2025



Special Commission of Inquiry into Healthcare Funding

Commissioner, The Honourable Justice Richard Beasley



ISBN: 978-0-646-71545-2

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Published April 2025.

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Chapter 24:

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Appendix A: Letters Patent

NEW SOUTH WALES

ENTERED on the Record by me in Register of Patents No. 93 Page 392 this 23 day of August 2023.

CHARLES THE THIRD, by the Grace of God, King of Australia and His other Realms and Territories, Head of the Commonwealth.

TO

Mr Richard Beasley SC

GREETING

By these Our Letters Patent, made and issued by Our Governor under the authority of the *Special Commissions of Inquiry Act 1983* with the advice of the Executive Council, We hereby authorise you as Commissioner to inquire into and report to Our Governor of the said State on:

- A. The funding of health services provided in NSW and how the funding can 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:
 - i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);
 - ii. the engagement and involvement of local communities in health service development and delivery;
 - iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;
 - iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;
 - v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population;
- C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;

SECRETARY
THE CABINET OFFICE

- D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;
- E. Opportunities to improve NSW Health procurement process and practice, to 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:
 - i. the distribution of health workers in NSW;
 - ii. an examination of existing skills shortages;
 - iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;
 - iv. existing employment standards;
 - v. the role and scope of workforce accreditation and registration;
 - vi. the skill mix, distribution and scope of practice of the health workforce;
 - vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;
 - viii. the relationship between NSW Health agencies and medical practitioners;
 - ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;
 - x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;
 - xi. 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.

AND FURTHER, WE authorise you to make recommendations to address the issues raised including in relation to National structures or settings, including the National public hospital funding model and/or National Health Reform Agreement and the impact of aged and disability care in NSW public hospitals, where such recommendations would support or enhance any changes recommended by the Special Commission.

AND hereby establish a Special Commission of Inquiry for that purpose. The Special Commission may be assisted by one or more experts on matters that you consider require expert opinion.

AND We direct you, in conducting the inquiry:

- J. To have regard to existing reviews, reports and recommendations in relation to the national public hospital funding model and other national settings insofar as they impact on the delivery of high quality, timely, equitable and sustainable public hospital and community health services in NSW, in particular co-payments, oversight of compliance and influence of private capital on the health services market; and
- K. That you are not required to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been or will be sufficiently and appropriately dealt with by another review, inquiry or investigation.

AND pursuant to section 21 of the *Special Commissions of Inquiry Act 1983* (NSW) it is hereby declared that section 24 shall apply to and in respect of the Special Commission issued to you by Our Letters Patent.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 24 August 2024, deliver your final report in writing of the results of your inquiry to the offices of the Premier and Our Governor in Sydney.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS Her Excellency the Honourable Margaret Beazley,
Companion of the Order of Australia, King's Counsel, Governor of the
State of New South Wales in the Commonwealth of Australia.

Dated this 23rd day of August 2023.

Margaret Beazley
Governor

By Her Excellency's Command,

Premier

NEW SOUTH WALES

ENTERED on the Record by me in Register of Patents No. 93 Page 430, this 21st day of February 2024.

THE SECRETARY
for SECRETARY
THE CABINET OFFICE



CHARLES THE THIRD By the Grace of God King of Australia and His other Realms and Territories, Head of the Commonwealth:

TO

Mr Richard Beasley SC

GREETING

WHEREAS, by Letters Patent, made and issued in the name of His Majesty King Charles the Third by Our Governor of Our State of New South Wales under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) with the advice of the Executive Council on 23 August 2023, We authorised you as sole Commissioner to inquire into and report to Our Governor of the said State on the matters set out therein,

AND WHEREAS it is desirable that the Letters Patent of 23 August 2023 be altered and varied to amend the date by which you are to report under the *Special Commissions of Inquiry Act 1983* (NSW), to amend the terms of reference, and to apply sections 22 and 23 of that Act to and in respect of the Special Commission issued to you,

NOW THEREFORE, by these Our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby alter and vary the Letters Patent of 23 August 2023 by

- a) removing the text at paragraph A and inserting instead “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) removing the text at paragraph B and inserting instead “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) removing the text at paragraph C and inserting instead “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;”
- d) removing the text at paragraph D and inserting instead “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) removing the text at paragraph E and inserting instead “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) removing the text at paragraph F and inserting instead “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) removing the words “section 24” in the paragraph commencing “AND pursuant to section 21 of the *Special Commissions of Inquiry Act 1983* (NSW)” and inserting instead the words “sections 22, 23 and 24”
- i. Omitting “24 August 2024” in the paragraph beginning “AND OUR further will” and inserting instead “26 March 2025”.

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS Her Excellency the Honourable Margaret Beazley,
Companion of the Order of Australia, King's Counsel, Governor of the
State of New South Wales in the Commonwealth of Australia.

Dated this 21st day of February 2024.

Margaret Beazley
Governor

By Her Excellency's Command,

[Signature]
Premier

NEW SOUTH WALES

ENTERED on the Record by me in Register of Patents No. 93 Page 1492, this 13th day of November 2024.

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SECRETARY
THE CABINET OFFICE

CHARLES THE THIRD By the Grace of God King of Australia and His other Realms and Territories, Head of the Commonwealth:

TO

Mr Richard Beasley SC

GREETING

WHEREAS, by Letters Patent, made and issued in the name of His Majesty King Charles the Third by Our Governor of Our State of New South Wales under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) with the advice of the Executive Council on 23 August 2023, We authorised you as sole Commissioner to inquire into and report to Our Governor of the said State on the matters set out therein,

AND WHEREAS, by Letters Patent, made and issued in the name of His Majesty King Charles the Third by Our Governor of Our State of New South Wales under the authority of the *Special Commissions of Inquiry Act 1983* (NSW), on 21 February 2024 the Letters Patent of 23 August 2023 were altered and varied to amend the date by which you are to report under the *Special Commissions of Inquiry Act 1983* (NSW), to amend the terms of reference, and to apply sections 22 and 23 of that Act to and in respect of the Special Commission issued to you,

AND WHEREAS, it is desirable that the Letters Patent of 23 August 2023 be further altered and varied to amend the date by which you are to report under the *Special Commissions of Inquiry Act 1983* (NSW),

NOW THEREFORE, by these Our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby alter and vary the Letters Patent of 23 August 2023 by omitting “26 March 2025” in the paragraph beginning “AND OUR further will” and inserting instead “24 April 2025”.

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent dated 23 August 2023 constituting your Commission as amended by the Letters Patent dated 21 February 2024.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS Her Excellency the Honourable Margaret Beazley,
Companion of the Order of Australia, King's Counsel, Governor of the
State of New South Wales in the Commonwealth of Australia.

Dated this 13th day of November 2024.

Margaret Beazley
Governor

By Her Excellency's Command,

Premier

Appendix B: Public Submissions made to the Special Commission

Submission made by	Date Received
NSW Health	7 November 2023
Northern NSW LHD Board	27 October 2023
Western NSW LHD	30 October 2023
South Eastern Sydney LHD	30 October 2023
Murrumbidgee LHD Board	30 October 2023
Murrumbidgee LHD	30 October 2023
Western Sydney LHD	31 October 2023
Far West LHD	31 October 2023
Northern Sydney LHD	31 October 2023
Southern NSW LHD	31 October 2023
South Western Sydney LHD, Cancer Services	31 October 2023
South Western Sydney LHD	31 October 2023
Sydney LHD	31 October 2023
Sydney Children's Hospitals Network	31 October 2023
Children's Hospital Westmead, Department of Orthopaedic Surgery	31 October 2023
Children's Hospital Westmead, Haematology Department	31 October 2023
Sydney Children's Hospital Network, Genetic Metabolic Disorders Service	31 October 2023
Clinical Excellence Commission	31 October 2023
Bureau of Health Information	31 October 2023
NSW Primary Health Networks	31 October 2023
PHN Central and Eastern Sydney	31 October 2023
NSW Health Pathology	31 October 2023

Submission made by	Date Received
Cancer Institute NSW	31 October 2023
Chinese Medicine Council of NSW	31 October 2023
Illawarra Shoalhaven LHD	3 November 2023
Justice Health and Forensic Mental Health Network	3 November 2023
Hunter New England LHD	14 November 2023
Adjunct Professor Kathy Eagar AM	20 October 2023
Australian Catholic University, SPHERE Clinical Career Pathway	24 October 2023
University of Sydney, Charles Perkins Centre	30 October 2023
Professor Jonathan Clark AM	30 October 2023
Chris O'Brien Lifehouse	30 October 2023
University of Technology, Sydney, Faculty of Health	31 October 2023
Wiser Healthcare	31 October 2023
Australian Social Prescribing Institute of Research and Education	31 October 2023
Department of Rural Health in the Faculty of Medicine & Health, University of Sydney	31 October 2023
University of Sydney, Menzies Centre for Health Policy and Economics	31 October 2023
Macquarie University, Australian Institute of Health Innovation	31 October 2023
Queensland University of Technology, Australian Centre for Health Law Research	31 October 2023
University of Melbourne, School of Population and Global Health	31 October 2023
University of Sydney, Brain and Mind Centre	31 October 2023
The George Institute for Global Health	31 October 2023
Associate Professor Ross Kerridge, Senior Staff Specialist, Anaesthesia and Perioperative Medicine at John Hunter Hospital	1 November 2023
Dr Edward Jegasothy, Epidemiologist and Biostatistician at University of Sydney School of Public Health	1 November 2023
University of Tasmania, College of Health and Medicine	2 November 2023

Submission made by	Date Received
Sax Institute	7 November 2023
University of Newcastle, Department of Rural Health	9 November 2023
Dr Rhonda Kerr, Health Economist	12 November 2023
Speech Pathology Australia	25 October 2023
Day Hospitals Australia	25 October 2023
Nursing and Midwifery Council of NSW	26 October 2023
Healthy Communities Foundation Australia	26 October 2023
National Disability Services (NDS)	27 October 2023
Lung Foundation Australia Submission by Mark Brooke, CEO	30 October 2023
Maari Ma Health Aboriginal Corporation Su	30 October 2023
Occupational Therapy Australia	30 October 2023
Australian and New Zealand College of Anaesthetists	30 October 2023
Paramedicine Council of NSW	30 October 2023
Cancer Council NSW	30 October 2023
Border Medical Association	30 October 2023
Maternity Consumer Network	30 October 2023
Australian Society for Inborn Errors of Metabolism	31 October 2023
Parkinson's NSW	31 October 2023
Australian Health Promotion Association	31 October 2023
Australasian College of Dermatology	31 October 2023
Juvenile Arthritis Foundation Australia	31 October 2023
The Pharmacy Guild of Australia, NSW Branch	31 October 2023
Positive Life NSW	31 October 2023
Australian Medical Association NSW	31 October 2023

Submission made by	Date Received
ACON	31 October 2023
Anglicare	31 October 2023
Australasian College for Emergency Medicine	31 October 2023
Physical Disability Council of NSW	31 October 2023
Health Services Association NSW	31 October 2023
Rare Voices Australia	31 October 2023
Macular Disease Foundation Australia	31 October 2023
Australian College of Mental Health Nurses	31 October 2023
NeuroEndocrine Cancer Australia	31 October 2023
Fiona Stanley AC, Telethon Kids Institute	31 October 2023
Health Consumers NSW	31 October 2023
Network of Alcohol and Other Drugs Agencies	31 October 2023
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	31 October 2023
Dietitians Australia	31 October 2023
Better Border Health	31 October 2023
National Heart Foundation of Australia	31 October 2023
The Royal Australian and New Zealand College of Ophthalmologists	31 October 2023
The Royal Australian College of General Practitioners	31 October 2023
NSW Therapeutic Advisory Group Submission by Sasha Bennett, CE	31 October 2023
Public Health Association of Australia	31 October 2023
BEING – Mental Health Consumers Ltd	1 November 2023
Australasian College of Health Service Management	1 November 2023
Australasian College of Pharmacy	2 November 2023
Royal College of Pathologists of Australasia	2 November 2023

Submission made by	Date Received
Minderoo Foundation	2 November 2023
Headspace Foundation	2 November 2023
Australasian College of Paramedicine	3 November 2023
Australian College of Nursing	3 November 2023
Exercise & Sport Science Australia	3 November 2023
Melanoma Institute Australia	3 November 2023
Royal Australasian College of Medical Administrators	3 November 2023
South Eastern Sydney LHD, Southern Cancer Care	31 October 2023
NSW Rural Doctors Network	7 November 2023
Health Services Union	7 November 2023
Australian College of Rural and Remote Medicine	7 November 2023
Arthritis NSW	9 November 2023
Cancer Voices NSW	10 November 2023
Royal Australasian College of Physicians	10 November 2023
Medical Deans Australia and New Zealand	10 November 2023
Council for Intellectual Disability	10 November 2023
Rural Doctors Association of New South Wales	13 November 2023
Australian Physiotherapy Association	13 November 2023
Ronald McDonald House Charities Australia	14 November 2023
NSW Nurses and Midwives' Association	14 November 2023
Australian College of Midwives	14 November 2023
Asthma Australia	14 November 2023
Uniting NSW/ACT	14 November 2023
Australian Health Practitioner Regulation Agency	31 October 2023
Private Healthcare Australia	31 October 2023

Submission made by	Date Received
Ernst & Young	31 October 2023
Honeysuckle Health	31 October 2023
Ramsay Health Care Australia	31 October 2023
Dental Service Operators Alliance	31 October 2023
Amplar Health	31 October 2023
Connected Medical Solutions Ltd T/A My Emergency Doctor	31 October 2023
Australian Association of Gerontology and AAG Research Trust	31 October 2023
Karitane	31 October 2023
ForHealth	31 October 2023
Edwards Lifesciences	7 November 2023
Medical Technology Association of Australia	14 November 2023
Nicole Gastrell	22 September 2023
Alexis McMahon	26 September 2023
Anonymous	3 October 2023
Northern NSW LHD	30 November 2023
Benjamin Gilmour, Paramedic	5 October 2023
Nepean Blue Mountains LHD	1 December 2023
Debbie Admoni, Psychologist	9 October 2023
Health Infrastructure NSW	1 December 2023
Fiorina Gibbons, Clinical Nurse Consultant at Western LHD	11 October 2023
Dr Peter Lipski, Geriatrician	11 October 2023
Heather Smith	14 October 2023
HealthShare NSW	5 December 2023
David McPherson	25 October 2023
Dr Ben Basger, Clinical Pharmacist	26 October 2023

Submission made by	Date Received
eHealth NSW	5 December 2023
NSW State Spinal Cord Injury Service, Northern Sydney LHD	6 December 2023
Associate Professor Michel Tchan, Head of Genetic Medicine, Westmead Hospital	29 October 2023
Sarah Auld, Consumer Advocate	7 November 2023
Laurence Hibbert, Advocate	31 October 2023
Professor Anthony Gill AM, Clinical Director of Pathology Anatomical Pathology, Royal North Shore Hospital and Professor of Surgical Pathology, University of Sydney	31 October 2023
Ken Barker PSM, Private Consultant	31 October 2023
Denise Fry, Adjunct Senior Fellow, Stretton Institute, University of Adelaide	31 October 2023
NSW Brain Injury Rehabilitation Program	10 December 2023
National Rural Health Alliance	22 December 2023
Michael Brady	31 October 2023
Trevor, Registered Nurse	31 October 2023
Dr Gull Herzberg, General Practitioner	31 October 2023
Associate Professor Graham Reece	31 October 2023
Elizabeth Atkins	31 October 2023
Australian Society of Anaesthetists	4 December 2023
Jill McGovern, Chair, Yass Hospital Community Consultative Committee	31 October 2023
Associate Professor James Mallows, Director of Emergency Medicine Research, Nepean Hospital	1 November 2023
Zac Chu	1 November 2023
Dr Margaret Faux, Solicitor and Chief Executive Officer, Synapse Medical Services	13 December 2023
Associate Professor Lukas Kairaitis, Head of Renal Services, Blacktown–Mt Druitt Hospitals	3 November 2023

Submission made by	Date Received
Dr Arthur Chesterfield-Evans, General Practitioner	6 November 2023
Children's Hospital at Westmead, Paediatric Urinary Incontinence Services	14 November 2023
Health Education and Training Institute	15 November 2023
Agency of Clinical Innovation	17 November 2023
Department of Paediatric Anaesthesia, Children's Hospital at Westmead	20 November 2023
General Medicine Service, Children's Hospital at Westmead	21 November 2023
Central Coast LHD	21 November 2023
Mental Health Commission of NSW	16 November 2023
Mental Health Carers NSW	16 November 2023
Carolyn Wales	29 November 2023
Consumer Leaders in Health Collective	17 November 2023
Association of Professional Staffing Companies	15 November 2023
Dr Amanda Cohn MLC, Greens NSW Spokesperson for Health including Mental Health	19 November 2023
NSW Ambulance	21 November 2023
Mid North Coast LHD	24 November 2023
Senior Medical Staff Council, Sydney Children's Hospital	27 November 2023
Royal Australasian College of Surgeons	24 November 2023
Australian Indigenous Doctors' Association	28 November 2023
Australian Salaried Medical Officers' Federation	28 November 2023
Medical Staff Council Executive, Children's Hospital at Westmead	28 November 2023
NSW Poisons Information Centre, Children's Hospital at Westmead	28 November 2023
Garvan Institute of Medical Research	30 November 2023
Associate Professor Ann McCormack, Senior Staff Specialist Endocrinology, St Vincent's Hospital	3 December 2023

Submission made by	Date Received
Australian Pituitary Foundation	3 December 2023
St Vincent's Hospital Sydney Limited	13 December 2023
The Pharmacy Guild of Australia, NSW Branch	21 December 2023
School of Population Health, University of New South Wales	19 December 2023
Robert Heron	18 December 2023
Medical Staff Council, Bankstown Lidcombe Hospital	8 April 2024
Justin Clancy MP, Member for Albury	22 March 2024
Rehabilitation Medicine Society of Australia and New Zealand	15 January 2024
Pharmaceutical Society of Australia	7 March 2024
NSW Ministerial Advisory Council on Ageing	22 March 2024
Australian and New Zealand Society for Geriatric Medicine Limited, NSW Division	27 March 2024
Services for Australian Rural and Remote Allied Health	29 February 2024
Dr Kenneth J Herington and Dr Justin M A Bowra	5 January 2024
Dr Behzad Eftekhari, Consultant Neurosurgeon, Nepean Public Hospital and Dr Timothy Ang, Consultant Neurointerventionalist, Nepean Public Hospital	9 February 2024
Dr Warren Hargreaves, General Surgeon, Griffith Base Hospital	19 March 2024
Richard Hendrie	7 April 2024
Dr Jonathan Gibson	9 January 2024
Mental Health Coordinating Council	11 May 2024
NSW Health	18 February 2025 and 6 March 2025
Australian Medical Association NSW	7 February 2025 and 25 February 2025
St Vincent's Health Network	10 February 2025 and 24 February 2025
Australian and New Zealand College of Anaesthetists	6 February 2025

Submission made by	Date Received
Royal Australasian College of Physicians	7 February 2025
Health Services Association	10 February 2025
Royal College of Pathologists of Australasia	17 February 2025
Royal Australian and New Zealand College of Psychiatrists	27 February 2025

Appendix C: Schedule of Summonses

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received ¹
Summonses issued to NSW Health				
STP-MOH-001	Secretary of NSW Health (“Health Secretary”)	27 November 2023	28 November 2023	1 electronic document
STP-MOH-002	Health Secretary	30 January 2024	31 January 2024	233 electronic documents
STP-CCL-001	Scott McLachlan, Chief Executive (CE), Central Coast Local Health District (CCLHD)	30 January 2024	31 January 2024	1 electronic document
STP-CEC-001	Adjunct Professor Michael Nicholl, CE, Clinical Excellence Commission (CEC)	30 January 2024	31 January 2024	1 electronic document
STP-HAC-001	Proper Officer, Health Administration Corporation	30 January 2024	31 January 2024	50 electronic documents
STP-SLH-001	Dr Teresa Anderson, CE, Sydney Local Health District (SLHD)	30 January 2024	31 January 2024	17 electronic documents
STP-SWS-001	Sonia Marshall, CE, South Western Sydney Local Health District (SWSLHD)	30 January 2024	31 January 2024	1 electronic document

¹ Due to the various manner in which material was produced, this is an estimate of the quantity of material received by the Special Commission. Further, where documents are produced both in redacted and unredacted form, the document produced is only counted once.

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-ISL-001	Margot Mains, CE, Illawarra Shoalhaven Local Health District (ISLHD)	31 January 2024	1 February 2024	3 electronic documents
STP-MLH-001	Jill Ludford, CE, Murrumbidgee Local Health District (MLHD)	19 March 2024	19 March 2024	1 electronic document
STP-MOH-005	Health Secretary	4 April 2024	5 April 2024	769 electronic documents
STP-MOH-006	Health Secretary	9 April 2024	24 April 2024	81 electronic documents
STP-MOH-007	Health Secretary	9 April 2024	24 April 2024	2 electronic documents
STP-MOH-008	Health Secretary	15 April 2024	17 April 2024	10 electronic documents
STP-MOH-009	Health Secretary	19 April 2024	19 April 2024	1 electronic document
STP-MOH-010	Health Secretary	26 April 2024	30 April 2024	2 electronic documents
STP-MOH-011	Health Secretary	26 April 2024	3 May 2024	Not pressed
STP-MOH-012	Health Secretary	2 May 2024	16 May 2024	1 electronic document
STP-MOH-013	Health Secretary	2 May 2024	3 May 2024	22 electronic documents
STP-MOH-017	Health Secretary	14 May 2024	24 May 2024	190 electronic documents
STP-MOH-018	Health Secretary	14 May 2024	24 May 2024	24 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-MOH-019	Health Secretary	14 May 2024	24 May 2024	162 electronic documents
STP-MOH-020	Health Secretary	14 May 2024	24 May 2024	28 electronic documents
STP-MOH-021	Health Secretary	14 May 2024	24 May 2024	20 electronic documents
STP-MOH-022	The Proper Officer, Nepean Blue Mountains Local Health District (NBMLHD)	24 May 2024	24 May 2024	136 electronic documents
STP-MOH-023	The Proper Officer, The Sydney Children's Hospital Network (SCHN)	24 May 2024	24 May 2024	90 electronic documents
STP-MOH-024	The Proper Officer, SLHD	24 May 2024	24 May 2024	Not pressed
STP-MOH-025	The Proper Officer, Northern Sydney Local Health District (NSLHD)	24 May 2024	24 May 2024	153 electronic documents
STP-MOH-026	Health Secretary	24 May 2024	5 June 2024	1,348 electronic documents
STP-MOH-027	Health Secretary	30 May 2024	7 June 2024	42 electronic documents
STP-MOH-028	Health Secretary	29 May 2024	31 May 2024	2 electronic documents
STP-MOH-029	Health Secretary	6 June 2024	21 June 2024	1 electronic document
STP-MOH-030	The Proper Officer, NBMLHD	7 June 2024	11 June 2024	10 electronic documents
STP-MOH-031	Health Secretary	11 June 2024	25 June 2024	1 electronic document

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-MOH-032	Tracey McCosker, CE, Hunter New England Local Health District (HNELHD)	13 June 2024	14 June 2024	370 electronic documents
STP-MOH-033	Margot Mains, CE, ISLHD	13 June 2024	14 June 2024	1 electronic document
STP-MOH-034	Sonia Marshall, CE, SWSLHD	13 June 2024	14 June 2024	46 electronic documents
STP-MOH-035	Graeme Loy, CE, Western Sydney Local Health District (WSLHD)	13 June 2024	14 June 2024	154 electronic documents
STP-MOH-036	Jill Ludford, CE, MLHD	14 June 2024	17 June 2024	43 electronic documents
STP-MOH-037	Lee Gregory, CE, NBMLHD	14 June 2024	17 June 2024	61 electronic documents
STP-MOH-038	Adjunct Professor Anthony Schembri AM, CE, NSLHD	14 June 2024	17 June 2024	45 electronic documents
STP-MOH-039	Mark Spittal, CE, Western NSW Local Health District (WNSWLHD)	14 June 2024	17 June 2024	2 electronic documents
STP-MOH-040	The Proper Officer, SLHD	17 June 2024	25 June 2024	128 electronic documents
STP-MOH-041	The Proper Officer, SWSLHD	17 June 2024	25 June 2024	134 electronic documents
STP-MOH-042	The Proper Officer, SCHN	17 June 2024	25 June 2024	16 electronic documents
STP-MOH-043	Tobi Wilson, CE, South Eastern Sydney Local Health District (SESLHD)	5 July 2024	12 July 2024	30 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-MOH-044	Graeme Loy, CE, SLHD	5 July 2024	12 July 2024	32 electronic documents
STP-MOH-045	Tracey McCosker, CE, HNELHD	5 July 2024	12 July 2024	105 electronic documents
STP-MOH-046	Sonia Marshall. CE, SWSLHD	5 July 2024	12 July 2024	42 electronic documents
STP-MOH-047	Health Secretary	5 July 2024	8 July 2024	2 electronic documents
STP-MOH-048	The Proper Officer, NSW Ministry of Health	15 July 2024	19 July 2024	41 electronic documents
STP-MOH-049	The Proper Officer, SLHD	15 July 2024	19 July 2024	9 electronic documents
STP-MOH-050	Margaret Bennett OAM, CE, Southern NSW Local Health District (SNSWLHD)	23 July 2024	2 August 2024	14 electronic documents
STP-MOH-051	Health Secretary	26 July 2024	30 July 2024	26 electronic documents
STP-MOH-054	Margaret Bennett OAM, CE, SNSWLHD	14 August 2024	15 August 2024	1 electronic document
STP-MOH-055	The Proper Officer, Mid North Coast Local Health District (MNCLHD)	23 August 2024	6 September 2024	1 electronic document
STP-MOH-056	Health Secretary	23 August 2024	30 August 2024	10 electronic documents
STP-MOH-057	The Proper Officer, Northern NSW Local Health District (NNSWLHD)	23 August 2024	30 August 2024	5 electronic documents
STP-MOH-058	Health Secretary	3 September 2024	9 September 2024	2 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received ¹
STP-MOH-059	Health Secretary	13 September 2024	20 September 2024	2 electronic documents
STP-MOH-060	The Proper Officer, MNCLHD	16 September 2024	17 September 2024	1 electronic document
STP-MOH-061	Health Secretary	17 September 2024	23 September 2024	252 electronic documents
STP-MOH-062	Health Secretary	27 September 2024	11 October 2024	2 electronic documents
STP-MOH-063	Health Secretary	18 October 2024	23 October 2024	10 electronic documents
STP-MOH-066	Health Secretary	28 January 2025	31 January 2025	459 electronic documents
STP-MOH-067	The Proper Officer, NSW Ministry of Health	11 February 2025	25 February 2025	3 electronic documents
STP-MOH-068	Health Secretary	18 February 2025	20 February 2025	11 electronic documents
Summonses issues to other persons				
STP-MHK-001	Neil Mangelsdorf, Chair, Murrumbidgee Health and Knowledge Precinct Board	13 March 2024	14 March 2024	138 electronic documents
STP-WMH-001	Jane McGuire, Executive Manager and Director of Nursing, Uniting War Memorial Hospital	20 March 2024	2 April 2024	8 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received ¹
STP-ROR-001	Matthew Mackay, Company Secretary and Group Chief Executive Officer, Royal Rehab	20 March 2024	2 April 2024	9 electronic documents
STP-STA-001	Lachlan Murdoch, Deputy Chief Executive Officer, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors	20 March 2024	2 April 2024	
STP-HAM-001	Felicity Burns, General Manager, Health and Palliative Care, HammondCare	20 March 2024	2 April 2024	
STP-CMN-001	Roslyn Everingham, General Manager, Calvary Mater Newcastle	20 March 2024	2 April 2024	9 electronic documents
STP-CHC-001	David Izzard, National Executive Advisor Aged Care, Calvary Health Care	20 March 2024	3 April 2024	
STP-KAR-001	Grainne O'Loughlin, Company Secretary and Chief Executive Officer (CEO), Karitane	20 March 2024	2 April 2024	16 electronic documents
STP-KAR-002	Grainne O'Loughlin, Company Secretary and CEO, Karitane	4 April 2024	18 April 2024	151 electronic documents
STP-TRE-001	Robert Mills, CEO, Tresillian	20 March 2024	2 April 2024	12 electronic documents
STP-TRE-002	Robert Mills, CEO, Tresillian	4 April 2024	18 April 2024	26 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-SVH-001	Anna McFadgen, CEO, St Vincent's Hospital Sydney Limited	9 April 2024	25 April 2024	74 electronic documents
STP-SVH-002	Anna McFadgen, CEO, St Vincent's Hospital Sydney Limited	15 May 2024	24 May 2024	99 electronic documents
STP-HSL-001	The Proper Officer, Healthscope Limited	15 May 2024	24 May 2024	707 electronic documents
STP-SJG-001	The Proper Officer, St John of God Health Care	15 May 2024	24 May 2024	220 electronic documents
STP-CGP-001	The Proper Officer, Royal Australian College of General Practitioners	29 May 2024	12 June 2024	64 electronic documents
STP-SCI-001	The Proper Officer, University of Sydney	28 May 2024	3 June 2024	65 electronic documents
STP-SCI-002	The Proper Officer, University of New South Wales	28 May 2024	3 June 2024	134 electronic documents
STP-SCI-003	The Proper Officer, University of Notre Dame Australia	28 May 2024	3 June 2024	27 electronic documents
STP-SCI-004	The Proper Officer, Macquarie University	28 May 2024	3 June 2024	85 electronic documents
STP-SCI-005	The Proper Officer, University of Wollongong	28 May 2024	3 June 2024	23 electronic documents
STP-SCI-006	The Proper Officer, Western Sydney University	28 May 2024	3 June 2024	8 electronic documents
STP-SCI-008	The Proper Officer, University of Technology Sydney	28 May 2024	3 June 2024	28 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-SCI-009	The Proper Officer, University of Newcastle	28 May 2024	3 June 2024	537 electronic documents
STP-SCI-010	The Proper Officer, Charles Stuart University	28 May 2024	3 June 2024	11 electronic documents
STP-SCI-011	The Proper Officer, Australasian College of Emergency Medicine	29 May 2024	12 June 2024	80 electronic documents
STP-SCI-013	The Proper Officer, The Royal Australian and New Zealand College of Ophthalmologists	29 May 2024	12 June 2024	39 electronic documents
STP-SCI-014	The Proper Officer, The Australasian College of Dermatologists	29 May 2024	12 June 2024	26 electronic documents
STP-SCI-015	The Proper Officer, Australian College of Rural and Remote Medicine	29 May 2024	12 June 2024	195 electronic documents
STP-SCI-016	The Proper Officer, College of Intensive Care Medicine	29 May 2024	12 June 2024	65 electronic documents
STP-SCI-018	The Proper Officer, The Royal Australasian College of Physicians	29 May 2024	12 June 2024	153 electronic documents
STP-SCI-019	The Proper Officer, Royal Australasian College of Surgeons	29 May 2024	12 June 2024	72 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-SCI-020	The Proper Officer, The Royal Australian and New Zealand College of Psychiatrists	29 May 2024	12 June 2024	119 electronic documents
STP-SCI-021	The Proper Officer, The Royal College of Pathologists of Australasia	29 May 2024	12 June 2024	52 electronic documents
STP-SCI-022	The Proper Officer, Australian and New Zealand College of Anaesthetists	29 May 2024	12 June 2024	34 electronic documents
STP-SCI-023	The Proper Officer, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	29 May 2024	12 June 2024	55 electronic documents
STP-SCI-024	The Proper Officer, Royal Australasian College of Medical Administrators	29 May 2024	12 June 2024	194 electronic documents
STP-SCI-025	The Proper Officer, Royal Australian and New Zealand College of Radiologists (RANZCR)	29 May 2024	12 June 2024	105 electronic documents
STP-SCI-026	The Proper Officer, Australian College of Nursing	31 May 2024	14 June 2024	7 electronic documents
STP-SCI-027	The Proper Officer, University of New England (UNE)	28 May 2024	3 June 2024	21 electronic documents
STP-SCI-028	The Proper Officer, Australian Catholic University Limited	28 May 2024	3 June 2024	74 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-SCI-029	The Proper Officer, Australian Psychological Association	31 May 2024	14 June 2024	Production not pressed.
STP-SCI-030	The Proper Officer, The Australasian College of Paramedicine	31 May 2024	14 June 2024	1 electronic document
STP-SCI-031	The Proper Officer, Australian Physiotherapy Association	31 May 2024	14 June 2024	5 electronic documents
STP-SCI-032	The Proper Officer, Australian College of Nurse Practitioners	31 May 2024	14 June 2024	5 electronic documents
STP-SCI-033	The Proper Officer, Southern Cross University	28 May 2024	3 June 2024	35 electronic documents
STP-SCI-034	The Proper Officer, Torrens University Australia	28 May 2024	3 June 2024	13 electronic documents
STP-SCI-035	The Proper Officer, Allied Health Professionals Australia	31 May 2024	14 June 2024	190 electronic documents
STP-SCI-036	The Proper Officer, Occupational Therapy Australia	31 May 2024	14 June 2024	3 electronic documents
STP-SCI-037	The Proper Officer, Australian College of Midwives	31 May 2024	14 June 2024	Nil documents produced
STP-SCI-038	The Proper Officer, Speech Pathology Australia	31 May 2024	14 June 2024	55 electronic documents
STP-SCI-039	The Proper Officer, Physiotherapy Board of Australia	6 June 2024	19 June 2024	18 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-SCI-040	The Proper Officer, Australian Psychological Society	13 June 2024	18 June 2024	24 electronic documents
STP-SCI-041	The Proper Officer, Australian College of Mental Health Nurses	31 May 2024	14 June 2024	4 electronic documents
STP-SCI-042	The Proper Officer, The Pharmacy Guild of Australia	31 May 2024	14 June 2024	6 electronic documents
STP-SCI-043	The Proper Officer, The Society of Hospital Pharmacists of Australia	31 May 2024	14 June 2024	9 electronic documents
STP-SCI-044	The Proper Officer, Pharmaceutical Society of Australia	31 May 2024	14 June 2024	9 electronic documents
STP-SCI-045	The Proper Officer, RANZCR	15 July 2024	19 July 2024	2 electronic documents
STP-SCI-046	Dr Lloyd Ridley, Staff Specialist, Radiologist, Concord Repatriation General Hospital	15 July 2024	16 July 2024	1 electronic document
STP-SCI-047	Associate Professor Monisha Gupta, Head of Department and Senior Staff Specialist, Department of Dermatology, Liverpool Hospital	26 August 2024	6 September 2024	2 electronic documents

Summons Code	Summons Recipient	Date Issued	Return Date	Material Received¹
STP-TRY-001	Michael Coutts-Trotter, Secretary, NSW Treasury	11 November 2024	12 November 2024	1 document
STP-SCI-049	The Proper Officer, Australian Salaried Medical Officers' Federation	18 February 2025	20 February 2025	235 electronic documents

Appendix D: Schedule of Meetings

Meetings between the Commissioner and/or staff of the Special Commission, and external parties. Excluding witness conferences, briefing sessions, site visit meetings, and roundtables.

Date	Organisation or Person ²
4 September 2023	Amanda Larkin, Lead NSW Health Response Team
6 September 2023	Australian Salaried Medial Officers' Federation (ASMOF): • Dr Tony Sara, President • Andrew Holland, Executive Director
9 September 2023	Senior Executive Forum, NSW Health
20 September 2023	Australasian College for Emergency Medicine (ACEM): • Dr Clare Skinner, President • Dr Trevor Chan, NSW Faculty Chair
27 September 2023	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG): • Dr Benjamin Bopp, President • Professor Boon Lim, Vice-President • Vase Jovanoska, Chief Executive Officer (CEO)
27 September 2023	Royal Australian and New Zealand College of Psychiatrists (RANZCP): • Dr Angelo Virgona, Chair NSW Branch • Richard Hensley, NSW Branch Policy and Advocacy Advisor
28 September 2023	Australasian College of Dermatologists (ACD): • Dr Haley Bennett, CEO • Dr Rebecca Saunderson, NSW Faculty Chair • Cathy Baynie, Manager Advocacy and Health Workforce • Dr Ian McCrossin OAM, NSW Rural Taskforce Committee Member
29 September 2023	NSW Nurses and Midwives Association: • Shaye Candish, General Secretary, • Michael Whaites, Assistant General Secretary
4 October 2023	Health Consumers NSW: • John Garbutt, Board Chair • Dr Anthony Brown, CEO

² The role referenced for each person is intended to be the role held at the time of the meeting.

Date	Organisation or Person ²
4 October 2023	Royal Australasian College of Medical Administrators (RACMA): • Dr Helen Parsons CSC, President • Associate Professor Peter Thomas, NSW CPD Coordinator and Chair of the Medical Workforce Policy and Advocacy Subcommittee • Dr Cameron Korb-Wells, Non-Executive Director
6 October 2023	Fiona Davies, CEO, Australian Medical Association (AMA)
9 October 2023	Royal Australian College of General Practitioners (RACGP) NSW and ACT: • Sarah Spagnardi, State Manager • Professor Charlotte Hespe AM, Member of Board of Directors • Dr Michael Wright, Chair, RACGP Expert Committee, Funding and Health System Reform • Dr Anju Aggarwal, Deputy Chair
9 October 2023	Australian College of Rural and Remote Medicine (ACRRM): • Dr Marita Cowie AM, CEO • Associate Professor Daniel Halliday, President
10 October 2023	SAX Institute: • Dr Martin McNamara, CEO • Professor Michael Frommer, Senior Advisor • Genevieve Ileris, Head of Partnerships and Communication
12 October 2023	ANZCA: • Dr Chris Cokis, President • Dr Tanya Selak, Councillor for NSW • Nigel Fidgeon, CEO VIC
18 October 2023	Susan Pearce AM, Secretary, NSW Health Amanda Larkin, Lead NSW Health Response Team
18 October 2023	The Honourable Ryan Park MP, Minister for Health & Regional Health
19 October 2023	Health Services Union (HSU): • Gerard Hayes AM, NSW State Secretary • Dustin Halse, Division Secretary, Strategy, Research and Projects
19 October 2023	Dr Amanda Cohn, MLC Greens NSW, Spokesperson for Health

Date	Organisation or Person ²
23 October 2023	Garvan Institute of Medical Research: • Professor Benjamin Kile, Executive Director • Taia Rowe, Chief of Staff, Executive Director • Professor Anthony Joshua, Program Director, Translational Oncology/Laboratory Head – Oncology Translational Research • Dr Meg Barnet, Staff Scientist Garvan Research Foundation: • Brad Timms, Deputy Director
25 October 2023	Professor Robyn Ward
27 October 2023	Donna Burns, CEO, Australian Indigenous Doctor's Association
27 October 2023	RACP: • Dr Jacqueline Small, President • Dr Sayontonee Ghosh, Chair, RACP NSW/ACT Committee • Dr Kudzai Kanhutu, Dean • Nicola Lewis, Executive General Manager of Policy and Advocacy
31 October 2023	ANZCA: • Nigel Fidgeon, CEO VIC • Professor David Story, Vice President • Dr Vanessa Beavis, Past President
1 November 2023	Mental Health Carers NSW: • Jonathan Harms, CEO • Richard Baldwin, Senior Policy Officer
1 November 2023	RACS: • Associate Professor Kerin Fielding, President • Professor Mark Frydenberg AM, Councillor, Chair, Health Policy and Advocacy Committee • Dr Michelle Atkinson, Chair, NSW State Committee • Etienne Scheepers, Executive General Manager, Fellowship Engagement • Chesney O'Donnell, Manager Policy and Advocacy
2 November 2023	Scope of Practice Review: • Professor Mark Cormack, Independent Review Lead • Kerri Kellett, Director, Scope of Practice Review Section, Health Workforce Planning and Strategies, Australian Government Department of Health and Aged Care • Vanessa Peters, Australian Government Department of Health and Aged Care

Date	Organisation or Person ²
3 November 2023	Mick Reid AM, Western Sydney LHD Board Member
7 November 2023	Jill Ludford PSM, Chief Executive (CE), Murrumbidgee LHD
10 November 2023	Western NSW LHD: • Mark Spittal, CE • Peter Bonnington, Executive Director Finance and Corporate • Josh Carey, Executive Director, Service Delivery • Maryanne Hawthorn, Executive Director, Strategic Reform, Planning and Partnerships • Nirav Bajoria, Acting Executive Director, Finance Infrastructure and Corporate
10 November 2023	Margot Mains, CE, Illawarra Shoalhaven LHD
10 November 2023	Stewart Dowrick, CE, Mid North Coast LHD
10 November 2023	Brad Astill, CE, Far West LHD
13 November 2023	Southern NSW LHD: • Margaret Bennett OAM, CE • Sarah Wallace, Director of Finance
13 November 2023	Dominic Morgan ASM, NSW Ambulance
13 November 2023	Professor Jeffrey Braithwaite, Founding Director of the Australian Institute of Health Innovation, Director of the Centre for Healthcare Resilience and Implementation Science and Professor of Health Systems Research, Macquarie University
13 November 2023	Central Coast LHD: • Scott McLachlan, CE • Professor Donald MacLellan, Board Chair • Fiona Wilkinson, District Director of Quality, Strategy and Improvement
13 November 2023	Menzies Centre for Health Policy and Economics, The University of Sydney
15 November 2023	Tobi Wilson, CE, Sout Eastern Sydney LHD
15 November 2023	Teresa Anderson, CE, Sydney LHD
16 November 2023	Cathryn Cox PSM, CE, The Sydney Children's Hospital Network
15 November 2023	Sonia Marshall PSM, Acting CE, South Western Sydney LHD
16 November 2023	Graeme Loy PSM, CE, Western Sydney LHD
16 November 2023	Tracey Maisey, CE, Northern NSW LHD

Date	Organisation or Person ²
16 November 2023	Hunter New England LHD: - Tracey McCosker PSM, CE, - Paul Craven, Executive Director of Children, Young People and Families, Medical Services, Networks and Streams - Lauren Cruz, Executive Director, Chief of Staff - Tony Gilbertson, Executive Director of Finance
17 November 2023	Lee Gregory, CE Nepean Blue Mountains LHD
17 November 2023	Adjunct Professor Kathy Eagar AM, Faculty of Medicine and Health, University of New South Wales
17 November 2023	Pharmacy Guild of Australia: - Daniel Kicuroski, NSW Branch Director - David Heffernan, NSW Branch President
17 November 2023	St Vincent's Health Network: - Anna McFadgen, CEO - Paul Jansz, Cardiothoracic Surgeon
20 November 2023	Charles Perkins Centre, The University of Sydney: - Professor Stephen Simpson, Academic Director - Emeritus Professor Stephen Colagiuri AO, Professor of Public Health
20 November 2023	HETI: - Adjunct Professor Annette Solman, CE - Dr Jo Burnand, Deputy Medical Director Ministry of Health: - Richard Griffiths, Executive Director, Workforce Planning and Talent Development
20 November 2023	Diane Watson, CE, BHI
20 November 2023	Health Infrastructure: - Rebecca Wark, CE - Emma Skulander, Chief Operating Officer (COO)
20 November 2023	Wendy Hoey PSM, CE, JHFMHN
21 November 2023	Adjunct Professor Michael Nicholl, CE, CEC

Date	Organisation or Person ²
21 November 2023	Ministry of Health: • Dr Kerry Chant AO PSM, Chief Health Officer and Deputy Secretary, Population and Public Health • Dr Nigel Lyons, Special Advisor • Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience • Amanda Larkin, Lead NSW Health Response Team • Sally Lee, Director NSW Health Response Team
21 November 2023	ACI: • Adjunct Professor Jean-Frédéric Levesque, CE and Deputy Secretary Clinical Innovation and Research • Dr Kim Sutherland PSM, Director, Evidence
21 November 2023	eHealth NSW: • Dr Zoran Bolevich, CE, eHealth NSW and Chief Information Officer, NSW Health • Petra Milnes, Director Communications, Engagement and Office of the CE
22 November 2023	University of Technology Sydney: • Professor Debra Anderson, Dean, Faculty of Health; Founding Director, Women's Wellness Research Collaborative • Professor Toby Newton-John, Acting Head of School, Graduate School of Health • Professor David Bedford, UTS Business School • Professor Emily Callander, Health Economist; Head of Discipline, Health Services Management, School of Public Health • Distinguished Professor Jane Hall AO, Health Economics, Centre for Health Economics Research and Evaluation
22 November 2023	Vanessa Janissen, CE, NSW Health Pathology
22 November 2023	Professor Tracey O'Brien AM, Chief Cancer Officer and CEO, Cancer Institute NSW
23 November 2023	HealthShare NSW: • Jennifer Van Cleef, Acting CE • Samantha Norris, Director of Office of Chief Executive • Paul Gavel, Director, People and Culture
23 November 2023	Associate Professor Winston Cheung, Senior Staff Specialist Intensive Care Unit, Concord Repatriation General Hospital

Date	Organisation or Person ²
29 November 2023	NSW Ministry of Health: - Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience - Adjunct Professor Alfa D'Amato, Chief Financial Officer
4 December 2023	Wiser Healthcare: - Professor Kirsten McCaffery, Co-Founder - Professor Katy Bell, Chief Investigator - Professor Paul Glasziou AO, Chief Investigator - Professor Christopher Maher AM, Chief Investigator - Professor Denise O'Connor, Chief Investigator
5 December 2023	Robyn Kruk AO, Independent Reviewer, Independent Review of Health Practitioner Regulatory Settings Pauline Sullivan, Department of the Prime Minister and Cabinet
5 December 2023	IHACPA: - Professor Michael Pervan, CEO - Joanne Fitzgerald, Executive Director, Hospital Policy and Classification - Julia Conway, Acting Director, Hospital Policy - Sarah Neville, Director, Analytics - Samuel Webster, Director, Pricing Development
5 December 2023	Dustin Halse, Division Secretary, Strategy, Research and Projects, HSU
6 December 2023	National Rural Health Alliance: - Susi Tegen, CE - Margaret Deearain, Director, Policy and Strategy Development
13 December 2023	University of Newcastle, Department of Rural Health: - Professor Jennifer May AM, Director - Associate Professor Leanne Brown, Deputy Director
18 December 2023	Medical Deans Australia and New Zealand - Helen Craig, CEO of Medical Deans - Professor Michelle Leech AM, President - Professor Zsuzsoka Kecskes, Secretary, Medical Deans' Executive Committee
19 December 2023	NSW Treasury: - Julian Cornelius, Director, Health - Louis Kastoun, Executive Director, Health and Stronger Communities

Date	Organisation or Person ²
22 January 2024	Network of Alcohol and other Drug Agencies: • Dr Robert Stirling, CEO • Chris Keyes, Deputy CEO
22 January 2024	NSW Rural Doctors Association: • Dr Sue Velovski, Committee Member (Lismore) • Dr Charles Evill, Ex-Officio/Past President
24 January 2024	Professor Anthony Gill AM, Senior Staff Specialist Anatomical Pathology, Royal North Shore Hospital
24 January 2024	Ernst and Young • Isaac Bromley, Partner • Francine Caratti, Director Business Transformation Health and Human Services • Darren Chua, Asia -Pacific Consulting Digital Strategy and Transformation Leader
2 February 2024	Health Services Association NSW (HSA) • Matt Mackay, President HSA and CE, Royal Rehab • Grainne O'Loughlin, Board Director HSA and CEO, Karitane • Dr Andrew Montague, Director and General Manager, Health & Palliative Care, HammondCare • Robert Mills, Treasurer HSA and CE, Tresillian • Mary Dowling, Executive Director HSA
2 February 2024	Ben Cant, CEO, State Medical Assistance
5 February 2024	Michael Gendy, Chief Procurement Officer, NSW Health
5 February 2024	Adjunct Professor Michael Nicholl, CE, CEC
6 February 2024	Medtronic: • Kate King, Director Government Affairs, Australia and New Zealand • Professor Gabriela Prada, Senior Director, Health Systems Policy, Global Government Affairs
7 February 2024	Associate Professor Stephen Della-Fiorentina, Clinical Director Cancer Services, South Western Sydney LHD • Nasreen Kaadan, Cancer Information Program Manager • Gary Gooze, Director, Medical Physics

Date	Organisation or Person ²
7 February 2024	HSU: • Debbie Haig, Lead Pharmacist, Clinical Trials, CCLHD • Jill Harris, Director of Radiation Therapy, Westmead and Blacktown Hospitals • Trish Han, Radiographer, Royal Prince Alfred Hospital • Associate Professor James Nol, Operations Director, Medical Imaging, Blacktown and Mount Druitt Hospitals • Julie Williams, Speech Pathologist previously at Manning Base Hospital • Steve Fraser, recently retired Intensive Care Paramedic and HSU Educator • Gerard Hayes AM, NSW State Secretary • Ellen Curtis, Manager of Counselling, Illawarra Drug and Alcohol Service • Sophie Jacob, Administration Officer, Sydney Children's Hospital at Randwick
8 February 2024	Carmen Rechbauer, CE, HealthShare NSW
8 February 2024	Vanessa Janissen, CE, NSW Health Pathology
8 February 2024	Sonia Marshall PSM, CE, South Western Sydney LHD
9 February 2024	Mark Spittal, CE, Western NSW LHD
9 February 2024	Dr Zoran Bolevich, CE, eHealth
9 February 2024	Adjunct Professor Jean-Frédéric Levesque, Deputy Secretary Clinical Innovation and Research; CE, ACI
9 February 2024	Dr Teresa Anderson, CE, Sydney LHD
14 February 2024	Chetankumar Mistry, Acting Manager End User Services, Sydney LHD
14 February 2024	Jacinta Ducat, Chief Information Officer (CIO), Southern NSW LHD
28 February 2024	Coolamon Shire Council: • David McCann, Mayor • Tony Donoghue, General Manager
29 February 2024	Associate Professor Nick Stephenson AM, Radiologist

Date	Organisation or Person ²
29 February 2024	Murrumbidgee PHN: • Ms Narelle Mills, CEO • Ms Melissa Neal, Executive Strategy and Innovation • Melissa Neal, Former CEO
1 March 2024	Robyn Manzie, Independent Chair of Murrumbidgee Mental Health Alliance
1 March 2024	Dr James Lawler, Child and Adolescent Psychiatrist and Director AMA
4 March 2024	Dr Rachel Christmas, President, NSW Rural Doctors Association
4 March 2024	IHACPA: • Professor Michael Pervan, CEO • Joanne Fitzgerald, Executive Director, Hospital Policy and Classification • Julia Conway, Acting Director, Hospital Policy Projects - Sam Webster, Director, Pricing Development - Dr Sarah Neville, Director, Analytics
4 March 2024	Temora Shire Council: • Rick Firman OAM, Mayor • Wendy Skidmore, Facility Manager, Temora Hospital • Trevor Player, Secretary, Local Health Advisory Council • Anne Rands, Executive Assistant
4 March 2024	The University of Sydney: • Professor Anya Johnson, Head of Discipline in Work and Organisational Studies; Co-director, Body, Heart and Mind in Business Research Group • Professor Helena Nguyen, Professor of Work and Organisational Studies; Co-director, Body, Heart and Mind in Business Research Group
5 March 2024	Dr Fred Betros, General Surgeon and Vice President AMA
5 March 2024	Murrumbidgee LHD Board Members: • Mr Adrian Lindner, Interim Board Chair • Professor Alam Yoosuff, Board Member • Elizabeth Dixon, Chair Safety Quality Sub-Committee • Tony Kolbe, Chair Planning Resources and Performance Sub-Committee
5 March 2024	Dr Joseph (Joe) McGirr MP, Independent Member for Wagga Wagga
6 March 2024	Dr Michael Bonning, GP and Former President AMA

Date	Organisation or Person ²
6 March 2024	RACGP NSW and ACT: • Dr Rebekah Hoffman, Chair • Dr Anju Aggarwal, Deputy Chair • Associate Professor Ayman Shenouda, Immediate Past Chair of RACGP Rural • Naomi Levack Payne, Faculty Officer • Sarah Spagnardi, State Manager
6 March 2024	Dr Kean-Seng Lim, General Practitioner and Past President AMA
7 March 2024	Dr Kathryn Austin, Staff Specialist Obstetrician and President AMA
7 March 2024	Berrigan Shire Council: • Julia Cornwell McKean, Mayor • Karina Ewer, CEO • Keelan McDonald, Communications, Marketing and Engagement
7 March 2024	AHMRC: • Shana Quayle, Acting CEO • Jamie Newman, Acting Chairperson • Jade Hansen, Director, Recovery and Compliance
7 March 2024	Justin Clancy MP, Albury State Electorate • Kim Haebich, psychologist, Gateway Health, Senior Researcher Law Trobe University, former Manager Psychology Department, Albury Wodonga Health • Albury Wodonga Health: • Bill Appleby, CEO • Jonathan Green, Board Chair • Kim White, Executive Director Quality, Governance and Patient Experience, Chief of Nursing and Midwifery • Dr John Elcock, Chief Medical Officer
8 March 2024	Rural Doctors Network • Richard Colbran, CEO • Mike Edwards, COO
8 March 2024	Professor Lesley Forster, Dean of Rural Medicine, Charles Sturt University
8 March 2024	Casey Hastings, Radiographer
8 March 2024	Dr Peter Lipski, Consultant Geriatrician and Director of Geriatric Medicine, Brisbane Waters Private Hospital, Woy Woy
11 March 2024	Peta Larsen, CEO, Riverina Medical and Dental Aboriginal Corporation

Date	Organisation or Person ²
11 March 2024	Western NSW LHD: • Mark Spittal, CE • Sarah Booker, Manager Primary Care Strategies • Maryanne Hawthorn, Executive Director Strategic Reform, Planning and Partnerships
12 March 2024	Associate Professor Paul Mara AM, Director University of New South Wales (UNSW) Murrumbidgee Regional Training Hub
12 March 2024	Far West LHD: • Brad Astill, CE
12 March 2024	UNSW: • Professor Tara Mackenzie, Associate Dean of Rural Health, School of Clinical Medicine • Tony Jordan, Clinical Campus Manager, Rural Clinical Campuses • Dr Zoe Terpening, Director Strategy and Precincts
25 March 2024	Dustin Halse, Division Secretary HSU
27 March 2024	Ken Barker PSM, retired - former Chief Financial Officer, NSW Health
27 March 2024	Dr Rhonda Kerr, Health Economist
28 March 2024	Adjunct Professor Kathy Eagar AM, Faculty of Medicine and Health, UNSW
2 April 2024	Wiser Healthcare: • Professor Kirsten McCaffery, Co-Founder • Professor Katy Bell, Chief Investigator • Professor Christopher Maher AM, Chief Investigator
2 April 2024	Charles Perkins Centre, The University of Sydney: • Professor Stephen Simpson, Academic Director • Emeritus Professor Stephen Colagiuri AO, Professor of Public Health • Professor Luigi Fontana, Scientific Director • Dr Zoe Szewczyk, Postdoctoral Researcher
3 April 2024	Mick Reid AM, Western Sydney LHD Board Member
3 April 2024	Northern Sydney LHD: • Dr Kenneth Herington, Resident Medical Officer Emergency Department, Royal North Shore Hospital • Dr Justin Bowra, Senior Staff Specialist and Clinical Lead in ED Ultrasound, Emergency Physician, Royal North Shore Hospital

Date	Organisation or Person ²
4 April 2024	Senior Clinicians for Health Care Reform: • Dr Kerrie MacDonald, Paediatrician • Associate Professor Anthony Joseph AM, Emergency Physician • Professor Alan Rosen, Senior Consultant Psychiatrist • Associate Professor Aniello Iannuzzi, GP
8 April 2024	Dr Fiona McDonald, Queensland University of Technology, Australian Centre for Health Law Research
8 April 2024	Dr Sanjay Hettige, Radiology Registrar and AMA Member
10 April 2024	Rural Doctors Network • Richard Colbran, CEO • Mike Edwards, COO
11 April 2024	Tobi Wilson, Chief Executive South Eastern Sydney LHD
12 April 2024	Marathon Health • Megan Callinan, CEO • Justine Summers, COO
12 April 2024	Murdi Paaki Regional Assembly: • Grace Gordon, Chair • Haylee Rogers, A/CEO
17 April 2024	Jen Bottrell, Manager Local Mental Health Programs Mission Australia
18 April 2024	Diane Watson, CE, BHI
19 April 2024	NSW/ACT PHN Network: • Michelle Quinn, Acting CEO of Western Sydney Primary Health Network • Nathalie Hansen, CEO, Central and Eastern Sydney PHN • Eamon Brodie, Policy Officer
19 April 2024	Paramedicine Council of NSW • Adjunct Associate Professor Alan Morrison, President • Peter Lang, Deputy President
22 April 2024	Brooke Fields, Regional Development Australia – Local Connector, Welcoming Service Initiative Far West LHD

Date	Organisation or Person ²
22 April 2024	National Rural Health Alliance: • Susi Tegen, CE • Margaret Deerrain, Director, Policy and Strategy Development Bogan Shire Council: • Derek Francis, General Manager • Deb Wood, Director People and Community Services
23 April 2024	Headspace • Julia Smith, COO • Kiera Mansfield, Head of Centre Services • Simon Dodd, Head of Workforce Planning and Development • Julie Petering, Principal Policy Advisor, Headspace National
24 April 2024	RACMA • Dr Helen Parsons CSC, President • Associate Professor Peter Thomas, NSW CPD Coordinator and Chair of the Medical Workforce Policy and Advocacy Subcommittee
24 April 2024	Shana Quayle, Acting CEO, AHMRC
26 April 2024	RFDS (South Eastern Section): • Greg Sam, CEO • Associate Professor Shannon Nott, Executive General Manager Health and Clinical Services, Chief Medical Officer • Annabey Whitehead, Executive General Manager Corporate Affairs and Fundraising • Hellen Georgopolous, External Policy Advisor for Health and Development
26 April 2024	Richard Weston, CEO, Maari Ma Health
29 April 2024	Paul Carr, Chair, Three Rivers Regional Assembly
30 April 2024	Health Consumers NSW: • John Garbutt, Board Chair • Dr Anthony Brown, CEO
30 April 2024	Margaret Bennett OAM, CE, Southern NSW LHD
30 April 2024	Tracey Maisey, CE, Northern NSW LHD
30 April 2024	Stewart Dowrick, CE, Mid North Coast LHD

Date	Organisation or Person ²
1 May 2024	The University of Sydney, School of Rural Health: • Professor Catherine Hawke, Head of Clinical School • Associate Professor Randall Greenberg, Deputy Head of Clinical School • Associate Professor Georgina Luscombe, Associate Professor Rural Health
2 May 2024	Professor Debra Jones, Head of School, Broken Hill University
2 May 2024	ACEM: • Dr Stephen Gourley, President • Dr Rhys Ross-Browne, NSW Faculty Chair • Caitlyn O'Dowd, General Manager, Policy and Public Affairs
2 May 2024	Dr Justin Bowra, Chair, ACEM Emergency Telehealth Network
2 May 2024	Jenna Bottrell, Manager Local Mental Health Programs Mission Australia
2 May 2024	Meredith Cummins, CEO, NeuroEndocrine Cancer Australia
2 May 2024	Dr Robin Williams, Chair, WNSWPHN
3 May 2024	Greg Tory, General Manager, Lachlan Shire Council
3 May 2024	Setthy Ung, Chair, SWSLHD Medical Staff Executive Council Liverpool Hospital Medical Staff Council: • Associate Professor Conjoint Miriam Levy, Executive • Dr Hari Nandakoban, Chair • Dr Daniel O'Neil, Secretary • Dr Zinta Harrington, Acting Director Medical Services
3 May 2024	Dr Warren Hargreaves, General Surgeon, and clinical Director of Surgery, Griffith Base Hospital
6 May 2024	Brad Cam, General Manager, Mid Western Council
6 May 2024	Brett Chambers, Manager, Virtual Clinical Pharmacy Service, Western NSW LHD
6 May 2024	Helen McFarlane, Director Mental Health, Drug and Alcohol, Western NSW LHD
6 May 2024	Dr Rosalind Bullock, GP, Nyrang Health Team

Date	Organisation or Person ²
6 May 2024	Centre for Sex and Gender Equity in Health & Medicine • Dr Cheryl Carcel, Program Head, Brain Program, George Institute for Global Health Australia • Dr Laura Downey, Senior Research Fellow, Health Systems Science • Professor Christine Jenkins, Head, Respiratory Group • Veronica Le Nevez, Head of Impact and Engagement Australia
6 May 2024	Debbie Bickerton, General Manager, Dubbo Health Service
6 May 2024	My Emergency Doctor: • Dr Justin Bowra, Founder • Sam Johnson, Chairman • Bill Maiden, former CEO • Dr Audra Gedmintas, Chief Medical Officer
6 May 2024	Cobar Shire Council: • Jarrod Marsden, Mayor • Kylie Smith, Director Corporate & Community Services
6 May 2024	Dr Rachel Christmas, President, NSW Rural Doctors Association
6 May 2024	Gilgandra Shire Council: • David Neeves, General Manager • Donna Dobson, Director Aged Care and Disability Services
7 May 2024	Sharon McKay, Director of Rural Health Services, Nyngan Health Service
7 May 2024	Dr Benjamin Canalese, GP VMO, Virtual Rural Generalist Service, Western NSW LHD
7 May 2024	Broken Hill City Council: • Tom Kennedy, Mayor • Jay Nankivell, General Manager • Lacey Butcher, Corporate Administrative Officer
7 May 2024	Dianne Harvey, Virtual Allied Health Manager and Service Improvement Lead, Western NSW LHD
7 May 2024	Tony Martin, Emergency Department Aboriginal Health & Wellbeing, Western NSW LHD
7 May 2024	Jacintha Victor John, Senior Policy and Advocacy Advisor, Exercise and Sports Science Australia Devlin Higgins, Exercise and Sports Science Australia Accredited Exercise Physiologist

Date	Organisation or Person ²
7 May 2024	Mary-Anne Spence, Director Aged Care, Palliative Care and Disability Services, Western NSW LHD
7 May 2024	Dr Michelle McRae, Dermatologist, Senior Director of Training for the Australasian College of Dermatologists
8 May 2024	Dr Ian Spencer, GP VMO, Wellington
9 May 2024	Murdi Paaki Regional Assembly: • Grace Gordon, Chair • Haylee Rogers, A/CEO • Judith Burns, Principal, Burns Aldis
9 May 2024	Dr Neil McCarthy, GP
16 May 2024	Barbara Turner, Deputy Manager, Remote Health Services, Far West LHD
16 May 2024	Isabella Bond, Second Year Transition to Practice Nurse, Far West LHD
16 May 2024	Jodie Miller, Director of Clinical Operations, Far West LHD
23 May 2024	Ben Edwards, CEO, St John of God Hospital Corporation
23 May 2024	Genevieve Adamo, Pharmacist
24 May 2024	Dr Angus Alexander, Chair, Medical Staff Council, Children's Hospital at Westmead (CHW)
27 May 2024	Dr Puneet Singh, Chair, Senior Medical Staff Council Sydney Children's Hospital, Randwick
27 May 2024	CHW, Department of Paediatric Anaesthesia: • Dr Andrew Weatherall, Co-Head • Dr Ramanie Jayaweera, Co-Head
27 May 2024	Associate Professor Davinder Singh-Grewal, Paediatric Rheumatology, CHW
27 May 2024	Children's Hospital at Westmead, General Medicine Service • Dr Christine Lau, Acting Head of General Medicine CHW and Sydney Children's Hospital Network (SCHN) Integrated Care Clinical Lead • Dr Jacqui Dalby-Payne, Clinical Stream Director, Medical Program • Amanda Carter, Head of Dietetics • Clare Klimes, Director of Allied Health • Dr Naren Nadanachandran, VMO Paediatrics and General Medicine • Melissa Perumal, Clinical Nurse Consultant, Complex and Chronic Care Needs

Date	Organisation or Person ²
28 May 2024	Ruth Colagiuri AM, Founder, Juvenile Arthritis Foundation Australia
29 May 2024	Professor Gordon Thomas, Staff Specialist, General Surgery, and Liver and Kidney Transplant Surgery Associate Professor Kathryn Browning Carmo, Senior Staff Specialist, Neonatologist at NETS and NICU at CHW
30 May 2024	Pharmacy Guild of Australia (NSW Branch): • David Heffernan, President • Daniel Kicuroski, Director • David Bryant, Group Manager – Pharmacy Viability • Johnson Lee, Chief Pharmacist • Felix Faber, Policy and Media Advisor
31 May 2024	ANZCA: • Michelle Moyle, Chair, NSW Regional Committee • Frances Page, Co-Deputy Chair, NSW Regional Committee • Mark Priestley, Chair, Leadership and Management Special Interest Group • Sharon Tivey, Co-Deputy Chair, NSW Regional Committee • Nilusha Moses, Government Relations Manager
3 June 2024	RANZCP: • Dr Angelo Virgona, Chair, NSW Branch Committee • Richard Hensley, Branch Policy and Advocacy Advisor
3 June 2024	Associate Professor Kaustuv Bhattacharya, Senior Staff Specialist, Genetic Metabolic Disorders Service, SCHN
6 June 2024	Dr Natalie Rainger, Consultant Otolaryngologist and Head and Neck Surgeon, WNSWLHD
11 June 2024	ACD: • Dr Adrian Lim, President-Elect • Dr Haley Bennett, CEO • Caroline Zoers, Director Policy, Advocacy and Engagement
12 June 2024	RACP: • Professor Inam Haq, Executive General Manager, Education, Learning and Assessment • Associate Professor Mitra Guha, Chair, RACP Education Committee • Nicola Lewis, Executive General Manager, Policy and Advocacy • Libby Newton, Manager, Education Policy, Research and Evaluation

Date	Organisation or Person ²
12 June 2024	RACMA: • Dr Helen Parsons CSC, President • Dr Cameron Korb-Wells, Non-Executive Director • Dr Tony Sara, Chair NSW Jurisdictional Committee
13 June 2024	RACS: • Associate Professor Kerin Fielding, President • Dr Stephanie Clota, CEO
14 June 2024	RACGP: • Dr Rebekah Hoffman, Chair, NSW and ACT Faculty • Glen Wallace, Executive Officer, GP Training
20 June 2024	Dr Martin McNamara, CEO, Sax Institute
26 June 2024	CICM: • Daniel Angelico, CEO • Olivia McLean, General Manager, Training • Michelle Gonsalvez, Policy & Advocacy Advisor
2 July 2024	RANZCOG: • Associate Professor Michael Rasmussen, Board Director • Vase Jovanovska, CEO • Bec McPhee, Head of Advocacy and Communications • May Raguine, Complaints Pathway Support Officer
4 July 2024	Nilusha Moses, Government Relations Manager, ANZCA
4 July 2024	RANZCR: • Duane Findley, CEO • Melissa Doyle, General Manager, Policy and Advocacy • Brendan Grabau, General Manager, Specialty Training Unit
5 July 2024	Australasian College of Dermatologists: • Dr Monisha Gupta, Director of Dermatology, Liverpool Hospital • Caroline Zoers, Director Policy, Advocacy and Engagement
5 July 2024	Professor Richard Hensley, Branch Policy and Advocacy Advisor, RANZCP
8 July 2024	CICM: • Daniel Angelico, CEO • Olivia McLean, General Manager, Training

Date	Organisation or Person ²
9 July 2024	RACP: • Professor Inam Haq Kudzai, Executive General Manager Education, Learning and Assessment • Associate Professor Kudzai Kanhutu, College Dean • Venus Amoro-Njuguna, Senior Legal Counsel • Libby Newton, Manager Education Policy, Research and Evaluation
9 July 2024	The University of Sydney: • Professor Anya Johnson, Deputy Head of Discipline in Work and Organisational Studies • Professor Helena Nguyen, Professor of Work and Organisational Studies
9 July 2024	RDN: • Mike Edwards, CEO • Richard Colbran, CEO
10 July 2024	ASMOF: • Dr Behny Samadi, Staff Specialist Intensive Care, St George Hospital • Michelle Piccone, Industrial Officer, ASMOF
12 July 2024	Dr Martin McNamara, CEO, Sax Institute
26 July 2024	Dr Martin McNamara, CEO, Sax Institute
31 July 2024	Dr Mohamed Haroon Kasim, Hospitalist, Hornsby Ku-ring-gai Hospital, Northern Sydney LHD
2 August 2024	South Eastern NSW PHN: • Prudence Buist, CEO • Andrew Gow, Director, Strategy and Performance
2 August 2024	Colin Shipard, Finance Director, Finance and Performance reporting, Katungul Aboriginal Corporation Regional Health and Community Services
5 August 2024	Peter Ryan, Lead of Save Batemans Bay ED Group
6 August 2024	Dr Andrew Gibson, General Practitioner and Member of Save Batemans Bay ED Committee
6 August 2024	Dr Corin Miller, GP working in ED and Paediatrics at South East Regional Hospital
7 August 2024	Adam Phillips, CEO, Grand Pacific Health
8 August 2024	Fiona Davies, CEO, AMA

Date	Organisation or Person ²
13 August 2024	Dr Nicola Holmes, GP, Coffs Medical Centre
14 August 2024	Julie Tongs OAM, CEO, Winnunga Nimmityjah Aboriginal Health and Community Services
14 August 2024	Save Batemans Bay ED Group: • Peter Ryan, Group Lead • Auntie Val Wright, Aboriginal Elder • Dr Andrew Gibson, GP • Ann McClintock, President, Batemans Bay Hospital Auxiliary
21 August 2024	The Hon. Chris Minns MP, Premier of NSW The Hon. Ryan Park MP, Minister for Health
23 August 2024	Dr Dubravka Jankovic, Psychiatrist, Coffs Harbour
26 August 2024	Tamworth Aboriginal Medical Service – Aboriginal Corporation: • Damion Brown, CEO • Kevin Duroux, Deputy CEO • Dr Rajesh Ishri, GP
26 August 2024	Scott Monaghan AM, CEO, Bulgarr Ngaru Medical Aboriginal Corporation
26 August 2024	Fay Adamson, CEO, Werin Aboriginal Corporation
27 August 2024	Pius X Aboriginal Corporation: • Donna Taylor, CEO • Rosemary Rose, Nurse Manager
27 August 2024	Paul Morris, CEO, Durri Aboriginal Corporation Medical Serice
29 August 2024	Professor Victoria Flood, Head of Rural Clinical School, Northern Rivers and Director to University Centre for Rural Health, Northern Rivers, with the Faculty of Medicine and Health, University of Sydney
29 August 2024	Dr Alan Forrester, Network Director, Emergency Medicine, Mid North Coast LHD
30 August 2024	Southern Cross University: • Professor Julie Jomeen, Executive Dean, Faculty of Health • Chris Ashton, Executive Director and Chief of Staff, Office of Vice Chancellor

Date	Organisation or Person ²
30 August 2024	Hunter New England and Central Coast PHN: - Mr Richard Nankervis, CEO - Dr Alison Koschel, Executive Manager Populations, Access and Performance
2 September 2024	Dr Cath Cosgrave, Founder and Lead Consultant, Attract Connect Stay
2 September 2024	Donna Ausling, Director, Planning and Sustainability, Narrabri Shire Council
2 September 2024	Professor Nick Zwar, Executive Dean, Bond University
2 September 2024	Dr Andrew Gottke, GP Anaesthetist, Narrabri Hospital
3 September 2024	Dr Gabriel Lau, Emergency Medicine Specialist, Port Macquarie
3 September 2024	Armajun Aboriginal Health Service: - Debbie McCowen, CEO - Belinda Tully, Inverell Operations Manager
10 September 2024	Dr Ian Kamerman, Principal, Northwest Health
10 September 2024	Headspace: - Simone Balzer, Senior Manager, Headspace Lismore - Cassandra Primmer, CFO, Headspace Lismore - Julie Petering, Principal Policy Officer, Headspace National
11 September 2024	Durri Aboriginal Corporation Medical Service: - Paul Morris, Acting CEO - Charlea Kennedy, Executive Assistant to CEO
12 September 2024	Dr Susan Velovski, Specialist General Surgeon
12 September 2024	Payden Samuelsson, CEO, Bullinah Aboriginal Health Service
12 September 2024	Dr Nicholas Spooner, Director of Emergency Medicine, Wyong Hospital and President, ASMOF
12 September 2024	HSU: - Gerard Hayes AM, NSW State Secretary - Dustin Halse, Division Secretary HSU
12 September 2024	Dr Judith Toman, GP VMO, Obstetrics, Moruya Hospital
13 September 2024	Dr Behny Samadi, Staff Specialist, Intensive Care Unit, St George Hospital
13 September 2024	Janelle Saffin MP, Member for Lismore

Date	Organisation or Person ²
16 September 2024	Dr Mark Priestley, Head of Department of Anaesthesia and Perioperative Medicine, Westmead Hospital
19 September 2024	Dr Janet Roberts, GP VMO, Obstetrics, Kempsey Hospital
25 September 2024	Rural Doctors Network: • Mike Edwards, COO • Richard Colbran, CEO
26 September 2024	Jivani Murugan, Policy Officer – Closing the Gap, AHMRC
4 October 2024	RANZCOG: • Professor Boon Lim, Vice-President • Dr Martina Mende, Associate Board Director • Arlen Keen, Policy Officer • Bec McPhee, Head of Advocacy and Communications
8 October 2024	RACP: • Professor Inam Haq, Executive General Manager, Education, Learning and Assessment • Associate Professor Kudzai Kanhutu, College Dean • Libby Newton, Manager, Education Policy, Research and Evaluation, Education, Learning and Assessment
9 October 2024	ANZCA: • Dr Frances Page, Co-chair (S & Q Officer) • Dr Sharon Tivey, Co-chair (S & Q Officer) • Dr Mark Priestley, Chair, Leadership and Management SIG
15 October 2024	Dr Martin McNamara, CEO, SAX Institute Mick Reid, Mick Reid and Associates
28 October 2024	Sax Institute: • Dr Martin McNamara, CEO • Sian Rudge, Head, Strategic Development • Sarah Thackway, Principal Consultant • Dr Jo Mitchell, Director, Policy by Proxy • Nadia Mastersson, Head, Prevention • Professor Andrew Milat, Public Health, University of Sydney
28 October 2024	LaVerne Belleair, CEO, AMS Redfern
31 October 2024	Professor Michelle Guppy, Head of School of Rural Medicine, University of New England

Date	Organisation or Person ²
4 November 2024	IHACPA: • Professor Michael Pervan, CEO • Joanne Fitzgerald, Executive Director, Hospital Policy and Classification • Professor Kees Van Gool, Executive Director, Pricing and Analytics
5 November 2024	Central and Eastern Sydney PHN: • Nathalie Hansen, CEO • Brendan Goodger, General Manager, Primary and Community Care Stream
5 November 2024	Sax Institute: • Dr Martin McNamara, CEO • Sian Rudge, Head, Strategic Development
5 November 2024	Andrew Newton, CE, Western Sydney PHN
7 November 2024	Public Health Association of Australia (PHAA): • Associate Professor Kate McBride, President, NSW PHAA Branch Committee • Terry Slevin, CEO
13 November 2024	NSW Treasury: • Louis Kastoun, Executive Director, Health and Stronger Communities Division • Julian Cornelius, Director, Health • Charles Cho, General Counsel • Tim Jap, Legal Counsel
13 November 2024	Dr Anne Rasmussen, Anaesthetist, Pacific Anaesthesia, Port Macquarie Private Hospital
14 November 2024	Mental Health Coordinating Council: • Dr Evelyn Tadros, CEO • Corinne Henderson, Director, Policy and Systems Reform
14 November 2024	AMA: • Luke Toy, General Manager Advocacy • Anthony Crook, Chief Economist
21 November 2024	Richelle McCausland, National Health Practitioner Ombudsman

Date	Organisation or Person ²
4 February 2025	HSA: • Mary Dowling, Executive Director, HSA • Robert Mills, Treasurer, HSA and CE, Tresillian • Matt Mackay, President, HSA and CE, Royal Rehab • Roz Everingham, General Manager, Calvary Mater Newcastle
19 February 2025	Professor Andrew Wilson AO, Co-Director, Leeder Centre for Health Policy, Economics and Data, University of Sydney
5 March 2025	NSW Opposition • Mark Speakman, Leader of the Opposition in the New South Wales Legislative Assembly • Kellie Sloane, Shadow Minister for Health

Appendix E: Schedule of Site Visits

No.	Location	Date
Northern Sydney Local Health District		
1.	Royal North Shore Hospital	8 November 2023
2.	Hornsby Ku-ring-gai Hospital	8 November 2023
Murrumbidgee Local Health District		
3.	Wagga Wagga Base Hospital	13 March 2024
4.	Riverina Medical and Dental Aboriginal Corporation (RivMed)	13 March 2024
5.	Batlow-Adalong Multi-Purpose Service	14 March 2024
6.	Tumut Hospital	14 March 2024
7.	Facilities in Finley – Finley Hospital, Finley Aged Care Service and Finley Medical Centre	15 March 2024
8.	Berrigan Multi-Purpose Service	15 March 2024
Western NSW Local Health District		
9.	Western NSW LHD Virtual Care Hub	8 May 2024
10.	Dubbo Health Service (Hospital)	8 May 2024
11.	Coonamble Multi-Purpose Service	9 May 2024
12.	Coonamble Aboriginal Medical Service	9 May 2024
13.	Nyngan Medical Centre and Multi-Purpose Service	10 May 2024
14.	Bogan Shire Council Medical Centre	10 May 2024
Far West Local Health District		
15.	Royal Flying Doctor Service	20 May 2024
16.	Maari Ma Health Aboriginal Corporation	20 May 2024
17.	Broken Hill Health Service	20 May 2024
18.	Menindee Multi-Purpose Service	21 May 2024

No.	Location	Date
19.	Wilcannia Multi-Purpose Service	21 May 2024
Southern NSW Local Health District		
20.	Bega South East Regional Hospital	12 August 2024
21.	Cooma Hospital	13 August 2024
22.	Bombala Multi-Purpose Service	13 August 2024
23.	Winnunga Nimmitjiah Aboriginal Health and Community Services	14 August 2024
24.	Katungul Aboriginal Corporation Regional Health and Community Services	14 August 2024
Central Coast Local Health District		
25.	Wyong Hospital	20 August 2024
26.	Long Jetty Urgent Care Centre	20 August 2024
Illawarra Shoalhaven Local Health District		
27.	Wollongong Hospital	21 August 2024
Northern NSW Local Health District		
28.	Lismore Base Hospital	4 September 2024
29.	Rekindling the Spirit Health Service – Jullums House	4 September 2024
30.	Namatjira Haven Drug & Alcohol Healing Centre	4 September 2024
31.	University of Sydney Centre for Rural Health Lismore	5 September 2024
32.	Healthy North Coast Primary Health Network	5 September 2024
33.	First Light Healthcare	5 September 2024
34.	Bulgarr Ngaru Medical Aboriginal Corporation	6 September 2024
35.	Tweed Valley Hospital	6 September 2024
Mid North Coast Local Health District		
36.	Galambila Aboriginal Health Service	9 September 2024
37.	Coffs Medical Centre	9 September 2024
38.	Coffs Harbour Health Campus	9 September 2024

No.	Location	Date
39.	Bowraville HealthOne	10 September 2024
40.	Macksville District Hospital	10 September 2024
41.	Durri Aboriginal Corporation Medical Service	11 September 2024
42.	Port Macquarie Base Hospital	11 September 2024
Hunter New England Local Health District		
43.	Tamworth Hospital	16 September 2024
44.	Tamworth Aboriginal Medical Service – Aboriginal Corporation	16 September 2024
45.	John Hunter Hospital	25 November 2024
Nepean Blue Mountains Local Health District		
46.	Nepean Hospital	21 October 2024
Western Sydney Local Health District		
47.	Westmead Hospital	23 October 2024
Sydney Local Health District		
48.	Concord Repatriation General Hospital	24 October 2024
49.	Aboriginal Medical Services Redfern	28 October 2024
Albury Wodonga Health		
50.	Albury Wodonga Aboriginal Health Service	29 October 2024
51.	Albury Base Hospital	30 October 2024
NSW Ambulance		
52.	NSW Ambulance Control Centre, Bankstown Ambulance Station and Bankstown Helicopter Base	1 November 2024
South Western Sydney Local Health District		
53.	Budyari (Miller) Community Health Centre	4 November 2024
54.	Liverpool Hospital Interventional Radiology Department	4 November 2024
55.	Liverpool Research and Education Centre	4 November 2024
Sydney Children's Hospitals Network		

No.	Location	Date
56.	Westmead Children's Hospital	6 November 2024
57.	The Sydney Children's Hospital Randwick	6 November 2024
South Eastern Sydney Local Health District		
58.	Prince of Wales Hospital	7 November 2024
59.	Headspace Bondi Junction	7 November 2024
Justice Health and Forensic Mental Health Network		
60.	The Forensic Hospital	8 November 2024
61.	Long Bay Hospital	8 November 2024
62.	Metropolitan Special Programs Centre	8 November 2024

Appendix F: Schedule of Roundtable Discussions

Date	Location	List of Attendees
13 March 2024	Wagga Wagga Base Hospital	Jill Ludford PSM, Chief Executive, Murrumbidgee LHD Carla Bailey, Executive Director Operations Professor Lenert Bruce, General Manager, Wagga Wagga Base Hospital, and Executive Director Medical Services, Murrumbidgee LHD Professor John Preddy, Clinical Director Murrumbidgee LHD Paediatric Department Dr Elmien Bruce, Clinical Director of Ambulatory Care Phil Major, Manager Patient Flow Transport Unit Catherine McCaig, Nurse Unit Manager, Rapid Access Clinic Charmaine Marshall, District Education and Development Manager Dr Martin Jude, Neurologist Emma Field, Director Integrated Care and Allied Health Elizabeth Martin, Manager Strategic Planning and Innovation, Mental Health Drug and Alcohol Ashlee Taylor, District Clinical Leader Mental Health Physical Healthcare and Clozapine, Murrumbidgee LHD Jesse Warran-Rigby, Senior Peer Worker Elle Minn, Clinical Director, Rapid Access Clinic
13 March 2024	Riverina Medical and Dental Aboriginal Corporation	Peta Larson, Chief Executive Dr Rachel Fikkers, General Practitioner Jane Kearnes, Practice Manager Together with five colleagues.
14 March 2024	Batlow-Adelong Multipurpose Service (MPS) and Tumut District Hospital	Jill Ludford PSM, Chief Executive, Murrumbidgee LHD Carla Bailey, Executive Director Operations Rosemary Garthwaite A/Director Integrated Care and Allied Health (District Manager) Emma Field, Director Integrated Care and Allied Health Kerry Lindeman, Cluster Manager

Date	Location	List of Attendees
		Sheena Luiz, Facility Manager, Batlow-Adelong MPS Jacqueline Anderson, Facility Manager, Tumut Hospital
15 March 2024	Finley Hospital and Berrigan MPS	Jill Ludford PSM, Chief Executive, Murrumbidgee LHD Carla Bailey, Executive Director Operations Craig McColm, Cluster Manager – Deniliquin Margreet Gutker, Facility Manager, Berrigan MPS Ben Levesque, Principal, Finley Regional Care Associate Professor Alam Yoosuff, Murrumbidgee LHD Board Member and Board Director, Principal GP, Finley Regional Care Syd Dudley, Chair, Local Health Advisory Committee, Finley Emma Field, Director Integrated Care and Allied Health Aman Deol, Facility Manager, Finley Hospital
8 May 2024	Western NSW LHD Virtual Care Hub	Mark Spittal, Chief Executive, Western NSW LHD Josh Carey, Executive Director, Service Delivery Meegan Connors, Director Western Virtual Health Connect Dr Benjamin Canalese, GP Visiting Medical Officer (VMO), Virtual Rural Generalist Service (VRGS) Co-Clinical Lead Brett Chambers, Pharmacist and Director Virtual Pharmacy Mary-Anne Spence, Director Aged, Palliative and Disability Services Dianne Harvey, Virtual Allied Health Manager Dr Mariam Joseph, Virtual Geriatric Service
8 May 2024	Dubbo Health Service	Mark Spittal, Chief Executive Western NSW LHD Josh Carey, Executive Director, Service Delivery Debbie Bickerton, General Manager Dubbo Health Service Dr Florian Honeyball, Medical Oncologist Dubbo Health Service Dr Thomas Eade, VMO Radiation Oncologist Dubbo Health Service Dr Thomas Gleeson, Haematologist Dubbo Health Service

Date	Location	List of Attendees
		Helen McFarlane, Director Mental Health Drug and Alcohol Services Dr Warren Kealy-Bateman, Clinical Director Mental Health Drug and Alcohol Dubbo and Regions Catherine Osborne, Deputy Chief Radiation Therapist
9 May 2024	Coonamble MPS	Mark Spittal, Chief Executive, Western NSW LHD Elizabeth Burnheim, Health Service Manager and Castlereagh Network Manager Dr Martin Hua, Acting Rural Health Director Medical Services, VRGS Co-Clinical Lead, GP VMO Tammy O'Connor, Senior Manager, Paediatrics Child and Family Wellness Tony Martin, Executive Director Aboriginal Health and Wellbeing Donna Stanley, Mental Health Drug and Alcohol Aboriginal Coordinator
9 May 2024	Coonamble Aboriginal Medical Service (AMS)	Phil Naden, CEO Tony Martin, Executive Director Aboriginal Health and Wellbeing Steve (JJ) Smith, Aboriginal Health Worker Beau Ewers, Executive Officer Ruth Luppino, Practice Manager
10 May 2024	Nyngan MPS	Mark Spittal, Chief Executive, Western NSW LHD Sharon McKay, Director Rural Health Services Renee Mendes, Residential Aged Care Coordinator Jenny Griffiths, Health Service Manager Ben Loiacona, Zone Manager Central and Far West, NSW Ambulance

Date	Location	List of Attendees
20 May 2024	Broken Hill Health Service (BHHS)	Brad Astill, Chief Executive, Far West LHD Dr Sarah Wenham, Executive Director Medical Services, Far West LHD Dr Cameron Spenceley, Clinical Director, Emergency Medicine, BHHS Jodie Miller, Director of Clinical Operations, BHHS Jane Bostock, Deputy Director of Nursing & Midwifery – Operational, BHHS Ryan Rooney, Deputy Director Mental Health, Drug & Alcohol, Far West LHD Julie Manoel, Director of Nursing & Midwifery/General Manager, BHHS Denise Jack, Director Mental Health, Drug & Alcohol, Far West LHD Melissa Welsh Director Allied Health & Integrated Community Services, Far West LHD Rebecca Smith, Manager, Integrated Care, Far West LHD Kahlia Liston, Clinical Nurse Consultant (CNC), Emergency & Critical Care, Far West LHD Tyrone Dallas, Nurse Unit Manager, Intensive Care Unit, BHHS
21 May 2024	Menindee Health Service	Brad Astill, Chief Executive, Far West LHD Sally Pearce, Board Chair, Far West LHD Corina Kemp, Director Aboriginal Health and Community Relations, Far West LHD Denise McCallum, General Manager, Remote Health Services, Far West LHD Barbara Turner, Deputy General Manager, Remote Health Services, Far West LHD Dearna Murray, Nurse Manager, Menindee Health Service A/Prof Shannon Nott, Chief Medical Officer, Royal Flying Doctor Service

Date	Location	List of Attendees
21 May 2024	Wilcannia MPS	Brad Astill, Chief Executive, Far West LHD Gillian Robbins, Health Service Manager, Wilcannia MPS Adrienne Evans, Nurse Practitioner, Wilcannia MPS Sally Pearce, Board Chair, Far West LHD Corina Kemp, Director Aboriginal Health and Community Relations, Far West LHD Barbara Turner, Deputy General Manager, Remote Health Services, Far West LHD Denise McCallum, General Manager, Remote Health Services, Far West LHD Michael Cassidy Kennedy, Chair, Wilcannia Local Aboriginal Land Council
12 August 2024	Bega South East Regional Hospital (SERH)	Margaret Bennett, Chief Executive, Southern NSW LHD Prue Buist, Chief Executive Southern NSW Primary Health Network (Coordinaire) Sarah Little, Facility Manager / Director of Nursing and Midwifery, SERH Dr Elizabeth Mullins, Director Medical Services, SERH, Southern NSW LHD Executive Director Medical Services Suzanne Eddie, Nurse Unit Manager, SERH Dr Nathan Oates, VMO Anaesthetist and Director Prevocational Education and Training, SERH Dr Susie Piper, Head of Paediatrics, SERH and District Paediatric Medical Lead Leonie Rolfe, Site Manager, Food and Patient Support Services Kelly Winter, Manager Alcohol and Other Drugs Kayeleen Brown, District Director Aboriginal Health, Southern NSW LHD Fiona Renshaw, Executive Director Operations, Southern NSW LHD Elizabeth Hoskins, Board Chair, Southern NSW LHD Brad Scotcher, General Manager, Coastal Network Dr Caroline Stewart, Paediatrician, Out Reach Clinic, Forensic Medical Services

Date	Location	List of Attendees
13 August 2024	Cooma Hospital	Margaret Bennett OAM, Chief Executive, Southern NSW LHD Kylie Williams, Director of Nursing and Midwifery, Site Manager, Cooma Hospital Dr Andrew Clarke, Senior ED Doctor Joann Cawthorne, Deputy Direct of Nursing and Midwifery Amy Simpson, Emergency Department Nursing Unit Manager Polly Witts, Pharmacist Jo-anne Hagger, Manager Pathology Hilary Keighley, Head of Department, Physiotherapy Kate Russell, Administration Chris Hanna, Snowy Mountains Mayor Fiona Renshaw, Executive Director Operations, Southern NSW LHD Brian Bonham, General Manager, Inland Network Dr Serena Ayers, Director of Medical Services, Inland Network
13 August 2024	Bombala MPS	Margaret Bennett, Chief Executive, Southern NSW LHD Jackie Ross, Director of Nursing Site Manager Naomi Burgess, Deputy Director of Nursing Melanie Flanagan, Clinical Nurse Educator John Russell, Registered Nurse Dr Hamish Steiner, VMO/GP Tracey Romans, Administration Officer Evelyn Walker, Health Services Manager Emily Guthrie, Clinical Nurse Consultant Deb Bailey, Community Health
20 August 2024	Wyong Hospital	Dr Elizabeth Reyneke, Neurologist & Co-Chair of Central Coast LHD Clinical Council Michael Swab, Director Pharmacy & Co-Chair of Central Coast LHD Clinical Council Dr Kat Taylor, Director Public Health Deanna Aplitt, Director Oral and Allied Health Shanell Bennett, Manager Aboriginal Health

Date	Location	List of Attendees
		Wendy Stanbrook-Mason, District Director Nursing and Midwifery Graeme Hopper, Nurse Manager – Central Coast Health at Home Melissa Pickering, Director Nursing Community Chronic and Complex Care Professor Boon Lim, Clinical Director Women, Children and Families Jennifer Burrows, Nursing Unit Manager Wyong Scott McLachlan, Chief Executive, Central Coast LHD
20 August 2024	Long Jetty Urgent Care Centre	Melissa Pickering, Director Nursing Community Chronic and Complex Care Fiona Young, Nursing Unit Manager Urgent Care Service Carmel Mezrani Medical Lead for Long Jetty Urgent Care Service James Consentino, Physiotherapist, Long Jetty Urgent Care Service Brooke Stone, Administration, Long Jetty Urgent Care Service Leanne McLaren, Health Manager Phelicity Templar, Community Health Community Nurse Nicole McDonald, Director Community Chronic and Complex Care Scott McLachlan, Chief Executive
21 August 2024	Wollongong Hospital	Margot Mains, Chief Executive, Illawarra Shoalhaven LHD Lou Fox, Executive Director of Integrated Community Services and Mental Health Megan Foye, Divisional Co-Director, Division of Aged Care and Rehabilitation, Registered Nurse Dr John McKenzie, Geriatrician Staff Specialist, Divisional Co-Director Division of Aged Care and Rehabilitation Dr Jan Potter, Geriatrician Staff Specialist, Divisional Co-Director Division of Aged Care and Rehabilitation Melissa Rees, Director of Nursing/Operations Manager, Registered Nurse Ben Wakeling, Director Clinical Strategy & Outcomes, Registered Nurse

Date	Location	List of Attendees
		Tim Bear, Quick Access Response Team (QuART) Physiotherapist and ED Allied Health Navigator Anna O'Hare, Co-Director Critical Care, Registered Nurse Mark Sewell, Consultant, Community Industry Group re Aged Care James Linden, Director of Strategic Partnerships and Innovation, Coordinare, Primary Health Network
21 August 2024	Wollongong Hospital	Margot Mains, Chief Executive, Illawarra Shoalhaven LHD Lou Fox, Executive Director of Integrated Community Services and Mental Health Dr Karen Murphy, Executive Director Medical Services Mark Garrick, Executive Director Strategy, Risk, Planning & Performance Sue-Ellen Hogg, Acting Executive Director Allied Health, Head of Discipline - Speech Pathology, Speech Pathologist Dr Joshua Rijdsdijk, Anaesthetist, Co-Director Anaesthetics, Medical Staff Council and Board staff representative Megan Blanchard, Manager, Performance Unit Lauren Wiedl, Nurse Educator, the Wollongong Hospital Angela Jones, Midwifery Co-Director, Division of Maternity and Women's Health, Midwife and Registered Nurse Prudence Buist, CEO, Coordinare, Primary Health Network Melanie Briggs, Senior Midwife, Waminda South Coast Aboriginal Women's Health and Welfare Corporation Cleone Wellington, Cultural Manager, Waminda South Coast Aboriginal Women's Health and Welfare Corporation
4 September 2024	Lismore Base Hospital (LBH)	Tracey Maisey, Chief Executive, Northern NSW LHD Ian Hatton, General Manager, LBH Narelle Gleeson, Director of Nursing, LBH Dr Sarah Coghill, Head of Department, General Medicine, LBH Stuart Rollans, Manager Corporate Services, LBH Trent Taylor, Strategic Partnerships and Innovation Manager, Mental Health Service, LBH

Date	Location	List of Attendees
		Kristie Allen, A/Nursing Unit Manager, Intensive Care Unit, LBH Emma McDonald, Head of Department, Physiotherapy, LBH Nancy Martin, Executive Officer/Director of Nursing, MPS Network Professor Vicki Flood, Executive Director, University Centre for Rural Health Jennifer Richter, Nurse Manager, Nursing and Midwifery, LBH Dr Katherine Willis-Sullivan, Director Medical Services, LBH Luke Elias, Director, Primary Care Impact and Partnerships, Healthy North Coast PHN
5 September 2024	Healthy North Coast Primary Health Network	Monica Wheeler, Chief Executive Dr Adrian Gilliand, Coffs Harbour Medical Susan Parker Pavlovic, Director, Aboriginal Health Partnerships Sigrid Patterson, Director, People, Planning and Performance Luke Elias, Director, Primary Care Impact and Partnerships Aimee McNeil, Director, Integrated Wellbeing
6 September 2024	Bulgarr Ngaru Medical Aboriginal Corporation	Scott Monaghan, Chief Executive Officer, Bulgarr Ngaru Medical Aboriginal Corporation Dr Marion Tait, GP Dr Josh Bush, GP Dr Andrew Black, GP Debbie Caldwell, Nurse Practitioner
6 September 2024	Tweed Valley Hospital (TVH)	Tracey Maisey, Chief Executive, Northern NSW LHD Adam Reid, Acting General Manager Rachael Andrew, Acting Director Nursing and Midwifery Tania Wittleton, Director Allied Health, Mental Health Alcohol and other Drugs Dr Robert Davies, Director Emergency Department, TVH Michelle Brinkman, Midwifery Unit Manager, TVH Dr Pierre Hofstee, Junior Resident Medical Officer, TVH

Date	Location	List of Attendees
		Armalie Muller, Head of Department, Speech Pathology, TVH Cameron Johnson, Aboriginal Workforce Manager Professor Nick Zwar, Executive Dean, Faculty of Health Sciences and Medicine, Bond University Luke Elias, Director, Primary Care Impact and Partnerships, Healthy North Coast PHN Georgia Baker, Registered Nurse, TVH
9 September 2024	Coffs Harbour Health Campus	Stewart Dowrick, Chief Executive, Mid North Coast LHD Dr Alan Tankell, Former Chair Medical Staff Council, Director of Emergency Department Peter Treseder, Board Chair Sandy Everson, Specialist Nurse Practitioner Psychogeriatrics, Coffs Harbour Health Campus Nicole Knight, Divisional Nurse Manager, Critical Care and Surgical Services, Coffs Harbour Health Campus Peter Brookes, Nurse Unit Manager, Surgical Ward B, Coffs Harbour Health Campus Dr Eileen Morrisroe, Director of Surgery, Coffs Harbour Health Campus Dr Adil Bahauddin, Director of Medicine Dr Marilyn Clarke, Clinical Director Obstetrics and Gynaecology Dr David Cooper, Director of Medical Services Amanda Buzio, Stroke CNC, Coffs Harbour Health Campus Lydia Dennett, Coordinator, Coffs Harbour Clinical Network and General Manager, Coffs Harbour Health Campus Robyn Stanning, Physiotherapist, A/District Manager Health Reform, Opportunities & Transition Dr Michael Su, Staff Specialist General Surgeon and Surgical Oncologist and Chair of the Medical Staff Council
10 September 2024	Bowraville HealthOne	Stewart Dowrick, Chief Executive, Mid North Coast LHD Jill Wong, Director Integrated Care, Allied Health and Community Services, Mid North Coast LHD

Date	Location	List of Attendees
		Kelvin Jarrett, Aboriginal Health Worker, Alcohol and Other Drugs, Coffs Harbour Health Campus and Bowraville HealthOne Dr Valerie Delpech, Regional Director, North Coast Population and Public Health Jo Butler, Manager Community Health, Macksville and Bellinger River District Hospitals, HealthOne Nambucca and Bowraville Ingrid Sivertsen, District Manager, Integrated Primary Care Leah Maitland, District Manager Integrated Virtual Care Juaques Kruger, District Manager, Aged Care and Chronic Disease James O'Brien, Health Relationship Manager, NSW Ambulance Service Dr Jayne Scofield, GP, Bowraville Dr Caitlin Driscoll, GP, Bowraville Jenny Zirkler, Governing Board Member
10 September 2024	Macksville District Hospital	Stewart Dowrick, Chief Executive, Mid North Coast LHD Josef Upston, Social Worker Dr Karly Field, Director of Emergency Medicine Breanna Greenup, Aboriginal Health Liaison Officer Lydia Dennett, Coordinator, Coffs Harbour Clinical Network and General Manager, Coffs Harbour Health Campus Andrew Bailey, Director, Research and Knowledge Transition, and Director of Nursing Jane Higgins, A/Nurse Unit Manager, Emergency Department Dr David Wong, Rural Generalist Anaesthetist (GP VMO) Ellen Delforce, Theatre Nursing Unit Manager Toni Winters, Patient Services Manager Dee Hunter, North Eastern Regional Representative for the United Hospital Auxiliaries

Date	Location	List of Attendees
11 September 2024	Port Macquarie Base Hospital	Stewart Dowrick, Chief Executive, Mid North Coast LHD Jill Wong, Director Integrated Care, Allied Health and Community Services, MNCLHD Peter Treseder, Board Chair, MNCLHD Penny Jones, Director Integrated Mental Health Drug and Alcohol Services Sarah Fox, District Manager Perinatal, Infant, Child and Youth Mental Health Services Emily Saul, Acting Director of Nursing and Midwifery, Port Macquarie Base Hospital, MNCLHD Dr Stephen Begbie, Executive Clinical Director, Hastings Macleay Clinical Network, Medical Oncologist and General Physician Dr Rob Hislop, VMO Intensive Care Specialist, General Physician, Port Macquarie Base Hospital and Chair of the Medical Staff Council, Port Macquarie Base Hospital Dr Dawn Martin, Network Director of Emergency Medicine, Hastings Macleay Clinical Network, MNCLHD Duncan Pretty, Nurse Unit Manager Dr Bruce Hodge, Director of Surgery, Port Macquarie Base Hospital, MNCLHD Lydia Dennett, Coordinator, Coffs Harbour Clinical Network and General Manager, Coffs Harbour Health Campus
16 September 2024	Tamworth Hospital	Tracey McCosker PSM, Chief Executive, Hunter New England LHD Susan Heyman, Executive Director, Operations Yvonne Patricks, General Manager Tamworth Hospital Elizabeth Grist, Executive Director, Clinical Services, Nursing and Midwifery, OAM Dr Andrew Woods, Senior Staff Specialist Maternity and Gynaecology, and Clinical Lead of the Women's Health and Maternity Network Michelle Foster, Network Manager Women's Health and Maternity Network Samantha Gardner, A/Director Nursing and Midwifery, Tamworth Hospital Kelly Ison, Nurse Manager, Maternity Services, Tamworth Hospital

Date	Location	List of Attendees
		Dr Kenneth Apen, Senior Staff Specialist, Maternity and Gynaecology, Tamworth Hospital Lisa Ramsland, General Manager, Armidale Hospital Tracey Barnden, Midwifery Educator, Armidale Hospital Elizabeth Pitman, Maternity Unit Manager, Inverell Dr Cheryl McIntyre, GP VMO Obstetrician, Inverell
16 September 2024	Tamworth Hospital	Tracey McCosker, Chief Executive, HNELHD Julie Tait, General Manager, John Hunter Hospital Susan Heyman, Executive Director, Operations Tony Gilbertson, Executive Director, Finance Michelle Whiteley, Director of Nursing and Midwifery Dr Jacki-Louise Cowell, ED physician Gemma Model, Physiotherapist Jonathan Holt, General Manager, Mental Health Services Anne Sweetapple, Allied Health Manager Roslyn Barker, Aged Care Emergency Service Nicola Swan, Hospital Social Worker Louise Lazic, General Manager, Integrated Care Julie Evans, Project Manager, Virtual Care
21 October 2024	Nepean Hospital	The Hon. Peter Collins, AM KC, Chair, Nepean Blue Mountains LHD Lee Gregory, Chief Executive, Nepean Blue Mountains LHD Dr Nhi Nguyen, Deputy Chair, Nepean Blue Mountains LHD, and ICU Doctor, Nepean Hospital Vanessa Clements, Director Planning, Redevelopment & Strategy Cathy Crowe, Director Community & Integration A/Prof James Mallows, Chair, Nepean Medical Staff Council, and Senior Emergency Physician, Nepean Hospital Dr Stavros Prineas, Chair, Blue Mountains Medical Staff Council, Anaesthetist, Nepean Hospital, and Head of Anaesthetics, Blue Mountains Hospital Dr Elizabeth Tompsett, Chair, Hawkesbury Medical Staff Council

Date	Location	List of Attendees
		Carmel Zucak, A/Director Nursing & Midwifery, Nepean Hospital Jamila Howarth Director, Allied Health, Nepean Hospital Lyn Day A/General Manager, Nepean Hospital Elizabeth Scott, Executive Officer to the Chief Executive
21 October 2024	Nepean Hospital	Lee Gregory, Chief Executive, Nepean Blue Mountains LHD Dr Nhi Nguyen, Deputy Chair, Nepean Blue Mountains LHD, and ICU Doctor, Nepean Hospital Chris Boothroyd, Clinical Nurse Consultant Emergency Blue Mountains & Lithgow Hospitals Derek Boersma, Head of Physiotherapy, Blue Mountains Hospital Sue Downward, Clinical Midwife Consultant, Maternity Services Nepean Hospital Susan Lane, Clinical Nurse Consultant, Neurology Nepean Hospital Jenella Cottle, Department Head, Social Work Nepean Hospital Dr Nardeen Habashy, Advanced Trainee Endocrinology, Nepean Hospital Brendan Shortis, Acting Nurse Manager Community Health Marta Emilia Wos, Community Nurse Darryn Egan, Team Leader Penrith Community Mental Health Team Elizabeth Scott, Executive Officer to the Chief Executive
23 October 2024	Westmead Hospital	Graeme Loy, Chief Executive, Western Sydney LHD Jason Sevil, General Manager Mental Health Services Dr Sara Ghaly, Director Medical Services, Mental Health Services Dr Priya Rajendran, Early Career Psychiatrist, Yaralla MICU Cumberland Campus Dr Raphael Fraser, Community Psychiatrist, Blacktown Emma Graham, NUM Riverview Unit, Cumberland Campus

Date	Location	List of Attendees
23 October 2024	Westmead Hospital	Graeme Loy, Chief Executive, Western Sydney LHD Professor Mark Dexter, Head of Department Neurosurgery Anna Lefebvre, Senior MRI Radiographer, Westmead Hospital Joanna Preece, Operations Manager, Medical Imaging Westmead Hospital Dr Sachin Gupta, Head of Neurology Children's Hospital Dr Chong Wong, Head of Neurology Westmead Hospital
23 October 2024	Westmead Hospital	Graeme Loy, Chief Executive, Western Sydney LHD Maria Lingam, Director Nursing & Midwifery Nicole Grice, Director People & Culture David Glastonbury, NUM ED, Mount Druitt Hospital Anna Lam, District Associate Director Professional Practice & Strategy Elizabeth Makepeace, New Graduate ICU Westmead Hospital Sahar Nazari, New Graduate, Endoscopy Blacktown Hospital Katie Heywood, New Graduate Registered Nurse, Continuing Orientation Unit Auburn Hospital
24 October 2024	Concord Repatriation General Hospital	Deborah Willcox, Chief Executive, Sydney LHD Associate Professor Sue Woolfenden, Director, Child and Family Hub Director, SLHD Rachel Walker, Director, Child and Family Health Services, SLHD Dr Santuri Rungan, Staff Specialist, Community Paediatrician, SLHD Dr Andrew McDonald, Clinical Director Mental Health Services, SLHD Alison Green, NUM, Naamuru, SLHD Dr Sylvia Lim-Gibson, Director, Clinical Services, Mental Health Services and Naamuru Parent and Baby Unit Dr Cameron Korb-Wells, Medical Director, National Centre for Veterans' Healthcare Kirsty Chapman, Operations Manager, National Centre for Veterans' Healthcare

Date	Location	List of Attendees
24 October 2024	Concord Repatriation General Hospital	Deborah Willcox, Chief Executive, Sydney LHD Dr Richard Totaro, Co-Director Intensive Care Service, Royal Prince Alfred Hospital Ruaidhri Carey, Clinical Nurse Consultant, ECMO Retrieval, SLHD Associate Professor Paul Forrest, Head CT Anaesthesia and Perfusion, SLHD Dr Kirk Austin, Colorectal Surgeon, Lead Pelvic Exenteration, Royal Prince Alfred Hospital Skye Cooke, Clinical Manager, Critical Care and Gastroenterology & Liver Services, SLHD Dr Sharon Carey, Intestinal Failure Service Lead, SLHD Miranda Pye, Nurse Practitioner Burns Unit, Concord Repatriation General Hospital Professor Peter Maitz, Director, Burns Unit Concord Repatriation General Hospital Dr Nicola Clayton, Clinical Specialist, Speech Pathology
29 October 2024	Albury Wodonga Aboriginal Health Service	David Noonan, Chief Executive Officer Craig Taylor, Chairperson Michelle Dean, Social and Emotional Wellbeing Manager Lauren Blatchford, Clinical Manager
30 October 2024	Albury Base Hospital	Bill Appleby, Chief Executive Officer Glenn Edwards, Chief Financial Officer Dr Lucie Shanahan, Chief Operating Officer, Allied Health & Mental Health & Chief Allied Health Officer Linda Hudec, Chief Operating Officer, Acute Hospital Services
30 October 2024	Albury Base Hospital	Bill Appleby, Chief Executive Officer Kim White, Executive Director Quality, Governance & Patient Experience & Chief of Nursing & Midwifery Dr John Elcock, Chief Medical Officer Rebecca Jhonston, Chief of People Operations
30 October 2024	Albury Base Hospital	Bill Appleby, Chief Executive Officer Shaun Strachan, Chief of Infrastructure Susan Medlin, Director of Capital Redevelopment

Date	Location	List of Attendees
1 November 2024	NSW Ambulance Control Centre	Dr Dominic Morgan, Chief Executive, NSW Ambulance Clare Beech, A/Executive Director, Clinical Operations Brent Armitage, Director, Control Centres Brett Tinker, Associate Director, Operational Governance & Performance Bernard Coren, Associate Director, Service Planning Carolyn Parish, Duty Operations Manager, Northern Sydney Zone Melissa McGovern, Intensive Care Paramedic, North Sydney Dr Thomas Evens, Executive Director, Medical Services & Research, and Staff Specialist Prehospital and Retrieval Medicine
1 November 2024	NSW Ambulance Control Centre	Dr Dominic Morgan, Chief Executive, NSW Ambulance Dr Sarah Coombes, Executive Director, Aeromedical & Special Operations Dr Thomas Evens, Executive Director, Medical Services & Research, and Staff Specialist Prehospital and Retrieval Medicine Bernard Coren, Associate Director, Service Planning Lauren Mansell, Associate Director, Western Sector Wayne Cannon, Critical Care Paramedic Michael 'Taz' Rundle, Regional Paramedic Andrew Weidmeir, P1 Paramedic (Regional)
4 November 2024	Budyari (Miller) Community Health Centre	Sonia Marshall PSM, Chief Executive, South Western Sydney LHD Simone Proft, Director, Strategy and Partnerships Jemma Milloy, A/Director, Aboriginal Health Mandy Williams, Director, Population Health Justin Duggan, General Manager, Primary and Community Health Maree Tohi, Team Leader NUM, Aboriginal Chronic Care Vicki Bright, Director of Nursing, Primary and Community Health

Date	Location	List of Attendees
4 November 2024	Liverpool Hospital Interventional Radiology Department	Scott McGrath, General Manager, Liverpool Hospital Dr Glen Schlaphoff, Head of Department, Interventional Radiology Simone Proft, Director, Strategy and Partnerships
4 November 2024	Liverpool Research and Education Centre	Sonia Marshall PSM, Chief Executive, SWSLHD Scott McGrath, General Manager, Liverpool Hospital Simone Proft, Director, Strategy and Partnerships A/Prof Deepak Bhonagiri, Clinical Director Critical Care Dr Setthy Ung, Chair Medical Staff Executive Council Dr Ahilan Parameswaran, Co-Head Department Bankstown-Lidcombe Hospital ED Dr Mitchell Smith, Director NSW Refugee Health Service Scott McDonnell, Director Nursing & Midwifery Services, Camden and Campbelltown Hospitals Jemma Milloy, A/Director Aboriginal Health Service Katherine Kelly, Disability & NDIS Coordinator Dragana Martinez, Nurse Manager Camden & Campbelltown EDs Dr Abhijit Pal, Medical Oncologist Dr Dean Yeh, Colorectal and General Surgeon, Campbelltown Hospital Angela Davey, A/Director of Finance Jennifer Glass, Operations Director, Mental Health Briony Chasle, Clinical Manager, Aged Care and Rehabilitation
6 November 2024	Children's Hospital Westmead	Cathryn Cox, Chief Executive, Sydney Children's Hospitals Network Christie Breen, Acting Executive Director, Clinical Operations Dr Mary McCaskill, Director, Medical Services and Clinical Governance Dr Jonathan De Lima, Staff Specialist, Anaesthetics Dr Angus Alexander, Surgeon/ Medical Staff Council Chair Dr Sasko Kadiev, Chief Radiographer Dr Jacqueline Dalby-Payne, Staff Specialist, Medical

Date	Location	List of Attendees
		Melissa Mroz, Clinical Stream Director, Critical Care Clare Klimes, Director Allied Health Stephanie Crescini, Quiet Pathway Coordinator/Anaesthetic CNC Anusha Joseph, Consultation-Liaison Clinical Nurse Consultant – Mental Health Dr Nadia Badawi, Staff Specialist, Grace Centre for Newborn Intensive Care (GCNIC) Dr Himanshu Popat, Staff Specialist, GCNIC Leah Winder, Nurse Manager, GCNIC Dr Michelle Lorentzos, Staff Specialist, Neurogenetics Dr Jagdev Singh, Staff Specialist, Virtual Kids Dr Grace Wong, Staff Specialist, Child Protection Associate Professor Richard Widmer, Head of Dentistry Dr Soundappan Soundappan, Paediatric Surgeon
6 November 2024	Sydney Children's Hospital Randwick	Cathryn Cox, Chief Executive, Sydney Children's Hospital Network Christie Breen, Acting Executive Director, Clinical Operations Dr Mary McCaskill, Director, Medical Services and Clinical Governance Alan Porritt, Director of Clinical Operations, Sydney Children's Hospital Dr Richard Mitchell, Director of Kids Cancer Centre Rachael McHenry, Nurse Manager, Oncology Lisa Vale, Director Allied Health, Sydney Children's Hospital Dr Puneet Singh, Staff Specialist/Medical Staff Council Chair Dr Susan Adams, Surgeon Prof Michelle Farrar, Staff Specialist, Neurology Elizabeth (Emma) Palmer, Clinical Geneticist Prof Adam Jaffe, Staff Specialist, Respiratory Dr Hugo Sampaio, Staff Specialist, Neurology Felicity Wright, Director of Pharmacy, SCH Kirsty-Leah Goymour, Child Life Therapist, Palliative Care

Date	Location	List of Attendees
		Sally Whitney, Acting Nurse Manager, Emergency Department Dr Chris Webber, Staff Specialist, Emergency Department
7 November 2024	Prince of Wales Hospital	Tobi Wilson, Chief Executive, South Eastern Sydney LHD Dr Gregory Levenston, SESLHD Board Kate Hackett, Director Nursing and Midwifery Jennie Barry, General Manager, Prince of Wales Hospital Barbara Daly, Co-Director Nursing & Operations, Emergency & Specialist Medicine Dr Amel Katrib, Medical Co-Director, Emergency & Specialist Medicine Dr David Murphy, Medical Director Emergency Department Brett Clarke, Nurse Manager Emergency Department Wayne Varndell, Clinical Nurse Consultant Sarah Caruana Physiotherapist, Aged Care Services Emergency Team Justin O'Hare Co-Director Nursing & Operations, Community Connection and Virtual Health Dr Srinivas Bolisetty, Clinical Co-Director, Newborn Care Centre, Royal Hospital for Women Hannah Allen, Clinical Operations Manager, Eastern Suburbs Mental Health Service Daniel Jeffery, Peer Worker, Eastern Suburbs Mental Health Service Aoife O'Mara, Clinical Nurse Consultant, Eastern Suburbs Mental Health Service
7 November 2024	Headspace Bondi Junction	Tobi Wilson, Chief Executive, South Eastern Sydney LHD Dr Gregory Levenston, SESLHD Board Member Kate Hackett, Director Nursing and Midwifery Chris Hay, General Manager, Mental Health Services Rebekah Lucas, A/headspace Manager Caitlin Dixon, Clinical Coordinator, Youth mental Health Services Shanje Liu, Community Engagement Officer Greer Fitzgibbon, Youth Access Clinician Olivia Allum, Youth Access Clinician

Date	Location	List of Attendees
		Denise Blunt, Youth Reference Group Toni Ottavio, Service Director, Eastern Suburbs Mental Health Service Professor Jackie Curtis, Clinical Lead, Youth Mental Health Services, SESLHD
8 November 2024	Justice Health and Forensic Mental Health Network	Wendy Hoey PSM, Chief Executive, Justice Health and Forensic Mental Health Network Dr Vindi Nanayakkara, General Manager Forensic Mental Health Kevin Baron, Service Director, Forensic Hospital Dr Matthew Hearps, Clinical Director, Custodial Mental Health Kerri Eagle, Clinical Director, Community Forensic Mental Health Kath Jones, Service Director NSW Community Forensic Mental Health Services John Kasinathan, Clinical Director Adolescent Mental Health Professor David Greenberg, Clinical Director Statewide Community and Court Liaison Service Dr Christina Matthews, Acting Clinical Director, Forensic Health Karen Lawes, Acting Director of Nursing, Forensic Hospital Dale Owens, Manager of Metro & Southern Courts Dr Ian Korbel, Chair, Mental Health Medical Staff Council – Consultant Forensic Psychiatrist Prof Denis King, Board Chair Matthew Tempest, Aboriginal Clinical Lead Trisha Lloyd, Service Director, Adolescent and Forensic Mental Health
8 November 2024	Justice Health and Forensic Mental Health Network	Wendy Hoey PSM, Chief Executive, Justice Health and Forensic Mental Health Network Rose Loughheed, General Manager Primary Care Colette Mcgrath, General Manager Population and Preventative Health Dr Natasha Hyde, Clinical Director Primary Care Gary Nicholls, Executive Medical Director

Date	Location	List of Attendees
		Leigh Haysom, Director Medical Services Joanne Grimsdale, Chair Medical Staff Council – Deputy Clinical Director Primary Care Tom Chapman, Acting Director Allied Health Deb Little, Primary Care Director of Nursing – Regional Chloe Prior, Acting Regional Nurse Manager, Women's and Metro North Craig Cooper, Service Director Drug & Alcohol Tracey Brown, Program Manager, Population Health Grantley Creighton, Director, Aboriginal Health Katerina Lagios, Clinical Director, Drug & Alcohol Dr Peter Thompson, Clinical Director, Drug & Alcohol Dr Keith Heap, Clinical Director, Dental Health Prof Denis King, Board Chair, Justice Health and Forensic Mental Health Network Shani Prosser, Manager, Health Advancement Population Health
8 November 2024	Justice Health and Forensic Mental Health Network	Wendy Hoey, Chief Executive, Justice Health and Forensic Mental Health Network Professor Denis King, Board Chair, Justice Health and Forensic Mental Health Network Tracey-Lee Varga, Director People & Culture Ing Yu, Chief Financial Office
25 November 2024	John Hunter Hospital	Tracey McCosker PSM, Chief Executive, Hunter New England LHD Susan Heyman, Executive Director, Operations Dr Elizabeth Pepper, Director of Neurology Dr Zoheb Williams, Staff Specialist Vascular Surgery and Director of Prevocational Education and Training Dr Zsolt Balogh, Director Trauma Services Dr Rohan Bhagwande, Cardiologist and clinical lead for TAVI services Dr Felicity Park, Director Maternal Fetal Medicine Dr Frank Alvaro, Paediatric Oncologist Dr Sam Vidler, Retrieval Services Dr Mary Morgan, Chair Medical Staff Council

Date	Location	List of Attendees
		Dr Ferdi Miteff, Interventional Neuroradiology Jenny Carter, Patient Flow Manager Natalie Duns, IUC/PICU Nurse Manager John Greentree, Patient Access Manager Alexandra Mexon, MACU Nurse Manager Julie Tait, Executive General Manager John Hunter Hospital
25 November 2024	John Hunter Hospital	Tracey McCosker PSM, Chief Executive, Hunter New England LHD Susan Heyman, Executive Director, Operations Julie Tait, Executive General Manager John Hunter Hospital Adam Walczak, Deputy Director John Hunter Health and Innovation Precinct Professor Francis Kay-Lambkin, Institute Director and CEO of the Hunter Medical Research Institute Warwick Dawson, Deputy Partnerships and Innovation, University of Newcastle Dr Mark Parsons, Director of Academic and Commercial Partnerships for the Precinct and Neurologist at John Hunter Hospital Dr Cate McIntosh, Director HNE Simulation Centre and Anaesthetist Dr Ramsey Awad, Executive Director Infrastructure, Planning and Sustainability Ishaq Khan, Director Clinical Technology A/Professor Chris Dayas, Deputy Head of College, Health, Medicine and Wellbeing, University of Newcastle

Appendix G: List of Appearances

Party/Witness	Name/Legal Representative	Dates
Senior Counsel Assisting	Edward Muston SC	Various
Counsel Assisting	Ross Glover	
	Tasmin Waterhouse	
	Ian Fraser	
	Dan Fuller	
NSW Health	Lachlan Gyles SC	19–23 February 2024, 26 February 2024
	Richard Cheney SC	Various
	Hilbert Chiu SC	
	Joanna Davidson	19–23 February 2024, 26 February 2024
		14–15 November 2024, 18–21 November 2024
	Hernan Pintos-Lopez	13–17 May 2024
		16 August 2024
		17–20 September 2024
	Emily Aitken	31 July 2024
		28 August 2024
		16–18 October 2024
	Christopher Chiam	18–22 March 2024
New South Wales Nurses and Midwives Association	Laura Toose, Solicitor	19–20 February 2024
	Neale Dawson, Solicitor	

Party/Witness	Name/Legal Representative	Dates
St John of God Hospital	Simon Fitzpatrick	12 June 2024
	Summer Dow, Solicitor	
St Vincent's Health Australia	Oliver Jones	12-14 June 2024
Australian Medical Association (NSW)	Scott Chapman, Solicitor	Various
NSW Treasury	Tim Jap, Special Counsel	18 November 2024

Appendix H: Schedule of Witnesses before the Special Commission³

A.1: Opening Hearings: 27–29 November 2023

Witness	Position	Attendance Date
Dr Kerry Chant AO PSM	Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Ministry of Health	28–29 November 2023
Dr Nigel Lyons	Special Advisor to the NSW Ministry of Health	28–29 November 2023
Deborah Willcox AM	Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health	28–30 November 2023
Adjunct Professor Alfa D'Amato	Deputy Secretary, Financial Services and Asset Management, NSW Ministry of Health	30 November 2023

A.2: Procurement Hearings: 19–23 February 2024, 26 February 2024

Witness	Position	Attendance Date
Kylie Tastula	Nurse Practitioner, Member of NSWNMA	19 February 2024
Paul Haines	Registered Nurse and Paramedic, Member of NSWNMA	19 February 2024
Nicholas Tribbia	Registered Nurse, Member of NSWNMA	19 February 2024
Nicholas Howson	Registered Nurse, Member of NSWNMA	19–20 February 2024

³ The position referenced for each person is intended to be the role held at the time the person gave evidence.

Witness	Position	Attendance Date
Ashleigh Vinton	Clinical Nurse Specialist, Clinical Products Coordinator, Wollongong Hospital, Illawarra Shoalhaven LHD	20 February 2024
Paul Dale	Director, Policy, Medical Technology Association of Australia	20 February 2024
Karolina Misevska	Business Manager, Sydney LHD	20 February 2024
Jodi Chiumento	Director of Procurement, Illawarra Shoalhaven LHD	21 February 2024
Maria Kokkinakos	Director Strategic Health Sourcing, Sydney LHD	21 February 2024
Dr Teresa Anderson AM	Chief Executive of Sydney LHD	21 February 2024
Michelle Swinger	Corporate Category Procurement Manager, South Western Sydney LHD	21 February 2024
Mitchell Clancy	District Procurement Manager, South Western Sydney LHD	22 February 2024
Sonia Marshall PSM	Chief Executive Officer, South Western Sydney LHD	22 February 2024
Carmen Rechbauer	Chief Executive, HealthShare NSW	22–23 February 2024
Michael Dickinson	Chief Information Officer and Director of Digital Health, South Western SLHD	22 February 2024
Jacinta Ducat	Chief Information Officer, Southern NSW LHD	22 February 2024
Dr Zoran Bolevich	Chief Executive of eHealth NSW and Chief Information Officer, NSW Health	23 February 2024
Michael Gendy	Chief Procurement Officer, NSW Health	23 February 2024
Adjunct Professor Jean-Frédéric Levesque	Deputy Secretary, Clinical Innovation and Research, Chief Executive for Agency of Clinical Innovation	26 February 2024

A.3: Murrumbidgee Local Health District Hearings: 18–22 March 2024

Witness	Position	Attendance Date
Dr Rachel Christmas	General Practitioner and President of Rural Doctors Association NSW	18 March 2024
Kay Hull AO	Chair, Palliative Care Enhancement Council	18 March 2024
Associate Professor Ayman Shenouda	General Practitioner, Wagga Wagga	18 March 2024
Karina Ewer	Chief Executive Officer, Berrigan Shire Council	18 March 2024
Dr Julia Cornwell McKean	Mayor of Berrigan Shire Council	18 March 2024
Adrian Lindner	Interim Board Chair, Murrumbidgee LHD	18 March 2024
Robyn Manzie	Independent Chair, Murrumbidgee Mental Health and Drug and Alcohol Alliance	19 March 2024
Emma Field	Director, Integrated Care and Allied Health, Murrumbidgee LHD	19 March 2024
Dr Nicholas Stephenson	Senior Radiologist (Clinical Director), I-MED Riverina	19 March 2024
Narelle Mills	Interim Chief Executive Officer, Murrumbidgee Primary Health Network	19 March 2024
Melissa Neal	Senior Advisor, Murrumbidgee Primary Health Network	19 March 2024
Cr David McCann OAM	Mayor, Coolamon Shire Council	20 March 2024
Tony Donoghue PSM	General Manager, Coolamon Shire Council	20 March 2024
Professor Tara Mackenzie	Associate Dean of Rural Health, School of Clinical Medicine, University of NSW	20 March 2024
Kevin Lawrence	Executive Director of Finance and Performance, Murrumbidgee LHD	20 March 2024

Witness	Position	Attendance Date
Dean Marchioni	Registered Nurse, Cluster Manager, Narrandera/Leeton Cluster Murrumbidgee LHD	20 March 2024
Elizabeth Dixon	Board Member, Murrumbidgee LHD	21 March 2024
Anthony Kolbe	Board Member, Murrumbidgee LHD	21 March 2024
Dr Alam Yoosuff	Board Member and Board Director, Murrumbidgee LHD; Board Director, Murrumbidgee Primary Health Network; Vice President, Rural Doctors Association NSW	21 March 2024
Professor Lenert Bruce	General Manager, Wagga Wagga Base Hospital; Executive Director for Medical Services, Murrumbidgee LHD	21–22 March 2024
Jill Ludford PSM	Chief Executive, Murrumbidgee LHD	22 March 2024

A.4: Governance Hearings: 15–19 April 2024, 22–24 April 2024, 29 April 2024

Witness	Position	Attendance Date
Fiona Wilkinson	District Director of Quality, Strategy and Improvement, Central Coast LHD	15 April 2024
Mark Zacka	Executive Director, Clinical Governance and Patient Experience, Northern Sydney LHD	15 April 2024
Michael Wood	Director of Clinical Governance, Nepean Blue Mountains LHD	15 April 2024
Matthew Russell	Director of Mental Health, Nepean Blue Mountains LHD	15 April 2024
Lee Gregory	Chief Executive, Nepean Blue Mountains LHD	16 April 2024

Witness	Position	Attendance Date
Sharon Smith	Executive Director, System Information and Analytics Branch, NSW Ministry of Health	16 April 2024
Adjunct Professor Michael Nicholl	Chief Executive, Clinical Excellence Commission	16 April 2024
Dr Ross Kerridge	Senior Staff Specialist, Anaesthetics, John Hunter Hospital; Associate Professor, University of Newcastle	17 April 2024
Grainne O'Loughlin	Chief Executive Officer, Karitane	18 April 2024
Robert Mills	Chief Executive Officer, Royal Society for the Welfare of Mothers and Babies (Tresillian)	18 April 2024
Matthew Mackay	Chief Executive Officer, Royal Rehab; President, Health Services Association	18 April 2024
Professor Anthony Gill AM	Head of Department of Anatomical Pathology, Royal North Shore Hospital	19 April 2024
Dr Michael Maley	Local Pathology Director, NSW Health Pathology, Liverpool and South Western Sydney LHD	19 April 2024
Adjunct Associate Professor James Branley	Local Pathology Director, NSW Health Pathology, Nepean Hospital	19 April 2024
Vanessa Janissen	Chief Executive, NSW Health Pathology	19 April 2024
Adjunct Professor Anthony Schembri AM	Chief Executive, Northern Sydney LHD	22 April 2024
Scott McLachlan	Chief Executive, Central Coast LHD	22 April 2024
Professor Donald MacLellan	Board Chairman, Central Coast LHD	23 April 2024
Pamela Rutledge AM	Board Member, Nepean Blue Mountains LHD	23 April 2024

Witness	Position	Attendance Date
Dr Stuart Browne	Clinical Director, NSW Brain Injury Rehabilitation Program, Royal Rehab	23 April 2024
Professor James Middleton	Clinical Director, NSW State Spinal Cord Injury Service	24 April 2024
Trevor Danos AM	Board Chair, Northern Sydney LHD	24 April 2024, 29 April 2024
Matthew Daly	Deputy Secretary, System Sustainability and Performance, Ministry of Health	29 April 2024
Deborah Willcox AM	Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health	29 April 2024

A.5: Western NSW Local Health District Hearings: 13–17 May 2024

Witness	Position	Attendance Date
Megan Callinan	Chief Executive Officer, Marathon Health	13 May 2024
Annette Crothers	Board Chair, Marathon Health; Board Member, Western NSW LHD	13 May 2024
Derek Francis	General Manager, Bogan Shire Council	13 May 2024
Deborah Wood	Director, People and Community Services, Bogan Shire Council	13 May 2024
Dr Michael Harfield	Director of Medical Services; Mudgee Hospital; Acting Rural Health Director Medical Services (Mudgee, Cowra, Parkes and Forbes Hospitals), Western NSW LHD	13 May 2024
Greg Tory	General Manager, Lachlan Shire Council	13 May 2024
Dr Ai-Vee Chua	General Practitioner, Dubbo	14 May 2024

Witness	Position	Attendance Date
Dr Rebekah Hoffman	Chair, Royal Australian College of General Practitioners (RACGP) NSW and ACT	14 May 2024
Dr Mary MacIsaac	General Practitioner, Coomealla Aboriginal Health Corporation, Dareton	14 May 2024
Allan Cobb	Chair, Lightning Ridge Community Working Party	14 May 2024
Grace Gordon	Independent Chairperson, Murdi Paaki Regional Assembly	14 May 2024
Anthony Knight	Chair, Weilmoringle Community Working Party	14 May 2024
Carl Mason	Chair, Collarenebri Community Working Party	14 May 2024
Doreen McHughes	Chair, Brewarrina Community Working Party	14 May 2024
Millie Shillingsworth	Chair, Enngonia Community Working Party	14 May 2024
Dr Martin Hua	Acting Rural Health Director of Medical Services, Western NSW LHD	15 May 2024
Helen McFarlane	Director, Mental Health, Drug and Alcohol, Western NSW LHD	15 May 2024
Dr Warren Kealy-Bateman	Clinical Director, Mental Health, Drug and Alcohol Dubbo and Regions, Western NSW LHD	15 May 2024
Professor Mark Arnold	Chief Medical Officer, Western NSW LHD	15 May 2024
Maryanne Hawthorn	Executive Director, Strategic Reform, Planning and Partnerships, Western NSW LHD	15 May 2024
Mark Spittal	Chief Executive, Western NSW LHD	16 May 2024
Dr Ian Spencer OAM	General Practitioner, Wellington	16 May 2024

Witness	Position	Attendance Date
Josh Carey	Executive Director, Service Delivery, Western NSW LHD	17 May 2024
Dr Colin McClintock	Board Member, Western NSW LHD	17 May 2024
Dr Robin Williams	Chair, Western Health Alliance Ltd Board	17 May 2024

A.6: Far West Local Health District Hearings: 22–23 May 2024

Witness	Position	Attendance Date
Greg Sam	Chief Executive Officer, Royal Flying Doctor Service, South Eastern Section	22 May 2024
Associate Professor Shannon Nott	Executive General Manager, Health and Clinical Services; Chief Medical Officer, Royal Flying Doctors Service, South Eastern Section	22 May 2024
Jenna Bottrell	Area Manager, Western and Far West NSW, Mission Australia	22 May 2024
Professor Debra Jones	Head of Rural Clinical School, Broken Hill University Department of Rural Health, Sydney Nursing School, Faculty of Medicine and Health, University of Sydney	22 May 2024
David Green	Director of People and Culture, Far West LHD	22 May 2024
Cr Thomas Kennedy	Mayor, Broken Hill City Council	22 May 2024
Jay Nankivell	General Manager, Broken Hill City Council	22 May 2024
Cr Jarrod Marsden	Mayor, Cobar Shire Council	22 May 2024
Kylie Smith	Director, Corporate and Community Services, Cobar Shire Council	22 May 2024
Sally Pearce	Board Chair, Far West LHD	23 May 2024

Witness	Position	Attendance Date
Justin Files	Board Member, and Co-Chair, Aboriginal Health and Workforce Committee, Far West LHD	23 May 2024
Dr Sarah Wenham	Executive Director, Medical Services, Far West LHD	23 May 2024
Associate Professor Ashish Agar	Ophthalmologist with sub-speciality in glaucoma	23 May 2024
Apsara Kahawita	Director, Finance and Corporate Services, Far West LHD	23 May 2024
Brad Astill	Chief Executive, Far West LHD	23 May 2024

A.7: Hospital Case Studies Hearings: 11–14 June 2024

Witness	Position	Attendance Date
Dr Shirley Alexander	Department Head, Children's Hospital Institute of Sports Medicine and Weight Management, Sydney Children's Hospitals Network	11 June 2024
Dr Joanne Ging	Executive Director, Clinical Operations, Sydney Children's Hospitals Network	11 June 2024
Cathryn Cox PSM	Chief Executive, Sydney Children's Hospitals Network	11 June 2024
Benjamin Edwards	Chief Operating Officer, St John of God Health Care	12 June 2024
Vanessa Clements	Director, Planning, Redevelopment and Project Management Office, Nepean Blue Mountains LHD	12 June 2024
Lee Gregory	Chief Executive, Nepean Blue Mountains LHD	12 June 2024
Christopher Blake	Group Chief Executive Officer, St Vincent's Health Australia	12 June 2024
Anna McFadgen	Chief Executive Officer,	13 June 2024

Witness	Position	Attendance Date
	St Vincent's Hospital Sydney	
Associate Professor John Preddy	Clinical Director, Paediatric Department, Murrumbidgee LHD; Co-Chair, Paediatric Network, Agency for Clinical Innovation	14 June 2024
Paul Craven	Executive Director, Children and Young People and Families, Medical Services and Networks Streams	14 June 2024
Dr Nigel Lyons	Special Advisor to the NSW Ministry of Health	14 June 2024

A.8: Workforce Hearings – Part 1: 22–25 July 2024, 30–31 July, 1–2 August, 5–7 August 2024

Witness	Position	Attendance Date
Dr Dustin Halse	Division Secretary (Strategy, Research and Projects), Health Services Union for NSW, ACT and QLD	22 July 2024
Adjunct Professor Annette Solman	Chief Executive, Health Education and Training Institute	22 July 2024
Dr Josephine Burnand	Acting Medical Director, Health Education and Training	22 July 2024
Professor Stephen Twigg	Head of Department of Endocrinology, Royal Prince Alfred Hospital, Sydney LHD; Head of Central Clinical School, Sydney Medical School, University of Sydney	22 July 2024
Dr Nicholas Spooner	Director of Emergency Medicine, Wyong Hospital	23 July 2024
Dr Rebecca Nogajski	Executive Director, Medical Services, Western Sydney LHD	23 July 2024
Professor Peter Hockey	Executive Director, Quality and Safety, Western Sydney LHD	23 July 2024

Witness	Position	Attendance Date
Emma-Kate Dewhurst	Director, Occupational Therapy, Illawarra Shoalhaven LHD	23 July 2024
Jacqui Cross PSM	Chief Nursing and Midwifery Officer, NSW Health	23 July 2024
Dr Frances Page	Co-Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists	24 July 2024
Dr Michelle Moyle	Past Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists, Director of Anaesthetic Department, St Vincent's Hospital	24 July 2024
Dr Angelo Virgona	Past Chair, NSW Branch Committee, Royal Australian and New Zealand College of Psychiatrists	24 July 2024
Professor Inam Haq	Executive General Manager, Education, Learning and Assessment, Royal Australasian College of Physicians	25 July 2024
Associate Professor Kudzai Kanhutu	Dean, Royal Australasian College of Physicians	25 July 2024
Jacqueline Dominish OAM	Director, Health Professionals Workforce, NSW Ministry of Health	25 July 2024
Duane Findley	Chief Executive Officer, Royal Australian and New Zealand College of Radiologists	25 July 2024
Associate Professor Kerin Fielding	President, Royal Australasian College of Surgeons	30 July 2024
Dr Stephanie Clota	Chief Executive Officer, Royal Australasian College of Surgeons	30 July 2024
Dr Linda MacPherson	Director, Workforce Reform, NSW Ministry of Health	30 July 2024
Dr Karen Murphy	Acting Executive Director, Medical Services and Clinical Governance, Illawarra Shoalhaven LHD	30 July 2024

Witness	Position	Attendance Date
Professor Steevie Chan	District Director Medical Services, Central Coast LHD	30 July 2024
Dr Lloyd Ridley	Staff Specialist, Department of Radiology, Concord Repatriation General Hospital	30 July 2024
Daniel Angelico	Chief Executive Officer, College of Intensive Care Medicine	31 July 2024
Clinical Associate Professor Winston Cheung	Senior Staff Specialist, Intensive Care Unit, Concord General Repatriation Hospital; Chair, Concord Hospital Medical Staff Council, Concord General Repatriation Hospital; Clinical Associate Professor, Sydney Medical School – Concord, University of Sydney	31 July 2024
Dr Andrew Hallahan	Executive Director, Medical Services, Clinical Governance and Risk, Sydney LHD	1 August 2024, 2 August 2024
Joseph Jewitt	Acting General Manager, Concord Repatriation General Hospital, Sydney LHD	2 August 2024
Dr Stewart Condon	Director, Medical Services, Concord Repatriation General Hospital, Sydney LHD	2 August 2024
Dr Bethan Richards	Chief Medical Wellness Officer, Sydney LHD; Senior Staff Specialist, Department of Rheumatology, Royal Prince Alfred Hospital; Co-Director, Institute for Musculoskeletal Health Sydney LHD	2 August 2024
Graeme Loy	Acting Chief Executive, Sydney LHD	5 August 2024
Dominique Egan	Director of Workplace Relations and Legal Counsel, Australian Medical Association Ltd (NSW)	5 August 2024

Witness	Position	Attendance Date
Melissa Collins	Acting Executive Director, Workplace Relations, NSW Ministry of Health	5 August 2024
Dr Teresa Anderson AM	Former Chief Executive, Sydney LHD; Chief Executive, Single Digital Patient Record Implementation Authority	6 August 2024
Richard Griffiths	Executive Director, Workforce Planning and Talent Development, NSW Ministry of Health	6 August 2024
Philip Minns	Deputy Secretary, People, Culture and Governance, NSW Ministry of Health	7 August 2024

A.9: Southern NSW Local Health District Hearings: 15–16 August 2024

Witness	Position	Attendance Date
Prudence Buist	Chief Executive Officer, South Eastern NSW Primary Health Network (Coordinare Ltd)	15 August 2024
Andrew Gow	Director, Strategy and Performance, South Eastern NSW Primary Health Network (Coordinare Ltd)	15 August 2024
Jennifer Gordon	Manager, South East NSW Regional Training Hub, School of Medicine and Psychology Rural Clinical School, Australian University; Board Member, Southern NSW LHD	15 August 2024
Dr Susie Piper	District Medical Lead, Paediatrics Department, Southern NSW LHD	15 August 2024
Dr Stuart Stapleton	Director, Emergency Department, Eurobodalla Health Service, Southern NSW LHD	15 August 2024
Dr Nathan Oates	Director of Prevocational Education and Training, Southern NSW LHD	15 August 2024
Dr Andrew Clarke	Senior Emergency Department Doctor, Cooma Hospital	15 August 2024

Witness	Position	Attendance Date
Dr Serena Ayers	Network Director of Medical Services Inland Network, SNSWLHD	15 August 2024
Joann Cawthorne	Deputy Director of Nursing and Midwifery	15 August 2024
Elizabeth Hoskins	Board Chair, SNSWLHD	16 August 2024
Terry Clout PSM	Deputy Board Chair, SNSWLHD	16 August 2024
Margaret Bennett	Chief Executive, SNSWLHD	16 August 2024

A.10: Evidence of Professor Jennifer May: 28 August 2024

Witness	Position	Attendance Date
Professor Jennifer May	Then Betty Fyffe Chair of Rural Health, University of Newcastle Department of Rural Health, Now, National Rural Health Commissioner	28 August 2024

A.11: Northern NSW Local Health District, Hunter New England Local Health District and Mid North Coast Local Health District Hearings: 17–20 September 2024

Witness	Position	Attendance Date
Dr David Scott	Physical and Gastroenterologist Visiting Medical Officer, Chair of Medical Staff Council, HNELHD	17 September 2024
John Slaven	Director of Finance and Performance, MNCLHD	17 September 2024
Dr Robert Davies	Director of Emergency Medicine, Tweed Valley Hospital, NNSWLHD	17 September 2024

Witness	Position	Attendance Date
Jennifer Richter AM	Nurse Manager, Nursing and Midwifery Workforce, Tweed Valley Hospital, NNSWLHD	17 September 2024
Ramsey Awad	Executive Director Infrastructure and Sustainability, Tamworth Hospital	18 September 2024
Jill Wong	District Director Integrated Care, Nursing and Community Services, MNCLHD	18 September 2024
Tracey Maisey	Chief Executive, NNSWLHD	18 September 2024
Dr Miriam Grotowski	Senior Lecturer, University of Newcastle, Department of Rural Health, General Practitioner, Tamworth	19 September 2024
Tracey McCosker PSM	Chief Executive, HNELHD	19 September 2024
Dr Richard Nankervis	Chief Executive Officer, HNECC Limited / Hunter New England Central Coast Primary Health Network, Founding Director on the Board of the Centre of Innovation in Regional Health, Various Clinical Management and Divisional roles at the CCLHD	19 September 2024
Dr Alison Koschel	Executive Manager Populations, Access and Performance, Hunter New England Central Coast Primary Health Network	19 September 2024
Associate Professor Martin Cohen	Board Chair, HNELHD	20 September 2024
Peter Carter	Board Chair, NNSWLHD	20 September 2024
Peter Treseder AO	Board Chair, MNCLHD	20 September 2024

A.12: Workforce Hearings – Part 2: 14–18 October 2024

Witness	Position	Attendance Date
Professor Kathleen Baird	Head of Nursing, University of Technology Sydney	14 October 2024
Richard Griffiths	Executive Director, Workforce Planning and Talent Development	14 October 2024
Michael Whaites	Assistant General Secretary, NSWNMA	14 October 2024
Jacqui Cross PSM	NSW Chief Nursing & Midwifery Officer	14 October 2024
Jacqueline Dominish OAM	Health Professionals Workforce, NSW Ministry of Health	14 October 2024
Professor Toby Newton-John	Head of Allied Health, University of Technology Sydney	14 October 2024
Professor Debra Anderson	Dean, University of Technology Sydney	14 October 2024
Dr Tom Morrison	Neurosurgery Registrar, St Vincent's Hospital	15 October 2024
Dr Matthew Ingram	Emergency Medicine Staff Specialists, Wyong Hospital, National Program Steering Committee, Accreditation Committee, and Trainee Review Panel Representative, Australian College of Emergency Medicine (ACEM)	15 October 2024, 18 October 2024
Philip Minns	Deputy Secretary People and Culture Governance, NSW Ministry of Health	15 October 2024, 17 October 2024
Jerry Yik	Head of Policy and Advocacy, Advanced Pharmacy Australia	16 October 2024
Dr Jonathan Penm	Vice Chair, NSW Branch Committee, Advanced Pharmacy Australia	16 October 2024
Dr Michael Bonning	General Practitioner and Former President, Australian Medical Association NSW	16 October 2024

Witness	Position	Attendance Date
Luke Sloane	Deputy Secretary, Regional Health, NSW Ministry of Health	16 October 2024
Dr Rachel Christmas	General Practitioner and President of Rural Doctors Association NSW	16 October 2024
Dr Rebekah Hoffman	Chair of the Royal Australian College of General Practitioners (RACGP) NSW & ACT Faculty Council	16 October 2024
Georgina Van de Water	Chief Executive Officer, The Royal Australian College of General Practitioners	16 October 2024
Gerard Hayes AM	NSW State Secretary, Health Services Union	17 October 2024
Shaye Candish	General Secretary, NSWNMA	17 October 2024
Melissa Collins	Acting Executive Director, Workplace Relations, NSW Ministry of Health	17 October 2024
Dominique Egan	Director of Workplace Relations, Australian Medical Association NSW	17 October 2024
Andrew Holland	Executive Director, Australian Salaried Medical Officers' Federation NSW	17 October 2024
Dr Michelle McRae	Senior Director of Training, Australasian College of Dermatologists	18 October 2024
Dr Natalie Rainger	Consultant Otolaryngologist, Head and Neck Surgeon (ENT), Orange NSW, Training Supervisor, Australian Society of Otolaryngology, Head and Neck Surgery	18 October 2024
Associate Professor Kerin Fielding	College President, Royal Australasian College of Surgeons	18 October 2024
Professor Boon Lim	College Vice-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists	18 October 2024

Witness	Position	Attendance Date
Dr Frances Page	Elected member (Safety and Quality Officer). Co-Deputy Chair, NSW Regional Committee, Australian and New Zealand College of Anaesthetists	18 October 2024
Libby Newton	Manager of Education, Policy, Research and Evaluation, Education, Learning and Assessment	18 October 2024
Professor Inam Haq	Executive General Manager Education, Learning and Assessment, Royal Australasian College of Physicians	18 October 2024
Associate Professor Kudzai Kanhutu	College Dean, Royal Australasian College of Physicians	18 October 2024
Dr Josephine Burnand	Acting Medical Director, Health Education and Training	18 October 2024
Dr Justine Harris	Chief Medical Workforce Advisor, NSW Ministry of Health	18 October 2024

A.13: Clinicians Hearings: 14–15 November 2024

Witness	Position	Attendance Date
Dr Robert Hislop	Acting Director of Medical Services Hastings Macleay Clinical Network, Chair, Port Macquarie Medical Staff Council, MNCLHD	14 November 2024
Dr Bruce Hodge	Director of Surgery, Port Macquarie Base Hospital, MNCLHD	14 November 2024
Dr Stephen Begbie	Executive Clinical Director, Hastings Macleay Network, MNCLHD	14 November 2024
Associate Professor James Mallows	Chair, Nepean Medical Staff Council, NBMLHD	14 November 2024
Dr Stavros Prineas	Chair, Blue Mountains Medical Staff Council, NBMLHD	14 November 2024

Witness	Position	Attendance Date
Dr Nardeen Habashy	Advanced Trainee, Endocrinology, Nepean Hospital, NBMLHD	14 November 2024
Darryn Egan	Team Leader, Penrith Community Mental Health Team, NBMLHD	14 November 2024
Benjamin Wakeling	Director, Clinical Strategy and Outcomes, Registered Nurse, ISLHD	15 November 2024
Rachael Hawkins	Nurse Unit Manager, Wollongong, ISLHD	15 November 2024
Amy Okulicz	Nurse Unit Manager, Rehabilitation and Geriatric Rehabilitation, CCLHD	15 November 2024
Melissa Pickering	Acting Director, Nursing and Midwifery, CCLHD	15 November 2024
Professor Jan Potter	Geriatrician Staff Specialist and Divisional Co-Director of Aged Care and Rehabilitation Division, ISLHD	15 November 2024
Brendan Shortis	Acting Nurse Manager, Community Health, NBMLHD	15 November 2024

A.14: Funding Hearings: 18–21 November 2024

Witness	Position	Attendance Date
Louis Kastoun	Executive Director, Health and Stronger Communities, NSW Treasury	18 November 2024
Julian Cornelius	Director, Health, NSW Treasury	18 November 2024
Adjunct Professor Alfa D'Amato	Deputy Secretary, Financial Services and Asset Management, NSW Ministry of Health	18 November 2024, 21 November 2024
Jude Constable	Acting Chief Executive, CCLHD	19 November 2024
Margot Mains	Chief Executive, ISLHD	19 November 2024
Peter Collins AM KC	Board Chair, NBMLHD	19 November 2024
Lee Gregory	Chief Executive Chief Executive, NBMLHD	19 November 2024

Witness	Position	Attendance Date
Tobi Wilson	Chief Executive, South Eastern Sydney LHD	19 November 2024
Dr Dominic Morgan ASM	Chief Executive, NSW Ambulance	19 November 2024
Cathryn Cox PSM	Chief Executive, Sydney Children's Hospital Network	19 November 2024
Wendy Hoey PSM	Chief Executive, Justice Health and Forensic Mental Health Network	19 November 2024
Professor Jeffrey Braithwaite	Director of Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University	20 November 2024
Professor David Bedford	Business School, Accounting Discipline, University of Technology Sydney	20 November 2024
Professor Rosalie Viney	Professor of Health Economics and Director of Centre for Health Economics Research and Evaluation	20 November 2024
Professor Stephen Duckett AM	Chair of Health Performance Council, South Australia	20 November 2024
Steven Carr	Executive Director, System Financial Performance, Deputy Chief Financial Officer, NSW Health	21 November 2024
Neville Onley	Director Activity Based Management Taskforce, NSW Health	21 November 2024
Matthew Daly	Deputy Secretary, System Sustainability Performance, Ministry of Health	21 November 2024
Joseph Portelli	Executive Director, System Purchasing Branch, System Sustainability and Performance, NSW Ministry of Health	21 November 2024
Sharon Smith	Executive Director, System Information and Analytics Branch, NSW Ministry of Health	21 November 2024

A.15: Roundtable Hearings of Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services: 27–28 November 2024

Witness	Position	Attendance Date
Remote/AVL participants		
Lisa Penrith	Practice Manager, Griffith Aboriginal Medical Service Incorporated	27 November 2024
Isaac Simon	Chief Executive Officer, Tobwabba Aboriginal Medical Service	27 November 2024
Payden Samuelsson	Chief Executive Officer, Bullinah Aboriginal Health Service	27 November 2024
Mark Burling	Chief Executive Officer Wellington Aboriginal Corporation Health Service	27 November 2024
Julie Tongs OAM	Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health and Community Services	27 November 2024
Dian Edwards	Manager, Namatjira Heaven Drug & Alcohol Healing Centre	27 November 2024
Christine Peckham	Chief Executive Officer, Peak Hill Aboriginal Medical Service	27 November 2024
Rosemary Rose	Nurse Manager / Clinic Coordinator, Pius X Aboriginal Corporation	27 November 2024
Debbie McCowen	Chief Executive Officer, Aramajun Aboriginal Health Service	27 November 2024
Kristine Falzon	Chief Executive Leader, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)	27 November 2024
Jessica Wheeler	Manager of Strategy and Operations, Eleanor Duncan Aboriginal Services	27 November 2024
Hayley Longbottom	Chief Executive Leader Team, Waminda (South Coast Women's Health and Wellbeing Aboriginal Corporation)	27 November 2024
In-person participants		
Cassandra Carley	Aboriginal Mental Health Worker, National Centre for Indigenous Excellence	28 November 2024

Witness	Position	Attendance Date
Kevin Duroux	Deputy Chief Executive Officer, Tamworth Aboriginal Medical Service Aboriginal Corporation	28 November 2024
Caine Raudino	Office Manager, Wamba Wamba, Albury Wodonga Aboriginal Health Service	28 November 2024
LaVerne Belleair	Chief Executive Officer, Aboriginal Medical Services Redfern	28 November 2024
Josh Roxburgh	Manager, Community Relations, Aboriginal Medical Services Redfern	28 November 2024
David MacQueen	Acting Chief Executive Officer, Katungal Aboriginal Corporation Regional Health and community Services	28 November 2024
Taasha Layer	Chief Executive Officer, Ungooroo Aboriginal Corporation	28 November 2024
Craig Layer	Chief Operational Officer, Ungooroo Aboriginal Corporation	28 November 2024
Cecil Lester	Chief Executive Officer, Condobolin Aboriginal Health Service	28 November 2024
Jamie Newman	Chief Executive Officer / Managing Director & Chairperson, Orange AMS and Bila Muuji Aboriginal Corporation Health Service	28 November 2024
Chris Binge	Chief Executive Officer, Rekindling the Spirit	28 November 2024
Fred Pitt	Executive Assistant, Rekindling the Spirit	28 November 2024

A.16: Expert and other witnesses Hearings: 10–12 December 2024

Witness	Position	Attendance Date
Adjunct Professor Kathy Eagar AM	Adjunct Professor, School of Clinical Medicine, Faculty of Medicine and Health, University of New South Wales	10 December 2024
Professor Luke Wolfenden	School of Medicine and Public Health, University of Newcastle	10 December 2024
Professor Andrew Milat	Professor of Public Health, University of Sydney	10 December 2024

Witness	Position	Attendance Date
Professor Don Nutbeam	Professor of Public Health, University of Sydney	10 December 2024
Dr Martin McNamara	CEO, Sax Institute	10–12 December 2024
Dr Jo Mitchell	Director, Policy by Proxy	11 December 2024
Nadia Mastersson	Sax Institute	11 December 2024
Professor Andrew Wilson AO	Co-Director, Menzies Centre for Health Policy and Economics	11–12 December 2024
Professor Michael Reid AM		12 December 2024
Professor Kees Van Gool	Health Policy and Systems Menzies Centre for Health Policy and Economics, University of Sydney	12 December 2024
Associate Professor Carmen Huckel Schneider	Senior Advisor, Evidence Connect, Sax Institute	12 December 2024

A.17: Final Hearings: 26–27 February 2025

Witness	Position	Attendance Date
Susan Pearce AM	Secretary, NSW Health	26 February 2025
Adjunct Professor Alfa D'Amato	Deputy Secretary, Financial Services and Asset Management, NSW Ministry of Health	26 February 2025
Philip Minns	Deputy Secretary, People, Culture and Governance, NSW Health	26 February 2025

Appendix I: List of Public Exhibits

A.18: Tender Bundle A – Opening Hearings (November 2023)

Exhibit No.	Description	SCOI Number	Document Date
A.1	Joint Report of Dr Nigel Lyons, Special Advisor, NSW Ministry of Health, Dr Kerry Chant AO PSM, Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Ministry of Health and Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health	MOH.9999.0001.0001	17 November 2023
A.2	CV of Dr Nigel Lyons	MOH.9999.0002.0001	Undated
A.3	CV of Dr Kerry Chant AO PSM	MOH.9999.0003.0001	Undated
A.4	CV of Deborah Willcox AM	MOH.9999.0004.0001	Undated
A.5	NSW Health LHDs Map	SCI.0001.0001.0001	Undated
A.6	NSW Health Model By-Laws for LHDs and SHNs	SCI.0001.0002.0001	7 October 2021
A.7	NSW Health, <i>Annual Report 2021-2022</i>	SCI.0001.0003.0001	November 2022
A.8	NSW Health, <i>Annual Report 2020-2021</i>	SCI.0001.0004.0001	October 2021
A.9	NSW Health, <i>Annual Report 2018-2019</i>	SCI.0001.0005.0001	October 2019
A.10	NSW Health, <i>Annual Report 2017-2018</i>	SCI.0001.0006.0001	October 2018
A.11	NSW Health, <i>Performance Framework</i>	SCI.0001.0007.0001	June 2023
A.12	NSW Health, <i>Corporate Governance and Accountability Compendium</i>	SCI.0001.0008.0001	September 2023

Exhibit No.	Description	SCOI Number	Document Date
A.13	NSW Health, <i>All of Us: An Introduction to Our Guide to Engaging Consumers, Carers and Communities Across NSW Health</i>	SCI.0001.0009.0001	May 2023
A.14	<i>Future Health Guiding the Next Decade of Care in NSW 2022-2032</i>	SCI.0001.0010.0001	May 2022
A.15	<i>Future Health Strategic Framework 2022-2032</i>	SCI.0001.0011.0001	undated
A.16	NSW Health, <i>Guideline Physical Health Care for People Living with Mental Health Issues</i>	SCI.0001.0012.0001	30 April 2021
A.17	<i>About South Western Sydney LHD Brochure</i>	SCI.0001.0013.0001	Undated
A.18	BHI, <i>Quarterly Report April to June 2023</i>	SCI.0001.0014.0001	6 September 2023
A.19	NSW Budget Paper No. 2, <i>Agency Financial Statements 2023-2024</i>	SCI.0001.0015.0001	19 December 2023
A.20	NSW Government, <i>Intergenerational Report 2021-2022</i>	SCI.0001.0016.0001	June 2021
A.21	Australian Government, <i>Intergenerational Report 2023: Australia's Future to 2063</i>	SCI.0001.0017.0001	2023
A.22	Australian Government, <i>Intergenerational Report 2021: Australia over the next 40 years</i>	SCI.0001.0018.0001	June 2021
A.23	The Commonwealth Fund, <i>Mirror, Mirror 2021 Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries</i>	SCI.0001.0019.0001	August 2021
A.24	NHRA	SCI.0001.0020.0001	August 2011
A.25	National Healthcare Agreement	SCI.0001.0021.0001	2012
A.26	Schedule I – Addendum to the NHRA	SCI.0001.0022.0001	July 2017

Exhibit No.	Description	SCOI Number	Document Date
A.27	Schedule J – Addendum to the NHRA	SCI.0001.0023.0001	July 2020
A.28	Addendum to NHRA (consolidated) 2020-2025	SCI.0001.0024.0001	
A.29	NHRA – Long-term Health Reforms Roadmap	SCI.0001.0025.0001	2021
A.30	NHRA – Bilateral agreement between Commonwealth and NSW	SCI.0001.0026.0001	2022
A.31	<i>National Preventive Health Strategy 2021-2030</i>	SCI.0001.0027.0001	2021
A.32	National Health Funding Pool, <i>Annual Report 2022-2023</i>	SCI.0001.0028.0001	2023
A.33	<i>General Practice Health of the Nation 2023</i>	SCI.0001.0029.0001	November 2023
A.34	AIHW, <i>Australian Burden of Disease Study 2022</i>	SCI.0001.0030.0001	13 December 2022
A.35	AIHW, <i>Australian Burden of Disease Study 2018</i>	SCI.0001.0031.0001	2018
A.36	AIHW, <i>The last year of life patterns in health service use and expenditure</i> (Web Report)	SCI.0001.0032.0001	21 July 2022
A.37	AIHW Bulletin 141, <i>Trends in cardiovascular deaths</i>	SCI.0001.0033.0001	September 2017
A.38	AIHW, <i>Alcohol, tobacco & other drugs in Australia, Tobacco and e-cigarettes</i> (Web Report)	SCI.0001.0034.0001	2023
A.39	AIHW, <i>Chronic disease – Australia’s biggest challenge 2014</i>	SCI.0001.0035.0001	2014
A.40	AIHW, <i>Health Expenditure Australia Report 2021-2022</i> (Web Report)	SCI.0001.0036.0001	25 October 2023

Exhibit No.	Description	SCOI Number	Document Date
A.41	AIHW, Health Expenditure Australia Report 2020-2021 (Web Report)	SCI.0001.0037.0001	23 November 2023
A.42	Older Australians, Health Service Use, AIHW (Web Report)	SCI.0001.0038.0001	28 June 2023
A.43	ABS, <i>Australia's Population by Country of Birth</i>	SCI.0001.0039.0001	31 October 2023
A.44	IHACPA, <i>Understanding the NEP and NEC Determinations 2023-2024</i>	SCI.0001.0040.0001	March 2023
A.45	<i>Australian Health Services: too complex to navigate</i> , Policy Issues Paper No. 1 – 2019, Victoria University	SCI.0001.0041.0001	February 2019
A.46	NSW Ministry of Health Organisation chart	SCI.0001.0042.0001	Undated
A.47	Northern Sydney LHD Service Agreement 2022-2023	SCI.0002.0013.0001	29 July 2022
A.48	NSW Health Workforce Plan 2022-2032	SCI.0001.0043.0001	Undated
A.49	NSW Regional Health Strategic Plan 2022-2032	SCI.0001.0044.0001	February 2023
A.50	NSW Health and NSW Primary Health Networks: Working together to deliver person-centred healthcare – Joint Statement	SCI.0001.0045.0001	Undated
A.51	NSW Health and NSW PHNs: Working together to deliver person-centred healthcare – Joint Statement – Summary	SCI.0001.0046.0001	Undated
A.52	Terms of Reference of NSW Health System Advisory Council	SCI.0002.0015.0001	9 March 2023

Exhibit No.	Description	SCOI Number	Document Date
A.53	Joint Report of Adjunct Prof Alfa D'Amato, Deputy Secretary, Financial Services and Asset Management, NSW Ministry of Health and Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health	MOH.9999.0005.0001	27 November 2023
A.54	CV of Adjunct Prof Alfa D'Amato	MOH.9999.0006.0001	Undated
A.55	NSW Health Pathology Customer Service Charter 7	SCI.0001.0047.0001	18 June 2021
A.56	NSW Ministry of Health, <i>Financial Requirements and Conditions of Subsidy (Government Grants) for year ending 30 June 2024</i>	SCI.0001.0048.0001	November 2023
A.57	NSW Premier and Cabinet, <i>NSW Grants Administration Guide</i>	SCI.0001.0049.0001	September 2022
A.58	NSW Health Policy Directive, <i>Administration of NSW Health Grant Funding for Non-Government Organisations</i>	SCI.0001.0050.0001	27 March 2019
A.59	NSW Health, <i>The First 2000 Days Framework</i>	SCI.0001.0051.0001	8 February 2019
A.60	NSW Health, <i>The First 2000 Days Implementation Strategy 2020-2025</i>	SCI.0001.0052.0001	21 February 2021
A.61	Australian Government, <i>Strengthening Medicare Taskforce Report</i>	SCI.0001.0053.0001	December 2022
A.62	NSW Health, <i>Strategic Framework for Integrating Care</i>	SCI.0001.0054.0001	November 2018
A.63	AIHW, <i>Social determinants of health</i> (Web Report)	SCI.0001.0055.0001	7 July 2022
A.64	Queensland Health, <i>Unleashing the potential: an open and equitable health system</i>	SCI.0001.0056.0001	August 2020

Exhibit No.	Description	SCOI Number	Document Date
A.65	Productivity Commission, <i>Shifting the dial: 5 year productivity review</i> , Inquiry Report No. 84 (Australian Government)	SCI.0001.0057.0001	3 August 2017

A.19: Tender Bundle B – Procurement Hearings (February 2024)

Exhibit No.	Description	SCOI Number	Document Date
B.1	Statement of Margot Mains, Chief Executive, Illawarra Shoalhaven LHD	MOH.0001.0260.0001	29 January 2024
B.2	Statement of Adjunct Prof Michael Nicholl, Chief Executive, CEC	MOH.0001.0262.0001	29 January 2024
B.3	Statement of Adjunct Prof Jean-Frédéric Levesque, Deputy Secretary, Clinical Innovation and Research and Chief Executive, ACI	MOH.0001.0435.0001	30 January 2024
B.4	Statement of Dr Teresa Anderson AM, Chief Executive, Sydney LHD	MOH.0001.0258.0001	31 January 2024
B.5	Statement of Michael Gendy, Chief Procurement Officer, NSW Health	MOH.0001.0434.0001	31 January 2024
B.6	Statement of Dr Zoran Bolevich, Chief Executive, eHealth NSW and Chief Information Officer, NSW Health	MOH.0001.0433.0001	31 January 2024
B.7	Statement of Sonia Marshall, Chief Executive, South Western Sydney LHD	MOH.0001.0261.0001	5 February 2024
B.8	Statement of Mark Spittal, Chief Executive, Western NSW LHD	MOH.0001.0263.0001	6 February 2024
B.9	Statement of Margaret Bennett, Chief Executive, Southern NSW LHD	MOH.9999.0007.0001	9 February 2024

Exhibit No.	Description	SCOI Number	Document Date
B.10	Statement of Vanessa Janissen, Chief Executive, NSW Health Pathology	MOH.9999.0008.0001	8 February 2024
B.11	Statement of Carmen Rechbauer, Chief Executive, HealthShare NSW	MOH.9999.0009.0001	12 February 2024
B.12	Statement of Nicholas Tribbia, Registered Nurse	SCI.0003.0001.0446	9 February 2024
B.13	Annexure A to Statement of Nicholas Tribbia – Nepean Blue Mountains LHD Procedure – Mental Health: Duress Alarm Response in Mental Health	SCI.0003.0001.0001	28 June 2023
B.14	Statement of Kylie Tastula, Nurse Practitioner	SCI.0003.0001.0009	12 February 2024
B.15	Statement of Paul Haines, Registered Nurse and Paramedic	SCI.0003.0001.0015	13 February 2024
B.16	Statement of Paul Dale, Director, Policy, Medical Technology Association of Australia (MTAA)	SCI.0003.0001.0022	14 February 2024
B.17	Appendix 1 – MTAA Submission to the Special Commission of Inquiry into Healthcare Funding	SCI.0003.0001.0030	Undated
B.18	Appendix 2 – Alira Health – Value Based Procurement in Australia	SCI.0003.0001.0048	Undated
B.19	Appendix 3 – MTAA – Guiding Principles for Procurement of Medical Technology	SCI.0003.0001.0088	Undated
B.20	Appendix 4 – MTAA – Procurement Survey Results 2023	SCI.0003.0001.0090	2023
B.21	Appendix 5 – Statement of Service 2022-2023 – HealthShare NSW <i>Duplicate not reproduced – see Tab B.31</i>	MOH.0001.0330.0001	12 August 2022

Exhibit No.	Description	SCOI Number	Document Date
B.22	Appendix 6 – MTAA – The Value of MedTech Report	SCI.0003.0001.0114	20 June 2023
B.23.1	CV of Michael Gendy	MOH.0001.0304.0001	Undated
B.23.2	CV of Carmen Rechbauer	MOH.0001.0437.0001	Undated
B.23.3	CV of Adjunct Prof Jean-Frédéric Levesque	MOH.0001.0300.0001	Undated
B.23.4	CV of Adjunct Prof Michael Nicholl	MOH.0001.0299.0001	Undated
B.23.5	CV of Dr Zoran Bolevich	MOH.0001.0307.0001	Undated
B.23.6	CV of Vanessa Janissen	MOH.0001.0306.0001	Undated
B.23.7	CV of Margot Mains	MOH.0001.0302.0001	Undated
B.23.8	CV of Dr Teresa Anderson AM	MOH.0001.0438.0001	Undated
B.23.9	CV of Margaret Bennett	MOH.0001.0301.0001	Undated
B.23.10	CV of Sonia Marshall	MOH.0001.0305.0001	Undated
B.23.11	<i>Intentionally left blank</i>		
B.23.12	CV of Mark Spittal	MOH.0001.0303.0001	Undated
B.23.13	NSW Health, <i>PD2023_028 NSW Health (Goods and Services) Procurement Policy</i>	MOH.0001.0037.0001	4 October 2023
B.23.14	NSW Health, <i>Procurement Procedures (Goods & Services), Version 1.0</i>	MOH.0001.0366.0001	June 2022
B.23.15	Audit Office of NSW, <i>Ensuring Contract Management Capability in Government – HealthShare NSW</i>	MOH.0001.0013.0001	31 October 2019
B.23.16	NSW Government, <i>Procurement Policy Framework</i>	MOH.0001.0132.0001	April 2022
B.23.17	NSW Government, <i>Supplier Code of Conduct, Version 1.1</i>	MOH.0001.0356.0001	November 2019

Exhibit No.	Description	SCOI Number	Document Date
B.23.18	NSW Government, <i>Small and Medium Enterprise and Regional Procurement Policy</i>	MOH.0001.0417.0001	Undated
B.23.19	NSW Government, <i>ICT/Digital SME Procurement Commitments</i>	MOH.0001.0334.0001	19 December 2022
B.23.20	NSW Government, <i>buy.nsw Small Business Shorter Payment Terms Policy</i>	MOH.0001.0416.0001	Undated
B.23.21	NSW Government, <i>Aboriginal Procurement Policy</i>	MOH.0001.0277.0001	January 2021
B.23.22	NSW Government, <i>Resource Efficiency Policy</i>	MOH.0001.0324.0001	2019
B.23.23	NSW Health, <i>Future Health: Guiding the next decade of health care in NSW 2022-2032</i>	MOH.0001.0320.0001	May 2022
B.23.24	NSW Health, <i>NSW Regional Health Strategic Plan 2022-2032</i>	MOH.0001.0372.0001	February 2023
B.23.25	NSW Health, <i>Corporate Governance & Accountability Compendium for NSW Health</i>	MOH.0001.0297.0001	September 2023
B.23.26	NSW Health, <i>Performance Framework 2023</i>	MOH.0001.0363.0001	Undated
B.23.27	NSW Health, <i>Service Agreement 2023-2024</i>	MOH.0001.0288.0001	undated
B.23.28	NSW Health, <i>PD2018_021 Disclosure of Contract Information</i>	MOH.0001.0148.0001	26 June 2018
B.23.29	NSW Health, <i>PD2015_045 Conflicts of Interest and Gifts and Benefits</i>	MOH.0001.0145.0001	27 October 2015
B.23.30	NSW Health, <i>PD2015_049 NSW Health Code of Conduct</i>	MOH.0001.0359.0001	16 December 2015
B.23.31	NSW Health, <i>PD2016_029 Corrupt Conduct – Reporting to the Independent Commission Against Corruption</i>	MOH.0001.0298.0001	15 July 2016

Exhibit No.	Description	SCOI Number	Document Date
B.23.32	NSW Health, <i>PD2022_038 Procurement Cards within NSW Health</i>	MOH.0001.0149.0001	2 September 2022
B.23.33	NSW Procurement Board, <i>PBD 2021-04 Approved Procurement Arrangements</i>	MOH.0001.0439.0001	23 November 2021
B.23.34	NSW Government, <i>ICT Service Scheme Rules</i>	MOH.0001.0333.0001	August 2023
B.23.35	NSW Ministry of Health, <i>Accounts & Audit Determination for Public Health Entities in NSW</i>	MOH.0001.0278.0001	9 March 2020
B.23.36	NSW Director-General, <i>Future Arrangements for Governance of NSW Health</i>	MOH.0001.0309.0001	2011
B.23.37	Delegation of Functions of the HealthShare Board	MOH.0001.0308.0001	29 November 2012
B.23.38	HealthShare, <i>Strategic Plan 2020-2024</i>	MOH.0001.0328.0001	13 October 2020
B.23.39	Order pursuant to s 126G of the <i>Health Services Act 1997</i>	MOH.0001.0404.0001	10 November 2008
B.23.40	NSW Health, <i>Standing Offer Agreement</i>	MOH.0001.0367.0001	13 December 2022
B.23.41	NSW Small Business Commissioner, <i>Faster Payment Terms Policy</i>	MOH.0001.0373.0001	31 December 2019
B.23.42	NSW Government, <i>TPP16-05 NSW Government Commissioning and Contestability Policy</i>	MOH.0001.0352.0001	November 2016
B.23.43	NSW Health, <i>PD2022_044 Asset Management</i>	MOH.0001.0150.0001	19 September 2022
B.23.44	NSW Government, <i>TPP18-06 NSW Government Business Case Guidelines</i>	MOH.0001.0351.0001	August 2018

Exhibit No.	Description	SCOI Number	Document Date
B.23.45	NSW Treasury, <i>TPG23-08 NSW Government Guide to Cost Benefit Analysis</i>	MOH.0001.0325.0001	February 2023
B.23.46	NSW Health, <i>PD2019_012 NSW Health Uniforms Policy</i>	MOH.0001.0369.0001	22 March 2019
B.23.47	NSW Ministry of Health, <i>Future of Work – Understanding the Impacts of Technology on Shared Services</i>	MOH.0001.0323.0001	May 2020
B.23.48	ACI, <i>Determination of Functions</i>	MOH.0001.0345.0001	21 August 2023
B.23.49	ACI, <i>Performance Agreement 2023-2024</i>	MOH.0001.0284.0001	31 October 2023
B.23.50	ACI, <i>Strategy 2023-2026</i>	MOH.0001.0350.0001	2023
B.23.51	NSW Ministry of Health, <i>NSW Health and Medical Research Strategic Review</i>	MOH.0001.0358.0001	2012
B.23.52	NSW Health, <i>Strategic Outcome 5 Steering Committee Terms of Reference</i>	MOH.0001.0422.0001	17 February 2023
B.23.53	NSW Health, <i>Future Health Measurement and Intelligence Council Terms of Reference</i>	MOH.0001.0319.0001	February 2023
B.23.54	NSW Health, <i>NSW Health System Advisory Council Terms of Reference</i>	MOH.0001.0368.0001	9 March 2023
B.23.55	eHealth Financial Statement	MOH.0001.0441.0001	30 June 2023
B.23.56	ACI, <i>Strategic Plan 2019-2022</i>	MOH.0001.0281.0001	2019
B.23.57	NSW Health, <i>PD2022_047 NSW Health Policies and Other Policy Documents</i>	MOH.0001.0364.0001	4 October 2022
B.23.58	ACI, <i>Implementation Guide: Putting a Model into Practice</i>	MOH.0001.0348.0001	Undated
B.23.59	<i>Intentionally left blank</i>		

Exhibit No.	Description	SCOI Number	Document Date
B.23.60	ACI, <i>Clinical Genomics Model of Care</i>	MOH.0001.0346.0001	Undated
B.23.61	NSW Health, <i>PD2023_039 The Use of the Emergency Care Assessment and Treatment (ECAT) Protocols</i>	MOH.0001.0430.0001	24 November 2023
B.23.62	ACI, <i>Emergency Care Assessment and Treatment Program Evaluation Plan Overview</i>	MOH.0001.0347.0001	November 2023
B.23.63	Critical Intelligence Unit, <i>In Brief Alternate Models of Providing Health Care</i>	MOH.0001.0287.0001	15 August 2023
B.23.64	ACI, <i>Clinical Practice Guide Value-Based Surgery</i>	MOH.0001.0282.0001	November 2023
B.23.65	<i>Intentionally left blank</i>		
B.23.66	NSW Health, <i>eHealth Strategy for NSW Health 2016-2026</i>	MOH.0001.0254.0001	Undated
B.23.67	NSW Health, <i>Virtual Care Strategy 2021-2026</i>	MOH.0001.0371.0001	February 2022
B.23.68	NSW Health, <i>GL2022_012 New Health Technologies and Specialised Services Framework</i>	MOH.0001.0343.0001	28 October 2022
B.23.69	NSW Health, <i>PD2023_017 Research Agreements in NSW Health Organisations</i>	MOH.0001.0403.0001	31 July 2023
B.23.70	NSW Health, <i>PD2007_035 Human Research Ethics Committee: Standards for Scientific Review of Clinical Trials</i>	MOH.0001.0331.0001	22 May 2007
B.23.71	NSW Treasury, <i>TPG22-22 Policy and Guidelines: Evaluation</i>	MOH.0001.0374.0001	February 2023

Exhibit No.	Description	SCOI Number	Document Date
B.23.72	Ward et al, 'Development of a novel and more holistic approach for assessing impact in health and medical research: the Research Impact Assessment Framework'	MOH.0001.0431.0001	11 September 2023
B.23.73	<i>Intentionally left blank</i>		
B.23.74	ACI, <i>Understanding the Use of Health Economics</i>	MOH.0001.0349.0001	May 2014
B.23.75	ACI, <i>The PRMs HOPE program process evaluation. Summarised report findings</i>	MOH.0001.0275.0001	October 2023
B.23.76	CEC, Determination of Functions of Statutory Health Corporation	MOH.0001.0293.0001	13 July 2012
B.23.77	CEC, <i>Performance Agreement 2023-2024</i>	MOH.0001.0294.0001	31 October 2023
B.23.78	NSW Government, <i>PD2022_056 Approval Process for Medicines and Their Use</i>	MOH.0001.0040.0001	2 December 2022
B.23.79	NSW Government, <i>PD2022_032 Medication Handling</i>	MOH.0001.0342.0001	11 August 2022
B.23.80	NSW Government, <i>buy.nsw ICT Purchasing Framework</i>	MOH.0001.0332.0001	1 September 2021
B.23.81	Instrument of Establishment of the NSW Health Pathology Division	MOH.0001.0380.0001	31 May 2012
B.23.82	Instrument of Constitution of the NSW Health Pathology Board	MOH.0001.0377.0001	8 October 2018
B.23.83	NSW Health Pathology, <i>NSWHP_CG_001 NSW Health Pathology – Delegations Manual</i>	MOH.0001.0361.0001	June 2023
B.23.84	NSW Government, <i>IB2020_014 Application of Policies for NSW Health Agencies</i>	MOH.0001.0036.0001	20 April 2020
B.23.85	NSW Health Pathology, <i>Policy Framework</i>	MOH.0001.0381.0001	3 March 2020

Exhibit No.	Description	SCOI Number	Document Date
B.23.86	Order pursuant to s 126G of the <i>Health Services Act 1997</i>	MOH.0001.0383.0001	13 June 2019
B.23.87	NSW Health Pathology, <i>Generic 2023-2024 Customer Charter</i>	MOH.0001.0379.0001	Undated
B.23.88	NSW Health, <i>PD2017_002 Staff Specialists Rights of Private Practice Arrangements</i>	MOH.0001.0419.0001	13 January 2017
B.23.89	NSW Health, <i>PD2010_048 Pathology Services provided to Private In-patients in Public Hospitals Policy Directive</i>	MOH.0001.0388.0001	7 July 2010
B.23.90	NSW Government, <i>PD2021_020 Infrastructure Charges for Visiting Medical Officers and Salaried Medical Practitioners Policy Directive</i>	MOH.0001.0335.0001	6 July 2021
B.23.91	NSW Health Pathology, <i>NSWHP_PR_047 Emergency Procurements Procedure</i>	MOH.0001.0378.0001	21 September 2023
B.23.92	NSW Health Pathology, <i>Statement of Service 2023-2024</i>	MOH.0001.0376.0001	10 November 2023
B.23.93	NSW Health Pathology, <i>Strategic Plan Towards 2025</i>	MOH.0001.0385.0001	Undated
B.23.94	NSW Health Pathology, <i>Clinical Services Plan 2019-2025</i>	MOH.0001.0384.0001	2021
B.23.95	NSW Procurement Board, <i>PD2019-05 Enforceable Procurement Provisions</i>	MOH.0001.0121.0001	16 September 2019
B.23.96	NSW Department of Premier and Cabinet, <i>C2017-015 Unsolicited Proposals Policy</i>	MOH.0001.0428.0001	22 December 2017
B.23.97	NSW Government, <i>Unsolicited Proposals Guide for Submission and Assessment</i>	MOH.0001.0427.0001	May 2022

Exhibit No.	Description	SCOI Number	Document Date
B.23.98	NSW Treasury, <i>TPG23-08 NSW Government Guide to Cost Benefit Analysis</i>	MOH.0001.0325.0001	February 2023
B.23.99	NSW Procurement Board, <i>PBD 2021-02 Mandated Use of ICT Purchasing Framework</i>	MOH.0001.0341.0001	1 July 2021
B.23.100	NSW Ministry of Health, <i>Financial Requirements and Conditions of Subsidy (Government Grants) for the Year Ending 30 June 2023</i>	MOH.0001.0318.0001	
B.23.101	NSW Government, <i>PD2023_030 NSW Health Motor Vehicle Procurement and Use</i>	MOH.0001.0370.0001	12 October 2023
B.23.102	NSW Health, <i>PD2008_013 Assets – Valuation of Physical Non-Current Assets at Fair Value</i>	MOH.0001.0292.0001	18 February 2008
B.23.103	Illawarra Shoalhaven LHD, <i>Fraud and Corruption Control Framework</i>	MOH.0001.0338.0001	29 June 2021
B.23.104	NSW Health, <i>PD2022_027 Software Asset Management</i>	MOH.0001.0418.0001	14 July 2022
B.23.105	NSW Government, <i>PD2021_043 NSW Health Foundation Information and Communication Technology (ICT) Services and Platforms</i>	MOH.0001.0210.0001	25 October 2021
B.23.106	Illawarra Shoalhaven LHD, <i>ISLHD_OPS_PD_22 Motor Vehicle Policy</i>	MOH.0001.0339.0001	July 2020
B.23.107	NSW Health, <i>PD2006_008 Prostheses – Surgically Implanted – Fees Chargeable by Public Health Organisations</i>	MOH.0001.0401.0001	30 January 2006
B.23.108	NSW Health, <i>PD2019_013 Administration of NSW Health Grant Funding for Non-Government Organisations</i>	MOH.0001.0285.0001	27 March 2019

Exhibit No.	Description	SCOI Number	Document Date
B.23.109	Illawarra Shoalhaven LHD, <i>ISLHD_CORP_PD_11 Delegations Framework</i>	MOH.0001.0337.0001	February 2021
B.23.110	Illawarra Shoalhaven LHD, <i>ISLHD_CORP_PD_43 Purchasing Card (PCard) Policy</i>	MOH.0001.0340.0001	
B.23.111	Infrastructure NSW, <i>Strategic Asset Management Program – Draft</i>	MOH.0001.0421.0001	
B.23.112	Infrastructure NSW, <i>Asset Management Program – Draft</i>	MOH.0001.0291.0001	
B.23.113	Illawarra Shoalhaven LHD, ISLHD CORP PD 10 <i>Management of Conflicts of Interest and Gifts and Benefits</i>	MOH.0001.0336.0001	June 2023
B.23.114	Sydney LHD, <i>Delegations Manual</i>	MOH.0001.0412.0001	June 2021
B.23.115	NSW Health, <i>Aboriginal Procurement and Participation Strategy</i>	MOH.0001.0276.0001	March 2022
B.23.116	Sydney LHD, <i>Service Agreement 2023-2024</i>	MOH.0001.0411.0001	8 November 2023
B.23.117	Sydney LHD, <i>2022-2023 Annual Financial Statements</i>	MOH.0001.0410.0001	Undated
B.23.118	NSW Health, <i>PD2023_026 Public Interest Disclosures</i>	MOH.0001.0151.0001	3 October 2023
B.23.119	NSW Health, <i>PD2018_031 Managing Misconduct</i>	MOH.0001.0391.0001	7 September 2018
B.23.120	Western NSW LHD, <i>Corporate Governance Attestation Statement</i>	MOH.0001.0432.0001	6 July 2022
B.23.121	South Western Sydney Local Health District, <i>Procurement Team Structure</i>	MOH.0001.0399.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
B.23.122	South Western Sydney LHD, <i>SWSLHD Strategic Procurement Advisory Board Terms of Reference</i>	MOH.0001.0423.0001	October 2022
B.23.123	NSW Government, <i>ICT Digital Assurance Framework Version 0.2 Draft</i>	MOH.0001.0357.0001	June 2020
B.23.124	eHealth Determination of Functions	MOH.0001.0312.0001	2 June 2023
B.23.125	NSW Treasury, <i>SCM0005 Scheme Rules Performance and Management Services Prequalification Scheme</i>	MOH.0001.0387.0001	
B.23.126	NSW Treasury, <i>Economic Data Briefing: Global Supply Chains</i>	MOH.0001.0375.0001	29 March 2022
B.23.127	<i>Intentionally left blank</i>		
B.23.128	NSW Treasury, <i>TPP21-02 Use Management of NSW Government Purchasing Cards</i>	MOH.0001.0426.0001	February 2021
B.23.129	HealthShare Statement of Service 2023-2024	MOH.9999.0010.0001	9 February 2024
B.23.130	Supplier Segmentation Framework (extract from Exhibit 14, Procurement Procedures (Goods & Services), Version 1.0)	MOH.0001.0442.0001	2018
B.23.131	<i>Intentionally left blank</i>		
B.23.132	Master Catalogue Solution Outline	MOH.0001.0443.0001	Undated
B.23.133	DeliverEASE Outline	MOH.0001.0016.0001	Undated
B.23.134	SmartChain Outline	MOH.0001.0017.0001	Undated
B.23.135	Evaluation of the SASH Home Modifications Program by EnableNSW	MOH.0001.0405.0001	Undated
B.23.136	Project Chef Outline	MOH.0001.0005.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
B.23.137	Task Allocation System Outline	MOH.0001.0010.0001_R	Undated
B.23.138	<i>Intentionally left blank</i>		
B.23.139	<i>Intentionally left blank</i>		
B.23.140	<i>Intentionally left blank</i>		
B.23.141	NSW Health Pathology, <i>Investment Decision Document</i>	MOH.0001.0444.0001	undated
B.23.142	<i>Intentionally left blank</i>		
B.23.143	Premier's Memorandum 2012-08, <i>Use of Biofuels</i>	MOH.0001.0429.0001	
B.23.144	NSW Health, <i>GL2023_023 NSW Health Fleet Management Guideline</i>	MOH.0001.0445.0001	12 October 2023
B.23.145	Illawarra Shoalhaven LHD, <i>Purchasing Manual</i>	MOH.0001.0446.0001	
B.23.146	Illawarra Shoalhaven LHD, <i>Purchasing Matrix</i>	MOH.0001.0447.0001	
B.23.147	Illawarra Shoalhaven LHD, <i>Sourcing & Contracts Framework</i>	MOH.0001.0448.0001	
B.23.148	Illawarra Shoalhaven LHD, example procurement data dashboard	MOH.0001.0449.0001	
B.23.149	Ernst & Young, <i>Procurement and Supply Chain team structure functional review</i>	MOH.0001.0033.0001	2018
B.23.150	<i>Intentionally left blank</i>		
B.23.151	Sydney LHD, <i>Major Procurement, Assets and Imaging Steering Committee Terms of Reference</i>	MOH.0001.0414.0001	Undated
B.23.152	Sydney LHD, <i>Director of Strategic Health Sourcing Statement of Duties</i>	MOH.0001.0420.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
B.23.153	Sydney LHD, <i>Contract Implementation Steering Committee Terms of Reference</i>	MOH.0001.0425.0001	May 2022
B.23.154	Sydney LHD, <i>Global Purchasing Agreements – Local (GPALS) Approval Process</i>	MOH.0001.0413.0001	Undated
B.23.155	Memorandum from the Chief Procurement Officer regarding Small and Medium Enterprise and Regional Procurement Policy Update	MOH.0001.0451.0001	13 December 2023
B.23.156	Western NSW LHD, Executive Group Structure	MOH.0001.0264.0001	Undated
B.23.157	<i>Intentionally left blank</i>		
B.23.158	NSW Health, Policy Directive PD2022_022 <i>Internal Audit</i>	MOH.0001.0265.0001	1 July 2022
B.23.159	Global Internal Audit Standards	MOH.0001.0266.0001	9 January 2024
B.23.160	Western NSW LHD, <i>Service Agreement with NSW Health</i>	MOH.0001.0267.0001	1 July 2023 – 30 June 2024
B.23.161	South Western Sydney LHD, <i>Delegations Manual</i>	MOH.0001.0268.0001	Undated
B.23.162	South Western Sydney LHD, <i>Strategic Plan 2022-2027</i>	MOH.0001.0269.0001	Undated
B.23.163	South Western Sydney LHD, <i>SWSLHD Major Procurement Requirements and Guidelines: Tenders, Expressions of Interest, Contracts and State Contract Equipment Purchases</i>	MOH.0001.0270.0001	May 2017
B.23.164	South Western Sydney Local Health District, <i>SWSLHD Nil Stock Escalation Process</i>	MOH.0001.0271.0001	Undated
B.23.165	NSW Health, PD2022-023 <i>Enterprise-wide Risk Management</i>	MOH.0001.0272.0001	1 July 2022

Exhibit No.	Description	SCOI Number	Document Date
B.23.166	Department of Communities and Justice, <i>NSW Government Legal Services Panel</i>	MOH.0001.0354.0001	15 December 2023
B.23.167	ACI, <i>Understanding the process to develop a Model of Care, An ACI Framework</i>	MOH.0001.0283.0001	May 2013
B.23.168	Sutherland, Kim and Adjunct Prof Jean-Frédéric Levesque, 'Unwarranted clinical variation in health care: Definitions and proposal of an analytic framework' (2020) 26 <i>Journal of Evaluation in Clinical Practice</i> 687	MOH.0001.0273.0001	April 2019
B.23.169	<i>Intentionally left blank</i>		
B.23.170	NSW Health, <i>PD2021-020 Infrastructure Charges for Visiting Medical Officers and Salaried Medical Practitioners</i>	MOH.0001.0335.0001	6 July 2021
B.23.171	NSW Health, <i>PD2017_005 Accreditation of Pathology Laboratories in NSW Health</i>	MOH.0001.0390.0001	15 May 2017
B.23.172	Order pursuant to s 126G of the <i>Health Services Act 1997</i>	MOH.0001.0383.0001	13 June 2019
B.23.173	Instrument of Establishment of the NSW Health Pathology Division	MOH.0001.0382.0001	6 June 2019
B.23.174	Procurement Board Direction <i>PBD23-03 Procurement opportunities for Small (and medium) businesses</i>	MOH.0001.0452.0001	7 December 2023
B.23.175	<i>Intentionally left blank</i>		
B.23.176	HealthShare, <i>Shared Service Evolution Program Comprehensive Expenditure Review</i>	MOH.0001.0015.0001	27 November 2023
B.23.177	NSW Health, <i>Contract Networking Group Terms of Reference</i>	MOH.0001.0296.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
B.23.178	KPMG, <i>Future of Work – Understanding the Impacts of Technology on Shared Services</i>	MOH.0001.0322.0001	May 2020
B.23.179	Southern NSW LHD, <i>Southern NSW LHD Procurement Guide</i>	MOH.0001.0457.0001	September 2023
B.23.180	Southern NSW LHD, <i>Delegations of Authority Manual</i>	MOH.0001.0453.0001	28 November 2023
B.23.181	Southern NSW LHD, <i>Service Agreement 2023-2024</i>	MOH.0001.0456.0001	26 October 2023
B.24	CEC, <i>Determination of Functions</i>	SCI.0003.0001.0385	13 July 2012
B.25	eHealth NSW 2013 Blueprint	SCI.0003.0001.0094	December 2013
B.26	HETI, <i>Determination of Functions</i>	SCI.0001.0060.0001	13 September 2017
B.27	BHI, <i>Determination of Functions</i>	SCI.0001.0063.0001	27 June 2018
B.28	NSW Auditor-General, <i>Performance Audit – Ensuring Contract Management Capability in Government – HealthShare</i>	SCI.0003.0001.0214	31 October 2019
B.29	NSW Auditor-General, <i>Financial Audit – Health 2020</i>	SCI.0003.0001.0255	10 December 2020
B.30	NSW Auditor-General, <i>Financial Audit – Health 2021</i>	SCI.0003.0001.0302	15 December 2021
B.31	HealthShare, <i>Statement of Service 2022-2023</i>	MOH.0001.0330.0001	10 August 2022
B.32	NSW Auditor-General, <i>Financial Audit – Health 2022</i>	SCI.0003.0001.0341	7 December 2022
B.33	<i>NSW Regional Health Strategic Plan 2022-2032 Priority Framework</i>	SCI.0001.0058.0001	21 February 2023
B.34	ACI, <i>Determination of Functions</i>	SCI.0001.0061.0001	21 August 2023
B.35	Health Infrastructure, <i>Statement of Service 2023-2024</i>	SCI.0003.0001.0386	31 October 2023

Exhibit No.	Description	SCOI Number	Document Date
B.36	NSW Health, <i>Annual Report 2022-2023</i>	SCI.0001.0059.0001	November 2023
B.37	NSW Auditor-General, <i>Financial Audit – Health 2023</i>	SCI.0003.0001.0404	19 December 2023
B.38	NSW Health Pathology, <i>2023-2025 Strategic Plan</i>	SCI.0003.0001.0439	Undated
B.39	Statement of Nicholas Howson, Registered Nurse	SCI.0003.0006.0001	16 February 2024
B.40	Annexure A to Statement of Nicholas Howson – Photo of Arista alarm	SCI.0003.0007.0001	Undated
B.41	Annexure B to Statement of Nicholas Howson – Email from Nicholas Howson	SCI.0003.0008.0001	24 February 2023
B.42	Annexure C to Statement of Nicholas Howson – Email from Janine van Bruinessen	SCI.0003.0009.0001_R	24 February 2023
B.43	Annexure D to Statement of Nicholas Howson – Email from Eliza Wright	SCI.0003.0010.0001_R	4 February 2024
B.44	Annexure E to Statement of Nicholas Howson – Email from Eliza Wright	SCI.0003.0011.0001_R	18 March 2021
B.45	Annexure F to Statement of Nicholas Howson – ims+ Incident	SCI.0003.0012.0001	25 February 2022
B.46	Annexure G to Statement of Nicholas Howson – Email from Mark Murphy	SCI.0003.0013.0001_R	22 February 2023
B.47	Annexure H to Statement of Nicholas Howson – Email from Nick Howson	SCI.0003.0014.0001_R	18 November 2022
B.48	Annexure I to Statement of Nicholas Howson – Email from Neethu Maria Babu	SCI.0003.0015.0001_R	21 November 2022

Exhibit No.	Description	SCOI Number	Document Date
B.49	Annexure J to Statement of Nicholas Howson – ims+ Incident	SCI.0003.0016.0001_R	1 November 2022
B.50	Annexure K to Statement of Nicholas Howson – Letter from Cumberland Branch of NSWNMA to Wade Norrie	SCI.0003.0017.0001_R	19 December 2022
B.51	Annexure L to Statement of Nicholas Howson – ims+ Incident	SCI.0003.0018.0001	14 February 2024
B.52	The Honourable Peter Anderson AM, <i>Improvements to Security in Hospitals – Final Report 2020</i>	SCI.0003.0019.0001	2020
B.53	NSW Health, <i>Protecting People and Property</i>	SCI.0003.0020.0001	February 2022
B.54	2022 eHealth NSW Customer Survey – Final Detailed Report	MOH.0001.0244.0001	16 February 2023
B.55	NSW Health ICT Experience Survey 2019 – Detailed Report	MOH.9999.0011.0001	Undated
B.56	Customer Value Survey 2020 – HealthShare NSW – Topline Report	MOH.9999.0012.0001	Undated
B.57	HealthShare NSW – Partner Experience Survey – Full Report	MOH.9999.0013.0001	Undated
B.58	HealthShare NSW Service Lines Overview	MOH.9999.0014.0001	Undated
B.59	NSW Health – Leading Better Value Care	SCI.0003.0021.0001	Undated
B.60	Employment and Financial Shared Services Evolution – Response to Review	MOH.0001.0014.0001	Undated
B.61	NSW Health, <i>Commissioning for Better Value Strategy 2021-2025</i>	MOH.0001.0198.0001	10 January 2023 revision
B.62	<i>Commissioning for Better Value Strategy at a Glance</i>	MOH.0001.0200.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
B.63	<i>Time for Care – Relieving the administrative burden from frontline clinicians in NSW Health</i>	MOH.0001.0209.0001	17 August 2023
B.64	<i>NSW Health Procurement (Goods and Services) Policy</i>	MOH.0001.0134.0001	4 October 2023
B.65	<i>HealthSupply, NSW Health Procurement Reform</i>	MOH.0001.0018.0001	24 November 2023
B.66	<i>HealthSupply, Warehousing and Distribution Reform – Project Overview</i>	MOH.0001.0020.0001	January 2024
B.67	<i>NSW Health, Warehousing and Logistics Review – Executive Summary</i>	MOH.0001.0021.0001	12 December 2022
B.68	<i>HealthShare, Employment and Financial Shared Services Review</i>	MOH.0001.0012.0001	April 2023
B.69	<i>Illawarra Shoalhaven LHD Board Delegations – Delegation Manual – Part 2</i>	MOH.9999.0015.0001	15 March 2021
B.70	<i>Illawarra Shoalhaven LHD Delegations Manual – Delegation Manual Part 1 – v10</i>	MOH.9999.0016.0001	10 August 2023
B.71	<i>eHealth NSW, Privacy and Security Assessment Framework Customer Guide</i>	MOH.9999.0017.0001	23 March 2023

A.20: Tender Bundle C – Murrumbidgee LHD Hearings (March 2024)

Exhibit No.	Description	SCOI Number	Document Date
C.1	<i>Murrumbidgee LHD, Quality and Safety Account</i>	SCI.0004.0034.0001	November 2023
C.2	<i>Intentionally left blank</i>		
C.3	<i>Murrumbidgee LHD, Corporate Governance Attestation Statement 2022-2023</i>	SCI.0004.0036.0001	27 September 2023

Exhibit No.	Description	SCOI Number	Document Date
C.4	Murrumbidgee LHD, <i>Budget Allocation Summary 2023-2024</i>	SCI.0004.0037.0001	September 2023
C.5	Sample of Murrumbidgee LHD Facility Budget Allocation 2023-2024	SCI.0004.0012.0001 SCI.0004.0023.0001 SCI.0004.0029.0001 SCI.0004.0002.0001 SCI.0004.0016.0001 SCI.0004.0022.0001 SCI.0004.0025.0001	
C.6	Murrumbidgee LHD, Audited Financial Statements 2022-2023	SCI.0004.0038.0001	3 October 2023
C.7	Murrumbidgee LHD, <i>Research Framework 2022-2027</i>	SCI.0004.0039.0001	April 2022
C.8	<i>Intentionally left blank</i>		
C.9	Murrumbidgee LHD, <i>Patient Safety First: Quality Health Care Framework 2017-2021</i>	SCI.0004.0041.0001	February 2018
C.10	Murrumbidgee Population and Health Summary	SCI.0004.0042.0001	October 2023
C.11	Murrumbidgee Aboriginal Health Profile	SCI.0004.0043.0001	December 2020
C.12	Murrumbidgee Aboriginal Health Indicators Summary	SCI.0004.0044.0001	December 2020
C.13	Murrumbidgee LHD, <i>Health Atlas 2019</i>	SCI.0004.0045.0001	March 2019
C.14	Murrumbidgee LHD, <i>Areas of Disadvantage – ABS Socioeconomic Indexes 2021</i>	SCI.0004.0046.0001	April 2023
C.15	Murrumbidgee LHD, <i>Lifestyle Risk Factors Trend</i>	SCI.0004.0047.0001	17 October 2023
C.16	Murrumbidgee LHD Board Commitment – Aboriginal and Torres Strait Islander Health	SCI.0004.0048.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
C.17	Murrumbidgee LHD Board Commitment – Environmental Sustainability	SCI.0004.0049.0001	April 2021
C.18	Concession Card Holders Murrumbidgee LHD by LGA	SCI.0004.0050.0001	
C.19	Murrumbidgee LHD, <i>Income Support by LGA</i>	SCI.0004.0051.0001	April 2022
C.20	Sample of Murrumbidgee LHD Aboriginal Population by LGA	SCI.0004.0052.0001 SCI.0004.0064.0001 SCI.0004.0071.0001 SCI.0004.0066.0001 SCI.0004.0068.0001	
C.21	Sample of Murrumbidgee LHD Population Projections by LGA	SCI.0004.0087.0001 SCI.0004.0093.0001 SCI.0004.0088.0001 SCI.0004.0090.0001	June 2022
C.22.1	Murrumbidgee LHD Cultural Diversity Dashboard Visuals – Berrigan LGA	SCI.0004.0109.0001	
C.22.2	Murrumbidgee LHD Cultural Diversity Dashboard Visuals – Coolamon LGA	SCI.0004.0142.0001	
C.22.3	Murrumbidgee LHD Cultural Diversity Dashboard Visuals – Snowy Valleys LGA	SCI.0004.0110.0001	
C.22.4	Murrumbidgee LHD Cultural Diversity Dashboard Visuals – Wagga Wagga LGA	SCI.0004.0112.0001	
C.22.5	Murrumbidgee LHD Cultural Diversity Dashboard Tables – Berrigan LGA	SCI.0004.0114.0001	
C.22.6	Murrumbidgee LHD Cultural Diversity Dashboard Tables – Coolamon LGA	SCI.0004.0117.0001	

Exhibit No.	Description	SCOI Number	Document Date
C.22.7	Murrumbidgee LHD Cultural Diversity Dashboard Tables – Snowy Valleys LGA	SCI.0004.0134.0001	
C.22.8	Murrumbidgee LHD Cultural Diversity Dashboard Tables – Wagga Wagga LGA	SCI.0004.0136.0001	
C.22.9	Murrumbidgee LHD Cultural Diversity – Language Filter – Not Stated	SCI.0004.0138.0001	
C.22.10	Murrumbidgee LHD Cultural Diversity – Language Filter – Other Language and Speak English – not well or at all	SCI.0004.0139.0001	
C.22.11	Murrumbidgee LHD Cultural Diversity – Language Filter – Other Language and Speak English – well or very well	SCI.0004.0140.0001	
C.22.12	Murrumbidgee LHD Cultural Diversity – Language Filter – Not Stated – Both Language	SCI.0004.0141.0001	
C.22.13	Murrumbidgee LHD Cultural Diversity – Language Filter – English Only	SCI.0004.0143.0001	
C.22.14	Murrumbidgee LHD Cultural Diversity – Language Codes	SCI.0004.0144.0001	
C.22.15	Murrumbidgee LHD Cultural Diversity – Public Health Information Development Unit – Birthplaces	SCI.0004.0145.0001	
C.22.16	Murrumbidgee LHD Cultural Diversity – Public Health Information Development Unit – Migrants	SCI.0004.0146.0001	
C.23.1	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Background	SCI.0004.0151.0001	

Exhibit No.	Description	SCOI Number	Document Date
C.23.2	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Main causes by age group	SCI.0004.0154.0001	
C.23.3	Murrumbidgee LHD Deaths Dashboard 2015-2019 – No 1 cause by age	SCI.0004.0155.0001	
C.23.4	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Leading 5 – 0-74 years	SCI.0004.0156.0001	
C.23.5	Murrumbidgee LHD Deaths Dashboard 2015-2019 – IHD	SCI.0004.0157.0001	
C.23.6	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Lung Cancer	SCI.0004.0158.0001	
C.23.7	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Suicide	SCI.0004.0159.0001	
C.23.8	Murrumbidgee LHD Deaths Dashboard 2015-2019 – COPD	SCI.0004.0160.0001	
C.23.9	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Colorectal Cancer	SCI.0004.0161.0001	
C.23.10	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Leading Cause by LGA	SCI.0004.0152.0001	
C.23.11	Murrumbidgee LHD Deaths Dashboard 2015-2019 – Aboriginal Population	SCI.0004.0153.0001	
C.24	Living Well Your Way, Collaborative Commissioning Care Pathway Design	SCI.0004.0162.0001	23 November 2021
C.25	NSW Health, Rural Doctors' Settlement Package Clarifications Reference Guide	SCI.0004.0163.0001	21 June 2023

Exhibit No.	Description	SCOI Number	Document Date
C.26	NSW Health, Policy Directive: Rural Health Workforce Incentive Scheme	SCI.0004.0164.0001	4 July 2023
C.27	DOHAC, <i>Workforce Incentive Program – Doctor Stream – Guidelines</i>	SCI.0004.0165.0001	1 January 2024
C.28	DOHAC, <i>Fact Sheet – Changes to the Workforce Incentive Program – Doctor Stream</i>	SCI.0004.0166.0001	September 2023
C.29	NSW Health, Regional Health Strategic Plan 2022-2032 Priority Framework	SCI.0004.0168.0001	February 2023
C.30	CV of Dr Rachel Christmas	RDA.0001.0001.0001_R	March 2024
C.31.1	Documents provided by Murrumbidgee PHN	MPH.0001.0001.0001	
C.31.2	CV of Narelle Mills	MPH.0001.0002.0001	
C.31.3	CV of Melissa Neal	MPH.0001.0003.0001	
C.32.1	CV of Dr Nicholas Stevenson	DNS.0001.0001.0001_R	February 2024
C.32.2	Appendix A – Journal References re Rural Workforce	DNS.0001.0002.0001	
C.33.1	Statement of Jill Ludford PSM, Chief Executive, Murrumbidgee LHD	MLH.0001.0016.0001	12 March 2024
C.33.2	Exhibit A to Statement of Jill Ludford PSM – CV of Jill Ludford	MLH.0001.0001.0001	2024
C.33.3	Exhibit B to Statement of Jill Ludford – NSW Aboriginal Health Plan, 2013-2023	MLH.0001.0002.0001	
C.33.4	Exhibit C to Statement of Jill Ludford – Murrumbidgee LHD Service Agreement 2023-2024	MLH.0001.0003.0001	1 July 2023 to 30 June 2024
C.33.5	Exhibit D to Statement of Jill Ludford – Murrumbidgee LHD Strategic Plan 2021 to 2026	MLH.0001.0004.0001	2021

Exhibit No.	Description	SCOI Number	Document Date
C.33.6	Exhibit E to Statement of Jill Ludford – Murrumbidgee LHD Clinical Governance Framework 2023-2027	MLH.0001.0005.0001	2023
C.33.7	Exhibit F to Statement of Jill Ludford – Model By-Laws	MLH.0001.0006.0001	2021
C.33.8	Exhibit G to Statement of Jill Ludford – Murrumbidgee LHD Board Governance Charter	MLH.0001.0007.0001	October 2023
C.33.9	Exhibit H to Statement of Jill Ludford – Murrumbidgee LHD and Southern LHD Risk Appetite Framework	MLH.0001.0008.0001	Undated
C.33.10	Exhibit I to Statement of Jill Ludford – Murrumbidgee LHD Risk Escalation Framework	MLH.0001.0009.0001	2023
C.33.11	Exhibit J to Statement of Jill Ludford – Murrumbidgee LHD Community Engagement Strategy 2024-2027	MLH.0001.0010.0001	2024
C.33.12	Exhibit K to Statement of Jill Ludford – Local Health Advisory Committee – Terms of Reference	MLH.0001.0011.0001	April 2022
C.33.13	Exhibit L to Statement of Jill Ludford – Murrumbidgee LHD Map	MLH.0001.0012.0001	Undated
C.33.14	Exhibit M to Statement of Jill Ludford – Murrumbidgee LHD and MPHNS Collaboration Agreement 2022-2025	MLH.0001.0013.0001	2022
C.33.15	Exhibit N to Statement of Jill Ludford – Joint Statement NSW Health and PHNs NSW	MLH.0001.0014.0001	September 2021
C.33.16	Exhibit O to Statement of Jill Ludford – Murrumbidgee LHD Procurement Guide	MLH.0001.0015.0001	May 2023
C.33.17	Murrumbidgee LHD Travelling Times	MLH.0001.0017.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
C.34.1	Attachment 1.1 – Coolamon Shire Council Local Strategic Planning Statement 2019-2039	CSC.0001.0001.0001	2019
C.34.2	Attachment 1.2 – Coolamon Shire Council Settlement Strategy 2040	CSC.0001.0002.0001	November 2021
C.34.3	Attachment 2 – Allawah Lodge Proposal	CSC.0001.0003.0001	June 2018
C.34.4	Attachment 3 – Allawah Lodge Income Statement and Balance Sheet 2014-2024	CSC.0001.0004.0001	2024
C.34.5	Attachment 4 – Letter to LGNSW re Advocacy for Councils	CSC.0001.0005.0001	21 April 2020
C.34.6	Attachment 5 – Allawah Lodge Delivery Program and Financial Plan	CSC.0001.0006.0001	2023
C.34.7	CV of Tony Donoghue	CSC.0001.0007.0001_R	2024
C.34.8	CV of Clr David McCann OAM	CSC.0001.0008.0001_R	2024
C.35.1	CV of Prof Tara Mackenzie	UNS.0001.0001.0001	2024
C.35.2	UNSW Rural Clinical Campuses Health Workforce Student– Graduate Data	UNS.0001.0002.0001	February 2024

A.21: Tender Bundle D – Governance and Wastage Hearings (April 2024)

Exhibit No.	Description	SCOI Number	Document Date
D.1	NSW Health Consolidated Exhibit Bundle		
D.1.1	CV of Lee Gregory	MOH.9999.0778.0001	Undated
D.1.2	CV of Philip Minns	MOH.9999.0779.0001	Undated
D.1.3	CV of Sharon Smith	MOH.9999.0780.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
D.1.4	CV of Scott McLachlan	MOH.9999.0781.0001	Undated
D.1.5	CV of Matthew Daly	MOH.9999.0782.0001	Undated
D.1.6	CV of Mark Zacka	MOH.9999.0783.0001	Undated
D.1.7	CV of Trevor Danos AM	MOH.9999.0784.0001	Undated
D.1.8	CV of Jacqueline Ferguson	MOH.9999.0785.0001	Undated
D.1.9	[Reference is to document previously tendered and marked Exhibit A.54]	MOH.9999.0006.0001	
D.1.10	[Reference is to document previously tendered and marked Exhibit A.4]	MOH.9999.0004.0001	
D.1.11	CV of Luke Sloane	MOH.9999.0786.0001	Undated
D.1.12	CV of Adjunct Prof Michael Nicholl	MOH.9999.0787.0001	Undated
D.1.13	CV of A/Prof Anthony Schembri AM	MOH.9999.0788.0001	Undated
D.1.14	CV of Fiona Wilkinson	MOH.9999.0789.0001	Undated
D.1.15	CV of Bruno Zinghini	MOH.9999.0790.0001	Undated
D.1.16	CV of Amanda Bock	MOH.9999.0791.0001	Undated
D.1.17	CV of James Ross	MOH.9999.0792.0001	Undated
D.1.18	CV of Dr Michael Maley	MOH.9999.0793.0001	Undated
D.1.19	[Reference is to document previously tendered and marked Exhibit A.11]	SCI.0001.0007.0001	
D.1.20	Nepean Blue Mountains LHD, <i>Service Agreement 2023-2024</i>	MOH.9999.0794.0001	29 December 2022
D.1.21	[Reference is to document previously tendered and marked Exhibit A.12]	SCI.0001.0008.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.1.22	ACSQHC, <i>National Safety and Quality Health Service Standards</i>	MOH.9999.0795.0001	May 2021
D.1.23	Nepean Blue Mountains LHD, <i>Safety and Quality Account 2023-2024</i>	MOH.9999.0796.0001	November 2023
D.1.24	NSW Health, <i>PD2024_002 Public Health Emergency Response and Preparedness</i>	MOH.9999.0797.0001	23 January 2024
D.1.25	NSW Health, <i>PD2024_005 Early Response to High Consequences Infectious Diseases</i>	MOH.9999.0798.0001	13 February 2024
D.1.26	Nepean Blue Mountains LHD, <i>Corporate Governance Attestation Statement 2022-2023</i>	MOH.9999.0799.0001	19 July 2023
D.1.27	Nepean Blue Mountains LHD, <i>New Governance Structure Implementation – Update for the Board</i>	MOH.9999.0800.0001	February 2023
D.1.28	[Reference is to document previously tendered and marked Exhibit A.56]	SCI.0001.0048.0001	30 June 2023
D.1.29	[Reference is to document previously tendered and marked Exhibit B.23.158]	MOH.0001.0265.0001	
D.1.30	[Reference is to document previously tendered and marked Exhibit B.23.165]	MOH.0001.0272.0001	
D.1.31	[Reference is to document previously tendered and marked Exhibit B.23.043]	MOH.0001.0150.0001	
D.1.32	Nepean Blue Mountains LHD, <i>Finance and Administrative Delegations</i>	MOH.9999.0801.0001	October 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.33	NSW Health, PD2005_608 <i>Patient Safety and Clinical Quality Program</i>	MOH.9999.0802.0001	26 July 2005
D.1.34	NSW Health, PD2020_047 <i>Incident Management</i>	MOH.9999.0803.0001	14 December 2020
D.1.35	NSW Health, PD2023_011 <i>Australian Health Services and Quality Accreditation Scheme in NSW Health Facilities</i>	MOH.9999.0804.0001	12 May 2023
D.1.36	Nepean Blue Mountains LHD, <i>Strategic Plan 2023-2028</i>	MOH.9999.0805.0001	Undated
D.1.37	Nepean Blue Mountains LHD, <i>Research Strategy and Implementation Plan 2022-2025</i>	MOH.9999.0806.0001	December 2022
D.1.38	Nepean Blue Mountains LHD, <i>Sustainability Plan 2019-2023</i>	MOH.9999.0807.0001	7 July 2020
D.1.39	[Reference is to document previously tendered and marked B.23.022]	MOH.0001.0324.0001	
D.1.40	Nepean Blue Mountains LHD, <i>Aboriginal Health Plan 2021-2026</i>	MOH.9999.0808.0001	Undated
D.1.41	[Reference is to document previously tendered and marked B.23.036]	MOH.0001.0309.0001	
D.1.42	NSW Health, PD2022_021 <i>Executive Performance Management</i>	MOH.9999.0809.0001	28 June 2022
D.1.43	[Reference is to document previously tendered and marked Exhibit A.14]	SCI.0001.0010.0001	
D.1.44	[Reference is to document previously tendered and marked Exhibit B.23.118]	MOH.0001.0151.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.1.45	NSW Health, <i>PD2017_003 Significant Legal Matter and Management of Legal Services</i>	MOH.9999.0810.0001	2 February 2017
D.1.46	NSW Health, <i>PD2014_021 Prosecution Policy and Guidelines</i>	MOH.9999.0811.0001	1 July 2014
D.1.47	[Reference is to document previously tendered and marked Exhibit B.23.035]	MOH.0001.0278.0001	
D.1.48	NSW Health, <i>Accounting Policy Manual</i>	MOH.9999.0812.0001	1 December 2023
D.1.49	NSW Health, <i>Accounting Manual for Public Health Organisations</i>	MOH.9999.0813.0001	9 January 2014
D.1.50	NSW Health, <i>Leave/Salaries Manual – Public Service Manual</i>	MOH.9999.0814.0001	24 October 2014
D.1.51	NSW Health, <i>Patient Matters Manual for Public Health Organisations</i>	MOH.9999.0815.0001	October 2023
D.1.52	[Reference is to document previously tendered and marked Exhibit B.53]	SCI.0003.0020.0010	
D.1.53	NSW Health, <i>PD2024_009 NSW Health Procurement (Goods and Services)</i>	MOH.9999.0816.0001	26 February 2024
D.1.54	NSW Health, <i>Combined Delegations Manual</i>	MOH.9999.0817.0001	22 May 2015
D.1.55	NSW Health, <i>Public Health Delegations Manual</i>	MOH.9999.0818.0001	28 November 2023
D.1.56	[Reference is to document previously tendered and marked B.23.083]	MOH.0001.0361.0001	
D.1.57	NSW Health, <i>eHealth NSW Delegations Manual</i>	MOH.9999.0819.0001	May 2019

Exhibit No.	Description	SCOI Number	Document Date
D.1.58	NSW Health, <i>Health Infrastructure Delegations Manual</i>	MOH.9999.0820.0001	May 2023
D.1.59	NSW Premier and Cabinet, <i>Boards and Committees Guidelines</i>	MOH.9999.0821.0001	September 2015
D.1.60	Northern Sydney LHD, <i>By-Laws</i>	MOH.9999.0822.0001	28 August 2021
D.1.61	Northern Sydney LHD, <i>Corporate Governance Framework 2023</i>	MOH.9999.0823.0001	2023
D.1.62	Northern Sydney LHD, <i>Strategic Plan 2022-2027</i>	MOH.9999.0824.0001	2022
D.1.63	[Reference is to document previously tendered and marked Exhibit B.23.030]	MOH.0001.0359.0001	
D.1.64	Northern Sydney LHD, <i>Clinical Governance Framework 2022-2025</i>	MOH.9999.0825.0001	2022
D.1.65	<i>Intentionally left blank</i>		
D.1.66	Northern Sydney LHD, <i>Board Charter</i>	MOH.9999.0826.0001	December 2023
D.1.67	Northern Sydney LHD, <i>Board Audit and Risk Committee – Terms of Reference</i>	MOH.9999.0827.0001	March 2023
D.1.68	Northern Sydney LHD, <i>Board Finance, Risk and Performance Committee – Terms of Reference</i>	MOH.9999.0828.0001	December 2023
D.1.69	Northern Sydney LHD, <i>Board Health Care Quality Committee – Terms of Reference</i>	MOH.9999.0829.0001	December 2023
D.1.70	Northern Sydney LHD, <i>Board Consumer Committee – Terms of Reference</i>	MOH.9999.0830.0001	February 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.71	Northern Sydney LHD, <i>Board Research, Innovation and Technology Committee – Terms of Reference</i>	MOH.9999.0831.0001	January 2024
D.1.72	<i>Intentionally left blank</i>		
D.1.73	Northern Sydney LHD, <i>Board Priorities for Chief Executive 2023-2024</i>	MOH.9999.0832.0001	January 2024
D.1.74	NSW Treasury, <i>TPP17-06 Certifying the Effectiveness of Internal Controls over Financial Information</i>	MOH.9999.0833.0001	May 2017
D.1.75	Australian Commission on Safety and Quality in Health Care, <i>National Model Clinical Governance Framework</i>	MOH.9999.0834.0001	November 2017
D.1.76	NSW Health, <i>PD2024_010 Clinical Governance in NSW</i>	MOH.9999.0835.0001	18 March 2024
D.1.77	Northern Sydney LHD, <i>Management of Patient/Consumer/Carer/Family Complaints</i>	MOH.9999.0836.0001	28 July 2023
D.1.78	NSW Health, <i>PD2020_013 Complaints Management</i>	MOH.9999.0837.0001	24 April 2020
D.1.79	NSW Health, <i>GL2020_008 Complaints Management Guidelines</i>	MOH.9999.0838.0001	24 April 2020
D.1.80	NSW Health, <i>Clinical Coding Leadership Group – Terms of Reference</i>	MOH.9999.0839.0001	Undated
D.1.81	NSW Health, <i>GL2019_002 NSW Health Data Governance Framework</i>	MOH.9999.0840.0001	14 March 2019
D.1.82	NSW Health, <i>KPI Data Supplement 2023-2024</i>	MOH.9999.0841.0001	October 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.83	NSW Health, <i>Improvement Measures Data Supplement 2023-2024</i>	MOH.9999.0842.0001	September 2023
D.1.84	NSW Health, <i>PD2013_010 Non-Admitted Patient Activity Reporting Requirements</i>	MOH.9999.0843.0001	4 June 2013
D.1.85	NSW Health, <i>GL2017_014 Non-Admitted Patient Classification Principles</i>	MOH.9999.0844.0001	16 August 2017
D.1.86	NSW Health, <i>IB2021_051 Non-Admitted Patient and Supplementary Services Data Collection: Core Minimum and Extended Data Set</i>	MOH.9999.0845.0001	28 September 2021
D.1.87	AIHW, <i>Non-admitted patient National Best Endeavours Data Set (NBEDS) 2022-2023</i>	MOH.9999.0846.0001	2024
D.1.88	NSW Health, <i>Lumos Monitoring and Evaluation Framework</i>	MOH.9999.0847.0001	September 2021
D.1.89	NSW Health, <i>Lumos Data Governance Framework</i>	MOH.9999.0848.0001	September 2021
D.1.90	NSW Health, <i>Lumos Factsheet – Management of Diabetes in the Community Influences for Acute Care and Mortality</i>	MOH.9999.0849.0001	Undated
D.1.91	NSW Health, <i>Lumos Factsheet – General Practice Activity Can Affect Hospital Visits</i>	MOH.9999.0850.0001	Undated
D.1.92	NSW Health, <i>Lumos Factsheet – Health Care Usage for Older People</i>	MOH.9999.0851.0001	Undated
D.1.93	NSW Health, <i>Lumos Factsheet – Impacts of Where People with Diabetes Live</i>	MOH.9999.0852.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
D.1.94	NSW Health, <i>Lumos Factsheet – Care in General Practice Can Affect Hospital Visits</i>	MOH.9999.0853.0001	Undated
D.1.95	NSW Health, <i>Continuity of Care Benefits Patients and the System</i>	MOH.9999.0854.0001	Undated
D.1.96	NSW Health, <i>Lumos – General Practice Report October 2020</i>	MOH.9999.0855.0001	October 2020
D.1.97	NSW Health, <i>Lumos Evaluation Report 1</i>	MOH.9999.0856.0001	December 2021
D.1.98	NSW Health, <i>Lumos Information for General Practitioners and Lumos Consent Form</i>	MOH.9999.0857.0001	Undated
D.1.99	NSW Health, <i>EDWARD Public Admitted Patient Care Data Stream – Data Dictionary</i>	MOH.9999.0858.0001	2021
D.1.100	Central Coast LHD, <i>Service Agreement 2023-2024</i>	MOH.9999.0859.0001	October 2023
D.1.101	Central Coast LHD, <i>Safety and Quality Account 2022-2023</i>	MOH.9999.0860.0001	October 2023
D.1.102	Australian Commission on Safety and Quality in Health Care, <i>Australian Safety and Quality Framework for Health Care</i>	MOH.9999.0861.0001	December 2010
D.1.103	NSW Health, <i>NSW Health Aboriginal Procurement Participation Strategy</i>	MOH.9999.0862.0001	March 2022
D.1.104	Central Coast LHD, <i>Policy, Procedure, Guideline, Standard Operating Practice (SOP Framework)</i>	MOH.9999.0863.0001	2 November 2020
D.1.105	Central Coast LHD, <i>PR2014_039 Policy, Procedure and Guideline – Development, Approval and Implementation System</i>	MOH.9999.0864.0001	10 December 2020

Exhibit No.	Description	SCOI Number	Document Date
D.1.106	Central Coast LHD, <i>Organisational Performance Framework</i>	MOH.9999.0865.0001	Undated
D.1.107	Central Coast LHD, <i>Caring for the Coast Strategy 2019-2024</i>	MOH.9999.0866.0001	November 2019
D.1.108	Central Coast LHD, <i>Organisational Sustainability Plan 2020-2023</i>	MOH.9999.0867.0001	October 2020
D.1.109	Central Coast LHD, <i>Caring for Our Community Plan 2021-2031</i>	MOH.9999.0868.0001	2021
D.1.110	Central Coast LHD, <i>Clinical Services Plan 2023-2028</i>	MOH.9999.0869.0001	November 2023
D.1.111	NSW Health, <i>PD2012_039 Real Property Disposal Framework</i>	MOH.9999.0870.0001	13 July 2012
D.1.112	Central Coast LHD, <i>Delegations Manual</i>	MOH.9999.0871.0001	November 2023
D.1.113	Central Coast LHD, <i>Corporate Governance Plan</i>	MOH.9999.0872.0001	July 2023
D.1.114	NSW Health, <i>Rostering Resource Manual</i>	MOH.9999.0873.0001	July 2019
D.1.115	[Reference is to document previously tendered and marked Exhibit A.53]	MOH.9999.0005.0001	
D.1.116	NSW Health, <i>PD2012_059 Delegations of Authority – Local Health Districts and Specialty Networks</i>	MOH.9999.0874.0001	13 November 2012
D.1.117	[Reference is to document previously tendered and marked Exhibit A.28]	SCI.0001.0024.0001	
D.1.118	NSW Treasury, <i>TC12-20 Budget Controls – Capital Expenditure Authorisation Limits</i>	MOH.9999.0875.0001	11 October 2012
D.1.119	<i>Intentionally left blank</i>		

Exhibit No.	Description	SCOI Number	Document Date
D.1.120	NSW Treasury, <i>TPG23-10 Annual Reporting Requirements</i>	MOH.9999.0876.0001	24 August 2023
D.1.121	NSW Treasury, <i>TPG23-03 Financial Reporting Code for NSW General Government Sector Entities</i>	MOH.9999.0877.0001	February 2023
D.1.122	NSW Treasury, <i>TPP20-08 Internal Audit and Risk Management Policy for the General Government Sector</i>	MOH.9999.0878.0001	August 2023
D.1.123	Audit Office of NSW, <i>Result of Health Cluster Agencies' Financial Statement Audits</i>	MOH.9999.0879.0001	7 December 2022
D.1.124	NSW Health, <i>Elevating the Human Experience – Our Guide to Action</i>	MOH.9999.0880.0001	1 September 2020
D.1.125	NSW Health, <i>Aboriginal Health Plan 2013-2023</i>	MOH.9999.0881.0001	December 2012
D.1.126	NSW Health, <i>PD2007_082 NSW Aboriginal Health Impact Statement and Guidelines</i>	MOH.9999.0882.0001	12 November 2007
D.1.127	NSW Cabinet Office, <i>Special Commission of Inquiry into Child Protection Services in NSW – Executive Summary and Recommendations</i>	MOH.9999.0883.0001	24 November 2008
D.1.128	NSW Health, <i>Guide to Service Plans: Informing Local Health District / Specialty Health Network Capital Planning</i>	MOH.9999.0884.0001	September 2023
D.1.129	NSW Health, <i>Guideline for Planning Non-Admitted Patient Services</i>	MOH.9999.0885.0001	July 2021
D.1.130	NSW Health, <i>Service Planning Tool Version 1.0</i>	MOH.9999.0886.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
D.1.131	NSW Health, <i>Chronic Kidney Disease Services Planning Guide</i>	MOH.9999.0887.0001	July 2023
D.1.132	NSW Health, <i>GL2022_012 New Health Technologies and Specialised Services</i>	MOH.9999.0888.0001	28 October 2022
D.1.133	NSW Health, <i>LHD/SN Service Development Priority Focus Areas – Template</i>	MOH.9999.0889.0001	September 2022
D.1.134	[Reference is to document previously tendered and marked Exhibit A.57]	SCI.0001.0049.0001	
D.1.135	[Reference is to document previously tendered and marked Exhibit A.58]	SCI.0001.0050.0001	
D.1.136	NSW Health, <i>Capital Strategy Group – Terms of Reference</i>	MOH.9999.0890.0001	21 April 2023
D.1.137	NSW Health, <i>Capital Contingency Management Framework</i>	MOH.9999.0891.0001	18 September 2023
D.1.138	Deloitte, <i>Governance Review of Recurrent Cost Impacts of Capital Projects – Ministry of Health: Final Report</i>	MOH.9999.0892.0001	17 November 2021
D.1.139	NSW Auditor-General, <i>Performance Audit – Health capital works</i>	MOH.9999.0893.0001	12 August 2020
D.1.140	NSW Health, <i>20-Year Health Infrastructure Strategy Summary</i>	MOH.9999.0894.0001	Undated
D.1.141	NSW Health, <i>State-wide Investment and Prioritisation Framework</i>	MOH.9999.0895.0001	July 2020
D.1.142	NSW Health, <i>GL2021_018 NSW Health Facility Planning Process</i>	MOH.9999.0896.0001	28 October 2021

Exhibit No.	Description	SCOI Number	Document Date
D.1.143	NSW Health, New Maitland Hospital Development – <i>Final Business Case</i>	MOH.9999.0897.0001	March 2016
D.1.144	NSW Health, Shoalhaven Hospital Redevelopment – <i>Final Business Case</i>	MOH.9999.0898.0001	October 2022
D.1.145	NSW Health, Tumut Hospital Redevelopment – <i>Business Case</i>	MOH.9999.0899.0001	April 2019
D.1.146	SCHN, <i>The Children's Hospital at Westmead – Clinical Services Plan 2018-2031</i>	MOH.9999.0900.0001	August 2020
D.1.147	NSW Health, <i>Cost Benefit Analysis Framework</i>	MOH.9999.0901.0001	2 February 2021
D.1.148	[Reference is to document previously tendered and marked Exhibit B.23.024]	MOH.0001.0372.0001	
D.1.149	NSW Health, <i>Regional Health Strategic Plan 2022-2032, Priority Framework</i>	MOH.9999.0902.0001	Undated
D.1.150	NSW Health, <i>Regional Health Strategic Plan 2022-2032 – Progress Snapshot 2022-2023</i>	MOH.9999.0903.0001	November 2023
D.1.151	NSW Health, <i>Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative</i>	MOH.9999.0904.0001	21 July 2023
D.1.152	Commonwealth Department of Health and Aged opCare, <i>COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas</i>	MOH.9999.0905.0001	May 2023
D.1.153	[Reference is to document previously tendered and marked Exhibit B.23.077]	MOH.0001.0294.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.1.154	CEC, <i>By-Laws</i>	MOH.9999.0906.0001	Undated
D.1.155	CEC, <i>Board Subcommittee Terms of Reference (consolidated)</i>	MOH.9999.0907.0001	Undated
D.1.156	[Reference is to document previously tendered and marked Exhibit B.23.076]	MOH.0001.0293.0001	
D.1.157	NSW Health, <i>PD2013_009 Safety Alert Broadcast System</i>	MOH.9999.0908.0001	27 May 2013
D.1.158	NSW Health, <i>PD2019_019 Coordination of responses to urgent system-level medicine or medical devices</i>	MOH.9999.0909.0001	17 May 2019
D.1.159	Northern Sydney LHD, <i>Senior Leadership Team Governance Framework</i>	MOH.9999.0910.0001	November 2023
D.1.160	Northern Sydney LHD & Royal Rehab Performance Committee – <i>Terms of Reference</i>	MOH.9999.0911.0001	April 2023
D.1.161	Northern Sydney LHD, <i>HammondCare Service Agreement 2023-2028</i>	MOH.9999.0912.0001	February 2024
D.1.162	Northern Sydney LHD, <i>NSW Health Service Agreement 2023-2024</i>	MOH.9999.0913.0001	October 2023
D.1.163	Northern Sydney LHD, <i>Corporate Governance Attestation Statement 2022-2023</i>	MOH.9999.0914.0001	August 2023
D.1.164	Northern Sydney LHD, <i>Internal Audit and Risk Management Attestation Statement 2022-2023</i>	MOH.9999.0915.0001	January 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.165	Northern Sydney LHD, Royal North Shore Hospital and Community Health Services PPP – <i>Project Deed</i>	MOH.9999.0916.0001	2008
D.1.166	Northern Sydney LHD, <i>Enterprise Risk Management Strategy and Plan 2022-2024</i>	MOH.9999.0917.0001	Undated
D.1.167	Northern Sydney LHD, Executive Risk Committee (ERC) – <i>Terms of Reference</i>	MOH.9999.0918.0001	20 November 2023
D.1.168	Northern Sydney LHD, Hornsby Ku-ring-gai Hospital Clinical Quality Council – <i>Terms of Reference</i>	MOH.9999.0919.0001	Undated
D.1.169	Northern Sydney LHD, Senior Leadership Team Meeting – <i>Terms of Reference</i>	MOH.9999.0920.0001	Undated
D.1.170	Northern Sydney LHD, Operational Leadership Team Meeting – <i>Terms of Reference</i>	MOH.9999.0921.0001	Undated
D.1.171	Northern Sydney LHD, Hornsby Ku-ring-gai Hospital Sustainability Committee – <i>Terms of Reference</i>	MOH.9999.0922.0001	October 2023
D.1.172	Northern Sydney LHD, <i>Hornsby Ku-ring-gai Hospital Report on Efficiency Improvement Plan (EIP) to NSLHD Financial Risk and Performance Committee</i>	MOH.9999.0923.0001	February 2024
D.1.173	Central Coast LHD, Board Health Care Quality Committee – <i>Terms of Reference</i>	MOH.9999.0924.0001	31 October 2023
D.1.174	Central Coast LHD, <i>Health Alliance Charter</i>	MOH.9999.0925.0001	Undated
D.1.175	<i>Intentionally left blank</i>		
D.1.176	<i>Intentionally left blank</i>		

Exhibit No.	Description	SCOI Number	Document Date
D.1.177	<i>Intentionally left blank</i>		
D.1.178	<i>Intentionally left blank</i>		
D.1.179	<i>Intentionally left blank</i>		
D.1.180	NSW Health, <i>Decision Making Framework for NSW Health Aboriginal Health Practitioners: undertaking clinical activities</i>	MOH.9999.0926.0001	May 2018
D.1.181	NSW Health, <i>PD2023_034 Open Disclosure</i>	MOH.9999.0927.0001	October 2023
D.1.182	NSW Government, <i>NSW Maternal and Perinatal Mortality Review Committee – Terms of Reference</i>	MOH.9999.0928.0001	18 November 2019
D.1.183	NSW Government, <i>Special Committee Investigating Deaths Under Anaesthesia – Terms of Reference</i>	MOH.9999.0929.0001	5 December 2021
D.1.184	NSW Government, <i>Collaborating Hospitals' Audit of Surgical Mortality Committee – Terms of Reference</i>	MOH.9999.0930.0001	10 October 2021
D.1.185	NSW Government, <i>Clinical Risk Action Group – Terms of Reference</i>	MOH.9999.0931.0001	14 February 2020
D.1.186	CEC, <i>Guidelines for Conducting and Reporting Morbidity and Mortality/Clinical Review Meetings</i>	MOH.9999.0932.0001	September 2020
D.1.187	NSW Health, <i>PD2018_032 Managing Complaints and Concerns about Clinicians</i>	MOH.9999.0933.0001	September 2018
D.1.188	CEC, <i>Corporate Governance Attestation Statement 2022-2023</i>	MOH.9999.0934.0001	August 2023
D.1.189	CEC, <i>Strategic Plan 2021-2024</i>	MOH.9999.0935.0001	August 2021

Exhibit No.	Description	SCOI Number	Document Date
D.1.190	CV of Luke Bellman	MOH.9999.0936.0001	Undated
D.1.191	CV of Michael Wood	MOH.9999.1064.0001	Undated
D.1.192	CV of A/Prof James Branley	MOH.9999.0937.0001	Undated
D.1.193	NSW Health, <i>Guide to the Role Delineation of Clinical Services</i>	MOH.9999.0938.0001	January 2024
D.1.194	NSW Health, <i>Purchasing Framework 2018-2019</i>	MOH.9999.0939.0001	2018
D.1.195	NSW Health, <i>Emergency Department Taskforce – Terms of Reference</i>	MOH.9999.0940.0001	14 March 2024
D.1.196	NSW Health, <i>Surgical Care Governance Taskforce – Terms of Reference</i>	MOH.9999.0941.0001	Undated
D.1.197	NSW Health, <i>The Out of Hospital Care Program – Information for Local Health Districts</i>	MOH.9999.0942.0001	June 2021
D.1.198	NSW Health, <i>Out of Hospital Care – ComPacks – Information for Local Health Districts</i>	MOH.9999.0943.0001	May 2021
D.1.199	NSW Health, <i>Out of Hospital Care – End of Life Packages – Information for Local Health Districts</i>	MOH.9999.0944.0001	May 2021
D.1.200	NSW Health, <i>Out of Hospital Care – SASH Packages – Information for Local Health Districts</i>	MOH.9999.0945.0001	May 2021
D.1.201	Central Coast LHD, <i>Organisational Chart</i>	MOH.9999.0946.0001	Undated
D.1.202	Central Coast LHD, <i>Committee Map</i>	MOH.9999.0947.0001	8 March 2024
D.1.203	Central Coast LHD, <i>Corporate Governance Attestation Statement 2021-2022</i>	MOH.9999.0948.0001	August 2022

Exhibit No.	Description	SCOI Number	Document Date
D.1.204	International Journal of Integrated Care, <i>Formative Evaluation of the Central Coast Integrated Care Program (CCICP), NSW Australia</i>	MOH.9999.0949.0001	2019
D.1.205	[Reference is to document previously tendered and marked Exhibit B.23.165]	MOH.0001.0272.0001	
D.1.206	NSW Government, <i>Net Zero Plan Stage 1: 2020 – 2030</i>	MOH.9999.0950.0001	March 2020
D.1.207	Northern Sydney LHD, <i>Clinical Council Terms of Reference</i>	MOH.9999.0951.0001	December 2023
D.1.208	NSW Health, <i>Decision Making Framework for Aboriginal Health Practitioners</i>	MOH.9999.0952.0001	28 May 2018
D.1.209	Northern Sydney LHD, <i>Safety and Quality Account 2023</i>	MOH.9999.0953.0001	July 2023
D.1.210	CV of Lynelle Hill	MOH.9999.0954.0001	Undated
D.1.211	CV of Simon Hill	MOH.9999.0955.0001	Undated
D.1.212	Central Coast LHD, <i>2024-2025 Resource Allocation Guidelines & Budget Principles</i>	MOH.9999.0956.0001	Undated
D.1.213	NSW Health, <i>Model By-Laws for chief executive governed statutory health corporations</i>	MOH.9999.0957.0001	13 September 2017
D.1.214	NSW Health, <i>Model By-Laws for board governed statutory health corporations</i>	MOH.9999.0958.0001	18 September 2017
D.1.215	NSW Health, <i>PD2022_047 NSW Health Policies and Other Policy Documents</i>	MOH.9999.0959.0001	4 October 2022
D.1.216	NSW Health, <i>Accounting Policy Manual</i>	MOH.9999.0960.0001	December 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.217	NSW Health, <i>As one system: The NSW Health System's Response to COVID-19</i>	MOH.9999.0961.0001	18 May 2023
D.1.218	[Reference is to document previously tendered and marked A.46]	SCI.0001.0042.0001	
D.1.219	Northern Sydney LHD, <i>Internal Audit Charter 2023</i>	MOH.9999.0962.0001	Undated
D.1.220	'Lumos: a statewide linkage programme in Australia integrating general practice data to guide system redesign' (2021) <i>Integrated Healthcare Journal</i> 202	MOH.9999.0963.0001	17 May 2021
D.1.221	NSW Health, <i>Prevention & Response to Violence, Abuse and Neglect Framework</i>	MOH.9999.0964.0001	August 2019
D.1.222	NSW Health, <i>Integrated Trauma Informed Care Framework</i>	MOH.9999.0965.0001	2023
D.1.223	NSW Health, <i>Children First 2022 – 2031</i>	MOH.9999.0966.0001	Undated
D.1.224	NSW Health, <i>Talking About It</i>	MOH.9999.0967.0001	Undated
D.1.225	NSW Health, <i>Child Safe Action Plan 2023 – 2027</i>	MOH.9999.0968.0001	August 2023
D.1.226	NSW Health, <i>PD2023_023 Identifying and responding to abuse of older people</i>	MOH.9999.0969.0001	September 2023
D.1.227	NSW Health, <i>LGBTIQ+ Health Strategy 2022 – 2027</i>	MOH.9999.0970.0001	March 2022
D.1.228	NSW Health, <i>Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW</i>	MOH.9999.0971.0001	March 2023

Exhibit No.	Description	SCOI Number	Document Date
D.1.229	NSW Health submission to Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW	MOH.9999.0972.0001	21 September 2023
D.1.230	NSW Health, <i>Elevating the Human Experience – Summary guide to action for patient, family, carer and caregiver experiences</i>	MOH.9999.0973.0001	April 2021
D.1.231	NSW Health, <i>GL2023_016 Consumer, carer and community member remuneration</i>	MOH.9999.0974.0001	
D.2	Statement of Adjunct Prof Michael Nicholl, Chief Executive, CEC	MOH.9999.0761.0001	8 April 2024
D.3	Statement of Scott McLachlan, Chief Executive, Central Coast LHD	MOH.9999.0762.0001	9 April 2024
D.4	Statement of Adjunct Prof Alfa D'Amato, Deputy Secretary and Chief Financial Officer, Financial Services and Asset Management	MOH.9999.0763.0001	9 April 2024
D.5	Statement of Philip Minns, Deputy Secretary, People Culture and Governance	MOH.9999.0764.0001	9 April 2024
D.6	Statement of Luke Sloane, Deputy Secretary, Regional Health	MOH.9999.0979.0001	9 April 2024
D.7	Statement of Lee Gregory, Chief Executive, Nepean Blue Mountains LHD	MOH.9999.0977.0001	9 April 2024
D.8	Statement of Matthew Daly, Deputy Secretary, System Sustainability Performance	MOH.9999.0976.0001	9 April 2024
D.9	Statement of Sharon Smith, Director, SIA Branch	MOH.9999.0980.0001	9 April 2024

Exhibit No.	Description	SCOI Number	Document Date
D.10	Statement of Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience	MOH.9999.0981.0001	9 April 2024
D.11	NSW Health, <i>Model By-Laws for LHDs and SHNs</i>	SCI.0007.0025.0001	7 October 2021
D.12	Nepean Blue Mountains LHD, <i>Strategic Plan 2023-2028</i>	SCI.0007.0037.0001	
D.13	Nepean Blue Mountains LHD, <i>Aboriginal Health Plan 2021-2026</i>	SCI.0007.0029.0001	
D.14	Nepean Blue Mountains LHD, <i>Service Agreement 2023-2024</i>	SCI.0007.0028.0001	Executed 27 and 31 October 2023
D.15	Nepean Blue Mountains LHD, <i>Service Agreement 2023-2024 Notes to the State Budget Schedule</i>	SCI.0007.0027.0001	
D.16	Northern Sydney LHD, <i>Service Agreement 2023-2024</i>	SCI.0007.0040.0001	
D.17	Northern Sydney LHD, <i>Model By-Laws 2021</i>	SCI.0007.0104.0001	
D.18	Northern Sydney LHD, <i>Expense Allocation 2023-2024</i>	SCI.0007.0100.0001	
D.19	Northern Sydney LHD, <i>2023-2024 Service Agreement Notes to the State Budget Schedule</i>	SCI.0007.0077.0001	
D.20	Northern Sydney LHD, <i>KPIs and Performance deliverables 2023-2024</i>	SCI.0007.0102.0001	
D.21	Central Coast LHD, <i>Model By-Laws</i>	SCI.0007.0063.0001	10 September 2021
D.22	Central Coast LHD, <i>Organisational Improvement and Innovation Framework</i>	SCI.0007.0064.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.23	Central Coast LHD, <i>Collaborative Partnership Agreement between Yerin Aboriginal Health Services Inc, Central Cost NSW Medicare Local and Central Coast Local Health District</i>	SCI.0007.0074.0001	2013
D.24	CEC, 'Statement of Business Ethics'	SCI.0007.0118.0001	
D.25	CEC, 'Performance Agreement 2023-2024'	SCI.0007.0072.0001	
D.26	BHI, 'Determination of Functions of Statutory Health Corporation'	SCI.0008.0033.0001	27 June 2018
D.27	BHI, Strategic Plan 2023-2026	SCI.0008.0036.0001	
D.28	Performance Agreement 2023-2024 between the Secretary of NSW Health and the BHI	SCI.0008.0038.0001	10 October 2023
D.29	iCare Certificate of Currency for NSW Health and Royal Rehab for 1 July 2020 – 30 June 2021 (TMFH 417-2021)	SCI.0008.0029.0001	21 April 2021
D.30	iCare Certificate of Currency for NSW Health 1 July 2021 – 30 June 2022 as provided by Royal Rehab	SCI.0008.0030.0001	1 September 2021
D.31	iCare Certificate of Currency for NSW Health 1 July 2022 – 30 June 2023 as provided by Royal Rehab	SCI.0008.0031.0001	1 July 2022
D.32	iCare Certificate of Currency for NSW Health and Royal Rehab 1 July 2023 – 30 June 2024	SCI.0008.0032.0001	8 August 2023
D.33	Performance Agreement between Northern Sydney Central Coast Area Health Service and Royal Rehabilitation Centre Sydney	SCI.0008.0028.0001	30 June 2012

Exhibit No.	Description	SCOI Number	Document Date
D.34	Budget – Attachment – Tab A – Royal Rehab 2022-2023	SCI.0008.0026.0001	
D.35	Letter from Jacquie Ferguson, Northern Sydney LHD to Matthew Mackay, Royal Rehab attaching budget for Royal Rehab for 2023-2024	SCI.0008.0027.0001_R	17 October 2023
D.36	iCare Certificate of Currency for NSW Health and Tresillian, 1 July 2020 – 30 June 2021	SCI.0008.0012.0001	16 July 2020
D.37	iCare Certificate of Currency for NSW Health and Tresillian 1 July 2021 –30 June 2022	SCI.0008.0011.0001	1 July 2021
D.38	iCare Certificate of Currency for NSW Health and Royal Society for the Welfare of Mothers and Babies 1 July 2022 – 30 June 2023	SCI.0008.0001.0001	1 July 2022
D.39	iCare Certificate of Currency for NSW Health and Royal Society for the Welfare of Mothers and Babies 1 July 2023 – 30 June 2024	SCI.0008.0002.0001	27 June 2023
D.40	Service Agreement 2020-2021 between Sydney LHD and the Tresillian Family Care Centres Affiliated Health Organisation	SCI.0008.0007.0001	February 2021
D.41	Service Agreement 2021-2022 between Sydney LHD and the Tresillian Family Care Centres Affiliated Health Organisation	SCI.0008.0008.0001	December 2021
D.42	Service Agreement 2022-2023 between Sydney LHD and the Tresillian Family Care Centres Affiliated Health Organisation	SCI.0008.0009.0001	November 2022
D.43	Service Agreement 2023-2024 between Sydney LHD and the Tresillian Family Care Centres Affiliated Health Organisation	SCI.0008.0010.0001	December 2023

Exhibit No.	Description	SCOI Number	Document Date
D.44	Service Agreement 2022-2023 between Hunter New England LHD and Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0014.0001	
D.45	Service Agreement 2020-2021 between Hunter New England LHD and Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0015.0001	
D.46	Service Agreement 2021-2022 between Hunter New England LHD and Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0016.0001	
D.47	Letter from Roslyn Everingham to the Special Commission of Inquiry into Healthcare Funding attaching documents sought under STP-CMN-001	SCI.0008.0017.0001_R	2 April 2024
D.48	Service Agreement 2023-2024 between Hunter New England LHD and Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0018.0001	
D.49	iCare Certificate of Currency 2020-2021 for NSW Health and Southern LHD provided by Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0020.0001	21 April 2021
D.50	iCare Certificate of Currency 2021-2022 for NSW Health provided by Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0021.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.51	iCare Certificate of Currency 2022-2023 for NSW Health provided by Calvary Mater Newcastle Affiliated Health Organisation	SCI.0008.0022.0001	
D.52	iCare Certificate of Currency 2023-2024 for NSW Health provided by Calvary Mater	SCI.0008.0023.0001	
D.53	iCare Certificate of Currency 2019-2020 for SWSHD and Karitane	SCI.0008.0044.0001	12 February 2020
D.54	iCare Certificate of Currency 2021-2022 for SWSHD and Karitane	SCI.0008.0043.0001	1 July 2021
D.55	iCare Certificate of Currency 2022-2023 for NSW Health provided by Karitane	SCI.0008.0045.0001	1 July 2022
D.56	Standard iCare Insurance Certificate of Currency for NSW Health Template	SCI.0008.0046.0001	27 June 2023
D.57	Service Agreement 2020-2021 between South Western Sydney LHD and Karitane Affiliated Health Organisation	SCI.0008.0039.0001	1 October 2020
D.58	Service Agreement 2021-2022 between South Western Sydney LHD and Karitane Affiliated Health Organisation	SCI.0008.0040.0001	27 September 2021
D.59	Service Agreement 2022-2023 between South Western Sydney LHD and Karitane Affiliated Health Organisation	SCI.0008.0041.0001	2 June 2023 and July 2023
D.60	Service Agreement 2023-2024 between South Western Sydney LHD and Karitane Affiliated Health Organisation	SCI.0008.0042.0001	(unsigned)

Exhibit No.	Description	SCOI Number	Document Date
D.61	Letter from Health Administration Corporation accepting variation of the Agreement between NSW Health and Karitane for the delivery of the Virtual Parenting Residential Service dated 1 February 2024	SCI.0008.0047.0001_R	1 February 2024
D.62	Assignment of Intellectual Property between Karitane Affiliated Health Organisation and Health Administration Corporation re Virtual Parenting Residential Service	SCI.0008.0050.0001	29 July 2021
D.63	Karitane Affiliated Health Organisation and NSW MOH signed Grant Agreement Virtual Parenting Residential Service NSW MoH 2020-2021	SCI.0008.0048.0001_R	16 June 2021
D.64	Letter from Karitane to the NSW Population and Health Services Research Ethics Committee Chair re evaluation of the Virtual Parenting Residential Service dated 5 August 2023	SCI.0008.0051.0001	5 August 2023
D.65	Funding Agreement: Grant for Virtual Residential Parenting Services FY 2020-2021 between Health Administration Corporation and Karitane (signed by Karitane)	SCI.0008.0052.0001_R	16 June 2021
D.66	NSW Health, <i>Funding Agreement: Grant for Karitane - Schedule 2 Performance Measures and Financial Schedules 2023-2024</i>	SCI.0008.0053.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.67	Letter from Liz Junkh to Grainne O'Loughlin re 2023-24 Performance Measures and Financial Schedule for the Funding Agreement 2021-2022- 2023-2024: Virtual Residential Parenting Service	SCI.0008.0054.0001_R	
D.68	Karitane and South Eastern Sydney LHD Collaboration Agreement 2020-2021	SCI.0008.0049.0001	28 January 2021
D.69	NSW Health (iCare) & War Memorial Hospital Certificate of Currency FY 2020-2021 (MFH 417-2021)	SCI.0008.0056.0001	21 April 2021
D.70	NSW Health (iCare) & War Memorial Hospital Certificate of Currency FY 2021-2022	SCI.0008.0057.0001	
D.71	NSW Health (iCare) & War Memorial Hospital Certificate of Currency FY 2022-2023	SCI.0008.0058.0001	
D.72	NSW Health (iCare) & War Memorial Hospital Certificate of Currency FY 2023-2024	SCI.0008.0059.0001	
D.73	Service Agreement 2020-2021 between South Eastern Sydney LHD and The Uniting Church in Australia Property Trust (NSW) for War Memorial Hospital (Waverley)	SCI.0008.0060.0001	30 April 2021
D.74	Service Agreement 2021-2022 between South Eastern Sydney LHD and The Uniting Church in Australia Property Trust (NSW) for War Memorial Hospital (Waverley)	SCI.0008.0061.0001	3 December 2021

Exhibit No.	Description	SCOI Number	Document Date
D.75	Service Agreement 2022-2023 between South Eastern Sydney LHD and The Uniting Church in Australia Property Trust (NSW) for War Memorial Hospital (Waverley)	SCI.0008.0062.0001	28 March 2023
D.76	Service Agreement 2023-2024 between South Eastern Sydney LHD and The Uniting Church in Australia Property Trust (NSW) for War Memorial Hospital (Waverley)	SCI.0008.0063.0001	14 February 2024
D.77	2023-2030 Nepean Blue Mountains Partnership Agreement between Nepean Blue Mountains LHD and Greater Western Aboriginal Health Service	MOH.9999.1086.0001	January 2024
D.78	Statement of A/Prof Anthony Schembri AM, Chief Executive, Northern Sydney LHD	MOH.9999.1062.0001_R	12 April 2024
D.79	<i>Intentionally left blank</i>		
D.80	Service Agreement 2023-2024 between South Western Sydney LHD and Karitane	SCI.0008.0169.0001_R	
D.81	SWSLD Service Funding Status for Service Level Agreement with Karitane 2015-2024	SCI.0008.0165.0001	
D.82	Letter from Karitane to Deborah Willcox AM dated December 2023	SCI.0008.0293.0001_R	18 December 2023
D.83	Statement of Prof Anthony Gill, Head of Department of Anatomical Pathology, Royal North Shore Hospital	SCI.0008.0305.0001	16 April 2024

Exhibit No.	Description	SCOI Number	Document Date
D.84	NSW Health Pathology, “Brief on increased workload RNS Lab 2023 v 2021-2022”, prepared for site visit 20 June 2023	SCI.0008.0300.0001_R	20 June 2023
D.85	NSW Health Pathology, ‘Anatomical Pathology Relative Workload Review 2023’ prepared by Prof Wendy Cooper, Anatomical Pathology Clinical Stream Lead	SCI.0008.0301.0001	2023
D.86	NSW Health Pathology – Brief for Strategic Leadership Team - Business case for new position dated 16 January 2024	SCI.0008.0302.0001_R	16 January 2024
D.87	Email exchange between Louise Wierholt (MOH) and Anthony Gill re briefing and staffing request on 15 and 16 January 2024	SCI.0008.0303.0001_R	15 -16 January 2024
D.88	Submission by Prof Anthony Gill to audit of Cancer Genetics	SCI.0008.0304.0001	1 April 2021
D.89	Northern Sydney LHD Clinical Services Plan 2019-2022	SCI.0008.0347.0001	
D.90	Letter from Northern Sydney LHD to Matt Mackay	MOH.9999.1110.0001_R	17 April 2024
D.91	Letter from Trevor Danos to Adjunct Prof Anthony Schembri dated 11 September 2023	MOH.9999.1109.0001	11 September 2023
D.92	Outline of evidence for Prof Ross Kerridge, Senior Staff Specialist of Anaesthetics, John Hunter Hospital	SCI.0008.0340.0001	
D.93	Outline of evidence for Adjunct A/Prof James Branley, Local Pathology Director, Nepean Hospital, NSW Health Pathology Lead Clinician	MOH.9999.0775.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.94	Government Gazette of the State of NSW No. 122 - Royal Society for the Welfare for Mothers and Babies - 2018 By-Laws	SCI.0008.0111.0001	16 November 2018
D.95	NSW Ministry of Health - Accounts and Audit Determination for Public Health Entities in NSW – effective 9 March 2020	SCI.0008.0112.0001	
D.96	Service Agreement 2023-2024 between Sydney LHD and Tresillian	SCI.0008.0113.0001	
D.97	Email exchange within Ministry of Health re Tresillian Certificates of Currency	SCI.0008.0114.0001_R	
D.98	iCare Certificate of Currency for NSW Health re Tresillian Family Care Centres and Education Services in China dated 4 July 2018	SCI.0008.0115.0001	4 July 2018
D.99	Email correspondence from Imelda Wunder (Ministry of Health) to Robert Mills attaching the Tresillian Certificate of Currency for 2019-2020	SCI.0008.0116.0001_R	24 September 2019
D.100	Health Services Amendment (Royal Society for the Welfare of Mothers and Babies) Order 2020 under the <i>Health Services Act 1997</i>	SCI.0008.0117.0001	18 March 2020
D.101	Email correspondence between Robert Mills and Ministry of Health (A/Principal Legal Officer) re Tresillian amendment to Schedule 3 Health Services Act	SCI.0008.0118.0001_R	March 2020

Exhibit No.	Description	SCOI Number	Document Date
D.102	Email correspondence between Robert Mills and Ministry of Health re Coverage Tresillian - ACT, Wagga and Macksville	SCI.0008.0119.0001_R	November 2021
D.103	Email correspondence between Robert Mills and Anette Marley, MOH re Tresillian schedule 3 column 2 update	SCI.0008.0120.0001_R	8 September 2022
D.104	Letter from Robert Mills to Minsiter Hazzard re Schedule 3 listed services and access to iCARE insurance	SCI.0008.0122.0001_R	8 February 2022
D.105	Letter from Minister Hazzard to Robert Mills, Tresillian AHO re iCare insurance cover	SCI.0008.0123.0001	28 February 2022
D.106	Email exchange between Mary Dowling and Rob Mills re iCare-Insurance	SCI.0008.0124.0001_R	April 2024
D.107	Draft changes to Schedule 3 of the Health Services prepared by Dr Tim Smyth	SCI.0008.0125.0001	
D.108	Email attaching correspondence from the Minister for Health – B22/1127	SCI.0008.0126.0001_R	22 December 2022
D.109	Letter from Minister Hazzard to Dowling, Health Services Association B22/1127	SCI.0008.0127.0001_R	20 December 2022
D.110	NSW Health and Health Services Association of NSW Working Group Agenda – Health System Strategy and Patient Experience – 15 AUG 2023	SCI.0008.0129.0001	15 August 2023
D.111	NSW Health HSA Working Group Agenda – Health System Strategy and Patient Experience – 24 JAN 2024	SCI.0008.0130.0001	24 January 2024

Exhibit No.	Description	SCOI Number	Document Date
D.112	Various certificates of currency for Tresillian (issued by various iCare, Gallagher Basset and Ansvar Insurance)	SCI.0008.0131.0001_R	27 May 2023
D.113	Email from Tish Bruce (Ministry of Health) to Rob Mills re Strategic Review: Final Report to inform 6 November meeting	SCI.0008.0133.0001_R	31 October 2023
D.114	Statement of Prof Donald McLellan, Board Chair, Central Coast LHD	MOH.9999.0769.0001	
D.115	Outline of evidence for Pamela Rutledge AM, Nepean Blue Mountains LHD Board Member	MOH.9999.1061.0001	
D.116	ACI and NSW State Spinal Cord Injury Service, “Evidence and Utilisation of spinal cord services in NSW”	MOH.9999.0296.0001	
D.117	Outline of evidence for Fiona Wilkinson, Director of Clinical Governance, Central Coast LHD	MOH.9999.0771.0001	
D.118	Outline of evidence for Mark Zacka, Executive Director, Clinical Governance & Patient Experience, Northern Sydney LHD	MOH.9999.0767.0001	
D.119	Outline of evidence for Michael Wood, Director of Clinical Governance, Nepean Blue Mountains LHD	MOH.9999.0774.0001	
D.120	Outline of evidence for Matthew Russell, Director of Mental Health, Nepean Blue Mountains LHD	MOH.9999.0978.0001	9 April 2024
D.121	Outline of evidence for Grainne O’Loughlin, Chief Executive Officer, Karitane	SCI.0008.0343.0001	

Exhibit No.	Description	SCOI Number	Document Date
D.122	Outline of evidence for Robert Mills, Chief Executive Officer, Royal Society for the Welfare of Mothers and Babies	SCI.0008.0344.0001	11 April 2024
D.123	Outline of evidence for Matthew Mackay Chief Executive Officer, Royal Rehab and President, Health Services Association	SCI.0008.0341.0001	
D.124	Outline of evidence for Michael Maley, NSWHP Local Pathology Director and Project Lead, Liverpool Pathology Lab	MOH.9999.0776.0001	
D.125	<i>Intentionally left blank</i>		
D.126	<i>Intentionally left blank</i>		
D.127	<i>Intentionally left blank</i>		
D.128	Outline of evidence for Trevor Danos AM, Board Chair, Northern Sydney LHD	MOH.9999.0765.0001	
D.129	Draft Independent review of Royal Rehab cost estimates (Taylor Fry)	SCI.0008.0082.0001_R	13 June 2023
D.130	Email from Louise Wienholt to Anthony Gill and Anor	MOH.9999.3133.0001_R	1 February 2024
D.131	Northern Sydney LHD Board Survey	MOH.9999.3134.0001	September 2023
D.132	Northern Sydney LHD Chief Executive's Board Report	MOH.9999.3135.0001	April 2024

A.22: Tender Bundle E – South Western LHD Hearings (May 2024)

Exhibit No.	Description	SCOI Number	Document Date
E.1	NSW Health, <i>Mid-Term Evaluation of the NSW Aboriginal Health Plan 2013-2023</i>	SCI.0009.0020.0001	May 2019
E.2	NSW Health, <i>Aboriginal Health Impact Statement</i>	SCI.0009.0019.0001	29 September 2017
E.3	NSW Health, <i>Services Aboriginal Cultural Engagement Self-Assessment Tool</i>	SCI.0009.0018.0001	20 April 2020
E.4	NSW Health, <i>Aboriginal Cultural Training -Respecting the Difference</i>	SCI.0009.0017.0001	15 July 2022
E.5	eHealth NSW, <i>Working as One: Collaboration Triumphs over the Tyranny of Distance 2019</i>	MOH.0001.0236.0001	2019
E.6	Western NSW PHN, <i>Strategic Plan Overview</i>	SCI.0009.0029.0001	2023
E.7.	Western NSW LHD, <i>Strategic Plan 2020-2025</i>	SCI.0009.0027.0001	September 2020
E.8	Western NSW LHD, <i>Strategic Plan on a Page 2020-2025</i>	SCI.0009.0028.0001	2020
E.9	Western NSW LHD, <i>Clinical Services Framework 2020-2025</i>	SCI.0009.0032.0001	December 2020
E.10	Western NSW LHD, <i>Corporate Governance Attestation Statement 2022-2023</i>	SCI.0009.0034.0001	18 July 2023
E.11	Western NSW LHD, <i>Facility Budget Growth 2023-2024</i>	SCI.0009.0036.0001	September 2023
E.12	Western NSW LHD, <i>Safety and Quality Account 2021-2022</i>	SCI.0009.0039.0001	2022

Exhibit No.	Description	SCOI Number	Document Date
E.13	Western NSW LHD, <i>Improving Aboriginal Health Strategy 2018-2023</i>	SCI.0009.0037.0001	2018
E.14	Western NSW LHD, <i>Aboriginal Workforce Affirmative Action Framework 2019-2023</i>	SCI.0009.0031.0001	2019
E.15	Dubbo Health Service Budget 2023-2024	SCI.0009.0035.0001	2023
E.16	Coonamble MPS Budget 2023-2024	SCI.0009.0033.0001	2023
E.17	Nyngan MPS Budget 2023-2024	SCI.0009.0038.0001	2023
E.18	ACI, <i>Spotlight on virtual care: Virtual Rural Generalists Services Western NSW LHD</i>	SCI.0009.0007.0001	June 2021
E.19	ACI, <i>Spotlight on virtual care: Geriatric Medicine Outreach Service, Sydney LHD, Western NSW LHD, Far West LHD</i>	SCI.0009.0002.0001	May 2021
E.20	ACI, <i>Spotlight on virtual care: vCare Western NSW LHD</i>	SCI.0009.0004.0001	May 2021
E.21	ACI, <i>Spotlight on virtual care: Virtual Allied Health Service Western NSW LHD</i>	SCI.0009.0005.0001	May 2021
E.22	ACI, <i>Spotlight on virtual care: Dubbo High Risk Foot Service virtual and in-person outreach Western NSW LHD</i>	SCI.0009.0001.0001	June 2021
E.23	ACI, <i>Spotlight on virtual care: Virtual Clinical Pharmacy Service Western NSW LHD</i>	SCI.0009.0006.0001	May 2022
E.24	ACI, <i>Spotlight on virtual care: Virtual Mental Health Emergency Care (MHEC) in NSW</i>	SCI.0009.0044.0001	June 2021

Exhibit No.	Description	SCOI Number	Document Date
E.25	National Rural Health Alliance (NRHA), <i>Evidence base for additional investment in rural health Australia</i>	SCI.0009.0016.0001	23 June 2023
E.26	Sax Institute, <i>Scalability Assessment: Collaborative Care and Place-Based Planning Approaches</i>	MOH.9999.1220.0001	December 2023
E.27	Sustainability of Primary Care in Small Towns and Communities Initiative	SCI.0009.0042.0001	23 January 2020
E.28	NRHA Primary Care and Rural Integrated Multidisciplinary Health Services (PRIM-HS)	SCI.0009.0043.0001	9 February 2023
E.29	Far West LHD, <i>2022-2023 Year in Review</i>	SCI.0009.0009.0001	2022
E.30	Far West LHD, <i>Corporate Governance Attestation Statement 2021-2022</i>	SCI.0009.0012.0001	29 August 2022
E.31	FWLHD, <i>Aboriginal Health Framework 2021</i>	SCI.0009.0011.0001	2021
E.32	Australian Health Ministers' Advisory Council National Aboriginal and Torres Strait Islander Health Standing Committee, <i>Cultural Respect Framework 2016-2026</i>	SCI.0009.0008.0001	Undated
E.33	ACI, <i>Spotlight on virtual care: In-home monitoring program for people with chronic conditions, Far West LHD</i>	SCI.0009.0003.0001	May 2021
E.34	RFDS, <i>Year in Review 2022-2023</i>	SCI.0009.0026.0001	2023
E.35	RFDS, <i>Best for the Bush Report</i>	SCI.0009.0025.0001	27 March 2024
E.36	Maari Ma, <i>Strategic Plan 2020-2024</i>	SCI.0009.0015.0001	2020

Exhibit No.	Description	SCOI Number	Document Date
E.37	Legislative Council, Health outcomes and access to health and hospital services in rural, regional and remote New South Wales	SCI.0009.0077.0001	May 2022
E.38	Statement of Fiona Bennett, Deputy Board Chair and Chair of Finance and Performance Committee, Western NSW LHD	MOH.9999.1280.0001	16 May 2024
E.39	Exhibit A to Statement of Fiona Bennett – Western NSW LHD Board Governance Charter	MOH.9999.1204.0001	1 February 2023
E.40	Exhibit C to Statement of Fiona Bennett – CV of Fiona Bennett	MOH.9999.1205.0001	Undated
E.41	Exhibit D to Statement of Fiona Bennett – Western NSW LHD Finance and Performance Committee Terms of Reference	MOH.9999.1206.0001	15 March 2024
E.42	Outline of evidence for Josh Carey, Executive Director, Service Delivery, Western NSW LHD	MOH.9999.1195.0001	30 April 2024
E.43	CV of Josh Carey	MOH.9999.1207.0001	Undated
E.44	Outline of evidence for Prof Mark Arnold, Chief Medical Officer, Western NSW LHD	MOH.9999.1199.0001	30 April 2024
E.45	Outline of evidence for Maryanne Hawthorn, Executive Director, Strategic Reform, Planning and Partnerships, Western NSW LHD	MOH.9999.1196.0001	30 April 2024
E.46	CV of Maryanne Hawthorn	MOH.9999.1208.0001	Undated
E.47	Statement of Mark Spittal, Chief Executive, Western NSW LHD	MOH.9999.1202.0001	30 April 2024

Exhibit No.	Description	SCOI Number	Document Date
E.48	Annexure A to Statement of Mark Spittal – TFM Family Investment Model – Western New South Wales	MOH.9999.1209.0001	Undated
E.49	Annexure B to Statement of Mark Spittal – Map of Western NSW LHD	MOH.9999.1210.0001	Undated
E.50	Annexure C to Statement of Mark Spittal – PD2011-031 - Inter-facility transfer process for adults requiring specialist care	MOH.9999.1211.0001	1 June 2011
E.51	Annexure D to Statement of Mark Spittal – Western NSW LHD Service Level Agreement – 2023-2024	MOH.9999.1212.0001	17 October 2023
E.52	Annexure E to Statement of Mark Spittal – Western NSW LHD People Strategy	MOH.9999.1213.0001	2023
E.53	Outline of evidence for Dr Colin McClintock, Board Member, Western NSW LHD	MOH.9999.1197.0001	29 April 2024
E.54	CV of Dr Colin McClintock	MOH.9999.1203.0001	Undated
E.55	Exhibit A to Outline of evidence for Dr Colin McClintock – Health Care Quality Committee Terms of Reference	MOH.9999.1218.0001	22 February 2023
E.56	Statement of Sandra Duff, Executive Director, People and Culture, Western NSW LHD	MOH.9999.1223.0001	6 May 2024
E.57	Exhibit A – CV of Sandra Duff	MOH.9999.1221.0001	Undated
E.58	Statement of Peter Bonnington, Executive Director, Finance and Corporate, Western NSW LHD	MOH.9999.1222.0001	6 May 2024
E.59	CV of Peter Bonnington	MOH.9999.1214.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
E.60	<i>Intentionally left blank</i>		
E.61	<i>Intentionally left blank</i>		
E.62	Outline of evidence for Megan Callinan, Chief Executive Office, Marathon Health	SCI.0009.0080.0001	10 May 2024
E.63	Marathon Health Pre-Budget Submission	SCI.0009.0046.0001	2024
E.64	Marathon Health, Youth Outreach Project Shaana Daley case study content	SCI.0009.0047.0001	Undated
E.65	Koff et al, 'Collaborative Commissioning: regional funding models to support value-based care in NSW'	SCI.0009.0048.0001	4 October 2021
E.66	Victorian Healthcare Association, <i>Victoria's community health service model</i>	SCI.0009.0049.0001	Undated
E.67	Outline of evidence for Annette Crothers, Board Chair, Marathon Health	SCI.0009.0090.0001	10 May 2024
E.68	Outline of evidence for Derek Francis, General Manager, Bogan Shire Council	SCI.0009.0079.0001	10 May 2024
E.69	Outline of evidence for Debb Wood, Director, People and Community Services, Bogan Shire Council	SCI.0009.0078.0001	10 May 2024
E.70	Outline of evidence for Dr Michael Harfield, Director of Medical Services at Mudgee Hospital, Acting Rural Health Director Medical Services, Western NSW LHD	SCI.0009.0091.0001	12 May 2024
E.71	Outline of evidence for Greg Tory, General Manager, Lachlan Shire Council	SCI.0009.0089.0001	13 May 2024

Exhibit No.	Description	SCOI Number	Document Date
E.72	Outline of evidence for Dr Ai-Vee Chua, General Practitioner, Dubbo	SCI.0009.0093.0001	14 May 2024
E.73	Outline of evidence for Dr Mary Elizabeth MacIsaac, General Practitioner, Coomealla Aboriginal Health Corporation	SCI.0009.0092.0001	13 May 2024
E.74	Outline of evidence for Dr Helen McFarlane, Director Mental Health Drug and Alcohol, Western NSW LHD	MOH.9999.1268.0001	13 May 2024
E.75	Outline of evidence for Dr Warren Kealy-Bateman, Clinical Director Mental Health Drug and Alcohol Dubbo and Regions, Western NSW LHD	MOH.9999.1270.0001	14 May 2024
E.76	Kealy-Bateman et al, 'Should we be Royal'	MOH.9999.1271.0001	2021
E.77	Kealy-Bateman et al, 'Use of a quality improvement strategy to introduce co-design of the mental health discharge plan in rural and remote New South Wales'	MOH.9999.1272.0001	2021
E.78	Kealy-Bateman et al, 'Working alongside next of kin to enhance discharge: A quality improvement collaboration to co-design discharge for mental health patients'	MOH.9999.1273.0001	2023
E.79	Western NSW LHD, <i>Mental Health Drug and Alcohol Service Information Guide</i>	MOH.9999.1274.0001	Revised 2022
E.80	Western NSW LHD, <i>Mental Health Drug and Alcohol Service Information Guide for Families and Carers</i>	MOH.9999.1275.0001	2020

Exhibit No.	Description	SCOI Number	Document Date
E.81	Western NSW LHD, <i>Mental Health Drug and Alcohol Service Information to Support Your Stay at Gundaymarra</i>	MOH.9999.1276.0001	Reviewed 2022
E.82	Western NSW LHD, <i>Mental Health Drug and Alcohol Service Information to Support Your Stay at Barraminya</i>	MOH.9999.1277.0001	Reviewed 2022
E.83	Western NSW LHD, <i>Safety and Quality Account 2022-2023</i>	SCI.0009.0097.0001	2023
E.84	Western NSW LHD, total annual specialist attendance per ERP for all persons 2013 and 2023 by LGA	SCI.0009.0098.0001	15 May 2024
E.85	Deloitte Access Economics, <i>General Practitioner workforce report 2022</i>	SCI.0009.0099.0001	2022
E.86	Outline of evidence for Dr Robin Williams, Chair of Western NSW PHN	SCI.0009.0106.0001	16 May 2024
E.87	National Health and Hospitals Reform Commission, 'A healthier future for all Australians – final report'	SCI.0009.0108.0001	27 July 2009

A.23: Tender Bundle F – Far West LHD Hearings (May 2024)

Exhibit No.	Description	SCOI Number	Document Date
F.1	Statement of Brad Astill, Chief Executive, FWLHD	MOH.9999.1258.0001	8 May 2024
F.2	Exhibit A to Statement of Brad Astill – CV of Brad Astill	MOH.9999.1259.0001	Undated
F.3	Exhibit B to Statement of Brad Astill – FWLHD Strategic Plan 2021-2026	MOH.9999.1260.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
F.4	Exhibit C to Statement of Brad Astill – FWLHD Service Agreement 2023-24	MOH.9999.1261.0001	30 October 2023
F.5	Statement of Maddison Stewart, Welcome Experience participant; Workforce Support Officer, FWLHD	MOH.9999.1279.0001	16 May 2024
F.6	CV of Maddison Stewart	MOH.9999.1217.0001	Undated
F.7	Outline of evidence for Sally Pearce, Board Chair, FWLHD	MOH.9999.1245.0001	Undated
F.8	Exhibit A to Outline of evidence for Sally Pearce – CV of Sally Peace	MOH.9999.1246.0001	Undated
F.9	Exhibit B to Outline of evidence for Sally Pearce – FWLHD Board Charter	MOH.9999.1247.0001	December 2023
F.10	Exhibit C to Outline of evidence for Sally Pearce – FWLHD Board Finance, Performance and Workforce Committee Terms of Reference	MOH.9999.1248.0001	29 May 2023
F.11	Exhibit D to Outline of evidence for Sally Pearce – FWLHD Board Aboriginal Health and Workforce Committee Terms of Reference	MOH.9999.1249.0001	30 October 2023
F.12	Outline of evidence for Apsara Kahawita, Director, Finance and Corporate Services, FWLHD	MOH.9999.1253.0001	Undated
F.13	CV of Apsara Kahawita	MOH.9999.1254.0001	Undated
F.14	Outline of evidence for Dr Sarah Wenham, Executive Director, Medical Services, FWLHD	MOH.9999.1256.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
F.15	CV of Dr Sarah Wenham	MOH.9999.1257.0001	Undated
F.16	Outline of evidence for David Green, Director, People and Culture, FWLHD	MOH.9999.1263.0001	Undated
F.17	Exhibit A to Outline of evidence for David Green – CV of David Green	MOH.9999.1264.0001	Undated
N/A	Exhibit B to Outline of evidence for David Green – FWLHD Strategic Plan 2021-2026 <i>Duplicate not reproduced – See Exhibit F.3</i>	MOH.9999.1260.0001	
F.18	Western NSW PHN, <i>Securing the future of Primary Health Care in small towns in Western NSW</i>	SCI.0009.0111.0001	2019
F.19	Statement of Melissa Welsh, Director Allied Health and Integrated Community Services, FWLHD	MOH.9999.1285.0001	22 May 2024
F.20	Exhibit A to Statement of Melissa Welsh – CV of Melissa Welsh	MOH.9999.1266.0001	Undated
F.21	Exhibit B to Statement of Melissa Welsh – Overview of Allied Health and Integrated Community Services portfolio	MOH.9999.1267.0001	Undated
F.22	Outline of evidence for Justin Files, Board Member and Co-Chair of Aboriginal Health and Workforce Committee, FWLHD	MOH.9999.1262.0001	Undated
F.23	CV of Justin Files	MOH.9999.1278.0001	Undated
F.24	Outline of evidence for Prof Debra Jones, Head of Rural Clinical School	SCI.0009.0094.0001	14 May 2024

Exhibit No.	Description	SCOI Number	Document Date
F.25	Outline of evidence for A/Prof Ashish Agar, Ophthalmologist, South Eastern Sydney LHD	SCI.0009.0104.0001	15 May 2024
F.26	Far West LHD, <i>Safety and Quality account – 2022-2023; 2023-2024 Future Priorities</i>	MOH.9999.1282.0001	28 August 2023
F.27	Far West LHD, <i>Service Development Priority Focus Areas</i>	MOH.9999.1283.0001	March 2024
F.28	Outline of evidence for Jenna Bottrell, Area Manager, Western & Far West NSW, Mission Australia	SCI.0009.0107.0001	16 May 2024
F.29	Attachment A to Outline of evidence for Jenna Bottrell - Mission Australia's 2020-2025 Strategy	SCI.0009.0105.0001	Undated
F.30	Outline of evidence for Jay Nankivell, General Manager, Broken Hill City Council	SCI.0009.0109.0001	20 May 2024
F.31	Outline of evidence for Greg Sam, Chief Executive Officer, Royal Flying Doctor Service, South Eastern Section and A/Prof Shannon Nott, Executive General Manager, Health & Clinical Services, CMO of the Royal Flying Doctors Service, South Eastern Section	SCI.0009.0110.0001	21 May 2024
F.32	Statement of Jarrod Marsden, Mayor, Cobar Shire Council	SCI.0009.0113.0001	21 May 2024
F.33	Attachment A to Statement of Jarrod Marsden – CV of Jarrod Marsden	SCI.0009.0114.0001	Undated
F.34	Attachment B to Statement of Jarrod Marsden – Aged Care Financial Report 2023 for Cobar Shire Council	SCI.0009.0112.0001	2023

Exhibit No.	Description	SCOI Number	Document Date
F.35	Far West LHD, 2023-2024 Service Agreement – Technical Budget Notes	MOH.9999.1284.0001	Undated

A.24: Tender Bundle G – Hospitals Block (June 2024)

Exhibit No.	Description	SCOI Number	Document Date
G.1	Nepean Blue Mountains LHD and SJOG Hawkesbury District Health Service – Deed of Extension of Services Agreement	SJO.0001.0001.0007	1 July 2022
G.2	Nepean Blue Mountains LHD and SJOG Hawkesbury - Deed of Variation	SJO.0001.0001.0008	December 2022
G.3	Nepean Blue Mountains LHD and SJOG - Second Amending Deed – Deed of Extension of Services Agreement	SJO.0001.0001.0010	25 January 2024
G.4	Nepean Blue Mountains LHD and HDHS 2020-2021 Final Service Agreement	SJO.0001.0003.0004	4 March 2021
G.5	Nepean Blue Mountains LHD and HDHS 2020-2021 Service Agreement Covering Letter	SJO.0001.0003.0011	18 December 2020
G.6	Nepean Blue Mountains LHD and HDHS Interim Service Agreement Covering Letter	SJO.0001.0003.0022	2 October 2020
G.7	Nepean Blue Mountains LHD and HDHS Interim Service Agreement 2020	SJO.0001.0003.0023	2 July 2020
G.8	Email from CEO HDHS to NSW Health re HDHS Overrun as at 30 April 2023	SJO.0001.0005.0009	18 May 2023

Exhibit No.	Description	SCOI Number	Document Date
G.9	Nepean Blue Mountains LHD and HDHS – Service Agreement 2021-2022	SJO.0001.0005.0033	6 September 2021
G.10	HDHS Final Budget Letter - Service Agreement 2021-2022	SJO.0001.0005.0036	30 June 2021
G.11	HDHS Pricing Proposal 2021-2022	SJO.0001.0005.0039	21 April 2021
G.12	Letter from Chief Executive, Nepean Blue Mountains LHD to CEO HDHS re 2023-2024 Service Agreement	SJO.0001.0005.0041	25 October 2023
G.13	Letter from Acting Chief Executive, Nepean Blue Mountains LHD to CEO HDHS re Interim 2023-2024 Service Agreement Schedules	SJO.0001.0005.0044	3 August 2023
G.14	HDHS Pricing Proposal 2023-2024	SJO.0001.0005.0046	11 April 2023
G.15	Letter from CEO HDHS to Chief Executive, Nepean Blue Mountains LHD - HDHS Service Agreement Budget 2023-2024	SJO.0001.0006.0046	28 November 2023
G.16	Email Correspondence between Nepean Blue Mountains LHD and HDHS - Indicative Funding Advice – FY 2024	SJO.0001.0006.0047	3 November 2023
G.17	NSW Health, Review of Governance for the Sydney Children's Hospital Network (<i>Alexander Report</i>)	SCI.0010.0004.0001	June 2019
G.18	E/Prof Richard Henry AM, <i>Review of health services for children, young people and families within the NSW Health system</i> (Henry Review)	SCI.0010.0001.0001	December 2019

Exhibit No.	Description	SCOI Number	Document Date
G.19	NSW Health, <i>The Henry Review Implementation Plan</i>	SCI.0010.0005.0001	July 2022
G.20	NSW Health and SCHN, <i>Service Agreement 2023-2024</i>	SCI.0010.0002.0001	20 October 2023
G.21	NSW Health and SCHN, <i>Service Agreement Explanatory Notes 2023-2024</i>	SCI.0010.0003.0001	October 2023
G.22	SCHN, <i>Strategic Plan 2023-2027</i>	SCI.0010.0015.0001	2023
G.23	SCHN, <i>Annual Review 2023</i>	SCI.0010.0008.0001	2023
G.24	SCHN, <i>Budget Allocation 2023-2024</i>	SCI.0010.0009.0001	2023
G.25	SCHN, <i>Budget Comparison by Facility</i>	SCI.0010.0010.0001	September 2023
G.26	SCHN, <i>Corporate Governance and Management Committee Framework</i>	SCI.0010.0014.0001	February 2019
G.27	SCHN, <i>Sydney Children's Hospitals Network Board Charter</i>	SCI.0010.0016.0001	May 2023
G.28	SCHN, <i>Committee Development and Administration Policy</i>	SCI.0010.0011.0001	24 April 2023
G.29	Statement of Anna McFadgen, Chief Executive Officer, St Vincent's Hospital Sydney Ltd	SVH.9999.0002.0001	4 June 2024
G.29.1	AM-1 Letter from James Palmer to SVHS	SVH.9999.0002.0016	23 April 2024
G.29.2	AM-2 Memorandum of Understanding with South Eastern Sydney Area Health Service and Western Sydney Area Health Service	SVH.9999.0002.0019	11 March 2003

Exhibit No.	Description	SCOI Number	Document Date
G.29.3	AM-3 Memorandum of Understanding between St Joseph's Hospital and Western Sydney Area Health Service	SVH.9999.0002.0039	4 September 2003
G.29.4	AM-4 NSW Government Gazette Declaring St Vincent's Hospital, Darlinghurst a Network Affiliated Health Organisation	SVH.9999.0002.0049	8 November 2023
G.29.5	AM-5 Service Purchasing Request – Additional Activity and ICU Beds	SVH.9999.0002.0051	17 April 2024
G.29.6	AM-6 Service Purchasing Request – Heart and Lung Activity	SVH.9999.0002.0056	17 April 2024
G.29.7	AM-7 Service Purchasing Request – Homeless Health Services	SVH.9999.0002.0061	19 April 2024
G.29.8	AM-8 NSW Health and SVHNS - Service Agreement 2022-2023	SVH.9999.0002.0066	2022
G.29.9	AM-9 NSW Health and SVHNS - Service Agreement 2023-2024	SVH.9999.0002.0096	16 November 2023
G.29.10	AM-10 Corporate Governance Attestation Statement for SVHN 2022-2023	SVH.9999.0002.0128	2022
G.29.11	AM-11 SVHNS Capital Investment Proposal – Integrated Translation Research and Education Centre	SVH.9999.0002.0146	2021
G.29.12	AM-12 SVHNS Capital Investment Proposal – West Street Translational Research and Education Centre	SVH.9999.0002.0161	2022

Exhibit No.	Description	SCOI Number	Document Date
G.29.13	AM-13 SVHNS Capital Investment Proposal – Mental Health Prevention and Recovery Centre (PARC)	SVH.9999.0002.0174	2021
G.29.14	AM-14 SVHNS Capital Investment Proposal – Redevelopment St Joseph's Hospital in Auburn	SVH.9999.0002.0192	2022
G.29.15	AM-15 Letter from Service and Capital Planning Unit to SVHN - Feedback on 2021 Capital Investment Proposals	SVH.9999.0002.0203	9 December 2021
G.29.16	AM-16 Letter from Strategic Reform and Planning Branch to SVHN - Feedback on 2023 Capital Investment Proposals	SVH.9999.0002.0206	11 December 2023
G.29.17	AM-17 Letter from Strategic Reform and Planning Branch to SVHN – DICR, Cahill-Cater Redevelopment Final Business Case	SVH.9999.0002.0209	30 August 2023
G.29.18	AM-18 SVHA Board Paper – SVHNS Interim Budget 2023-2024	SVH.9999.0002.0240	31 August 2023
G.29.19	AM-19 Letter from Anna McFadgen to Deputy Secretary, Financial Services – SVHNS Financial Support 2023-2024	SVH.9999.0002.0255	19 February 2024
G.29.20	AM-20 Letter from Secretary NSW Health to Anna McFadgen - Response to SVHNS Financial Support 2023-2024	SVH.9999.0002.0259	28 February 2024
G.29.21	AM-21 Letter from Anna McFadgen to Secretary NSW Health – NSW Health 2023-2024 Service Level Agreement with SVHS	SVH.9999.0002.0260	15 November 2023

Exhibit No.	Description	SCOI Number	Document Date
G.29.22	AM-22 Letter from Chair SVHA to Secretary NSW Health – Funding Agreement with SVHS	SVH.9999.0002.0262	25 March 2024
G.29.23	AM-23 FSVHA Finance and Investment Committee - SVHNS Year to Date Results	SVH.9999.0002.0263	21 March 2024
G.29.24	AM-24 Letter from Chair SVHA to Minister for Health and Medical Research – SVHN Strategy and St Joseph's Hospital	SVH.9999.0002.0272	December 2020
G.30	Statement of Christopher Blake, Group Chief Executive Office, St Vincent's Health Australia	SVH.9999.0004.0001	6 June 2024
G.30.1	CB-1 Letter from James Palmer to SVHS	SVH.9999.0004.0010	23 April 2024
G.30.2	CB-2 NSW Health and SVHNS - Service Agreement 2023-2024	SVH.9999.0004.0013	16 November 2023
G.31	Statement of Benjamin Edwards, Chief Operating Officer, SJOG Hospital Group	SJO.9999.0001.0001	4 June 2024
G.32	Statement of Genevieve Adamo, Senior Pharmacist, Poisons Information, NSW Poisons Information Centre	SCI.0011.0065.0001	5 June 2024
G.32.1	Huynh et al, GA-1 Paper 2022	SCI.0011.0066.0001	13 November 2019
G.33	Statement of A/Prof John Preddy, Clinical Director, Murrumbidgee LHD Paediatric Department	SCI.0011.0067.0001	30 May 2024
G.34	Letter from CEO SVHN to CFO NSW Health - Decommissioning Costs - St Joseph's Hospital	SVH.0002.0001.0208	24 October 2023

Exhibit No.	Description	SCOI Number	Document Date
G.35	Letter from CFO SVHN to CFO NSW Health - Closure of St Joseph's Hospital	SVH.0002.0001.0327	15 May 2023
G.36	Letter from CD SVHN to Minister for Health - Decommissioning of St Joseph's Hospital	SVH.0002.0001.0486	14 June 2023
G.37	PowerPoint - St Joseph's Hospital Future Strategy	SVH.0002.0002.0001	1 June 2020
G.38	Letter from Chair SVHN to Chair Western Sydney LHD - Briefing for Meeting on St Joseph's Hospital	SVH.0002.0002.0015	6 July 2020
G.39	PowerPoint - St Joseph's Hospital Future Plans	SVH.0002.0003.0002	30 May 2019
G.40	Letter from Chairmans SVHN to Minister for Health - SVHN Sydney EMR Business Case/St Joseph's Hospital	SVH.0002.0003.0015	11 February 2022
G.41	Letter from Secretary NSW Health to Chairman SVHN - SVHN Sydney EMR Business Case/St Joseph's Hospital	SVH.0002.0003.0017	23 June 2022
G.42	Email Correspondence between ED NSW Health and CEO SVHN - Purchasing Discussion Action Items SVHN and St Joseph's Activity Transfer	SVH.0002.0001.0108	7 September 2023
G.43	NSW Health, Financial Requirements and Conditions of subsidy (Government Grants)	SVH.0002.0001.0154	20 September 2023
G.44	[Not in use – duplicate of G.29.21]		
G.45	SVHN, 2023-2024 <i>Interim Funding Allocation</i>	SVH.0002.0001.0022	30 June 2023

Exhibit No.	Description	SCOI Number	Document Date
G.46	SVHN, <i>2023-2024 Service Agreement - Notes to State Budget Schedule</i>	SVH.0002.0001.0147	20 September 2023
G.47	Letter from Secretary NSW Health to Chair SVHN – 2023-2024 Service Agreement	SVH.0002.0001.0202	19 September 2023
G.48	Letter from Board Chair SVHA to Secretary NSW Health – Future Service Agreements with SVHS	SVH.0002.0001.0280	15 November 2023
G.49	Letter from Secretary NSW Health to CE SVHN – 2023-2024 Service Agreement	SVH.0002.0001.0284	17 November 2023
G.50	NSW Health and SVHNS, <i>Service Agreement 2020-2021</i>	SVH.0001.0001.0083	18 February 2021
G.51	NSW Health and SVHNS, <i>Service Agreement 2021-2022</i>	SVH.0001.0001.0407	31 August 2021
G.52	Letter from Secretary NSW Health to Board Chair SVHN – Interim 2023-2024 Service Agreement Schedules	SVH.0001.0001.0780	30 June 2023
G.53	[Not in use – duplicate of G.48]		
G.54	SVHS, <i>Financial Report 2022</i>	SVH.0001.0001.0441	12 October 2022
G.55	SVHS, <i>Financial Report 2023</i>	SVH.0001.0001.0016	12 October 2023
G.56	Correspondence from SVHNS to NSW Health Secretary – Proposed Service Strategy with Attachment	SVH.0001.0003.0019 SVH.0001.0003.0020	13 April 2021
G.57	SVHA St Vincent's Integrated Healthcare Campus Darlinghurst - Clinical Services Strategy – 2027	SCI.0010.0017.0001	Undated
G.58	SVHNS Inclusive Health Strategic Plan 2020-2025	SCI.0010.0019.0001	2020

Exhibit No.	Description	SCOI Number	Document Date
G.59	Capital Investment Proposal - Cahill Cater	SVH.0001.0001.0067	1 October 2022
G.60	SVHNS – EMR Business Case Submission to MoH	SVH.0001.0001.1296	24 December 2020
G.61	Capital Investment Proposal - Electronic Medical Record	SVH.0001.0001.0226	1 May 2021
G.62	SVHNS Capital Investment Proposal – Electronic Medical Record	SVH.0001.0001.0724	1 January 2022
G.63	[Not in use – duplicate of G.41]		
G.64	Capital Investment Proposal - St Joseph's Hospital	SVH.0001.0001.0396	27 June 2022
G.65	[Not in use – duplicate of G.45]		
G.66	SVHA Finance and Investment Committee – SVHNS December Results and Financial Sustainability Plan	SVH.0001.0002.0236	31 January 2024
G.67	Letter from Anna McFadgen to Secretary NSW Health – SVHN Financial Support 2023-24	SVH.0001.0001.0664	7 March 2024
G.68	Letter from Anna McFadgen and Barry Mitrevski to Alfa D'Amato Financial Performance Report YTD March 2024	SVH.0001.0001.0775	11 March 2024
G.69	[Not in use – duplicate of G.29.24]		
G.70	Dot Point Advice – Post-meeting follow up SVHN EMR Business Case/St Joseph's Hospital	MOH.9999.1507.0001	26 June 2022
G.71	Correspondence Brief – Electronic Medical Records, SVHNS	MOH.9999.1509.0001	15 August 2021

Exhibit No.	Description	SCOI Number	Document Date
G.72	[Not in use – duplicate of G.36]		
G.73	Letter from Secretary NSW Health to Chair SVHN – 2024-2025 Service Agreement with St Vincent's Hospital Sydney	MOH.9999.1580.0001	3 May 2024
G.74	[Not in use – duplicate of G.29.22]		
G.75	[Not in use – duplicate of G.51]		
G.76	NSW Health, Financial Requirements and Conditions of Subsidy (Government Grants)	MOH.9999.1610.0001	21 June 2022
G.77	SVHN, Service Agreement 2022-2023	MOH.9999.1617.0001	18 August 2022
G.78	[Not in use – duplicate of G.45]		
G.79	[Not in use – duplicate of G.52]		
G.80	NSW Health, Financial Requirements and Conditions of Subsidy (Government Grants)	MOH.9999.1632.0001	19 September 2023
G.81	[Not in use – duplicate of G.47]		
G.82	[Not in use – duplicate of G.48]		
G.83	SVHN, 2023-2024 NSW Health Purchasing Roadshow Presentation	MOH.9999.1647.0001	8 March 2023
G.84	SVHN, Service Agreement Purchasing Discussion Presentation	MOH.9999.1649.0001	27 July 2023
G.85	Letter from CEO SVHN to Deputy Secretary, System Sustainability and Performance – NWAU performance	MOH.9999.1650.0001	22 March 2024

Exhibit No.	Description	SCOI Number	Document Date
G.86	Letter from CEO SVHN to NSW Health DS FSAM and CFO – Additional Activity	MOH.9999.1651.0001	13 May 2024
G.87	NSW Health, <i>Brief to Minister – Transfer of St Joseph’s Hospital to Western Sydney LHD</i>	MOH.9999.1654.0001	20 October 2023
G.88	NSW Health Correspondence Brief – SVHN 2024-2025 Service Agreement	MOH.9999.1881.0001	2 May 2024
G.89	Letter from Group CEO SJOGHC to Deputy Secretary, Minister for Health – Notification of Exit from HDHS	MOH.0002.0166.0001	5 December 2023
G.90	NSW Health Brief – Hawkesbury District Health Service Transition Planning	MOH.9999.1303.0001	22 December 2023
G.91	NSW Health Brief – Handover of Hawkesbury District Health Service	MOH.9999.1304.0001	23 January 2024
G.92	Statement of Amanda Carter, Department Head, Dietetics CHW	SCI.0011.0069.0001	7 June 2024
G.93	Statement of Erin Longbottom, Nursing Unit Manager, St Vincent’s Homeless Outreach Service	SVH.9999.0005.0001	7 June 2024
G.93.1	EL-1 Curriculum Vitae	SVH.9999.0005.0009	2024
G.93.2	EL-2 SVH Homeless Health Service: Bridging of the Gap Paper	SVH.9999.0005.0011	August 2016
G.94	Statement of Dr Shirley Alexander, Clinical Stream Medical Director – Connected Care SCHN	MOH.9999.1286.0001	6 June 2024

Exhibit No.	Description	SCOI Number	Document Date
G.95	Statement of Paul Craven, Executive Director, Children, Young People and Families, Medical Services and Networks and Streams Hunter New England LHD	MOH.9999.1289.0001	7 June 2024
G.95.1	Annexure A – Children, Young People and Families Organisation Chart	MOH.9999.1289.0007	May 2024
G.96	Statement of Dr Joanne Ging, Executive Director, Clinical Operations SCHN	MOH.9999.1292.0001	6 June 2024
G.96.1	[Not in use – duplicate of G.17]		
G.97	Statement of Cathryn Cox PSM, Chief Executive SCHN	MOH.9999.1869.0001	6 June 2024
G.97.1	[Not in use – duplicate of G.17]		
G.98	Statement of Lee Gregory, Chief Executive, NMBLHD	MOH.9999.1293.0001	6 June 2024
G.99	Curriculum Vitae of Lee Gregory	MOH.0002.0134.0001	June 2024
G.100	Email from Lee Gregory to Chief Executive, SJOG Health Care – Accepting Term Sheet	MOH.0002.0122.0001	18 October 2023
G.101	[Not in use – duplicate of G.89]		
G.102	Statement of Vanessa Clements, Director, Planning, Redevelopment and Project Management Office, Nepean Blue Mountains LHD	MOH.9999.1287.0001	6 June 2024
G.103	Statement of Matthew Daly, Deputy Secretary, System Sustainability and Performance, Ministry of Health	MOH.9999.1290.0001	6 June 2024

Exhibit No.	Description	SCOI Number	Document Date
G.104	Statement of Deborah Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, Ministry of Health	MOH.9999.1297.0001	6 June 2024
G.105	Statement of Dr Nigel Lyons, Specialist Advisor, Ministry of Health	MOH.9999.1870.0001	7 June 2024
G.106	NSW Health, <i>Paediatric Service Capability (Paediatric Medicine and Surgery for Children) Guideline</i>	MOH.0002.0144.0001	1 December 2023
G.107	NSW Health, <i>Paediatric Clinical Care and Inter-hospital Transfer Arrangements</i>	MOH.0002.0146.0001	7 August 2023
G.108	Children Young People and Families Executive Steering Committee (CYPFESC) 2023 Annual Report	MOH.0002.0147.0001	December 2023
G.109	Statement of Davinder Singh-Grewal, Head of Paediatric Rheumatology, SCHN	SCI.0010.0022.0001	9 June 2024
G.109.1	DSG-1 ACI Report, The Model of Care for the NSW Paediatric Rheumatology Network	SCI.0010.0024.0001	May 2013
G.109.2	DSG-2 The NSW Paediatric Rheumatology Services Advisory Group Findings and Recommendations	MOH.9999.2149.0001	October 2023
G.110	Statement of Dr Angus Alexander, Chair, Staff Medical Council, the Children's Hospital at Westmead	SCI.0010.0021.0001	7 June 2024
G.111	Statement of A/Prof Kathryn Browning Carmo, Senior Staff Specialist Neonatologist and Paediatric Critical Care Physician	SCI.0010.0026.0001	5 June 2024

Exhibit No.	Description	SCOI Number	Document Date
G.112	Statement of Philip Minns, Deputy Secretary, People, Culture and Governance, Ministry of Health	MOH.9999.1868.0001	7 June 2024
G.113	Statement of Kaylene Joan Gaffney, Group Chief Financial officer, SVHA	SVH.9999.0006.0001	11 June 2024
G.113.1	KG-1 SVHS Financial Statement 2018-2019	SVH.9999.0006.0005	2019
G.113.2	KG-2 SVHS Financial Statement 2020-2021	SVH.9999.0006.0052	2021
G.113.3	KG-3 SVHS Financial Statement 2022-2023	SVH.9999.0006.0102	2023
G.114	Heads of Agreement between SCHN and Hunter New England LHD	MOH.9999.1676.0001	December 2020
G.115	Heads of Agreement between SCHN and South Western Sydney LHD	MOH.9999.1678.0001	30 October 2020
G.116	Service Level Agreements between SCHN and Prince of Wales Hospital – Shared Clinical Services within the Randwick Health Precinct	MOH.9999.1680.0001	June 2023
G.117	Statement of Paul Preisz, Chief Medical Officer, SVHS	SVH.9999.0007.0001	11 June 2024
G.117.1	PP-1 Curriculum Vitae of Paul Preisz	SVH.9999.0007.0008	2024
G.118	Statement of Paul Jansz, Cardiothoracic and Transplant Surgeon, SVHS	SVH.9999.0008.0001	11 June 2024
G.119	NSW Health, CYPFESC – <i>Terms of Reference</i>	MOH.9999.3132.0001	31 May 2024

A.25: Tender Bundle H – Workforce 1 Hearings (July and August 2024)

Exhibit No.	Description	SCOI Number	Document Date
H1.0	NSW Health, <i>Delegations Manual: Combined Administrative Financial Staff</i>	MOH.9999.0817.0001	22 May 2015
H1.1	HETI, <i>Higher Education Governing Council Terms of Reference</i>	MOH.0010.0042.0001	15 December 2015
H1.2	The Royal Australasian College of Physicians, <i>Reconsideration Review and Appeals Process By-Law</i>	ACP.0001.0018.0001	10 February 2017
H1.3	The Royal Australasian College of Surgeons, <i>Accreditation Application</i>	RCS.0001.0024.0001	June 2017
H1.4	The Royal Australasian College of Surgeons, <i>Accreditation of Hospitals and Posts for Surgical Education and Training</i>	RCS.0001.0023.0001	2017
H1.5	College of Intensive Care Medicine, <i>List of Specialties, Fields of Specialty Practice and Related Specialist Titles</i>	SCI.0011.0241.0001	1 July 2018
H1.5.1	The Royal Australian and New Zealand College of Radiologists, <i>Accreditation Standards for Education, Training and Supervision of Clinical Radiology Trainees</i>	COR.0002.0006.0001	December 2018
H1.6	The Royal Australasian College of Physicians, <i>Training Provider Accreditation Program: A blueprint for pursuing training excellence in the workplace</i>	SCI.0011.0176.0001	2018
H1.7	The Royal Australasian College of Physicians, <i>Training Network Principles</i>	SCI.0011.0175.0001	2018

Exhibit No.	Description	SCOI Number	Document Date
H1.8	The Royal Australasian College of Physicians, <i>Trainees registered in training programs by location</i>	ACP.0001.0095.0001	2018 - 2023
H1.9	HETI, <i>Health Education and Training Institute By-Laws</i>	MOH.0010.0040.0001	8 April 2019
H1.10	John Leung et al, <i>Faculty of Radiation Oncology 2018 workforce census</i>	SCI.0011.0268.0001	14 July 2019
H1.11	General Surgeons Australia, <i>Hospital Accreditation and Trainee feedback regulations for the General Surgical Education and Training Program</i>	MOH.0010.0065.0001	29 November 2019
H1.12	The Royal Australasian College of Physicians, <i>Basic Training Accreditation Requirements: For Adult Internal Medicine</i>	SCI.0011.0167.0001	2019
H1.13	The Royal Australasian College of Physicians, <i>Basic Training Accreditation Requirements: For Paediatrics & Child Health</i>	SCI.0011.0168.0001	2019
H1.14	College of Intensive Care Medicine, <i>Objectives of Training for the Anaesthesia Term Policy (T-8 2009)</i>	SCI.0011.0237.0001	2019
H1.14.1	The Royal Australasian College of Surgeons, <i>Rural Health Equity Strategic Action Plan</i>	RCS.0001.0063.0001	15 December 2020
H1.15	The Royal Australasian College of Physicians, <i>Training Provider Standards: for Clinical Training Programs</i>	SCI.0011.0177.0001	2020

Exhibit No.	Description	SCOI Number	Document Date
H1.16	Royal Australian College of General Practitioners, <i>Standards for General Practice Training</i>	CGP.0001.0016.0001	April 2021
H1.16.1	Letter from Kiel Harvey to Dr Tom Karplus, <i>Re: Medical Management of Staff Specialists at the Concord Repatriation General Hospital Emergency Department</i>	MOH.0002.0090.0001_R	11 June 2021
H1.17	The Royal Australasian College of Surgeons, <i>Hospital Training Post Accreditation Standards for Surgical Education and Training</i>	SCI.0011.0236.0001	June 2021
H1.17.1	HETI, <i>Determination of Functions of Statutory Health Corporation</i>	SCI.0001.0060.0001	13 September 2021
H1.18	College of Intensive Care Medicine, WCA [Workplace Competency Assessment] <i>Information Sheet for Trainees and Fellows</i>	SCI.0011.0240.0001	September 2021
H1.19	NSW Health, <i>Executive Director of Workplace Relations Role Description</i>	MOH.0010.0145.0001	October 2021
H1.20	Western Sydney LHD and The Royal Australian and New Zealand College of Radiologists, <i>Memorandum of Understanding</i> (signed by RANZCR)	MOH.0010.0296.0001	1 November 2021
H1.21	Western Sydney LHD and The Royal Australian and New Zealand College of Radiologists, <i>Memorandum of Understanding</i> (signed by Western Sydney LHD)	MOH.0010.0295.0001	1 November 2021

Exhibit No.	Description	SCOI Number	Document Date
H1.21.0	The Royal Australian and New Zealand College of Radiologists Faculty of Radiation Oncology, <i>Accreditation Standards and Criteria for Training Networks and Sites</i>	COR.0002.0007.0001	March 2022
H1.21.1	Letter from the RACP to Western NSW LHD (Dr Jaydeep Mandal, Director of Physician Education)	MOH.0010.0329.0001_R	3 May 2022
H1.21.2	Letter from the RACP to Western NSW LHD (Cathy Marshall, Mark Spittal and Dr Marco 'Mattelo')	MOH.0010.0334.0001_R	22 July 2022
H1.21.3	Letter from Western NSW LHD (Mark Spittal, Cathy Marshall, Dr Marco Metelo) to the RACP	MOH.0010.0335.0001	29 July 2022
H1.21.4	Bathurst Health Service Action Plan (RACP)	MOH.0010.0336.0001	16 August 2022
H1.22	Letter to Dr Genevieve Wallace, General Manager of CRGH	MOH.0010.0002.0001_R	24 August 2022
H1.23	HETI, <i>Prevocational Accreditation Committee</i>	MOH.0010.0153.0001	30 August 2022
H1.24	Letter from A/Prof Winston Cheung to Sydney LHD Board	MOH.0010.0003.0001	12 October 2022
H1.25	The Royal Australian and New Zealand College of Radiologists, <i>2020 Clinical Radiology Workforce Census Report: Australia</i>	SCI.0011.0250.0001	21 October 2022
H1.26	Letter from A/Prof Winston Cheung to Joseph Jewitt	MOH.0010.0004.0001_R	24 October 2022
H1.27	Sydney LHD, CRGH Finance Manager Presentation	MOH.0010.0005.0001	27 October 2022

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H1.27.1	Bathurst Health Service Action Plan	MOH.0010.0338.0001	8 November 2022
H1.27.2	Bathurst Health Service Action Plan completed	MOH.0010.0333.0001	29 November 2022
H1.28	Letter from Dr Teresa Anderson AM to A/Prof Winston Cheung, <i>Concerns about governance, patient safety, and the health and wellbeing of staff at Concord Repatriation General Hospital</i>	MOH.0010.0006.0001_R	16 December 2022
H1.28.1	The Royal Australasian College of Surgeons, 2022 <i>RACS Activities Report</i>	RCS.0001.0049.0001	October 2023
H1.28.2	The Royal Australasian College of Surgeons, <i>Surgical Workforce 2022 Census Report</i>	RCS.0001.0052.0001	2022
H1.29	College of Intensive Care Medicine, <i>Objectives of Training for the Medicine Term Policy (T-7 2022)</i>	SCI.0011.0238.0001	2022
H1.30	Royal Australian College of General Practitioners, <i>Guide to Implementation of Accreditation Standards</i>	CGP.0001.0012.0001	2022
H1.31	French National Academy of Medicine, <i>Facing medical deserts: a citizen medical service. Press Release of the French National Academy of Medicine</i>	MOH.0010.0344.0001	2022
H1.32	The Royal Australasian College of Physicians, <i>Monitoring a Training Provider</i>	SCI.0011.0170.0001	1 January 2023
H1.32.1	Letter from Western NSW LHD (Cathy Marshall, Dr Marco Metelo) to RACP	MOH.0010.0340.0001	11 January 2023

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H1.32.2	Letter from Western NSW LHD (Mark Spittal) to the RACP	MOH.0010.0349.0001	25 January 2023
H1.32.3	Letter from Western NSW LHD to RACP	MOH.0010.0324.0001	6 February 2023
H1.32.4	Letter from Western NSW LHD (Mark Spittal) to RACP	MOH.0010.0326.0001	17 February 2023
H1.32.5	Western NSW LHD Application for Review of a Decision to the RACP	MOH.0010.0328.0001_R	5 March 2023
H1.32.6	The Royal Australian and New Zealand College of Psychiatrists, <i>NSW Mental Health Workers Unite to Call for Urgent Action Ahead of State Election</i>	SCI.0011.0270.0001	14 March 2023
H1.33	Australian Medical Council, <i>Standards for Assessment and Accreditation of Specialist Medical Programs 2023</i>	MOH.0010.0062.0001	23 March 2023
H1.34	The Royal Australian and New Zealand College of Radiologists, <i>Clinical Radiology Training Program Handbook</i>	SCI.0011.0252.0001	27 March 2023
H1.35	Impact Economics and Policy and HSU, <i>Reform Critical – A Fragmented Health System at Breaking Point</i>	SCI.0011.0162.0001	March 2023
H1.36	The Royal Australasian College of Physicians, <i>Capacity to Train Guidance</i>	SCI.0011.0259.0001	20 April 2023
H1.37	The Royal Australasian College of Physicians, <i>Accreditation of a Training Provider</i>	SCI.0011.0165.0001	27 April 2023
H1.38	The Royal Australasian College of Physicians, <i>Regional, Rural and Remote Physician Strategy</i>	ACP.0001.0129.0001	23 June 2023

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H1.39	HETI, <i>Higher Education Governance Structure</i>	MOH.0010.0041.0001	28 June 2023
H1.40	Australian Medical Council, <i>Standards for Assessment and Accreditation of Primary Medical Programs</i>	MOH.0010.0057.0001	July 2023
H1.41	Royal Australian College of General Practitioners, <i>Terms of Reference for Regional Accreditation Panels</i>	CGP.0001.0015.0001	August 2023
H1.41.1	Australian Medical Association, <i>Submission to the Upper House Inquiry into Mental Health Services</i>	SCI.0011.0278.0001	6 September 2023
H1.41.2	<i>Intentionally left blank</i>		
H1.41.3	Health Professional Workforce Unit, <i>Workforce Planning and Development Branch</i>	MOH.0010.0029.0001	September 2023
H1.41.4	Colleges Regulation 2017 – Registration and Selection to Surgical Education and Training	RCS.0001.0010.0001	September 2023
H1.42	Australian Medical Council, <i>Communication Protocol</i>	MOH.0011.0006.0001	September 2023
H1.43	NSW Health, <i>Registered Training Organisations Terms of Reference</i>	MOH.0010.0044.0001	September 2023
H1.44	HSU Submission to NSW Legislative Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW	SCI.0011.0160.0001	September 2023
H1.45	HETI, <i>2023-24 Performance Agreement</i>	MOH.0010.0046.0001	31 October 2023
H1.46	HETI, <i>2023-2026 Strategic Plan</i>	MOH.0010.0045.0001	October 2023

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H1.47	HSU Submission to the Special Commission of Inquiry into Healthcare Funding	SCI.0011.0157.0001	8 November 2023
H1.48	<i>Intentionally left blank</i>		
H1.49	Australian Physiotherapy Association, <i>2023 Workforce Census</i>	AUP.0001.0001.0001	November 2023
H1.50	The Royal Australasian College of Physicians, <i>Initial Accreditation Process</i>	SCI.0011.0169.0001	1 December 2023
H1.51	Royal Australian College of General Practitioners, <i>Accreditation Policy</i>	CGP.0001.0010.0001	13 December 2023
H1.52	Memorandum from Gina Finocchiaro to all Sydney LHD Staff re Return of Staff Car Parking Fees	MOH.0002.0081.0001	20 December 2023
H1.53	NSW Health, <i>Priority List 2024 Medical Intern Recruitment Campaign</i>	MOH.0010.0059.0001	December 2023
H1.53.1	Australian and New Zealand College of Anaesthetists, <i>ANZCA Handbook for Training</i>	ACA.0001.0003.0001	December 2023
H1.53.2	Australian and New Zealand College of Anaesthetists, <i>ANZCA Handbook for Accreditation</i>	ACA.0001.0007.0001	December 2023
H1.54	Royal Australian College of General Practitioners, <i>Australian General Practice Training Program Eligibility and Application Guide</i>	CGP.0001.0004.0001	2023
H1.55	Illawarra Shoalhaven LHD, <i>Triage Tool</i>	MOH.0010.0257.0001	2023

Exhibit No.	Description	SCOI Number	Document Date
H1.55.1	The Royal Australian and New Zealand College of Psychiatrists, <i>Accreditation of Training Programs: Training Program Accreditation Standards</i>	SCI.0011.0276.0001	2023
H1.56	The Royal Australasian College of Physicians, <i>Recognition of Prior Learning Policy</i>	SCI.0011.0258.0001	1 January 2024
H1.57	Medical Board of Australia, <i>Registration standard: Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of postgraduate year one training</i>	MOH.0010.0058.0001	1 January 2024
H1.58	Letter from C Heuston, Executive Director, Industrial Relations NSW Health to Unions NSW regarding NSW Government Fair Pay and Bargaining Policy 2023	MOH.0010.0150.0001	15 January 2024
H1.59	Royal Australian College of General Practitioners, <i>Training Programs Entry Policy</i>	CGP.0001.0008.0001	16 January 2024
H1.60	The Royal Australian and New Zealand College of Radiologists, <i>Radiation Oncology Accredited Training Site Listing</i>	SCI.0011.0254.0001	25 January 2024
H1.61	The Royal Australian and New Zealand College of Radiologists, <i>Re: Accreditation Site Visit Report for Concord Radiology</i>	SCI.0011.0264.0001_R	30 January 2024
H1.62	The Royal Australian and New Zealand College of Radiologists, <i>Clinical Radiology Learning Outcomes</i>	SCI.0011.0253.0001	January 2024

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H1.63	The Royal Australian and New Zealand College of Radiologists, <i>Radiation Oncology Learning Outcomes</i>	SCI.0011.0255.0001	January 2024
H1.64	The Royal Australasian College of Physicians, <i>Active Management Process: For Accreditation Committees</i>	SCI.0011.0166.0001	January 2024
H1.65	The Royal Australian and New Zealand College of Radiologists, <i>Clinical Radiology Accredited Training Site Listing</i>	SCI.0011.0251.0001	20 February 2024
H1.66	Western NSW LHD, <i>Centre for Rural Education Simulation and Training Overview</i>	MOH.0010.0033.0001	February 2024
H1.67	HETI, <i>Health Education and Training Institute Functional Structure</i>	MOH.0010.0047.0001	11 March 2024
H1.68	Industrial Relations Commission (NSW), Recommendation 2022/00106180 Re <i>Liverpool City Council v New South Wales Local Government, Clerical, Administrative, Energy, Airlines and Utilities Union</i>	MOH.0010.0141.0001	18 March 2024
H1.69	The Royal Australian and New Zealand College of Radiologists, <i>Concord Repatriation General Hospital & Canterbury Hospital</i>	SCI.0012.0172.0001	March 2024
H1.70	The Royal Australian and New Zealand College of Psychiatrists, NSW Branch, <i>NSW Branch 2024-25 Pre-Budget Submission</i>	ZCP.0001.0127.0001	March 2024
H1.70.1	Sydney LHD, <i>Clinical Governance Framework</i>	MOH.0002.0053.0001	4 April 2024

Exhibit No.	Description	SCOI Number	Document Date
H1.70.2	Sydney LHD and University of Technology, Sydney, <i>Memorandum of Understanding</i>	MOH.0010.0378.0001	5 April 2024
H1.70.3	Memorandum from Dr Teresa Anderson AM to all Sydney LHD Staff re timely reporting of incidents and adverse events	MOH.0002.0055.0001	5 April 2024
H1.70.4	A/Prof Winston Cheung, <i>Concord Repatriation General Hospital (CRGH) Medical Staff Council (MSC) Chair's Report for the Sydney Local Health District (SLHD) Medical Staff Executive Council (MSEC)</i>	MOH.0002.0060.0001	24 April 2024
H1.71	HETI, <i>Prevocational Training Council Terms of Reference</i>	MOH.0010.0070.0001	April 2024
H1.71.1	Letter from the RACP to Western NSW LHD (Dr R Das)	MOH.0010.0332.0001	30 May 2024
H1.72	The Royal Australasian College of Surgeons, <i>Surgical Supervisors Policy (POL-2019)</i>	SCI.0011.0235.0001	May 2024
H1.73	The Royal Australasian College of Surgeons, <i>Surgical Trainers Policy (POL-2020)</i>	SCI.0011.0239.0001	May 2024
H1.74	The Royal Australian and New Zealand College of Radiologists, <i>Re: Accreditation of Concord Repatriation General Hospital Progress Report for Clinical Radiology Training</i>	SCI.0012.0173.0001	20 June 2024
H1.75	Royal Australian College of General Practitioners, <i>Practice Experience Program Specialist Application Handbook</i>	CGP.0001.0006.0001	June 2024

Exhibit No.	Description	SCOI Number	Document Date
H1.76	Royal Australian College of General Practitioners, <i>Practice Experience Program Specialist Substantially Comparable Stream Handbook</i>	CGP.0001.0021.0001	June 2024
H1.77	Royal Australian College of General Practitioners, <i>Practice Experience Program Specialist Partially Comparable Stream Handbook</i>	CGP.0001.0020.0001	June 2024
H1.78	Western NSW LHD, <i>Nurses and Allied Health Numbers for 2023-2024 Financial Year</i>	MOH.0010.0036.0001	June 2024
H1.79	The Royal Australian and New Zealand College of Psychiatrists, <i>Accrediting Posts, Programs & Courses</i> (webpage)	SCI.0011.0199.0001	As at 16 July 2024
H1.80	The Royal Australian and New Zealand College of Psychiatrists, <i>Faculties</i> (webpage)	SCI.0011.0200.0001	As at 16 July 2024
H1.81	The Royal Australian and New Zealand College of Psychiatrists, <i>Hunter New England Training in Psychiatry (HNET)</i> (webpage)	SCI.0011.0201.0001	As at 16 July 2024
H1.82	The Royal Australian and New Zealand College of Psychiatrists, <i>Postgraduate Programs – Brain and Mind Centre</i> (webpage)	SCI.0011.0202.0001	As at 16 July 2024
H1.83	The Royal Australian and New Zealand College of Psychiatrists, <i>Psychiatry Courses – HETI Higher Education</i> (webpage)	SCI.0011.0203.0001	As at 16 July 2024
H1.84	The Royal Australian and New Zealand College of Psychiatrists, <i>Psychiatry Networks</i> (webpage)	SCI.0011.0204.0001	As at 16 July 2024

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H1.85	The Royal Australian and New Zealand College of Psychiatrists, <i>Training Program – HETI</i> (webpage)	SCI.0011.0205.0001	As at 16 July 2024
H1.86	The Royal Australian and New Zealand College of Psychiatrists, <i>RANZCP Program Structure</i> (webpage)	SCI.0011.0206.0001	As at 16 July 2024
H1.87	The Royal Australian and New Zealand College of Psychiatrists, <i>Sections</i> (webpage)	SCI.0011.0208.0001	As at 16 July 2024
H1.88	The Royal Australian and New Zealand College of Psychiatrists, <i>Specialist areas in psychiatry</i> (webpage)	SCI.0011.0209.0001	As at 16 July 2024
H1.89	The Royal Australian and New Zealand College of Psychiatrists, <i>Working and advisory groups</i> (webpage)	SCI.0011.0210.0001	As at 16 July 2024
H1.90	HSU Workforce Survey Questions	SCI.0011.0161.0001	July 2024
H1.91	HETI, <i>NSW Prevocational Training Networks</i>	MOH.0010.0263.0001	July 2024
H1.91.1	Unit Profile Report – Balmain	MOH.0010.0382.0001_R	July 2024
H1.91.2	Unit Profile Report – Concord	MOH.0010.0386.0001_R	July 2024
H1.91.3	Unit Profile Report – Canterbury	MOH.0010.0384.0001_R	July 2024
H1.91.4	Unit Profile Report – RPA	MOH.0010.0388.0001_R	July 2024
H1.91.5	Unit Profile Report – Sydney LHD	MOH.0010.0381.0001_R	July 2024

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H1.92	Royal Australian College of General Practitioners, <i>Australian General Practice Training Program Guide 2024</i>	CGP.0001.0022.0001	2024
H1.93	NSW Health, <i>Intern numbers by facility</i>	MOH.0010.0060.0001	2024
H1.94	Marie Bonal et al, <i>A French classification to describe medical deserts: a multi-professional approach based on the first contact with the healthcare system</i>	MOH.0010.0346.0001	2024
H1.95	Centre for Rural Education Simulation and Training, <i>Training Feedback</i>	MOH.0010.0037.0001	2024
H1.95.1	College of Intensive Care Medicine, <i>Complaints Policy (IC-9)</i>	SCI.0011.0285.0001	2024
H1.95.2	College of Intensive Care Medicine, <i>Prevention of Bullying, Discrimination and Harassment in the Workplace</i>	SCI.0011.0284.0001	2024
H1.96	Royal Australasian College of Physicians, <i>Overseas Trained Physicians Guidelines (Australia)</i>	SCI.0011.0171.0001	Undated
H1.97	Royal Australasian College of Physicians, <i>Capacity to Train Guidance E-Module</i>	SCI.0011.0260.0001	Undated
H1.98	Letter from HSU re recommendations in Universities Accord	SCI.0011.0194.0001_R	Undated
H1.99	Royal Australian and New Zealand College of Radiologists, <i>Case Study 5</i>	SCI.0011.0263.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H1.100	Royal Australian College of General Practitioners, <i>Australian General Practice Training Program Accreditation Application Handbook</i>	CGP.0001.0013.0001	Undated
H1.101	NSW Health, <i>Registered Training Organisations Proposed Governance Structure</i>	MOH.0010.0043.0001	Undated
H1.102	HETI, <i>Education and Training Courses by the Mental Health Portfolio List</i>	MOH.0010.0048.0001	Undated
H1.103	HETI, <i>Leadership Management Development and Educational Design Portfolio List of Courses</i>	MOH.0010.0049.0001	Undated
H1.104	Illawarra Shoalhaven LHD, <i>Strategic Education and Training Committee Terms of Reference</i>	MOH.0010.0074.0001	Undated
H1.105	NSW Health, <i>Whole of Health Nursing Agency Panel Initiative</i>	MOH.0010.0281.0001	Undated
H1.106	Revised Proposal for the Anaesthesia and Intensive Care Departments	MOH.0010.0148.0001	Undated
H1.107	NSW Treasury, <i>Treasury Codes – Definitions</i>	MOH.0010.0315.0001	Undated
H1.108	Australian Medical Council, <i>Training and assessment requirements for prevocational PGY1 and PGY2 training programs</i>	MOH.0010.0264.0001	Undated
H1.109	Australian Medical Council, <i>Training environment – National standards and requirements for prevocational PGY1 and PGY2 training programs and terms</i>	MOH.0010.0265.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H1.110	Australian Medical Council, <i>Quality Assurance – AMC domains and procedures for assessing and accrediting prevocational PGY1 and PGY2- training accreditation authorities</i>	MOH.0010.0266.0001	Undated
H1.111	Western NSW LHD, <i>Nursing Workforce Pathways</i>	MOH.0010.0034.0001	Undated
H1.112	Western NSW LHD, <i>Virtual Education Team Services</i>	MOH.0010.0035.0001	Undated
H1.113	Sydney LHD, <i>Colleague Care</i>	MOH.0002.0074.0001	Undated
H1.114	NSW Health, <i>Mental Health Key Plans, Frameworks and Strategies</i>	SCI.0011.0272.0001	Undated
H1.115	NSW Health, <i>Psychiatry Workforce Modelling Factsheet</i>	SCI.0011.0273.0001	Undated
H1.116	NSW Health Network Information, <i>Psychiatry Trainee Recruitment for 2025</i>	SCI.0011.0271.0001	Undated
H1.117	The Royal Australian and New Zealand College of Psychiatrists, <i>Upper House Inquiry into Mental Health Services</i>	ZCP.0001.0122.0001	Undated
H1.118	The Royal Australian and New Zealand College of Psychiatrists, <i>Entry Requirement for the Fellowship Training Program</i>	ZCP.0001.0042.0001	Undated
H1.119	<i>Distribution of Student Placements by Discipline and Health Agency</i>	MOH.0010.0273.0001	Undated
H1.120	<i>Statewide Mandatory Training Numbers</i>	MOH.0010.0076.0001	Undated
H1.121	<i>Distribution of Medical Specialties by LHD</i>	MOH.0010.0077.0001	Undated

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H1.122	Health Services Union, <i>A NSW Health Workforce at Breaking Point</i>	SCI.0011.0266.0001	Undated
H1.123	Sydney LHD, Clinical Quality Council Terms of Reference 2022	MOH.0010.0448.0001	2022
H1.124	Sydney LHD, Clinical Quality Council Terms of Reference 2023	MOH.0010.0447.0001	2023
H1.125	Sydney LHD, Clinical Quality Council Terms of Reference 2024	MOH.0010.0449.0001	2024
H1.126	Melissa Collins, <i>Table of impediments posed by Awards to efficiency of health system</i>	MOH.0010.0454.0001	4 August 2024
H2.1	NSW Health Council, <i>Report of the NSW Health Council: A Better Health System for NSW</i>	SCI.0011.0211.0001	March 2000
H2.2	Greater Metropolitan Transition Taskforce, <i>Metropolitan Hospitals Report: Service Enhancements and New Roles for Metropolitan Hospitals</i>	SCI.0011.0212.0001	August 2002
H2.3	Australian Competition & Consumer Commission, <i>Determination: Application for Authorisation lodged by the Royal Australasian College of Surgeons</i>	SCI.0011.0134.0001	30 June 2003
H2.4	Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee, <i>Report to Australian Health Ministers: Review of Australian specialist medical colleges</i>	SCI.0011.0140.0001	July 2004

Exhibit No.	Description	SCOI Number	Document Date
H2.5	Productivity Commission, <i>Australia's Health Workforce: Productivity Commission Research Report</i>	SCI.0011.0132.0001	22 December 2005
H2.6	Auditor-General, <i>Report into Visiting Medical Officer and Staff Specialists</i>	MOH.0010.0133.0001	14 December 2011
H2.7	Parliament of the Commonwealth of Australia House of Representatives Standing Committee on Health and Ageing, <i>Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors</i>	SCI.0011.0138.0001	March 2012
H2.8	NSW Health, <i>Workforce Plan 2012-2022: Revised 2015</i>	SCI.0011.0154.0001	1 September 2015
H2.9	NSW Health, <i>JMO Wellbeing & Support Forum</i>	MOH.0010.0345.0001	6 June 2017
H2.10	Productivity Commission, <i>Shifting the Dial: Supporting Paper No. 4 – Why a better health system matters</i>	SCI.0011.0151.0001	3 August 2017
H2.11	Productivity Commission, <i>Shifting the Dial: Supporting Paper No. 5 – Integrated care</i>	SCI.0011.0152.0001	3 August 2017
H2.12	Productivity Commission, <i>Shifting the Dial: Supporting Paper No. 6 – Impacts of health recommendations</i>	SCI.0011.0153.0001	3 August 2017
H2.13	Deborah Frew, Jane Booth, Michael Gorton AM and Martin Fletcher, <i>Review of Governance of the National Registration and Accreditation Scheme (NRAS)</i>	MOH.0013.0004.0001	November 2017

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H2.14	Prof Michael Woods, <i>Australia's Health Workforce: strengthening the education foundation</i>	SCI.0011.0135.0001	November 2017
H2.15	NSW Health, <i>Health Professionals Workforce Plan 2012-2022: Progress Report Year 5</i>	SCI.0011.0144.0001	11 July 2018
H2.16	NSW Legislative Assembly Public Accounts Committee, <i>Inquiry into the Management of Health Care Delivery in NSW</i>	SCI.0011.0213.0001	18 September 2018
H2.17	NSW Government, <i>Government Response: Management of Health Care Delivery in NSW</i>	SCI.0011.0214.0001	17 June 2019
H2.18	Australian Government Department of Health, <i>Australia's Long Term National Health Plan</i>	SCI.0011.0133.0001	August 2019
H2.19	NSW Health, <i>Health Professionals Workforce Plan Consultation Summary Report</i>	MOH.0010.0276.0001	August 2019
H2.20	NSW Ministry of Health, <i>Review of Trainees in Unaccredited Positions: Discussion Paper</i>	SCI.0011.0150.0001	21 August 2020
H2.21	NSW Legislative Council Portfolio Committee No 2, <i>Current and future provision of health services in the South-West Sydney Growth Region</i>	SCI.0011.0143.0001	November 2020
H2.22	National Health Practitioner Ombudsman, <i>Terms of Reference: Independent review of the procedural aspects of accreditation processes</i>	MOH.0010.0052.0001	December 2020

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H2.23	AHPRA Medical Board, <i>Standards: Specialist medical college assessment of specialist international medical graduates</i>	SCI.0011.0256.0001	1 January 2021
H2.24	NSW Government, <i>NSW Government Response: Inquiry into the current and future provision of health services in the South-West Sydney Growth Region</i>	SCI.0011.0148.0001	28 May 2021
H2.25	Sax Institute, <i>Rural Healthcare Paper 1: Changes in rural medical workforce and health service delivery since 1990</i>	MOH.0010.0299.0001	2021
H2.26	Australian Government Department of Health, <i>National Medical Workforce Strategy 2021-2031</i>	MOH.0010.0056.0001	15 March 2022
H2.27	NSW Government, <i>Business Case: Central Resource Unit</i>	MOH.0010.0303.0001	May 2022
H2.28	NSW Health, <i>Workforce Macro Trends Report</i>	MOH.0003.0234.0001	May 2022
H2.29	NSW Health, <i>Talent Strategy 2022-2032</i>	MOH.0010.0271.0001	June 2022
H2.30	ACI, <i>myVirtualCare Survey Results July 2021 to March 2022</i>	MOH.0010.0304.0001	August 2022
H2.31	NSW Health, <i>Talent Strategy 2022-2032 Horizon 1 Implementation Plan (Years 1 – 3)</i>	MOH.0010.0272.0001	2022
H2.32	DOHAC, <i>How Accreditation Practices Impact Building a Non-General Practice Rural Specialist Medical Workforce Report</i>	SCI.0011.0137.0001	2022

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H2.33	DOHAC, <i>How Accreditation Practices Impact Building a Non-General Practice Rural Specialist Medical Workforce: Appendices</i>	SCI.0011.0136.0001	2022
H2.34	Illawarra Shoalhaven LHD, <i>Allied Health Workforce Plan</i>	MOH.0010.0154.0001	2022
H2.35	NSW Health, <i>Rural Nurse Practitioners: A framework for service and training in NSW Health</i>	MOH.0010.0032.0001	January 2023
H2.35.1	CEC, <i>Post implementation safety risk assessment for Adjusted Medical Model of Care, Bathurst Health Service: Final Report</i>	MOH.0010.0348.0001	March 2023
H2.35.2	The Royal Australian and New Zealand College of Psychiatrists, <i>The NSW mental health care system on the brink: Evidence from the frontline</i>	ZCP.0001.0125.0001	March 2023
H2.36	NSW Health, <i>NSW Health Workforce Plan 2022-2032: A supplementary guide</i>	MOH.0010.0275.0001	24 April 2023
H2.37	Robyn Kruk AO, <i>Independent review of overseas health practitioner regulatory settings: Interim report</i>	SCI.0011.0146.0001	April 2023
H2.38	NSW Health, <i>People and Culture for Future Health NSW Report</i>	MOH.0010.0274.0001	June 2023
H2.39	National Health Practitioner Ombudsman, <i>Processes for progress, Part one: A roadmap for greater transparency and accountability in specialist medical training site accreditation</i>	MOH.0010.0053.0001	October 2023

Exhibit No.	Description	SCOI Number	Document Date
H2.40	National Health Practitioner Ombudsman, <i>Appendices to Processes for Progress review report</i>	SCI.0010.0027.0001	October 2023
H2.41	<i>Communication Protocol: Accreditation of specialist medical training sites/posts in Australian public hospitals and health facilities</i>	SCI.0010.0036.0001	3 November 2023
H2.42	Health Ministers Meeting, <i>Communique</i>	MOH.0010.0302.0001	10 November 2023
H2.43	ACI, <i>myVirtualCare Survey Results April 2022 to June 2023</i>	MOH.0010.0305.0001	November 2023
H2.44	<i>Intentionally left blank</i>		
H2.45	Robyn Kruk AO, <i>Independent Review of Australia's regulatory settings relating to overseas health practitioners: Final report</i>	MOH.0010.0051.0001	2023
H2.46	Australian Government, <i>National Mental Health Workforce Strategy 2022-2032</i>	SCI.0011.0147.0001	2023
H2.47	Australian Universities Accord – Summary of Final Report	SCI.0010.0030.0001	23 February 2024
H2.48	HETI, <i>NSW Basic Physician Training Network Training Operating Framework</i>	MOH.0010.0067.0001	February 2024
H2.48.1	Sydney LHD, <i>Concord Hospital Restorative Actions</i>	MOH.0002.0149.0001	15 March 2024
H2.48.2	NSW Government, <i>Sydney Local Health District (SLHD) Patient Feedback Report – reporting period: March 2024</i>	MOH.0002.0061.0001	9 May 2024
H2.48.3	NSW Government, <i>ims+ Clinical Incident Summary Report for April 2024</i>	MOH.0002.0059.0001	9 May 2024

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H2.49	Australian Government, <i>Australian Universities Accord: Budget Summary</i>	SCI.0010.0028.0001	15 May 2024
H2.50	Illawarra Shoalhaven LHD, <i>Allied Health Strategic Plan 2024-2027</i>	MOH.0010.0258.0001	May 2024
H2.51	NSW Health, <i>Corporate Governance and Accountability Compendium</i>	MOH.0010.0256.0001	May 2024
H2.52	National Health Practitioner Ombudsman, <i>Independent Review of Regulatory Complexity of the National Registration and Accreditation Scheme Terms of Reference</i>	MOH.0010.0055.0001	May 2024
H2.53	Medical Board of Australia, <i>Draft Revised Registration Standard: Specialist Registration</i>	MOH.0010.0054.0001	3 June 2024
H2.53.1	NSW Legislative Council Portfolio Committee No 2, <i>Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales</i>	SCI.0011.0280.0001	4 June 2024
H2.54	NSW Health, <i>Culture and Staff Experience Framework</i>	MOH.0010.0278.0001	June 2024
H2.55	NSW Health, <i>NSW Health Culture and Staff Experience Framework in Practise</i>	MOH.0010.0277.0001	Undated
H2.56	The Royal Australian and New Zealand College of Radiologists, <i>Facilities Survey Reports Insights and Trends from 2010-20</i>	SCI.0011.0267.0001	Undated
H2.57	NSW Health, <i>Model By-Laws for LHDs and SHNs</i>	SCI.0001.0002.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H3.1	Higher Grade Duty Payments to Nurses and Midwives	SCI.0011.0192.0001	3 August 2008
H3.2	Standardised Licence Arrangements for VMOs Providing Private Non-Admitted Services	MOH.9999.0079.0001	11 June 2009
H3.3	Managing Excess Staff of the NSW Health Service	MOH.9999.1327.0001	30 April 2012
H3.4	<i>Intentionally left blank</i>		
H3.5	Visiting Medical Officer Claims Auditing	MOH.9999.0080.0001	20 November 2013
H3.6	Payment to Medical Officers Undertaking a Clinical Appraisal Remotely	MOH.0013.0017.0001	10 January 2014
H3.7	Pilot Model Annualised Salary Agreement for Midwifery Group Practices	MOH.0013.0018.0001	20 August 2014
H3.8	Enrolled Nurse – Special Grade	MOH.0013.0003.0001	12 November 2014
H3.9	Salaries and Wages – Charging of Commission for Deductions	MOH.0013.0021.0001	15 December 2014
H3.10	Staff Specialists Rights of Private Practice Disbursement of Funds No 2 Accounts	MOH.9999.0084.0001	24 February 2015
H3.11	Allied Health Professionals' Right of Private Practice in NSW Health Facilities	MOH.9999.3136.0001	24 February 2015
H3.12	Guideline to notify arrangements to facilitate more effective scrutiny of VMO claims to ensure that they are appropriate to be paid	MOH.9999.0134.0001	November 2015
H3.13	Code of Conduct	MOH.0001.0359.0001	16 December 2015
H3.14	NSW Hospital Peer Groups 2016	MOH.0011.0003.0001	6 April 2016

Exhibit No.	Description	SCOI Number	Document Date
H3.15	Official Travel	MOH.0013.0015.0001	13 April 2016
H3.16	Medical Specialty Coding in StaffLink	MOH.0010.0066.0001	4 May 2016
H3.17	Staff Specialist Employment Arrangements across more than one Public Health Organisation	MOH.9999.1008.0001	30 June 2016
H3.18	Resolving Workplace Grievances	MOH.0002.0047.0001	18 October 2016
H3.19	Mandatory Training – Criteria for Approval as a NSW Health Requirement	MOH.0010.0261.0001	3 November 2016
H3.20	Variation to the Public Health System Nurses' and Midwives' (State) Award	SCI.0011.0193.0001	16 November 2016
H3.21	Visiting Practitioner Appointments in the NSW Public Health System	MOH.0011.0004.0001	16 November 2016
H3.22	Staff Specialist Rights of Private Practice	MOH.0001.0419.0001	13 January 2017
H3.23	Oral Health Practitioners Private Practice Scheme	MOH.0013.0016.0001	31 January 2018
H3.24	Living Away from Home Allowance	MOH.0013.0010.0001	10 May 2018
H3.25	Definition of Aboriginal Health Worker	MOH.0010.0308.0001	24 May 2018
H3.26	Decision Making Framework for Aboriginal Health Practitioners	MOH.0010.0306.0001	May 2018
H3.27	Multiple Assignments Award Provisions for Various Groups	MOH.0013.0011.0001	2 August 2018
H3.28	Managing Complaints and Concerns about Clinicians	MOH.9999.0933.0001	7 September 2018
H3.29	Non-Standard Remuneration or Conditions of Employment	MOH.0010.0144.0001	19 October 2018

Exhibit No.	Description	SCOI Number	Document Date
H3.30	NSW Health Service Senior Executive Agreements	MOH.0013.0013.0001	10 January 2019
H3.31	Employment and Management of Locum Medical Officers by Public Health Organisations	MOH.9999.0074.0001	1 February 2019
H3.32	Recognition of Continuous Casual Service – Health Employees’ Conditions of Employment (State) Award	MOH.0013.0019.0001	4 April 2019
H3.33	Employment Arrangements for Medical Officers in the NSW Public Health Service	MOH.9999.3118.0001	2 July 2019
H3.34	Training, Education and Study Leave for Staff Specialists	MOH.9999.0082.0001	3 September 2019
H3.35	Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists	MOH.0010.0320.0001	25 September 2019
H3.36	Clinical Academics Employed in the NSW Health Service	MOH.9999.0118.0001	20 November 2019
H3.37	Allied Health Assistant Framework	MOH.0010.0307.0001	26 February 2020
H3.38	<i>Intentionally left blank</i>		
H3.38.1	Sydney LHD, Governance and Development of Policy, Procedures and Guidelines	MOH.0002.0058.0001	January 2021
H3.39	Area of Need Program	MOH.0010.0311.0001	1 March 2021
H3.39.1	Sydney LHD, Serious Incident Management	MOH.0002.0062.0001	26 March 2021
H3.40	Service Check Register for NSW	MOH.9999.0132.0001	24 June 2021
H3.41	NSW Health Student Placement Agreement	MOH.0010.0260.0001	25 June 2021
H3.42	Prevention and Management of Bullying in NSW Health	MOH.0002.0087.0001	3 August 2021

Exhibit No.	Description	SCOI Number	Document Date
H3.43	Prevention and Management of Unacceptable Workplace Behaviours in NSW Health – JMO Module	MOH.9999.1319.0001	3 August 2021
H3.44	Remuneration Rates for Fee-for-Service Visiting Medical Officers	MOH.9999.1034.0001	4 November 2021
H3.45	Aboriginal Cultural Training – Respecting the Difference	MOH.0010.0312.0001	15 July 2022
H3.46	Student Placements in NSW Health	MOH.0010.0262.0001	13 October 2022
H3.47	Nurse Practitioners	MOH.0010.0031.0001	2022
H3.48	Rural Doctor's Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers	MOH.9999.0077.0001	1 September 2023
H3.49	Ministerial Policy Direction 2023-1: Medical college accreditation of training sites	MOH.0010.0063.0001	1 September 2023
H3.50	Staff Specialist (State) Award Salary Increases	MOH.0013.0022.0001	4 September 2023
H3.51	Recruitment and Selection of Staff to the NSW Health Service	MOH.0010.0064.0001	5 September 2023
H3.52	Increased Rates of Pay and Allowances for Nursing and Midwifery Staff	MOH.0013.0007.0001	26 September 2023
H3.53	Remuneration Arrangements for Staff Specialist Emergency Physicians	MOH.0013.0020.0001	16 October 2023
H3.54	Increased rates of pay and allowances – HSU and ASMOF Awards	MOH.0013.0009.0001	8 November 2023
H3.55	Commonwealth paid parental leave	MOH.0013.0001.0001	14 November 2023
H3.55.1	Increase in Car Parking Fees	MOH.0002.0076.0001	17 November 2023

Exhibit No.	Description	SCOI Number	Document Date
H3.56	Staff Specialists' Training Education and Study Leave New Funding Entitlement 2023/2024	MOH.9999.0083.0001	23 November 2023
H3.57	National Health and Medical Research Council Research Staff Salary Rates 2023	MOH.0013.0012.0001	28 November 2023
H3.58	Fair Pay and Bargaining Policy 2023	MOH.0010.0143.0001	November 2023
H3.58.1	Leading Performance, Development and Talent Management	MOH.0002.0078.0001	8 December 2023
H3.59	Leave Matters for NSW Health Service	MOH.9999.0107.0001	18 December 2023
H3.60	Aboriginal Workforce Composition	MOH.0010.0313.0001	18 December 2023
H3.61	Aboriginal Workforce Composition Minimum Targets	MOH.0010.0309.0001	18 December 2023
H3.61.1	Industrial Consultative Arrangements	MOH.9999.1332.0001	10 January 2024
H3.62	Increased rates of pay and allowances for Operational Ambulance Managers	MOH.0013.0008.0001	10 January 2024
H3.63	Increased rates of pay and allowances for Ambulance Service of NSW Administrative and Clerical Staff	MOH.0013.0005.0001	11 January 2024
H3.64	Increased Rates of Pay and Allowances for Broken Hill Health Employees	MOH.0013.0006.0001	21 February 2024
H3.65	Rural Health Workforce Incentive Scheme	MOH.0010.0314.0001	4 April 2024
H3.66	The Workforce Mobility Placement (WMP) Policy	MOH.0010.0310.0001	23 April 2024

Exhibit No.	Description	SCOI Number	Document Date
H3.67	Continuing Education Allowances in the Public Health System Nurses' and Midwives' (State) Award	MOH.0013.0002.0001	11 June 2024
H3.68	Nurses and Midwives – Payment of the 'In Charge of a Ward or Unit' Allowance	MOH.0013.0014.0001	21 June 2024
H3.69	Aboriginal Talent Pool Creation	MOH.0010.0318.0001	27 June 2024
H3.70	Policies Applicable to NSW Health Employees	MOH.0010.0301.0001	Undated
H4.1	Public Hospital Medical Officers (State) Award 2023	MOH.0010.0122.0001	21 July 2023
H4.2	Public Hospital Career Medical Officers (State) Award 2023	SCI.0011.0227.0001	21 July 2023
H4.3	Staff Specialists (State) Award 2022	SCI.0011.0234.0001	21 July 2023
H4.4	Public Health System Nurses' and Midwives' (State) Award 2023	MOH.0010.0129.0001	22 September 2023
H4.5	Health Employees' Medical Radiation Scientists (State) Award 2023	SCI.0011.0218.0001	11 September 2023
H4.6	Health and Community Employees Psychologists (State) Award 2023	SCI.0011.0215.0001	1 September 2023
H4.7	Health Employees' (State) Award 2023	SCI.0011.0216.0001	25 August 2023
H4.8	Health Employees' Technical (State) Award 2023	SCI.0011.0219.0001	11 September 2023
H4.9	Health Industry Status of Employment (State) Award 2023	SCI.0011.0220.0001	25 August 2023
H4.10	Health Employees' Conditions of Employment (State) Award 2023	SCI.0011.0217.0001	25 August 2023

Exhibit No.	Description	SCOI Number	Document Date
H4.11	Public Hospitals (Professional and Associated Staff) Conditions of Employment (State) Award 2023	MOH.0010.0126.0001	25 August 2023
H4.12	Health Professional and Medical Salaries (State) Award	MOH.0010.0110.0001	25 August 2023
H4.13	Health Managers (State) Award	MOH.0010.0109.0001	17 August 2023
H4.14	Medical Practitioners Award 2020	SCI.0011.0223.0001	1 July 2024
H4.15	Nurses Award 2020	SCI.0011.0225.0001	1 July 2024
H4.16	Health Professionals and Support Services Award 2020	SCI.0011.0222.0001	1 July 2024
H4.17	Staff Specialists Determinations 2015	MOH.9999.0081.0001	2015
H4.18	Public Hospitals (Visiting Medical Officers – Sessional Contracts) Determination 2014	MOH.0010.0100.0001	2014
H4.19	Public Hospitals (Visiting Medical Officers - Fee-for-Service Contracts) Determination 2014	MOH.0010.0090.0001	2014
H4.20	Medical Radiation Scientists – Commencement rate (Determination 25 of 2023)	SCI.0011.0224.0001	2023
H4.21	Public Hospital (Medical Officers) Award – Conditions - NSW Department of Health Circular No. 83/250	MOH.9999.0105.0001	19 August 1989
H4.22	<i>Intentionally left blank</i>		
H4.23	Remuneration Rates for Sessional Visiting Medical Officers (IB2024_001)	MOH.9999.1038.0001	10 January 2024
H4.24	NSW Health, Overview of Staff Specialist employment arrangements	MOH.0010.0136.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H4.25	Industrial Relations Commission, Statement regarding ASMOF v Health Secretary, SCHN	MOH.0010.0149.0001	2 November 2022
H4.26	ASMOF, Lodged Dispute	MOH.0010.0134.0001	12 January 2022
H4.27	NSW Health Secretary, Award Variation Application	MOH.0010.0147.0001	26 June 2023
H4.28	NSW Health Information Bulletin, IB2023_036 Rural Doctors' Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers	MOH.0010.0140.0001	1 September 2023
H4.29	NSW Health, Policy Directive PD2012_046 Remuneration Rates for non-specialist medical staff – short term/casual (locum)	MOH.0010.0321.0001	10 August 2012
H4.30	Awards and Determinations Applicable to NSW Health Employees	MOH.0010.0300.0001	Undated
H5.1	Statement of Dr Stewart Condon, Director, Medical Services, Concord Hospital, Sydney LHD	MOH.9999.1288.0001	6 June 2024
H5.1.1	CV of Dr Stewart Condon	MOH.9999.2129.0001	2024
H5.2	Statement of Dr Pamela Garrett, Director, Planning, Sydney LHD	MOH.9999.1291.0001	6 June 2024
H5.2.1	CV of Dr Pamela Garrett	MOH.9999.2133.0001	2024
H5.3	Statement of Dr Andrew Hallahan, Executive Director, Sydney LHD	MOH.9999.1294.0001	6 June 2024
H5.3.1	CV of Dr Andrew Hallahan	MOH.9999.2136.0001	2024
H5.3.2	Supplementary Statement of Dr Andrew Hallahan, Executive Director, Sydney LHD	MOH.0011.0033.0001	30 July 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.3.2.1	Exhibit 1 – Medical Board of Australia, <i>2023 Medical Training Survey Report for NSW</i>	MOH.0010.0419.0001	2023
H5.3.2.2	Exhibit 2 – 2023 Medical Training Survey Report for Canterbury Hospital, Concord Hospital, and Royal Prince Alfred Hospital	MOH.0010.0420.0001	2023
H5.3.2.3	Exhibit 3 – 2023 Medical Training Survey Report for Concord Hospital	MOH.0010.0417.0001	2023
H5.3.2.4	Exhibit 4 – 2023 Medical Training Survey Report Sydney LHD Comparison	MOH.0010.0418.0001	2023
H5.3.2.5	Exhibit 5 – Sydney LHD, <i>Medical Training Survey Strategic Action Plan</i>	MOH.0010.0414.0001	2023
H5.3.2.6	Exhibit 6 – The Royal Australasian College of Radiologists, <i>Concord Hospital's Site Accreditation: Self-Assessment and Site Visit Form</i>	MOH.0010.0412.0001	14 September 2023
H5.3.2.7	Exhibit 7 – Sydney LHD, <i>Medical Training Survey Strategic Action Plan Presentation</i>	MOH.0010.0411.0001	September 2023
H5.3.2.8	Exhibit 8 – Letter from Duane Findley to Dr Teresa Anderson AM	MOH.0005.0172.0001	21 February 2024
H5.3.2.9	Exhibit 9 – Sydney LHD, <i>RANZCR Concord Hospital three monthly progress report</i>	MOH.0010.0413.0001	11 March 2024
H5.3.2.10	Exhibit 10 – Sydney LHD, <i>Medical Workforce Profile as at June 2024</i>	MOH.0011.0008.0001	June 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.3.2.11	Exhibit 11 – Sydney LHD Clinical Quality Council, <i>Medical Accreditation Report – July 2024</i>	MOH.0010.0410.0001	July 2024
H5.4	Statement of Nathan Rudd, Deputy Director and Legal Counsel, Workforce, Sydney LHD	MOH.9999.2145.0001	6 June 2024
H5.4.1	CV of Nathan Rudd	MOH.9999.2130.0001	2024
H5.5	Statement of Dr Bethan Richards, Chief Medical Wellness Officer, Sydney LHD; Senior Staff Specialist, Department of Rheumatology, Royal Prince Alfred Hospital; Co-Director, Institute for Musculoskeletal Health, Sydney LHD	MOH.9999.2147.0001	7 June 2024
H5.5.1	CV of Dr Bethan Richards	MOH.0002.0013.0001	2024
H5.6	Statement of Prof Michael Hensley, Director, Medical Services, Royal Prince Alfred Hospital	MOH.9999.1295.0001	7 June 2024
H5.6.1	CV of Prof Michael Hensley	MOH.9999.2137.0001	2024
H5.7	Statement of John Kumanidis, Deputy Workforce Manager, Concord Repatriation General Hospital	MOH.9999.2143.0001	7 June 2024
H5.7.1	CV of John Kumanidis	MOH.9999.2142.0001	2024
H5.8	Statement of Joseph Jewitt, Acting General Manager, Concord Repatriation General Hospital	MOH.0010.0244.0001	4 July 2024
H5.8.1	CV of Joseph Jewitt	MOH.9999.2139.0001	2024
H5.9	Statement of Jacqueline Dominish OAM, Health Professionals Workforce, Ministry of Health	MOH.0010.0243.0001	5 July 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.9.1	CV of Jacqueline Dominish OAM	MOH.0010.0068.0001	2024
H5.10	Statement of Jacqui Cross PSM, Chief Nursing and Midwifery Officer, Ministry of Health	MOH.0011.0007.0001	8 July 2024
H5.10.1	CV of Jacqui Cross PSM	MOH.0010.0030.0001	2024
H5.11	Statement of Annette Solman, Chief Executive, HETI	MOH.0011.0012.0001	9 July 2024
H5.11.1	CV of Annette Solman	MOH.0010.0039.0001	2024
H5.12	Statement of Prof Peter Hockey, Executive Director, Quality and Safety, Western Sydney LHD	MOH.0011.0013.0001	10 July 2024
H5.12.1	CV of Prof Peter Hockey	MOH.0010.0028.0001	2024
H5.13	Statement of Prof Stephen Twigg, Head of Department Endocrinology, Royal Prince Alfred Hospital and Head of Central Clinical School, Sydney Medical School, University of Sydney	MOH.0011.0014.0001	11 July 2024
H5.13.1	CV of Prof Stephen Twigg	MOH.0010.0268.0001	2024
H5.14	Statement of Barbara Crawford, Acting Director, Nursing and Midwifery, Illawarra Shoalhaven LHD	MOH.0011.0015.0001	11 July 2024
H5.14.1	CV of Barbara Crawford	MOH.0010.0072.0001	2024
H5.15	Statement of Dr Josephine Burnand, Acting Medical Director, HETI	MOH.0011.0017.0001	11 July 2024
H5.15.1	CV of Dr Josephine Burnand	MOH.0010.0267.0001	2024
H5.16	Statement of Jacqueline Blackshaw, District Manager, Education and Training, Western NSW LHD	MOH.0011.0016.0001	11 July 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.16.1	CV of Jacqueline Blackshaw	MOH.0010.0038.0001	2024
H5.17	Statement of Emma-Kate Dewhurst, Director, Occupational Therapy, Illawarra Shoalhaven LHD	MOH.0011.0018.0001	10 July 2024
H5.17.1	CV of Emma-Kate Dewhurst	MOH.0010.0069.0001	2024
H5.18	Statement of Dr Karen Murphy, Acting Executive Director, Medical Services and Clinical Governance, Illawarra Shoalhaven LHD	MOH.0011.0019.0001	12 July 2024
H5.18.1	CV of Dr Karen Murphy	MOH.0011.0002.0001	2024
H5.19	Statement of Dr Linda MacPherson, Director, Workforce Reform, Ministry of Health	MOH.0011.0020.0001	12 July 2024
H5.19.1	CV of Dr Linda MacPherson	MOH.0010.0050.0001	2024
H5.19.2	Supplementary Statement of Dr Linda MacPherson, Director, Workforce Reform, Ministry of Health	MOH.0011.0032.0001	29 July 2024
H5.19.2.1	Exhibit 1 - NSW Health, <i>Statement of Agreed Principles on a Respectful Culture in Medicine</i>	MOH.0010.0415.0001	September 2017
H5.20	Statement of Dr Rebecca Nogajski, Executive Director, Medical Services, Western Sydney LHD	MOH.0011.0021.0001	16 July 2024
H5.20.1	CV of Dr Rebecca Nogajski	MOH.0010.0317.0001	2024
H5.21	Statement of Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health	MOH.0011.0022.0001	16 July 2024
H5.21.1	CV of Richard Griffiths	MOH.0010.0280.0001	2024

Exhibit No.	Description	SCOI Number	Document Date
H5.21.2	Supplementary Statement of Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health	MOH.0011.0039.0001	2 August 2024
H5.21.2.1	Annexure A – Responses to questions taken on notice	MOH.0010.0450.0001	Undated
H5.21.2.2	Exhibit 1 – Australian Human Resources Institute, <i>AHRI's Quarterly Australian Work Outlook: September Quarter 2023</i>	MOH.0010.0453.0001	September 2023
H5.21.2.3	Exhibit 2 – Psychiatry Workforce Vacancies	MOH.0010.0451.0001	February 2024
H5.21.2.4	Exhibit 3 – Deloitte, <i>2024 Gen Z and Millennial Survey</i>	MOH.0010.0455.0001	2024
H5.21.2.5	Exhibit 4 – Letter from Richard Griffiths to Chief Executives, Local Health Districts & Specialty Networks, <i>Medical officer vacancy data collection</i>	MOH.0010.0452.0001	Undated
H5.22	Statement of Philip Minns, Deputy Secretary, People and Culture Governance, Ministry of Health	MOH.0011.0024.0001	17 July 2024
H5.23	Statement of Melissa Collins, Acting Executive Director, Workplace Relations, Ministry of Health	MOH.0011.0025.0001	17 July 2024
H5.23.1	CV of Melissa Collins	MOH.0010.0142.0001	2024
H5.23.2	Supplementary Statement of Melissa Collins, Acting Executive Director, Workplace Relations, Ministry of Health	MOH.0011.0038.0001	3 August 2024
H5.24	Workforce Data Report of Rian Thompson	MOH.0010.0377.0001	17 July 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.25	Statement of Melissa Pickering, Acting Director, Nursing and Midwifery, Central Coast LHD	MOH.0011.0026.0001	18 July 2024
H5.25.1	CV of Melissa Pickering	MOH.0010.0376.0001	2024
H5.26	Statement of Hayley Scuriaga, Acting Executive Director, Nursing and Midwifery Services, Sydney LHD	MOH.0011.0027.0001	18 July 2024
H5.26.1	CV of Hayley Scuiraga	MOH.0010.0380.0001	2024
H5.27	Statement of Mark Spittal, Chief Executive, Western NSW LHD	MOH.0011.0023.0001	17 July 2024
H5.28	Statement of Jonathan Morris, Deputy Director, Human Resources Services, Central Coast LHD	MOH.0011.0028.0001	19 July 2024
H5.28.1	CV of Jonathan Morris	MOH.0010.0391.0001	2024
H5.29	Statement of Sarah Whitney, District Director, Allied Health, Sydney LHD	MOH.0015.0001.0001	22 July 2024
H5.29.1	CV of Sarah Whitney	MOH.0010.0366.0001	2024
H5.30	Statement of Graeme Loy, Chief Executive, Western Sydney LHD	MOH.0011.0030.0001	25 July 2024
H5.30.1	CV of Graeme Loy	MOH.0010.0375.0001_R	2024
H5.30.2	Exhibit 1 – Western Sydney Area Health Service, WSAHS <i>Networking Agreement 2nd Edition Imaging Services</i>	MOH.0010.0282.0001	24 May 2004
H5.30.3	Exhibit 2 – The Royal Australian and New Zealand College of Radiologists, <i>Accreditation Site Visit Report: Westmead Hospital</i>	MOH.0010.0285.0001	25 October 2019

Exhibit No.	Description	SCOI Number	Document Date
H5.30.4	Exhibit 3 – Letter from Luci Caswell to Dr Tom Karplus, <i>RE: Notice of discontinuation of Over Award Agreement between Westmead and Blacktown Hospital Radiologists</i>	MOH.0010.0283.0001_R	24 July 2020
H5.30.5	Exhibit 4 – Letter from Graeme Loy to Dr Michael Vowels, <i>RE: Notice of discontinuation of the 'Radiology Agreement between Westmead Hospital and The Staff Specialists Radiologists, Westmead Hospital' (Agreement)</i>	MOH.0010.0365.0001_R	25 July 2020
H5.30.6	Exhibit 5 – Letter from Dr Mark Phillips to Dr Jane Li and Dr Mohamed Nasreddine, <i>Re: Accreditation of Westmead Hospital for Clinical Radiology Specialty Training</i>	MOH.0010.0286.0001	14 September 2020
H5.30.7	Exhibit 6 – Email from Nathan Rudd to Daniel Laine and Rebecca Oxley, <i>FW: Dispute ASMOF-v-Secretary for Health in respect of WSLHD re Radiology Agreement</i>	MOH.0010.0357.0001_R	5 November 2020
H5.30.8	Exhibit 7 – Western Sydney LHD, <i>Westmead Hospital's response to the Royal Australian and New Zealand College of Radiologists (RANZCR) regarding accreditation</i>	MOH.0010.0287.0001_R	12 November 2020
H5.30.9	Exhibit 8 – Andrew Holland, <i>Notice to Industrial Registrar of Industrial Dispute Pursuant to section 132</i>	MOH.0010.0353.0001_R	November 2020

Exhibit No.	Description	SCOI Number	Document Date
H5.30.10	Exhibit 9 – Australian Salaried Medical Officers’ Federation (NSW) v Health Secretary in respect of the Western Sydney Local Health District [2021] NSWIRComm 1002	MOH.0010.0354.0001	29 January 2021
H5.30.11	Exhibit 10 – Letter from Dr Meredith Thomas to Dr Jane Li and Dr Mohamed Nasreddine, <i>Re: Accreditation of Westmead Hospital for Clinical Radiology Specialty Training</i>	MOH.0010.0390.0001	10 March 2021
H5.30.12	Exhibit 11 – Timeline of meetings re Westmead Hospital Radiology Department	MOH.0010.0364.0001	16 March 2021 to 17 June 2022
H5.30.13	Exhibit 12 – Letter from Dr Meredith Thomas and Prof Michael Bynevelt to Graeme Loy, <i>Re: Accreditation of Westmead Hospital for Clinical Radiology Specialty Training</i>	MOH.0003.0130.0001	3 June 2021
H5.30.14	Exhibit 13 – Letter from Graeme Loy to Dr Meredith Thomas and Prof Mike Benevylet, <i>The Royal Australian and New Zealand College of Radiologists’ training site accreditation of Westmead Hospital Department of Radiology</i>	MOH.0010.0288.0001 _R	19 July 2021
H5.30.15	Exhibit 14 – Letter from Prof Michael Benevylet to Graeme Loy, <i>Re: Accreditation of Westmead Hospital for Clinical Radiology Specialty Training</i>	MOH.0003.0133.0001	21 July 2021
H5.30.16	Exhibit 15 – Letter from Graeme Loy to Prof Mike Benevylet, <i>Response to letter of 21 July 2021</i>	MOH.0010.0293.0001 _R	26 July 2021

Exhibit No.	Description	SCOI Number	Document Date
H5.30.17	Exhibit 16 – Letter from Dr Lance Lawler, A/Prof Sanjay Jeganathan and Dr Meredith Thomas to Graeme Loy, <i>Re: Withdrawal of Accreditation for Westmead Hospital for Clinical Radiology</i>	MOH.0003.0131.0001	3 August 2021
H5.30.18	Exhibit 17 – Australian Salaried Medical Officers' Federation (NSW) v Health Secretary in respect of the Western Sydney Local Health District (No 3) [2022] NSWIRComm 1076	MOH.0010.0284.0001	16 September 2022
H5.30.19	Exhibit 18 – Letter from Prof Michael Benevlyet to Dr Susan Grayson, <i>Re: Westmead Hospital Application for Clinical Radiology Training</i>	MOH.0010.0294.0001	October 2022
H5.30.20	Exhibit 19 – NSW Health, <i>Determination No. 4 of 2023: Non-Standard Remuneration Arrangements for Staff Specialists employed in Radiology at Western Sydney Local Health District</i>	MOH.0010.0356.0001	29 March 2023
H5.31	Statement of Steevie Chan, District Director, Medical Services, Central Coast LHD	MOH.0011.0031.0001	29 July 2024
H5.31.1	CV of Steevie Chan	MOH.0010.0347.0001	2024
H5.31.2	Exhibit 1 – The Royal Australian and New Zealand College of Radiologists, <i>Central Coast Cancer Centre Accreditation Site Visit Report</i>	MOH.0010.0392.0001	2 December 2019
H5.31.3	Exhibit 2 – The Royal Australian and New Zealand College of Radiologists, <i>Accredited Training Site Assessment Report</i>	MOH.0004.0001.0001	9 May 2022

Exhibit No.	Description	SCOI Number	Document Date
H5.31.4	Exhibit 3 – Letter from Dr Vanessa Estall to Dr Louise Nardone, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) For Radiation Oncology Training</i>	MOH.0004.0007.0001	30 September 2022
H5.31.5	Exhibit 4 – Letter from Dr Louise Nardone to Dr Vanessa Estall, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0192.0001	17 November 2022
H5.31.6	Exhibit 5 – Letter from Dr Yaw Chin to Dr Louise Nardone, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) For Radiation Oncology Training</i>	MOH.0004.0006.0001	12 December 2022
H5.31.7	Exhibit 6 – Central Coast LHD, <i>RANZCR 3 Month Progress Report</i>	MOH.0010.0193.0001	7 February 2023
H5.31.7.1	Enclosure 1 – Excel spreadsheet, <i>2022 no reg clinics</i>	MOH.0010.0195.0001	2021 – 2023
H5.31.7.2	Enclosure 2 – Rad Onc Registrar Clinic Roster 16/05/2022 – 20/05/2022	MOH.0010.0211.0001	16-20 May 2022
H5.31.7.3	Enclosure 3 – Email from Dr Roland Yeghaian-Alvandi to Central Coast LHD RO Consultants, <i>Working from Home</i>	MOH.0010.0203.0001	25 May 2022
H5.31.7.4	Enclosure 4 – Rad Onc Registrar Clinical Roster 06/06/2022 – 10/06/2022	MOH.0010.0207.0001	6-10 June 2022
H5.31.7.5	Enclosure 5 – Rad Onc Registrar Clinical Roster 20/06/2022 – 24/06/2022	MOH.0010.0213.0001	20-24 June 2022

Exhibit No.	Description	SCOI Number	Document Date
H5.31.7.6	Enclosure 6 – Rad Onc Registrar Clinical Roster 22/08/2022 – 24/08/2022	MOH.0010.0214.0001	22-24 August 2022
H5.31.7.7	Enclosure 7 – Rad Onc Registrar Clinic Roster 12/09/2022 – 16/09/2022	MOH.0010.0209.0001	12-16 September 2022
H5.31.7.8	Enclosure 8 – Rad Onc Registrar Clinic Roster 19/09/2022 – 23/09/2022	MOH.0010.0212.0001	19-23 September 2022
H5.31.7.9	Enclosure 9 – Rad Onc Registrar Clinic Roster 26/09/2022 – 30/09/2022	MOH.0010.0215.0001	26-30 September 2022
H5.31.7.10	Enclosure 10 – Rad Onc Registrar Clinic Roster 03/10/2022 – 07/10/2022	MOH.0010.0206.0001	3-7 October 2022
H5.31.7.11	Enclosure 11 – Rad Onc Registrar Clinical Roster 07/11/2022 – 11/11/2022	MOH.0010.0208.0001	7-11 November 2022
H5.31.7.12	Enclosure 12 – Rad Onc Registrar Clinic Roster 12/12/2022 – 16/12/2022	MOH.0010.0210.0001	12-16 December 2022
H5.31.7.13	Enclosure 13 – Rad Onc Registrar Clinical Roster 19/12/2022 – 23/12/2022	MOH.0010.0205.0001	19-23 December 2022
H5.31.7.14	Enclosure 14 – 2022 Radiation Oncology Teaching Calendar	MOH.0010.0202.0001	2022
H5.31.7.15	Enclosure 15 – Kathy Fletcher, <i>Audit of CT Sim patients as requested by Head of Department, Dr Roland Alvandi</i>	MOH.0010.0197.0001	2 February 2023
H5.31.7.16	Enclosure 16 – Kathy Fletcher, <i>Data Collection – RO clinic attendance</i>	MOH.0010.0198.0001	2 February 2023

Exhibit No.	Description	SCOI Number	Document Date
H5.31.7.17	Enclosure 17 – Emails from Dr Louise Nardone to Central Coast LHD, <i>WAIT TO HEAR FROM LOUISE – Central Coast Cancer Centre accreditation progress report; response to letter CD22/76887</i>	MOH.0010.0194.0001_R	7 February 2023
H5.31.7.18	Enclosure 18 – Letter from Dr Louise Nardone to Dr Vanessa Estall, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0200.0001	7 February 2023
H5.31.7.19	Enclosure 19 – 2023 CCCC ROR Education Timetable	MOH.0010.0196.0001	2023
H5.31.7.20	Enclosure 20 – Culture Review Outcomes	MOH.0010.0201.0001	Undated
H5.31.7.21	Enclosure 21 – Radiation Oncology External Review Debrief	MOH.0010.0204.0001	Undated
H5.31.8	Exhibit 7 – Letter from Dr Vanessa Estall and Dr Lisa Sullivan to Dr Louise Nardone, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0218.0001	15 February 2023
H5.31.9	Exhibit 8 – Letter from Prof Steevie Chan to the Royal Australian and New Zealand College of Radiologists, <i>Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0350.0001_R	21 February 2023
H5.31.10	Exhibit 9 – Letter from Dr Vanessa Estall and Dr Lisa Sullivan to Prof Steevie Chan, <i>Re: Accreditation of Central Coast Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.9999.2897.0001	23 February 2023

Exhibit No.	Description	SCOI Number	Document Date
H5.31.11	Exhibit 10 – Letter from Prof Steevie Chan to the Royal Australian and New Zealand College of Radiologists, <i>Provision of the External Culture Review Report</i>	MOH.0010.0351.0001	1 March 2023
H5.31.12	Exhibit 11 – Letter from Dr Vanessa Estall and Dr Lisa Sullivan to Prof Steevie Chan, <i>Re: Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0219.0001	1 March 2023
H5.31.13	Exhibit 12 – Email from Sarah Gray to the Royal Australian and New Zealand College of Radiologists, <i>Culture Review Report – Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training (Our Ref: CD23/25303)</i>	MOH.0010.0220.0001 _R	27 March 2023
H5.31.13.1	Exhibit 12.1 – People Strengths, <i>Radiation Oncology Department: Workplace Culture Report</i>	MOH.0010.0190.0001	June 2022
H5.31.14	Exhibit 13 – Letter from Dr Vanessa Estall and Dr Lisa Sullivan to Central Coast LHD, <i>RE: Withdrawal of Accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0004.0005.0001	6 April 2023
H5.31.15	Exhibit 14 – Letter from Dr Lisa Sullivan to Dr Louise Nardone, <i>RE: Withdrawal of Accreditation for Radiation Oncology Training at Central Coast Cancer Centre (Gosford Hospital)</i>	MOH.0004.0004.0001 _R	11 July 2023

Exhibit No.	Description	SCOI Number	Document Date
H5.31.16	Exhibit 15 – Letter from Prof Steevie Chan to Dr Lisa Sullivan, <i>Re: Withdrawal of Accreditation for Radiation Oncology Training at Central Coast Cancer Centre (Gosford Hospital)</i>	MOH.0010.0231.0001	19 July 2023
H5.31.17	Exhibit 16 – Scott McLachlan, <i>Reconsideration Review Application to the Royal Australian and New Zealand College of Radiologists</i>	MOH.0010.0233.0001_R	21 July 2023
H5.31.18	Exhibit 17 – Email from Scott McLachlan to Fatima Zia, <i>RE: Central Coast LHD – Chief Executive Response to RANZCR – Withdrawal of Accreditation for Radiation Oncology Training at Central Coast Cancer Centre</i>	MOH.0010.0239.0001_R	August 2023
H5.31.19	Exhibit 18 – Letter from Duane Findley to Scott McLachlan, <i>Re: Accreditation of Central Coast Cancer (Gosford Hospital) for Radiation Oncology</i>	MOH.0010.0240.0001	29 September 2023
H5.31.19.1	Exhibit 18.1 – The Royal Australian and New Zealand College of Radiologists, <i>Reconsideration Decision with Respect to an Accreditation Decision Pertaining to Central Coast Local Health District – Central Coast Cancer Centre (Gosford Hospital)</i>	MOH.0010.0241.0001	29 September 2023
H5.31.20	Exhibit 19 – Central Coast LHD, <i>Clinical Services Plan 2023-2028</i>	MOH.9999.0869.0001	2023
H5.31.21	Exhibit 20 – Central Coast LHD, <i>Information Brief to Phil Minns</i>	MOH.0010.0223.0001	24 April 2024

Exhibit No.	Description	SCOI Number	Document Date
H5.31.22	Exhibit 21 – Letter from Prof Steevie Chan to Dr Vanessa Estall, <i>Withdrawal of accreditation of Central Coast Cancer Centre (Gosford Hospital) for Radiation Oncology Training</i>	MOH.0010.0226.0001	27 April 2024
H5.31.23	Exhibit 22 – Central Coast LHD, <i>Grand Rounds Program</i>	MOH.0010.0370.0001	2024
H5.31.24	Exhibit 23 – Central Coast LHD, <i>Intern Education Program</i>	MOH.0010.0371.0001	2024
H5.31.25	Exhibit 24 – Central Coast LHD, <i>Resident Medical Officer Education Program</i>	MOH.0010.0372.0001	2024
H5.31.26	Exhibit 25 – Central Coast LHD, <i>BPT Lecture Series Education Sessions</i>	MOH.0010.0374.0001	2024
H5.32	Statement of Dr Teresa Anderson AM, Chief Executive, Single Digital Patient Record Implementation	MOH.0011.0034.0001	30 July 2024
H5.32.1	Exhibit 1 – Brief dated 18 November 2016 requesting procurement of second MRI machine, signed by Dr Teresa Anderson AM	MOH.0010.0404.0001 _R	18 November 2016
H5.32.2	Exhibit 2 – Letter from ASMOF to Concord Hospital dated 2 September 2019	MOH.0010.0407.0001 _R	2 September 2019
H5.32.3	Exhibit 3 – Concord Hospital, Clinical Governance Framework 2021	MOH.0010.0024.0001	2021
H5.32.4	Exhibit 4 – A/Prof Winston Cheung, <i>Why there must be change at Concord Hospital</i>	MOH.0010.0393.0001	26 February 2022

Exhibit No.	Description	SCOI Number	Document Date
H5.32.5	Exhibit 5 – Letter from A/Prof Winston Cheung to Dr Genevieve Wallace dated 22 May 2022	MOH.0010.0394.0001_R	22 May 2022
H5.32.6	Exhibit 6 – Concord Hospital, Medical Staff Council, draft terms of Reference	MOH.0010.0403.0001	25 May 2022
H5.32.7	Exhibit 7 – Letter from A/Prof Winston Cheung to Dr Genevieve Wallace dated 6 June 2022	MOH.0010.0395.0001_R	6 June 2022
H5.32.8	Exhibit 8 – Email from Dr Andrew Hallahan to Dr Anderson dated 23 June 2022	MOH.0010.0397.0001_R	23 June 2022
H5.32.9	Exhibit 9 – Minutes from MSC meeting on 23 June 2022	MOH.0010.0398.0001_R	23 June 2022
H5.32.10	Exhibit 10 – Minutes from MSC meeting on 28 July 2022	MOH.0010.0399.0001_R	28 July 2022
H5.32.11	Exhibit 11 – Letter from Dr Teresa Anderson AM to A/Prof Winston Cheung dated 18 October 2022	MOH.0010.0400.0001_R	18 October 2022
H5.32.12	Exhibit 12 – Brief to Sydney LHD Board regarding Concord Hospital	MOH.0010.0416.0001	9 November 2022
H5.32.13	Exhibit 13 – Sydney LHD, Staff Accountability Framework	MOH.0010.0007.0001	January 2023
H5.32.14	Exhibit 14 – Sydney LHD, Management Accountability Framework	MOH.0010.0008.0001	January 2023
H5.32.15	Exhibit 15 – Email from Dr John Sammut to Dr Teresa Anderson AM dated 1 February 2023	MOH.0010.0401.0001_R	1 February 2023
H5.32.16	Exhibit 16 – Handwritten notes of meeting dated 21 February 2023	MOH.0010.0402.0001	21 February 2023

Exhibit No.	Description	SCOI Number	Document Date
H5.32.17	Exhibit 17 – Letter from Dr Teresa Anderson AM to Dr Michael Bynevelt, <i>Re: Accreditation of Concord Hospital for Clinical Radiology Specialty Training</i>	MOH.0014.0006.0001_R	24 November 2023
H5.32.18	Exhibit 18 – Letter from Dr Teresa Anderson AM to Prof John Slavotinek, <i>Re: RANZCR Accreditation Concord and Canterbury Hospitals</i>	MOH.0014.0005.0001_R	8 January 2024
H5.32.19	Exhibit 19 – Notes from meeting with ProActive ReSolutions and radiology department on 28 February 2024	MOH.0010.0405.0001	28 February 2024
H5.32.20	Exhibit 20 – Email from Dr Teresa Anderson AM to Duane Findley, <i>Re: Accreditation Site Visit Report for Concord Radiology</i>	MOH.0014.0002.0001_R	30 January 2024
H5.32.21	Exhibit 21 – Email from John McDonald dated 1 March 2024	MOH.0010.0406.0001_R	1 March 2024
H5.32.22	Exhibit 22 – Letter from RANZCR to Sydney LHD dated 21 February 2024	MOH.0005.0172.0001	21 February 2024
H5.32.23	Exhibit 23 – Concord and Canterbury Hospitals, 3 month radiology accreditation progress report	MOH.0010.0408.0001	8 March 2024
H5.32.24	Exhibit 24 – Letter from Dr Teresa Anderson AM to Duane Findley, <i>Re: Accreditation Site Visit Report for Concord Radiology</i>	MOH.0014.0021.0001_R	8 May 2024
H5.32.25	Exhibit 25 – People Matter Employee Survey comparative report	MOH.0010.0396.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H5.33	Statement of Dr Jo Karnaghan, Director, Clinical Governance and Medical Services, South Eastern Sydney LHD	MOH.0011.0088.0001	8 November 2024
H5.33.1	Exhibit A – CV of Dr Jo Karnaghan	MOH.0010.0726.0001	Undated
H5.33.2	Exhibit B – St George Hospital 3 Month Progress Report	MOH.0010.0704.0001	17 March 2023
H5.33.3	Exhibit C – St George Hospital 6 Month Progress Report	MOH.0010.0705.0001	20 March 2023
H5.33.4	Exhibit D – Email from RANZCR to South Eastern Sydney LHD, <i>RANZCR: CR NSW St George Hospital Site Visit</i>	MOH.0010.0706.0001 _R	6 July 2023
H5.33.5	Exhibit E – St George Hospital 9 Month Progress Report and supporting evidence	MOH.0010.0708.0001 _R	20 September 2023
H5.33.6	Exhibit F – St George Hospital 12 Month Progress Report and supporting evidence	MOH.0010.0707.0001 _R	15 December 2023
H6.1	Statement from the Royal Australasian College of Physicians (RACP)	SCI.0011.0185.0001	12 July 2024
H6.2	Statement from the Royal Australasian College of Surgeons (RACS)	SCI.0011.0178.0001	15 July 2024
H6.2.1	Appendix 1 to the Statement from RACS – Submission from RACS to the NSW Special Commission of Inquiry into Healthcare Funding	RCS.0001.0054.0001	24 November 2023

Exhibit No.	Description	SCOI Number	Document Date
H6.2.2	Appendix 2 to the Statement from RACS –Office of the National Rural Health Commissioner and RACS, <i>National Rural Surgeons' Training and Retention Workshop February 2024</i>	SCI.0011.0180.0001	February 2024
H6.3	Statement of Daniel Angelico, College of Intensive Care Medicine (CICM)	SCI.0011.0183.0001	15 July 2024
H6.4	Statement from the Australian and New Zealand College of Anaesthetists (ANZCA)	SCI.0011.0181.0001	15 July 2024
H6.4.1	Appendix A to the Statement from ANZCA – NSW Anaesthesia training sites	SCI.0011.0196.0001	15 July 2024
H6.5	Statement of Dr Angelo Virgona, The Royal Australian and New Zealand College of Psychiatrists (RANZCP)	SCI.0011.0269.0001	18 July 2024
H6.6	Statement from the Royal Australian and New Zealand College of Radiologists (RANZCR)	SCI.0011.0182.0001	15 July 2024
H7.1	Statement of Jill Harris, Director, Radiation Therapy, Westmead and Blacktown Hospitals	SCI.0011.0155.0001	12 July 2024
H7.2	Statement of Dr Fred Betros, General Surgeon and Visiting Medical Officer	SCI.0011.0156.0001	12 July 2024
H7.3	Statement of Dr Dustin Halse, Division Secretary, Health Services Union for NSW, ACT and QLD	SCI.0011.0197.0001	15 July 2024
H7.4	Statement of A/Prof Lloyd Ridley, Staff Specialist (Radiology), Concord Repatriation General Hospital	SCI.0011.0195.0001	14 July 2024

Exhibit No.	Description	SCOI Number	Document Date
H7.4.1	Annexure A – RE: Internal Audit – Fact-finding interview – Allegation of time not worked	SCI.0012.0058.0001_R	16 January 2023
H7.4.2	Annexure B – Accredited Training Site Assessment Report	SCI.0012.0059.0001	14 September 2023
H7.4.3	Annexure C – Concord Repatriation General Hospital	SCI.0012.0060.0001	8 March 2024
H7.4.4	Annexure D – Re: Accreditation of Concord Repatriation General Hospital for Clinical Radiology Specialty Training	SCI.0012.0061.0001	12 December 2023
H7.4.5	Annexure E – Fwd: Next meeting for the Division of Medicine – Thursday, 15 th August, 2019 @ 5.00pm	SCI.0012.0062.0001_R	25 May 2024
H7.4.6	Annexure F – Radiology Presentation to CE Sydney LHD for Medical Staff Council	SCI.0012.0063.0001	21 February 2023
H7.4.7	Annexure G – Letter from Chief Executive, Sydney LHD to Ridley re Procurement of MME, Recruitment of Radiologists	SCI.0012.0064.0001_R	17 May 2023
H7.4.8	Annexure H – Concord Repatriation General Hospital Medical Staff Council AGM	SCI.0012.0065.0001_R	22 June 2023
H7.4.9	Annexure I, Part 1 – Presentation of the Sydney LHD Board – Radiology Issues	SCI.0012.0066.0001	9 August 2023
H7.4.10	Annexure I, Part 2 – Text for Board Presentation	SCI.0012.0067.0001	9 August 2023
H7.5	Statement of A/Prof Lil Vrklevski, Director, Psychology, Sydney LHD	SCI.0011.0198.0001	16 July /2024

Exhibit No.	Description	SCOI Number	Document Date
H7.6	Statement of Dr Nicholas Spooner, Director, Emergency Medicine, Wyong Hospital	SCI.0011.0249.0001	17 July 2024
H7.7	Annexure 1 – ACEM, G23 Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce	SCI.0011.0242.0001	November 2023
H7.8	Statement of Dr Michelle McRae, Dermatologist, Pinnacle Dermatology	SCI.0011.0257.0001	17 July 2024
H7.9	<i>Intentionally left blank</i>		
H7.10	Statement of Dr Kathryn Austin, Obstetrician and Maternal Fetal Medicine Specialist	SCI.0011.0277.0001	24 July 2024
H7.11	<i>Intentionally left blank</i>		
H7.12	Statement of Clinical A/Prof Winston Cheung, Senior Staff Specialist, Intensive Care Unit, Concord Repatriation General Hospital	SCI.0012.0174.0001	16 July 2024
H7.12.1	Annexure A – Letter from A/Prof Winston Cheung to Sydney LHD Board re proposed meeting between Board and MSC	SCI.0012.0108.0001	12 October 2022
H7.12.2	Annexure B – Letter from Dr Teresa Anderson AM to A/Prof Winston Cheung re proposed meeting	SCI.0012.0069.0001_R	13 October 2022
H7.12.3	Annexure C – Minutes – CRGH Medical Staff Council Meeting with Executive	SCI.0012.0001.0001	24 November 2022
H7.12.4	Annexure D – Letter from Dr Teresa Anderson AM to A/Prof Winston Cheung	SCI.0012.0113.0001_R	16 December 2022

Exhibit No.	Description	SCOI Number	Document Date
H7.12.5	Annexure E – NSQHS Standards Second Edition Version 2 – Organisation-Wide Assessment Final Report – Concord Hospital	SCI.0012.0070.0001	July 2022
H7.12.6	Annexure F – Email from Winston Cheung to John Ajaka re ‘Arranging time to discuss Concord clinical issues at Sydney LHD Clinical Quality Council meeting 22 Feb’	SCI.0012.0072.0001_R	1 February 2023
H7.12.7	Annexure G – Email from Dr John Sammut to A/Prof Winston Cheung re ‘Arranging time to discuss Concord clinical issues at Sydney LHD Clinical Quality Council meeting 22 Feb’	SCI.0012.0071.0001_R	1 February 2023
H7.12.8	Annexure H – Email chain between A/Prof Winston Cheung and Dr John Sammut re ‘Arranging time to discuss Concord clinical issues at Sydney LHD Clinical Quality Council meeting 22 Feb’	SCI.0012.0074.0001_R	1-2 February 2023
H7.12.9	Annexure I – Email from Dr Teresa Anderson AM to A/Prof Winston Cheung re ‘Arranging time to discuss Concord clinical issues at Sydney LHD Clinical Quality Council meeting 22 Feb’	SCI.0012.0073.0001_R	1-2 February 2023
H7.12.10	Annexure J – Speech notes of Dr Belinda Hokin	SCI.0012.0164.0001	Undated
H7.12.11	Annexure K – Speech notes of A/Prof Lloyd Ridley	SCI.0012.0076.0001	Undated
H7.12.12	Annexure L – Letter from Dr Tony Sara (ASMOF) to A/Prof Winston Cheung re meeting of ASMOF members from Concord Hospital	SCI.0012.0077.0001_R	18 April 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.13	Annexure M – Letter from A/Prof Winston Cheung to Dr Rosalba Cross re 'Letter from ASMOF to CRGH Medical Staff Council'	SCI.0012.0004.0001_R	20 April 2023
H7.12.14	Annexure N – Draft (Proposed) Terms of Reference – Concord Repatriation General Hospital Medical Staff Council	SCI.0012.0041.0001	3 March 2023
H7.12.15	Annexure O – Letter from Dr Teresa Anderson AM to A/Prof Winston Cheung re draft Terms of Reference and Code of Conduct	SCI.0012.0079.0001	21 April 2023
H7.12.16	Annexure P – NSW Health Code of Conduct	SCI.0012.0081.0001	16 December 2015
H7.12.17	Annexure Q – Sydney LHD By-Laws	SCI.0012.0080.0001	Undated
H7.12.18	Annexure R – Email from Dr Andrew Hallahan to A/Prof Winston Cheung re 'CRGH MSC Draft Terms of Reference'	SCI.0012.0167.0001_R	21 April 2023
H7.12.19	Annexure S – Email from A/Prof Winston Cheung to Dr Teresa Anderson AM re 'Response for letter from 21 April on CRGH MSC Terms of Reference'	SCI.0012.0008.0001_R	1-5 May 2023
H7.12.20	Annexure T – Email from A/Prof Winston Cheung to Dr Andrew Hallahan re '20230509 Letter to Dr Winston Cheung'	SCI.0012.0168.0001_R	10 May 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.21	Annexure U – Email from Dr Rosalba Cross to MSC members forwarding correspondence from A/Prof Winston Cheung re ‘MSC Discussion and Vote of No Confidence in the Chief Executive of the Sydney LHD’	SCI.0012.0014.0001_R	15 June 2023
H7.12.22	Annexure V – Concord MSC Meeting Minutes	SCI.0012.0170.0001_R	22 June 2023
H7.12.23	Annexure W – Concord MSC Meeting Minutes	SCI.0012.0015.0001	29 June 2023
H7.12.24	Annexure X – Letter from A/Prof Winston Cheung to Sydney LHD Board re results of No confidence Vote in the CE of Sydney LHD	SCI.0012.0084.0001_R	30 June 2023
H7.12.25	Annexure Y – Letter from John Ajaka to A/Prof Winston Cheung re results of No confidence Vote in the CE of Sydney LHD	SCI.0012.0083.0001_R	4 July 2023
H7.12.26	Annexure Z – Letter from A/Prof Winston Cheung to John Ajaka re matters arising from no confidence vote	SCI.0012.0016.0001_R	5 July 2023
H7.12.27	Annexure AA – Letter from John Ajaka to A/Prof Winston Cheung re meeting	SCI.0012.0017.0001_R	6 July 2023
H7.12.28	Annexure BB – Letter from A/Prof Winston Cheung to the Hon. Ryan Park MP re vote of no confidence	SCI.0012.0086.0001_R	9 July 2023
H7.12.29	Annexure CC – Email correspondence re meeting on 20 July 2023	SCI.0012.0161.0001_R	7-11 July 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.30	Annexure DD – Email from John McDonald to A/Prof Winston Cheung re engagement of proactive resolutions	SCI.0012.0162.0001_R	20 July 2023
H7.12.31	Annexure EE – Minutes of meeting of MSC 20 July 2023	SCI.0012.0023.0001	20 July 2023
H7.12.32	Annexure FF – Letter from A/Prof Winston Cheung to John Ajaka re outcome of meeting of MSC on 20 July 2023	SCI.0012.0088.0001_R	21 July 2023
H7.12.33	Annexure GG – Email correspondence between A/Prof Winston Cheung and John McDonald re scope of engagement of Proactive solutions	SCI.0012.0089.0001_R	21-24 July 2023
H7.12.34	Annexure HH – Letter from A/Prof Winston Cheung to John Ajaka re context of no confidence vote	SCI.0012.0093.0001_R	25 July 2023
H7.12.35	Annexure II – Letter from the Hon. Ryan Park MP to A/Prof Winston Cheung re response to issues raised	SCI.0012.0163.0001_R	Undated
H7.12.36	Annexure JJ – Letter from John Ajaka to A/Prof Winston Cheung re cancellation of meeting on 27 July 2023	SCI.0012.0092.0001	25 July /2023
H7.12.37	Annexure KK – Email from John McDonald to A/Prof Winston Cheung re arrangements for meeting	SCI.0012.0027.0001_R	26 July 2023
H7.12.38	Annexure LL – Email from A/Prof Winston Cheung to John McDonald re meeting and presentations	SCI.0012.0028.0001_R	26 July 2023
H7.12.39	Annexure MM – Agenda for meeting on 9 August 2023	SCI.0012.0031.0001	9 August 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.40	Annexure MM.1– Speech notes Dr Belinda Hokin	SCI.0012.0095.0001	8 August 2023
H7.12.41	Annexure MM.2– Speech notes A/Prof Lloyd Ridley	SCI.0012.0094.0001	Undated
H7.12.42	Annexure MM.3– Speech notes Mojgan Soltanifard	SCI.0012.0097.0001	Undated
H7.12.43	Annexure MM.4– Speech notes Dr Raoul Pope	SCI.0011.0059.0001	Undated
H7.12.44	Annexure MM.5– Speech notes Department of Nursing	SCI.0012.0099.0001	Undated
H7.12.45	Annexure MM.6– Speech notes patient representative	SCI.0012.0096.0001	Undated
H7.12.46	Annexure NN – Letter from Philip Minns to A/Prof Winston Cheung re external review	SCI.0012.0100.0001_R	11 August 2023
H7.12.47	Annexure OO – Minutes of MSC meeting 24 August 2023	SCI.0012.0033.0001	24 August 2023
H7.12.48	Annexure PP – Letter from A/Prof Winston Cheung to John Ajaka re request for independent investigation	SCI.0012.0101.0001_R	25 August 2023
H7.12.49	Annexure QQ – Letter from A/Prof Winston Cheung to Susan Pearce AM and Philip Minns re formal request for an independent investigation	SCI.0012.0102.0001_R	25 August 2023
H7.12.50	Annexure RR – Letter from Philip Minns to A/Prof Winston Cheung re ombudsman	SCI.0012.0103.0001_R	29 August 2023
H7.12.51	Annexure SS – Letter from A/Prof Winston Cheung to John Ajaka re request for formal confirmation of lack of independent investigation	SCI.0012.0104.0001_R	6 September 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.52	Annexure TT – Letter from A/Prof Winston Cheung to Susan Pearce AM re request for formal confirmation of lack of independent investigation	SCI.0012.0105.0001_R	6 September 2023
H7.12.53	Annexure UU – Letter from Philip Minns to A/Prof Winston Cheung re complaints from MSC	SCI.0012.0106.0001_R	8 September 2023
H7.12.54	Annexure VV – Letter from John Ajaka to A/Prof Winston Cheung re correspondence from Philip Minns	SCI.0012.0107.0001	11 September 2023
H7.12.55	Annexure WW – NSW People Matter Employee Survey 2023 – Health portfolio	SCI.0012.0003.0001	2023
H7.12.56	Annexure XX – NSW People Matter Employee Survey 2023 – Concord Hospital	SCI.0012.0002.0001	2023
H7.12.57	Annexure YY – Email from Dr Rosalba Cross to A/Prof Winston Cheung re vote of no confidence meeting	SCI.0012.0034.0001_R	25 September 2023
H7.12.58	Annexure ZZ – Concord Hospital Medical Staff Council MSC Meeting Minutes	SCI.0012.0035.0001	28 September 2023
H7.12.59	Annexure AAA – Concord Hospital Medical Staff Council Meeting with Executives Minutes	SCI.0012.0036.0001	12 October 2023
H7.12.60	Annexure BBB – Sydney LHD Workforce Factsheet CORE Values Behaviours	SCI.0012.0160.0001	Undated
H7.12.61	Annexure CCC – Concord Hospital Medical Staff Council Meeting with Executives Minutes	SCI.0012.0109.0001	26 October 2023

Exhibit No.	Description	SCOI Number	Document Date
H7.12.62	Annexure DDD – Letter from A/Prof Winston Cheung to Sydney LHD Board passing of vote of no confidence	SCI.0012.0110.0001_R	27 October 2023
H7.12.63	Annexure EEE – Letter from A/Prof Winston Cheung to the Hon. Ryan Park MP re passing of no confidence vote	SCI.0012.0111.0001_R	1 November 2023
H7.12.64	Annexure FFF – Concord Hospital Medical Staff Council Meeting with Executives Minutes	SCI.0012.0037.0001	9 November 2023
H7.12.65	Annexure GGG – Letter from John Ajaka to A/Prof Winston Cheung re postponing meeting	SCI.0012.0112.0001	22 November 2023
H7.12.66	Annexure HHH – Email from A/Prof Winston Cheung to John McDonald re 'Summary of ProActive ReSolutions achievements at Concord Hospital for MSC meeting in December'	SCI.0012.0171.0001_R	30 November 2023
H7.12.67	Annexure III – Concord Medical Staff Council Meeting with Executives Minutes	SCI.0012.0040.0001	14 December 2023
H7.12.68	Annexure JJJ – Letter from the Hon. Ryan Park MP to A/Prof Winston Cheung re issues at Concord Hospital	SCI.0012.0116.0001_R	Undated
H7.12.69	Annexure KKK – Memo from Concord A/General Manager to Concord Staff re 'Invitation – Concord COVID-19 Reflection Sessions'	SCI.0012.0117.0001	15 January 2024
H7.12.70	Annexure LLL – Email from A/Prof Winston Cheung to John McDonald re 'Updates for MSC meeting 22 February'	SCI.0012.0165.0001_R	13 April 2024

Exhibit No.	Description	SCOI Number	Document Date
H7.12.71	Annexure MMM – Email from A/Prof Winston Cheung to John McDonald re 'Discussion to table at upcoming MSC meeting'	SCI.0012.0051.0001_R	29 April 2024
H7.12.72	Annexure NNN – Email from Susan Pearce AM and John Ajaka to Sydney LHD Staff re workplace dispute re workplace dispute	SCI.0012.0052.0001	2 May 2024
H7.12.73	Annexure OOO – Concord Hospital Medical Staff Council Meeting with Executives Minutes re workplace dispute	SCI.0012.0055.0001	27 June 2024
H7.12.74	Annexure PPP – Letter from Juliette Rex to A/Prof Winston Cheung re workplace dispute re workplace dispute	SCI.0012.0140.0001_R	10 November 2023
H7.12.75	Annexure QQQ – Email from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0166.0001_R	10-22 November 2023
H7.12.76	Annexure RRR – Email from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0143.0001_R	10-22 November 2023
H7.12.77	Annexure SSS – Letter from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0144.0001_R	21 December 2023
H7.12.78	Annexure TTT – Email from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0169.0001_R	3 January 2024
H7.12.79	Annexure UUU – Email from Sydney LHD Concord HR to Concord Staff re workplace dispute	SCI.0012.0114.0001_R	3 January 2024

Exhibit No.	Description	SCOI Number	Document Date
H7.12.80	Annexure VVV – Email from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0147.0001_R	4 January 2024
H7.12.81	Annexure WWW – Letter from A/Prof Winston Cheung to Juliette Rex re workplace dispute	SCI.0012.0148.0001_R	9 February 2024
H7.12.82	Annexure XXX – Letter from Gina Finocchiaro to A/Prof Winston Cheung re workplace dispute	SCI.0012.0149.0001_R	27 February 2024
H7.12.83	Annexure YYY – Letter from Goldrick Farrell Mullan Lawyers to Gina Finocchiaro re workplace dispute	SCI.0012.0150.0001_R	12 April 2024
H7.12.84	Annexure ZZZ – Letter from Gina Finocchiaro to Goldrick Farrell Mullan Lawyers re workplace dispute	SCI.0012.0151.0001_R	30 April 2024
H7.12.85	Annexure AAAA – Letter from Goldrick Farrell Mullan Lawyers to Gina Finocchiaro re workplace dispute	SCI.0012.0152.0001_R	8 May 2024
H7.12.86	Annexure BBBB – Email from David Farrell to A/Prof Winston Cheung re workplace dispute	SCI.0012.0153.0001_R	30 April 2024 to 13 May 2024
H7.12.87	Annexure CCCC – Letter from Goldrick Farrell Mullan Lawyers to Gina Finocchiaro re workplace dispute	SCI.0012.0154.0001_R	21 May 2024
H7.13	Statement of Dominique Egan, Director, Workplace Relations and Legal Counsel, Australian Medical Association NSW	SCI.0011.0283.0001	25 July 2024
H7.13.1	Attachment 1 – Visiting Medical Officers case 1991 – 1993 – Reasons for determination	SCI.0011.0288.0001	25 March 1993

Exhibit No.	Description	SCOI Number	Document Date
H7.13.2	Attachment 2 – Visiting Medical Officers case 1991 – 1993 – Appendices to the reasons for determination	SCI.0011.0289.0001	25 March 1993
H7.13.3	Attachment 3 – Orders made by the Full Commission	SCI.0011.0290.0001	24 December 1993
H7.13.4	Attachment 4 – Reasons for decision of the Full Commission	SCI.0011.0291.0001	24 December 1993
H7.13.5	Attachment 5 – Full Commission Minutes of Determination and Order Statement	SCI.0011.0292.0001	24 March 1994
H7.13.6	Attachment 6 – 1994 Sessional Determination	SCI.0011.0293.0001	1994
H7.13.7	Attachment 7 – Sessional Determination Contextual Overview	SCI.0011.0294.0001	Undated
H7.13.8	<i>Intentionally left blank</i>		
H7.13.9	Attachment 9 – Public Hospitals (Sessional Contracts) Determination 2007	SCI.0011.0296.0001	2007
H7.13.10	Attachment 10 – Terms of Settlement of the NSW Doctor's Dispute	SCI.0011.0297.0001	7 March 1996
H7.13.11	Attachment 11 – Agreement between the NSW Branch of the Australian Medical Association and the NSW Department of Health	SCI.0011.0298.0001	Undated
H7.13.12	Attachment 12 – Fee-for-Service Standard Form Contract	SCI.0011.0299.0001	Undated
H7.13.13	Attachment 13 – Fee-for-Service Contextual Overview	SCI.0011.0300.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
H7.13.14	Attachment 14 – Public Hospitals (Fee-for-Service Contracts) Determination 2007	SCI.0011.0301.0001	2007

A.26: Tender Bundle I – Southern New South Wales Hearings (August 2024)

Exhibit No.	Description	SCOI Number	Document Date
I.1	Southern NSW LHD, <i>Safety and Quality Account</i>	SCI.0011.0321.0001	2021 – 2022
I.2	Southern NSW LHD, <i>Service Agreement</i>	MOH.0012.0081.0001	2021 – 2022
I.3	Southern NSW LHD, <i>Services Plan</i>	SCI.0011.0323.0001	2021 – 2026
I.4	Southern NSW LHD, <i>Service Agreement</i>	MOH.0012.0082.0001	2022 – 2023
I.5	Southern NSW LHD, <i>Year in Review</i>	SCI.0011.0325.0001	2022 – 2023
I.6	Southern NSW LHD, <i>Safety and Quality Account</i>	SCI.0011.0322.0001	2022 – 2023
I.7	Southern NSW LHD, <i>Budget Allocation</i>	SCI.0011.0319.0001	2023 – 2024
I.8	New Eurobodalla Regional Hospital Development – Fact Sheet	MOH.9999.1101.0001	March 2022
I.9	New Eurobodalla Regional Hospital Development – Project Overview	SCI.0011.0317.0001	April 2022
I.10	New Eurobodalla Regional Hospital Development – Project Overview	MOH.0012.0083.0001	August 2022
I.11	New Eurobodalla Regional Hospital Development – Community Feedback	SCI.0011.0311.0001	November 2022

Exhibit No.	Description	SCOI Number	Document Date
I.12	New Eurobodalla Regional Hospital Development – Fact Sheet	SCI.0011.0312.0001	January 2023
I.13	New Eurobodalla Regional Hospital Development – Project Update	SCI.0011.0314.0001	January 2024
I.14	Batemans Bay Community Health – Project Update and FAQs	SCI.0011.0309.0001	January 2024
I.15	Batemans Bay Community Health – Consultation Outcomes Report	SCI.0011.0307.0001	March 2024
I.16	Hansard – NSW Legislative Assembly – Batemans Bay Emergency Department	SCI.0011.0310.0001	20 June 2024
I.17	Batemans Bay Community Health – Community Update	SCI.0011.0306.0001	July 2024
I.18	Memorandum of Understanding between The Canberra Hospital and Health Services and Southern NSW LHD	MOH.0012.0086.0001	23 December 2016
I.19	Memorandum of Understanding between South Eastern Sydney LHD and Southern NSW LHD for the provision of NSW Telestroke Service from 31 January 2022	MOH.0012.0091.0001	12 November 2021
I.20	Cross Border Stroke Patient Transfers, Memorandum of Understanding between Canberra Health Services, Calvary Public Hospital Bruce, Southern NSW LHD, Murrumbidgee LHD and NSW Ambulance	MOH.0012.0084.0001	14 December 2021

Exhibit No.	Description	SCOI Number	Document Date
I.21	Flow Reversal of Elective Procedures Memorandum of Understanding between Canberra Health Services and Southern NSW LHD	MOH.0012.0090.0001	24 December 2021
I.22	Southern NSW, South Western Sydney and Illawarra Shoalhaven LHDs Memorandum of Understanding	MOH.0012.0093.0001	26 July 2023
I.23	ACT & Southern NSW Joint Operations Committee – Key Priorities and Business Plan 2023 – 2024	MOH.0012.0089.0001	2023 - 2024
I.24	Southern NSW LHD, Canberra Health Service, Calvary Patient Flow Key Performance Indicator Agreement	MOH.0012.0085.0001	Undated
I.25	Statement of Michael Grayson, Intensive Care Paramedic and Station Officer, NSW Ambulance	SCI.0011.0302.0001	2 August 2024
I.26	Statement of Elizabeth Hoskins, Board Chair, Southern NSW LHD	MOH.0011.0035.0001	2 August 2024
I.26.1	CV of Elizabeth Hoskins	MOH.0010.0444.0001	Undated
I.26.2	Southern NSW LHD, <i>Elevate Execution Framework & Tactics</i>	MOH.0010.0442.0001	July 2018
I.26.3	Southern NSW LHD, <i>Board Charter</i>	MOH.0010.0421.0001	June 2022
I.26.4	Southern NSW LHD, <i>People and Culture Committee Terms of Reference</i>	MOH.0010.0439.0001	February 2023
I.26.5	Southern NSW LHD, <i>Community Engagement Framework</i>	MOH.0010.0427.0001	November 2023

Exhibit No.	Description	SCOI Number	Document Date
I.26.6	Southern NSW LHD, <i>People Strategy 2024 – 2026</i>	MOH.0010.0430.0001	2024 - 2026
I.26.7	Southern NSW LHD, <i>Pride in Southern Promise</i>	MOH.0010.0443.0001	1 March 2024
I.26.8	Southern NSW LHD, <i>Performance Committee Terms of Reference</i>	MOH.0010.0440.0001	23 July 2024
I.27	Statement of Fiona Renshaw, Executive Director Operations, Southern NSW LHD	MOH.0011.0036.0001	2 August 2024
I.27.1	CV of Fiona Renshaw	MOH.0010.0445.0001	Undated
I.28	Statement of Sarah Wallace, District Director Finance and Performance, Southern NSW LHD	MOH.0011.0037.0001	2 August 2024
I.28.1	CV of Sarah Wallace	MOH.0010.0446.0001	Undated
I.28.2	Southern NSW LHD Finance and Performance Organisation Chart	MOH.0010.0424.0001	Undated
I.29	Statement of Terry Clout, Deputy Board Chair, Southern NSW LHD	MOH.0011.0040.0001	6 August 2024
I.29.1	CV of Terry Clout	MOH.0014.0241.0001	Undated
I.29.2	Southern NSW LHD, <i>Health Care Quality Committee Terms of Reference</i>	MOH.0010.0437.0001	22 August 2023
I.29.3	Southern NSW LHD, <i>Medical & Dental Appointments Advisory Committee Terms of Reference</i>	MOH.0010.0438.0001	21 November 2023
I.30	Statement of Margaret Bennett, Chief Executive, Southern NSW LHD	MOH.0011.0041.0001	6 August 2024

Exhibit No.	Description	SCOI Number	Document Date
I.30.1	Southern NSW LHD, <i>Monaro Regional Health Clinical Services Plan 2015-2019</i>	MOH.0014.0248.0001	2015 - 2019
I.30.2	Southern NSW LHD, <i>Cooma Health Services Clinical Services Plan 2016</i>	MOH.0014.0247.0001	2016
I.30.3	Southern NSW LHD, <i>Eurobodalla Health Service Clinical Services Plan</i>	MOH.0014.0245.0001	March 2020
I.30.4	NSW Health, <i>NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025</i>	MOH.0014.0243.0001	December 2020
I.30.5	Southern NSW LHD, <i>Aboriginal Mental Health & Wellbeing Strategy 2020-2025, Implementation plan</i>	MOH.0010.0426.0001	2020 - 2025
I.30.6	Southern NSW LHD, <i>Batemans Bay Community Health Clinical Services Plan</i>	MOH.0014.0246.0001	May 2023
I.30.7	Southern NSW LHD, <i>Clinical Services Plan 2023-2028</i>	MOH.0014.0244.0001	2023 - 2028
I.30.8	Southern NSW LHD, <i>Strategy 2026</i>	MOH.0010.0431.0001	2026
I.30.9	Southern NSW LHD, <i>Organisation Structure</i>	MOH.0010.0422.0001	Undated
I.30.10	Southern NSW LHD, <i>Facilities Map</i>	MOH.0010.0428.0001	Undated
I.31	Statement of Brian Bonham, General Manager, Southern NSW LHD	MOH.0011.0042.0001	7 August 2024
I.31.1	CV of Brian Bonham	MOH.0014.0231.0001	Undated
I.32	Statement of Bradley Scotcher, General Manager, Southern NSW LHD	MOH.0011.0043.0001	7 August 2024
I.32.1	CV of Bradley Scotcher	MOH.0014.0232.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
I.33	Statement of Dr Susie Piper, District Medical Lead for Paediatrics, Southern NSW LHD	MOH.0011.0044.0001	7 August 2024
I.33.1	CV of Dr Susie Piper	MOH.0010.0458.0001	Undated
I.34	Statement of Rebekah Bowman, District Midwifery Manager, Southern NSW LHD	MOH.0011.0045.0001	7 August 2024
I.34.1	CV of Rebekah Bowman	MOH.0014.0233.0001	August 2024
I.35	Statement of Dr Nathan Oates, Director, Prevocational Education and Training, Southern NSW LHD	MOH.0011.0046.0001	8 August 2024
I.35.1	CV of Dr Nathan Oates	MOH.0010.0459.0001	Undated
I.36	Statement of Serena Ayers, Network Director, Medical Services, Inland Network Southern NSW LHD	MOH.0011.0047.0001	8 August 2023
I.36.1	CV of Serena Ayers	MOH.0010.0461.0001	Undated
I.37	Statement of Peter Ryan, Chairperson, “Don’t Close Batemans Bay ED Committee”	SCI.0011.0334.0001	8 August 2024
I.37.1	Letter from the Hon. Ryan Park MP, Minister for Health M23/5389	SCI.0011.0335.0001	Undated
I.38	Statement of Dr Stuart Stapleton, ED Director Eurobodalla Health Service, Southern NSW LHD	MOH.0011.0048.0001	9 August 2024
I.38.1	CV of Dr Stuart Stapleton	MOH.0014.0242.0001	Undated
I.39	Statement of Valentine Wright	SCI.0011.0339.0001	12 August 2024
I.39.1	Valentine Wright Presentation	SCI.0011.0337.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
I.39.2	Eurobodalla Shire Council Minutes, Ordinary Meeting of Council	SCI.0011.0336.0001	30 April 2024
I.40	Statement of Jennifer Gordon, Manager SENSW Regional Training Hub, Rural Clinical School, ANU Medical School, ANU College of Medicine and Psychology	SCI.0011.0349.0001	13 August 2024
I.40.1	CV of Jennifer Gordon	SCI.0011.0338.0001	Undated
I.41	Statement of Dr Andrew Gibson, General Practitioner, Member of the “Don’t Close Batemans Bay Emergency Department Committee”	SCI.0011.0350.0001	13 August 2024
I.41.1	CV of Dr Andrew Gibson	SCI.0011.0340.0001	Undated
I.42	Statement of Prudence Buist, Chief Executive Officer, SENSW PHN	SCI.0011.0351.0001	14 August 2024
I.42.1	CV of Prudence Buist	SCI.0011.0343.0001	Undated
I.42.2	Regional Mental Health and Suicide Prevention Plan 2021	SCI.0011.0327.0001	2021
I.42.3	Lived Experience (Peer) Workforce Framework	SCI.0011.0330.0001	Undated
I.43	Statement of Andrew Gow, Director, Strategy and Performance, SENSW PHN	SCI.0011.0379.0001	14 August 2024
I.43.1	CV of Andrew Gow	SCI.0011.0378.0001	Undated
I.43.2	National Health Rural Alliance, <i>2024-2025 Pre-Budget Submission</i>	SCI.0011.0348.0001	25 January 2024
I.43.3	Rural Doctor’s Association Australia, <i>Make 2023 the ‘Year of Thinking Outside the Box’ on rural health, doctors urge</i> (Media Release)	SCI.0011.0347.0001	15 December 2022

Exhibit No.	Description	SCOI Number	Document Date
I.43.4	Jolyon Attwooll, <i>Government flags shift in fee-for-service model</i>	SCI.0011.0346.0001	23 January 2023
I.44	ACT Government and Southern NSW LHD, Secondment Agreement regarding Junior Medical Officers	MOH.0010.0462.0001	October 2023
I.45	Outline of evidence for Amanda Bock, Executive Director Rural and Regional, Health Infrastructure NSW	MOH.9999.1060.0001	12 April 2024

A.27: Tender Bundle J – Evidence of Prof Jenny May (August 2024)

Exhibit No.	Description	SCOI Number	Document Date
J.1	Statement of Prof Jennifer May, Director, Department of Rural health, University of Newcastle	SCI.0011.0384.0001	27 August 2024
J1.1	Annexure A – ABS GP Waiting Times	SCI.0011.0385.0001	2022 - 2023
J1.2	Annexure B – The Royal Australian College of General Practitioners General Practice Health of Nation 2023	SCI.0011.0386.0001	November 2023
J1.3	Annexure C – The pathway to more rural doctors the role of universities	SCI.0011.0387.0001	7 August 2023
J1.4	Annexure D – National Medical Workforce Strategy 2021-2031	SCI.0011.0388.0001	2021
J1.5	Annexure E – Extract of Report Preview for Hunter New England LHD Reports (FY 2024-2025)	SCI.0011.0393.0001	2024

Exhibit No.	Description	SCOI Number	Document Date
J1.6	Annexure F – Extract from a Lumos PowerPoint presentation	SCI.0011.0390.0001	Undated
J1.7	Annexure G – Extract from AIHW Rural and Remote Health	SCI.0011.0391.0001	Undated
J.2	Supply and Demand Study – General Practitioners in Australia (August 2024 – DOHAC)	SCI.0011.0392.0001	August 2024

A.28: Tender Bundle K – Northern New South Wales Hearings (September 2024)

Exhibit No.	Description	SCOI Number	Document Date
K.1	Northern NSW LHD, <i>Strategic Plan 2019-2024</i>	SCI.0011.0394.0001	2019
K.2	Corporate Governance Framework 2019	SCI.0011.0395.0001	31 September 2019
K.3	Aboriginal Health Action Plan 2021-2026	SCI.0011.0396.0001 (SCI.0011.0395.0001)	2021
K.4	Initial Budget Allocations 2023-2024	SCI.0011.0397.0001	September 2023
K.5	Auditors report and financial statements for the year ended 30 June 2023	SCI.0011.0398.0001	28 September 2023
K.6	<i>Service Agreement 2023-2024</i>	MOH.9999.0064.0001 (MOH.0100.0017.0001)	31 October 2023
K.6.1	<i>Service Agreement 2024-2025</i>	SCI.0011.0437.0001	22 August 2024
K.7	<i>Intentionally left blank</i>		
K.8	Northern NSW LHD, <i>By-Laws</i>	SCI.0011.0401.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
K.9	<i>Clinical Service Plan 2018-2022</i>	SCI.0011.0402.0001	April 2018
K.10	Mid North Coast LHD, <i>Aboriginal Health Plan 2019-2023</i>	SCI.0011.0403.0001	2019
K.11	Mid North Coast LHD, <i>Partnering with Consumers for Patient Safety & Quality Framework 2021-2026</i>	SCI.0011.0404.0001	2021
K.12	<i>Corporate Governance Framework</i>	SCI.0011.0405.0001	1 April 2021
K.13	Mid North Coast LHD, <i>By-Laws</i>	SCI.0011.0406.0001	10 September 2021
K.14	Mid North Coast LHD, <i>Year in Review 2022-2023</i>	SCI.0011.0407.0001	2022
K.15	<i>Employee Wellbeing Framework 2022-2024</i>	SCI.0011.0408.0001	2022
K.16	Mid North Coast LHD, <i>Strategic Plan 2022-2032</i>	SCI.0011.0409.0001 (MOH.0010.0599.0001)	July 2022
K.17	Mid North Coast LHD, <i>Strategy Map</i>	SCI.0011.0410.0001	July 2022
K.18	Mid North Coast LHD, <i>Initial Budget Allocation 2023-2024</i>	SCI.0011.0411.0001	2023
K.19	Mid North Coast LHD, <i>Expense Budget 2023-2024</i>	SCI.0011.0412.0001	September 2023
K.20	Mid North Coast LHD, <i>Safety and Quality Account 2022-2023</i>	SCI.0011.0413.0001	November 2023
K.21	Mid North Coast LHD, <i>Aboriginal Health Strategic Framework 2024-2034</i>	SCI.0011.0414.0001	2024

Exhibit No.	Description	SCOI Number	Document Date
K.22	Mid North Coast LHD, <i>Service Agreement 2024-2025</i>	SCI.0011.0415.0001 (MOH.0010.0598.0001)	31 July 2024
K.23	Hunter New England LHD, <i>Strategic Plan 2021-2026</i>	SCI.0011.0416.0001 (MOH.0010.0665.0001)	2021
K.24	Calvary Mater Service Agreement 2022-2023	SCI.0011.0417.0001	10 May 2023
K.25	Corporate Governance Attestation Statement	SCI.0011.0418.0001	19 July 2023
K.26	Hunter New England LHD, <i>Overall Budget Allocation 2024-2025</i>	SCI.0011.0419.0001	2024
K.27	Notes to the State Budget Schedule 2024-2025	SCI.0011.0420.0001	2024
K.28	Hunter New England LHD, <i>Service Agreement 2024-2025</i>	SCI.0011.0421.0001 (MOH.0010.0662.0002)	31 July 2024
K.29	KPI and Improvement Measures Data Supplement Part 1 of 2 – Version 1.2	SCI.0011.0422.0001	July 2024
K.30	KPI and Improvement Measures Data Supplement Part 2 of 2	SCI.0011.0423.0001	August 2024
K.30A	Service Delivery Agreement between HCoA Operations (Australia) Pty Ltd trading as John Flynn Gold Coast Private Hospital and Northern Rivers Area Health Service	MOH.0100.0021.0001_R	1 April 2011
K.31	Northern NSW Aboriginal Health Partnership Agreement Feb 2014-Dec 2015_100214_Signatures Redacted	MOH.0100.0019.0001	10 February 2014

Exhibit No.	Description	SCOI Number	Document Date
K.32	Memorandum of Agreement on Interstate Application of Mental Health Laws – between Queensland and NSW	MOH.0100.0012.0001	16 November 2018
K.33	Queensland and NSW Memorandum of Understanding for Cross-Border Collaboration	MOH.0100.0014.0001	15 December 2023
K.34	Statement of Tracey Maisey, Chief Executive, Northern NSW LHD	MOH.0011.0064.0001	9 September 2024
K.34.1	CV of Tracey Maisey	MOH.0010.0607.0001	Undated
K.35	Statement of Peter Carter, Board Chair, Northern NSW LHD	MOH.0011.0059.0001	5 September 2024
K.35.1	CV of Peter Carter	MOH.0010.0581.0001	Undated
K.35.2	Supplementary Statement of Peter Carter, Board Chair, Northern NSW LHD	MOH.0011.0074.0001	19 September 2024
K.36	Statement of Jennifer Richter, Nurse Manager, Nursing and Midwifery Workforce, Northern NSW LHD	MOH.0011.0056.0001	5 September 2024
K.36.1	CV of Jennifer Richter	MOH.0011.0052.0001	Undated
K.37	Statement of Kathryn Watson, A/Director Integrated Care and Allied Health, Northern NSW LHD	MOH.0011.0057.0001	5 September 2024
K.37.1	CV of Kathryn Watson	MOH.0010.0596.0001	Undated
K.38	Statement of Dr Ralph Cheng, Head of Medicine Department, Grafton Hospital, Northern NSW LHD	MOH.0011.0067.0001	11 September 2024
K.38.1	CV of Dr Ralph Cheng	MOH.0010.0637.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
K.39	Statement of Dr Robert Davies, Director of Emergency Medicine, Tweed Valley Hospital, Northern NSW LHD	MOH.0011.0072.0001	16 September 2024
K.39.1	CV of Dr Robert Davies	MOH.0010.0539.0001	Undated
K.40	Statement of Tracey McCosker PSM, Chief Executive, Hunter New England LHD	MOH.0011.0062.0001	13 September 2024
K.40.1	CV of Tracey Lee McCosker	MOH.0010.0536.0001	Undated
K.41	Statement of Dr David Scott, Physician and Gastroenterologist Visiting Medical Officer and Chair of Medical Staff Council, Hunter New England LHD	MOH.0011.0055.0001	4 September 2024
K.41.1	CV of Dr David Robert Scott	MOH.0010.0538.0001	Undated
K.42	Statement of David Quirk, General Manager, Rural and Regional Health Services, Hunter New England LHD	MOH.0011.0053.0001	4 September 2024
K.42.1	CV of David Quirk	MOH.0010.0595.0001	Undated
K.43	Statement of Susan Heyman, Executive Director, Clinical Operations, Hunter New England LHD	MOH.0011.0054.0001	5 September 2024
K.43.1	CV of Susan Lee Heyman	MOH.0010.0535.0001	Undated
K.44	Statement of Tony Gilbertson, Executive Director, Finance, Hunter New England LHD	MOH.0011.0065.0001	9 September 2024
K.44.1	CV of Tony Gilbertson	MOH.0010.0609.0001	Undated
K.45	<i>Intentionally left blank</i>		

Exhibit No.	Description	SCOI Number	Document Date
K.46	Statement of Dr Chris Levi, Director, Learning Health Systems, John Hunter Health and Innovation Precinct and Executive Director, Research and Innovation, Hunter New England LHD	MOH.0011.0070.0001	13 September 2024
K.46.1	CV of Dr Chris Levi	MOH.0010.0634.0001	Undated
K.47	Statement of Dr Paul Craven, Executive Director of Children, Young People and Families, Medical Services, and of Networks and Streams, Hunter New England LHD	MOH.0011.0063.0001	6 September 2024
K.47.1	CV of Dr Paul Craven	MOH.0002.0005.0001	Undated
K.48	Statement of A/Prof Martin Cohen, Board Chair, Hunter New England LHD	MOH.0011.0073.0001	16 September 2024
K.48.1	CV of A/Prof Martin Cohen	MOH.0010.0588.0001	Undated
K.49	<i>Intentionally left blank</i>		
K.50	Statement of Robyn Martin, Director, Aboriginal Health and Primary Partnerships, Mid North Coast LHD	MOH.0011.0058.0001	5 September 2024
K.50.1	CV of Robyn Martin	MOH.0010.0590.0001	Undated
K.51	Statement of Taresa Rosten, Director, People and Culture, Mid North Coast LHD	MOH.0011.0060.0001	6 September 2024
K.51.1	CV of Tara Rosten	MOH.0010.0636.0001	Undated
K.52	Statement of Jill Wong, District Director Integrated Care, Allied Health and Community Services, Mid North Coast LHD	MOH.0011.0061.0001	6 September 2024
K.52.1	CV of Jill Wong	MOH.0010.0540.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
K.53	Statement of John Slaven, Director, Finance and Performance, Mid North Coast LHD	MOH.0011.0066.0001	11 September 2024
K.53.1	CV of John Slaven	MOH.0010.0597.0001	Undated
K53A	Statement of Lydia Dennett, General Manager, Coffs Harbour Health Campus, Coffs Network Coordinator, Mid North Coast LHD	MOH.0011.0068.0001	12 September 2024
K53A.1	CV of Lydia Dennett	MOH.0010.0610.0001	Undated
K53B	Statement of Stewart Dowrick, Chief Executive, Mid North Coast LHD	MOH.0011.0069.0001	12 September 2024
K53B.1	CV of Stewart Dowrick	MOH.0010.0605.0001	Undated
K.54	Statement of Peter Treseder AO, Board Chair, Mid North Coast LHD	MOH.0011.0071.0001	13 September 2024
K.54.1	CV of Peter Treseder AO	MOH.0010.0589.0001	Undated
K.54.2	Supplementary Statement of Peter Treseder, Board Chair, Mid North Coast LHD	MOH.0011.0075.0001	20 September 2024
K.55	Policy Directive PD2012_042 – Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients	MOH.0010.0643.0001	25 July 2012
K.56	Policy Directive – PD2017_034 – Aboriginal Health Impact Statement	MOH.0010.0646.0001	29 September 2017
K.57	Policy Directive – PD2018_011 – Critical Care Tertiary Referral Networks and Transfer of care (ADULTS)	MOH.0010.0580.0001	28 March 2018

Exhibit No.	Description	SCOI Number	Document Date
K.58	Policy Directive PD2019_006 –Employment and Management of Locum Medical Officers by NSW Public Health Organisations	MOH.0011.0005.0001	1 February 2019
K.58.1	Hunter New England LHD, <i>By-Laws</i>	MOH.0010.0661.0001	April 2019
K.59	Partners in Health – A Community Engagement Framework for Northern NSW LHD	MOH.0010.0611.0001	May 2019
K.60	Northern NSW LHD, <i>Strategic Plan 2019-2024</i>	MOH.0010.0626.0001	2019
K.61	Northern NSW LHD, <i>Research Strategic Plan 2019-2024</i>	MOH.0010.0625.0001	2019
K.61.1	Mid North Coast LHD, <i>Service Planning: Bellinger River District Hospital</i>	MOH.0010.0602.0001	November 2020
K.61.2	Mid North Coast LHD, <i>Service Planning – Wauchope District Memorial Hospital</i>	MOH.0010.0603.0001	November 2020
K.62	Northern NSW LHD, <i>Board Development Plan –Proposed KPIs</i>	MOH.0010.0582.0001	October 2021
K.63	Northern NSW LHD, <i>Board Development Working Party: Notes of Implementation Meeting</i>	MOH.0010.0583.0001	23 November 2021
K.64	Policy Directive PD2022_028 – Aboriginal Cultural Training – Respecting the Difference	MOH.0010.0644.0001	15 July 2022
K64A	Port Macquarie Base Hospital Clinical Services Plan – Final	MOH.0010.0601.0001	15 September 2022
K.65	Northern NSW LHD, <i>Virtual Care Strategy 2021-2026</i>	MOH.0010.0623.0001	September 2022

Exhibit No.	Description	SCOI Number	Document Date
K.66	Mid North Coast LHD, <i>Strategic Plan 2022-2032</i>	MOH.0010.0599.0001	2022
K.67	Hunter New England LHD, <i>Media Alert – Temporary reduction of services at Wee Waa Health Service</i>	MOH.0010.0593.0001	20 April 2023
K.68.	Policy Directive PD2023-046 – Aboriginal Workforce Composition	MOH.0010.0642.0001	18 December 2023
K.69.	Aboriginal Health Performance Report 2022-23 Mid North Coast LHD	MOH.0010.0645.0001	2023
K.70	Memorandum of Understanding between Healthy North Coast and Mid North Coast LHD and Northern NSW LHD	MOH.0010.0585.0001 (MOH.0010.0604.0001)	6 February 2024
K.70.1	Appendix 1 to Memorandum of Understanding between Healthy North Coast, Mid North Coast LHD and Northern NSW LHD – Schedule of Works	MOH.0010.0670.0001	18 March 2024
K.71	Northern NSW LHD, <i>Terms of Reference – Community Partnership Advisory Council</i>	MOH.0010.0617.0001	February 2024
K.72	Northern NSW LHD, <i>Terms of Reference – Tweed Community Advisory Group</i>	MOH.0010.0631.0001	February 2024
K.73	Northern NSW LHD, <i>Community Advisory Group evaluation</i>	MOH.0010.0612.0001	February 2024
K.74	Information Bulletin IB2024_013 – Adult Critical and Specialist Care Interhospital Transfer	MOH.0010.0579.0001	6 March 2024

Exhibit No.	Description	SCOI Number	Document Date
K.75	Northern NSW LHD, <i>Health Care Services Plan – Priority Focus Areas</i>	MOH.0010.0622.0001	March 2024
K.76	Letter from Northern NSW LHD to Tweed Shire Council	MOH.0010.0651.0001	8 May 2024
K.77	Mid North Coast Aboriginal Health Accord 2024-2029	MOH.0010.0640.0001	12 June 2024
K.78	Memorandum of Understanding between Bulgarr Ngaru Medical Aboriginal Corporation and Northern NSW LHD – Chronic Care for Aboriginal People Program	MOH.0010.0620.0001_R	5 July 2024
K.79	Letter from Special Commission of Inquiry into Healthcare Funding to Crown Solicitor's Office re topics for September hearing	MOH.0010.0542.0001_R	14 August 2024
K.80	Strengthening Local Health Committees across Hunter New England LHD	MOH.0010.0594.0001 (MOH.0010.0664.0001)	21 August 2024
K.81	Letter from Special Commission of Inquiry into Healthcare Funding to Crown Solicitor's Office re witnesses for September hearing	MOH.0010.0541.0001_R	22 August 2024
K.81.1	KPI and Improvement Measures Data Supplement Part 1 of 2 – Version 1.3	MOH.0010.0663.0001_R	August 2024
K.82	Northern NSW LHD, <i>Model By-Laws</i>	MOH.0010.0628.0001	August 2024
K.83	Guide to the Mid North Coast Aboriginal Health Accord 2024-2029	MOH.0010.0641.0001	2024

Exhibit No.	Description	SCOI Number	Document Date
K.84	Darrundaygirr darruyaygam maabu-daariwaygam Girrwaanbigundi – Aboriginal Health Strategic Framework 2024-2034	MOH.0010.0648.0001	2024
K.85	Northern NSW LHD, <i>Hospitals and Multipurpose Services</i>	MOH.0010.0619.0001	2024
K.85.1	Mid North Coast LHD, <i>Draft Organisational Performance Framework</i>	MOH.0010.0633.0001	2024
K.85.2	Hunter New England LHD, <i>Board committee schedule 2024</i>	MOH.0010.0666.0001	2024
K.86	Prevalence of long-term health conditions in Northern NSW LHD	MOH.0010.0630.0001	Undated
K.87	Map of Northern NSW LHD	MOH.0010.0621.0001	Undated
K.88	Northern NSW LHD, <i>Aboriginal Health Steering Committee – Terms of Reference</i>	MOH.0010.0632.0001	Undated
K.89	Northern NSW LHD, <i>Aboriginal Health Promotion</i>	MOH.0010.0615.0001	Undated
K.90	Northern NSW LHD, <i>Aboriginal Chronic Care Program</i>	MOH.0010.0616.0001	Undated
K.91	Northern NSW LHD, <i>Aboriginal Palliative Care Services</i>	MOH.0010.0627.0001	Undated
K.92	Northern NSW LHD, <i>Aboriginal Hospital Liaison Officer</i>	MOH.0010.0613.0001	Undated
K.93	Better Health Outcomes for North Coast Communities – Tool for reporting progress on the memorandum of understanding	MOH.0010.0584.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
K.94	Hunter New England LHD organisational structure	MOH.0010.0533.0001	Undated
K.95	Hunter New England LHD organisational structure – Finance	MOH.0010.0608.0001	Undated
K.96	Hunter New England LHD Clinical Networks and Streams	MOH.0010.0534.0001	Undated
K.97	Map of Hunter New England LHD	MOH.0010.0592.0001	Undated
K.98	Hunter New England LHD Hospital Facilities	MOH.0010.0652.0001	Undated
K.99	Hunter New England LHD Organisational structure	MOH.0010.0638.0001	Undated
K.100	Mid North Coast LHD, <i>Finance and Performance Organisational Chart</i>	MOH.0010.0635.0001	Undated
K.101	Mid North Coast LHD, <i>Planning and Accountability Framework</i>	MOH.0010.0600.0001	Undated
K.102	Bringing Clinical Trials to the Bush – improving access to innovating healthcare in rural, regional and remote NSW and ACT	MOH.0010.0657.0001	Undated
K.103	Mid North Coast LHD, <i>Governing Board Charter</i>	MOH.0010.0654.0001	Undated
K.104	Statement of Dr Shehnarz Salindera, General Surgeon, Coffs Harbour Hospital	SCI.0011.0342.0001	8 August 2024
K.105	Statement of Richard Nankervis, Chief Executive Officer, HNECC and Dr Alison Koschel, Executive Manager Populations, Access and Performance, HNEECC	SCI.0011.0433.0001	16 September 2024

Exhibit No.	Description	SCOI Number	Document Date
K.105.1	Annexure A – CV of Richard Nankervis	SCI.0012.0192.0001_R	Undated
K.105.2	Annexure B – CV of Dr Alison Koschel	SCI.0012.0191.0001_R	Undated
K.106	Outline of evidence for Dr Miriam Grotowski, Clinical Dean, Peel Clinical School, University of Newcastle	SCI.0011.0438.0001	18 September 2024
K.107	The value of extended short-term medical placements in smaller rural and remote locations on future work location: a cohort study	SCI.0011.0439.0001	16 January 2023
K.108	Hunter New England LHD – Rural Clinician Accommodation Strategy – Dr Ramsey Awad	MOH.0010.0667.0001	September 2024
K.109	HNELD – Sustainable Healthcare Together Towards Zero – Dr Ramsey Awad	MOH.0010.0668.0001	September 2024
K.110	Arunima Malik et al, 'The carbon footprint of Australian health care' (2018) 2 <i>Lancet Planet Health</i> e27-35	SCI.0011.0440.0001	January 2018
K.111	Institute for Healthcare Improvement White Paper – Framework for Effective Board Governance of Health System Quality	SCI.0011.0442.0001	2018
K.112	Hunter New England and Central Coast PHN General Practice Viability Insights Report	SCI.0011.0444.0001	July 2024
K.113	Hunter New England and Central Coast PHN Needs Assessment and Planning	SCI.0011.0445.0001	Undated

Exhibit No.	Description	SCOI Number	Document Date
K.114	Hunter New England and Central Coast PHN Core Needs Assessment 2022-2025	SCI.0011.0446.0001	Undated
K.115	Hunter New England and Central Coast PHN Core Needs Assessment 2022-2025 – Summary Version	SCI.0011.0447.0001	Undated

A.29: Tender Bundle L – Workforce 2 Hearings (October 2024)

Exhibit No.	Description	SCOI Number	Document Date
L.1	Statement of Jacqueline Dominish OAM, Director, Health Professionals Workforce, Ministry of Health	MOH.0011.0078.0001	2 October 2024
L.1.1	Annexure A – Emergency Department Paramedic – Mudgee Health Service Pilot	MOH.0010.0673.0001	Undated
L.1.2	Annexure B – Paramedicine Scope of Practice – Mudgee Health Service Pilot	MOH.0010.0674.0001	Undated
L.2	Statement of Justine Harris, Chief Medical Workforce Advisor, Ministry of Health	MOH.0011.0077.0001	2 October 2024
L.2.1	CV of Justine Harris	MOH.0010.0672.0001	2 October 2024
L.2.2	Annexure A – Final Recommendations of the Review of Trainees	MOH.0010.0676.0001	November 2020
L.2.3	Annexure B – Role Description of Medical Support Officer	MOH.0010.0677.0001	Undated
L.2.4	Annexure C – International Medical Graduate Clinical Readiness Report	MOH.0010.0678.0001	April 2024
L.3	Statement of Luke Sloane, Deputy Secretary, Rural and	MOH.0011.0079.0001	3 October 2024

Exhibit No.	Description	SCOI Number	Document Date
	Regional Health, Ministry of Health		
L.3.1	Annexure A – Strengthening Local Health Committees in Regional NSW Report	MOH.0010.0685.0001	February 2023
L.3.2	Independent Evaluation of the Rural Health Multidisciplinary Training Program – Summary of Final Report to the Commonwealth Department of Health	MOH.0010.0687.0001	June 2020
L.3.3	Rural training pathways: the return rate of doctors to work in the same region as their basic medical training	MOH.0010.0688.0001	22 October 2018
L.3.4	Primary Health Network (PHN) Cooperative Response to Consultation on Thin Markets in Regional and Remote Australia Contact	MOH.0010.0689.0001	20 October 2023
L.4	Statement of Dr Josephine Burnand, Acting Medical Director, HETI	MOH.0011.0080.0001	4 October 2024
L.4.1	Annexure A – Rural Preferential Recruitment Procedure	MOH.0010.0684.0001	March 2024
L.5	Statement of Melissa Collins, Acting Executive Director, Workplace Relations, Ministry of Health	MOH.0011.0081.0001	4 October 2024
L.5.1	Annexure A – Roll up Allowances – Total HSU	MOH.0010.0681.0001	Undated
L.5.2	Annexure B – ASMOF NSW Award Reform Claims	MOH.0010.0686.0001	12 August 2024
L.6	Statement of Philip Minns, Deputy Secretary, People, Culture and Governance, Ministry of Health	MOH.0011.0082.0001	8 October 2024

Exhibit No.	Description	SCOI Number	Document Date
L.6.1	Annexure A – Supply and Demand Study – General Practitioners	MOH.0010.0680.0001	August 2024
L.6.2	Annexure B – A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behaviour by Physicians	MOH.0010.0679.0001	July 2012
L.6.3	Supplementary Statement of Philip Minns, Deputy Secretary, People, Culture and Governance, Ministry of Health	MOH.0011.0085.0001	16 October 2024
L.6.4	Annexure A – Registrant Reconciliation Nurses NSW, Power Point Presentation	MOH.0010.0699.0001	11 September 2024
L.6.5	Annexure B – Registrant Reconciliation Midwives NSW, Power Point Presentation	MOH.0010.0700.0003	11 September 2024
L.6.6	Annexure C – Registrant Reconciliation Medical Practitioners, Power Point Presentation	MOH.0010.0701.0001	11 September 2024
L.6.7	Annexure D – Registrant Reconciliation Paramedics, Power Point Presentation	MOH.0010.0702.0001	11 September 2024
L.7	Statement of Richard Griffiths, Executive Director, Workforce Planning and Talent Development, Ministry of Health	MOH.0011.0083.0001	8 October 2024
L.7.1	Annexure A – Allied Health Workforce Educator Role – Project Report	MOH.0010.0683.0001	July 2024
L.8	Statement of Dr Michael Bonning, General Practitioner	SCI.0011.0275.0001	23 July 2024
L.8.1	Annexure A – Strengthening Care for Children (SC4C)	SCI.0011.0274.0001	28 September 2022
L.9	Statement of Dr Natalie Rainger, Consultant	SCI.0011.0286.0001	28 July 2024

Exhibit No.	Description	SCOI Number	Document Date
	Otolaryngologist and Head & Neck Surgeon		
L.10	Statement of Dr Sanjay Hettige, Radiologist, Nepean Hospital	SCI.0011.0287.0001	31 August 2024
L.11	Statement of Dr Nicola Holmes, General Practitioner	SCI.0011.0436.0001	16 September 2024
L.11.1	Annexure A – Letter to Sara Shaugnessy	SCI.0011.0425.0001	6 February 2019
L.11.2	Annexure B – Letter to Stewart Dowrick's secretary	SCI.0011.0426.0001	9 September 2022
L.11.3	Annexure C – Letter to Board CHHC/Mid North Coast LHD	SCI.0011.0424.0001	10 September 2023
L.11.4	Annexure D – Letter from Kim Edwards (Acting Director, Integrated Mental Health Alcohol and Other Drugs Services, Mid North Coast LHD)	SCI.0011.0427.0001_R	29 September 2023
L.11.5	Annexure E – Letter to MNCLHC Board	SCI.0011.0428.0001_R	23 March 2024
L.11.6	Annexure F – Letter from Delwyn Kruk (Manager Governance and Executive Services, Mid North Coast LHD)	SCI.0011.0429.001_R	11 April 2024
L.11.7	Annexure G – Mid North Coast LHD Early Psychosis Procedure	SCI.0011.0432.0001_R	19 May 2023
L.12	Statement of Dr Nicholas Spooner, Director, Emergency Medicine, Wyong Hospital	SCI.0011.0448.0001	20 September 2024
L.13	Statement of Jerry Yik, Head of Policy and Advocacy, Advanced Pharmacy Australia and Dr Jonathan Penm, Vice Chair, NSW Branch Committee, Advanced Pharmacy Australia	SCI.0011.0459.0001	26 September 2024

Exhibit No.	Description	SCOI Number	Document Date
L.13.1	Annexure A – SHPA Standard of Practice – Clinical Pharmacy Services	SCI.0011.0449.0001	2013
L.13.2	Annexure B – NSW Health Workforce Plan 2022-2032	MOH.9999.3112.0001	2022
L.13.3	Annexure C – NSW Government Response Inquiry into the impact of ambulance ramping and access	SCI.0011.0451.0001	Undated
L.13.4	Annexure D – Multi-site Evaluation of Partnered Pharmacist Medication and in-hospital Length of Stay	SCI.0011.452.0001	Undated
L.13.5	Annexure E – Deakin University, Partnered Pharmacist Medication Charting (PPMC) Scaling Project	SCI.0011.0453.0001	2021
L.13.6	Annexure F – Clinical Excellence Commission Garling Inquiry NSW	SCI.0011.0454.0001	27 November 2008
L.13.7	Annexure G – Standard of Practice for Pharmacy Technicians to support Clinical Pharmacy Services	SCI.0011.0456.0001	12 November 2019
L.13.8	Annexure H – Australian Universities Accord Final Report Summary Report (2024)	SCI.0010.0030.0001	23 February 2024
L.13.9	Annexure I – NSW Health Undergraduate Clinical Placement Grants 2024	SCI.0011.0458.0001	4 July 2024
L.14	Statement of Dr Matthew Ingram, Staff Specialist, Emergency Physician, Wyong Hospital	SCI.0011.0461.0001	27 September 2024
L.15	Statement of Gerard Hayes AM, Secretary, Health Services Union for NSW	SCI.0011.0464.0001	30 September 2024

Exhibit No.	Description	SCOI Number	Document Date
L.16	Statement of Andrew Holland, Executive Director, Australian Salaried Medical Officers Federation NSW	SCI.0011.0469.0001	30 September 2024
L.17	Statement of Dr Behny Samadi, Intensive Care Specialist, St George Hospital	SCI.0011.0465.0001	30 September 2024
L.18	Statement of University of Technology Sydney Experts (Prof Debra Anderson, Prof Kathleen Baird and Prof Toby Newton-John)	SCI.0011.0473.0001	1 October 2024
L.18.1	CV of Prof Debra Anderson	SCI.0011.0470.0001	1 October 2024
L.18.2	CV of Prof Kathleen Baird	SCI.0011.0471.0001	1 October 2024
L.18.3	CV of Prof Toby Newton-John	SCI.0011.0472.0001	1 October 2024
L.19	Statement of Lesley Horsburgh, Managing Director, Association of Professional Staffing Companies Australia	SCI.0011.0467.0001	1 October 2024
L.20	Statement of Dr Tom Morrison, Registrar, St Vincent's Hospital	SCI.0011.0478.0001	4 October 2024
L.20.1	CV of Dr Tom Morrison	SCI.0011.0475.0001	3 October 2024
L.21	<i>Intentionally left blank</i>		
L.22	<i>Using Coworker Observations to Promote Accountability for Disrespectful and Unsafe Behaviours by Physicians and Advanced Practice Professionals</i>	MOH.0010.0697.0001	April 2016
L.23	<i>Implementation of Peer Messengers to Deliver Feedback: An Observational Study to Promote Professionalism in Nursing, Journal Article</i>	MOH.0010.0694.0002	1 January 2023

Exhibit No.	Description	SCOI Number	Document Date
L.23.1	Deloitte AMA White Paper, <i>Medical Workforce Pressures in NSW</i>	SCI.0011.0490.0001	February 2023
L.24	<i>A Proposed Approach to Allegations of Sexual Boundary violation in Health Care</i>	MOH.0010.0691.0001	2023
L.25	<i>Physician Specialty Differences in Unprofessional Behaviours Observed and Reported by Coworkers</i>	MOH.0010.0696.0001	6 June 2024
L.26	NSWNMA, <i>Final Rapid Business Case Report</i>	SCI.0011.0462.0001	20 August 2024
L.27	<i>Leveraging Consistent Communication Tools and Organizational Values to Promote Accountability Among Health Care Providers, Journal Article</i>	MOH.0010.0695.0002	September 2024
L.27.1	<i>Final Report Midwifery Futures, Building the Future Australian Midwifery Workforce</i>	SCI.0011.0520.0001	October 2024
L.28	<i>An Effective Program to Reduce Malpractice Claims and Payments in a Large Orthopaedic Practice, Journal Article</i>	MOH.0010.0692.0002	2024

A.30: Tender Bundle M – Funding Hearings (November 2024)

Exhibit No.	Description	SCOI Number	Document Date
M.1	Submission of NSW Treasury	TRY.0001.0001.0001	11 November 2024
M.1.1	Letter From Secretary, NSW Treasury enclosing submission	TRY.0001.0002.0001_R	11 November 2024

Exhibit No.	Description	SCOI Number	Document Date
M.1.2	Report on Government Services 2024, Health (Part E)	SCI.0011.0528.0001	31 January 2024
M.1.3.1	IHACPA, Cost per NWAU (2020-2021) NSW	SCI.0011.0526.0001	Undated
M.1.3.2	IHACPA, Cost per NWAU (2020-2021) VIC	SCI.0011.0529.0001	Undated
M.1.3.3	IHACPA, Cost per NWAU (2020-2021) QLD	SCI.0011.0527.0001	Undated
M.1.4	AIHW, Health system Accessibility 2024 (Electronic copy only)	SCI.0011.0530.0001	Undated
M.1.5	BHI, Healthcare Quarterly April to June 2024	SCI.0011.0531.0001	September 2024
M.1.6	Queensland Health, Planned surgery performance 2024	SCI.0011.0532.0001	August 2024
M.1.7	Victorian Agency for Health Information, Planned surgery 2024	SCI.0011.0533.0001	Undated
M.1.8	Queensland Health, Emergency care performance 2024	SCI.0011.0534.0001	September 2024
M.1.9	Victorian Agency for Health Information, Emergency care 2024	SCI.0011.0524.0001	Undated
M.1.10	BHI Survey Results – Experiences of adults admitted to hospital in 2023	SCI.0011.0525.0001	August 2024
M.2	Statement of Prof Tracey O'Brien AM, Chief Cancer Officer and CEO, Cancer Institute NSW	MOH.0011.0087.0001	12 November 2024
M.2.1	CV of Prof Tracey O'Brien AM	MOH.0010.0722.0001	12 November 2024

Exhibit No.	Description	SCOI Number	Document Date
M.3	Statement of Wendy Hoey PSM, Chief Executive, Justice and Forensic Mental Health Network NSW	MOH.0011.0086.0001	13 November 2024
M.3.1	CV of Wendy Hoey PSM	MOH.0010.0723.0001	13 November 2024
M.4	Statement of Matthew Daly, Deputy Secretary, System Sustainability and Performance, Ministry of Health, Joe Portelli, Executive Director, System Purchasing Branch, Ministry of Health and Sharon Smith, Executive Director, System Information and Analytics Branch, Ministry of Health	MOH.0011.0089.0001	14 November 2024
M.4.1	CV of Joe Portelli	MOH.0010.0730.0001	14 November 2024
M.4.2	<i>Intentionally blank</i>		
M.4.3	NSW Budget Statement 2024-2025	SCI.0011.0545.0001	18 June 2024
M.4.4	Financial Requirement Conditions of Subsidy (Government Grants) for FY ending 30 June 2025	MOH.0010.0732.0001	30 September 2024
M.5	Statement of A/Prof Anthony Schembri AM, Chief Executive, Northern Sydney LHD	MOH.0011.0090.0001	13 November 2024
M.5.1	2024-2025 Service Agreement between NSW Health and Northern Sydney LHD	MOH.0010.0731.0001	1 August 2024

Exhibit No.	Description	SCOI Number	Document Date
M.6	Statement of Neville Onley, Director, Activity Based Funding Taskforce, NSW Health, Adjunct Prof Alfa D'Amato, Deputy Secretary and Chief Financial Officer, Financial Services and Asset Management, NSW Health and Steven Carr, Executive Director, System Financial Performance and Deputy Chief Financial Officer, NSW Health	MOH.0011.0091.0001	14 November 2024
M.6.1	Memorandum of Understanding between the Commonwealth of Australia and NSW in relation to the cooperative implementation of the Council of Australian Governments Improving Access to Primary Care in Rural and Remote Areas Initiative (COAG s 19(2) Exemptions Initiative)	MOH.0100.0288.0001	13 May 2022
M.6.2	Murrumbidgee LHD, 2024-2025 Service Agreement	SCI.0011.0576.0001	31 July 2024
M.6.3	NSW Treasury Policy and Guidelines TPG 21-11: Parameter and Technical Adjustments and New Policy Proposals (Measures)	SCI.0011.0579.0001	December 2021
M.6.4	NSW Budget 2016 – 17, Budget Paper No. 5, Intergenerational Report	SCI.0011.0572.0001	2016-2017
M.6.5	2024-2025 NSW Health Expense Budget	SCI.0011.0570.0001	2024-25
M.6.6	NSW Treasury Policy and Guidelines TPG 24-03: Agency Direction for the 2023-2024 Mandatory Early Close	SCI.0011.0573.0001	6 March 2024

Exhibit No.	Description	SCOI Number	Document Date
M.6.7	NSW Treasury Policy and Guidelines TPG 24-08 CFO Certification on the Internal Control Framework over Financial Systems and Information	SCI.0011.0580.0001	15 April 2024
M.6.8	NSW Treasury Policy and Guidelines TPG 24-17: Agency Direction for the 2023-2024 Mandatory Annual Returns to Treasury	SCI.0011.0581.0001	12 June 2024
M.6.9	NSW Treasury Policy and Guidelines TPG 24-33: Reporting framework for first year climate-related financial disclosures	SCI.0011.0582.0001	October 2024
M.6.10	Treasurer's Direction TD19-02: Mandatory Early Close as at 31 March each year	SCI.0011.0574.0001	19 March 2024
M.6.11	Treasurer's Direction TD21-02: Mandatory Annual Returns to Treasury	SCI.0011.0578.0001	June 2021
M.7	NSW Government Response – Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales	SCI.0011.0501.0001	4 September 2024
M.8	Regional Health Strategic Plan 2022-2032 – Progress Snapshot 2022-23	MOH.0100.0297.0001	1 November 2023
M.9	Small Hospitals Funding Model Review Report	MOH.0100.0294.0001	July 2024
M.10	Australian Medical Association, <i>Discussion paper: Public hospitals – Cycle of crisis</i>	SCI.0011.0548.0001	2021

Exhibit No.	Description	SCOI Number	Document Date
M.11	Australian Medical Association, <i>Discussion paper: Rethinking funding models to align with population health goals</i>	SCI.0011.0519.0001	2023
M.12	Macquarie University Centre for the Health Economy, 'Getting More Value from Mental Healthcare Funding and Investment'	SCI.0011.0502.0001	August 2023
M.13	Royal Australian College of General Practitioners, 'General Practice: Health of the Nation 2024'	SCI.0011.0506.0001	November 2023
M.14	David Peiris et al, 'Overcoming Silos in Health Care Systems through Meso-Level Organisations: A Case Study of Health Reforms in New South Wales, Australia'	SCI.0011.0494.0001	15 February 2024
M.15	AIHW, 'Australia's Health 2024: In Brief'	SCI.0011.0498.0001	2 July 2024
M.16	AIHW, 'Australia's Health 2024: Data Insights'	SCI.0011.0499.0001	2 July 2024
M.17	Alan Shiell et al, 'How Do We Fund Public Health in Australia? How Should We?'	SCI.0011.0495.0001	5 August 2024
M.18	Steve Robson, 'Our Hospitals Are Full of Patients Whose Surgeries Could Have Been Prevented'	SCI.0011.0497.0001	21 September 2024
M.19	KPMG, 'Economic impact of the broader adoption of virtual hospitals in Australia'	SCI.0011.0518.0001	September 2024
M.20	Prof Stephen Duckett, 'Report on Commonwealth-State financial arrangements in health care'	SCI.0011.0500.0001	13 September 2023

Exhibit No.	Description	SCOI Number	Document Date
M.20.1	Stephen Duckett, 'Chopping and changing Medibank part 1: Implementation of a new policy'	SCI.0011.0564.0001	1979
M.20.2	Stephen Duckett, 'Chopping and changing Medibank part 2: An interpretation of the policy making process'	SCI.0011.0568.0001	1980
M.20.3	Scott Bennett and Richard Webb, 'Specific purpose payments and the Australian federal system'	SCI.0011.0567.0001	2008
M.20.4	Stephen Duckett, 'Hospital payment arrangements to encourage efficiency: The case of Victoria, Australia'	SCI.0011.0569.0001_R	1995
M.20.5	Amanda Biggs, 'Recent developments in federal government funding for public hospitals: a quick guide'	SCI.0011.0565.0001	2018
M.20.6	Vijaya Lakshmi Ramamurthy, 'Australian federalism and the use of tied grants: case studies of public hospitals and schools'	SCI.0011.0566.0001	2012
M.20.7	J.R.G Butler, 'Specific Purpose Payments and the Commonwealth Grants Commission'	SCI.0011.0563.0001	1992
M.21	PWC, <i>Funding for value</i>	SCI.0011.0588.0001_R	2018
M.22	Nepean Blue Mountains LHD Financial Recovery Plan	MOH.0100.0283.0001	December 2021
M.23	Shoalhaven Financial Recovery Plan Recommendations	MOH.0100.0282.0001	April 2023
M.24	Northern NSW LHD Review	MOH.0100.0033.0001	August 2023

Exhibit No.	Description	SCOI Number	Document Date
M.25	Submission of Australian Institute of Health Innovation, Macquarie University	SCI.0011.0589.0001	31 October 2023
M.26	Submission of University of Technology Sydney	SCI.0011.0590.0001	31 October 2023
M.27	Mid North Coast LHD Review	MOH.0100.0034.0001	November 2023
M.28	Murrumbidgee LHD Review	MOH.0100.0280.0001	December 2023
M.29	Hunter New England LHD Review	MOH.0100.0035.0001	February 2024
M.30	NSW Ambulance data table and graph of percentage change for the number of Ambulance Officer FTE and Emergency Incidents by Financial Year	SCI.0011.0587.0001	2010/11-2023/24
M.31	AIHW analysis of the National Elective Surgery Waiting Times Data Collection	SCI.0011.0583.0001	2024

A.31: Tender Bundle N – Wrap-Up Hearings (December 2024)

Exhibit No.	Description	SCOI Number	Document Date
N1.1	Sax Institute, Expert Report 1 – Resource management in NSW Health	SCI.0011.0607.0001	29 November 2024
N1.2	Sax Institute, Expert Report 2 – Strengthening the focus on prevention of chronic disease through applying evidence-based insights	SCI.0011.0608.0001	29 November 2024

Exhibit No.	Description	SCOI Number	Document Date
N1.3	Sax Institute, Expert Report 3 – Building capabilities to drive health system improvements	SCI.0011.0605.0001	29 November 2024
N2.1	Statement of Damion Brown, Chief Executive Officer, Tamworth Aboriginal Medical Service, Aboriginal Corporation	SCI.0011.0434.0001	16 September 2024
N2.1.1	Annexure A – NSW Rural Doctors Network, State of Play of the GP Workforce in Gunnedah Shire	SCI.0011.0435.0001	15 February 2021
N2.2	Statement of Dian Edwards, Service Manager, Namatjira Haven Drug & Alcohol Healing Centre	SCI.0011.0491.0001	3 October 2024
N2.3	Transcript of ACCHO Virtual Roundtable	SCI.0011.0635.0001	27 November 2024
N2.4	Transcript of ACCHO In-Person Roundtable	SCI.0011.0637.0001	28 November 2024
N3.1	Interim Report on The Future Provision of Medical and Allied Services 1920	SCI.0011.0606.0001	May 1920
N3.2	Government response – Report No 57 – PC 2 – Health – Health outcomes and access to health and hospital services in rural, regional and remote New South Wales	SCI.0011.0516.0001	1 September 2022
N3.3	NSW Treasury NSW Public Private Partnership Policy and Guidelines – Preparation, Procurement and Contract Management TPG22-21	SCI.0011.0698.0001	October 2022
N3.4	<i>Intentionally left blank</i>		
N3.5	NSW Ministry of Health Schedule of Delegates	MOH.9999.1089.0001	1 April 2024

Exhibit No.	Description	SCOI Number	Document Date
N3.6	Statement of Dr Trevor Chan, Emergency Physician at St George Hospital, Clinical Director of Emergency Care Institute, ACI, and Co-Chair of NSW Health Emergency Department Taskforce	MOH.0006.0001.0001	17 June 2024
N3.6.1	Annexure A – CV of Dr Chan	MOH.0006.0002.0001	17 June 2024
N3.6.2	Annexure B – Emergency Department Taskforce Terms of Reference	MOH.0006.0003.0001	27 March 2024
N3.6.3	Annexure C – ED Taskforce Newsletter	MOH.0006.0004.0001	3 May 2024
N3.7	Statement of Karol Petrovska, Director, Virtual Care Unit, Ministry of Health	MOH.0006.0023.0001	17 June 2024
N3.7.1	Annexure A – CV of Karol Petrovska	MOH.0006.0019.0001	17 June 2024
N3.7.2	Annexure B – Virtual Care Strategy 2021-2026	MOH.0006.0020.0001	February 2022
N3.7.3	Annexure C – Virtual Care Services Guide	MOH.9999.2597.0001	May 2023
N3.7.4	Annexure D – TOR of the Virtual Care Steering Committee	MOH.0006.0022.0001	2023
N3.8	Statement of Prof Ian Alexander, Director Laboratory Research and Senior Staff Specialist, The Children's Hospital at Westmead, SCHN, Head, Gene Therapy Research Unit SCHN and Children's Medical Research Institute, Professor in Paediatrics and Molecular Medicine, University of Sydney	MOH.0006.0024.0001	17 June 2024
N3.8.1	Annexure A – CV of Prof Ian Alexander	MOH.0006.0037.0001	17 June 2024

Exhibit No.	Description	SCOI Number	Document Date
N3.9	Statement of Matthew Jennings, Director Allied Health, Liverpool Hospital, South Western Sydney LHD	MOH.0006.0018.0001	18 June 2024
N3.9.1	Annexure A – CV of Matthew Jennings	MOH.0006.0009.0001	18 June 2024
N3.9.2	Annexure B – ACI – MSK – Osteoarthritis Care Program model of care	MOH.0006.0010.0001	May 2019
N3.9.3	Annexure C – ACI – MSK – Osteoporotic refracture prevention model of care	MOH.0006.0011.0001	October 2017
N3.9.4	Annexure D – Lower Back Pain Model of Care	MOH.0006.0012.0001	May 2019
N3.9.5	Annexure E – South Western Sydney LHD Older Persons and Rehabilitation Plan to 2027	MOH.0006.0013.0001	Undated
N3.9.6	Annexure F – South Western Sydney LHD Advance Care Planning End of Life Palliative care Strategic Plan 2016-2021	MOH.0006.0014.0001	January 2016
N3.9.7	Annexure G– NSW Health End of Life and Palliative Care Framework 2019-2024	MOH.0006.0015.0001	February 2019
N3.9.8	Annexure H – A Framework to Evaluate Musculoskeletal Models of Care	MOH.0006.0016.0001	Undated
N3.9.9	Annexure I – “Implementing models of care for musculoskeletal conditions in health systems to support value-based care”, Best Practice & Research Clinical Rheumatology 34 (2020) 101548	MOH.0006.0017.0001	25 July 2020

Exhibit No.	Description	SCOI Number	Document Date
N3.10	Statement of Olivia Hibbitt, Director, Specialty Service and Technology Evaluation Unit, Ministry of Health	MOH.0006.0008.0001	18 June 2024
N3.10.1	Annexure A – CV of Olivia Hibbitt	MOH.0006.0005.0001	18 June 2024
N3.10.2	Annexure B – Terms of Reference – New Technology and Specialised Services Committee March 2023	MOH.0006.0006.0001	August 2022
N3.10.3	Annexure C – Framework for the assessment, funding and implementation of high cost, highly specialist therapies and services	MOH.0006.0007.0001	April 2024
N3.11	Statement of Dr Nhi Nguyen, Intensive Care Staff Specialist, Clinical Lead, Nepean Redevelopment, and Board Member, Nepean Blue Mountains LHD, Clinical Director, Intensive Care NSW, ACI, Co-Chair, NSW Health System Advisory Council	MOH.0006.0036.0001	18 June 2024
N3.11.1	Annexure A – CV of Dr Nhi Nguyen	MOH.0006.0025.0001	18 June 2024
N3.11.2	Annexure B – ACI – Intensive Care Service Model: NSW Level 4 Adult ICUs	MOH.0006.0026.0001	November 2020
N3.11.3	Annexure C – ACI – Intensive Care Service Model: NSW Level 4 Adult ICUs Implementation Guide	MOH.0006.0027.0001	November 2020
N3.11.4	Annexure D – ACI – ICNSW – NSW Intensive Care Service Model: Patient Feedback	MOH.0006.0028.0001	November 2020
N3.11.5	Annexure E – ACI – ICNSW – NSW Intensive Care Service Model: Staff Feedback	MOH.0006.0029.0001	November 2020

Exhibit No.	Description	SCOI Number	Document Date
N3.11.6	Annexure F – ACI – ICNSW – ICU Exit Block Project – Evidence Review	MOH.0006.0030.0001	9 February 2019
N3.11.7	Annexure G – ACI – ICNSW – Addressing ICU Exhibit Block: right care, right patient, right place	MOH.0006.0031.0001	November 2020
N3.11.8	Annexure H – ACI– ICNSW – Guiding principles to optimise intensive care capacity, A whole of hospital approach to improving patient flow October 2019	MOH.0006.0032.0001	October 2019
N3.11.9	Annexure I – ACI – ICNSW – Guiding principles to optimise intensive care capacity	MOH.0006.0033.0001	November 2020
N3.11.10	Annexure J – ACI – ICNSW – Managing high acuity child outside a tertiary children's hospital key principles	MOH.0006.0034.0001	June 2024
N3.11.11	Annexure K – ACI – ICNSW – Intensive Care NSW Forum Program	MOH.0006.0035.0001 _R	11 June 2024
N3.12	Statement of Adjunct Prof Jean-Frédéric Levesque, Deputy Secretary, Clinical Innovation and Research, Ministry of Health and Chief Executive, ACI	MOH.0006.0038.0001	19 June 2024
N3.12.1	Annexure A – AI Taskforce Terms of Reference	MOH.0006.0039.0001	8 February 2024
N3.12.2	Annexure B – NSW Health Directors of Research Committee Terms of Reference	MOH.0006.0040.0001	Undated
N3.12.3	Annexure C – Innovation Executive Strategic Committee Terms of Reference	MOH.0006.0041.0001	July 2023

Exhibit No.	Description	SCOI Number	Document Date
N3.12.4	Annexure D – Evidence and utilisation of spinal cord injury services in NSW	MOH.0006.0042.0001	August 2020
N3.12.5	Annexure E – ACI Prioritisation Toolkit	MOH.0006.0043.0001	August 2022
N3.12.6	Annexure F – NSW Government AI Assurance Framework	MOH.0006.0044.0001	Undated
N3.13	Progress Report – Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales	SCI.0011.0517.0001	30 June 2024
N3.14	<i>Intentionally left blank</i>		
N3.15	NSW Health Guide to the Role Delineation of Clinical Services	SCI.0011.0598.0001	1 August 2024
N3.16	Statement of Emma Skulander, Acting Chief Executive, Health Infrastructure NSW	MOH.0011.0084.0001	15 October 2024
N3.16.1	CV of Emma Skulander	MOH.0010.0698.0001	15 October 2024
N3.16.2	Annexure D – NSW Government Media Release re Boost to Rural Health Worker Accommodation	MOH.0010.0690.0001	17 June 2024
N3.17	Rosemary Huxtable AO PSM, <i>Mid-Term Review of the National Health Reform Agreement Addendum 2020-2024 – Final Report</i>	SCI.0011.0585.0001	24 October 2024
N3.18	Health Statistics NSW, Daily Smoking in Adults	SCI.0011.0709.0001	Undated
N3.19	Health Statistics NSW, E-cigarette use (vaping)	SCI.0011.0710.0001	Undated
N3.20	AIHW, Overweight and Obesity Web Report	SCI.0011.0711.0001	17 June 2024

Exhibit No.	Description	SCOI Number	Document Date
N3.21	Health Statistics NSW, Overweight and obesity in adults	SCI.0011.0712.0001	Undated
N3.22	Health Statistics NSW, Overweight and Obesity in Children	SCI.0011.0713.0001	Undated
N3.23	ABS, National Study of Mental Health and Wellbeing, 2020-2022	SCI.0011.0714.0001	5 October 2023
N3.24	Health Statistics NSW, High or Very High Psychological Distress in Adults	SCI.0011.0715.0001	Undated
N3.25	Cancer Institute NSW, Cancer incidence, mortality and relative survival	SCI.0011.0716.0001	Undated
N3.26	Submission of Prof Kathy Eagar, University of New South Wales, to Special Commission of Inquiry into Healthcare Funding	SCI.0011.0718.0002_R	October 2023
N3.27	NSW Health Annual Report 2023-24	SCI.0011.0717.0001	October 2024
N3.28	Statement of Scott McLachlan, Chief Executive, Central Coast LHD	MOH.0011.0095.0001	9 December 2024
N3.28.1	Annexure A - CV of Scott McLachlan	MOH.0010.0736.0001	Undated
N3.29	Statement of Dr Jan Fizzell, Acting Chief Health Officer and Deputy Secretary, Population and Public Health, Ministry of Health	MOH.0011.0094.0001	9 December 2024
N3.29.1	Annexure A – CV of Dr Jan Fizzell	MOH.0010.0746.0001	Undated
N3.29.2	Annexure B – Return on Investment of Public Health Interventions, Journal Article	MOH.0010.0747.0001	7 March 2024

Exhibit No.	Description	SCOI Number	Document Date
N3.29.3	Annexure C – The Value of Prevention Report, The Australian Prevention Partnership	MOH.0010.0748.0001	February 2024
N3.29.4	Annexure D – Economic Benefits of Reducing Childhood and Adolescent Overweight and Obesity in Australia, Journal Article	MOH.0010.0749.0001	October 2024
N3.29.5	Annexure E – What are the Monetary Returns of Investing in Programs that reduce Demand for Illicit Drugs, Trends & Issues in Crime & Criminal Justice, Australian Institute of Criminology	MOH.0010.0750.0001	September 2022
N3.29.6	Annexure F – Ace-Prevention Pamphlets Series, Pamphlet 1 Cost-Effectiveness of Prevention in the General Population, The University of Queensland	MOH.0010.0751.0001	Undated
N3.29.7	Annexure G - Paving a new Pathway to Prevention, NHS Confederation	MOH.0010.0752.0001	October 2024
N3.30	Joint Statement of Ashley Brown, Phillip Bannon and Nathan Jones, The Centre for Aboriginal Health	MOH.0011.0096.0001	10 December
N3.30.1	Annexure A – CV of Ashley Brown	MOH.0010.0743.0001	Undated
N3.30.2	Annexure B – CV of Nathan Jones	MOH.0010.0744.0001	Undated
N3.30.3	Annexure C – CV of Phillip Bannon	MOH.0010.0745.0001	Undated
N3.31	NSW Aboriginal Health Plan 2024-2034 Sharing Power in System Reform, NSW Health	SCI.0011.0744.0001	2024

Exhibit No.	Description	SCOI Number	Document Date
N3.32	NSW Budget Paper No. 2 2014-2015	SCI.0011.0741.0001	13 June 2014
N3.33	NSW Budget Paper No. 1 2015-2016	SCI.0011.0722.0001	19 June 2015
N3.34	NSW Budget Paper No. 1 2016-2017	SCI.0011.0723.0001	16 June 2016
N3.35	NSW Budget Paper No. 1 2017-2018	SCI.0011.0724.0001	16 June 2017
N3.36	NSW Budget Paper No. 1 2018-2019	SCI.0011.0730.0001	30 June 2018
N3.37	NSW Budget Paper No. 1 2019-2020	SCI.0011.0725.0001	18 June 2019
N3.38	NSW Budget Paper No. 1 2020-2021	SCI.0011.0726.0001	November 2020
N3.39	NSW Budget Paper No. 1 2021-2022	SCI.0011.0727.0001	22 June 2021
N3.40	NSW Budget Paper No. 1 2022-2023	SCI.0011.0728.0001	21 June 2022
N3.41	NSW Budget Paper No. 1 2023-2024	SCI.0011.0729.0001	19 September 2023
N3.42	NSW Budget Paper No. 1 2024-2025	SCI.0011.0545.0001	18 June 2024
N3.43	NSW Budget Paper No. 2 2024-2025	SCI.0011.0570.0001	18 June 2024
N3.44	National Health Funding Body Annual Report 2023-2024	SCI.0011.0745.0001	20 September 2024
N3.45	IHACPA response to request for information from the NSW Special Commission of Inquiry into Healthcare Funding	SCI.0011.0748.0001	11 December 2024
N3.46	NSW Health Revised Budget Data Report	MOH.0010.0753.0001	10 December 2024

A.32: Supplementary Tender Bundle N (January 2025)

Exhibit No.	Description	SCOI Number	Document Date
N4.1	First Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals – Inquiry into the circumstances of the appointment of Graeme Reeves by the former Southern Area Health Service	SCI.0011.0777.0001	31 July 2008
N4.2	Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals: Overview	SCI.0011.0756.0001	27 December 2008
N4.3	Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals: Volume 1	SCI.0011.0758.0001	27 December 2008
N4.4	Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals: Volume 2	SCI.0011.0760.0001	27 December 2008
N4.5	Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals: Volume 3	SCI.0011.0762.0001	27 December 2008
N4.6	Outline of evidence for Bruno Zinghini, Executive Director Western Region, Health Infrastructure NSW	MOH.9999.1063.0001	12 April 2024
N4.6.1	List of exhibits to Outline of evidence for Bruno Zinghini	MOH.9999.1065.0001	15 April 2024
N4.6.2	Campbelltown Hospital Redevelopment – Project Governance Arrangements	MOH.9999.1066.0001	March 2018
N4.6.3	NSW Health Policy Directive – Process of Facility Planning	MOH.9999.1067.0001	7 June 2010
N4.6.4	Campbelltown Hospital Redevelopment – Stage Two Masterplan Report	MOH.9999.1069.0001	24 January 2018

Exhibit No.	Description	SCOI Number	Document Date
N4.6.5	Campbelltown Hospital Redevelopment Project – Value Management Study Report	MOH.9999.1070.0001	November 2017
N4.6.6	Campbelltown Hospital Stage Two Redevelopment – Functional Design Brief	MOH.9999.1071.0001	March 2018
N4.6.7	Cost Plan Review for Business Case – Campbelltown Hospital Redevelopment – Stage Two	MOH.9999.1072.0001	9 May 2018
N4.6.8	Campbelltown Hospital Redevelopment – Stage Two Concept Design Report – Volume 1	MOH.9999.1073.0001	30 April 2018
N4.6.9	Campbelltown Hospital Redevelopment – South Western Sydney LHD –Project Resource Schedule	MOH.9999.1074.0001	9 May 2018
N4.6.10	Campbelltown Hospital Redevelopment – Workforce Plan	MOH.9999.1075.0001	12 March 2018
N4.6.11	Campbelltown Hospital Redevelopment – Risk Management Plan	MOH.9999.1076.0001	March 2018
N4.6.12	Campbelltown Hospital Redevelopment – Benefits Realisation Plan – Parts A and B	MOH.9999.1077.0001	March 2018
N4.6.13	Campbelltown Hospital Redevelopment – Change Management Strategy 2018 to 2023	MOH.9999.1078.0001	9 May 2018
N4.6.14	Campbelltown Hospital Redevelopment – Communication and Engagement Plan	MOH.9999.1079.0001	March 2017
H4.6.15	Campbelltown Hospital Redevelopment – Delivery and Procurement Strategy	MOH.9999.1080.0001	March 2018

Exhibit No.	Description	SCOI Number	Document Date
N4.6.16	Campbelltown Hospital Redevelopment – Information and Communications Technology Strategy	MOH.9999.1081.0001	December 2017
N4.6.17	Campbelltown Hospital Redevelopment – Master Program	MOH.9999.1082.0001	20 April 2018
N4.6.18	Campbelltown Hospital Redevelopment – Furniture, Fittings and Equipment/Major Medical Equipment Project Plan	MOH.9999.1083.0001	March 2018
N4.6.19	Campbelltown Hospital Redevelopment – Phase One – Planning – Project Management Plan	MOH.9999.1084.0001	1 April 2024
N4.6.20	Campbelltown Hospital Redevelopment – Stage Two – Final Business Case – Cost-Benefit Analysis	MOH.9999.1085.0001	8 May 2018
N4.7	NSW Health GL2024_008 New Health Technologies and Specialised Services Guideline	MOH.0100.0022.0001	24 June 2024
N4.8	NSW Auditor-General's report Ambulance Services in regional New South Wales, Performance Audit	MOH.0010.0755.0001	28 June 2024
N4.9	Terms of Reference, Aboriginal and Torres Strait Islander Patient and Community Serious Incident Review (SIR) Sub-Committee, CEC	MOH.0010.0757.001	3 July 2024
N4.10	Supplementary Statement of Adjunct Prof Alfa D'Amato, Deputy Secretary and Chief Financial Officer, Financial Services and Asset Management	MOH.0011.0029.0001	23 July 2024
N4.10.1	Annexure A - Email from Anna McFadgen to Adjunct Prof Alfa D'Amato re St Vincent's response to the Saturday Paper	MOH.0010.0245.0001_R	20 December 2023

Exhibit No.	Description	SCOI Number	Document Date
N4.10.2	Annexure B - Email from Anna McFadgen to Adjunct Prof Alfa D'Amato re Summary of SVHN Meeting	MOH.0010.0249.0001_R	22 December 2023
N4.10.3	Annexure C - Email from Abbas Alibhai to Adjunct Prof Alfa D'Amato re SVHN's cashflow position	MOH.0010.0250.0001_R	11 January 2024
N4.10.4	Annexure D - Email from Anna McFadgen providing draft letter to Adjunct Prof Alfa D'Amato	MOH.0010.0252.0001_R	2 February 2024
N4.10.5	Annexure E – Email from Anna McFadgen re additional information on costs pressures faced by SVHN	MOH.0010.0254.0001_R	14 February 2024
N4.10.6	Annexure F – Email from Anna McFadgen acknowledging receipt of Planned Recovery Plan and Request for Financial Support from Final Quarter 2023-2024	MOH.0010.0246.0001_R	4 March 2024
N4.10.7	Annexure G – Email from SVHN to Adjunct Prof Alfa D'Amato setting out revised cashflow position	MOH.0010.0247.0001_R	7 March 2024
N4.10.8	Annexure H – St Vincents Network Narrative – May 24	MOH.0010.0298.0001_R	May 2024
N4.10.9	Annexure I - St Vincent's Draft Recovery Plan FY 2025-2027	MOH.0010.0270.0001	2 May 2024
N4.11	NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework	MOH.0010.0740.0001	27 September 2024
N4.12	Rapid Literature Review prepared by Prof Braithwaite and Colleague at Macquarie University	SCI.0011.0754.0001	29 November 2024
N4.13	Submission of Dr Rhonda Kerr	SCI.0011.0755.0001	9 December 2024

Exhibit No.	Description	SCOI Number	Document Date
N4.14	Letter from Prof Denis King OAM, re Justice Health NSW's response to evidence before the Inquiry 21 November 2024	MOH.0010.0754.0001	December 2024
N4.15	Healthcare Quarterly Report – July to September 2024	SCI.0011.0750.0001	December 2024
N4.16	Supplementary Statement of Prof Tracey O'Brien AM, Chief Cancer Officer and CEO, Cancer Institute NSW	MOH.0011.0098.0001	17 December 2024
N4.17	Council Chart, South Western Sydney LHD	MOH.0010.0756.00 01	Undated

A.33: Tender Bundle O – Additional Documents (March 2025)

Exhibit No.	Description	SCOI Number	Document Date
O.1	Sir William Beveridge, Social Insurance and Allied Services Report	SCI.0011.0844.0001	November 1942
O.2	Parliament of NSW, Report of the Committee on Community Health Services, No 91. 1969	SCI.0011.0815.0001	November 1969
O.3	James Fries, <i>The Compression of Morbidity</i>	SCI.0011.0811.0001	1983
O.4	NSW Health, <i>Annual Report 1999–2000</i>	SCI.0011.0863.0001	December 2000
O.5	CJ Cummins, <i>A History of Medical Administration in NSW: 1788–1973</i>	SCI.0011.0778.0001	October 2003
O.6	World Health Organisation, <i>Global Forum IV on Chronic Disease Prevention and Control</i>	SCI.0011.0845.0001	2005
O.7	NSW Health, <i>Annual Report 2004–2005</i>	SCI.0011.0858.0001	1 November 2005

Exhibit No.	Description	SCOI Number	Document Date
O.8	Lord Darzi of Denham, <i>High Quality Care for All: NHS Next Stage Review Final Report</i>	SCI.0011.0857.0001	June 2008
O.9	Transcript of National Press Club Q&A Canberra, Health and Hospital Reform	SCI.0011.0836.0001	3 March 2010
O.10	Independent Panel, Third Progress Report: Appendices	SCI.0011.0856.0001	November 2010
O.11	NSW Health, <i>Annual Report 2011–2012</i>	SCI.0011.0859.0001	October 2012
O.12	Australian Health Ministers' Advisory Council, <i>National Strategic Framework for Chronic Conditions</i>	SCI.0011.0852.0001	2017
O.13	Jaithri Ananthapavan et al, Assessing Cost-Effectiveness of Obesity Prevention Policies in Australia	SCI.0011.0851.0001	2018
O.14	Paul Crosland et al, The Economic Cost of preventable disease in Australia: a systematic review of estimates and methods	SCI.0011.0860.0001	2019
O.15	Andrea Teng et al, Impact of sugar-sweetened beverage taxes on purchase and dietary intake: Systematic review and meta-analysis	SCI.0011.0837.0001	2019
O.16	The Medicare Benefits Review Taskforce, Final Report to the Ministry for Health, An MBS for the 21 st Century, Recommendations, Learnings and Ideas for the Future	SCI.0011.0810.0001	December 2020
O.17	Final Report of the Royal Commission into Aged Care and Quality Safety	SCI.0011.0774.0001	2021

Exhibit No.	Description	SCOI Number	Document Date
O.18	Productivity Commission, Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study	SCI.0011.0816.0001	March 2021
O.19	Australian Government, Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032	SCI.0011.0806.0001	March 2022
O.20	National Obesity Strategy 2022-32: Enabling Australian to eat well and be active	SCI.0011.0812.0001	4 March 2022
O.21	Tristan Dry and Phillip Baker, Why Doesn't Australia Have a Sugar-Sweetened Beverage Tax?	SCI.0011.0842.0001	11 March 2022
O.22	G Sacks and D Mann, Policies for tackling obesity and creating healthier food environments: Scorecard and recommended actions for the Australian Federal Government	SCI.0011.0834.0001	October 2022
O.23	Mary Angeles et al, Challenges for Medicare and universal health care in Australia since 2000	SCI.0011.0805.0001	2023
O.24	Reaping Broader Economic Benefits from an Effective Healthcare System: a visual lens	SCI.0011.0882.0001	24 July 2019
O.25	Grace Hampson et al, Reimagining Prevention for a healthier, more prosperous society	SCI.0011.0832.0001	October 2023
O.26	World Health Organisation, Universal Health Coverage Factsheet	SCI.0011.0843.0001	5 October 2023
O.27	Peter Beadon and Jessica Geraghty, Sickly Sweet: It's time for a sugary drinks tax	SCI.0011.0807.0001	May 2024

Exhibit No.	Description	SCOI Number	Document Date
O.28	Hansard, Legislative Council	SCI.0011.0850.0001	8 May 2024
O.29	AIHW, <i>What are the determinants of health?</i>	SCI.0011.0841.0001	2 July 2024
O.30	New South Wales, <i>Budget estimates 2024-2025 Portfolio Committee No 2 – Health</i>	SCI.0011.0849.0001	9 September 2024
O.31	Prof Mark Cormack, <i>Unleashing the Potential of our Health Workforce: Scope of Practice Review</i>	SCI.0011.0839.0001	October 2024
O.32	Paul Cairney et al, <i>Unlocking prevention in integrated care systems</i> , NHS Confederation	SCI.0011.0840.0001	October 2024
O.33	Karinna Saxby and Yuting Zhang, <i>Bulk-billing rates and out-of-pocket costs for general practitioner services in Australia, 2022, by SA3 region: analysis of Medicare claims data</i>	SCI.0011.0835.0001	2025
O.34	Demos and The Health Foundation, <i>The Preventative Shift: How can we embed prevention or achieve long term missions</i>	SCI.0011.0809.0001	February 2025
O.35	Far West LHD – Independent Auditor's Report	SCI.0011.0865.0001	5 September 2024
O.36	Mid North Coast LHD – Independent Auditor's Report	SCI.0011.0870.0001	6 September 2024
O.37	Illawarra Shoalhaven LHD – Independent Auditor's Report	SCI.0011.0868.0001	10 September 2024
O.38	Western NSW LHD – Independent Auditor's Report	SCI.0011.0880.0001	12 September 2024
O.39	Justice Health and Forensic Mental Health Network – Independent Auditor's Report	SCI.0011.0869.0001	13 September 2024

Exhibit No.	Description	SCOI Number	Document Date
O.40	Hunter New England LHD – Independent Auditor's Report	SCI.0011.0867.0001	13 September 2024
O.41	South Eastern Sydney LHD – Independent Auditor's Report	SCI.0011.0875.0001	13 September 2024
O.42	Central Coast LHD – Independent Auditor's Report	SCI.0011.0864.0001	16 September 2024
O.43	Sydney LHD – Independent Auditor's Report	SCI.0011.0878.0001	16 September 2024
O.44	Western Sydney LHD – Independent Auditor's Report	SCI.0011.0881.0001	17 September 2024
O.45	Nepean Blue Mountains LHD – Independent Auditor's Report	SCI.0011.0872.0001	18 September 2024
O.46	South Western Sydney LHD – Independent Auditor's Report	SCI.0011.0876.0001	18 September 2024
O.47	SCHN – Independent Auditor's Report	SCI.0011.0879.0001	20 September 2024
O.48	Murrumbidgee LHD – Independent Auditor's Report	SCI.0011.0871.0001	23 September 2024
O.49	Northern Sydney LHD – Independent Auditor's Report	SCI.0011.0874.0001	25 September 2024
O.50	Southern NSW LHD – Independent Auditor's Report	SCI.0011.0877.0001	25 September 2024
O.51	Northern NSW LHD – Independent Auditor's Report	SCI.0011.0873.0001	2 October 2024
O.52	Health Administration Corporation – Independent Auditor's Report	SCI.0011.0866.0001	14 October 2024
O.53	DOHAC, <i>About Primary Care</i>	SCI.0011.0887.0001	3 April 2023
O.54	Local Health Districts, Health Stats NSW	SCI.0011.0883.0001	Undated
O.55	Ministers, Parliament of New South Wales	SCI.0011.0884.0001	Undated
O.56	Regional Health, NSW Health	SCI.0011.0885.0001	17 February 2025

Exhibit No.	Description	SCOI Number	Document Date
O.57	Structure, NSW Health Infrastructure	SCI.0011.0886.0001	17 February 2025
O.58	Ministry of Health Organisation Chart	SCI.0011.0888.0001	4 March 2025
O.59	Public Service Commission, Workforce Profile Report	SCI.0011.0889.0001	2023
O.60	ABS, Population by Age and Sex, New South Wales	SCI.0011.0890.0001	29 June 2000
O.61	AIHW, Health and Wellbeing of First Nations people	SCI.0011.0891.0001	2 July 2024
O.62	ABS, Health Conditions Prevalence	SCI.0011.0892.0001	15 December 2023
O.63	ABS, Twenty Years of Population Change	SCI.0011.0893.0001	17 December 2020
O.64	AIHW, Australia's Health 2022: Data Insights, Chapter 4: Changing Patterns of Mortality in Australia since 1900	SCI.0011.0894.0001	7 July 2022
O.65	Albury Wodonga Health, 2021 Clinical Services Plan	SCI.0011.0854.0001	February 2021
O.66	ABC News, Victoria and NSW governments commit to redevelopment of Albury Base Hospital	SCI.0011.0853.0001	27 October 2022
O.67	HealthShare NSW Statement of Service 2024-25	SCI.0011.0895.0001	9 August 2024
O.68	AIHW, Chronic Diseases and Associated Risk Factors in Australia	SCI.0011.0897.0001	November 2006
O.69	AIHW, Chronic Diseases and Associated Risk Factors in Australia, 2001	SCI.0011.0896.0001	2002

Exhibit No.	Description	SCOI Number	Document Date
O.70	Interim Committee of the National Hospitals and Health Services Commission, A Community Program for Australia	SCI.0011.0899.0001	June 1973
O.71	Centre for Epidemiology and Evidence, Life expectancy at birth for Persons by LHD	SCI.0011.0898.0001	2002



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