

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Wednesday, 20 November 2024 at 10.00am

(Day 063)

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

Also present:

Mr Hilbert Chiu SC with Ms Joanna Davidson for NSW Health

1 THE COMMISSIONER: Good morning. Good morning, Mr Muston.

2

3 MR MUSTON: The first witness we have this morning,
4 Commissioner, is Jeffrey Braithwaite.

5

6 <JEFFREY BRAITHWAITE, affirmed [10.01 am]

7

8 THE COMMISSIONER: Please go ahead.

9

10 MR MUSTON: Professor Braithwaite, would you state your
11 full name for the record, please?

12 A. Jeffrey Braithwaite.

13

14 Q. And you have assisted in the preparation of a
15 submission made by the Australian Institute of Health
16 Innovation at Macquarie University?

17 A. I did.

18

19 Q. Where you currently are employed?

20 A. Indeed.

21

22 Q. What role do you have within that institute?

23 A. So I'm the founding director and professor of health
24 systems research.

25

26 Q. For the benefit of the Commission, could you just give
27 us a snapshot of your experience and research within the
28 health sector, what's brought you to the position that
29 you're in today?

30 A. So I've been a health systems researcher for a couple
31 of decades. Before that I was working in the health system
32 in various policy and leadership roles. The Australian
33 Institute of Health Innovation, which I run, has got about
34 300 people all doing health system research, receiving
35 funding from the National Health and Medical Research
36 Council, the Medical Research Future Fund and other sources
37 where we do partner-based research. We examine health
38 systems, looking at patient safety, how the health system
39 functions and how it can function better, and use - and
40 investigate and use tools such as big data, machine
41 learning, AI and health economics, putting a health
42 economic lens over our studies.

43

44 Q. Could I - I should probably ask you this first. Have
45 you had an opportunity to review your submission prior to
46 giving your evidence today?

47 A. I have.

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Q. That's a submission dated 31 October 2023. You're satisfied that the views you've expressed in that submission remain true and correct today?

A. I am.

MR MUSTON: We might tender that in due course, Commissioner.

THE COMMISSIONER: Sure.

MR MUSTON: Just to set a bit of a baseline, could I test a few propositions with you. The first is obviously health and spending on health is a fundamentally important part of any government operations, but health is one of those bottomless buckets, as it were, where even if you had all of the efficiency in the world there would probably be things that with any amount of money you could spend within the health sector which would produce beneficial outcomes for patients and, as ideal as it would be to be able to spend as much money as you could possibly spend on producing those beneficial outcomes, there will always need to be a decision made about how much of the state's budget is going to be devoted to health? You'll have to answer out loud.

A. Sure. Yes.

Q. And that ultimately will mean decisions need to be made about which of the very many things you could do which would provide health benefits are the ones that should be prioritised in spending that more limited envelope of money that you have made available to you?

A. I agree.

Q. What I'm interested in exploring with you is both at a local level, so within LHDs, and also at a broader systemic level just how the system might best go about making those decisions and approaching that system management task so as to enable decisions to be made about what the health budget should ideally be spent on and where, and, equally, to perhaps create a greater transparency around or a greater visibility of the things that are not being included in that spend. So to the extent that that is something people think really ought be covered, then that either can result in further funding being provided or, alternatively, can result in a slightly more transparent reallocation or reprioritisation of the various services that are being

1 provided?

2 A. So I guess it depends on your starting point. So, if
3 we think about that question more broadly, there's 8
4 million people plus in the population in New South Wales,
5 and if you think about a starting point of the sustainable
6 development goals of the United Nations, which Australia is
7 a signatory to, then you start to think, "Okay, how do we
8 keep the population healthy? How do we promote wellbeing,"
9 because when you focus in too narrowly, say, on the
10 hospital system you're really talking about an illness
11 system rather than a health and wellbeing system. So just
12 stay broad. The remit I guess for Australia, for New South
13 Wales and internationally is how do you keep your
14 population healthy and with plenty of wellbeing. So that's
15 a different starting point for funding than if you start
16 with hospitals are really pressed, staff are burnt out, we
17 don't have enough doctors, and we've got all those
18 difficulties; how do we fund that.

19
20 So stay at the population level for a bit with me. If
21 we start there, then we know some top-line numbers about
22 the population. Some 60 per cent of the care that's
23 delivered to them is in line with level 1 evidence or
24 guidelines. That's the gold standard type way we should
25 deliver care to the population.

26
27 MR MUSTON: Just can I ask you about that. Gold standard,
28 does that effectively mean not only care that is delivered
29 well and effectively but care that was genuinely required
30 to be delivered to a particular individual?

31 A. It's a great question. So it's the care that has a
32 randomised trial to suggest that that will be beneficial
33 for the patient, it will deliver good outcomes, or it's the
34 care that is delivered by the guidelines that expert
35 clinicians say is the way care should be delivered for that
36 condition. So about 60 per cent is in line with level 1
37 evidence or consensus-based guidelines, those two elements.
38 Often the level 1 care is enshrined in the guidelines.

39
40 So that gives scope for more care to be delivered in
41 line with the guidelines and level 1 evidence. Now,
42 there's a whole lot of problems you may not want to go into
43 about why doesn't care get delivered the way the guidelines
44 suggest, or I can speak to that if you wish.

45
46 Q. If you in a nutshell?

47 A. In a nutshell, it's multifactorial, but there's

1 36 million papers in PubMed, that's the medical database of
2 all the research that has ever been produced, and it takes
3 on average 17 years for only 14 per cent of that evidence
4 ever to get into practice - that's ever to get in
5 practice - because there's a whole lot of clinical choices
6 with patients that are made, which means that every patient
7 doesn't get absolutely evidence-based care all the time.
8 There's a time lag. There's a, "Is that the right care for
9 this patient in this set of circumstances? Have we got the
10 equipment, the new technology that would deliver that care
11 the way the level 1 evidence suggests?" So there's all
12 sorts of factors that inhibit that. Still, most experts
13 would say if 60 per cent of care is in line with guidelines
14 or level 1 evidence we could probably do better than that.
15 However, health systems have struggled with that question.
16

17 The second number is 30 per cent. Thirty per cent of
18 care is deemed at some level to be some sort of waste or
19 not delivering good outcomes to patients, and that attracts
20 people, including the Commission no doubt, because that's
21 an area where we can be more efficient or make savings --
22

23 Q. That's what we heard described as low value care?

24 A. Low value care is one way of describing it, and
25 there's a few things to do with the way the system's set up
26 that inhibit us from - inhibit us from being efficient.
27

28 Q. Without wanting to pick on any particular example, are
29 you able to, just to make it tangible for us, give an
30 example of something that might fall into that 30 per cent?

31 A. A patient might move through the system very fast,
32 we've taken some tests and the test results never get seen
33 because the patient's now discharged. Or there's a lot of
34 bureaucracy. You've got to go through lots of screens or
35 lots of paperwork to deliver care. That's not adding
36 value. It's necessary perhaps, but it's not actually
37 directly adding value. We could maybe do that more
38 efficiently. I'm sure that people working in the system
39 could give you better examples, but that's the broad idea.
40

41 Q. So just the tests example that you put forward the
42 first time at one level the fact that the tests have been
43 done, the person's moved through the system and they're out
44 the door before the results have been received obviously
45 means that there's very limited value in that test because
46 it hasn't influenced or informed in any way the treatment
47 that the patient's received while they're there?

1 A. Sure.

2

3 Q. There might be a slight distinction to be drawn
4 between the test that should have been done more quickly
5 and should have been paid attention to which would have
6 provided a better clinical outcome for the patient on the
7 one hand or, on the other, a test which is being done
8 because it's part of just routine practice but actually,
9 having regard to the presentation of that patient, probably
10 didn't need to be done at all?

11 A. Yes, and maybe the GP's just done a battery of tests
12 but they don't get seen in the hospital when the patient's
13 admitted, so there's opportunities for a more - I know
14 you've heard this a lot - a more joined-up system, yes,
15 where people can access data that's already been gathered.

16

17 Q. So that's our 30 per cent. Would --

18

19 THE COMMISSIONER: Is care that's provided but provided at
20 a time where it's past the time that was clinically
21 appropriate for that care an example of something in the
22 30 per cent?

23 A. Yes, yes.

24

25 MR MUSTON: Or maybe in the 10 per cent?

26 A. The 10 per cent is --

27

28 THE COMMISSIONER: Could be. Could be both.

29

30 MR MUSTON: We're about to hear about the 10 per cent,
31 hopefully, if my maths is right?

32 A. The 10 per cent is harm. So 10 per cent - one in 10
33 inpatient admissions has some level of harm. A lot of it
34 is not consequential for the patient, but there's a
35 proportion which is significant. People will have talked
36 to you about sentinel events or really serious harm that
37 occurs. New South Wales and other health systems have
38 tried really hard to reduce the level of harm to patients.
39 There's some scary evidence in New England Journal of
40 Medicine - that's a major journal - I just released about
41 six months ago which suggests in Massachusetts hospitals,
42 which are not known for their lack of funding in
43 Massachusetts in the US, had harm at the level of about
44 22 per cent of admissions. We don't know if that's the
45 case in New South Wales or other wealthy health systems.
46 But that's a very difficult number.

47

- 1 Q. How is that measured? How would we as a system
2 measure that if --
- 3 A. We've done studies like that where you go in and look
4 at the medical record and have a look at what care was
5 delivered and have a look at incident reports. We're
6 currently doing a large study out of South Australia on
7 what actually happens with all the incident reports that
8 are produced by their system and how people close the loop
9 on that, which is very difficult.
- 10
- 11 Q. We could probably all imagine more extreme examples of
12 harm that could occur within the health system: the patient
13 who goes in to have a knee replacement of their left knee
14 and gets the right knee, which was otherwise perfectly
15 fine, operated on or --
- 16 A. And now they've got two problems.
- 17
- 18 Q. -- a pharmaceutical issue which has resulted in a --
- 19 A. Yes.
- 20
- 21 Q. -- medication mishap occurring that's caused some harm
22 to them. But what is the broad range of things which are
23 captured by that harm? Is it everything just at that
24 extreme end, or is there a much wider spectrum?
- 25 A. There's a long tail, but the three crucial things are
26 falls, medication safety harm and then maybe a patient not
27 responding well, some level of complication to their care
28 that maybe was anticipatable but quite frequently is not
29 anticipatable.
- 30
- 31 Q. Medication safety, just to pick up on that example,
32 we've heard some evidence from, it's called, Advanced
33 Pharmacy Australia - it used to be the organisation that
34 represented hospital pharmacists - who have told us about
35 what they perceive to be the potential benefits of greater
36 utilisation of pharmacists effectively at the bedside as
37 part of a multidisciplinary team delivering care, and what
38 they've told us is that charting errors, medication errors,
39 where a pharmacist, who's, to use their words, I think, a
40 bit of a pharmacy nerd, is actually the person doing that
41 rather than the busy doctor, who is trying to think of
42 everything else --
- 43 A. Yes.
- 44
- 45 Q. Could then produce a substantial reduction in those
46 sort of medication errors. Is that - how does that fit
47 into this equation?

1 A. I think that's right. I think that's right. The
2 problem is every allied health professional group, if you
3 have more of them, would contribute to safer care and
4 better care. So if you had more physiotherapists or speech
5 pathologists you'd have better care and probably safer
6 care.

7
8 Q. But, coming back to another one of your examples, more
9 allied health professionals, potentially less falls within
10 hospitals?

11 A. Sure, but your problem is you've got an envelope of
12 funding and you can't fund everything, and every specialist
13 group is going to say, "We can make care safer in our area
14 for the conditions that we treat." So it's the dilemma of
15 health care, isn't it?

16
17 Q. Yes.

18 A. Yes.

19

20 Q. So can I maybe tease through those individually,
21 starting with the 10 per cent, as you tell us. A system
22 which identifies the 10 per cent or is able to identify the
23 10 per cent and make informed health and economic decisions
24 around whether or not it would be beneficial to employ
25 more, say, hospital pharmacists to be more involved in the
26 care in a way that will reduce medication errors and the
27 like would seem to be a good system. Whether that results
28 in more pharmacist being employed or not ultimately is a
29 decision to be made in an informed way, but - would that be
30 right?

31 A. Sure. So I'm a scientist. I would treat that as a
32 piece of science. So we could run a trial. So we could
33 have - randomise some hospitals into receiving extra
34 pharmaceutical expertise and some hospitals that didn't,
35 and see if the medication error problem reduced. So --

36

37 Q. You could potentially collaborate with an economist,
38 who could tell you what's - in a business case sense --

39 A. Yes.

40

41 Q. -- what are the pros and cons financially of paying
42 for that extra allied health professional when compared
43 with the costs borne by the system or by society of
44 medication errors --

45 A. Yes.

46

47 Q. -- and to what extent does the available reduction of

1 those errors in a scientific sense produce potential
2 economic benefit?
3 A. Yes, true. I think all I'm saying is I agree but
4 I would test that. I would run some sort of a trial to see
5 if it works first, because you can spend a lot of money on
6 things - look, politicians - I don't want to - we're not
7 here to critique our masters, our political masters, but
8 politicians do that all the time. Someone comes to see
9 them, they get a good idea from somewhere and they want to
10 fund it because they believe fervently that it's good for
11 the community, good for the system. But that's not a piece
12 of science that tells you if it's actually going to work.

13
14 Q. So at a system level how do we embed that sort of
15 science into the way we make decisions within the hospital
16 system, within the healthcare system?

17 A. We and others do some of that by getting National
18 Health and Medical Research - where I started from, you
19 know, National Health and Medical Research Council grants
20 to try and do research of that kind to see if a proposal
21 that looks good on the surface is actually going to work in
22 the real world. That's the problem with randomised trials,
23 even drug trials, they work on a small proportion of the
24 population that is enrolled in the study but how does it
25 work in the real world of busy clinical practice, and often
26 there's not a direct correspondence.

27
28 And may I say, if it pleases the Commission, that's
29 going to be one of the problems with your recommendations:
30 how do they get taken up? That's probably a story for you
31 when you write your report later.

32
33 Q. If they do. So the starting point is the research.
34 If we reach a point where through that process of research
35 we conclude that there would be potential benefit and we
36 identify what that potential benefit would be, how do we go
37 about translating that into practice as part of overall
38 healthcare system management?

39 A. So that's hard. I think implementation of even things
40 that we know work well has proven difficult in complex
41 systems like this. What's the take-up of the individual
42 clinician level? How does the LHD manage that? How does
43 the right policy settings get put in place by New South
44 Wales Health? And then how does the take-up radiate across
45 the whole of New South Wales, including in places where
46 they may be resource strapped, staff are a bit burnt out,
47 they haven't got the resources in the right place?

1
2 So what we've shown and others have shown is it's very
3 hard even when you have all the right settings, the right
4 policy, good recommendations from a commission and good
5 people in place to actually get everything taken up
6 uniformly across a system. Standardisation is very
7 difficult in health care, standardised take-up of something
8 that we know is beneficial.
9

10 Q. When you refer to standardisation, that doesn't
11 necessarily mean decision making from the middle as to the
12 way in which things will be done standardly across the
13 system but rather - or, for example, what particular
14 procedures will be done where in the system but, rather,
15 who's - presumably, standardisation is more dealing with
16 the way in which these concepts are picked up within
17 decision making at - both centrally but also in local
18 settings, where decisions might be being made based on
19 particular factual scenarios as they crop up?

20 A. Yes. Yes.

21
22 Q. Starting again with the 10 per cent, one could readily
23 see how a system informed by some scientific analysis of
24 the type you refer to perhaps backed up with a bit of
25 economic analysis should be capable of making decisions
26 around whether or not it's worth, to take up the example
27 that we've taken, spending some further money on allied
28 health professionals because that spend will result in
29 systemic benefits that will result in --

30 A. Yes, you get people out of hospital, for example.

31
32 Q. And will avoid harm.

33 A. Yes, yes.

34
35 Q. That's, one can see in the world of decisions, one of
36 the easier ones that needs potentially to be made in
37 health?

38 A. Yes.

39
40 Q. Properly informed, if harm can be avoided in a way
41 that's economically beneficial and of obvious benefit to
42 the patients, it would be good to try and systematise that.
43 Let's come up now to the 30 per cent. The 30 per cent of
44 care --

45 A. May I?

46
47 Q. Yes, please do.

1 A. Just on the 10 per cent, has the Commission read the
2 six books that we've written on the 90 per cent?

3
4 Q. I have not. I won't speak for the Commissioner.

5 A. I'm teasing you. Sorry, I shouldn't do this from
6 the --

7
8 THE COMMISSIONER: Someone will.

9 A. So everyone's focused across the world, including in
10 New South Wales, heavily on the 10 per cent and said, "How
11 do we have less harm," which is an absolutely legitimate
12 question - how do we report incidents that occur, those
13 really dramatic ones that make the Sydney Morning Herald's
14 front page, through to lots of - you know, like the
15 medication was missed or it didn't get delivered in the
16 right dose or at the right time and it doesn't ultimately
17 harm the patient but we could have done better. So there's
18 lots of sort of types of harm.

19
20 So what we did about 10 years ago was started to
21 rethink that, and the rethinking took the place of what we
22 now call safety 2. All of that trying to reduce harm is
23 called safety 1. We labelled it that way. So safety 2 is
24 how come so much goes right in a system this complex and
25 patients get really good care lots of times, like most of
26 the time, like the vast majority of the time, considering
27 how much could go wrong, and that's like a weird question
28 to some extent, but it's a very powerful one.

29
30 So we were advocating and have been for about - more
31 than 10 years for safety 2, looking at when things go right
32 and trying to do more of it, and saying to clinicians,
33 "We've noticed how much goes right," because what happens
34 is clinicians, including in this Inquiry, essentially are
35 the lightning rod for lots of criticism, even if it's
36 guarded, like, you know, "We recommend this," but it's
37 actually saying, "You're not doing well enough."

38
39 So we argued for let's look at the 90 per cent that
40 goes well, really much more systematically, and try and do
41 more of it. So when you do a root cause analysis - I'm
42 sure the Commission's come across root cause analysis.
43 There's an incident - it's like an inquiry like this on a
44 smaller scale. Something goes wrong in the health system,
45 so it's sufficiently worrying, concerning, that we cause a
46 root cause analysis to occur. So budget people get
47 together and say, "What was the ultimate cause of this?"

1
2 So we've argued that's actually perpetuating a wrong
3 view of the system, which is there's harm all the time.
4 There's not harm all the time, there's only harm some of
5 the time, so why don't we do an RCA and when we do an RCA
6 on things going wrong say, "How many times did this
7 procedure go right, and what can we learn from that?" So
8 it's a bit like if I was a researcher of marriage and
9 I only researched divorce I wouldn't know what a happy
10 marriage was. So I don't understand the health system if
11 I just keep looking at when things go wrong and patients
12 get harmed. I should understand the whole system and how
13 it works and how it functions when it should, and that's a
14 good news story, and New South Wales is one of the better
15 health systems in the world, and we should therefore
16 concentrate sometimes more than we do on what goes well.

17
18 Q. And by approaching it in the safety 2 way does that
19 assist in working out how to systematise those changes that
20 might need to be made to get the 10 per cent as low as it
21 could possibly be?

22 A. Yes. It might be protective. We might do more good
23 care, and that would reduce the amount of harm, the
24 10 per cent, that we do. So it's two sides of the coin.
25 If we just focus on harm we're essentially always
26 criticising the system for not doing well, and yet it does
27 very well many, many times.

28
29 THE COMMISSIONER: Can I ask - and feel free to tell me
30 this is either a stupid question or the wrong question, but
31 I'm here to ask those sort of questions --

32 A. I understand that there's no stupid questions from the
33 Commission or the Commissioner.

34
35 THE COMMISSIONER: Well, that's a good start, but you're
36 not necessarily correct. That might be in the 10 per cent,
37 whatever. Most of what the State spends money on in terms
38 of health is for acute services in hospitals. But that's
39 only a portion of population health, the population health
40 that you spoke of in your very first answer. There are
41 other aspects of health care that they might be spending
42 money on, prevention for example, which might be some form
43 of health care plan and long consultations with either a GP
44 or a suitably experienced and qualified nurse or allied
45 health with someone that's at risk of developing diabetes
46 because of developing obesity, or it might be spending
47 money on paediatric interventions in young children that

1 might have a health-related learning issue that is
2 capable - they're capable of being assisted with.

3
4 Do health systems in terms of spending money and
5 resources on that aspect of health care do anything that
6 might be akin to some form of cost-benefit analysis? What
7 I have in mind is, you know, if a property developer is
8 going to buy land they'll do an analysis of what the
9 quantity surveyors will tell them it might cost to build a
10 development and they'll have an internal rate of return,
11 which will guide them about what the return of
12 the investment might be, taking into account the time value
13 of money.

14
15 Does health - do any health systems, whether it's ours
16 or any other health system you might be aware of, do an
17 analysis, "If we spend X billion dollars on making sure
18 that there's - for example, no child that's got some form
19 of health-related disability always gets seen within a
20 clinically appropriate time" - is there any modelling done
21 that says, "Well, in 20 years or 30 years time the benefit
22 to the economy from that population level intervention will
23 mean that we've got this many more taxpayers and this many
24 more economically active people such that the investment
25 might have been 5 billion but, even taking into account the
26 time value of money, the payoff for the economy in 20 years
27 or 30 years will be 30 billion?" Of course, if it's 30
28 billion it sounds like a good investment to make. If it
29 was only 4 billion, it sounds like - well, who knows? But
30 is there that sort of --

31 A. Yes.

32
33 THE COMMISSIONER: Do health systems look at things that
34 way?

35 A. It's a great question. I can't think of a study at
36 the moment - and I'm not a health economist, okay?

37
38 THE COMMISSIONER: Yes, understood.

39 A. I can't think of a study at the moment, but let me
40 answer it this way. So all those patients who aren't
41 coming in to hospital now because of - let me give you the
42 big four. Seat belts was a, you know --

43
44 THE COMMISSIONER: Massive, yes.

45 A. It cost very little. In fact, all the car
46 manufacturers were required to do it and people were
47 required to wear them. It was a legislative thing. So

1 seat belts. Pool fences.

2

3 THE COMMISSIONER: Yes.

4 A. Smoking cessation. When I was a kid it was
5 60 per cent - even some doctors smoked - and now it's
6 hovering at about 12 per cent, and it's still tracking to
7 go down. And you'll remember the Slip, Slop, Slap
8 campaign. Any New South Wales kid --

9

10 THE COMMISSIONER: Yes, just a couple of years that. But,
11 anyway, yes, you're right, I do remember it, yes.

12 A. But almost the benefits are not that measurable
13 because - I suppose you can measure historically how many
14 people now don't go through the windscreen because of their
15 seat belts.

16

17 THE COMMISSIONER: Yes.

18 A. Or how many kids used to drown and now don't get
19 drowned because of pool fences, and so on and so forth. So
20 mostly the economic analysis as I see that's done
21 afterwards to say, "Well, that decision we made those
22 decades ago saved all these lives and all these
23 hospitalisations."

24

25 THE COMMISSIONER: Yes.

26 A. I think it's very hard to do it prospectively because
27 it's hard to know what --

28

29 THE COMMISSIONER: I'll probably ask other people as well.

30 A. Yes.

31

32 THE COMMISSIONER: I mean, the modelling might be hard.

33 A. Yes.

34

35 THE COMMISSIONER: Of course, the result of the modelling
36 will be wrong, but it is a question of how close to right
37 it might be, but --

38 A. And I mentioned PubMed. I would - immediately in a
39 question like that I would go into PubMed and start
40 interrogating the dataset and say, "What studies have been
41 done in this area?"

42

43 THE COMMISSIONER: Yes.

44 A. Yes. Hope that helps.

45

46 THE COMMISSIONER: It does, yes, thanks.

47 A. I don't think there's a natural answer to your

1 question, but there's some illustrative examples. Yes.

2

3 THE COMMISSIONER: Yes. Thanks.

4

5 MR MUSTON: So I think we've covered off understand the
6 10 per cent. Move up to the 30 per cent.

7 A. Yes.

8

9 Q. Decision making around the 30 per cent, the
10 effectively low value care. How as a system do we approach
11 trying to make decisions which reduce ideally the amount of
12 low value care which is being delivered?

13 A. So there's a number of initiatives underway, and no
14 doubt the Commission has met some of these. There's an
15 initiative called Choosing Wisely, which is a collaboration
16 between clinicians, clinician groups and patients, and
17 patients groups, to say, "Do we have a voice for the
18 patient in care, and are we delivering care that's of high
19 value rather than low value?" New South Wales has done a
20 lot of work on low value care, and it's very good work.

21

22 Q. Just touching quickly on the Choosing Wisely, one can
23 understand the value of increasing patient autonomy,
24 enabling patients to make better informed decisions about
25 their care and the extent to which they need or want it.
26 But does that not potentially have the risk of tipping over
27 the other way, where patients, if given a greater freedom
28 of choice about whether they want particular procedures,
29 that they from their perspective may think they want a
30 procedure which ultimately when viewed objectively might be
31 characterised as low value care?

32 A. Well, I think that could be true, but it's more likely
33 that if you work with a patient to explain the benefits and
34 disbenefits of, say, a particular surgical procedure and
35 there's not that much benefit they're more likely to come
36 to a more reasoned decision. Yes, treating patients not
37 just as the object of the system to do stuff on but a
38 co-creator of their care is - in the modern sort of idiom
39 co-created care - we think has more benefits than
40 disbenefits.

41

42 And choosing Wisely even coming up with a list of
43 things that are a bit iffy about whether they deliver
44 benefits is not the worst thing to have happened. New
45 South Wales has done a lot of work - I'm not sure if that's
46 been tendered by New South Wales Health - on low value care
47 across I think, at last count, maybe more than 14 different

1 conditions where it did concerted effort over the last
2 10 years. We did a little bit of work on that project to
3 look at the extent to which we can reduce the amount of low
4 value care that's delivered, and that means informing
5 patients and providers.
6

7 Q. At a much earlier time in the Commission I recall we
8 were given some evidence about what seemed like an
9 exceptionally long period of time it can take to change
10 behaviour within the system --

11 A. Sure.

12
13 Q. -- to remove or reduce low value care. Clinicians who
14 have provided a particular form of treatment or a
15 particular procedure will continue to do it or want to
16 continue to do it in circumstances where systemically a
17 view might be taken that it's low value care, but that
18 difficult balance between the autonomy of the clinician,
19 the autonomy of the patient and the system means bringing
20 that change about is not easy. Do you have any views about
21 how systemically those changes could best be effected?

22 A. Yes, I think we're not very good in New South Wales or
23 any modern health system in really measuring what long-term
24 benefit or gain was produced. Doing more of that. You
25 know, I think if we followed patients - this has been known
26 for more than a hundred years, by the way. There's some
27 famous work a hundred years ago where one of the luminaries
28 in American health care said, "Why don't we follow patients
29 after we've intervened and see what happens to them, and
30 then feed that back into clinicians' knowledge," and health
31 systems, despite that meme being a hundred years old, we
32 still don't that very well.
33

34 I mean, BHI does that in a way by doing a big survey
35 every now and again of patients' views, but targeting that
36 to did that particular intervention or the kind that we
37 envisaged, say, around diabetes or knee surgery or whatever
38 it might be - did that deliver benefits and is the person
39 then two years later functionally occupying a place in
40 society or bedridden, we don't do that very well. There's
41 a cost to that, though.
42

43 Q. Is that - well, the cost to that is the cost of
44 collecting and collating the data?

45 A. Yes.

46
47 Q. We've reached a stage in our development as a society

1 where the collection of data is probably a cheaper exercise
2 and an easier exercise than it was in the past. Are there
3 opportunities that you see for better collection of data
4 across the siloed systems that comprise the public health
5 system in New South Wales?

6 A. Well, there's some tools. There's some very short
7 instruments to find out if a patient, say, two years after
8 they were discharged has got functional gain and they're
9 actively contributing after their hip replacement or knee
10 surgery or heart surgery or whatever. So there are fairly
11 efficient tools to gather that information, and then we'd
12 have to find good ways to feed it back to the particular
13 clinician groups.

14
15 Q. Breaking that down into the two stages, do you think
16 we're using those tools effectively at the moment or is
17 there a lot of room for improvement?

18 A. There's room for improvement. In some places some of
19 the time people do that well, not so much in others.

20
21 Q. In terms of the feeding back into the system, do you
22 think that to the extent that it's being utilised there is
23 an effective feedback mechanism which is adjusting practice
24 within the system?

25 A. I can't answer that. I'm not on the ground in the
26 system, so I don't know in New South Wales whether that's
27 being done well. I suspect it's done well in some places
28 and not others, and we could do better, we could improve.

29
30 Q. So ideally with perhaps a better data collection and
31 collaboration between the different siloed parts of the
32 health system we could be collecting - gathering that data,
33 feeding it back into the health system in a way that might,
34 if things are working well, drive change that reduces that
35 30 per cent of low value care as best as it can be reduced?

36 A. It would be a good strategy. You know, systems work
37 well if they're given feedback and good data, trustworthy,
38 credible data. That's why BHI, the Bureau of Health
39 Innovation, is very important, because it tries to do that
40 at a population level, at a systems level.

41
42 Q. We'll come back shortly to ways in which funding
43 arrangements might be able to be utilised to drive some of
44 that change as well. But before we do that I just want to
45 come to the 60 per cent, the level 1 care, and, just
46 picking up on where we started, a system which is operating
47 perfectly and has reduced as much as can be reduced the

1 30 per cent of low value care and the 10 per cent of harm
2 will nevertheless run up against a situation, will it not,
3 where whatever amount of funding you choose to provide to
4 the system there is level 1 care that could be delivered
5 with that money and you have to make a choice within a
6 limited budgetary envelope as to which pieces of level 1
7 care you are going to provide and which pieces you're not?
8 A. I wouldn't describe it that way. If I may?
9

10 Q. No, please.

11 A. What I would say is if we were so - if we project the
12 Commission's work into the future, say, five or 10 years,
13 the current trends are we won't be able to fund all of the
14 care that's going to be needed. I don't think anybody
15 disagrees with that. It's probably one of the reasons why
16 the Special Commission came into existence, because if you
17 just project into the future and extrapolate on the trends
18 how do we deliver all the care with an aging population,
19 with much more capacity for medicine to do things that it
20 could never do before, you know, the equation just seems to
21 be move into the future and how are we going to afford all
22 of that, is it going to take 27 per cent of GDP instead of
23 10 per cent?
24

25 So will we be forced to explicitly ration or
26 explicitly prioritise is a question many experts are
27 thinking about. So there's been a couple of experiments
28 about that, one in Oregon in the US 15, 20 years ago and
29 one in New Zealand where they said, "Maybe what we should
30 do is just provide core services to everybody and then the
31 extra services you have to pay for," and many people who
32 want the system to be delivering equitably don't like that
33 at all, and most of us want a level of equity in our health
34 system in Australia and in New South Wales. So that's
35 really being wrestled with, and I think it's core to what
36 the Special Commission is going to have to think about when
37 it gets to the end.
38

39 THE COMMISSIONER: The example of Oregon went pear shaped,
40 didn't it --

41 A. Yes.
42

43 THE COMMISSIONER: -- when a child needed --

44 A. Sure.
45

46 THE COMMISSIONER: -- some very expensive - I think it was
47 a bone marrow --

1 A. As soon as you get the test case and if it's a kid, if
2 it's a paediatric patient that goes on TV, the politicians
3 change their mind.

4
5 THE COMMISSIONER: Yes, yes.

6 A. So it is extremely difficult to do this. It is very
7 hard to ration. But we do ration. We ration by having
8 waiting lists. That's the chief rationing device.

9
10 MR MUSTON: But let me test this. You identify the fact
11 that the cost of delivering health care is increasing, the
12 range of interventions that we can offer are ever
13 increasing. No doubt many or a large proportion of those
14 interventions would be categorised as level 1 care.
15 They're things that would be of value to the patient?

16 A. Yes.

17
18 Q. But in circumstances where we have approximately
19 30 per cent of the state budget devoted to health
20 historically, which figure was arrived at at some point in
21 the past on the basis of a health system that no-one can
22 presently recall, to the extent that that's the amount of
23 money that was once sufficient to deliver on whatever the
24 public health system was, if we could use that term, if the
25 cost of delivering health care increases but the base or
26 the extent of your funding doesn't increase, the gap
27 between the two obviously is growing?

28 A. M'hmm.

29
30 Q. And in a practical sense what that really means is one
31 of two things, isn't it: one, either the public health
32 system, which is everything to everyone in a rather
33 nebulous way, just gets spread thinner and thinner and
34 thinner within that budgetary envelope until suddenly the
35 entire system is under stress, which potentially results in
36 not only workforce challenges but also exposes patients to
37 risk of - increasing the 10 per cent of harm and perhaps
38 doesn't deliver the care that would most ideally be
39 provided - so that's the spreading thin option. The other
40 option is it contracts and, whether it's something that's
41 identified and spoken of or not, the reality is if the
42 budgetary envelope available to deliver health care stays
43 the same but the cost of delivering health care gets bigger
44 then what comprises the public healthcare system will
45 necessarily contract, won't it, in terms of what it has to
46 offer?

47 A. That's true. So one question arising out of that is

1 how do we figure out how to treat health care as an
2 investment in society's wellbeing and healthiness, fund
3 those things or provide incentives for those things to be
4 done that offer the best bang for the buck, and not
5 emphasise, defund or de-implement those that don't.
6

7 Now, you need levers to do that. You need the levers
8 of a special commission making recommendations to change
9 the way funding works. But you also need levers to change
10 clinical behaviour because - I'm just tracking back to what
11 you said earlier about the clinician who has done this for
12 10 or 15 years, the same procedure. That's what they do.
13 They're funded to do that. They've built a livelihood
14 around that, and that's what they deliver. So that may
15 require a generational change, and I'm sure the Special
16 Commission has heard people talk to that because it's hard
17 to change clinical behaviour.
18

19 Q. We also have - we heard some evidence yesterday about
20 sort of doing - effectively doing things because it's the
21 way we've always done them --

22 A. Yes.
23

24 Q. -- and the example that cropped up was --

25 A. The example that cropped up was the law. The entire
26 law is based on that, isn't it, on precedent, if I may go
27 into a territory I know nothing about. So my point is many
28 professions do stuff that's got a time lag about it or
29 maybe they could modernise or - but they continue on
30 because, I don't know, it's what we've always done or it's
31 got some benefit, and medicine's no different.
32

33 Q. Yes. So what I'm trying to get to the bottom of -
34 maybe I'll pick up an example that the Commissioner gave
35 and mix it with another. So we have an increased
36 recognition within the population of children who either
37 have neurodivergence or have developmental issues which
38 with an intervention, timely intervention, could
39 potentially change the trajectory of their lives, have it
40 sorted out before they start school or before they fall
41 behind at school. We see that potentially as being level 1
42 care. If you can identify that child, provide that
43 intervention in a way that will turn the child's life
44 around, that would be level 1 care, would it not?

45 A. I would just use level 1 care in the way that it's
46 used technically by clinicians and researchers, which is
47 that care which has a randomised trial - level 1 evidence

1 is where it has a randomised trial and demonstrates without
2 any doubt that it would work.

3

4 Q. Yes, okay. So --

5 A. It's just a terminology issue.

6

7 Q. No, no, no, it's important.

8 A. Yes.

9

10 Q. So, in terms of these interventions that we might be
11 making in this hypothetical paediatrics space, starting
12 position is based on a randomised trial to the extent that
13 they exist - and acknowledging it might be a difficult one
14 to implement?

15 A. Yes.

16

17 Q. But nevertheless randomised trials, if there is an
18 evidence basis to show an intervention at an early stage
19 will have benefit in terms of the child's trajectory, life
20 trajectory --

21 A. Yes.

22

23 Q. -- that becomes part of the 60 per cent of care that
24 we could be providing at the moment, which is level 1 care.
25 We then have elective surgery at the other end of
26 the spectrum for a person who's into the second half of
27 their life, has discomfort in their knee, for example, and
28 they need a knee replacement to improve their quality of
29 life, maybe improve their productivity, but it really
30 depends on a range of very personal circumstances. But,
31 again, if the intervention at that point is provided in a
32 way that is beneficial to that patient and there's a
33 randomised trial which tells us if we give this patient a
34 knee replacement the outcome for them will be better, then
35 that's also level 1 care. But within a system we might not
36 have - particularly with this contraction of what is the
37 public health system, we might not have enough money to do
38 both, and I recognise they're probably not good examples to
39 say one's in or one's out, but they're perhaps useful for
40 the purposes of this discussion. How do we make a decision
41 systemically about which one we do?

42 A. So if both have level 1 evidence and they're going to
43 benefit the patient we're going to do both. We're always
44 going to privilege kids and paediatric care because that's
45 just the way humans are, isn't it? I mean - and there's
46 lots of evidence to say if you do things for children in
47 the first 1,000, 2,000, 5,000 days that's going to have

1 huge benefits for them, the economy, society, the health
2 system later on.

3
4 Q. Can I test that one. What we do have within most of
5 the service level agreements with the LHDs and the BHI
6 measures, and we hear a lot about, is waiting times for
7 elective surgery being within parameters?

8 A. Yes.

9
10 Q. And so to the extent that that person with the
11 uncomfortable knees is deemed a suitable candidate for a
12 knee replacement by a surgeon, they go onto a list and then
13 we start the stopwatch, and that patient does, because we
14 are incentivised to keep that timeframe to click the
15 stopwatch off as quickly as we possibly can, get the
16 procedure that they get or that they need. But with the
17 child who might need the intervention, if we don't have any
18 metrics which are holding us to account in terms of waiting
19 lists to see a paediatrician, community paediatrician, for
20 example, or waiting lists to receive care through a speech
21 pathologist, then I'm not sure that it's right that we'll
22 always treat the child and in the current system we are
23 always treating the child, but I'm interested to hear what
24 your response to that is?

25 A. So I don't think it's a tradeoff between those two.
26 I don't think that's really ever made, even implicitly by
27 the system. I think it's more a tradeoff of that
28 distinction you were making earlier about low value and
29 high value care. If I've got - if I'm in my 60s and I've
30 been a runner for 30 years and looked after myself but now
31 I've got osteoarthritis of the knee and I can't run anymore
32 and I go to a surgeon, I might get the surgeon saying,
33 "Well, we're going to operate on you," or, "You need a knee
34 replacement." But if I go to a physiotherapist and get
35 community-based physiotherapy I might just do as well, in
36 that case I probably will do just as well - in fact, that's
37 a real case, that's me - so I do just as well not having a
38 knee operation and having effective physiotherapy regime,
39 which is much less costly to New South Wales Health. I may
40 pay for that physio privately, but the overall cost is much
41 lower to the economy. That's a good outcome.

42
43 Q. We might not be implicitly making those decisions and
44 certainly not explicitly making that choice between those
45 two, but I just wonder whether unconsciously those choices
46 are being made by the way in which funding structures
47 operate and the way in which things like KPIs and

1 performance measures are implemented across the system? So
2 funding for the knee replacement, there is activity
3 generated by a knee replacement. The LHD gets money for
4 doing that procedure?

5 A. Yes.

6
7 Q. It potentially complies with its KPI because the
8 waiting time for that operation is something that we have a
9 stopwatch on, whereas the waiting time for the child to
10 present at and be seen and treated by a paediatrician or an
11 allied health professional who they need to see is not
12 being - whilst it may be being measured, it's not being
13 measured in a way which is being used to hold the health
14 system to account in any way. Maybe unconsciously we are
15 actually making that choice through the systemic levers
16 that we are pulling?

17 A. Yes, and even at the institutional level the way we
18 fund hospitals or LHDs and then the way we fund Sydney
19 Children's Hospitals Network we're making some societal
20 level decisions that way, and then their ability to get
21 philanthropic support in addition to the fundings they've
22 got. So I think society is making some of those choices.
23 I think absolutely you're right. Yes.

24
25 Q. Is there a way that we could adjust either the funding
26 structure or the general discourse around the way in which
27 system planning happens within health that could actually
28 bring some of these potentially unconscious decisions more
29 to the fore so they are in fact a little bit more obvious;
30 that is to say by continuing to provide this service which
31 for the 60-year-old runner may have some potential benefit,
32 may not, as opposed to the child who needs this
33 intervention, there's some benefit there, there may not be
34 some benefit there, but ultimately if you have a limited
35 budgetary envelope and you have to make a choice about
36 which one you want to do, assuming that you can't do both
37 or you can't do both properly within the existing funding
38 envelope, is there a way we could adjust the system, do you
39 think, that would perhaps flesh that out a little bit more
40 so we know what we're doing in what choices we're making?

41 A. Yes. I mean, good data is going to be important
42 there, and also criteria for making rational decisions is
43 going to be crucial. So, I mean, if we think about the
44 system, there's three bits to it, isn't there? There's how
45 do people get into the system in the first place. I'm now
46 not playing population game now. I'm just talking about
47 New South Wales Health, the health system that you are

1 trying to work out the funding mechanism for.
2

3 Q. Just so I can understand, are we talking about the
4 acute care setting or the delivery of health care across
5 New South Wales through primary care, private settings,
6 allied health and the acute care space?

7 A. We can talk about both, but how do people get in in
8 the first place. So we published a paper in the Medical
9 Journal of Australia in 2015 and we talk about the conveyor
10 belt. So there's people in the community right now who are
11 going about their New South Wales business, and something
12 happens, they get to a GP, or they fall over in a shopping
13 mall or something happens, they're in a car crash or
14 something happens to them, and they get taken to an
15 emergency department, and then a bit later they find
16 themselves in an ICU bed, which is the most costly place
17 you can put people. Was that the right place for them to
18 be? Well, there's no master controller, no-one made a
19 decision. The patient went through to Emergency via the
20 ambulance system, and then somebody made a decision to put
21 them in a ward, and then they deteriorated or something
22 happened with them and they ended up in ICU.
23

24 Now, a third of patients die in ICU. So no
25 intensivist, intensive care specialist, wants to be in
26 intensive care and die. What they want to be is what we
27 all want: at the end of life you want to be surrounded by
28 your family, pain free, having had good palliative care
29 services. So how do we stop that conveyor belt from
30 getting people into the system and into the right place in
31 the right - so that the patient gets treated in the right
32 place at the right time for the right kind of care? That's
33 the big question.
34

35 So you can have people on waiting lists, but do we
36 have - and I don't know the answer to this in New South
37 Wales - do we have people looking at those waiting lists
38 and deciding, "That person would be much better off, rather
39 than getting a knee operation, getting a good physiotherapy
40 treatment," and I don't know that we have because the
41 waiting lists, aren't they owned in New South Wales by
42 the - I'll have to get advice on this - aren't they owned
43 by the surgeons? And so where's the nexus between whether
44 we can make a rational decision on care versus the clinical
45 opinion that that person needs surgery? That's an example.
46 So one question is how do people get into the system? Is
47 it - are the right people getting into the system and

1 getting this expensive care? So that's one question.

2

3 Q. Does that not have another driver sort of in the
4 middle of it, which is that patient who's in the acute
5 setting, having been placed on the conveyor belt, who then
6 ends up in an intensive care bed, the system sees itself as
7 having succeeded in providing the right service at the
8 right place because the patient who became very sick in
9 that hospital or who deteriorated in that hospital was able
10 to be moved immediately into an intensive care bed, so that
11 incentivises building more intensive care beds?

12 A. True, but you know there's plenty of evidence that
13 doctors get less care than anyone else?

14

15 Q. Through voluntary choice or --

16 A. Yes. They know more than the general public whether
17 it's worthwhile having that particular treatment or
18 whether - and they tend not to overmedicalise. They
19 may - I'm not criticising the medical profession. It does
20 a great job. But they can overmedicalise conditions and it
21 gets treated, whereas they don't for themselves. That's
22 very telling, isn't it? There's a saving if we could get
23 everybody in society to get the same level of care that
24 doctors got. There would be a saving to the system.

25

26 Q. I think I distracted you with that.

27 A. Yes. So one bit's how do you get into hospital,
28 conveyor belt or, you know, what is the criteria? Another
29 bit is what do we do when they're in there in terms of
30 procedures or moving them out of hospital quickly into
31 maybe the community and doing Hospital in the Home, and no
32 doubt people have talked about that. And then the other
33 bit is how do we discharge them, because - and I know
34 you're having other people who were reporting to you about
35 the difficulty, is we've got people, maybe 20 per cent -
36 I don't know what the number is, maybe 20 per cent of
37 people who are currently occupying a bed in New South Wales
38 could safely be discharged into another setting, and that's
39 a great saving to the system. There would be more - the
40 waiting lists would go down, people would get better care
41 who are waiting for it. So how do we do that? If you can
42 provide some advice and recommendations and suggestions on
43 that, that would be really very well received.

44

45 Q. So that requires in effect a bridging of the silos --

46 A. It does.

47

1 Q. -- of care both from a funding point of view and
2 for --

3 A. You need the federal government at the table, and it's
4 one of the limits of having an inquiry in a particular
5 state.

6
7 Q. You refer in the submission that you made to the
8 concept of value-based payments and suggest that they might
9 be something that should be looked at as an alternative way
10 of approaching the funding of health care. Could you
11 explain that concept and how you see it might make
12 differences to the way in which we deliver the public
13 health system?

14 A. So value is what's delivered when there are benefits
15 to the patients, benefits to the system, benefits to
16 society, really, for the amount of cost that's produced, to
17 produce that care, that's generated to produce that care.
18 So that's - so what you want to do is produce more care
19 that's high value and less care that's low value, and
20 I mentioned that before on Choosing Wisely and other things
21 that New South Wales has done that I hope you access about
22 the work they've done on producing high value - more high
23 value care across those 14 - I think there's at least 14
24 conditions where they've done work on that.

25
26 It would be an interesting question to ask now several
27 years later to what extent has that had take-up and been
28 implemented, and that speaks to how hard it is for the
29 system to take on board any initiative, including your
30 recommendations when you formulate them.

31
32 Q. So having said that, though, you've identified these
33 forms of low value care, wanting to incentivise the
34 delivery of high value care. How do value-based payments
35 operate in that context? Just perhaps talk us through by
36 way of a hypothetical example how a value-based payment
37 might be structured.

38 A. So I'm not an economist. I'm not a health economist.
39 It's a question, really, rather than an answer to your
40 question: could we design a system where we provide more
41 incentives, systems incentives or even clinician
42 incentives, to treat more high value care than low value
43 care? Now, we've got that in a way, and that's the MBS
44 schedule. It's not New South Wales. It's Australia wide.
45 There's been lots of attempts to try and change that
46 because there are some procedures that generate a great
47 deal of benefit to the provider, we're not sure if there's

1 an equal amount of benefit to the receiver of the care, and
2 some people are making a very good living out of that.
3 Now, that's a federal question. But New South Wales is a
4 big voice in the health system and I'm sure regularly is
5 looking at that and discussing that with the federal
6 ministry of health.

7
8 Q. Even if we do get to the point where we can through a
9 funding structure incentivise the delivery of high value
10 care, is there not still a point where we have to make a
11 decision about what is going to be delivered through the
12 public health system, what can we do and what can we do
13 properly, as opposed to let's try and do as much as we
14 possibly can, if the consequence of that is delivering a
15 lot of care in a highly strained way because aspects of it,
16 through the thin spreading --

17 A. Yes.

18
19 Q. -- of the budgetary envelope, are not being resourced
20 properly?

21 A. If there's excessive thin spreading, I think that's
22 not wise. There's definitely a relationship between volume
23 and outcomes. In other words, if you have a surgical group
24 that does a lot of a certain kind of procedure, heart
25 bypass surgery or something like that, they get really good
26 at it and really efficient. You don't want that done in a
27 remote setting, where you can't guarantee the quality and
28 it's only done once a week or once a fortnight or something
29 like that. You don't want to receive that care. You want
30 to receive it in a big centre where lots of - there's lots
31 of throughput.

32
33 Q. Not good for the patient, obviously, to have someone
34 performing a procedure which is - they're doing
35 infrequently and perhaps not as safely as it's being done
36 by those doing it more regularly?

37 A. But citizens and taxpayers, rather than patients, they
38 would like a teaching hospital right next door, even if
39 they live in a remote place, but that's not going to
40 happen.

41
42 Q. That takes us to the next step, which is there may
43 well be a point at which a procedure can be delivered
44 safely because it's being done sufficient times within a
45 setting, maybe the hospital that's next door to our
46 hypothetical taxpayer, for it to be, based on evidence,
47 safe, but it might not be the most efficient way of

1 delivering that care because delivering it at a large
2 teaching hospital which is doing a much higher volume of it
3 actually means that there are greater efficiencies in
4 delivering that care in that setting. Does that - how do
5 we grapple with that in terms of deciding whether or not we
6 should be providing care to everyone everywhere as opposed
7 to confined to certain settings where it's more
8 economically feasible or more efficient systemically to
9 deliver it so as to reduce the extent of the thinning of
10 the financial envelope?

11 A. Yes. So, you know, streamlining that way where you
12 get more centres of excellence, which are super specialised
13 quaternary, super specialised groups. The problem is
14 politically that's not been a very happy hunting ground
15 because politicians don't like taking things away from that
16 hospital to give to that hospital, and the clinicians
17 themselves sometimes are in competition with each other for
18 equipment and patients, et cetera. So it's kind of - it's
19 easy to recommend but hard to do, is the problem.
20

21 Q. But is part of the difficulty - and this might be more
22 of a political question than a --

23 A. We're trying not to be political.
24

25 Q. But is part of the difficulty with that the political
26 challenge that's raised raises its head in large part
27 because, as you characterise it, we're taking away from one
28 hospital to give to another, but there's no clear
29 identification of the benefit that attaches to that
30 decision; that is to say, everyone looks at the detriment,
31 something is being taken away from one hospital, where you
32 have to drive further for this procedure now, but there's
33 no - in the way the system is currently being formulated
34 and articulated, there's no transparency around, "Well,
35 we're doing that because that means we can provide our
36 paediatric service," for example, "and we've made an
37 evidence-informed decision that this is actually more
38 important than being able to provide that procedure
39 20 minutes away from your house as opposed to an hour away
40 from your house"?

41 A. Sure. No, I just - I can't anything but agree that
42 that's right. It's not in the interests of people
43 to - it's better to travel and get very, very good care
44 than get care next door that's substandard or not up to
45 scratch because they're just not doing enough of those
46 procedures.
47

1 Q. But that's relatively self-evident, but then it might
2 also be better, may it not, for the person to travel to get
3 the excellent care, which could be safely provided next
4 door --

5 A. Yes.

6

7 Q. -- if the upside of that is there is some other
8 service which they or some other member of their community
9 might actually have a genuine need for that would otherwise
10 not be provided --

11 A. Yes.

12

13 Q. -- which is what you can deliver through the saving
14 that you've made by centralising in a cost-effective and
15 safe way the particular procedure that our hypothetical
16 taxpayer needs?

17 A. That's true. That's true. The way hospitals have
18 developed, though, because you've got an emergency
19 department that anyone can come to you, the big ones, then
20 you tend to provide the widest range of services possible
21 to cope with all of those. We haven't done a very good job
22 perhaps of integrating across the system - even when we
23 formed LHDs, and before that there was area health
24 services and - I was at the inception of the first
25 experiments with those, I go back that far. We haven't
26 done a very good job of saying how do we link this up so
27 that we communicate better. The new digital record thing
28 going on is probably one way that we're going to do a
29 better job with that.

30

31 Q. A single digital patient record theoretically enables
32 patients to transition from one setting to another --

33 A. Yes.

34

35 Q. -- in a way that reduces unnecessary tests that might
36 already have been done, maximises the extent to which the
37 quality of their health care is enhanced by knowledge of
38 the health care they've been delivered in a different
39 setting?

40 A. Yes.

41

42 Q. But it doesn't necessarily help us so much with those
43 decisions around what should the public health system
44 actually look like at each of these locations, should we
45 have this procedure being offered in this facility or not,
46 and I guess what I'm interested to explore with you is how
47 we might go about as a system making those decisions?

1 A. So that might be through sitting down and centrally
2 planning the New South Wales - the Sydney Basin, because
3 it's mainly the Sydney Basin where this occurs. The other
4 way is to think - this is not going to be popular with
5 clinicians, but measure, if there's two units or three
6 units in three different hospitals, which ones deliver good
7 outcomes, which ones deliver the best outcomes. It's not
8 going to be popular because no clinician wants to think
9 that they're not doing as well as the people over there.
10 But somehow we have to have a rational criteria and
11 rational decision making about that. Even then, it's going
12 to be hard.

13

14 Q. This is coming back to science. Just to pick up on
15 something you said, the extent to which good outcomes might
16 be produced in one setting but not another?

17 A. Yes.

18

19 Q. That's not necessarily just a function of the quality
20 of the surgeon or surgeons, for example, who are operating
21 in that facility, is it? It may well be a range of
22 factors, like the mix of different procedures that are
23 being offered, which in turn informs the skill set of the
24 entire team throughout the hospital conveyor belt for those
25 particular patients?

26 A. And how well it's governed and the structure of the
27 place, but also the culture.

28

29 Q. So the quality of the outcome in each of these
30 settings is a factor which if you were making decisions
31 about creating centres of excellence, for example, would
32 potentially feature, but likewise presumably you would need
33 to make decisions based on things like the location of that
34 setting relative to --

35 A. Yes.

36

37 Q. -- population densities and those sorts of things?

38 A. You absolutely would.

39

40 Q. Is there a reason that you've been able to observe why
41 this - as a system, the health service has not done well at
42 centrally managing the system in the way - in the
43 coordinated way that we've been talking about?

44 A. It hasn't done a bad job. It hasn't done a bad job
45 because we've got functional LHDs right across the Sydney
46 Basin for a population of 5.5 million, which is pretty
47 good. But why they haven't been able to do that? I think

1 Sydney's population has been growing and changing, and
2 always services are playing catch-up. I go back when
3 I remember in '78 when Westmead opened. That was a major
4 thing for the people in the west. It's probably in the
5 east - Westmead is probably eastern Sydney now, the
6 population has grown out so much. So, you know,
7 populations grow, gotten older, developed, been more
8 demanding, and we've been trying to in a way play catch-up
9 with distributing services sufficiently well, and then
10 every large hospital wants to do the wide range of things
11 that its patients might require. So that sort of mitigates
12 against building specialist centres where people go to for
13 their care, unlike, say, somewhere like India, where
14 there's a heart hospital that only does hearts and
15 everybody comes there from miles, kilometres around and
16 that's where they go to, and they get really good at that.
17 So we haven't historically got the right background to have
18 created those in New South Wales.

19
20 Now, can we? That's a question we have to really have
21 a look at internationally, I suspect.

22
23 Q. To the extent that we have done that and think of a
24 couple of examples that we've encountered are - heart and
25 lung transplants being a good example, it seems that the
26 circumstances which led that to being a service that was
27 provided in the one location that it is provided didn't
28 really have much to do with a long-term planning process
29 but, rather, a particular clinician or group of clinicians
30 who had particular grants who did work in a particular
31 place, which in turn created the possibility of this
32 surgery, which happenstance then led to it being the place
33 where it was done.

34
35 But I guess that's another question around this
36 planning. How should we be dealing with the extent to
37 which those sorts of circumstances can produce innovation,
38 and valuable innovation, but doing it in a way that enables
39 us to be a little bit more focused on our system planning
40 whilst it's being rolled out?

41 A. It's the perennial problem for every system, not just
42 in health: what's the right mix of top down versus bottom
43 up, and can we let a thousand flowers bloom because that
44 treats lots of innovation, but it also creates a lot of
45 wastage, you know. I run the Australian Institute of
46 Health Innovation. We talk about this almost every day.
47 How do you get innovation in a system where we also want

1 standardised care, so, equitably, everybody gets a good
2 quality of care, and we want hospitals to be able to
3 provide a wide range of services to people so that if you
4 go to hospital and whatever happens to you, whatever your
5 multi-morbidity is, you get access to care there in the one
6 place. So these are perennial problems. There's no magic
7 solution for that.

8
9 Q. Is that part of the problem, though, just the notion
10 that you go to a hospital with a problem and you'll have
11 that problem dealt with, unless it's one of these extremely
12 pointy end sort of procedures, at that hospital? Is that a
13 mode of thinking which might have once worked when the
14 delivery of medicine was simpler --

15 A. Yes.

16
17 Q. -- and sub-specialisation and particular techniques
18 and medical innovations had not yet occurred, but within
19 the existing funding envelope might it be the case that
20 that's just not a realistic way of approaching health care
21 anymore?

22 A. Sure. It happens a little bit because people get
23 an - you know, clinicians get an interest and they super
24 specialise and then patients come to them, and if that's
25 not happening at that hospital or facility they might go to
26 another one and set up shop there and - so it does happen a
27 little bit. But in the current strapped-for-cash system it
28 happens less than it did in the old days, I suspect.

29
30 On that, you know, I wanted to mention about medical
31 emergency teams. They've been spectacularly successful and
32 are a good change model.

33
34 Q. Tell us about that model.

35 A. So medical emergency teams - and New South Wales did
36 very well here. It's a case example that might be of
37 interest to you. So in the old days what used to happen is
38 if a patient had a cardiac arrest you'd send the crash team
39 in to deal with that cardiac arrest, and that worked that
40 way for decades. But, really, in a way that was insane
41 when you think about it because why would you wait until
42 after the person had their cardiac arrest as an inpatient
43 before you send in the team? So medical emergency teams
44 came in the last 20 years - also called rapid response
45 system. So what happens now is, if a patient is on a ward
46 and they're starting to deteriorate, that ward may not
47 necessarily have the skills to deal with the deterioration

1 but all they have to do is notice the deterioration and
2 call the medical emergency team. So now before the patient
3 actually goes into a big crash the medical emergency team
4 is called, and then they come out of intensive care and
5 they deal with the person.
6

7 So New South Wales - we published some papers on this,
8 and it was the Clinical Excellence Commission that did
9 this - invented a program called Between the Flags, an
10 Aussie icon type thing where if the patient was swimming
11 between the flags it was okay but if they went outside
12 the flags you should call - that was deterioration and they
13 were now at risk and you could call the medical emergency
14 team.
15

16 And then some places have - I don't know about New
17 South Wales, but some places have extended that so that the
18 patient or the patient's relative can call the crash team,
19 can call the medical emergency team. Now, that's kind of
20 way outside of medicine's understanding of how care works,
21 that they're the experts. So that was quite radical. But
22 now if, say, in a kids' hospital - the person who knows
23 whether the patient is deteriorating best is the mother or
24 the father, so they can call the medical emergency team if
25 they think their child is deteriorating, and it's probably
26 saved a lot of lives.
27

28 So the question is how did that arise, how did we
29 manage to get that up against the medical culture which is
30 the doctor in charge owns the patient and, "You can't do
31 anything with that patient unless I approve it, I authorise
32 it. I'm the authorising person." So that managed to get
33 up in many parts of the world, including in many hospitals
34 in Australia. It's a good example of how change can be
35 done if you're looking for to hang some of your
36 recommendations on a good model.
37

38 Q. How was it done?

39 A. Sorry?

40
41 Q. How was that change effected?

42 A. Over time with a group of committed people, committed
43 intensivists and people like me doing research, finding
44 that a research interest, to slowly get that done over
45 time, and convince others who were sort of saying, "Well,
46 we don't need that in our hospital. We look after our
47 patients well." But that wasn't true.

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Q. In relation to research of that kind, another thing you've pointed to in your submission is the desirability of there being greater transparency of data --

A. Yes.

Q. -- so health systems can learn and, I'm assuming based on answers you've given, learned from research conducted by organisations like yours. What did you have in mind when you were suggesting greater transparency of data? I fully appreciate the more data we can collect the more there is for you to work with, but only if you can get access to it?

A. I can submit a paper to you that we wrote just recently on the idea of learning health systems, health systems that continuously improve and learn, and it's the idea that there's lots of data lying around in health care, huge amounts. How do we turn that into intelligence? Firstly, we've got to turn it into information that is useful for people who make a decision - policy makers, clinicians, leaders, patients - and then how do we turn that into intelligence, that's intelligent data.

So there's people coming up with dashboards - there's lots of that in New South Wales hospitals now compared to 10 years ago - people using data much more wisely, but there's a huge - there's a deluge of it. So how do we pick and choose the right KPIs, the right incentives for people to use data, how do we liberate data while still preserving privacy. There's a raft of issues here.

THE COMMISSIONER: This is the theme of "The patient will see you now"?

A. Sorry?

THE COMMISSIONER: This is the theme of "The patient will see you now"?

A. Yes.

THE COMMISSIONER: The Topol book. Yes

A. Well, patients are going to do it anyway. Who doesn't, if they have a twinge or get some symptoms, go to Google or ChatGPT or Copilot and have a quick look at what that means before they go to the GP? That's radically different to 10 years ago or 20 years ago. So you're either going to see Dr Google and sort of make a judgment as a patient, or you're going to get some good advice or even a second opinion. So people are using data all the

1 time.

2

3 MR MUSTON: You tell us about the potential value of
4 preventative care. How do we value preventative care and
5 see it as - particularly in the context of what might
6 historically within the New South Wales public health
7 system have been a more acute care focused system --

8 A. Yes.

9

10 Q. -- how do we - do we introduce and value preventative
11 care as part of that system, or how should we be?

12 A. Yes. So if you've got a dollar to spend and you're
13 running an LHD and you've got patients trying to get in
14 with acute conditions, you know, that's often where the
15 money goes, and that's completely understandable. But the
16 long-term benefits - it was Commissioner's question
17 earlier, the long-term benefits of preventative care, the
18 problem is you don't see it in, dare I say it, an electoral
19 cycle or even the medium term. You're going to get the
20 benefits later on down the track. These are very difficult
21 questions. I'm going to go away, Commissioner, and have a
22 look at any studies, economic studies, of the longer term
23 benefits of preventative care --

24

25 THE COMMISSIONER: Thank you.

26 A. -- and health education.

27

28 MR MUSTON: The last thing I wanted to ask you about was
29 where you talk about the human development and the obvious
30 importance of the workforce to the health system. But what
31 you tell us is robust evidence-based health workforce
32 planning, not just of the medical workforce, is essential
33 to enable healthcare systems to respond to significant
34 challenges. What do you regard as being robust
35 evidence-based health care - health workforce planning?
36 What might that look like?

37 A. So this is a question for Australia as well as New
38 South Wales. We sort of haven't done a very good job of
39 predicting ahead of time how many doctors we'll need, how
40 many nurses we'll need, and we sort of - it's like a
41 seesaw, we zig and zag, sometimes there's a surfeit of
42 people and then there's a scarcity. So maybe that's a
43 product of medical and nursing and allied health educations
44 distributed across universities, and it's a federal
45 government problem as much as anyone's. But we really need
46 to do better at planning workforce, and this comes from my
47 colleague Professor Yvonne Zurynski, who works in my

1 research institute. We can send you some of her papers.
2 It's just being much more robust about planning for the
3 workforce and trying to do better at extrapolating and
4 forecasting and predicting what's needed.

5
6 Q. But that presumably requires a far greater level of
7 collaboration between, say, the health system that is the
8 recipient of that workforce and the education system,
9 including vocational education of doctors - tertiary
10 education of doctors, nurses and allied health
11 professionals and the like in terms of what do we forecast
12 as our need, how are we now going to facilitate in
13 collaboration with educational institutes and medical
14 colleges for delivery of that workforce --

15 A. Yes, it's a big collaboration.

16
17 Q. -- in a timely way?

18 A. And then we've got that unfortunate problem - that
19 unfortunate intervention in the health system called
20 COVID-19, which, you know --

21
22 Q. We've heard a lot about that.

23 A. I'm sure - which, you know, created a lot of
24 subsequent burnout and fatigue and people not wanting to
25 do - become a clinician, and that's posing us a problem
26 that's going to last for a while. So it's hard to forecast
27 and predict these things.

28
29 Q. That's probably brings one last question up. We have
30 been told repeatedly that there is a demographic change or
31 a social change in the demographic of people who are
32 clinicians entering the system, either nurses, doctors,
33 allied health professionals. There was a time when many of
34 them would take it on as a vocation and work from the sun
35 up until sun down and go out at night if they needed to be
36 called upon for an emergency, that that was the way they
37 approached their professional lives, whereas nowadays
38 younger people entering these professions don't want to
39 work and live that way any more. So we've been given a
40 whole lot of statistics, which I suspect are largely
41 rubbery figures, but for each one FTE of a retiring medical
42 professional you need 1.5 or two or sometimes people have
43 said up to three to replace them?

44 A. Yes.

45
46 Q. Is that a reality that just contributes to that
47 increasing cost of delivering health care, we're no longer

1 in effect getting more than one FTE worth of work out of
2 one FTE worth of salary and that's something we're just
3 going to have to come to grips with?

4 A. I don't know. It's an empirical question that needs
5 to be tested. But, just thinking of my own involvement
6 with health care over decades, it certainly was the case
7 that there was a lot of goodwill amongst especially
8 doctors, who would devote themselves to a particular
9 facility and, you know, be on call night and day and all
10 that sort of stuff. It was also a less demanding era. You
11 know, we can do lots more now. It's become more
12 professionalised in a way. And we do think that the latest
13 generation of Millennials or whatever title, Gen Z or
14 whatever they're called these days, you know, are quite
15 happy to do their shift but not necessarily do that extra
16 mile.

17
18 It seems real. I'd have to do more work to think
19 whether it was actually empirically real. But if it is
20 real then that's true, we've got a problem of extra costs
21 because of that. So, if your hypothesis is right, it's an
22 extra difficulty for the system to navigate.

23
24 MR MUSTON: I have no further questions for this witness,
25 Commissioner.

26
27 THE COMMISSIONER: Mr Chiu?

28
29 MR CHIU: I have no questions.

30
31 THE COMMISSIONER: Professor, thank you very much for your
32 time. We're very grateful for the assistance you've given
33 the Inquiry. Thank you.

34 A. Thank you, Commissioner. Thank you, counsel.

35
36 THE COMMISSIONER: All right. We'll take the morning
37 break now and come back at 11.45.

38
39 <THE WITNESS WITHDREW

40
41 **SHORT ADJOURNMENT**

42
43 THE COMMISSIONER: Yes.

44
45 MR MUSTON: Commissioner, the next two witnesses from your
46 left to your right on screen are Professor David Bedford of
47 the Business School at UTS within the accounting discipline

1 and Rosie Viney, who is a professor of health economics and
2 the Director of the Centre for Health Economics Research
3 and Evaluation also at UTS.

4
5 THE COMMISSIONER: Thank you. Professor Bedford, can you
6 hear me?

7
8 PROFESSOR BEDFORD: I can.

9
10 <DAVID STUART BEDFORD, affirmed: [11.51 am]

11
12 <ROSALIE CLAIRE VINEY, affirmed:

13
14 <EXAMINATION BY MR MUSTON:

15
16 MR MUSTON: Professor Bedford, I might just get you to
17 state your full name for the record, please.

18
19 PROFESSOR BEDFORD: David Stuart Bedford.

20
21 MR MUSTON: And, Professor Viney, I might ask you to do
22 the same.

23
24 PROFESSOR VINEY: Rosalie Claire Viney.

25
26 MR MUSTON: Thank you. Can I just start by testing some
27 propositions with you that we've explored with other
28 witnesses over the past couple of days. Accepting that the
29 budgetary envelope which will be available to health is
30 always going to be confined, that is to say it's not a
31 limitless amount of money, there will always - that budget
32 will always be able to be exhausted by delivering care to
33 patients which is, at least to those patients, of high
34 value, even in a system where all relevant inefficiencies
35 have been weeded out; would you agree with that?

36
37 PROFESSOR VINEY: Yes, I'd definitely agree with that.

38
39 MR MUSTON: And, having delivered all of that care, there
40 will be no doubt a wide range of care that you could
41 continue to deliver to patients which would be of high
42 value to those individual patients if you had more money;
43 is that right?

44
45 PROFESSOR VINEY: Yes. David?

46
47 PROFESSOR BEDFORD: Yes, I would agree with both those

1 statements.

2

3 MR MUSTON: That is to say health is a bit of a bottomless
4 bucket in the sense that there's probably no end to the
5 amount of money that you could actually spend on the public
6 health system and do so in a way which was at least from a
7 health perspective of genuine benefit to the community,
8 assuming that the system was operating even at perfect
9 efficiency.

10

11 PROFESSOR VINEY: Yes, I'd agree with that.

12

13 PROFESSOR BEDFORD: Yes, that's correct.

14

15 MR MUSTON: Of course back in the world of reality there
16 is a limited budget available to a government, and
17 decisions need to be made about how to spread that
18 budgetary envelope across the varying competing priorities
19 which are faced by government, including education,
20 transport, justice et cetera. And you'll need to answer
21 out loud. Whilst you're both nodding --

22

23 PROFESSOR BEDFORD: Yes.

24

25 MR MUSTON: -- the transcript doesn't pick up the nod.

26

27 PROFESSOR VINEY: Yes, agreed.

28

29 MR MUSTON: And it's not quite so simple as saying money
30 spent on health helps health and money spent on, say,
31 education or community services helps those respective
32 areas. Particularly having regard to things like the
33 social determinants of health, there are ways in which
34 money allocated to other sections of the budget, for
35 example, education, community services and the like, which
36 can in the long-term have significant benefits from a
37 public health point of view or population health point of
38 view.

39

40 PROFESSOR BEDFORD: That's correct.

41

42 PROFESSOR VINEY: Yes. I think there are several examples
43 where we see that investing in other areas such as housing
44 or improving the environment et cetera can make a big
45 difference to people's health.

46

47 MR MUSTON: Just for present purpose could we start by

1 looking at the envelope of money which is made available to
2 health. So, accepting that there are other ways of
3 spending money within the economy which could produce
4 health benefits, for present purposes I just want us to
5 focus on the health budget.

6
7 PROFESSOR BEDFORD: Yes.

8
9 MR MUSTON: To the extent that there is more that could be
10 done with the money within the health budget than we have
11 money to actually spend on those things, decisions need to
12 be made about which of the services or forms of care that
13 we deliver and the way in which we deliver them so as to
14 make the best use of the budgetary envelope that we have
15 available; would that be right?

16
17 PROFESSOR VINEY: Yes, correct.

18
19 PROFESSOR BEDFORD: That's correct.

20
21 MR MUSTON: In terms of what we should be aiming to
22 achieve in terms of making the best use of - to use my
23 inelegant phrase - what in general terms do you think the
24 objectives of that spend should be in terms of what are we
25 trying ideally to achieve through the way in which we
26 deploy that money?

27
28 PROFESSOR VINEY: So I think the way we should think about
29 it is we're aiming to improve population health, improve
30 the health and wellbeing of individuals within New South
31 Wales, and ensure that that's done in a way that's
32 equitable; also ensuring that people have access to care.

33
34 PROFESSOR BEDFORD: And I'd just add to that it's done in
35 as efficient manner as possible.

36
37 MR MUSTON: When you said - I think did you say "as
38 efficient"?

39
40 PROFESSOR BEDFORD: "As efficient", yes, not inefficient.

41
42 MR MUSTON: It was no doubt the speaker, but it came
43 across as sufficient, which probably needs to be done in as
44 sufficient a way as possible as well. You tell us in your
45 submission - we might come back to exactly what those
46 objectives might look like in a slightly more nuanced way.
47 But you tell us in your submission - the submission that

1 you've made, and perhaps I should actually go back to
2 that. Each of you I think have contributed to a submission
3 dated 31 October 2023 which was provided to the Commission;
4 is that correct?

5
6 PROFESSOR BEDFORD: That's correct.

7
8 PROFESSOR VINEY: That's correct.

9
10 MR MUSTON: Have you had an opportunity to review that
11 submission before giving your evidence today or more
12 recently than 31 October 2023?

13
14 PROFESSOR BEDFORD: Yes.

15
16 PROFESSOR VINEY: Yes.

17
18 MR MUSTON: And you're satisfied that the views that you
19 expressed in that submission remain views that you hold or
20 continue to be views that you hold?

21
22 PROFESSOR BEDFORD: Yes.

23
24 PROFESSOR VINEY: Yes.

25
26 MR MUSTON: In due course, Commissioner, that might be
27 tendered as well, actually.

28
29 THE COMMISSIONER: Yes.

30
31 MR MUSTON: In that submission you tell us about or tell
32 us that costing information is integral for healthcare
33 funding as it allows for efficient resource allocation,
34 aids in budget planning and forecasting, promotes cost
35 efficiency, enables comparative analysis for benchmarking,
36 supports the assessment of potential impact, enhances
37 transparency and accountability, and facilitates evidence
38 based decision-making whilst driving quality improvement
39 efforts. Could I just ask either of you or whichever of
40 you is best qualified to do so to just, first of all,
41 explain what the costing information you're referring to is
42 and exactly how you think it might better be used within
43 the funding structures or decision-making structures around
44 public health.

45
46 PROFESSOR BEDFORD: Sure. So each of the local health
47 districts in New South Wales have to submit their costing

1 data or the patient level costing data to the
2 NHCD - through the NHCDC, which is the national health
3 costing and data collection process. So that's mandated in
4 the NHRA. And this information attempts to cost the
5 delivery of services or episodes of care to patients within
6 a one-year period. So that costing information should
7 cover nearly all costs. There's a few things that are
8 excluded for various reasons from the patient level costs.
9 But that helps informed primarily funding at a national and
10 state level.

11
12 As you mentioned, from our submission there's many
13 other ways in which that information is then used by state
14 and local administrators such as benchmarking, you know,
15 local hospitals against other hospitals in the LHD or
16 against other LHDs; looking at ways of improving clinical
17 practice; using costing information to improve models of
18 care or tender business case submissions for employing new
19 people or for the purchase of new equipment where they can
20 justify doing so by lowering care or improving quality.

21
22 Whatever funding method that New South Wales Health
23 and the federal government take in future, costing
24 information is going to be critical to implementing any
25 form of funding arrangement, and the reason why is because
26 that patient level cost information indicates simply the
27 cost of providing services to patients. So if that data is
28 incorrect then you'll be misfunding different DIGs or
29 services at the local level.

30
31 So what we've seen in research that I've done is that
32 the quality of that cost information varies a lot; so that
33 some LHDs and hospitals have very good information about
34 the cost of the services that they deliver, but many others
35 do not and they make a series of assumptions about how they
36 arrive at a cost where most of the patient cost is assumed
37 rather than actual cost, which essentially means it's done
38 through accounting estimates rather than knowing, you know,
39 what the true cost of service delivery is.

40
41 MR MUSTON: Are there any checks and balances that can be
42 used to test the accuracy of those assumptions in the sense
43 that, if a hospital knows what its overall spend on staff
44 and other overheads might be, if there's then been a
45 process of assuming based on a range of estimates and
46 assumptions what the cost of delivering a particular type
47 of care might be, is there a way of going back and saying,

1 "We know what the total care delivered is; we know what the
2 total cost is," do the two add up?

3
4 PROFESSOR BEDFORD: Yes, so they'll add up. It's just
5 about the allocation between the services that are
6 provided. So when you're making decisions about where a
7 service should be provided, for instance, if you don't
8 understand the cost at the different centres of treatment
9 then you can't make a valid decision about where it might
10 be most cost effective, and that cost effectiveness gets
11 into calculations about value because you want the best
12 outcomes at the lowest cost, you'll have distorted
13 information and won't be able to make good decisions about
14 value based care.

15
16 MR MUSTON: So that's dealing with making a proper
17 assessment of the cost incurred in delivering services as
18 they're delivered.

19
20 PROFESSOR BEDFORD: That's right.

21
22 MR MUSTON: Obviously it's critically important that any
23 costing data that's relied on is as accurate as possible.

24
25 PROFESSOR BEDFORD: That's right.

26
27 MR MUSTON: And does that costing data take into account
28 or is part of that costing data any sort of assessment of
29 the efficacy of the care that's being provided through that
30 spend? So let me give you an example. You might identify
31 that for a particular procedure which is performed in a
32 hospital or a particular service which is being delivered
33 in a hospital there is a cost per patient or per bed day or
34 per procedure. Is there any assessment made of the extent
35 to which the outcomes - or how do the outcomes of the
36 procedure factor into that costing, if at all?

37
38 PROFESSOR BEDFORD: They don't factor into the costing.
39 So those assessments are made on an ad hoc basis,
40 not - it's definitely not a systematic basis. The
41 only - there's an exception to that in that both state and
42 federal funding has certain adjustments that get made; so,
43 for instance, sentinel events. So if there was a mortality
44 then you wouldn't get funded for that particular event.
45 But there's no systematic tracking of outcomes related to
46 costs. That would all be ad hoc at a LHD level or
47 sometimes at a higher level when certain studies are

1 commissioned.

2

3 MR MUSTON: So the costing data that's gathered, for
4 example, other than in the ad hoc way that you tell us
5 and/or in the event of sentinel events, it doesn't say that
6 X dollars per patient or per bed day to provide that
7 service whilst maybe very low and efficient is not actually
8 producing the sort of quality of outcome that spending a
9 little bit more on that same service might produce?

10

11 PROFESSOR BEDFORD: No, in theory that all can be
12 calculated, but as far as I know it's not done on a
13 systematic basis.

14

15 MR MUSTON: And I assume that the costing also doesn't
16 take into account the extent to which, say, a workforce
17 might be stretched. So if in the ideal world you might
18 have four clinicians who are involved in the delivery of a
19 particular service through a facility but, for workforce
20 reasons, you've only managed to attract three or through
21 decision-making around the allocation of resources that are
22 available there's only three people who are - clinicians
23 who are delivering that service at that time, that on its
24 face would produce a lower cost of delivering the service
25 but would not recognise the extent to which those
26 delivering the service might not wish to continue
27 delivering that service in the longer term?

28

29 PROFESSOR BEDFORD: That's correct. So once you have a
30 look at the cost data it's relatively aggregated. So you
31 can't easily unpick, at least at state level, what is going
32 into that cost; so, you know, how many clinicians were
33 actually involved in delivering a patient's care. In some
34 cases - some LHDs would have that information, others would
35 not. And this also goes into, you know, questions later on
36 that you might have about would you see cost efficiencies
37 arise if you implement new models of care, and often you
38 don't because you still have the same staff, same
39 structures, facilities, et cetera, and the cost is still
40 there even if you reduce the services or provide services
41 in a different way. So it becomes difficult then to make
42 these - actually identify whether particular changes are
43 leading to changes in cost or not, given the current
44 granularity of the cost data that is available.

45

46 MR MUSTON: Now, can I turn to the costing of services
47 from a planning point of view rather than just identifying

1 what the cost of delivering the services might have been in
2 any given period. Is there a different exercise undertaken
3 that you're aware of or is it possible to do a different
4 exercise whereby one identifies a service that might
5 ideally form part of a service mix and works out what the
6 cost of delivering that service properly would be?

7
8 PROFESSOR BEDFORD: Yes. So to do that correctly you need
9 to commission an actual cost analysis to be done of a
10 service. So these are done. So LHDs do do this. So when
11 you have a best practice pathway of care or model of care
12 then you can actually go in and track all the resources
13 that are being used to deliver that model of care, and then
14 you can compare that to what is being done on a state or
15 national basis.

16
17 MR MUSTON: But if you are, say, making a decision
18 about - as part of your prioritisation and decisions around
19 how you're going to deploy a limited health budget across
20 the system through the rolling out of particular services
21 would it be possible to identify the cost of each of those
22 potential services so as you could decide whether spending
23 that money on that service would be something that would be
24 justified as opposed to spending perhaps the equivalent
25 amount of money or a smaller amount of money or a larger
26 amount of money on a different service?

27
28 PROFESSOR BEDFORD: Yes, again, in theory. So you'd be
29 relying - so what I would do would be rely on the larger
30 LHDs because they tend to have more investment into
31 technology, IT infrastructure to collect more accurate cost
32 data. The only issue then of course is if you try and say,
33 "We'll take that cost to delivering in a remote or rural
34 setting," it's not going to hold because they don't have
35 the scale, their costs are going to be more because many of
36 these specialties require locums to come in so you're
37 paying at a greater rate et cetera, et cetera. So in
38 theory, yes, but in practice it becomes more complicated to
39 actually identify this.

40
41 MR MUSTON: So, to the extent that it becomes complicated
42 and difficult to do, how might costing information be
43 used - to use your phrase - as part of evidence based
44 decision-making?

45
46 PROFESSOR BEDFORD: Yes, so although I'm saying many
47 things about the lack of quality in some of the cost data,

1 in general and by world standards we do have good cost
2 data. So that should be on the record, that Australia in
3 general and New South Wales and a few other states in
4 particular really do - we're at the pointy end of the world
5 in terms of the quality of the data that we collect.
6

7 So where cost data probably becomes more useful is
8 where you have services where you have a known model of
9 care and outcomes, and then you look at variability in
10 those costs. So when you have a relatively standardised
11 practice then it becomes easier to identify outliers and
12 cost variations and go and find out why are those cost
13 variations happening.
14

15 When there are services that are delivered
16 infrequently or they're services that have significant
17 costs associated with them that may not be allocated
18 effectively then it becomes more complicated. But in terms
19 of - you mentioned in our submission, for instance,
20 maternity care. We have very good data about the various
21 ways in which maternity care is delivered, and you have
22 quite high confidence in the data, in the cost data and
23 outcome data, in order to make decisions at least to that
24 particular service.
25

26 MR MUSTON: So maybe let me unpack that a little bit.
27 Say, just taking as a hypothetical example, a community
28 based paediatric service that might be offered, not a huge
29 amount of technical equipment and inputs that go into it,
30 it's predominantly going to be a collection of salaries and
31 wages which you identify the team that would be required to
32 provide that service. From a costing point of view there
33 might be some slight complexities around it, but it
34 wouldn't be an overly complicated task, would it, to work
35 out the cost of delivering a service like that?
36

37 PROFESSOR BEDFORD: No. So if you wanted to deliver
38 community maternity care prior to birth then you would be
39 able to do a reasonably good job in costing what that
40 service would be, and then you would be able to compare
41 that to pregnancies that did not have - whether the female
42 didn't have maternity care prior or didn't have access to
43 community care et cetera. Because many of these studies
44 have been done, so you would be able to identify a
45 reasonable population of people and work out the costs in
46 an effective way. Rosalie might have something to say
47 about that.

1
2 PROFESSOR VINEY: If I might add there I think if we take
3 that example of a community based paediatric service, yes,
4 it would be relatively straightforward to say, "Okay, this
5 is what the service is, this is the population that it's
6 covering, this is the kinds of services that we
7 might" - I think from a planning point of view if you were
8 setting up such a new service the question you need to be
9 able to answer is also, "What would happen if we didn't
10 have that service? What would happen - where would the
11 services be delivered? Would there be people not getting
12 services? Would they be going elsewhere?" So I think it's
13 actually getting that comparative component that is really
14 important in thinking about the planning of services. So
15 the costing information, one way or another, will be there;
16 but also thinking about what will happen under this new
17 delivery of services compared with what is happening now.

18
19 MR MUSTON: Definitely coming back to that. That's an
20 important point once I've understood exactly how the
21 costing works. So we've got our relatively straightforward
22 example of the community paediatric service which is
23 predominantly going to be a workforce cost, with some
24 additional expenses.

25
26 We then get into something a little bit more
27 complicated like, say, the delivery of primary care through
28 acute or co-located site, for example, where you've got a
29 workforce cost of a general practitioner or a rural
30 generalist and perhaps a practice nurse, maybe an allied
31 health professional or two, depending on the precise
32 service that you were wanting to build, but those costs
33 would be relatively easy to quantify?

34
35 PROFESSOR BEDFORD: Yes. So the one limitation here is
36 that you would perhaps have to go and collect those costs.
37 So the costs that are collected through the process at the
38 moment are only going to be for the items that are on the
39 general list, you know, determined by IHACPA. So if there
40 is something like a community care or allied health that is
41 not part of the list of services that are being funded then
42 there's perhaps no current collection of that data.

43
44 So one thing if I was making a recommendation is that
45 when you set up these service contracts with community
46 health and allied health is that you require them to
47 provide cost and activity data, because then that helps

1 everyone in the longer term. But at the moment we hear
2 reports of allied health professionals no longer providing
3 the LHD with activity or cost data, and that limits the
4 resources that we have in order to make informed decisions
5 going forward.

6
7 MR MUSTON: In a well-functioning system ideally those
8 resources or such resources as are available would enable a
9 decision-maker to make an assessment or have available to
10 them an assessment of the actual cost of delivering a
11 service before they actually decide to do so so as they can
12 make an informed decision about whether that's the right
13 service to be delivering to a community in the location
14 which it's proposed as opposed to something else.

15
16 PROFESSOR BEDFORD: That's correct.

17
18 MR MUSTON: So in terms of just to deal with that primary
19 care example you've got - it might not yet be readily
20 available because it's not part of the IHACPA ABF suite of
21 activity, but nevertheless you've got your salary and wage
22 component which is something that someone with the right
23 skill set could probably pull together as an estimate of
24 the likely cost of delivering the service, I would have
25 thought?

26
27 PROFESSOR BEDFORD: That's correct.

28
29 MR MUSTON: And then in addition to that there might be
30 some other overhead costs associated with running a
31 facility like that, some equipment, some consumables, but
32 again it's not likely to be overly challenging, is it, for
33 someone who's got the right information available to them
34 and the right skill set to be able to work out, whilst not
35 down to the dollar accuracy, with reasonable accuracy what
36 it's likely to cost --

37
38 PROFESSOR BEDFORD: That's right. That's right. You
39 don't need perfect data; you just need useful data.

40
41 MR MUSTON: Yes.

42
43 PROFESSOR VINEY: Can I just --

44
45 MR MUSTON: No, please.

46
47 PROFESSOR VINEY: I think the other side of this, though,

1 in designing that service there's a question about demand.
2 So you might say we have, you know, a nurse, we have a
3 general practitioner, we have a primary care provider, but
4 I think a lot of the information about the true costs and
5 what the service is likely to deliver will depend upon what
6 happens once that service is there.

7
8 MR MUSTON: I guess there's a couple of ways - just to
9 pick up on that, there's a couple of issues that come out
10 of that, is there not? The first is there's the
11 possibility that if you create a service there will be
12 somewhere out there an unmet demand that will consume that
13 service. And if it's consumed in full then - that is to
14 say if the demand makes full use of the service which is
15 there, then the cost will be at the upper end of your
16 hopefully reasonably accurate estimate of what it would
17 likely cost to deliver the service?

18
19 PROFESSOR BEDFORD: Yes. So, I mean, the more you use a
20 service the cheaper the cost is because you spread those
21 costs across more patients. So there's that aspect to
22 costing. So you first need to know what the demand is of
23 that service and then you also have to work out what
24 reduction in demand for other services might be.

25
26 So what often is reported is when you have the
27 community or alternative paths of care rather than in the
28 hospital setting people report, "Well, there's been no cost
29 saving." And they report that because they often omit the
30 opportunity cost. So you free up a bed day in the
31 hospital, but that cost of freeing up a bed day is not
32 incorporated or taken off the cost of delivering the new
33 service.

34
35 And then like you very early on said as soon as you
36 open up bed days in the hospital that's going to be
37 consumed by other activity. So the total cost never goes
38 down. It's just that you're able to provide more activity
39 to patients. So those two things, what Rosalie mentioned,
40 and the opportunity costs that arise need to be taken into
41 account.

42
43 MR MUSTON: Just to pick up on your point,
44 Professor Viney, another issue about demand that's
45 important is if the demand greatly outstrips the extent to
46 which the service that you've developed is able to meet it
47 then the extent to which it's not being met might not be

1 readily measurable, that is to say all of those people who
2 are not able to get access to the service we don't know
3 anything about them by creating the service, other than
4 we're treating those people who are able to access it and
5 are being treated and we're busy so that's positive, but as
6 to whether or not there's more we're not quite sure; is
7 that right?

8
9 PROFESSOR VINEY: I think that's absolutely correct, and
10 that comes to the point that it may be that the people who
11 are able to access the services may not be the ones who
12 most need to access the service.

13
14 MR MUSTON: And is there also a risk that if there is
15 excessive demand on the service that might actually
16 manifest itself in the form of wait lists which become so
17 long that the clinical benefit of the service that you're
18 proposing to put forward is lost or compromised?

19
20 PROFESSOR VINEY: I think I would agree with that.

21
22 MR MUSTON: I'll come back just briefly to the costing
23 side of it before we get into that more substantive - the
24 benefit side of the cost-benefit analysis. Where we are
25 talking about acute services, say, a procedure - obstetrics
26 service I think is the example that you used - is your
27 point that the data that's available and submitted by the
28 LHDs, starting with the metro LHDs where the data you tell
29 us is perhaps more reliable, does give you a reasonable
30 ability to assess roughly what it costs when you take into
31 account the proportion of staff time which is being
32 deployed in this service, some of it in that case your
33 obstetricians and midwives are probably largely
34 100 per cent being applied towards that service, but there
35 may be other staff within the hospital who have cross-over,
36 consumables, et cetera. Whilst not perfect --

37
38 PROFESSOR BEDFORD: Yes.

39
40 MR MUSTON: -- within the metro LHDs, high volumes like
41 that, you get a reasonable good estimate of what it would
42 cost per baby to deliver an obstetrics service.

43
44 PROFESSOR BEDFORD: That's correct, yes. You might still
45 need to make a few assumptions about how much of that cost
46 is variable, that is for each additional unit you have or
47 take away how much of that cost actually gets saved. So

1 some is fixed; some is variable. But someone that's
2 skilled in doing this analysis would be able to make those
3 assumptions effectively, I think.

4
5 MR MUSTON: And that's - so the fixed and variable costs -
6 I introduced perhaps a complicating factor, which is the
7 price per baby. But at one level if you weren't trying to
8 break it down into the price per baby but, rather, were
9 just looking at what does it cost to actually provide a
10 service which is capable of delivering up to a certain
11 number of babies per week --

12
13 PROFESSOR BEDFORD: That's right.

14
15 MR MUSTON: This is what it's going to cost?

16
17 PROFESSOR BEDFORD: Yes.

18
19 MR MUSTON: And working out that costing but accepting
20 that there might be some additional loading for things like
21 locums and other increased costs, if you're delivering a
22 service that's capable of delivering up to a certain number
23 of babies in a metro hospital the cost will potentially be
24 roughly the same as the cost of delivering that service in
25 a rural location, save that in the rural location there
26 might not actually be anywhere near as many deliveries per
27 week, so the cost per baby will be a lot higher but the
28 cost of the service itself might be roughly the same?

29
30 PROFESSOR BEDFORD: Yes, but - yes, on some level.
31 I mean, the size of the - well, the capacity of the service
32 will differ, right? So in the metropolitan area you would
33 have far more - the capacity should be far more, and in a
34 rural setting it might be far less, depending on where it's
35 located, but yes.

36
37 MR MUSTON: I suppose for present purposes the more
38 important point is you work out what your demand is likely
39 to be, you're able to at least conceptualise a service that
40 would be capable of meeting that demand even if it was
41 under-utilised because the demand didn't sort of reach the
42 point of that base service, and you'd work out what
43 it - you'd be able to work out roughly what it would cost
44 to deliver that service?

45
46 PROFESSOR BEDFORD: Yes.

47

1 MR MUSTON: Could I now come to the next part of that
2 equation - sorry, one last thing on costing. You did say a
3 moment ago that at the pointy end some of those more
4 complex and innovative type procedures were more
5 complicated to deal with. I assume there you - are you
6 talking about some of these emerging therapies and
7 treatments where there's very little data in relation to
8 them, there's small numbers of people who are receiving
9 that treatment at the moment, and they tend to be quite
10 high cost?

11
12 PROFESSOR BEDFORD: Yes. So there's two probably.
13 There's the innovative technologies like CAR T-cells for
14 cancer treatments, but then also even more routine services
15 like haemodialysis. So with haemodialysis it's a
16 short-stay procedure, but it has very high pharmacy costs.
17 So in the LHDs that cost this correctly they'll what's
18 known as trace the pharmacy cost to the patient that is
19 receiving the haemodialysis. So you'll know exactly how
20 much pharmacy cost is being incurred per delivery of
21 haemodialysis or even, you know, per patient. Whereas at
22 other points of delivery they will allocate the pharmacy
23 cost on some driver, like bed days or hours in the
24 hospital, and it will just be an average cost. So in those
25 hospitals the costs will be - the average cost will be much
26 lower because they're not accounting for the much greater
27 pharmacy cost involved.

28
29 And so there was one example that we had where an LHD
30 was wondering why their cost was so much higher than their
31 comparable - hospitals that were comparable, and it was
32 because they're costing it correctly and others are not.
33 And in that case what - generally the average washes out,
34 you know, some over-cost, some under-cost, but in that case
35 it seemed like that service was systematically under-cost
36 and underfunded because the accurate cost data wasn't
37 available for that.

38
39 MR MUSTON: So turning from the cost side of the equation
40 to the potential benefit side of the equation, in making
41 decisions about how to deploy the finite economic resources
42 that are available in the public health system, presumably
43 a well-functioning system would have regard to the cost of
44 a service, the extent to which it's unavoidable in a
45 practical sense, and if it's in that wide range of things
46 that you could avoid doing but you'd like to do you need to
47 make a decision about which one amongst them you're going

1 to do?

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Perhaps let's me put that more elegantly. There will be things that a hospital service can't really avoid doing, like a patient who presents with a trauma or a heart attack or a burst appendix, it's broadly accepted I think that the system needs to be able to treat that urgent condition in a way that prevents them from having an adverse outcome; do we generally accept that as a proposition?

PROFESSOR VINEY: Yes. I mean, I think fundamentally a hospital or a health service is there to meet the needs of the population, and so the population that presents does need to be treated. I think where you're going perhaps with the question is what about if we want to change the way that we treat patients and we want to do something different.

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MR MUSTON: Where I'm going - and I'm happy for you to develop this thought if I sort of start it off. Where I'm going is I'm interested to explore whether as a matter of practical reality within the current budgetary envelope and perhaps any budgetary envelope we will never actually be able to meet all of the needs of the community within the public health system, and how do we approach decision making around which of those needs we should actually be meeting. So, in making that decision around what to prioritise and what to utilise the budgetary - or the funds that are available, how do we go about making that decision from an economic perspective?

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PROFESSOR VINEY: So I think it's not a question that is easily answered at the system level. You really have to come down to particular services or particular models of care and then ask the question about - you know, using economic evaluation techniques to say what is the cost of this, what are the outcomes of this particular service compared with what the alternative might be.

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THE COMMISSIONER: An example of that might be - I've seen a paper recently about greater utilisation of virtual hospitals, where there's analysis done, well, we invest in this - assuming this can be done safely - it will save this number of bed days, and therefore saving X number of bed days means saving Y amount of money, and there might also be a saving in expenditure on the capital infrastructure expenses because we don't need - we may not need as many

1 hospitals because we're using more virtual hospitals. So
2 an analysis is done telling us if we embrace more virtual
3 hospital care then there's some kind of net cost avoidance
4 or cost saving.

5
6 PROFESSOR VINEY: And potentially benefits as well. But
7 I think it's really important that - again, there's two
8 parts of that question. One of them is the should we
9 invest more in virtual care and set up virtual hospitals.
10 But there's also the question about to whom are we
11 delivering the virtual care, under what circumstances and
12 what do we know about the effectiveness of that virtual
13 care, or indeed the safety, as you said. So - you know,
14 there are examples going on in New South Wales, for
15 example, of virtual wound care at the moment, and you can
16 see a lot of benefit of that. But you really do want to
17 know that you've evaluated that correctly against the
18 alternative model, which is somebody coming in and having
19 their wound treated or somebody going out to their house to
20 look after their wound.

21
22 THE COMMISSIONER: Sure. I guess some proposed or
23 innovative model of care might have a cost saving, but if
24 it's providing poor value care it's not such a great
25 investment.

26
27 PROFESSOR VINEY: Yes, I guess I'm putting a little bit of
28 a plug for systematic economic evaluation of those new
29 models of care.

30
31 THE COMMISSIONER: What about things that are much longer
32 term? Mr Muston's mentioned paediatric interventions that
33 might result in - if children with whatever health care
34 condition, if there's an early intervention means that
35 there's a much greater prospect of them becoming either
36 taxpayers and economically active or, if it's a health
37 intervention, means they won't have as many health care
38 problems as they grow up. Are there sort of rates of
39 return, cost-benefit analysis possible to be done that look
40 forward, you know, 20 or 30 years as to what might be the
41 secondary benefits flowing from those kind of health
42 interventions?

43
44 PROFESSOR VINEY: There definitely are, and there are lots
45 of examples of that, either - whether it is investment in
46 screening, those things, and indeed, you know, these
47 happens all the time. I think the thing to be cautious of

1 is, yes, we can project that benefit into the future but it
2 won't necessarily always be realised. So you might get
3 better outcomes, yes.

4
5 MR MUSTON: The same could be said presumably for other
6 forms of care as well. For example, let's take the example
7 of the knee replacement. You can project into the future
8 what you anticipate will be the clinical benefit of
9 replacing someone's arthritic knee, but you're not
10 guaranteed to get those returns in every patient. You
11 would hope to, but you might not; would that be right?

12
13 PROFESSOR VINEY: Yes, that's always going to be true.
14 But I guess if you've done good clinical evaluation and
15 good costing then you have a fair idea of what those
16 benefits will be relative to the costs.

17
18 MR MUSTON: And is your point that the - well, are you
19 able to do the same sort of analysis and make the same
20 assessment of costs in the case of, say, a hypothetical
21 paediatric - community-based paediatric care, or is it the
22 point that it's more challenging because of the long
23 timeframe?

24
25 PROFESSOR VINEY: It's perhaps more challenging because
26 it's not just one pathway of care, it's not just one
27 intervention. A paediatric community service might be
28 multiple different interventions, and, again, from an
29 economic point of view you always want to know what would
30 have happened without that service. So how is the service
31 changing the models of care? Now, that doesn't mean that's
32 not doable. It just means that it needs that systematic
33 approach to saying, "If we set up this paediatric service,
34 how will the model of care change, who will be seen, who is
35 seeing them, what would have happened otherwise and how do
36 we expect that?" And it might be that there's therefore
37 multiple evaluations that need to be undertaken to make
38 those projections.

39
40 MR MUSTON: And each of those steps needs to be done
41 obviously in an evidence-based way?

42
43 PROFESSOR VINEY: Yes, yes.

44
45 MR MUSTON: In relation to some of those longer term
46 propositions, are you aware - I mean, have people done that
47 sort of analysis of the extent to which early

1 interventions - I think the Commissioner might have touched
2 on this a moment ago, but the extent to which early
3 interventions and investments in, say, preventative health
4 care can have long-term benefits which manifest themselves
5 outside, say, the health budget?
6

7 PROFESSOR VINEY: There are multiple evaluations of those.
8 I hope you'll accept me taking it on notice to actually
9 provide reference --
10

11 THE COMMISSIONER: Yes. Thank you, we would appreciate
12 that. Thank you.
13

14 MR MUSTON: So I gather, just going back to you,
15 Professor Bedford, where you refer in the submission to the
16 need for greater standardisation of costing practices
17 across the local health districts, what you have in mind
18 there is what you told us about a bit earlier, which was
19 the fact that some districts are using different
20 assumptions to in a rough and ready way quantify the cost
21 of delivering services whereas others are being more
22 precise about it, and a level of standardisation across the
23 board would enhance the quality of costing information we
24 have?
25

26 PROFESSOR BEDFORD: That's right. So, again, I want to
27 say that New South Wales has its own cost accounting
28 guidelines, it's not the case for every jurisdiction, and
29 those are regularly updated. So in terms of standardised
30 practice we're in theory very good, but then actually when
31 it's done there's either not enough resources at the LHD
32 level or there's not the technology available to automate
33 many of those cost allocations, like, for instance,
34 tracking pharmacy products to the patient.
35

36 MR MUSTON: What are the sort of resources, both human and
37 technology, that might be required in order to do that
38 effectively?
39

40 PROFESSOR BEDFORD: So the technology ones are - material
41 tracking services would be one for pharmacy goods, but then
42 also there's all these - maybe there's 30-odd feeder
43 systems, so these come from transport, pharmacy, radiology,
44 et cetera. So they're all different systems and they need
45 to connect to one another, and I think one person described
46 it as a bowl of spaghetti as to how all these systems
47 integrate with each other, meaning that they don't really

1 do it very well. So, going forward, investment into
2 technology that is integrated across not just in terms of
3 acute or hospital care but also across allied and community
4 health as well. So there's that sort of technology
5 investment.

6
7 But human resources is really important. So many LHDs
8 might only have one person doing all the costing for that
9 LHD, and that's just going to be insufficient in order to
10 actually go beyond just the very - you know, just in terms
11 of just trying to get the submission done for the NHCDC or
12 to IHACPA.

13
14 And then secondly on the human resources side is that
15 clinicians do not - generally are not that engaged with
16 costing information. So one thing is that they're time
17 poor. The systems are not very accessible for them, so the
18 way that information is delivered is extremely difficult to
19 access for someone that doesn't have integrating costing,
20 let's say. And then also for managers. They need to know
21 about how to properly make use of this information. So
22 there's always two sides. If we think about devolving
23 decisions to LHDs in some cases as to how to provide care,
24 our best care, to the population, if they don't understand
25 about how to use the cost information then they're not
26 going to be informed to make the best decisions at that
27 local level.

28
29 MR MUSTON: I might raise this question with you,
30 Professor Viney, on the topic of the devolving of decision
31 making. Starting proposition is decisions - we are told
32 decisions made closer to the patients tend to be better
33 decisions from a patient outcome perspective. Is that
34 general proposition one that rings true with you?

35
36 PROFESSOR VINEY: I think that's generally true. I think
37 the thing to consider there is that when a decision is made
38 at a - right down at the patient level it's a decision
39 about that patient made by that clinician and may not take
40 into account what the overall resource allocation questions
41 are. So I think we've got that tension between what's best
42 for this patient at this time versus what's best for all
43 patients.

44
45 MR MUSTON: So, moving up a step in that resource
46 allocation piece, you've then got decisions which are being
47 made at the local health district level, which one would

1 hope are informed by an assessment of the health needs of
2 the population of that local health district and the extent
3 to which decisions made about the way in which resources
4 available are allocated will meet those needs?

5
6 PROFESSOR BEDFORD: That's correct.

7
8 MR MUSTON: Let's take it up to the next step again. Is
9 there also scope for or need for systemic decision making
10 to operate above those LHDs so as to examine what services
11 are being made available - well, what is the need in each
12 of these LHDs in terms of a particular health need, what
13 are the services that might be required in order to meet
14 that need, and where should those services be provided, if
15 not in every LHD, which ones and at which --

16
17 PROFESSOR BEDFORD: That's correct.

18
19 PROFESSOR VINEY: Yes.

20
21 MR MUSTON: Do you have a view, Professor Viney, as to the
22 way in which one might approach that process of decision
23 making?

24
25 PROFESSOR VINEY: I think that comes down to an assessment
26 of health need. So I think what you're referring to is the
27 idea that you don't necessarily need every level of service
28 in every local health district. It may not be efficient to
29 do that. So there's a - you know, obviously there's going
30 to be a trade-off between asking people to travel to
31 receive a particular service versus the practicality of
32 having it available. I mean, obviously that's where
33 virtual care may come in because there may be different
34 ways of delivering it.

35
36 The other part of I think what you're referring to is
37 that if you've got evidence that there is a good new model
38 of care that is likely to be more efficient, more effective
39 then it may be that you need a systemic approach to
40 implementing that model of care rather than leaving it to
41 just being taken up at the local health district level. So
42 it may be that you need to give the incentives to each
43 local health district to implement that new model of care.

44
45 MR MUSTON: Can we take it back down to that middle step,
46 the decision making at the LHD level. If the reality is
47 it's not going to be practicable to provide in an effective

1 way services which meet all of the health needs of the
2 community within the existing budgetary envelope, how does
3 one go about making decisions - economically informed
4 decisions about which services should be offered, starting
5 of course with I guess an issue you just raised, which is
6 to what extent are those services able to be met from
7 resources external to the LHD? But let's assume for
8 present purposes that you can't, that is to say it's not a
9 service which can readily be accessed outside the LHD, how
10 should we in an economically informed way be making
11 decisions about what to offer and what not to?

12
13 PROFESSOR VINEY: So I think some of that comes down to
14 what services - having the information not just about the
15 cost of services but what services are needed, so
16 understanding the health of the population, and then from a
17 planning point of view thinking about what are the overall
18 program budgets that are needed for those services to be
19 delivered and what can we do at the margins to shift
20 between services.

21
22 MR MUSTON: So we start with an assessment of the local
23 population, which is probably something better done at an
24 LHD level than at a central level; would that be right?

25
26 PROFESSOR VINEY: On the whole, although obviously it will
27 be informed by information at the New South Wales Health
28 level, yes.

29
30 MR MUSTON: Might tell the LHD that within their catchment
31 there is a particular preponderance of, say, diabetes when
32 compared with other LHDs, or even if not, that they've got
33 a particular preponderance of diabetes within their LHD
34 that they need to provide services to address?

35
36 PROFESSOR VINEY: Or even things like the population is
37 more culturally and linguistically diverse, and so you need
38 to cater for the additional challenges of delivering
39 services to a culturally and linguistically diverse
40 population.

41
42 MR MUSTON: That, on one view, comes back into the costing
43 piece, doesn't it? That is to say, a particular service,
44 say delivering endochronological care to people with
45 diabetes, might cost a particular amount if you're dealing
46 with a health-literate community that are predominantly
47 speaking the same language as the endocrinologist, whereas

1 it might be more expensive to deliver if you're dealing
2 with a different community that doesn't have that health
3 literacy and has language barriers?
4

5 PROFESSOR BEDFORD: That's correct.
6

7 MR MUSTON: But that's not - whilst that's part of your
8 costing and presumably would need to be factored into
9 assessing what it would cost to deliver the care of that
10 endocrinology service or diabetes service as compared with
11 the cost of delivering, say, a community paediatric
12 service, if these were and no doubt many others that were
13 on the table in your decision about how do we prioritise
14 what we should be delivering to this community and what we
15 shouldn't, I'm just wondering what sort of economic tool at
16 a system level when we're making our system planning we
17 might be able to employ in order to help us to make those
18 decisions about effectively what should we be - what should
19 the public health system be delivering to this community in
20 this location and what - whilst it would be great if we
21 could, what really needs to fall on the other side of the
22 line unless and until we get more funding?
23

24 PROFESSOR VINEY: So my answer to that question I think is
25 really that some of this depends upon having the right
26 evidence available and the research. So if we take the
27 endocrinology example, it's not just a matter of the - for
28 the culturally and linguistically diverse population that
29 they need to speak the same language as the
30 endocrinologist. It might be that because of the cultural
31 backgrounds that it's harder for them to know that they
32 need that service, and so we need that kind of evidence.
33 So I think it comes down to making sure that we have
34 research at the local level that informs the design of
35 services. I'm not sure if that's what you meant, but ...
36

37 MR MUSTON: Well, I suppose what I'm trying to explore is
38 let it be assumed that you have the information you need to
39 identify a need within the population, you've identified a
40 service which is capable of meeting that need, and you've
41 identified in an evidence-based way the cost of delivering
42 that service, and then you're having to make a decision as
43 a health administrator about whether or not you do deliver
44 that service or whether instead you take the resources
45 which might be - you know, the financial resources which
46 that service would consume and use them to deliver a
47 different service, because I'm starting from the premise -

1 and, again, I invite you to disagree with it, but I'm
2 starting from the premise that we're not going to be able
3 to offer as part of the public health system all of the
4 services that are required to meet all of the health needs
5 within the community. As regrettable as that might be,
6 it's a reality. Do you agree with that premise?
7

8 PROFESSOR VINEY: I do agree with that premise --
9

10 MR MUSTON: Again, I'll invite you to respond to another
11 premise, which is the risk of not approaching the planning
12 of service delivery in a systemic way which actually takes
13 into account which of those needs we feel we can deliver
14 and should deliver, and which, within the funds available,
15 we can't, is - we just try and do our best to deliver on
16 all of those needs in the way that the health system
17 organically does, which produces a situation where the
18 funds are spread so thin that in fact none of them are
19 being dealt with adequately or as well as they could be,
20 and they're placing the workforce who's involved in the
21 delivery of those services under increasing strain. Is
22 that a potential consequence of not having a slightly more
23 strategic approach to deciding which services within a
24 constrained budgetary environment you will deliver and
25 deliver well and which ones, regrettably, you won't?
26

27 PROFESSOR VINEY: I think it's absolutely essential that
28 there is a systematic approach to planning and delivery of
29 services, and, as you said, there will be some services
30 that always have to be delivered because you have to deal
31 with the person who comes to the emergency department.
32 What I think we're talking about here, though, is using the
33 costing information that David's been talking about plus
34 the activity information to say what are the services that
35 we're delivering and what are the outcomes that we're
36 achieving from them, and then asking the question for each
37 of those, if you like, programs of activity, if we took
38 resources away from them and put them elsewhere, what would
39 we achieve and what would we lose.
40

41 MR MUSTON: That's exactly the question.
42

43 PROFESSOR VINEY: (Indistinct) an economics way of thinking
44 to that planning, and I am absolutely convinced that within
45 local health districts that is happening.
46

47 MR MUSTON: What leads you to that view that that

1 considered analysis of the cost of particular services and
2 the benefits of those services are being taken into account
3 in deciding which services to offer and which ones not to?
4

5 PROFESSOR VINEY: I guess I've seen through multiple
6 examples across many years that that kind of thinking is
7 applied within local health districts, within local health
8 services, not necessarily systematically all the time but
9 that it is part of what informs decision making,
10 particularly around the design of new services.
11

12 THE COMMISSIONER: We have to be careful, though, don't
13 we, to distinguish between the mere offering of a service
14 and what - for want of a better expression I'll say,
15 offering a service at an optimal or appropriate level? For
16 example, we've talked about paediatric services. They're
17 offered and they're available. But what the clinicians
18 have told me is that they've never seen wait times so long
19 and that children that need these services are being seen
20 beyond the time that they clinically should have been; in
21 other words, clinically inappropriate delay. That's
22 offering a service but not in the manner that might be
23 best.
24

25 PROFESSOR VINEY: I definitely would agree with that, and
26 I think some of that comes down to the question of you can
27 do what - you can do the best you can with the available
28 resources, but if the available resources are not
29 sufficient you may not be able to address those waiting
30 time issues or it may not - you can't always rearrange
31 things to make things more efficient and make sure that you
32 meet all those needs.
33

34 MR MUSTON: You may not be able to rearrange them
35 immediately or overnight, but it may well be that you could
36 rearrange them over a period of time by disinvesting in
37 other services and diverting that money into, say, this
38 hypothetical community-based paediatric service to actually
39 deliver that care in a way which is sufficiently resourced
40 to meet the needs of the children when they need to be met
41 rather than when they're a few years into their schooling
42 and they've already fallen behind, for example. You could
43 do that, couldn't you? It depends on the budgetary
44 envelope, obviously, but --
45

46 PROFESSOR VINEY: Yes, it depends upon the budgetary
47 envelope. So it depends on what services, and I think it's

1 important to realise that - so, for example, if we thought
2 about that and we could see that there would be savings
3 that could be made and better outcomes because we can look
4 at children now who use more services because they didn't
5 get that early intervention, the problem is you can't not
6 give them that service, if you see what I mean? So, even
7 though we might want to invest for the future for the
8 children who will be in primary school in five years time,
9 we also need to recognise that you also have to deliver the
10 service that is needed for the children who didn't get that
11 early intervention, if that makes sense?
12

13 MR MUSTON: No, that does. But that goes to the size and
14 scale of this hypothetical paediatric service. I guess the
15 question I'm trying to engage with is maybe in order to
16 properly fund and resource the paediatric service which
17 deals not only with the kids who haven't yet got it but
18 those who might benefit from it now, otherwise you're like
19 a dog chasing its tail, you might need to say - make a
20 difficult decision about whether you, say, provide
21 different types of elective surgery to people in the latter
22 half of their lives - knee replacements, hip replacements,
23 for example. You might say, well, if there is a limited
24 budgetary envelope and we need to make a decision about
25 whether providing that paediatric care is what we should be
26 doing or providing hip replacements to a cohort of patients
27 within our community who require that, accepting there's
28 going to be one, you might need to make those decisions,
29 and I'm just trying to explore with you whether there are
30 ways in which you think we should at a systematic level be
31 approaching those decisions through an economic lens.
32

33 PROFESSOR VINEY: So what I would say from an economic
34 lens is that we do have ways - we don't necessarily always
35 have the information everywhere, but we could assess that
36 on the basis of quality-adjusted life years. I think it's
37 really important to make sure that we are also still being
38 distributionally fair. But we could assess all of these
39 different potential programs or potential services on the
40 basis of incremental cost per quality-adjusted life year
41 and invest in those that are likely or predicted to provide
42 the most qualities. And so that would mean that we would
43 be able to think about what is the gain to the population
44 of people who are having hip replacements versus the
45 population of children who are getting early interventions
46 for hearing problems. I'm not saying it's easy.
47

1 MR MUSTON: I don't think I have any further questions for
2 these witnesses, Commissioner.

3
4 THE COMMISSIONER: Thank you. Mr Chiu, do you have any
5 questions?
6

7 MR CHIU: I have no questions, thank you, Commissioner
8

9 THE COMMISSIONER: To both of you, thank you very much for
10 your time. We're very grateful for the assistance you've
11 given to the Inquiry. So thank you.
12

13 PROFESSOR BEDFORD: You're welcome.
14

15 THE COMMISSIONER: And we'll adjourn until 2 o'clock.
16 Adjourn until then. Thank you.
17

18 PROFESSOR VINEY: Thank you.
19

20 PROFESSOR BEDFORD: Thank you.
21

22 <THE WITNESSES WITHDREW
23

24 LUNCHEON ADJOURNMENT
25

26 UPON RESUMPTION
27

28 THE COMMISSIONER: Yes.
29

30 MR MUSTON: Thank you, Commissioner. The next witness is
31 Professor Stephen Duckett AM.
32

33 THE COMMISSIONER: Professor Duckett, can you hear me?
34

35 PROFESSOR DUCKETT: Yes, I can indeed, thank you,
36 Commissioner.
37

38 <STEPHEN JOHN DUCKETT, sworn: [2.01 pm]
39

40 <EXAMINATION BY MR MUSTON:
41

42 MR MUSTON: Thank you, Professor Duckett, could you state
43 your full name for the record, please?
44

45 A. Stephen John Duckett.
46

47 Q. And you are, amongst other things, currently the chair
of the Health Performance Council in South Australia?

1 A. Yes.

2

3 Q. Perhaps it would be more efficient if I let you rattle
4 through the other roles that you have.

5 A. Thank you. I chair the board of the Eastern Melbourne
6 Primary Health Network. I'm a member of the board of
7 Healthdirect Australia, which provides community health
8 services across Australia and advice services. I'm Deputy
9 Chancellor of RMIT University, and I'm on a number of
10 Commonwealth advisory committees.

11

12 Q. You had some involvement in the establishment of the
13 ABF or the ABF as a way of capturing the cost of delivering
14 acute health care in New South Wales?

15 A. Indeed. In Victoria I was the person who designed and
16 implemented activity based funding in 1993, the first such
17 implementation in Australia and in the world, really, other
18 than the United States. And I was also a member of the
19 National Health and Hospital Reform Commission, which
20 recommended the introduction of activity based funding
21 nationally. And I was a consultant to the Independent
22 Hospital Pricing Authority on the design of the national
23 activity based funding framework.

24

25 Q. Could you tell us what you perceive to be the benefits
26 that ABF funding has to offer in terms of a model for the
27 funding of at least acute care within the public health
28 system?

29 A. Yes. It's been implemented in a number of countries
30 now and the general objective - there are a number of
31 general objectives associated with its introduction. First
32 of all is to drive efficiency improvements; that is, the
33 whole point of activity based funding is you pay a hospital
34 for what it does. In Australia we call it the national
35 efficient price; that is, hospitals that cost more to
36 provide an appendicectomy, for example, don't get paid more
37 for providing that appendicectomy. It also is equitable in
38 the sense that all hospitals get paid the same and it's
39 also fair in the sense that everybody knows what everybody
40 else is getting and why they're getting it.

41

42 Q. In terms of driving efficiency we've heard the
43 distinction drawn between technical and allocative
44 efficiency in the evidence that's been received and
45 submissions made. Could you perhaps just explore with us
46 the type of efficiency that you had in mind when you were
47 referring to the ABF model driving efficiency?

1 A. Yes. So when I was using that term I was specifically
2 thinking of technical efficiency. Technical efficiency is
3 the way you describe cost per unit of output - that is,
4 cost per patient treated - and you try and drive efficiency
5 in that sense. If you don't have technical efficiency you
6 can't have the other sort of efficiency, namely allocative
7 efficiency, which is where you get the same amount of
8 outcome for the cost. Of course allocative efficiency is
9 very difficult to achieve because it's also - it's very
10 difficult to achieve - to measure outcomes.

11

12 Generally in the implementation of activity based
13 funding you move towards allocative efficiency by capping
14 your spending; that is, you might say to a hospital, "We're
15 only going to fund you up to this number of admissions,"
16 and it's up to the hospital to rank admissions to the
17 hospital so that the most needy get admitted.

18

19 Q. To some extent is there a relationship between the two
20 in the sense that a system which is technically efficient
21 is able to make better use of the budget that's been
22 allocated to it and, by doing things that need to be done
23 efficiently, it leaves you headroom to do other things that
24 might able to be done which are of benefit to the patient
25 cohort?

26 A. Yes, I agree with that characterisation.

27

28 Q. We have heard some evidence in our travels about the
29 extent to which - at least it's suggested by those who
30 operate some different types of services, for example rural
31 and regional services and highly specialist services like
32 paediatric networks and the like - that the ABF model at
33 least as currently formulated is not, to their minds,
34 capturing the actual cost of delivering the care that they
35 are delivering in the settings that they are having to
36 deliver it in. Do you have a view in relation to that?
37 Let's start with rural and regional settings?

38 A. If I start with rural.

39

40 Q. Yes.

41 A. If we start with small rural, very small hospitals,
42 the cost is essentially driven by keeping the doors open;
43 that is, you have to have a minimum number of staff whether
44 you treat one patient or a million. So in the national
45 funding arrangements in the National Health Reform
46 Agreement there is a recognition that those very small
47 hospitals have to be so called block funded; that is,

1 funded on a keeping the doors open basis with a minimum
2 amount of activity based funding associated with it. And
3 the same --
4

5 Q. Pausing you there, because at a relatively small
6 hospital you'll have an array of fixed costs like
7 electricity, a necessary staffing level to operate a
8 hospital of that size, whatever activity it might generate,
9 and such other fixed costs as might attach to the operation
10 of a facility. No amount of activity that goes through it
11 is ever going to be enough to reach those fixed costs and
12 so there's an acceptance, is there, that a block of funding
13 needs to be provided - to use your terms - to keep the
14 doors open and the lights on, but then there is still some
15 amount of activity based funding to incentivise technical
16 efficiency to the extent care is being delivered?

17 A. Yes, yes. So, you know, you have to have - in a very
18 small hospital you have to have two staff on at night for
19 occupational health and safety reasons and to provide good
20 care to the patients. So, you know, if you don't have
21 enough activity based funding to employ two staff you're in
22 deep trouble. There's a small amount of activity payments
23 to recognise that, if you admit an extra patient, you have
24 to change the sheets for example and so on. So there is a
25 small activity based funding component associated with
26 those very small hospitals as well.
27

28 Q. So that's at the very small hospital end of the
29 spectrum. At the very large hospital end of the spectrum
30 where you've got very high turnover, a lot of activity
31 being generated, how does the activity based funding system
32 work in the context of that setting?

33 A. So in the very large hospitals that's the ideal
34 setting for activity based funding because activity based
35 funding is based on averages, and the formula would say,
36 "Look, the average cost of treating a person for an
37 appendicectomy or a hip replacement or whatever is X." But
38 some patients are going to cost more and some patients are
39 going to cost less.
40

41 And so you need a certain volume to cope with the
42 so-called swings and roundabouts that you're going to get
43 paid too much for some patients and too much for other
44 patients, but on average you're paid the right amount of
45 money, and you have the incentives associated with that
46 average. So it's the ideal situation in those very large
47 hospitals.

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Q. Is it potentially also an ideal situation in a large hospital because I think we've been told in some evidence given today that within a large hospital setting where you've got a large number of procedures being performed those procedures can often be performed more efficiently than in a slightly smaller setting?

A. Yes, there is a fair amount of literature which says that "practice makes perfect"; that is, the more you do a particular procedure, the better your quality. And, similarly, if you do a lot of cataract operations, for example, lens procedure operations, you can actually structure your services to do it efficiently so that all the staff, not just the surgeons but the nurses and everybody else around the patient, knows what they're doing and does it efficiently.

Q. So in between those two extremes - the very large hospital and the very small hospital - we've got a range of hospitals which vary in size, some of them in metropolitan areas, some in regional areas and some in quite remote areas. Perhaps if we start - I think I interrupted you a bit earlier. If we start with the rural hospitals. It's suggested to us that the cost of delivering care through rural hospitals tends to be higher for a range of reasons, including greater reliance on premium labour, for example, increased costs of having things delivered to them in rural settings, and a range of other factors which have been identified as increasing, the general proposition, the cost of delivering health care in that setting.

A. Yes.

Q. How does ABF account for that, if at all?

A. So the principle underlying ABF is that - and the principle underlying a formula funding of hospitals is that hospitals should be held to account to provide service efficiently for things for which they are responsible. And the idea behind that - it's an idea about accountability and so on.

But the issue of workforce is an interesting one. New South Wales has a system of awards and, typically, if the enterprise bargaining award changes, the state government actually effectively changes the price. It's not precisely what it does, but it's effectively what it does. And that assumes that everybody is facing the award price for what they do.

1
2 Now, in some cases the hospital is mismanaging its
3 staff and they have huge staff turnover and people don't
4 want to work there because of management failings, and in
5 which case it doesn't seem fair to me that the hospital
6 should get paid extra just because it's badly managed. In
7 other cases the state government has failed to provide
8 sufficient workforce in a particular location, has not done
9 good workforce planning - the state or the federal
10 government - and in those circumstances you might say,
11 "Well, you know, if there is a hospital where they're
12 paying huge amounts for locum staff, then maybe the
13 activity based funding should be adjusted for that just as
14 it is adjusted if there is an award increase."
15

16 Q. When you referred a moment ago to the management
17 issues, that could capture a range of different failings.
18 At one level a management problem might be active
19 management decisions which have created a negative
20 workplace environment, but at another level a workplace
21 which is under increasing or continued financial strain
22 will potentially become a workplace which is not
23 necessarily a happy place which can tend to contribute to
24 these turnover issues.

25 A. Yes, I'd agree with that. Staff dissatisfaction could
26 be associated with poor management locally. But, on the
27 other hand, if everybody is working too hard, that is there
28 is not enough money to provide the services of a standard
29 that they would like - that the staff would like to see it
30 provided, that then is not really the responsibility of
31 management. Health staff, be they professional or not
32 professional, want to come to work to do what is right for
33 the patients and, if they feel that they have to cut
34 corners, that creates stress situations and
35 dissatisfaction; yes.
36

37 Q. Can I explore this with you. Is there a sense to
38 which perhaps the perceived need to be everything to
39 everyone within a health system such that if someone turns
40 up at their local hospital, they have a particular problem,
41 they expect for it to be treated, it drives us to deliver
42 or attempt to deliver within a budgetary envelope the
43 services that are required to meet all of those various
44 needs perhaps in circumstances where there is not
45 sufficient money to deliver all of them adequately or at
46 all, which results in all of the services being delivered
47 in that hospital being done so under a significant degree

1 of pressure both financially and workforce driven?

2 A. So we know that not every hospital in Australia can
3 provide heart transplants. So we know that some services
4 are not going to be able to be provided safely in every
5 hospital across New South Wales. And, in my view, we
6 should not attempt to do so; that is, we should attempt to
7 work out what is the right mix of services in this location
8 and say that, "What our job is in this location is that if
9 something goes wrong in an emergency we have the capacity
10 in this location to stabilise the patient and get them to
11 the right service as safely and efficiently and as quickly
12 as possible." And similarly for planned procedures; that
13 is, we know that not every hospital in New South Wales can
14 do every sort of planned procedure.

15
16 So a critical part of management at both the local or
17 area level, district level, and at the state level is
18 working out what should be the role of every hospital in
19 the state. And I would agree with the view that when there
20 is a disjunction between the capacity of the hospital and
21 the funding of the hospital and what is it expected to do
22 that then in itself creates stress.

23
24 And it is unclear to me whether the responsibility for
25 that alignment is entirely the State Government's
26 responsibility, the Department of Health, or entirely the
27 district's responsibility, or some mix of the two. And
28 I think obviously where I'm going it's some mix of the two.
29 The district should have views on what each of the
30 hospitals within the district can do safely and for which
31 there is adequate funding. And it should be ensuring that
32 the ministry in Sydney knows about those issues and
33 challenges. And I think it's inappropriate for a district
34 or a small hospital to be asked to do things for which it
35 has neither the funding nor the capacity.

36
37 Q. And in terms of that global oversight by the ministry
38 decisions, say, to withdraw or disinvest in a service which
39 can't be provided effectively - even if safely but can't be
40 provided efficiently and effectively within the budgetary
41 envelope, it's important that the LHD discusses that
42 presumably with the ministry to ensure that people living
43 within the catchment of that LHD do have the service
44 available to them somewhere which is sufficiently proximate
45 to be acceptable from a social and political level and, if
46 not, can make an application for further funding in order
47 to enable them to deliver that service locally?

1 A. Yes. So it is incumbent on the district to actually
2 engage with its local community to talk about what the
3 constraints are, and also to engage with the ministry to
4 talk about what the constraints are. And the reality is
5 the amount of money available that is allocated to the
6 health system is capped. And so we need to engage with the
7 community to say, "In this environment we can't do
8 everything for everybody. And we have to accept that the
9 best thing to do is that orthopaedic services are
10 centralised within the district at this hospital, and this
11 local hospital is just not going to be able to do
12 significant joint replacements, for example."

13
14 Q. A discussion that we don't seem to have, and if you
15 think it's happening or if you have experience of it
16 happening either here or elsewhere please tell us about
17 it --

18 A. We're often too scared to do it because they don't
19 trust the local communities. But there's been a lot of
20 work done on so-called community citizen juries and so on
21 which, when you come clean with the public and say, "These
22 are the choices we've got," they seem to understand that.

23
24 Q. It would seem logical that it's easier to comprehend
25 why something is not being provided if you understand what
26 is being provided instead; that is to say, "Here's the
27 resources we have. Here's the needs of the community.
28 We've prioritised them in a way which means we think these
29 services are the ones we should provide and provide really
30 well. We can't provide those ones because to add them to
31 the mix would result in compromising the extent to which
32 we're delivering on the other ones, and in fact probably
33 all of them. That's why we've made this decision." That's
34 an understandable proposition, even if unacceptable to the
35 individual who doesn't have access to that particular
36 services at the location they want it.

37
38 But are you aware of any jurisdiction which is doing
39 better than we are in terms of having that more transparent
40 discussion about, "Here's the limited resources we've got
41 and here's why we're making decisions about how to deploy
42 them in a way which is good for some people but bad for
43 others"?

44 A. The problem in discovering these is that the best ones
45 take place very quietly; that is, they don't hit the
46 newspaper, so you don't see the successful ones. But
47 what's happening in Victoria in some smaller towns is that

1 mergers have occurred recently and the public is being
2 engaged to say, "Look, you know, we're going to provide
3 these additional services here because we now can," or,
4 "We're not going to provide these services here because we
5 can't provide it safely." So, as I said, they're not
6 getting much public attention because the
7 community - they're not hitting the newspapers.

8
9 Q. For example, a discussion with a community around the
10 possibility of replacing an expensive and perhaps what
11 might objectively be viewed as a clinically unnecessary
12 emergency department in a small rural hospital with a
13 co-located primary care service, if delivered to the
14 community in a way which enables them to understand what
15 their perceived needs are from the LHD's perspective the
16 way in which those needs are going to be met and the
17 advantages of doing what's proposed might be received
18 better than a, "We're going to close your emergency
19 department," and the front page of the local rag that that
20 would no doubt generate?

21 A. Yes, exactly. And there's the recognition that
22 attracting and retaining medical staff in some of these
23 small hospitals and nurse practitioners is very hard. And
24 so you've got to actually use their skills wisely and say,
25 "Look, we know that one of the issues of concern to you is
26 that if something goes wrong then you can get care quickly
27 and safely. But that might mean you only get stabilised at
28 this location; you don't get definitive treatment."

29
30 Q. Just coming back to ABF funding, there are the small
31 hospitals which are block funded; we understand. There are
32 then a cohort of hospitals which either across the entirety
33 of their operations or with respect to particular services
34 that they feel compelled to deliver they have the
35 perception that the ABF funding model is not adequately
36 capturing the cost of delivering those services. What's
37 your response to that?

38
39 I'll give you an example perhaps to engage with.
40 Cooma Hospital tells us that they have to provide a 24/7
41 obstetric service to deliver something in the order of
42 107-ish babies a year which, if you multiply the relevant
43 state efficient - NWAU and state efficient price by 107 it
44 doesn't really come close to the hard costs of operating
45 that 24-hour service for the moment when a mother walks in
46 having need for obstetric services.

47 A. So it would be highly unusual if every service line -

1 say maternity services, orthopaedic services, neurology
2 services or whatever - each of them runs at a surplus in
3 any hospital; even the biggest hospital that would be
4 highly unusual. So there is inevitably going to be a need
5 for cross-subsidisation between those service lines. And
6 in my view that should be an overt - it should be an
7 accepted thing, that's part of what boards of directors do
8 or management does, and it should be overt; that is, "We
9 believe it's important to provide ophthalmic services and
10 we're going to provide that at a loss because we provide
11 trauma services" or whatever and there is an interaction,
12 and so one service is going to cross-subsidise another. So
13 that's what in my view ought to happen.
14

15 But the problem is if you're in a tiny hospital, in a
16 smallish hospital like Cooma, you may not be able to
17 cross-subsidise; that is, you may not have enough money
18 surplus in those other services that your obstetric service
19 can be cross-subsidised from the surplus you make on
20 geriatric services or on other services. Now, then that
21 becomes a much more difficult situation because you can't
22 have hospitals putting their hand up and saying, "We've got
23 this one line that we're making a loss on, so we want to be
24 funded fully for that one and we're not going to tell you
25 about all these other ones."
26

27 But I think you shouldn't expect that the only thing
28 you have to do in managing a health system is once a year
29 make a pricing decision and not do any active management of
30 anything else in the meantime, the next 364 days. So what
31 you should be saying is looking at a situation like Cooma,
32 looking at the whole hospital and say, "Does it" - or the
33 whole district maybe, but looking at the whole hospital and
34 say, "Does it have the capacity to cross-subsidise?" And
35 if it does not then you've got to say, "Do we want to
36 provide obstetric services here or not?" And that's
37 political state or district decisions. But, once you've
38 decided to provide it, it has to be funded properly.
39

40 Q. Which is not necessarily the decision as between the
41 Commonwealth and the state, I gather, but is a decision as
42 between the state, its local health district, and perhaps
43 the local health district and the facility?

44 A. Yes, the Commonwealth-state relationship is pretty
45 clear. The National Health Reform Agreement says that the
46 state is the system manager, and there's no-one in the
47 Commonwealth who says, "You've got to provide obstetric

1 services in Cooma."

2

3 Q. Just so I can understand the way that arrangement
4 works, obviously it's a national average price which is
5 arrived at which presumably means, just taking into account
6 your - there are some services and some locations that
7 produce surpluses and some that produce losses, but if it
8 is in fact a true average it all evens out to that figure.
9 Does that essentially mean that the funding delivered from
10 the Commonwealth to the state with respect to all of those
11 services, including, say, the paediatric service - the
12 orthopaedic service offered at Cooma is in fact adding up
13 to the actual cost or broad cost of delivering those
14 services, even in a high cost centre like Cooma?

15 A. So New South Wales is a big state and so on average
16 across New South Wales you would expect it to be able - the
17 average cost of providing maternity services across New
18 South Wales to be pretty close to the national cost of
19 providing maternity services, for example, across the whole
20 country because it's big enough that all the swings and
21 roundabouts can even out.

22

23 Q. In working out that average, though, let's say that
24 because the hard cost of keeping a maternity service open
25 24/7 at Cooma are what they are whether you have 107 babies
26 or 1,070 babies, is that average price which is arrived at
27 as part of the process, albeit slightly delayed by a couple
28 of years, does that take into account the fact that at
29 Cooma the cost of a delivery is total cost of running a
30 24/7 service divided by 107? I think that's very rough and
31 ready, I appreciate, but you get the gist.

32 A. The actual answer is the number of babies delivered at
33 Cooma is a rounding error in the number of babies delivered
34 within New South Wales. So on average, you know, when you
35 add up all the other maternity services in Sydney they
36 provide 80 per cent, 90 per cent, I don't know,
37 whatever per cent of the babies across the state,
38 75 per cent of the babies across the state by the time you
39 add Wollongong and Newcastle, but the big hospitals drive
40 the costs and the small hospitals, as I said, yes, on
41 average it's going to be more expensive to provide
42 maternity services at Cooma than it is at Westmead or
43 Prince Alfred or wherever, but on average across the state
44 it ought to balance out.

45

46 Q. Assuming that a decision were made that it was needed
47 to deliver obstetric services at Cooma for reasons

1 associated with population, geography and the like,
2 climate, but that the ABF or the activity generated through
3 that was not going to be sufficient to meet the cost of
4 running that 24/7 service, presumably it wouldn't do
5 violence to the ABF's system or its capacity to drive
6 efficiency to block fund that service or to provide some
7 supplementary funding to Cooma Hospital or Southern Local
8 Health District to enable that service to be delivered in a
9 cost-effective way?

10 A. Yes, the - or rather phrase it no. The block funding
11 principles at the moment only apply to a whole site; that
12 is, a whole hospital such as Cooma. They tend not to
13 apply - they don't apply to a specific service within a
14 hospital. I think there's a very strong case that if you
15 make a decision to provide, for whatever reason, maternity
16 services in Cooma then someone has to take responsibility
17 for ensuring they're viable; that is, you can't just say to
18 the district, "You're required to provide maternity
19 services in Cooma and you have to find the money somewhere
20 else," because they may be too small to find the money
21 somewhere else.

22
23 Q. Or put another way, "You have to provide maternity
24 services in Cooma and here's 107 babies' worth of activity
25 that we're going to purchase from you for the purpose of
26 delivering that service"?

27 A. "We will fund 107 babies - maternity service to
28 provide for that level of service." But as I said about
29 the very, very small hospitals you've got to have midwives
30 available 24/7 if you're going to have a maternity service,
31 and you've got to have on-call anaesthetists or GP
32 anaesthetists to provide caesareans, and on-call GP
33 obstetricians or obstetricians. So if you're going to
34 provide the service you've got to make a commitment to
35 provide it safely and to fund it accordingly.

36
37 Q. When you say there's got to be a commitment to do it,
38 just for clarity, that's a commitment by the state or the
39 ministry?

40 A. Well, if I were in the ministry I would say, "The
41 district has to do it." But then you've got to make sure
42 that the district has the capacity to do it. You can't
43 just pass all the responsibilities down to the district and
44 assume that they've got sufficient surplus, because Cooma
45 might not be the only problem, it might have the exact same
46 problem in Queanbeyan or wherever.

47

1 Q. And it would presumably depend very much on the
2 particular service we're talking about. There will be some
3 which might be politically necessary. There are others
4 that might be clinically necessary. And where something is
5 clinically necessary it's very hard to say, "Well, it's up
6 to you, district, to decide whether or not you want to
7 provide this, but we're not going to give you adequate
8 funding to do it."

9 A. Yes. And in my view the ministry almost inevitably
10 has to be involved, partly because of the political issues,
11 partly because they're the ones that have to find the money
12 if the district can't find it, and partly also the district
13 may not have the skills. I mean, working out whether you
14 need a maternity service is not just a simple issue. And
15 so you've got to actually have support and understand - so
16 you've got to marry the local knowledge and understanding
17 as well as the technical support that you'd require from
18 ministry to make those sorts of decisions. And the
19 ministry should have information that enables it to compare
20 and contrast Cooma with some other hospital of similar size
21 and similar demand.

22
23 Q. The ministry has that technical skill and ability to
24 compare and contrast, but the ministry also presumably has
25 a helicopter view of the wider system and an ability to
26 say, "You might think you need to offer that particular
27 service in Cooma. But we know what's being offered in an
28 adjacent LHD, and we think actually when you two work
29 together there's a far more effective way of delivering a
30 service through the adjacent LHD rather than through
31 yours."

32 A. Yes, they can make an informed decision about the risk
33 of babies being born on the road to Canberra, for example,
34 versus providing the service and make a service choice.
35 But, as I said, if they make the service choice to provide
36 they have to make sure it's viable.

37
38 Q. What about at the other end of the spectrum the
39 potentially larger facility that delivers small turnover
40 but high complexity care? We have heard paediatric
41 services or we're told paediatric services are potentially
42 not well captured by ABF funding because of the added
43 complexity associated with dealing with paediatric
44 patients, the sort of care and treatments they're given
45 coupled with the need to liaise not only with patients but
46 families; similarly high complexity procedures like heart
47 transplants and things like that?

1 A. I'm not sure what the New South Wales funding formula
2 is, but in the national funding formula there is a loading
3 for paediatric services, specialist paediatric services, in
4 the formula. You've got to be - yes. And that came about
5 partly because every state has exactly the same issue.
6 It's not that in one state for whatever historic reasons
7 the children's services, paediatric services, are more
8 expensive. It turns out that in every state they're more
9 expensive. So the formulae leads to - gives a loading for
10 that.

11

12 Q. And arriving at that loading, is that - just trying to
13 understand how that works in the context of the system. Is
14 that loading used by the Commonwealth and presumably
15 thereafter the state just to set some parameters around the
16 distribution of the money that's paid or is it --

17 A. No, the distribution of the money is entirely a state
18 responsibility once it arrives in the state coffers. The
19 national efficient price is based on essentially averages
20 across the country. If it turns out that admitting a First
21 Nations patient costs more, or admitting a patient who
22 lives remotely from the hospital costs more, or admitting a
23 patient to a paediatric unit costs more than the other
24 patient, than an adult patient or a non-First Nations
25 patient, then there is a loading. And there is a loading
26 in the national efficient price. So the price for cancer
27 treatment, paediatric cancer treatment, is higher than the
28 price for an adult cancer treatment because on average that
29 is what's happening across the whole country.

30

31 Q. I'm just trying to understand that, though. If the
32 ordinary approach is you work out what the average cost of
33 delivering, say, this hypothetical cancer treatment to the
34 population is that will give you the average cost, which at
35 the upper end of the scale will be the paediatric patients,
36 at the lower end of the scale will be the adult patients,
37 and somewhere in the middle lies the average. At one level
38 why does the Commonwealth need to apply the weightings
39 where, in essence, it's for the state to decide how it
40 wants to distribute that average across the high cost and
41 the low cost centres?

42 A. That is true. But the whole point is that if
43 different patients are systematically more expensive than
44 other patients and there's enough of them then that should
45 be recognised. And it's the same as appendicectomies, for
46 example. There are two appendicectomy diagnosis related
47 groups because some patients with severe complications are

1 more expensive than others in a systematic way with is not
2 the result of inefficiency. So the same is true of First
3 Nations patients. The same is true of paediatric patients,
4 specialist paediatric patients.
5

6 Q. I understand. So you have your average price which is
7 identified. A weighting is then added to work out roughly
8 what the average price would be, if it were a First Nations
9 patient or a paediatric patient, for example. And then
10 year on year you're not going to be potentially suffering a
11 detriment if you happen to have a year where you treat more
12 First Nations or paediatric patients than expected or a
13 benefit if you treat less, because the idea is through this
14 average it provides a funding stream which reflects the
15 actual care which was delivered to the patient cohort which
16 presented?

17 A. The whole point is it's a fair payment relative to the
18 needs.
19

20 Q. Just building on that a little bit, though, and
21 perhaps touching on something we were addressing with our
22 little Cooma example, there's nothing which compels the
23 state to distribute the money received through the activity
24 based funding formula from the Commonwealth in a way which
25 reflects perfectly the activity which it's gathered and the
26 locations from which that activity is being gathered, is
27 there? It can distribute the money in a way which
28 potentially better reflects the cost of delivering the
29 services in different locations? It can provide more money
30 to an expensive cost centre and less money to a more
31 efficient cost centre?

32 A. There are two issues here. First of all, in the
33 National Health Reform Agreement the state is described as
34 the system manager; that is, it is the system manager for
35 public hospitals. It is accountable for public hospitals.
36 It decides where maternity services are going to be. It
37 decides whether a small hospital is going to exist or not
38 exist. And that is a state responsibility.
39

40 So it can decide whether it is not going to apply a
41 single brain cell between what the national efficient price
42 says and what goes out the door or it can decide, "We will
43 apply a single additional brain cell and we're going to
44 change it in these ways because we've got a value added
45 role here, and what might be sensible nationally isn't
46 sensible in far western New South Wales," for example.
47

1 Q. Can I move to another topic. You've provided to us a
2 document that is headed, "Report on Commonwealth-State
3 Financial Arrangements in Healthcare"?

4 A. Yes.

5

6 MR MUSTON: I don't think it has a date on it,
7 Commissioner, but that document is exhibit M20.

8

9 THE COMMISSIONER: Yes, I have it.

10

11 MR MUSTON: Have you had an opportunity to review that
12 document recently?

13 A. Yes, I have. Yes, I've got it in front of me, as a
14 matter of fact.

15

16 Q. Presumably, unless you tell us otherwise, are we safe
17 to proceed on the basis that it still reflects views that
18 you hold?

19 A. Yes, it does.

20

21 Q. I note that it does draw on some data principally from
22 the year 21/22. But is it the case --

23 A. 2021, yes.

24

25 Q. 2021. I take it that the more recent data has
26 not - would not cause you to draw different conclusions
27 that you've addressed in that document?

28 A. Yes, the most recent data is one year later, 21/22,
29 and there's no significant - no material difference in the
30 data from 21/22 and so my conclusions are the same.

31

32 Q. I might ask you to explain exactly how it works but,
33 as I understand the conclusions you draw, effectively - and
34 whilst not dollar for dollar - the proposition that by
35 increasing the amount of activity based funding that you
36 can gather from the Commonwealth under the National Health
37 Reform Agreement does not necessarily result in an
38 equivalent increase in the total funding available to the
39 state which can be allocated to health, but rather
40 adjustments are made through the Grants Commission the
41 effect of which is to reduce other sources of funding such
42 that the state's funding remains roughly the same; have
43 I broadly captured that?

44 A. So you've nicely summarised in one or two minutes what
45 I took 13 pages to summarise - to describe. But, yes,
46 essentially there are two funding streams we need to think
47 about: the National Health Reform Agreement, which has

1 these highly specific formulae and so on, and you can
2 actually see the funding flow and there are agencies which
3 tell you the funding flow down to the nearest dollar. But,
4 although important I think for symbolic reasons, the
5 National Health Reform Agreement, its main role in terms of
6 total funding is it determines the total flow of money from
7 the Commonwealth to the states collectively.

8
9 More importantly, New South Wales funding is
10 determined by what the Grants Commission assesses as New
11 South Wales' needs; that is, the state government is
12 essentially obligated to provide a similar level of
13 services to other states or vice-versa. South Australia is
14 obligated to provide a similar level of services as New
15 South Wales. And different states have different capacity
16 to pay for that, and different states have different costs
17 associated with providing that similar level of services.
18 And that's the job of the Grants Commission, and has been
19 for almost 100 years.

20
21 And its job is to say, "What are the costs of
22 providing a similar level of services in the other states
23 to New South Wales, for example, and what are the revenue
24 that New South Wales gets that - or Queensland gets that
25 New South Wales can't get?" And it allocates the GST money
26 on that basis and takes into account in doing so the amount
27 of money the National Health Reform Agreement provides New
28 South Wales. And so the GST that New South Wales gets is
29 big or smaller if New South Wales gets bigger or smaller
30 amounts of National Health Reform Agreement funding. So if
31 you increase the number of patients in New South Wales by
32 1,000 that will not essentially change the amount of money
33 New South Wales gets in the long-term because of the GST
34 equalisation effects.

35
36 Q. Can I just explore another way of potentially putting
37 that. If New South Wales could persuade IHACPA to agree
38 that a range of community based services which didn't fit
39 neatly into the ABF structure because they weren't acute
40 care of the type that ABF was probably invented to deal
41 with, nevertheless were to be counted as activity for the
42 purposes of the formula, that would not necessarily - I
43 gather from what you've just told us - result in New South
44 Wales on the whole getting more money from the
45 Commonwealth; it would just potentially result in more
46 money which is quarantined for health?

47 A. Yes, the one caveat I'd make to that is, because New

1 South Wales is a big state, if New South Wales was able to
2 persuade the Commonwealth to do that you might be able to
3 notice it in the national figures, that is if you increase
4 activity significantly in a state which is a third of the
5 stuff that gets put into the pool - you know, a third of
6 the population, a third of the activity - it might flow
7 through to New South Wales. It wouldn't flow through
8 directly, but it will wash through the Grants Commission.
9 But you might be able to measure it.

10
11 Q. In what way might you be able to measure it? So New
12 South Wales has persuaded IHACPA to include a new community
13 based form of care - sorry, persuaded IHACPA that a new
14 community based form of care should be counted as activity
15 for the purposes of the formula. New South Wales is big.
16 It's doing that a lot. That increases New South Wales'
17 activity. And the cost of doing that activity in the
18 community is being captured and passed on to IHACPA. Where
19 do we go from there?

20 A. So, okay, let's assume that this new community
21 services activity counts as 1,000 NWAU, for example, and
22 New South Wales does not hit the cap that's in the National
23 Health Reform Agreement of 16.5 per cent growth. But let's
24 assume that there's 1,000 extra NWAU produced in New South
25 Wales. If you simply looked at the National Health Reform
26 Agreement you would say that New South Wales would get
27 45 per cent times the NWAU times 1,000.

28
29 However, that's not how it works. You have to look at
30 how the Grants Commission would manage all that. And the
31 Grants Commission says New South Wales has to
32 provide - sorry, the total pot that flows out of Canberra
33 to the states collectively would increase slightly because
34 of that 1,000 extra NWAU. And so the total pot that flows
35 to all the states is going to be slightly bigger because of
36 those 1,000 NWAU. How that money gets distributed is
37 entirely up to the Grants Commission. And New South Wales
38 will not get 1,000 NWAUs worth of extra because it will be
39 spread across all the states. So New South Wales might get
40 a third times a half, 45 per cent, you know, it might get
41 extra, but it's not going to be 1,000.

42
43 Q. So is the point because of the complexity of the
44 broader arrangements, let's say it was \$10 worth of NWAU
45 just to keep the numbers very easy that was being added.
46 The Grants Commission might look at that and in the context
47 of all of the considerations that apply to New South Wales

1 it might actually say, "Well, you've got \$10 worth of
2 additional NWAU coming in through the reform agreement.
3 That's a form of own source revenue that we take into
4 account as part of our calculation, which means we can
5 reduce the GST moneys by an amount." It might not be \$10,
6 though, it might be \$8; or, alternatively, it might be \$10;
7 whereas in, say, the Northern Territory the same \$10 worth
8 of NWAU might actually only result in a GST reduction of
9 \$2, it just depends on the way the Grants Commission deals
10 with it?

11 A. Yes, exactly, and the fact that the pot is slightly
12 bigger than it used to be; yes.

13
14 Q. But the broad effect of it is it's definitely not an
15 additional \$10 worth of NWAU that can be added to the New
16 South Wales budget --

17 A. No.

18
19 Q. -- because there will be some reduction through the
20 GST side of the equation?

21 A. Yes.

22
23 Q. However, insofar as the way New South Wales deals with
24 that budget, it is an additional \$10 worth of NWAU which is
25 effectively quarantined for health. So it would be
26 difficult for New South Wales to take that \$10 worth of
27 NWAU generated through this new community service and use
28 it to build a road or fund a school?

29 A. I don't know how New South Wales Treasury allocates
30 money to New South Wales Health, but in the ordinary course
31 of events if the National Health Reform Agreement funding
32 goes up the public would expect the health funding to go
33 up.

34
35 MR MUSTON: I don't have any other questions for this
36 witness, Commissioner, unless you had anything you wanted
37 to address.

38
39 THE COMMISSIONER: I do. Can I ask you something,
40 Professor, that feel free to tell me it's either a
41 nonsensical question or I'm missing something entirely,
42 but --

43 A. As long as you promise you won't send me to gaol if
44 I say --

45
46 THE COMMISSIONER: It's something that's been troubling
47 me. Part of the context is I was listening to two

1 economists talk on a podcast last night, which is what I do
2 for fun now, and amongst the things they said - they were,
3 first of all, extremely critical about the Bank of England
4 and its modelling and failing to see the GFC, and then
5 raising interest rates too late and not reducing them early
6 enough et cetera, et cetera. And then they were critical
7 of the incoming Labour government in the UK for being timid
8 in relation to infrastructure spending. And the just of
9 what they've said was there's too much consideration given
10 about how much money government spends and not enough on
11 what it actually spends the money on, and too often they
12 don't do a rate of return analysis.

13
14 And I was thinking, well, you know, if it was a
15 property developer and they were going to buy land, they'd
16 never buy land in order to develop it without doing a lot
17 of calculations, including ultimately leading through an
18 internal rate of return and risk factors et cetera in terms
19 of considering what would the profit likely be from buying
20 the land.

21
22 The reason I'm raising that is we've got - most of
23 the money that New South Wales spends goes on acute
24 services. So we have to provide those. So a child goes
25 into emergency with a broken arm, it's going to be seen in
26 a timely fashion by skilled clinicians and we're always
27 going to fund those services. It could be any trauma or
28 any acute illness that the child has to go into hospital
29 for.

30
31 But we're then told for other services we're in these
32 constrained financial circumstances and there's a limit to
33 what we can do. I accept that New South Wales government
34 has to fund - as I do - has to fund education, roads,
35 police, et cetera. It's got limited revenue raising
36 capacity as compared to the Commonwealth et cetera. So
37 there is a limited budget. And I apologise for the length
38 of this question.

39
40 But we're told as an example that certain paediatric
41 services that involve early interventions in children, the
42 clinicians are saying got really long wait lists and the
43 kids are waiting longer than is clinically appropriate for
44 intervention that might cause or might contribute to a
45 lifetime of change. It might make the difference between
46 the child becoming an economically active taxpayer and not
47 a burden on the health system as distinct from a child that

1 ends up in the criminal justice system as an adult.

2
3 Is there a means in which if it was thought to be
4 appropriate or ought to at least consider funding that kind
5 of service so that every child is seen in a clinically
6 appropriate time, there could be - and I guess it would be
7 complex, but economic modelling done such that you could at
8 least have an analysis of for this level of investment in a
9 certain period of time, whether it's 20 years or 30 years,
10 the modelling would at least show there will be this level
11 of secondary benefits, whether it's productivity, taxpayers
12 et cetera; in other words, an investment of \$5 will have a
13 return of \$15, or maybe it will only be \$3 and so we've got
14 to think about it carefully? Does that happen in health?
15 A. So I don't know who the economists on the podcasts
16 were but I think there's probably not an economist who
17 wouldn't agree with them; that is, that you've got to think
18 about the benefits of any public spending as well as the
19 amount of any public spending.

20
21 That said, I don't think cost-benefit analysis or
22 cost-effective analysis should be the sole criterion for
23 allocating --

24
25 THE COMMISSIONER: No. There are social benefits of
26 providing health services as well that are beyond
27 economics; yes.

28 A. Yes. And there are also status hierarchies in the
29 health system, and some services are generally underfunded
30 because the people who get them are lower status. So
31 mental health services are very often underfunded because
32 the public doesn't value them as much as an emergency
33 department.

34
35 THE COMMISSIONER: So is that throwing a form of politics
36 into the equation?

37 A. Yes, yes. Yes, exactly. So in an ideal world the New
38 South Wales government would say, "We can do a business
39 case here" - well, not in an ideal world. But one of the
40 things the New South Wales government could say is, look,
41 let's do a business case here, and let us say that if we
42 invested in removing this waiting list then there would be
43 a return in five years or 10 years time, and it is possible
44 we - using pretty standard economic techniques to convert
45 an internal rate of return, as I think you mentioned.

46
47 In fact, New Zealand tried to do that in the health

1 and welfare sector, just saying, look, if we did early
2 intervention with some of these kids, they wouldn't go
3 into, you know, care and homes and all those sorts of
4 things, they'd be actually able to get productive jobs
5 10 years down the track, and so on. And so it is being
6 done, and I think it is appropriate to do, that is you
7 know, if you have a long cataract waiting list, the people
8 on the cataract waiting list might end up breaking their
9 leg because they tripped, and so it's those sorts of things
10 you've got to think through that when you're making
11 allocation decisions you've got to think through what the
12 consequence of those allocation decisions, and it might be
13 there's a good business case to spend money in this place
14 because of the return, and the return might be outside the
15 health sector.

16
17 THE COMMISSIONER: Yes.

18 A. As well as a return inside the health sector.

19
20 THE COMMISSIONER: Yes. Before I ask Mr Chiu whether he's
21 got any questions, we're extremely grateful for the time
22 you've given us and the assistance you've given the
23 Inquiry. Could I ask you, though, in relation to the topic
24 we've discussed, if anything - any study comes to mind -
25 you've mentioned the New Zealand one - I mean, of course,
26 I've seen studies like, you know, if we use more virtual
27 hospital services it will save X number of bed days and
28 that will save a certain amount of money, et cetera,
29 et cetera. But in terms of what we were discussing, if
30 there's any studies that come to mind, if you could shoot
31 an email to the Inquiry I'd be very grateful.

32 A. Yes, I am in Abu Dhabi at the moment.

33
34 THE COMMISSIONER: I understand.

35 A. I'll do that when I get back.

36
37 THE COMMISSIONER: Within the bounds of reasonableness
38 that request is made. Mr Chiu, do you have any questions?

39
40 MR CHIU: Just one issue.

41
42 THE COMMISSIONER: Yes, go ahead.

43
44 MR CHIU: Thank you, Commissioner.

45
46 <EXAMINATION BY MR CHIU:

[2.58 pm]

47

1 MR CHIU: Professor, one of the points --

2

3 THE COMMISSIONER: Sorry, this is Mr Chiu, who's
4 representing - he's the senior counsel now representing New
5 South Wales Health.

6

7 MR CHIU: Thank you, Commissioner. Professor Duckett, one
8 of the points you made earlier, and this is at 6476 of
9 the transcript, was that it is hard to achieve allocative
10 efficiency because outcomes are hard to measure, and
11 I think one of the things that you discussed with the
12 Commissioner just now is some of the different ways in
13 which you can try to measure outcomes. Could you just talk
14 through why are outcomes difficult to measure in health?

15 A. So thank you. I think for a number of reasons. First
16 of all, we have - different groups within the health sector
17 have different perspectives on what is important to
18 measure, and so clinicians, for example, might say what is
19 important to measure is the clinical outcome that the
20 patient achieves; that is, I have a hip replacement and
21 that operation goes really well. From a patient's
22 perspective, they might say, "The reason I fronted up to
23 hospital was because I had pain in my hip and what I wanted
24 resolved was the pain. I didn't ask for a hip
25 replacement," and the clinician decided that a hip
26 replacement was the way of reducing the pain. So you have
27 a clinical perspective or a patient perspective, and they
28 might be different.

29

30 Secondly, let's assume we're going to entirely go from
31 a patient's perspective. Then you have to have a
32 standardised way of measuring what are called the patient's
33 preferred outcomes, and it's called in the jargon
34 patient-reported outcome measures, so called PROMs. Now,
35 the problem with patient-reported outcome measures is we
36 don't do it very often and if you're going to measure
37 outcomes you've got to measure what the level of pain is
38 before the operation and what the level of pain is after
39 the operation, and so you can compare the improvement that
40 was achieved, and we tend not to do that.

41

42 So, because we don't have really very much measurement
43 of outcomes at all, trying to move to allocative efficiency
44 to compare the outcomes of an orthopaedic operation and the
45 outcomes of a dental treatment is really, really very hard,
46 because you've got to be able to measure in a way which is
47 commensurate, that is in a way which adjusts the dental for

1 the orthopaedic, for example.

2
3 Q. Is there also a way of measuring outcomes beyond an
4 individual patient, i.e. you look at it from a population
5 or a society and you measure outcome as overall are you
6 achieving a healthy population? That may have tension as
7 against individual patient outcomes, wouldn't it?

8 A. Yes, yes, yes. So the problem is the more you move
9 away from the aggregation of individual outcomes to broader
10 outcomes such as life expectancy, for example, the more
11 there are other factors other than the health system that
12 impact on life expectancy. So, if you're trying to
13 attribute an improvement in life expectancy or an
14 improvement in self-rated quality of life to the health
15 sector, there are all these other intervening variables
16 that affect it, for example living conditions or employment
17 or whatever.

18
19 So in international comparisons we very, very often
20 use life expectancy, and in fact I've used that myself.
21 But whenever I do it I have to put in that caveat that it
22 may be the best we've got but there are all these other
23 things that impact it.

24
25 Q. Are there any systems that have either adopted or even
26 considered funding by reference not to activity but to
27 outcomes or a version of outcomes?

28 A. There's an enormous amount of talk about that, and
29 I don't - I'm not aware of any systematic implementation
30 across a whole health system; that is, it is possible to
31 think about doing it for a part of the health system, say
32 orthopaedic services, but to do it across the whole health
33 system I have not seen anybody do it. As I said, that's
34 not to say there's not a lot of talk about it. But just to
35 give you some examples of the complexity of this, if
36 I stick with orthopaedics, if I have two orthopaedic
37 services, one which has a great outcome, better than the
38 national average, for example, and one which has a worse
39 outcome, do you give the hospital with the best outcomes
40 more money or less money? And then the one with the best
41 outcomes might be the most expensive already versus the one
42 with the worst outcome might be the cheapest. And in fact
43 in some of my presentations I actually have a graph of
44 exactly that kind, because in the United Kingdom they
45 measure outcomes for joint replacements and you can plot
46 them on whether the hospital is more or less expensive
47 relative to the national average and whether it's got

1 better or worse outcomes relative to the national average,
2 and the hospitals are all over the place. But no-one has
3 done anything with that information because it's too
4 complex, really.

5
6 Q. Right.

7 A. There's no reason why we couldn't do the same in New
8 South Wales, except we don't have the outcome measures for
9 that yet.

10
11 Q. Suppose you develop the outcome measures and the
12 infrastructure to measure those things, and you could
13 foreseeably see a - develop a system where - at least for
14 something like chronic disease, managing chronic disease in
15 the population against quality-adjusted life years of that
16 population, it's possible, isn't it, to develop a system
17 where you fund certain types of activity that are directed
18 to that outside of the acute space?

19 A. So I think if you're asking whether it's possible to
20 write a business case which says, "If we invest in this,
21 then we would get exactly the same increase or more - a
22 better increase in quality-adjusted life years than if we
23 invested in additional orthopaedic services," for
24 example --

25
26 Q. Yes.

27 A. -- yes, of course you could do that. But don't forget
28 New South Wales tried this approach with its area-based
29 funding for decades and didn't ever do it.

30
31 Q. Can you just explain that last comment a little bit
32 more? You say New South Wales tried that approach?

33 A. Yes. So I live in Victoria but I grew up in New South
34 Wales. So it's very interesting to compare the evolution
35 of the health systems in both states. Victoria has never
36 adopted an area based model of funding, or its service
37 delivery for that matter, and New South Wales did and for a
38 very long time it had a resource allocation formula to
39 allocate funding to the areas on the assumption that, with
40 an area based funding formula, the area would have an
41 incentive to do exactly what we've just been talking about,
42 to do exactly that business case to compare investing in X
43 versus investing in Y. None of them ever did it. And so
44 this lasted for 20, 30 years, from I think the mid-70s
45 potentially through to 2010 or 15, whenever it was. And it
46 is very, very complex. That's why it didn't happen. It's
47 nice in theory, very strongly supported in theory, but

1 doing it in practice is pretty hard.

2

3 MR CHIU: Commissioner, I have no further questions.

4

5 THE COMMISSIONER: Can I ask just one more and,
6 I apologise, it's an impossibly broad question, but you're
7 here so I'm going to ask it anyway. I know your extensive
8 knowledge and how much you've written about the
9 introduction of Medibank/Medicare. We have in our travels
10 around regional New South Wales and to certain very remote
11 towns fairly consistently been told a combination of
12 either, "Our GPs have disappeared," or, "The ones that
13 exist have got closed books and it takes X number of weeks
14 to get a standard GP appointment."

15

16 We've been told about certain solutions to that,
17 whether it's the single employer/section 19(2) exemptions
18 model or at least one instance a local council stepping in
19 and employing a GP for primary care. And I know some of
20 Professor Cormack's recommendations in his scope of
21 practice review will be relevant to this. But I know
22 you're on the - well, you certainly were on the
23 Strengthening Medicare Taskforce. Other than the things
24 I've mentioned, is there any solutions to ensuring this
25 state can have - people can access and adequately access
26 primary care, GP-led primary care?

27 A. Thank you. So I think the implementation of the
28 recommendations of the Strengthening Medicare Taskforce and
29 the subsequent review of GP incentives, which I was also
30 on, will help. But the fundamental issue is there's been a
31 collapse of workforce planning in this country, health
32 workforce planning in this country. No-one does anything
33 about it and no-one takes any responsibility for it.

34

35 So it does seem to me that New South Wales
36 Health - and part of the problem is that there are lots of
37 irons in the fire; that the Commonwealth government funds
38 universities, the universities make autonomous decisions,
39 the state government funds clinical placements in hospitals
40 and other certain locations and so on and so forth. So
41 there are lots of people having fingers in the pie, and
42 that can either lead to a complex way of doing things or
43 nothing happening at all, and it's the latter that's
44 happened.

45

46 So, in my view, I think the New South Wales Government
47 ought to have responsibility for actually doing something

1 about this in conjunction with the universities and the
2 Commonwealth. And it ought to say New South Wales ought to
3 be net self-sufficient in every health discipline; that is,
4 we should no longer have to rely on international medical
5 graduates or international physios or whatever, and we
6 should train enough in New South Wales to meet New South
7 Wales' needs. Of course some people are going to go
8 overseas and some people are going to come in but, by and
9 large, we ought to make sure that the intakes are enough to
10 produce the workforce we need.

11
12 And it is especially true west of the divide that you
13 might say that New South Wales west of the divide ought to
14 be net self-sufficient. And what we know is that if you
15 set up a medical school, say, at Charles Sturt University,
16 and Charles Sturt University says, "We are going to
17 prioritise students who grew up west of the divide, who
18 come to university west of the divide, who do all of their
19 clinical placements west of the divide," they will stay
20 west of the divide. And that is true and there is evidence
21 about that. But we haven't tended to do that. So the New
22 South Wales Government has to lobby the Commonwealth, has
23 to say to the universities, "This has to be your selection
24 process" and so on.

25
26 And you've got to start with the workforce production.
27 There's no point saying, "We're going to expand the
28 University of New South Wales in Kensington," in the vein
29 hope that this is somehow going to help Orange or Bathurst.
30 Well, it won't and it hasn't. But you've got to start with
31 the workforce, getting the workforce right. Of course in
32 the meantime - because that's a long-term strategy. In the
33 meantime you've got to deal with all these other issues
34 like multidisciplinary teams and sharing the loads and all
35 those sorts of things. But, unless you start with a
36 workforce strategy, you'll never fix the workforce
37 strategy.

38
39 THE COMMISSIONER: Yes. Did anything come out of that
40 that you want to ask a question about?

41
42 Professor, thank you very much for your time.
43 A. Pleasure.

44
45 THE COMMISSIONER: Especially talking to us from so far
46 away. We are very grateful for the assistance you've
47 given. Thank you.

1 A. Thanks. A pleasure.
2

3 <THE WITNESS WITHDREW
4

5 THE COMMISSIONER: All right. So we adjourn until
6 10 o'clock tomorrow. All right. We'll adjourn until then.
7

8 **AT 3.12PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
9 **TO THURSDAY, 21 NOVEMBER 2024 AT 10AM**
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