Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Thursday, 12 December 2024 at 10.00am

(Day 069)

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 for NSW Health

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THE COMMISSIONER: Good morning.

MR MUSTON: Good morning, Commissioner. We have the authors of a report entitled "Resource management in NSW Health" giving evidence.

There is a slight change to the arrangements which I was informed of this morning. In person, you have Professor Wilson again and Dr McNamara, who we have heard evidence from previously. And now, attending remotely, Mr Michael Reid, Professor Kees Van Gool and Associate Professor Carmen Huckel Schneider.

THE COMMISSIONER: Okay. Can I just ask, those of you appearing remotely - well, can I ask you first, Associate Professor Schneider, are you in Sydney?

A/PROF HUCKEL SCHNEIDER: Yes, I am in Sydney.

THE COMMISSIONER: Is there a reason you're not here in person?

A/PROF HUCKEL SCHNEIDER: Unfortunately, I had to attend a different online event that concluded only briefly before this hearing and therefore requested to join remotely to ensure I could be here on time.

THE COMMISSIONER: And what about you, Professor Van Gool?

PROFESSOR VAN GOOL: I am in Sydney. I asked and was given the opportunity.

THE COMMISSIONER: Is there a reason why you asked to appear remotely?

PROFESSOR VAN GOOL: Just a convenience thing because I have other meetings to attend very shortly after 1 o'clock.

THE COMMISSIONER: What about you, Mr Reid?

MR REID: I'm down in Jervis Bay, Commissioner, so I would have to come back here this evening, so it was a 4am flight and I asked also if it was okay and I was told it was okay.

THE COMMISSIONER: Sorry, where are you?

MR REID: Jervis Bay.

THE COMMISSIONER: Okay. All right. We will proceed.

I have to say, hearings, whether they are court or inquiries like this, it's always better, if possible, for the witnesses to be in person rather than remotely, for a range of reasons I won't run through. In any event, there's not much we can do about it now, so we'll just proceed.

Please let me know, any of you, do you have a preference to give - the options are to give your evidence either under oath or by affirmation. Does anyone want to give their evidence by giving an oath? If it's all by affirmation, we can do it all at once.

PROFESSOR WILSON: That's fine, Commissioner.

<ANDREW WILSON, affirmed: [10.04am]

<MARTIN MCNAMARA, affirmed:

<CARMEN HUCKEL SCHNEIDER, affirmed:

<KEES VAN GOOL, affirmed:

<MICHAEL REID, affirmed:

MR MUSTON: Professor Wilson and Dr McNamara, we know who you are and where you are from, so we might pass immediately to the witnesses on the screen.

Associate Professor Huckel Schneider, could you tell us who you are and what you do when you are not contributing to reports like this one?

A/PROF HUCKEL SCHNEIDER: Yes, thank you very much. I'm an associate professor in health policy at the University of Sydney School of Public Health. I'm also the deputy director of the Leeder Centre for Health Policy, Economics and Data, of which the co-director is Andrew Wilson, who is also there, and I have a research background in comparative health systems research as well as health governance.

MR MUSTON: And Professor Van Gool?

PROFESSOR VAN GOOL: Good morning, Kees Van Gool, also from the Leeder Centre for Health Policy, Economics and Data at the University of Sydney and I have a joint appointment with the Independent Health and Aged Care Pricing Authority, but I am here to represent the paper as written with colleagues from Sax and Sydney Institute and, of course, Mick Reid. My background is in health economics.

MR MUSTON: Thank you. Mr Reid?

MR REID: Mick Reid. I am an adjunct professor at the University of Sydney in health policy and an adjunct professor in the University of Western Sydney. I'm on the board of Western Sydney LHD. I have my own - I previously was director-general of health in New South Wales and also Queensland and really do consulting work around the country on aspects of health policy.

MR MUSTON: Thank you.

You have each contributed to the preparation of a report entitled "Resource management in NSW Health" dated 29 November 2024. That's correct?

(Witnesses nod)

MR MUSTON: The contents of that report continue to reflect views that each of you hold; is that right?

(Witnesses nod)

MR MUSTON: Commissioner, that's [SCI.0011.0605.0001]. It will form part of the bulk tender at the end of today.

Do you each have a copy of that report available to you this morning?

MR REID: Yes.

PROFESSOR VAN GOOL: Yes.

A/PROF HUCKEL SCHNEIDER: Yes.

MR MUSTON: I might just say at the outset, in terms of the questions that I ask and the areas in which I invite you to expand on things that have been set out in the

report, any one of you who feels best qualified to answer the question should jump in and do so. To the extent that it seems obvious who that person is, I might direct a question to one of you, but if I get it wrong, feel free to pass it on to someone else.

PROFESSOR WILSON: If it is okay with you, I might assist you in that and just direct, given that I know all the parties fairly well.

MR MUSTON: That would be excellent. For those of you who are online, if there is anything that you want to add or contribute to evidence that has been given by someone else, just from a logistics point of view, it would probably be good if you could use the "hands up" button on the Teams platform. We'll see the hand up on the screen and I will come to you very quickly thereafter; likewise, if either of the two of you who are here in person would like to contribute something to someone else's answer or offer a different perspective, just look my way and wave your hand and I will come to you quickly.

The final thing to say about that, probably, is to the extent that there are things that we traverse during the evidence this morning where any of you feel that either through contributing a different perspective or perhaps even asking questions of one another to try and flesh out the answer, feel free to do it.

It's a relatively informal process that we are engaged in here. It's not evidence of an old-fashioned kind where I ask you short questions and you give me a yes or no. We're genuinely interested in the exchange of ideas and to have a format in which you are able to assist us with your collective views in relation to the issues that are touched on in the report.

With that, could I ask you to go to paragraph 13 of your report where you tell us, in a summary way, what a number of the objectives of the NHRA are.

Do you see the first bullet point there that refers to one of those objectives being to encourage activity that considers not just technical efficiency but also aims to improve access, for example, by reducing waiting lists?

In relation to that observation, can I ask the first

question: what type of waiting lists are we talking about there - waiting lists or waiting for what?

PROFESSOR WILSON: So Kees and Mick will probably want to add to this, but the issue here is when we talk about waiting lists, there are two - there are a number of ways of conceptualising what a waiting list is. You might be talking about the number of people on it, you might be talking about the wait time on a list in that regard. Either of those are applicable in terms of this statement. One wants to have the shortest number of people waiting, but also, more importantly from a patient perspective, is the time that one waits to have a procedure or appointment.

We also have the complexity that you can have tiers, interlinked tiers of waiting lists. So you can be waiting, for example, for an appointment to see a surgeon, you see the surgeon, you then go on to a waiting list for the surgical procedure that follows that. So you will get those sort of interlinking issues.

Mick or Kees may want to comment on this. My interpretation of that National Health Reform Agreement was the intent was to try and reduce both of those, but particularly was focused on the bit which is usually the one which is most prominent and best measured, I guess, is a poor description of it, which is really that second one, the time between seeing your consultant and getting some procedure undertaken.

I might also add that, you know, waiting lists for procedural processes are different to waiting lists for seeing a specialist like a rheumatologist, for example, which, across Australia within the public sector, have very long waiting lists and are hard to get into, but once you are seen, you are basically then being managed from that point on.

MR MUSTON: You used the term "best measured". Is the reality that that waiting list which is you've been identified by a surgeon as someone who requires a piece of surgery within the public system and then there is a date at some point in the future when you are going to get that surgery - it's whether that's best measured or perhaps is it easiest to measure?

PROFESSOR WILSON: It's most visible once you've seen the

proceduralist and been put on a list subsequently for a procedure. So it's most transparent at that point.

The transparency of the waiting list to see a specialist is less clear, because people get reprioritised all the time in those lists, and places have different approaches to this, so some places, you get an appointment for a specific specialist and in other places you will have an appointment to a clinic and you will see one or other of the specialists in that clinic with no particular choice in that regard, and that then influences, you know, what the waiting list looks like.

MR MUSTON: How is it that than NHRA seeks to improve access by reducing waiting lists in that second category - that is, for example, the child who has been assessed through a particular program as requiring a paediatric intervention or, to use your example, an individual who has been assessed as requiring an appointment with a rheumatologist?

PROFESSOR WILSON: The NHRA was a really important advance, because it tied the Commonwealth contribution to activity, whereas previously, what happened was there was just a block of funding that came to the state, that block was set over a five-year period, it increased over that five-year period, but it basically came to the state and territories as a block.

What the NHRA did was tie that to activity, and so that had two consequences. One is that activity had to occur to get the funding; and, two, it had a growth factor in it, whereas before, basically the states largely wore the risk within that block funding of growth in activity and, to some extent, that was predictable but it does vary, whereas this tied it to the actual activity that occurred. So you got a different driver.

And I can see that Kees wants to leap in here. He knows far more about it than I do.

PROFESSOR VAN GOOL: No, no, I was just going to supplement. Sorry, I shouldn't say --

MR MUSTON: No, please, do.

PROFESSOR VAN GOOL: All I was going to say is to add to

Andrew's comment and say growth in not just activity but also in a cost, the Commonwealth contribution is tied to both activity and cost.

MR MUSTON: To the extent, though, that the activity which is recognised under the NHRA is predominantly hospital based or historically has been a hospital based activity, I'm just trying to understand how that mechanism has, at least in a realistic sense, an objective of reducing waiting times for, say, out of hospital clinics to see a rheumatologist or a paediatrician or something like that?

PROFESSOR WILSON: Kees, do you want to comment?

PROFESSOR VAN GOOL: Yes. So under the NHRA, there are different types of classifications, and classifications allow you to essentially count activity. There is an admitted acute classification; there is a non-admitted classification system; there is an emergency department classification system, non-admitted.

You know, as these classifications have developed over time, we've been able to count that activity in a more comprehensive way. So it's not just what happens, you know, within the four walls of an admitted acute hospital; it also is broader than that in terms of, yes, non-admitted, subacute, admitted mental health now as well.

MR MUSTON: Just to pick up on Professor Wilson's example of a rheumatologist who might be providing care through a public clinic, that public clinic, outpatient clinic, is something which is now, or would now be, captured as a species of activity under the NHRA?

PROFESSOR VAN GOOL: Yes, I can't go to the specifics, but non-admitted patient classifications are typically counted and there are a range of ways of counting that, and specialist consultations are part of that as well.

MR MUSTON: I understand, based on your report and a wealth of other evidence, how it is said that that ABF model that is embodied within the NHRA seeks to drive technical efficiency in the delivery of, say, that outpatient clinic delivered by a staff specialist rheumatologist, but how does the NHRA seek to improve access to a clinic like that by reducing waiting lists for an outpatient service of that type, if at all?

MR REID: I think it goes back to Andrew's point of saying that it was a fundamental reform, and when this reform was brought in, there was - as there is today, but somewhat less so - considerable interest by all state authorities on reducing their waiting lists and waiting times. You'll recall one previous premier promised to reduce it by half in his first six years of office in New South Wales. But I think it's addressing that, of trying to link the Commonwealth funding to activity levels which was the characteristic feature. So I'm not too sure the wording or the analysis at the time went further beyond that the subset of that.

MR MUSTON: Maybe this is a question for you, Mr Reid, but where you refer to the premier's priority being to reduce waiting lists, that priority was to reduce the time that people waited for what?

PROFESSOR WILSON: It was procedural.

MR REID: Time they waited for elective surgery, and around this time, you know, there were a significant number on the waiting list for elective surgery and there was an endeavour by government to reduce it. So it was deemed that the NHRA would contribute to that. It wasn't just New South Wales; it was all states.

PROFESSOR WILSON: You've really cut to one of the most important distinctions in the whole issue around the sort of waiting list debate, and it is which waiting list are you talking about? Most of the stuff that you see in the media is around waiting for procedural, so waiting for elective surgery or not necessarily even elective surgery list, but some sort of procedural list.

There has been much less focus on the waiting lists for areas like specialist clinics for non-procedural medicine, and that is a problem, but it's a more complex problem than the other one. That's why I was saying, you know, separating those two sorts of waiting lists. All of this is about capacity in the system, it's about how many doctors or other health providers there are to do this, and in the ambulatory space, there have always been issues around access to specialists, to consultants, either surgical or other specialties, and in the sort of non-procedural areas.

We have had, since about - I'm just trying to remember; Mick might remember - the late '90s, up until the late '90s, in effect, there was no basis for public hospitals to be able to bill services. Even though there were sort of arrangements, there was a growth even prior to the late 90s in clinics which were operating, it wasn't quite clear where they sat legally in relation to that.

In the late '90s, there was an agreement between the states and the Commonwealth which basically said you have to keep operating all the public clinics that you can at the moment, but if you grow additional capacity in the ambulatory care setting, then you can bulk-bill for those services.

So what has happened in that, in the 20 years in there, as we've seen, is growth in clinics which are - they have a whole range of arrangements that essentially bill the MBS to increase this.

But of course, you know, you still have to have doctors who are willing to do that, and if you are billing, bulk-billing, for a patient, then it raises this whole issue of well, how is this different to my private practice, et cetera. In some places, the doctors haven't been prepared to enter into agreements which would basically allow for bulk-billing, ie, no co-payments for patients, and so we have seen situations, and we will see across the state quite variable access to specialists, which largely relates to the number of specialists that are there are but also this factor of whether they are willing to provide these bulk-billing clinics, because that has been where the greatest growth in outpatients has been, and it's a real - for me, and you'll see it coming through in the paper repeatedly, to me, the real issue here is an equity issue of access for people, because as soon as you force people into the private sector, then there will be co-payments, and that's a problem.

MR MUSTON: A problem because that excludes a wide range of potentially quite ill people who just can't afford the co-payment?

PROFESSOR WILSON: It's inequitable in a whole range of ways. One, you've got to be able to afford it; two, if you've got a chronic disease, you have to afford it over

and over again. If you're just going to see a surgeon and you've got a one-off fee, that goes with it, well, you can manage that. If you've got a cancer, if you've got a chronic condition where you're having to repeatedly go there, then you're going to have a repeat co-payment every time now. Yes, there is a safety net in the MBS arrangements in terms of that, but that can be quite - for many people, it can be quite problematic.

Then, you know, this is assuming that you can get the access in the first instance, which is really problematic for ambulatory care around the state.

MR MUSTON: Accepting that part of the capacity of the system to deliver that sort of care is informed by the willingness of members of the medical profession who are within these specialties to step in and deliver it, it's also informed, is it not, by the way in which decision-making historically has shaped the system - that is to say, if there's a focus on the delivery of surgical care, then that means that, within a limited budgetary envelope, you're spending money on providing that surgical care and that is money that you're not potentially spending on building a workforce with training pathways and the like in that ambulatory space?

PROFESSOR WILSON: Sorry, I just noticed that Carmen had her hand up before. She might want to have added something about the previous --

MR MUSTON: Sure. If I forget my question, I might have to get it read back.

PROFESSOR WILSON: I'll answer your question for you, but I just wondered if she had something to add that might have been useful.

MR MUSTON: Sure.

A/PROF HUCKEL SCHNEIDER: I wanted to come back to the question about what was the idea about the NHRA to reduce those waiting lists, and the passing of the NHRA came at a time where there were similar movements towards so-called diagnosis related group type activity based funding in a lot of different health systems, and reduction of waiting lists was cited as a motivation for doing so in a lot of different health systems.

There was a simplified theory behind this in that if funding is activity based, there's a national efficient price and then for each type of diagnosis there is then a complexity weighting, and then a so-called inlier length of stay. That means that the amount of funding for that particular activity should be incentivised to be completed efficiently and within a certain amount of time.

Then the theory behind that was that that would incentivise hospitals to have more throughput at that efficient price rather than simply more patients or more activity - so incentivised efficient activity.

This then led to an extension of that theory that the efficient activity would allow greater throughput and, therefore, patients moving through in a safe and efficient way, which would enable then a shortening of the waiting list.

Already back then, though, there were lots of people that talked about the complexities that might not necessarily mean that it would actually reduce waiting lists, but I just wanted to put in that that was the theory behind setting up funding in this way, in that the incentive with a DRG based - a diagnosis related group based activity funding is that the throughput in an efficient way is meant to be incentivised, which was then meant to lead to the throughput and therefore the reduced waiting list.

MR MUSTON: Again, to make sure we're on the same page in terms of what it is we're waiting for, that works in a way that at least I think I can understand if we're dealing with someone who's requiring a piece of elective surgery, where, if you are able to drive efficiency in your system and perform that elective surgery as a same-day surgery as opposed to a three-day stay surgery, or a two-day stay as opposed to a three-day stay surgery, then I can understand that that might be both more efficient and have, as an outcome, a reduction in the time that an individual might wait to receive that surgery, because there's a bed day that you've freed up there, or three bed days that you've potentially freed up there that you could have somewhere between one and three additional patients attended to.

But that doesn't quite translate, does it, into this

other type of waiting list that we're talking about, which is waiting to see your rheumatologist or waiting to see your paediatrician for a childhood intervention, say, before they start school?

MR REID: That's absolutely right. And what Andrew said - people's concept back in those times was when they talked about waiting lists, they talked about waiting lists or waiting times for elective surgery. There was not the concept anywhere near as well developed or well understood, as well politicised, as waiting times for outpatient services.

MR MUSTON: I think that brings me back to my earlier question.

PROFESSOR WILSON: Yes, so coming to your question about, you know, the policy settings, et cetera. I mean, if you have a system, which all states and territories in Australia have, where there is, essentially, a health budget, and the Ministry of Health is expected to manage within that and its provider units are provided an amount of money to operate within that, then they've got to work out how they're going to manage to meet as much demand as they can within the system, within that system.

So, you know, broadly, what are the things that they can do to do that? Well, yesterday we spoke a bit about prevention and we talk about the sort of issues that, you know - while we may be able to prevent some of this, it doesn't necessarily lead to a massive reduction in demand, but it may free up capacity to meet some other demands.

More broadly, then, you've got to either aim to - you are going to try to manage that resource in there, so the other way of managing that resource is through waiting times, and so you've only got a certain number of people that you can put through, through a period of time. So for those things where, from a clinical point of view, you may be able to - there may not be as much urgency, then you'll have some sort of delays built into the system to meet with that demand.

Or you can try and improve the efficiency of the system, and we talked about, and you've just given a nice example, where you try and reduce the length of stay and, therefore, you can increase the number of people going

through, recognising, however, that if you do that, there is actually an additional cost to it, but at least under activity for - at least under the NHRA part of that, you're getting 45 per cent of that back from the Commonwealth so it's not as much of a hit as it could be in that regard.

Then you can also look at whether or not there are cheaper ways of doing things, more efficient, from that perspective, so not only just keeping people in hospital for the minimum clinically necessary period of time, but also whether or not you can actually manage them in other settings, whether you can use virtual care to provide services - those sorts of things are another way of reducing the cost of your services in that regard.

Then, the other thing you can do is that you can look at, well, where can we share this cost? So if you can move services out of the public system into some other, into the MBS billing system, then, you know, you achieve the same end of managing within the budget you've got. So there are large incentives for managers in the health system to use all of those strategies to try and meet demand.

MR MUSTON: In terms of the extent to which the current system and its workforce has the capacity to meet that demand, have we, for perhaps largely historical reasons, unwittingly prioritised the demand for surgical services over the demand for other forms of services, by, say, measuring wait times for elective surgery because they're easy to measure, and holding ourselves strictly to account if we --

PROFESSOR WILSON: I'm a physician by background, so I couldn't possibly comment on that.

MR MUSTON: I'm going to ask you to anyway.

PROFESSOR WILSON: Look, I think it's - I mean, these are about the - governments pick up signals about what's important to the community, and for whatever reason, that signal about surgical waiting times has been a very strong signal, whereas waits for other sorts of care in the system have been given less emphasis in that regard, and it is long, longstanding, and I think it partly relates to the fact that, you know, the state-based systems were focused on hospital care, and so what was a large part of hospital care - well, increasingly what hospital care was about was

about procedural medicine and it was about surgery, because we moved so much of the other stuff out of hospital. So I think there were sort of a whole range of dynamics which have influenced that particular aspect.

MR MUSTON: In terms of what matters to the population, or at least a government's perception of what matters to the population - this is a little bit off topic when it comes to funding - the government, in a way, has potentially got a capacity to shape that, doesn't it, by determining what it reports on or what it invites, say, the BHI to report on, and the data that it insists its practitioners and its local health districts collect and report on?

PROFESSOR WILSON: And I think that has been recognised, and Mick can comment on this better than I. It has been recognised at ministerial level and senior levels, that, you know, we do need to measure a broader range of issues in - a broader range of areas within the health system for exactly that reason. But Mick might want to comment.

MR MUSTON: Mr Reid?

MR REID: I would just support the comment of Andrew. I think governments, particularly over the past five to six years, have very much gone back and looked at some of the waiting times for outpatient services. Sometimes they're up to four or five years, existing then, and there has been an endeavour to do that, but there is no doubt there is still - you could argue that that has not received the same political attention as the political attention on elective surgery waiting times, and that still predominates, and I think the physicians who work in hospitals would argue that often they feel disadvantaged by the change in bed availability, access to theatres, access to other - focus in elective surgery rather than other activities of the hospital, to the detriment of patient care.

So I think there would be a view around what you've said is true, but I do think there has been considerably more attention to those aspects of hospital care more recently.

MR MUSTON: But to test the foundation, we've been told that there is a sound evidence base for the proposition that a delay in receiving your elective surgery - if you've been screened by a surgeon and it's been determined that

you are someone who needs elective surgery, a delay is a negative thing. That is to say, the sooner that you get that surgery, the better, in terms of your health outcomes, as a general proposition. Would that be right? Perhaps let --

THE COMMISSIONER: There are periods beyond which where it starts to become clinically significant.

MR MUSTON: Let me put it another way. The thresholds that we hold ourselves to in times to surgery for elective surgery undoubtedly have an evidentiary basis?

PROFESSOR WILSON: Look, I think in general, if you've got a disease or condition which is likely to be progressive, then the longer you wait, then the less desirable it is.

MR REID: And we have a categorisation, Andrew, of elective surgery which has an evidence base.

PROFESSOR WILSON: Yes. But, you know, not all conditions are the same in terms of their propensity to either shorten your life or lead to disability. So the system has a system for categorising the need to do that, and it is based on evidence, on clinical input into what would work to create those different categories for it.

If you are a patient, sometimes that doesn't seem very fair, that you are categorised into a lower need category than others. But it is part of that way of managing demand.

MR MUSTON: Whilst equally imprecise no doubt, an equivalent evidence based categorisation could no doubt be created for all manner of outpatient care? For example, an example we've used many times here, the paediatric intervention where a child is identified as requiring paediatric intervention, there would undoubtedly be some evidentiary basis that could be found out there to support the proposition that if they get it before they start school, the outcome will be better both in terms of health and life, than if they get it in year 4, for example?

PROFESSOR WILSON: Yes, my understanding is that there is a triaging process for public outpatients as well and people are assessed as to their need.

It is a more complex issue, because sometimes, the person needs access to that specialist to be able to assess what their need is, if you like. And also, it may be an important determinant of access to a particular type of medicine because you have to see the specialist, you know, before you can get access to that medicine.

So I think that sort of earlier triaging is more complicated, but it is, and as far as possible, it is based on an evidentiary approach where there's some assessment of the referral letter that comes from the general practitioner, you know, in terms of, you know, why is this - what's the urgency in this particular referral.

THE COMMISSIONER: I think that's right. I mean, that's what we've been told in our travels. But when we're told about paediatric wait lists, say, at John Hunter, for which the range was given two to five years, with a question: "How could the wait list extend to five years?" The answer is, "Because we do triage and the really critically urgent cases keep bumping back those that are at a different triage level." But that doesn't mean that waiting three, four, five years when you're three years old or four years old or five years old isn't hugely clinically significant in a bad way.

PROFESSOR WILSON: Yes, I couldn't disagree with you, Commissioner. It is a problem. I can't speak specifically for paediatric wait lists but --

THE COMMISSIONER: Well, getting data about --

PROFESSOR WILSON: -- I certainly know that, you know, you've got things like developmental delay - what does that mean, for a start; and then triaging that is quite problematic. And then getting the treatment - getting to get the right assessment and then getting a comprehensive response to that is, you know, quite complex. It's certainly, potentially, a lot more complex than, you know, a waiting list for a hip replacement.

THE COMMISSIONER: Sure, of course.

MR MUSTON: Accepting it's more complex, though, it's not beyond the capacity of the system and the many very clever people who contribute to it to create at least some sort of a guideline as to when, informed by an evidence base,

someone who presents with a particular condition or is referred to a particular type of specialist to be assessed or offered some treatment --

PROFESSOR WILSON: I'm feeling a little nervous here because you're taking me into some areas of, you know, specificity in terms of the health system, and I'm just conscious that I don't want to mislead you in terms of some of these things here. So I think some of the questions you ask are better targeted to people who deal very specifically with the sorts of areas that you are dealing - you know, that you're asking about. But in general, you know, I think this is, I feel, one of the areas that requires a lot more attention within our system across Australia. It is an area that's problematic.

MR MUSTON: Without descending into the specifics of how long one might need to wait for a paediatrician or whether you could, in fact, set a guideline for that as opposed to a rheumatologist and the like, to the extent that it is possible to do that - it may not be but to the extent that it is possible - it's not something we're doing at the moment in holding ourselves to account as a health system in terms of our performance?

PROFESSOR WILSON: I would say I'm nervous here because I don't know. I think you would need to ask - I would be surprised if there isn't some attempt to do that at the moment, to do - to base - to use an evidence base and guidelines to do that, but in the particular setting you're talking about I'm not - I don't know.

MR MUSTON: Mr Reid, you might know. Are you aware of whether the BHI, for example, routinely publishes data on how long people wait to receive care through specialist outpatient clinics where it's been determined that they require it as opposed to those statistics that we see on the front page of the newspaper so routinely, for waiting times in emergency and waiting times for elective surgery?

MR REID: We clearly, as you know, publish quite detailed information on the latter, so you're right in the sense there's the sin of omission that occurs there that we don't publish the same detail outside elective surgery for waiting times.

There are some KPIs in the service level agreement at

the moment which relate to waiting, you know, management and efficiency within the elective - within the outpatient areas. But I think your point - my view is your point is quite correct, that we don't have the same degree of priority setting and accountability for those things which may have just the same deleterious consequences from delays as some forms of elective surgery, as they might do in outpatient areas. I think it's a gap.

MR MUSTON: Or maybe more - may have a more deleterious --

MR REID: Yes, that's what I'm saying.

MR MUSTON: -- consequence?

MR REID: Yes.

MR MUSTON: As a results of the things that we're measuring and the things that we're reporting on, and those failings within the system that we're calling out - namely, a failure to meet a particular time frame with respect to elective surgery or waiting time in an emergency department - we're, in effect, prioritising those things over what might potentially be equal or even greater failings in other aspects of the public health system, because we're not measuring them and we're not calling out our failures and so the system is not incentivised to fix them, at least until they have fixed those other things that we are reporting on. Would that be a fair comment, do you think? Mr Reid, you are probably best placed.

MR REID: My response is I think yes, what you say is correct.

Do remember what Andrew said. I mean, this is no way to excuse it, but what Andrew said at the start is pretty critical, that the entree into elective surgery waiting times has a capacity of assessing the problem prior to getting on the waiting list in some ways, and there's a difficulty in many of the outpatient services that the problem is identified and assessed once the meeting takes place. So that element of how you prioritise has some complexities, but that doesn't mean it cannot be done or shouldn't be done, but it does have additional complexities to it.

THE COMMISSIONER: Is there any reason, though - accepting

we get really good data about elective surgery wait times and wait times in EDs and wait times for ambulances, and we get that quarterly report every quarter from the bureau, is there any reason why it would be hard to make it as easy to access data on, for example, how long, you know, a child might wait to see an occupational therapist or behavioural paediatrician?

MR REID: In principle, Commissioner, no. And it's not - and I think you've identified, as Andrew said, a significant --

THE COMMISSIONER: At a minimum, it would be at least useful to know.

MR REID: Yes.

MR MUSTON: The low-hanging fruit would seem to be areas where we do have existing screening programs. So the Brighter Beginnings program, which identifies children needing a potential paediatric intervention of some sort - it wouldn't be difficult to measure the number of individuals who have been identified through that screening program as requiring a paediatric intervention and then assessing that against the time that it's taken for them to receive that, even if it is just an initial assessment, to work out precisely what the further intervention might be. That is measurable.

PROFESSOR WILSON: I can see that Carmen has her hand up. So, before I --

MR MUSTON: Yes.

A/PROF HUCKEL SCHNEIDER: I just wanted to re-emphasise what Mick had said, in that I am aware of quite a number of outpatient services that do have wait time targets for different categories of prioritisation and that they do tend to be reported between LHDs and the NSW Ministry of Health.

One of the things to consider, then, is, you know, if and when targets are being missed or overshot and to any extent, what can then be done in terms of capacity building, activity, investigating the reasons why there is that overshoot of those targets. So my understanding is that that is reported for quite a number of outpatient

services, as Mick said, including incorporated into service level agreements.

MR REID: Commissioner, I think - and this is a very difficult area and I'm not trying to justify it in any way, shape or form - the interface between the primary care sector and the acute care sector often plays itself out in the outpatient area in the main, so that, in some degree, just like emergency departments, it is, in some degree, a last resort or a place of alternative going for these services when there's a combination of public and private service provision for them.

That has always been, I think - and I'm just trying to reflect upon the history of health, but it has been probably partly a determinant why there might be a far greater - a stronger focus on elective surgery waiting time, which is clearly a function of the hospital system in the public sector, as distinct from waiting times where, if you get them down considerably in the outpatient services, you might have, you know, additional demand brought about by those reduced waiting times. It's not to justify it in any way, shape or form but it might be a reality.

MR MUSTON: But that would be because, in the particular community that is served by that local health district, the need might be greatest in that latter area, namely, the need for those outpatient services.

MR REID: That's correct.

PROFESSOR WILSON: Certainly I think that is one of the issues, the equity issues, that specialists are not evenly distributed, of any type, throughout the community. And particularly once you get outside of the metropolitan areas, the number of specialists falls off rapidly and so, you know, access to those services becomes much more problematic, but in exactly the same setting or situations, the availability of clinics which don't require out-of-pocket payments becomes - or access without out-of-pocket payments falls off almost in the same way. So you get the sort of double inequity there: you get an inequity of access but you also then get an inequity of also having to pay for the services anyway. So it's problematic.

Can I just perhaps reverse the discussion slightly.

MR MUSTON: Yes.

PROFESSOR WILSON: When Martin first approached us about this paper for the Commission, we said to Martin, "Well, what does the Commission want to achieve in its recommendations?" Because fundamentally, your funding model and your resourcing model and your resourcing distribution model is about - it shouldn't be the thing that's setting the agenda; it should be the thing that is trying to achieve the objectives that you are stating.

So in asking us, you know, what are the advantages or disadvantages of different systems for doing this, we can give you, as we've done here, what we think are the advantages and disadvantages and you've already heard from lots of people, I'm sure, around the state who are unhappy with funding arrangements, et cetera. But if, basically what - if we are wanting to recommend to you some changes that could be made, it would be dependent on what you wanted to achieve.

You know f we want to achieve an improvement in outpatient services, then, yes, there will be funding changes that you could do that would incentivise that. It won't necessarily solve the problem, because part of the problem, you know, in the specialist access area is actually just the number, the workforce that's available, you know, which can be very problematic, particularly when you go into the paediatric area, where paediatric specialists in particular areas like rheumatology are very limited. I think there are 13, something like that, paediatric rheumatologists, around Australia. A very small number in relation to that.

But, you know, it may be then you sort of have to actually also think about the model of care that you are providing, that the traditional model of care which says you get referred to a specialist and that sort of opens all the doors to these things, is not the right place; that you actually have to have a model which allows for an assessment which might be made by somebody other than that paediatric specialist; it might be overseen by them but the initial assessment might be a specialist physiotherapist, for example, in that area, who would then do a triaging, an assessment, which would give a much more effective triaging as to whether this person needs to see that rheumatologist

or potentially gets them started on a treatment program earlier.

So you have to sort of think about the whole - in changing this, you have to sort of think about the whole - what you're trying to achieve and then we can say to you, "Well, look, here are the things which will and won't work within the existing funding system to achieve what you want to achieve in that regard."

THE COMMISSIONER: Well, if we've achieved not perfect, but a high level of, technical efficiency, which I think everyone says we have, then we want to achieve something else, and equity would be a big thing, for many reasons. Throughout our travels, particularly to the regions, but it also exists even in metropolitan areas, there is a lack of equity. So that's a big thing that would be good to achieve.

PROFESSOR WILSON: Yes, and I think in the paper, we've sort of pointed towards some of the things which can help. Mick has his hand up.

MR REID: Just reinforcing what was already said. I think, to go to Andrew's point, if the sole responsibility of the funding other than the NHRA is for the states to run the hospital system, then the only issue is, you know, do you put additional money in terms of keeping people out of hospitals doing that? But the funding model is really a service delivery model, as you well understand.

And then if we have a responsibility for the health of the population, that has that fairness element, which you have just mentioned, Commissioner, coming into it, as to how that's done, and in having that, that's where we go to that discussion where we have the various options of how you balance up measurements of technical versus allocative efficiency and how do you bring them into play in a new funding model.

But I think we would argue, probably the people on this call, and we argued in the paper, that there has been a strong focus over time which has been quite beneficial in where we got to on technical efficiency but we have probably lost some of the ground on whether we're delivering services in a fair way.

The only problem is there to be careful we're not delivering them as a back-fill against it. How do we address the issue of whether we deliver them as a back-fill to Commonwealth absence of services, and how well do we deliver them just in terms of the use of the state funding in that, which I presume we'll come to a discussion on later.

THE COMMISSIONER: Sure. There is a statutory obligation on the LHDs for population health that clearly extends beyond what happens in the public hospitals, where most of the focus is.

MR MUSTON: Can I just bring us back to the report. In paragraph 14, you make the observation that after the introduction of the ABF through the NHRA, it was adopted as the hospital funding model for health authorities across all of the states and territories.

We heard some evidence from Professor Eagar to the effect that New South Wales made a choice, at that point, to apply the ABF funding model as the mechanism for making funding decisions as between the ministry and local health districts, in circumstances where it did not need to do that, and I think, to summarise her view, it ought not to have done that.

Do any of you have a view on whether a shift to an ABF model as opposed to the two-tiered model that existed before that was (a) an essential decision and, if not (b) was it a wise decision? I might ask (c): Could you practically reverse it now, even if you wanted to?

PROFESSOR WILSON: Again, we would have some views, and I think you can probably read that into the paper. But I would caution it by saying: what is it that you want to achieve? You know. I think in the paper here we are probably saying something which keeps the benefits of activity based funding, of set pricing arrangements, et cetera, as a core element of it, is important. But you also want to provide more flexibility to respond to population need; you want to be able to address the issues of equity, and sometimes that will mean that you will not be working with the most efficient - the national efficient price, although that might be the basis under which you then - you use from and then change for that.

So, yes, I guess we're pointing that there's probably some hybrid between what we have at the moment and other approaches need to be thought about. Yes.

MR REID: I would add to Andrew that yes, we did have a two-tiered model which led to a decision to move to activity based funding and we've lost some of that emphasis on population based analysis, but the funding model of activity was nowhere near the sophistication as it is now under ABF.

So we've gained a lot under ABF in getting a much better technical understanding of the service delivery, of how a hospital operates, et cetera, but I think, as Andrew said, and I think the whole team would agree, we feel we need to rebalance that in one or two ways which are suggested in the paper further on with how we retain the elements of the ABF and the technical efficiency with a new focus on - with a revitalised focus on population.

MR MUSTON: Would it be right that a resource distribution model which, in and of itself, is going to have to be based on some formula that makes assumptions about what is to be prioritised and what's important within particular communities, is of itself not necessarily a safe mechanism to ensure you get genuine equity in the delivery of health services across a wide population?

MR REID: Again going to the point of what you mean by "equity", but if you mean "equity" in terms of, you know, distribution on a per capita basis, weighted in some way in terms of how we utilise the funds, yes, we'll move towards that. But there is still an essential element of that, that the vast majority of our money goes into running the hospital system and we have to work out how to do that in the most efficient and effective way possible.

PROFESSOR WILSON: Let's just say that, you know, you move to a system whereby you distributed whatever the government gave to the ministry each year on the basis of some population weighted index for each local health district. That would, at one level, at least improve the equity in terms of the distribution, but it won't address issues of the equity in the maldistribution of health workforce and accessibility to health care, because we know that if you look at, for example, the MBS data, the amount of billings

in rural and regional areas are lower than they are in metropolitan areas. So there is something else, you know, there are other factors that if you truly want to move towards an equity based model, which would say, you know, if you are trying to balance up those effects, and if that is the responsibility of the state, then, in fact, you are going to over-allocate to those areas to make up for that difference.

But if you're going to do that, you really need to have the Commonwealth at the table to be able to say, "Well, look, you're actually underpaying for these areas" - sorry - "under-contributing for these areas. We need to have an agreement about how we have an equitable share of the health dollar in combination that goes to those communities".

I don't think that's an implausible position to reach to. It's not going to occur instantaneously, but we have - you know, Commonwealth, through the ABF, has come to a more equitable share, I believe, in relation to public health activity, and maybe the next step is that there is an agreement in the next NHRA which is around an equitable share for those communities which are under-provisioned.

THE COMMISSIONER: Let me ask an impossibly general question. If the focus is "What do you want to achieve", and accepting that we're always going to need public hospitals to provide acute care, and that's just a given, and that elective surgery lists have to be dealt with and all those sorts of things in terms of traumatic injury, elective surgery services and disease that's acute, but - and we also want an equitable system which isn't just value for money but has, at least in my mind, some form of justice, beyond that, what is the most significant thing we want to achieve?

Is it that, in a more general way - because chronic disease is so important, is it that we provide services, and perform actions, some of which can't be only from health, picking up yesterday on prevention, that narrow the number of years that the population generally has in ill health, on the basis that it seems that the most amount of money we spend in the system is on the elderly that are unwell? Or is there some other thing we should be aiming for? This is a question for all of you.

PROFESSOR WILSON: There is a lot to unpack in that, Commissioner.

THE COMMISSIONER: Yes. I said it was an impossibly broad general question.

PROFESSOR WILSON: The first thing I would just say, it always concerns me a little bit when people start to sort of focus on the fact that so much expenditure goes on in the last years of life. Of course it does, because that's when people get sick. So, you know, while we can more - I think we don't necessarily use the - we could use the money better in that period in those last couple of years of life, in that regard, that there's, I think, a lot of low-value care which is provided in that period of time, it is inevitable that there will be more money - that the healthcare system will be spending more on that group than it will on others.

I think my view is that what we're aiming to do is, with any finite amount of money that we have, what are the best options in respect of investment across all the things that we can do to achieve optimal health outcomes for the community and address issues in inequity in health outcomes which exist at the present time, and, sorry, in health outcomes but also in health more generally in that regard. That's just a philosophical basis under which I work in trying to achieve that.

Now, we are stuck with a system which has, you know, bodies which - as you quite rightly said, we need to have those hospitals there, they have a fixed cost and, you know, we've got to live with that because they provide it.

Then it becomes, well, actually, how do we efficiently utilise that resource in that, whilst still trying to meet the other objectives - the broader population health objectives and trying to balance out in those areas. That's why that focus on efficiency and that particular parameter, I think, is exceedingly important, because it consumes a very large - they are expensive to run and so we need to be absolutely clear that they are being run as efficiently as possible and being used as appropriately as possible, because they are just about the most expensive thing that we have in the health system to achieve that.

So I think there are good reasons why we should focus

on the efficiency and the appropriateness of care in the hospital sector, not because we don't need those things, not because we're saying they're not - they are important, but they're very expensive to run and in a fixed budget you need to make sure that you're using that as efficiently as possible.

MR MUSTON: Could I ask, when you use the term "appropriateness of care" in that hospital setting, what you have in mind?

PROFESSOR WILSON: So we don't want people being admitted to hospital when they could be managed in an equally effective way in a less expensive environment. Note I said "equally effective" environment. So, for example, it used to be, when I started in medicine, quite normal for people to be admitted to hospital for back pain; right? Now, we know that, in fact, there is good evidence to suggest that's not how you should manage back pain. There should be a minimum number of people. There will always be some people who will need to be in hospital for that condition, but most people can be managed outside of that. So that's sort of an example of what I'm talking about.

MR MUSTON: In terms of the appropriateness of what is offered in hospitals, is there also a need, perhaps, for there to be closer consideration given - in a system-wide level - to what is offered where? And so, for example, ear, nose and throat surgery, just as an example. Each local health district might be seeking to offer that surgery in each location they think they can find an ear, nose and throat surgeon who will deliver it. Maybe that's legitimate and justified having regard to population need, maybe it is not. But does there need to be some consideration given to the rationalisation of the way in which certain care is delivered through our hospitals so, as part of an overarching prioritisation of what is it we're going to do with this limited budgetary envelope, we're not spreading it too thin and trying to do everything for everyone but not really doing all of it as well as we possibly could?

PROFESSOR WILSON: Again, there are different elements in terms of what you're saying there. There have been - people have made the case, and there have been experiments of saying, "Okay, there are certain types of procedural medicine that you can most efficiently do if you actually

establish special places that provide them." You know, cataract surgery is an example of that, and there are places which have set up and centralised arrangements to have your cataract surgery, you know, you can just go there, and they do large numbers through in a day because that's the way they are set up.

But almost always, when you do that, you're centralising that service in some way, so you're disadvantaging people in rural and remote areas, or regional centres, if you're really going to the sort of high-volume set-ups in relation to it.

There is also a question around whether that unbundling of different - sorry, of teasing apart different types of surgical or procedural services leads to different types of care being provided in different settings. That may or may not be appropriate.

The others may want to comment on that as well.

DR McNAMARA: Can we just go back to the Commissioner's question a few moments ago.

MR MUSTON: Before we come back to that question, can I just finish on --

THE COMMISSIONER: I wanted to go back to it, but we'll get there.

MR MUSTON: We will go back to it. I assure you we will go back to it.

Just on the issue, for example, of the cataract surgery that you referred to, with the level of centralisation, you say, you will always disadvantage people in more rural and remote areas, that's because they will need to travel to obtain that procedure, whereas someone who might serendipitously live in the centre where it's being provided will not need to travel.

PROFESSOR WILSON: Yes, it is a trade-off, basically, in terms of, you know, what happens in relation to that.

I mean, the other reason you centralise things is where you can demonstrate that volume is related to outcomes. It's not - it's frequently quoted but in actual

fact, when you look at the literature, it's not as straightforward as it might sort of seem, even for quite complicated surgery. But, you know, I think there are still - I think people would generally support the notion that for complex surgery, you're better off in a centre which does it regularly and has a certain volume to achieve, so there are good reasons for centralising that.

For those sorts of things, I do sort of question whether or not it is actually appropriate to provide those things in places in which you are doing low volumes because you are probably disadvantaging the patient, the person with the condition, when you do that.

MR MUSTON: Higher volumes also have the capacity, potentially, to produce efficiencies which might not be able to be captured if you're doing smaller volumes of the same procedure in an array of different locations.

PROFESSOR WILSON: Yes, you might have models of doing it which are more efficient.

MR MUSTON: In the context of a limited budgetary envelope, for every winner, there's going to be a loser in the health system, in a sense, that if you, say, centralised, perhaps not to a single centre, but if you created hubs across the state that did, hypothetically, this cataract surgery and you provided - well, let me take it in steps.

To create hubs that provide our hypothetical cataract surgery, in order for that to remain accessible to everyone and create that equity that is required, you would need to ensure that there was appropriate patient transport.

PROFESSOR WILSON: People could get there. Transport there and accommodation while they're there and recognising, you know, for some people that will be problematic. Cataract surgery is probably not a good example. It is pretty easy.

MR MUSTON: Day surgery.

MR REID: Radiation therapy would be a good example of that, I think

PROFESSOR WILSON: Well, yes. In part that's driven

because of the capital costs of trying to - there's quite substantive infrastructure for radiation therapy.

I mean, radiation therapy is an interesting example of a successful government program, in that we had highly centralised, highly centralised, radiation services. Queensland was - there were two places in Queensland you could get radiation therapy when I was training. New South Wales was somewhat better when I first came here, but it was still highly centralised.

We now provide radiation therapy, it's available in most regional centres in New South Wales, and other services are continuing to open up. Now, some of that has been about technology improvements, but a lot of it has been about the funding model which has promoted the proliferation, you know, of these services, and they are closer to home so people haven't had to travel as much for their therapy.

It is also an interesting example of the issues around co-payments and equity issues, because most of that proliferation has actually occurred in the private sector and that means that many patients haven't - you know, are being charged co-payments for access to it, and that can be problematic.

MR MUSTON: From an equity and accessibility point of view, decision-making around what could be centralised and delivered through a hub or what should be delivered in a more disparate array of locations will, of course, be informed by a range of factors including how often you need to get it.

PROFESSOR WILSON: The other aspect of this is, if we want to maintain services in regional centres, some of these less complex things are an essential part of the business model for proceduralists there. So, you know, if you say, "We're going to do all our cataracts in Newcastle for the Hunter New England area", that's a problem for those regional centres if they want to try to keep ophthalmology services locally, because that's basically what is bread and butter for ophthalmologists. So you do have to think. Sometimes you can have perverse consequences for what it seems may improves patient access - may improve patient access - but it may actually lead to, you know, loss of other services because they are tied to that. So it's not

straightforward.

MR MUSTON: We might come back to that, but we can come back to your question now, Commissioner.

THE COMMISSIONER: The reason I raised the general point that I did is, it's frustrating to read government intergenerational reports that say, on health, "The health budget is growing at a greater rate than any other government service, and we've really got to do something about chronic disease, otherwise we're all going to go broke." But the reality is that one way of providing health services other than acute care services, and putting more money into prevention and dealing with chronic disease, would be for the Commonwealth to engage in tax reform and get more money. That's unlikely to happen because of anything I say, and it might be unlikely to happen anyway.

In terms of the state government, it's got limited financial power in terms of revenue raising, and if it pours more money into the health budget, that means there's less money for either the police - which may or may not be a good thing, I have no idea - or for public education -, which would definitely be a bad thing. This means, regardless of what I say, we're probably left with a budget for NSW Health that's around the percentage that it is now, and that may never change, I don't know, but it doesn't look like it's going to change soon.

Which means we are left with - if we want to achieve better health outcomes for the population with both just the social benefits that might have, as well as - if you read technical budget papers that say, "If we can compress the period of morbidity, we will save this amount of money", which would be a financial benefit, what do we need to do differently than we are?

That's the real question, I think, because the idea of, really, a whole lot more money from the Commonwealth is probably fanciful, and the idea that the New South Wales Government is going to take money from other departments and give it to health, even if it would be a good thing, is probably unlikely, too.

So where we end up with is: is there a way of funding that either has benefits for health of the population

and/or benefits for the health of the population that might also have, because of productivity gains or some other economic benefit, also dollar sign gains. That's where we're really - at the fundamental level, where we are, isn't it?

MR REID: I can't see Andrew, so I don't know if he is responding, Commissioner.

THE COMMISSIONER: He was nodding vaguely, I think.

MR REID: That would be right. Look, I will put my two bobs' worth in. It is a very complex question, but I would have thought that this Commission of Inquiry - I presume, Commissioner, that you are not recommending significantly greater or less determination by government as to what occurs into the health budget and --

THE COMMISSIONER: Well, I don't think it's up to an inquiry like this to start talking dollars.

MR REID: No, and that's what you said --

THE COMMISSIONER: You know, that really is a matter for executive government as to what they spend.

MR REID: Exactly.

THE COMMISSIONER: You can say, "You should do this service, you should do this in prevention", and that might mean money has to be spent on that if they adopt the recommendation, but I certainly don't think it is part of this Inquiry to say, "The health budget should be 40 per cent, not 33 per cent" --

MR REID: Correct.

THE COMMISSIONER: -- "or X dollars" - you know (a) we're not set up to do that; but (b) I just don't think it is appropriate.

MR REID: Yes. And so the answer to your question as to what we can do, you're doing it within the envelope of whatever budget is determined by the government of the day and the contribution of the Feds to what constitutes that health budget, and we know that currently, you know, globally, it's running mid-level OECD; globally, it's not

changing too much in that pathway, where it sits as a percentage of Australia's budget that goes into health. But I think the pathway you are going - and this is not meant to be gratuitous advice, but I think the pathway you're going in terms of can we expend the existing amount of money in a way that fulfills the requirements of the legislation as to what NSW Health is about, maybe creates greater incentives on prevention and health promotion and ways of keeping people out of hospital, and at the same time, shows that the way we're distributing these funds moves to greater or lesser fairness in the allocation of money, seems to be the end game of where you are heading.

I think there's a whole array of other things. There are things about whether you can achieve greater efficiencies through greater centralisation of some of the clinical services. I'm not too sure, you know, the pain is going to be worth the gain in a lot of those areas and much of that might go against the notion of equity as well, because, as Andrew said, you want to build up those regional centres that might be marginal, some of them, not the high-level tertiary services that will always be, you know, in a major tertiary hospital, but you want to build up that full scope of practice for clinicians working in regional centres in order to promote equity.

So I think, you know, it's a complex question, but if your answer is not to determine the budget, I think the answer is to determine how can you best use the existing budget in a way that takes the pressure off some of the health systems in ways that's probably not being done as well as possible at the moment.

DR McNAMARA: Commissioner, I just want to flag, there's a connection back to the discussion on Tuesday here as well, I think, about how well this system is equipped to innovate and drive change at a sort of local level as well, and what support structures need to be available to do that better. Because a lot of what we've talked about today is --

THE COMMISSIONER: I think there is a link between that and I think there is a link between yesterday to today, yes.

Sorry, I think Professor Huckel Schneider wants to say something.

A/PROF HUCKEL SCHNEIDER: I would contribute and emphasise that we obviously - moving towards the goal of equity so that more people can live longer, and larger parts of their lives that are healthy, and most certainly there is - you know, there's the broader contextual reasons for what are the determinants of health and then you move into realms like we're talking about here, that range from the health promotion and the prevention and the screening type activities. But there's a large chunk in the middle between the prevention, screening, promotion and the acute care, which is ensuring that people get access to care early.

I actually think the discussion we were having right at the start of this session went to the heart of that, which is getting access to that next step after a primary care visit or a screening. That is where we have this complex middle between Medicare benefits schedule funded services and those that are then serviced through various different financing models as outpatient services. We do have a lot of people that still find it difficult to navigate that pathway between the different types of services that are offered in different locations under different models, and ultimately funded through different modes within our health system.

Being able to enable access in a way that makes sense to people, in a way that they are comfortable with and a way that they can navigate and in a way that they can afford, shifts care to the early detection, early management, links, then, to prevention, and links in to being able to watch and monitor individuals as their health changes over time, with the goal of having a much later stage in life when they might be having those acute care needs.

That does require that ability to be able to innovate and shift to ensure that that access is available, and it comes back to several things that we wrote in the paper about it being necessary to identify in various different local regions where is the capacity to make sure that there are no gaps in that journey, where are there additional needs to be able to close those gaps in that journey? And that's where the thought to moving towards a system that, firstly, maps but then also recognises and then takes steps towards equity to make up for where that gap between those

services actually needs to be closed.

PROFESSOR WILSON: I think all state and territory governments are concerned, actually, that the proportion of their money, of their funds, which are going on health is actually increasing as a proportion, and as you quite rightly point out, that's going to be at the consequences of other service areas, and so what's the broader expression of what that's about?

I mean, I think in thinking about - one also needs to recognise that health infrastructure and health services have a broader implication in the communities where they are.

I've had the unpleasant experience of having to tell a small community that we were going to close their hospital, and the consequence of closing that hospital was that we'll probably lose the bakery, because they were providing that - the butcher and other employment positions. This was in a situation where we had already established other health services which were going to meet, you know, most of the local needs.

So there is a question here, a broader sort of social infrastructure support that health and health care brings to communities, that are also part of thinking about what we do and how we do it, which goes beyond just providing the healthcare services itself.

I can see Kees has his hand up there, Commissioner.

PROFESSOR VAN GOOL: Yes, so I was just going back to your question, Commissioner, about the more general efficiency questions. I think, you know, Australia is no different to anywhere else, but we tend to sort of, in health care, find the institution and then find ways to fund it. And there are, you know, really strong evidence bases, data and governance structures, as Andrew, everybody knows, around the PBS and around the MBS and around the NHRA and hospital funding, whereas that systematic way of thinking about it in terms of prevention is perhaps a little bit lacking in that sense.

So without that sort of institutional kind of backing that comes alongside the evidence and the data, prevention might always fall a little bit behind because of those

different - the disparity in those institutional factors.

THE COMMISSIONER: Yes.

PROFESSOR WILSON: And, sorry, the other thing I was going to add before was, when we're thinking about, you know, where can we gain, where are the potential gains within whatever budget we have, I mean, I think there's a strong case that says one of the biggest areas of inefficiency in our current system is the division between the Commonwealth and the states, and until we start to address that area, we are not going to be able to get the most efficient health system that we could, and we're not going to be able to get the best outcomes for our communities.

So I would urge - even though I know you can't change that, I think I would hope that your final report will just reinforce the importance of that, and the more you go outside of major cities, the more that becomes an important issue and the more that there does not seem to be, in my mind, to be very good reasons for maintaining those sorts of divides.

I mean, when you go to some small country towns and you find - and you look at the sort of subsidies which are being provided by governments, both governments, you know, to maintain sort of minimal health services within those areas, it's quite extraordinary. The MBS program which was - which led to sort of merging of small hospitals with aged care facilities, et cetera, was a great advance at the time when it occurred, but there are other opportunities for doing that around the system, to further do that around the system and improve the efficiency in terms of that relationship in that space and it will have patient benefits.

We've spoken also in the paper about - in fact, actually it's not just the health system, but we also have the problem now, we have health, we have aged care and now we have NDIS, and we have clients who go across - people who are getting services from all three of those services within areas - well, at least two of those services in any district, and sometimes getting the services from the same provider, you know, from the same provider --

THE COMMISSIONER: Worst case scenario, they're in the system but then they are dropped at an ED for a particular

reason because they've become - you know, their behaviour has become problematic or some other reason, or they got unwell.

MR MUSTON: What is the real impediment there? The first point is there's, in terms of the funding as between the state and the Commonwealth, an array of different ways in which that's delivered, so we've got ABF funding through the NHRA, there's some block funding through the NHRA, there's MBS funding, there's potential aged care funding through that system, and then you've got other grants and general GST, Grants Commission money. Is that one of the impediments, just the complex and disparate array of ways in which what is essentially the same bucket of money is passed from the Commonwealth to the state?

PROFESSOR WILSON: Yes, and, you know, the more sort of different streams you have, the more problematic it is to manage them, the more inefficiencies you see.

I mean, the Aboriginal controlled medical services have had this problem for a long period of time, that they've had these streams of funding coming from different sources, and they're a fantastic example of how you manage under those sorts of streams - so bringing these funds together for the best outcomes for it. I mean, they're a model for what --

THE COMMISSIONER: Not without struggle, though.

PROFESSOR WILSON: They're a model for what primary health care could be like if we had a better integrated approach to allowing the pooling of these funds once they reach a particular point.

There are some examples of that being done between the Commonwealth and the state in different locations, and what we now need to try and see is a bit more scaling up of that.

Now, my personal view is that that is likely to occur at a district level. I mean, I think that is, in my mind, one of the reasons to justify continuing LHD, local health districts, or some other form of district, that the pooling, if there is going to be pooling, it is going to be in an area like that, it might be even at a sub-unit below that to allow that to occur. But, you know, I think that

is part of the strength of that model.

THE COMMISSIONER: Pooling as an example for what - primary care services where they've disappeared?

PROFESSOR WILSON: At the very least, bringing together anything which is a bundled payment, anything which is not actually an activity funded service but any of the other ones, bringing them together.

MR MUSTON: For that reason, whilst it might be best driven out of the local health districts for reasons we might come to, it necessarily involves a collaboration, doesn't it, between the local health district and the ministry, because it's the ministry, and perhaps treasury, who are going to be negotiating with the Commonwealth to make sure that each of those disparate funding streams can be brought together and pooled in a way that enables the delivery of the care that those on the ground at the local health district see as being --

PROFESSOR WILSON: And the ministry and the government wear the risk, as well. So yes, they have to be, because, you know, if a local health district actually goes over budget, you know, what are the consequences? Well, actually, the consequences are worn by the government.

MR MUSTON: Whilst you indicate that it's being done in a number of locations, and we've seen in our travels a number of locations where a void, for example, in primary care has been filled by a state-funded, outstanding wrap-around primary care service that is well integrated with the acute care service in that area - Bowraville is a good example - the experience seems to be, if you build it, then you have the discussion about the funding, then the funding flows, but you are not going to get the funding from the Commonwealth if the state and the Commonwealth point at one another across a void in care, and say, "This is your fault, you've got to pay for it", "No, it's your fault, you've got to pay for it." Someone has to take the step to build it, and the state would seem to be the logical person, entity.

PROFESSOR WILSON: Well, the state ends up having to do it anyway, because it is the default provider, when everything else fails.

THE COMMISSIONER: Last resort.

PROFESSOR WILSON: It is the state that comes in and has to provide the services.

In smaller rural communities across Australia, that's occurring, that the states are having to pick up services in those locations. In some places they've always provided them, but there are places, you know, where services are not going to be --

MR REID: And I think the difficulty of getting to an agreed NHRA is it's still the feelings of most of the jurisdictions - all of the jurisdictions around Australia - that the Commonwealth has not filled that void well enough. Now, whether the state is still doing it - as you know, Commissioner, there are 500 people today in hospitals who have been aged care assessed and ready to go into an aged care setting who, for a variety of reasons, can't get in there. So the state is picking up those types of people, and the NDIS people, and also the particularly important one, in rural and remote communities that Andrew mentioned, of back-filling primary care.

I think there is a lot of work going on in the primary care sector in terms of the initiatives by the federal health minister, and I think the strengthening primary care - the development of the urgent care centres, my belief, will have some impact upon taking the burden off some of the hospital system and provide a more sustainable service at a local level. But I think there is a long way to go, and you're absolutely right, the state is - the Commonwealth is not the point of last resort for provision of service because it's not a service provider, so the states and territories do tend to do it.

MR MUSTON: Confronted by those gaps in services which are delivered through Commonwealth funding streams - aged care and primary health, for example - the current structural arrangements of the state mean that that care, as the provider of last resort, is being delivered in a way which is probably least efficient and perhaps of poorer benefit to the patients. For example, an aged care patient who is in an acute bed in a hospital is costing a lot more and probably producing poorer health outcomes than that same aged care patient who is in an aged care bed, perhaps provided by the state but funded through the Commonwealth;

or, in the case of primary care, the person who turns up at an emergency department with something that could and should have been managed through good primary care being delivered in a continuous way in a different setting, is not receiving their care in the most efficient or effective location.

PROFESSOR WILSON: I think it would be useful to ask Carmen to comment a little bit on the work that she has been involved in commissioning, which is another way of addressing this, but before I ask her to do that, if you don't mind, I just want to address that last question, because it was on my list of things to say --

MR MUSTON: Yes, please do.

PROFESSOR WILSON: -- because it comes back to our earlier discussion about specialist clinics. You've heard a lot of testimony about patients being seen in emergency departments who really should be seen in general practice, and you've heard the tension there is with the emergency physicians who say, "Well, that's nonsense, these patients, you know, are complex patients, they need the sort of care that we can provide here. They're never going to be managed", and that. We have the urgent care clinics that will address some of those patients - whether it impacts on emergency waiting times I don't know. But what I do feel is that some of those complex patients that they're talking about, if they were being properly managed in ambulatory specialist services, that you could actually do a lot more about keeping them away from emergency departments.

So they may not be preventible in the sense that GPs can do something about it, but I think if they're getting good care from the right specialist, whether it's a geriatrician or whether it's a general physician or other, depending on their condition, then I think there is a lot more that could be done to keep some of those patients out. So I do think there is this link which hasn't been well identified in relation to that particular aspect of demand.

MR MUSTON: Your observation that urgent care clinics might not be doing much in terms of waiting times, can I just quickly unpack that?

In terms of the waiting times which are published --

PROFESSOR WILSON: I didn't say that. I don't know the answer to that. I don't think we know the answer yet because there hasn't been an evaluation of the urgent care clinics. They are certainly going to - they're certainly looking popular, they're certainly meeting a need. Whether they're meeting a need which is patients who would have otherwise gone to hospital, I don't know yet. The evaluation is not there.

MR MUSTON: I think, Professor Huckel Schneider, we were going to come to you, but before we do, I just note the time.

THE COMMISSIONER: Yes, we might have a break.

To those of you online, I think it's easier to stay on the link, but we'll take a break until 12. So go and have a cup of tea or coffee or whatever you want. We'll come back at 12. So we'll adjourn until then.

MR MUSTON: The individuals who you can't see who are frantically typing down everything that we say very quickly, for their physical health and sanity, need to be given the opportunity to have a break.

THE COMMISSIONER: All right. We'll come back at 12.

SHORT ADJOURNMENT

MR MUSTON: Associate Professor Huckel Schneider, I think you were about to tell us about some work that you've been doing which feeds in to the matters that we were discussing before the adjournment.

A/PROF HUCKEL SCHNEIDER: Thanks. Yes, I think this is, in part, a reflection on some evaluative work that we've been doing looking at the regions. We were talking earlier about the challenges of the health system for people in it navigating that space between primary care and Medicare benefit services, and those that are provided through the hospital networks.

What we see is that in order to be able to put the focus on living healthier longer, and trying to reduce the extent to which people end up with acute care needs earlier in life than they really should be, we often have

situations where, potentially, after a primary care visit or a certain extent of primary care management, there are needs for early management or further care that needs to be provided by - you know, in the realm of diagnostics or in the realm of nursing care, access to specialists, allied health care like physiotherapists, mental health care, social support, and a range of different care needs that theoretically would be provided in the community, but often there are barriers to access.

So these barriers can be distance barriers; these barriers can be simply availability because all of those services are full up and have waiting lists themselves or have closed their books; they can be cost barriers; and they can also be knowledge barriers, because the system can be very complex and it's difficult to know exactly what services are available for any individual when the need particularly arises.

The extent to which there are both needs for those kinds of services and to which there are barriers to those kinds of services, so, you know, accessing spirometry, for example, or getting access to a cardiologist - paediatrician is another one that is often cited, diabetes educators is another one that's often cited, endocrinologist is another one that's often cited - is often hidden, certainly hidden at a broader planning level but is often even hidden within local areas and local systems.

This is why one of the - a couple of the points that we made in the paper really emphasise considering the possibility of better mapping and allocating according to need, but also consideration of decision-making shifting to local levels, where there is joint decision-making, joint mapping and joint identification of what are not only the needs of the population of each region but what are the specific gaps and barriers to accessing that point between primary care and hospital care.

There are a range of different - you know, there have been some experiments done in developing local joint decision-making mapping and review, and a range of different solutions that have been sort of born out of these kinds of experiments. They include things along the lines of lifting primary care to top of scope with capacity building that can come through a range of different ways,

you know, access to regular case conferencing, for example; setting up structures for telehealth; access to specialists with a range of different financing mechanisms. Once again, what we discussed right at the beginning of this session around how do we ensure that access to the outpatient services is a large part of that.

Also, various different embedding models, where various different wrap-around services would be embedded, potentially as an outreach type of service, into multipurpose services or into primary care clinics.

So we do see that there is sort of a lot of different locally - local-level modes to try and fill that kind of gap through various different arrangements. The way that they emerge I think is a bit of an indicator of what are the barriers that need to be worked around. So that includes, you know, the time, the distance, the willingness, but also the knowledge of the gaps so that there can be some joint decision-making at local levels about which gaps need to be closed - service-type gaps needs to be closed. And then how that is arranged in terms of funding and financing is often very much a product of what is available, what would be acceptable to largely private providers in order to be - to move into an arrangement for payment, whether that be as a VMO in an outpatient clinic or whether that be having an ease of arrangements so that it's efficient to tap into MBS schedule funding for services, and they're always the backdrop of these local-level solutions.

MR MUSTON: Does that really point to a need for a somewhat wider scope of needs assessment and planning than what might be a somewhat facility-focused approach currently taken, at least in some local health districts?

A/PROF HUCKEL SCHNEIDER: So I would say it certainly points to a need for a broader needs assessment that includes not only population characteristics but also the mix of availability of services and professions across not just those within hospital network realm but also those that are more broadly available across primary care, but also specialist care. And so much now of which doesn't neatly fit into primary, specialist or hospital care, as we have people with complex needs and we're becoming more aware of broader determinants, and that includes mental health, it includes drug and alcohol, it includes domestic

violence services, it includes family and children services, it includes allied health and physical therapy types of services.

So a more comprehensive mapping would look at that broad array and I think that there are structural challenges to doing that because we have, effectively, these split systems.

MR MUSTON: So if we start from the mapping, we're talking about, essentially, identifying as a starting point the populations within a particular catchment's need for health services, and I gather from what you tell us that that's something first best done at a local level. Would that be right?

A/PROF HUCKEL SCHNEIDER: Yes, so I would say there would be a need for a mix. So we get data about our health system and data about our population and its needs from a lot of different sources, and so the data collection capacity, purely at a local level, I would say, would be partly limited, but there are also a lot of insights around actual service patterns and availability and ways of working that would only be captured at a local level, which would supplement broader population level data.

MR MUSTON: So going back to a comment you made earlier about hidden need, you can have your more centralised data collection around demographic data, census data, service use data across the spectrum, which will give you some picture of need, but that won't necessarily tell you about the need that might be out there that's not being picked up because people are not filling out their census or they're not accessing health services when they should be, for example?

A/PROF HUCKEL SCHNEIDER: Yes, that's right. I think it can be very difficult to capture from the broad data, for example, on service use, reasons why the service use patterns are the way that they are.

MR MUSTON: And so to best capture that need or to carry out that needs analysis, one might start with the data that's available, but then needs to delve further into the detail in a way that might involve ongoing dialogue between, say, the local health district, informed by data provided by the ministry, the PHN informed by data that it

might have provided to it by not only the Commonwealth's broader data collection but also clinicians on the ground that it might engage with, but fundamentally, other organisations like Aboriginal community controlled health organisations and the like, who, in a particular area, might have a great sense of what is needed but not being accessed or provided and might be missed by some of that data. So whilst imperfect, by bringing together those entities and no doubt a range of others which might be unique to particular geographies, you will have an ability to identify, as best as you can, a picture of the needs which the public health system might need to deliver, at least contribute to the delivery of?

PROFESSOR WILSON: Yes, so there is the identification of need, and some of the health districts have done this very well, doing exactly what you say, bringing together those different datasets to give a mapping of what's there. Then there is the process of priority setting within those needs. At the moment, that's really a fairly obscure process.

MR MUSTON: Can I come back to the first point, just before we move to the priority setting? That sophisticated collaborative identification of the need, which you say some local health districts are doing well, that's fundamental to planning a health system which delivers on anything.

PROFESSOR WILSON: It is fundamental to population health planning. You have to do that, you have to understand your population health need before you can do population health planning of health services.

MR MUSTON: Because we're about to move to the next step, I use the word "prioritisation": it's not possible, in any meaningful or sensible way, to prioritise the delivery of health services if you don't have that core understanding of what the underlying need is that you are seeking to meet through the exercise of prioritisation.

PROFESSOR WILSON: And those priorities - they're not just driven by some metric of health need, they're also recognising other needs that a community have like, you know, having emergency services available, right? It may not actually - if you measured it, it may not actually look like it's a high need, but clearly, every community wants

to have that service available to them, so it is another priority within your overall scheme of things.

MR MUSTON: Just sticking with step one momentarily, is there anything about the existing funding arrangements or structural arrangements within the public health system in New South Wales which inhibits that needs assessment, the collaborative needs assessment, which ideally, in fact almost essentially, needs to take place?

PROFESSOR WILSON: I think Mick wants to say something.

MR MUSTON: Mr Reid?

MR REID: To answer the question, I think it is variable. Ideally, this is done between PHNs and LHDs. New South Wales is very blessed to have its boundaries of PHNs somewhat conterminous with the LHDs. It varies from LHD to LHD and PHN to PHN as to how collaborative that approach is.

MR MUSTON: Why is that?

MR REID: There might be a boundary issue or it might be an issue of the personalities involved or it might be an issue of some LHDs are almost exclusively focused on their hospital system, understandably, for the reasons that Andrew spoke about earlier, you know, in terms of the quantum and volume.

MR MUSTON: Having regard to the fundamental importance of this mapping exercise to the delivery of a health service which adequately and equitably meets the needs of a population, is there anything that could or should be changed about either the funding structures or the governance structures within NSW Health that would enable, if not require, that to occur?

MR REID: I think there is an agreement now between NSW Health and the PHN collective in New South Wales that will move to much more developed conjoint planning processes, but I do think it would benefit from a push into how that is done. And there are still some barriers in terms of access to Commonwealth data around some of those issues, around MBS, et cetera, and the use of marrying that into the needs collection. But fundamentally, there is absolutely no reason why there couldn't be conjoint PHNs,

LHDs, health needs assessments done from the existing datasets.

MR MUSTON: Would you accept that whilst PHNs and LHDs are probably some of the key players in that process, there's a critical role to be played from one community to another by a range of other providers or observers of the health of a population, including, for example, Aboriginal community controlled health organisations?

MR REID: Correct.

MR MUSTON: Aged care providers within a region, et cetera?

MR REID: Correct.

PROFESSOR WILSON: And local councils are important, you know.

MR REID: All of those. Yes.

MR MUSTON: So step one, if we get that right, we get our identification of the needs of the population - sorry, Professor Van Gool, did you want to contribute in relation to that - the needs assessment step?

PROFESSOR VAN GOOL: No, I think just to your question about whether there are current funding barriers to doing that.

MR MUSTON: Yes.

PROFESSOR VAN GOOL: I think the Commonwealth and state aspects still are a driver here as well. Under the NHRA, it's 45 per cent contribution from Commonwealth, whereas it's 100 per cent under the MBS. So there is still that discrepancy between funding sources, depending on where you can shift your costs to, in particular in the non-admitted space.

PROFESSOR WILSON: But I think your question is: are there any financial barriers to doing the joint planning?

MR MUSTON: Yes.

PROFESSOR VAN GOOL: No.

PROFESSOR WILSON: There are no financial barriers to doing that, and local health districts are encouraged to do so, and there is increasingly infrastructure in New South Wales to achieve that. There is a new data system which is being developed jointly with PHNs which will produce unique data - which is producing unique data on what is happening in PHN, in primary care and particularly general practice relative - you know, which is not available elsewhere.

MR MUSTON: Just picking up on an observation you made earlier, Professor Wilson, in relation to the role that local government might have in that planning, is it right for me to read into that that local government, as in effect a representative of the community that's being served by the health services within a particular area, is a key conduit which would enable the community to be part of this needs analysis as well as, and perhaps moving into the planning part, but --

PROFESSOR WILSON: I think this comes to my earlier comment about health care. Health services have other implications for communities but, you know, I think they are locally elected officials who, you know, represent views within their communities and I think that they're an important part of it. But also, you know, when you go - I don't want to revisit yesterday's discussions, but in the prevention space, they can be very important partners in prevention.

MR MUSTON: It might sound a bit glib, but particularly in relation to something as important as the delivery of health care, doing that, performing that exercise with the community that's being served as opposed to doing something to the community or for the community that's being served is a subtle but fairly important one?

PROFESSOR WILSON: It can be quite - look, I think they have to be seen as part of the stakeholders and need to be involved in the planning process. I mean, I think sometimes that can actually add a level of complexity, but I don't think they can be ignored.

MR MUSTON: Associate Professor Huckel Schneider, before we get into the planning and prioritisation --

A/PROF HUCKEL SCHNEIDER: Yes. I just wanted to emphasise

that, you know, while there are the financial barriers there, it is challenging to do the service mapping part of the needs assessment, so population characteristics and needs and data, and to a certain extent we're going to have better systems to map services, but it is still very challenging.

There's a big difference between what LHDs can know about services that they offer, because they are part of the health district and they come under one umbrella. It is more challenging to be able to map services that are, effectively, in the community sector, and it can be very consequential when there are changes in even just the offerings of a few services, particularly in rural and remote locations.

The closing of an allied health centre can dramatically change the available services, or the closing of a cardiology service or a respiratory physician leaving a district, for example, can actually hugely change the landscape of service availability.

So while, you know, there is already a lot of work being done working together between PHNs and LHDs in understanding population needs, it is actually quite difficult and needs a really good local knowledge to understand what kinds of clinics are offering what kinds of services and who has books open and who has what kinds of wait lists, if we're going to then take that equity lens to be able to think about filling the gaps that do exist.

MR MUSTON: So complex as an exercise to start with; dynamic, because things constantly change, for reasons including those that you've just alluded to, people retiring, people moving; and inherently place based. Would that right?

MR REID: Yes. Commissioner, just one other thing, if the outcome of the Commission's Inquiry is to emphasise the role and responsibilities of LHDs in population health, that's a strong incentive for the LHDs being stronger involved in a needs assessment of the population base and the sequelae of that.

MR MUSTON: That complex and local task, to be done properly, requires FTE locally, as in warm bodies who are local and actually actively and perhaps constantly engaged

in the process of assessing, monitoring and mapping the needs that a particular community has from one day to the next, in respect of its health; is that right?

PROFESSOR WILSON: It has to be recognised that it has a resource consequence if you're going to do it and if you're going to do it properly but, you know, as I say, most local health districts are doing some level of planning and in some cases quite sophisticated arrangements. I mean, as Carmen's flagged, it can be quite complicated - it can be quite complicated to capture what actually - so having a service or a specialist or something present is quite different to what service is that able to actually address, if it doesn't --

MR MUSTON: And for whom?

PROFESSOR WILSON: If it is a specialist who doesn't bulk-bill, immediately there is a barrier in terms of what service level they might do. But that doesn't stop you from planning and recognising that gap in that regard.

MR MUSTON: But from a resourcing point of view, that person or group of people who are involved in that task are not generating any activity which might be captured by more traditional activity targets that are set out or established under service level agreements or the NHRA, I assume - there is no NWAU for planning?

PROFESSOR WILSON: I mean, the districts don't have to do it alone. There is capacity within New South Wales, very good capacity, to help with that planning, you know, to provide some of the technical support and expertise, and it is probably better provided in that way in the same way as we are talking about efficient use of resources. Some aspects of it will probably be better done through the ministry, supporting the local health districts in that planning task.

MR MUSTON: So done perfectly, it requires some allocation of resources to the planning exercise, both centrally and locally, and as to which of those two branches does what most of efficiently, that's going to depend on what information is available to them respectively and best placed to know that are those people who sit in those two locations.

PROFESSOR WILSON: Yep. That's my view.

MR MUSTON: So we've got our service mapping or our needs mapping step. Step two, to pick up on the word you used a moment ago, Professor Wilson, "prioritisation" - the next step is working out exactly what will be provided, or maybe the next step is to work out what is being provided external to the local health district, at least within the catchment of the local health district, so to what extent are private providers of health care, Aboriginal community controlled health organisation and the like, from one place to the next, delivering on that need?

PROFESSOR WILSON: So in my sort of vision of what you would do in population health planning, that needs assessment, or an assessment of that capacity that you are talking about, is an integral part of that needs assessment, or if you like, it's the next bit of the needs assessment. As you've assessed the need, now you're assessing the capacity to respond to that need, and that, you know, has its challenges, as we've just flagged, including the new one that you just identified, which is that the services may not all be provided within the local health district. There is a significant flux of people across borders. We don't require passports just yet for local health district services, for people to access services out of their own local health district. And yes, so understanding that.

Then you've got to - then exploring where there is flexibility or where there is an opportunity to expand those or how, where there is a gap which needs to be addressed, and can that be done through enhancement of local services, can it be done - is it plausible that you can get new services, and if not, how else could you provide those services? Could they be provided virtually or by fly-in/fly-out services, if you're talking about in a rural and remote area. It doesn't even have to be that, for that matter. Anyway, so looking at what are the options for trying to meet that need.

Recognising that for the district, even in the best case scenario, the amount of funding which is moveable, may be relatively small, because a lot of your funding is tied with fixed infrastructure and you can't readily close that, so your opportunity for new investment might be - out of your total budget is going to be a relatively small

component.

MR MUSTON: Is that because, for reasons of history, we have within local health districts an array of services that are being offered at the moment through the facilities that they have? Whether that's the best mix of services to be offered through that local health district and its facilities to meet the needs of the population as at today might be questionable, but whether it is or isn't, you can't turn around overnight and say, "We're going to cut these - disinvest in these three services and replace them with these five services that are cheaper but more needed", because you've got human beings who are delivering the care. You've got doctors, specialists, other persons.

PROFESSOR WILSON: Yes, you've got people who are providing those services now, so there are - or providing a service which you might deprioritise, so there are both human and industrial issues associated with that that you have to take into account.

MR MUSTON: And the impact on existing patients who, whether it's the most efficient and effective place for them to be receiving that care, that's where they're currently receiving it.

PROFESSOR WILSON: That's where they're currently receiving it and they will be very worried until they actually know that there is an option to replace that. And that's one of the problems in - you know, one of the challenges in introducing new models of care, that you're asking people to trust you that you're going to be able to provide at least the equivalent of what you are providing now. You know, you really need to have a community which trusts that you are doing the right thing by them.

MR MUSTON: So you need the community to be - need the process to be sufficiently transparent so the community understands what you're doing and why you're doing it, and for each service that, over a particular time horizon, might be the subject of disinvestment, it's being done because that results in an enhancement of other aspects of the service which --

PROFESSOR WILSON: Yes, people are concerned - so, you know, we've just published a series of papers on an evaluation of what was called the virtual rural generalist

program in Western New South Wales. We were fortunate enough to work with a range of people - with the district and people who were providing that - and the centre for rural health in Orange, et cetera, did a very extensive evaluation of the vRGS, including extensive interviews with patients and clinicians in the range of small hospitals that the vRGS service is provided into. While it was, you know, basically very positively received - vRGS basically provides a virtual doctor to support small rural hospitals where there isn't either a permanent doctor or where you are providing relief to a local doctor for after hours and weekend care, et cetera.

MR MUSTON: We visited the vRGS.

PROFESSOR WILSON: Did you? The interviews are largely very positive from community people, but there is an undertone that says that, you know, "What does this actually mean?" You know, "Does this mean that you are going to remove some other service that we're provided? The doctor that we have at the moment, who is here five days a week, does this mean he won't be there anymore" - or "he or she won't be here anymore?" You know, so you have to bring the community with you, even though it's quite clear it's providing excellent service, excellent care.

MR MUSTON: As part of this next stage, which is planning a service mix which is to be delivered to meet the unmet need within the community in a way that prioritises that which is perceived to be best bang for buck, to use a term we used yesterday, that's also presumably a collaborative process which ideally needs to take place with all of those other key stakeholders that have been involved in the initial needs analysis process?

PROFESSOR WILSON: My personal experience in doing this is that one of the hardest bits is the degree of transparency that you can give other stakeholders about what is actually on the table.

MR MUSTON: In what respect?

PROFESSOR WILSON: If you can't do that, then how can you have a proper dialogue about what you can and can't do with the priorities that are there? So --

MR MUSTON: What inhibits that transparency at the moment?

PROFESSOR WILSON: So sometimes, it's because you don't know yourself what money's going to come, because, you know, you go from year to year in terms of dollars and it goes up and down in terms of what you can do in that space. Sometimes it's because there's a desire on the part of government not to create expectations. I mean, it's a reasonable concern, but it does make it much harder to do that, if you are not prepared to be transparent about what you can and can't do. Clearly, you know, you don't want to alarm a community that you might be going to change services unnecessarily.

MR MUSTON: But whilst they might be alarmed by it, in order to get that community buy-in and shared decision-making around what services should be delivered, what should be disinvested, you've got to tell them before you make the decision, so it's hard to avoid that, isn't it?

PROFESSOR WILSON: Yes.

MR MUSTON: And the consequence, whilst it might be distressing for them to think that something's going to be disinvested, of not telling them and sharing with them the potential enhancements that might flow if that happens is you're telling them after the decision's been made, and that's --

PROFESSOR WILSON: And unfortunately, that is not infrequent.

MR MUSTON: I think we've seen some evidence of that around the state as well.

The next thing, in terms of that planning process where you're mapping out the extent to which the unmet need of the population is to be delivered as part of the public health system, would it be right to assume that that process, as a piece of good planning, should not be seeking to divide up what might historically have been Commonwealth funded activities and state funded activities; they're all health needs of the community, so primary care, for example, should be in the mix in terms of at least determining whether or not there is an unmet need for primary care and making decisions around how it should be met, if your prioritisation exercise determines that that's

something that should be given a high priority?

PROFESSOR WILSON: I find it - it would be - you can't do population health planning unless you're prepared to look at the whole resource capacity that's available. Whether you can change or move that at all, as part of the planning process, is to say, "We know that that's there, but it's nothing - we can't do anything about it", and that's important. That's part of your planning process, to identify and be realistic about what you can and can't change.

MR MUSTON: So, for example, the existence of a Commonwealth funded primary health service as a concept is all good and well, but you need, as part of your planning, to take into account the practical reality that, in a particular town or community, the market ain't never going to provide a primary care service through that mechanism, and so something else will need to be done.

PROFESSOR WILSON: Yep. And it might be that you can - you know, it might be that you can get a general practitioner, for example, for two days a week, but you've got to have some other arrangement that's going to need to do that. So for that two days a week that you're going to be able to get a GP, what is the most important thing that they can do while they are there that nobody else can do?

Similarly, you know, when you focus on - if you then sort of go into the allied health areas, is it realistic to expect a full-time occupational therapist there, or do you have some other arrangement, say virtually or whatever, to provide this? And you might need for people to either have a visiting OT to do an assessment every so often for those bits which can't be done virtually, or, you know, is that where the person needs to actually go somewhere where they can do a face-to-face, even though you can't do it locally?

I mean, these are compromises. They're not necessarily ideal, but if you're trying to address the need and you're trying to address it with a principle that says wherever possible that should be as close to home as possible, providing it doesn't impact on quality of care, if that's a principle that you've adopted in your planning process, then you look at different ways of achieving that.

MR MUSTON: That would also extend, in the current

environment, to aged care, presumably? So again, you could look at the absence of aged care delivered through a market based scheme as a problem and something that's causing bed block, but if the market is never going to deliver an aged care facility in a particular area which will enable that bed block challenge to be met, then it has to be on the table in terms of decision-making from a local health district's perspective about how it might potentially involve itself in the delivery of that care?

PROFESSOR WILSON: Yes. I mean, we have an aspiration in our approach to ageing, ageing in place, trying to keep people at home for as long as possible, and it's certainly I'm sure what most of us would want, but delivering that in a rural community can be very, very difficult. To actually provide services into somebody's homes can be very, very difficult aspiration to actually provide.

MR REID: It's both a difficult aspiration but - not "but", it bounces up against the funding process where the state feels they're being drawn into a provision of services where the Commonwealth are taking inadequate response to provide those services.

Yes, we could argue that they should be the provider of last resort, but my view is that that should be accompanied by a funding agreement with the Commonwealth that that will be funded as a state-based service even though it's primarily a Commonwealth responsibility.

THE COMMISSIONER: On the basis that aged care funding is a Commonwealth responsibility?

MR REID: On the basis that aged care - I mean, one of the LHDs is currently looking at establishing an aged care service to accommodate the large number of aged care patients they have in their hospital at the moment, actually setting it up and funding it and running it, as they are in other jurisdictions, but they're clearly driving to long conversations with the Commonwealth about it providing the funding at least for those patients who would have been previously being funded in the local LHD aged care services, which are not.

So the concurrent arrangements doing the planning and establishing a service of last resort still have to accommodate the funding model which the states currently

work under and the LHDs, doesn't pick up those services.

MR MUSTON: At one level, whilst they are coterminous, the planning exercise and the prioritisation of services --

PROFESSOR WILSON: Critical.

MR MUSTON: -- and the identification of those services that need to be delivered to a particular community is the logical second step. Then the third step might be to say, "Our ability to deliver those services to our local community is dependent upon funding", and at that point there are discussions with the Commonwealth about the extent to which, say, in the case of primary care, a 19(2) exemption is available for the delivery through the state of a primary care service; or the 19(2) equivalent of the funding of an aged care facility of a type which no doubt has been harnessed to enable the state to deliver the MPS facilities around the state. Is that --

MR REID: And Commissioner, much of this already happens in a planning model and an approach model and a discussion. What I think you are pointing to is there still is not that comprehensive planning approach that probably needs to be in place right at the start. But, you know, at any one day there are numerous conversations occurring between the Commonwealth and the state about states being last resort across the country into any service delivery module and what the Commonwealth do to support that.

MR MUSTON: Just while we're on that planning and the prioritisation, accepting that we can't meet every need in every facility, or perhaps even in every local health district, there have to be decisions and compromises around what we're going to deliver where - that, as a basic proposition, would be right, would it?

MR REID: "We" being the state?

MR MUSTON: The state, yes.

MR REID: Yes, correct.

MR MUSTON: Those sorts of compromises should, in the ideal world, be informed by an assessment of the extent of the need in a particular location for that service and the ability, from a workforce perspective and other limiting

factors, to deliver the service in that location, and the extent to which delivering it outside of that location means that, as a matter of practical reality, you are depriving someone of realistic access to it - they're all factors which need to be taken into account as part of the sophisticated planning and prioritisation.

MR REID: And the prioritisation of the need.

MR MUSTON: Yes.

MR REID: Correct.

PROFESSOR WILSON: Yes, and as you have said previously, there are always lots of compromises between different elements of this.

MR MUSTON: An important driver for that assessment of priorities and decision-making around compromises is going to be the local health district, informed by that local understanding of the health needs, which, in turn, will have perhaps more central information filtered into it - would that be right? That is to say, there is value in having the local health districts with their local knowledge as a driver of that prioritisation and planning?

PROFESSOR WILSON: Well, I've not seen a model anywhere that successfully does that unless it has some sort of regional basis for doing it. There may be, but I've never seen a model which - where there is a sense that the communities are involved in that decision-making that doesn't involve some sort of sub-unit. I mean it probably doesn't matter a lot what size - there are other reasons, factors, that influence what the size of that might be, but to get it, you need to define a population, basically.

MR MUSTON: But there is a role for the centre, isn't there, in that planning process, because only the centre has that overarching, system-wide view which might enable decision-making to be informed not only by the needs of the population within the local health district's catchment and the services which are currently being delivered there, but also what is being delivered elsewhere and the extent to which what's being delivered elsewhere might actually be, as part of that grand compromise, called upon to meet some of the health needs of a local health district's community?

PROFESSOR WILSON: The needs will never, ever be addressed entirely from within. Even a large district, even a large population district, it is highly likely there will be services that have to be provided elsewhere or that are more convenient for patients to be provided elsewhere, and so yes. Somebody has to sort of - so there are statewide services that people will need to access. Renal transplantation, or transplantation generally, is never going to be something that happens in every district, even in every large town. So how do you coordinate the access to that? That's a statewide - that has to be done at the state level.

MR MUSTON: And whilst we can point to those obvious examples of things that should be statewide services - transplantation being a good one - there is an extent to which even those services which might form more of the business as usual of the health service, to be coordinated at a system-wide level?

PROFESSOR WILSON: Yes. So absolutely. You've got to ensure that there is overall - you've got to think about it - there's the local population but there is also the overall population, and also, you know, within our community - you know, our communities are not bound by these local health districts, and there are other things that link people together like their families and whatever. So sometimes the most convenient service for somebody is not in their local town, or not in the nearest town, but in the one where their family is, so how do you deal with that as part of your planning process? You need to - somebody needs to keep an eye on what's happening over the whole system.

In some work we did for Queensland Health a couple of years ago, we proposed that you could actually have different levels, that you could have - you had your local health districts, but because of the geography of Queensland, that you might have some supra-district arrangements to take into account the state's clustering of services which were actually shared across districts on a geographic basis.

For example, we proposed that there might be a supra-regional allocation of funds to a district which might be Far North Queensland, but within Far North Queensland, you would maintain those sorts of districts

because of the geographic spread to allow for that sort of local planning arrangement. So we talked about some funding going to those supra-regional structures and then decisions about how that be made by that cluster of districts, whereas other stuff, funding went directly to the district because it was for conventional services as such.

MR MUSTON: But part of that system-wide planning might also involve, to pick up an example that we touched on earlier, your cataract surgery, even if there might be a reasonably high demand for it within a local health district, if you can travel to an adjacent local health district because there is a centre where that is being provided effectively and perhaps more efficiently, that, by disinvesting in that service in the other local health district, you might free up some funding to enable the delivery of some primary care in communities that don't have it.

PROFESSOR WILSON: The dollar has to follow the activity, so yes, you might, because there might be some infrastructural costs associated with providing that service, but a significant proportion of the dollar is actually going to have to follow the patient.

MR MUSTON: But to the extent that efficiencies can be found within the system, those efficiencies are able to be - will produce dollars which can be perhaps better utilised to meet aspects of the unmet health needs in other facets of the health system?

PROFESSOR WILSON: Yes, and, you know, there's an adage in health care about cost savings, that the only time you truly see it is when you close a hospital bed.

MR REID: A group of hospital beds, Andrew. Not just one. A group.

PROFESSOR WILSON: That's the only time you really, you know, see that sort of thing. And that, of course, has significant implications once you do that.

MR MUSTON: Professor Van Gool, I think you had raised your hand.

PROFESSOR VAN GOOL: I was just going to say that in that

prioritisation exercise, of wanting to centralise or decentralise services, perspective is really important. So whilst we might say efficiency from the perspective of the health system, you need to take into account the patient costs in that as well. The system is never going to absorb all those costs, but as far as prioritisation decisions are concerned, at least a decision ought to take those other factors, other costs into account as well.

MR MUSTON: But, of course, the centralisation also has the potential to create benefits that are not solely financial. It might overcome a workforce challenge. If you have a centre for excellence in cataract surgery in Dubbo, for example, that might mean that challenges in attracting clinicians to deliver that sort of surgery in a number of other regional centres can be avoided or mitigated.

PROFESSOR WILSON: There may be, yes. But I think Kees is wisely saying we've just got to make sure you consider the whole cost. So, you know, for example, with an evaluation of the virtual services, one of the things that we've been looking at is carbon footprint saving, you know, and it is actually quite - it is quite amazing, even having virtual services within Sydney, what carbon footprint reductions you can get through virtual services.

MR MUSTON: But from an access point of view, perhaps picking up on the carbon footprint, if you do centralise a service, or move a service further away from people's homes, the health system, in order to maintain access to that service so it is still capable of delivering on all the health needs of the people in the region, needs to work out a way of getting those patients to the service and back, it's not sufficient --

PROFESSOR WILSON: Yes, I just think, in doing that, we have to be mindful of those broader implications. You know, birthing services is one that comes up quite regularly. For Indigenous people, it is important to birth on land. There are real issues in trying to maintain the safe and accessible services, birthing services, in smaller communities. You know, it would be very easy, and we've sort of done it almost by default, to keep on concentrating these things in areas but, you know, there are other social goods that we need to think about in doing what might seem to be the most sensible, safe and effective and efficient

way of doing things which may not meet certain broader goals, so we need to think about that.

MR MUSTON: The best way to strike that balance is through a meaningful collaboration between the local, by which I mean not only the local health district but also those other collaborators in the delivery of health care within a local area on the one hand, the community, on the other, and central governance of the health system, which probably has a better capacity to identify system efficiencies, workforce - solutions to workforce challenges, et cetera.

PROFESSOR WILSON: Yes and this is where that local element becomes so important. There is a fantastic example in Western New South Wales where the local health service and the AMS, et cetera, have worked with the community and the community has developed a model for supporting Indigenous mothers, Aboriginal mothers. In that period of time, they spend as minimum time off land as possible during that period of time, they've got support, and they feel like they still remain part of the community, and then when they come back - you know, come back to land or whatever, it's very --

MR MUSTON: I think we've heard some evidence from --

PROFESSOR WILSON: It was developed locally. It was a local initiative to achieve that.

MR MUSTON: We've heard some equivalent evidence, I think, from the Aboriginal Medical Service in Nowra, Waminda. They do have an excellent birthing on country program.

So bringing us back to funding, we've identified potentially a system whereby, through identifying the need and engaging in a proper and collaborative process for prioritising the way in which that need might be met by the public health system and divvying up the limited budgetary envelope available to the public health system in a way which enables that to be delivered, is the next real challenge.

How do we, from a funding point of view, create structures that enable those mapping and planning processes to actually be converted into the actual hard and fast delivery of healthcare services in a way which ensures that they are sufficiently funded for them to be real?

PROFESSOR WILSON: Carmen has her hand up. I don't know whether she wanted to answer that question.

MR MUSTON: If not, you can answer another one and we'll come back to it.

A/PROF HUCKEL SCHNEIDER: Yes, just directly on that, what we're, effectively, reaching when we get to this point is how to implement services that have been identified as not being met, for whatever reason. So when we've reached that point, we're trying to overcome all of those challenges and barriers that were the reasons why there were those gaps in services in the first place, and that's what makes it - so the availability, the time, the clinicians and workforce that are available.

The injection of funding, through whatever mechanism at that point, needs to identify alternative solutions, because saying, "We're going to get another primary care clinic there", or "We're going to get another allied health clinic there", will still face those initial barriers that were the reason why it wasn't there serving the community in the first place. So it is about identifying alternative solutions to either incentivise more activity there, to fill those identified gaps and meet those priorities, or find alternative ways to provide those services and fill those gaps.

PROFESSOR WILSON: Coming to your question, I think what we're suggesting is recognising that there have been real gains from activity based funding, that we don't want to lose, but we also have other objectives that we're trying to meet, other than just the technical efficiency of the system, that some sort of - some form of allocation of funding to a local health district on some sort of weighted population basis, but also taking into account the cost structures of those districts, et cetera, but as a sort of fundamental plank to that whole notion of population health planning, but then practically recognising that the bulk of that money is actually going to be tied up in infrastructure, we still think that that's the most transparent way of doing it, that within the districts, there is an expectation that those things which are most appropriately funded through an activity based model would be done - would be done in that way, but there might be some other things where there are other approaches to some

hybrid model of funding for other types of services, like bundled costing, et cetera, that that would give you a mixed model but where you retain the benefits of the activity based funding model but you actually have a more transparent distribution of the funds.

What it doesn't do is address the issues - it doesn't necessarily address some of the - while it equitably distributes the funds, that doesn't mean it addresses issues of equity of health outcomes within that area. That's a slightly different question to the equitable distribution of the funds, and I think Kees has his hand up there.

PROFESSOR VAN GOOL: I did, but you said exactly what I was going to say. All I would add to that is, yes, the bundling payment is an innovative way of paying for healthcare services. The innovative aspect of it is to try and coordinate different types of services across sectors over time, and the other aspect that is innovative is that it might then also start a discussion between all different payers on how they can contribute to that bundle, rather than it becoming still, you know, a point of contention between different levels of funding.

MR MUSTON: For example --

MR REID: The - sorry --

MR MUSTON: I'll come back to you, Mr Reid.

THE COMMISSIONER: Go ahead, Mr Reid.

MR MUSTON: You go ahead.

MR REID: Sorry, just to clarify, the paper identifies six opportunities of how you might change aspects of the funding model, which are not mutually exclusive, but they do try and bring elements of how do you improve at least an understanding of the fairness of the system, in whatever population based weighted system. And it could go back to the future, which either operated beforehand or not, or go to the Queensland possibility, which is allocation on a population to HHSs and then using activity based funding, or you could carry it as an example model, which is what they did in New South Wales for many years, so that you could demonstrate you were moving to better equity and

population based allocations over time, even though the funding model was different.

Then it also goes to a fundamental question as to whether the activity based funding, as it currently stands, is appropriate, and this goes to the new arrangements for aged care funding which are now in place, which more goes to a fixed and variable component and which is, in a sense what Kathy Eagar has argued to you in some way, shape or form, and then you go to the other components as to whether you start to adjust your weightings in whatever you retain in the hospital system to reflect differential costs of providing the same services within that hospital or group of hospitals, which many of the submissions have argued to you, on the basis of ethnicity or chronic and complex conditions being more prevalent in the community there. That's a slightly different argument to at least having something which has a demonstration of what the overall population based allocation is.

In that overall population based allocation, the first one, we would argue that Commonwealth money should be included in that so you understand the totality of health funding but be differentiated within it, so you understand what the state funding is and the Commonwealth funding.

THE COMMISSIONER: And this is the distinction between what you've called opportunity 4, which we were discussing I think slightly beforehand --

MR REID: Correct.

THE COMMISSIONER: -- and what you have just focused on, which is opportunity 5?

MR REID: Correct. That's correct.

THE COMMISSIONER: I interrupted you, Mr Muston, I think. Sorry.

PROFESSOR WILSON: And given that you can't fix the Commonwealth/state funding arrangements.

THE COMMISSIONER: You can have a crack, but it would be hard.

PROFESSOR WILSON: At least if that was reflected in what

the allocation should look like, then the state, you know, would have a lever that it can use in its negotiations in the future in relation to - with the Commonwealth around some of those things.

MR REID: And the notion of fairness should not differentiate the state/Commonwealth arrangements. There should be fairness of accessing health dollars regardless of which government it comes from.

PROFESSOR WILSON: And sorry, just to be clear, because we've sort of belatedly introduced the issue of bundled payments in the discussion, by that we mean where you have some mechanism for estimating the total cost of care in particular sorts of circumstances, and there is an allocation in the same way as an activity unit, you know, is focused on a particular narrow area, this would be a broader type of service.

An example of that might be mother and child, the first 2000 days. There might be a bundled payment for that period of time - sorry, for the services that you would expect to provide in that area, and that would go to, you know, the district on that basis, as opposed to the activity based funding.

MR MUSTON: I think you have answered the question that I was going to ask Professor Van Gool when we changed tack slightly, but just to make sure I have understood it, I will ask either you or Professor Van Gool to tell me if I'm wrong: a bundled payment in the context of, say, primary care, might make an assessment of what, if, as a matter of prioritisation of the meeting of health needs, a local health district determines the primary care service, say, co-located with an MPS facility is something that would be of use to a community and the best use of health dollars in that community, a bundled payment might say, "We've worked out roughly what the workforce for that sort of service would be in terms of the mix of different types of clinicians", it no doubt will have been worked out in the background what sort of money might be generated through a 19(2) exemption if one were able to be secured. From the LHD's perspective, other than making sure that it clicks the Medicare card every time it provides a service to ensure that funding stream flows, it gets given a bundle of money which is what is anticipated to be or estimated to be the cost of delivering good primary care to a community

and it is then up to that local health district to decide exactly how it will deliver that through some mix of doctors, nurses, allied health professionals, cross-referrals in to specialists that might be available through the local health districts, base hospitals, for example.

PROFESSOR WILSON: And the district, as part of its planning process, would make decisions about how that could be most efficiently and effectively provided for a particular setting, so that might mean an arrangement with the local - working with the local GP and whatever, to provide that service; in other situations, it might be using a nurse practitioner; and in another setting it might be using some other sort of provider appropriate to the type of support and care that is necessary.

It could be any mix of traditional approaches and virtual approaches, et cetera, but the expectation is that they will deliver a package of care meeting a certain standard and a certain evidenced requirement for what was required in that space.

MR MUSTON: It might, in some instances, include providing funding in a bundled way to the local Aboriginal community controlled health organisation to provide that primary care across the full population of a town.

PROFESSOR WILSON: Yes, absolutely.

THE COMMISSIONER: Can I ask you a question, you are not under any time pressure, other than a date of April and neither am I, but the witnesses might be. Do you have a feeling for how much longer, and then I will ask the witnesses what their --

MR MUSTON: I can probably be finished within half an hour, 15 minutes.

THE COMMISSIONER: Right. Can I just ask the five of you, do you have any time constraints after 2 o'clock?

PROFESSOR WILSON: I do have time constraints after --

MR REID: And I do also.

THE COMMISSIONER: If it's okay with the icourts people,

can we keep going? Is that - we can. It might be better, for the witnesses' convenience, if we just keep going, if there's only up to half an hour left, rather than take the lunch break. So I think we might just proceed.

MR MUSTON: Certainly. I'll try to compress it.

Could I come directly to the opportunities that you have identified at the end of the report, commencing at paragraph 72, what you've described as "Opportunity 1". At paragraph 73 you refer to the potential use of some of the more traditional bases upon which funding was divided up as a monitoring guide.

Do I understand that to essentially be you saying that some of those population based assessments of need and population based means by which health funding has traditionally, in some places, been divided up, whilst you might not use that as the driver for the funding decisions that you are making, it nevertheless might remain a useful tool in terms of just checking to see whether the funding model that you are using is producing outcomes which are wildly at odds with what that more population based/needs based funding approach would suggest they should be?

MR REID: This suggestion was based on how do you bring on to the table something which looks at a population based understanding, to understand where there's different areas of need across different geographies. This suggestion was put on the table more as, as you said, as a monitoring guide, but it was akin to what was in place, as Carmen said, in New South Wales prior to the 2011 agreement with the Commonwealth and states, and it was published by - it was done every year, published by the health minister to demonstrate where there was inequities between LHDs, whether they were being rectified by the funding model and how they were being changed by the funding model over time. They were also trying to be very transparent, or much more transparent, to differential population growths which occurred between LHDs which had then had different need bases.

When it was in place, it demonstrated over a six-year period that there was a movement to greater equity between populations across all the LHDs. So it was used as a way of going - a public document which went out, which people could see, that however those moneys went out in activity

based funding or however it went out in whatever way, shape or form, then it was still going out in a way that when you adjust particularly for patient flows, which are appropriate patient flows, that there was - if you were living in a more disadvantaged area, let's say, in terms of the starting point in the year it started, each year there was some movement in the dollar allocation to that person over a period of time, and as populations were weighted according to their age, sex, Indigeneity and obviously adjusted for patient flows and use of private sector and other things. So it was broadly a tool to measure whether we were moving away from or towards a fairer system, at least on that basis.

PROFESSOR WILSON: And back to what we were talking about yesterday about ratcheting up, you know, if you were to suddenly tomorrow say, "We're going to distribute this according to a formula", and you suddenly had to shift $100 million from one district to another district, the disruption that that would cause would be - it just would be intolerable at a whole range of levels. You just couldn't do it.

So even if you introduce - even if you decide to move to a more equitable distribution of the funds, it's not going to occur - it's going to occur progressively, and it may well be largely due to an uneven distribution of the new funds coming into the system, in other words, rather than focusing too much on the money which is already tied up; when there is new growth funding in the system it differentially goes to one of those areas which are - it took 20 years, I think, Mick, something like that, under the previous formula to move things closer to RFD.

The Garling Inquiry - I found a section in the Garling Inquiry which said, you know, that it had moved within I think - it was something like I think the figure was 20 per cent or something of equitable share between the districts at the point when the Garling Inquiry was held. So I don't know where it ended up eventually in relation to that. The ministry almost certainly knows. But, you know, it is a progressive process.

MR MUSTON: Whatever model you use as your underlying funding driver, if you are monitoring the extent to which, at this population level, the funds are being distributed equitably, and you are publishing that, that introduces

a level of transparency around either the need to shift investment progressively on the one hand, or alternatively provide an equally transparent explanation as to why, because --

MR REID: The reality is, Commissioner, that the shift to greater equity comes, as Andrew said, with the additional funds that come in year on year, rather than fundamental changes or closures of hospitals or those types of things, which aren't going to occur anyway. So it just provides that transparency and something that could be done relatively quickly off existing datasets that New South Wales currently has, that just requires that transparency in publishing and undertaking the exercise.

MR MUSTON: Can I take you to opportunity 3.

MR REID: So this opportunity which we talked about, Commissioner, was really saying if we're going to retain an activity based funding arrangement or some arrangement for funding inpatient hospital care and outpatient care, and we recognise that many of the drivers to get a more efficient hospital system are still funding sources that go outside the hospital and, as Carmen said, they're not just right out in the prevention, the other side, but there's a whole range of other areas which are not picked up in ABF funding at the moment - that if you retain some form of activity based funding, and going back to your very first comments about the legislative role of what the Department of Health does, then the funding model doesn't very well accommodate that legislative role, and you would argue in that that then - and there is some funding which does go to various forms of community based activity at the moment, but it is difficult to assess in a transparent fashion how useful - whether it goes in an appropriate way.

This is more identifying a much more significant envelope of non-activity based funded services which would be funded where their role is health promotion, health prevention, keeping people - reducing lengths of stay, and could also pick up other issues around health literacy in hospitals, et cetera, in health care. But it's setting a pool of money aside which would be for that primary care/community based services.

MR MUSTON: How do we measure the extent to which those funds are directed at addressing equity in the sense you

contemplate in paragraph 80? How is that measured?

PROFESSOR WILSON: Addressing equity?

MR MUSTON: Addressing inequity.

PROFESSOR WILSON: Well, I think that, in part, will be - that is part of really - and it should be explicit within your population health planning as to what are the things that you're doing to address inequity as part of your population health planning, and as part of that, it may be specifying that certain types of services are provided in an inequitable way to address the inequity, differentially address inequity.

MR MUSTON: So, for example, if one of your key priorities was "Closing the Gap", that might mean that a larger proportion of the funding envelope is deployed --

MR REID: Correct.

MR MUSTON: -- toward First Nations communities and into Aboriginal community controlled health organisations because you are wanting to produce an outcome there which increases, in the longer term, equity.

PROFESSOR WILSON: Yes.

MR REID: And if you include your federal dollars in opportunity 1 in monitoring that kind of equity, those kinds of investment would be picked up in the trend over time in opportunity 1.

MR MUSTON: I have one last question. Could I ask you to go to paragraph 89 of your statement - or report, I should say. We're dealing there with opportunity 5, so the potential refinement of the ABF model, even just for the hospital based funding.

MR REID: This has kind picked up on the new funding model for the aged care sector, which has a fixed and variable component. It's argued on the basis that by having the totality of hospital dollars as variable dollars leads to complexities in how it's distributed, even though it's done in a way which is diagnostic specific, and I don't think we, as a team, are well - this would require quite a considerable effort to assess how it would be done, but

the proposition here is that you categorise hospitals according to their tiers, which currently NSW Health has in place, so the smaller hospitals would get a much higher proportion of a fixed budget and a smaller variable activity based funding, and the bigger hospitals would have a much smaller fixed component, bigger activity based funding, and there would be variations between the gradations of hospitals as to what the ABF was.

It picks up very much on the aged care funding which the Commonwealth now has place.

MR MUSTON: Professor Van Gool?

PROFESSOR VAN GOOL: It's just to add to Mick's comments, that in the NEC - the national efficient cost - model for smaller rural hospitals, that already exists, but of course, essentially it cuts out at 3,500 NWAU, and I think what the proposition here is is to extend that and look at hospitals that just sort of fit on the other side of 3,500, so that you have a broader --

MR REID: I think if the Commission had an interest in this, Commissioner, it's something you would recommend be further developed to assess its viability rather than jump into it, because it does need a lot of work, which was quite beyond Martin's brief in terms of how you would get to it. But it is something that has been advocated in a number of the submissions that have come to you.

THE COMMISSIONER: Sure.

MR MUSTON: This perhaps is a question best directed to you, Professor Van Gool. The starting proposition is activity is based and funded through the national efficient price, at least at the IHACPA level. Once the state gets that money, it, as we understand the system currently, creates a state efficient price, which is the price that New South Wales feels, based on its data, it's able to deliver efficiently the care through hospitals.

You effectively, as I understand it, through opportunity 5, identify two potential adjustments. The first is you either, for those, let's just call them, medium sized hospitals that sit between a block funded small hospital and a hospital which is large enough to genuinely absorb the wins and the losses of activity based

funding - for those medium sized hospitals you either have a fixed cost block that covers turning on the lights and opening the doors with a top-up through some activity which continues to drive efficiency through that hospital but guarantees that there will always be a sufficient funding envelope available to operate the hospital and the services that it needs. That's one potential adjustment to the existing arrangement. Have I understood that correctly?

PROFESSOR VAN GOOL: Yes. So the national efficient price is obviously allocated to ABF hospitals, but then there is the national efficient cost for smaller hospitals that produce less than 3,500 NWAU per year.

MR MUSTON: Yes.

PROFESSOR VAN GOOL: Those hospitals are funded on a fixed and variable component. So still block funded, so it is a little bit retrospective, but still fixed and block - so if you are a very small hospital, something like less than 200 NWAU per year, essentially, you are all block funded; there's just a fixed component.

As you expand your activity, there's a reward for that expansion of activity and your block funding reduces. That block funding, I must say, or should add, goes to the state, it doesn't go to the LHD, and so it's up to the state to redistribute --

MR REID: The Commissioner is right, in a sense, Kees, that this is a state activity of how we would fund it once we got the Commonwealth dollars.

PROFESSOR VAN GOOL: Absolutely. Yes, I'm sorry. I'm purely referring to what the Commonwealth contribution does here, yes.

PROFESSOR WILSON: Just to put that in the context, we're talking something which means you've got 10 services a day which are doing that, so there would be 10 patients in hospital a day, so we're talking pretty small hospitals, 10 or less than 10, because it's 10 activity units. So it's not necessarily a patient in a hospital for a day, but we're talking - at the moment, that cuts off at some very small hospitals.

MR MUSTON: The small facilities with one or two acute

beds in the emergency department.

PROFESSOR WILSON: Yes.

MR MUSTON: But we have heard some evidence from slightly larger hospitals - Cooma Hospital, I think, is a good example - where it's been suggested that to maintain a number of the services that they operate, if you add up all of the NWAU you get there delivering 105 babies, it doesn't come close to the cost of maintaining a 24/7 obstetric service, but for reasons of geography and population, a decision has been made that that service must be offered.

PROFESSOR WILSON: And this is nothing new. This happens now. All we're trying to - you know, local health districts get a whole range of different bits of money at the moment. It is only a small proportion of their total budget. But it's something they are used to managing. So it's not a problem from that perspective. What we're just trying to do is systematise that in a way. I mean, if I had any - and I guess the other part of systematising it is you are pushing it into some sort of formula for doing it, and that has less opportunity for people to give funding for reasons other than good health measures, shall I put it that way.

MR MUSTON: Can I ask this last question in relation to the systematisation. If we do reach a point where there is good health needs mapping and collaborative and transparent planning of the way in which those health needs or the extent to which those health needs are going to be delivered by the public health system in each LHD, would it be right to say that whatever funding model or approach you might take, decision-making around funding being driven by the anticipated cost of delivering the services which sit on that plan is going to be a superior system, in terms of health outcome, to a somewhat more arbitrary number which comes from an historical basis, and is then used by the local health districts to "do the best they can".

PROFESSOR WILSON: The community would be better served by having more transparency around these issues; it would understand - that's not to say or to mean that they're happy, but at least they would actually understand, and "community" includes the clinicians as well as the general public in terms of understanding what is actually happening

with the distribution of the dollars. It's not going to solve everything but I think it will at least improve that.

MR REID: I think I agree with Andrew. The only slightly contrary point is that I think if one doesn't establish a clear non-hospital based funding block of money, the historical trend is that that tends to be drawn back into acute care service provision over time, by whatever rationale of politics, waiting times, whatever it might be.

MR MUSTON: I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: All right. To all five of you, but starting with those in the hearing room, is there any aspect of your report or the opportunities identified in it that you don't feel we've sufficiently covered or you want to add something to? I will start with Professor Wilson.

PROFESSOR WILSON: Look, I just go back to the comment I made midway through the morning that a funding model should be designed to achieve the objectives of what you want to achieve from it, and there are wrong funding models but there are no right funding models, in that essence. So I think as you start to formulate your recommendations and are clearer about things that you really want to see happen, then we can probably help give you some better advice about which of the funding models would achieve that and which are feasible within the structures that are currently in place.

THE COMMISSIONER: We might hold you to that offer. Dr McNamara, is there anything you --

DR McNAMARA: Nothing from me, thanks.

THE COMMISSIONER: Professor Van Gool, is there anything further?

PROFESSOR VAN GOOL: I'm all good, thank you.

THE COMMISSIONER: Mr Reid?

MR REID: All good, thank you very much, Commissioner.

THE COMMISSIONER: And Professor Huckel Schneider, is there anything further from you?

A/PROF HUCKEL SCHNEIDER: Nothing further from me, thank you very much.

THE COMMISSIONER: I will just check with Mr Chiu whether he has any questions?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: All right. To all five of you, first of all, thank you very much for the time you have given us but also thank you for the assistance you have given not only through your evidence today but also through the report that you have done. We're very grateful.

Having said that, again, thank you, and we adjourn to a date to be fixed; is that where we're up to?

MR MUSTON: Yes, I think so.

THE COMMISSIONER: All right. We'll adjourn to a date to be fixed in - good grief - 2025. Thank you.

<THE WITNESSES WITHDREW

AT 1.28PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO A DATE TO BE FIXED

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