

**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)**

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

**Also present:**

**Mr Hilbert Chiu SC for NSW Health**

1 THE COMMISSIONER: Good morning.

2

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

6

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

13

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

17

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

19

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

22

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

27

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

29

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

32

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

35

36 PROFESSOR VAN GOOL: Just a convenience thing because  
37 I have other meetings to attend very shortly after  
38 1 o'clock.

39

40 THE COMMISSIONER: What about you, Mr Reid?

41

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

45

46 THE COMMISSIONER: Sorry, where are you?

47

1 MR REID: Jervis Bay.

2

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

4

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

11

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

17

18 PROFESSOR WILSON: That's fine, Commissioner.

19

20 <ANDREW WILSON, affirmed: [10.04am]

21

22 <MARTIN MCNAMARA, affirmed:

23

24 <CARMEN HUCKEL SCHNEIDER, affirmed:

25

26 <KEES VAN GOOL, affirmed:

27

28 <MICHAEL REID, affirmed:

29

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

33

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

37

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

45

46 MR MUSTON: And Professor Van Gool?

47

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

9  
10 MR MUSTON: Thank you. Mr Reid?

11  
12 MR REID: Mick Reid. I am an adjunct professor at the  
13 University of Sydney in health policy and an adjunct  
14 professor in the University of Western Sydney. I'm on the  
15 board of Western Sydney LHD. I have my own - I previously  
16 was director-general of health in New South Wales and also  
17 Queensland and really do consulting work around the country  
18 on aspects of health policy.

19  
20 MR MUSTON: Thank you.

21  
22 You have each contributed to the preparation of  
23 a report entitled "Resource management in NSW Health" dated  
24 29 November 2024. That's correct?

25  
26 (Witnesses nod)

27  
28 MR MUSTON: The contents of that report continue to  
29 reflect views that each of you hold; is that right?

30  
31 (Witnesses nod)

32  
33 MR MUSTON: Commissioner, that's [SCI.0011.0605.0001]. It  
34 will form part of the bulk tender at the end of today.

35  
36 Do you each have a copy of that report available to  
37 you this morning?

38  
39 MR REID: Yes.

40  
41 PROFESSOR VAN GOOL: Yes.

42  
43 A/PROF HUCKEL SCHNEIDER: Yes.

44  
45 MR MUSTON: I might just say at the outset, in terms of  
46 the questions that I ask and the areas in which I invite  
47 you to expand on things that have been set out in the

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

6  
7 PROFESSOR WILSON: If it is okay with you, I might assist  
8 you in that and just direct, given that I know all the  
9 parties fairly well.

10  
11 MR MUSTON: That would be excellent. For those of you who  
12 are online, if there is anything that you want to add or  
13 contribute to evidence that has been given by someone else,  
14 just from a logistics point of view, it would probably be  
15 good if you could use the "hands up" button on the Teams  
16 platform. We'll see the hand up on the screen and I will  
17 come to you very quickly thereafter; likewise, if either of  
18 the two of you who are here in person would like to  
19 contribute something to someone else's answer or offer  
20 a different perspective, just look my way and wave your  
21 hand and I will come to you quickly.

22  
23 The final thing to say about that, probably, is to the  
24 extent that there are things that we traverse during the  
25 evidence this morning where any of you feel that either  
26 through contributing a different perspective or perhaps  
27 even asking questions of one another to try and flesh out  
28 the answer, feel free to do it.

29  
30 It's a relatively informal process that we are engaged  
31 in here. It's not evidence of an old-fashioned kind where  
32 I ask you short questions and you give me a yes or no.  
33 We're genuinely interested in the exchange of ideas and to  
34 have a format in which you are able to assist us with your  
35 collective views in relation to the issues that are touched  
36 on in the report.

37  
38 With that, could I ask you to go to paragraph 13 of  
39 your report where you tell us, in a summary way, what  
40 a number of the objectives of the NHRA are.

41  
42 Do you see the first bullet point there that refers to  
43 one of those objectives being to encourage activity that  
44 considers not just technical efficiency but also aims to  
45 improve access, for example, by reducing waiting lists?

46  
47 In relation to that observation, can I ask the first

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

3  
4 PROFESSOR WILSON: So Kees and Mick will probably want to  
5 add to this, but the issue here is when we talk about  
6 waiting lists, there are two - there are a number of ways  
7 of conceptualising what a waiting list is. You might be  
8 talking about the number of people on it, you might be  
9 talking about the wait time on a list in that regard.  
10 Either of those are applicable in terms of this statement.  
11 One wants to have the shortest number of people waiting,  
12 but also, more importantly from a patient perspective, is  
13 the time that one waits to have a procedure or appointment.

14  
15 We also have the complexity that you can have tiers,  
16 interlinked tiers of waiting lists. So you can be waiting,  
17 for example, for an appointment to see a surgeon, you see  
18 the surgeon, you then go on to a waiting list for the  
19 surgical procedure that follows that. So you will get  
20 those sort of interlinking issues.

21  
22 Mick or Kees may want to comment on this. My  
23 interpretation of that National Health Reform Agreement was  
24 the intent was to try and reduce both of those, but  
25 particularly was focused on the bit which is usually the  
26 one which is most prominent and best measured, I guess, is  
27 a poor description of it, which is really that second one,  
28 the time between seeing your consultant and getting some  
29 procedure undertaken.

30  
31 I might also add that, you know, waiting lists for  
32 procedural processes are different to waiting lists for  
33 seeing a specialist like a rheumatologist, for example,  
34 which, across Australia within the public sector, have very  
35 long waiting lists and are hard to get into, but once you  
36 are seen, you are basically then being managed from that  
37 point on.

38  
39 MR MUSTON: You used the term "best measured". Is the  
40 reality that that waiting list which is you've been  
41 identified by a surgeon as someone who requires a piece of  
42 surgery within the public system and then there is a date  
43 at some point in the future when you are going to get that  
44 surgery - it's whether that's best measured or perhaps is  
45 it easiest to measure?

46  
47 PROFESSOR WILSON: It's most visible once you've seen the

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

3  
4 The transparency of the waiting list to see  
5 a specialist is less clear, because people get  
6 reprioritised all the time in those lists, and places have  
7 different approaches to this, so some places, you get an  
8 appointment for a specific specialist and in other places  
9 you will have an appointment to a clinic and you will see  
10 one or other of the specialists in that clinic with no  
11 particular choice in that regard, and that then influences,  
12 you know, what the waiting list looks like.

13  
14 MR MUSTON: How is it that than NHRA seeks to improve  
15 access by reducing waiting lists in that second category -  
16 that is, for example, the child who has been assessed  
17 through a particular program as requiring a paediatric  
18 intervention or, to use your example, an individual who has  
19 been assessed as requiring an appointment with  
20 a rheumatologist?

21  
22 PROFESSOR WILSON: The NHRA was a really important  
23 advance, because it tied the Commonwealth contribution to  
24 activity, whereas previously, what happened was there was  
25 just a block of funding that came to the state, that block  
26 was set over a five-year period, it increased over that  
27 five-year period, but it basically came to the state and  
28 territories as a block.

29  
30 What the NHRA did was tie that to activity, and so  
31 that had two consequences. One is that activity had to  
32 occur to get the funding; and, two, it had a growth factor  
33 in it, whereas before, basically the states largely wore  
34 the risk within that block funding of growth in activity  
35 and, to some extent, that was predictable but it does vary,  
36 whereas this tied it to the actual activity that occurred.  
37 So you got a different driver.

38  
39 And I can see that Kees wants to leap in here. He  
40 knows far more about it than I do.

41  
42 PROFESSOR VAN GOOL: No, no, I was just going to  
43 supplement. Sorry, I shouldn't say --

44  
45 MR MUSTON: No, please, do.

46  
47 PROFESSOR VAN GOOL: All I was going to say is to add to

1 Andrew's comment and say growth in not just activity but  
2 also in a cost, the Commonwealth contribution is tied to  
3 both activity and cost.  
4

5 MR MUSTON: To the extent, though, that the activity which  
6 is recognised under the NHRA is predominantly hospital  
7 based or historically has been a hospital based activity,  
8 I'm just trying to understand how that mechanism has, at  
9 least in a realistic sense, an objective of reducing  
10 waiting times for, say, out of hospital clinics to see  
11 a rheumatologist or a paediatrician or something like that?  
12

13 PROFESSOR WILSON: Kees, do you want to comment?  
14

15 PROFESSOR VAN GOOL: Yes. So under the NHRA, there are  
16 different types of classifications, and classifications  
17 allow you to essentially count activity. There is an  
18 admitted acute classification; there is a non-admitted  
19 classification system; there is an emergency department  
20 classification system, non-admitted.  
21

22 You know, as these classifications have developed over  
23 time, we've been able to count that activity in a more  
24 comprehensive way. So it's not just what happens, you  
25 know, within the four walls of an admitted acute hospital;  
26 it also is broader than that in terms of, yes,  
27 non-admitted, subacute, admitted mental health now as well.  
28

29 MR MUSTON: Just to pick up on Professor Wilson's example  
30 of a rheumatologist who might be providing care through  
31 a public clinic, that public clinic, outpatient clinic, is  
32 something which is now, or would now be, captured as  
33 a species of activity under the NHRA?  
34

35 PROFESSOR VAN GOOL: Yes, I can't go to the specifics, but  
36 non-admitted patient classifications are typically counted  
37 and there are a range of ways of counting that, and  
38 specialist consultations are part of that as well.  
39

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



1  
2 MR REID: I think it goes back to Andrew's point of saying  
3 that it was a fundamental reform, and when this reform was  
4 brought in, there was - as there is today, but somewhat  
5 less so - considerable interest by all state authorities on  
6 reducing their waiting lists and waiting times. You'll  
7 recall one previous premier promised to reduce it by half  
8 in his first six years of office in New South Wales. But  
9 I think it's addressing that, of trying to link the  
10 Commonwealth funding to activity levels which was the  
11 characteristic feature. So I'm not too sure the wording or  
12 the analysis at the time went further beyond that the  
13 subset of that.

14  
15 MR MUSTON: Maybe this is a question for you, Mr Reid, but  
16 where you refer to the premier's priority being to reduce  
17 waiting lists, that priority was to reduce the time that  
18 people waited for what?

19  
20 PROFESSOR WILSON: It was procedural.

21  
22 MR REID: Time they waited for elective surgery, and  
23 around this time, you know, there were a significant number  
24 on the waiting list for elective surgery and there was an  
25 endeavour by government to reduce it. So it was deemed  
26 that the NHRA would contribute to that. It wasn't just  
27 New South Wales; it was all states.

28  
29 PROFESSOR WILSON: You've really cut to one of the most  
30 important distinctions in the whole issue around the sort  
31 of waiting list debate, and it is which waiting list are  
32 you talking about? Most of the stuff that you see in the  
33 media is around waiting for procedural, so waiting for  
34 elective surgery or not necessarily even elective surgery  
35 list, but some sort of procedural list.

36  
37 There has been much less focus on the waiting lists  
38 for areas like specialist clinics for non-procedural  
39 medicine, and that is a problem, but it's a more complex  
40 problem than the other one. That's why I was saying, you  
41 know, separating those two sorts of waiting lists. All of  
42 this is about capacity in the system, it's about how many  
43 doctors or other health providers there are to do this, and  
44 in the ambulatory space, there have always been issues  
45 around access to specialists, to consultants, either  
46 surgical or other specialties, and in the sort of  
47 non-procedural areas.

1  
2 We have had, since about - I'm just trying to  
3 remember; Mick might remember - the late '90s, up until the  
4 late '90s, in effect, there was no basis for public  
5 hospitals to be able to bill services. Even though there  
6 were sort of arrangements, there was a growth even prior to  
7 the late 90s in clinics which were operating, it wasn't  
8 quite clear where they sat legally in relation to that.  
9

10 In the late '90s, there was an agreement between the  
11 states and the Commonwealth which basically said you have  
12 to keep operating all the public clinics that you can at  
13 the moment, but if you grow additional capacity in the  
14 ambulatory care setting, then you can bulk-bill for those  
15 services.  
16

17 So what has happened in that, in the 20 years in  
18 there, as we've seen, is growth in clinics which are - they  
19 have a whole range of arrangements that essentially bill  
20 the MBS to increase this.  
21

22 But of course, you know, you still have to have  
23 doctors who are willing to do that, and if you are billing,  
24 bulk-billing, for a patient, then it raises this whole  
25 issue of well, how is this different to my private  
26 practice, et cetera. In some places, the doctors haven't  
27 been prepared to enter into agreements which would  
28 basically allow for bulk-billing, ie, no co-payments for  
29 patients, and so we have seen situations, and we will see  
30 across the state quite variable access to specialists,  
31 which largely relates to the number of specialists that are  
32 there are but also this factor of whether they are willing  
33 to provide these bulk-billing clinics, because that has  
34 been where the greatest growth in outpatients has been, and  
35 it's a real - for me, and you'll see it coming through in  
36 the paper repeatedly, to me, the real issue here is an  
37 equity issue of access for people, because as soon as you  
38 force people into the private sector, then there will be  
39 co-payments, and that's a problem.  
40

41 MR MUSTON: A problem because that excludes a wide range  
42 of potentially quite ill people who just can't afford the  
43 co-payment?  
44

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

1 and over again. If you're just going to see a surgeon and  
2 you've got a one-off fee, that goes with it, well, you can  
3 manage that. If you've got a cancer, if you've got  
4 a chronic condition where you're having to repeatedly go  
5 there, then you're going to have a repeat co-payment every  
6 time now. Yes, there is a safety net in the MBS  
7 arrangements in terms of that, but that can be quite - for  
8 many people, it can be quite problematic.  
9

10 Then, you know, this is assuming that you can get the  
11 access in the first instance, which is really problematic  
12 for ambulatory care around the state.  
13

14 MR MUSTON: Accepting that part of the capacity of the  
15 system to deliver that sort of care is informed by the  
16 willingness of members of the medical profession who are  
17 within these specialties to step in and deliver it, it's  
18 also informed, is it not, by the way in which  
19 decision-making historically has shaped the system - that  
20 is to say, if there's a focus on the delivery of surgical  
21 care, then that means that, within a limited budgetary  
22 envelope, you're spending money on providing that surgical  
23 care and that is money that you're not potentially spending  
24 on building a workforce with training pathways and the like  
25 in that ambulatory space?  
26

27 PROFESSOR WILSON: Sorry, I just noticed that Carmen had  
28 her hand up before. She might want to have added something  
29 about the previous --  
30

31 MR MUSTON: Sure. If I forget my question, I might have  
32 to get it read back.  
33

34 PROFESSOR WILSON: I'll answer your question for you, but  
35 I just wondered if she had something to add that might have  
36 been useful.  
37

38 MR MUSTON: Sure.  
39

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

1  
2           There was a simplified theory behind this in that if  
3 funding is activity based, there's a national efficient  
4 price and then for each type of diagnosis there is then  
5 a complexity weighting, and then a so-called inlier length  
6 of stay. That means that the amount of funding for that  
7 particular activity should be incentivised to be completed  
8 efficiently and within a certain amount of time.

9  
10           Then the theory behind that was that that would  
11 incentivise hospitals to have more throughput at that  
12 efficient price rather than simply more patients or more  
13 activity - so incentivised efficient activity.

14  
15           This then led to an extension of that theory that the  
16 efficient activity would allow greater throughput and,  
17 therefore, patients moving through in a safe and efficient  
18 way, which would enable then a shortening of the waiting  
19 list.

20  
21           Already back then, though, there were lots of people  
22 that talked about the complexities that might not  
23 necessarily mean that it would actually reduce waiting  
24 lists, but I just wanted to put in that that was the theory  
25 behind setting up funding in this way, in that the  
26 incentive with a DRG based - a diagnosis related group  
27 based activity funding is that the throughput in an  
28 efficient way is meant to be incentivised, which was then  
29 meant to lead to the throughput and therefore the reduced  
30 waiting list.

31  
32           MR MUSTON:   Again, to make sure we're on the same page in  
33 terms of what it is we're waiting for, that works in a way  
34 that at least I think I can understand if we're dealing  
35 with someone who's requiring a piece of elective surgery,  
36 where, if you are able to drive efficiency in your system  
37 and perform that elective surgery as a same-day surgery as  
38 opposed to a three-day stay surgery, or a two-day stay as  
39 opposed to a three-day stay surgery, then I can understand  
40 that that might be both more efficient and have, as an  
41 outcome, a reduction in the time that an individual might  
42 wait to receive that surgery, because there's a bed day  
43 that you've freed up there, or three bed days that you've  
44 potentially freed up there that you could have somewhere  
45 between one and three additional patients attended to.

46  
47           But that doesn't quite translate, does it, into this

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

5  
6 MR REID: That's absolutely right. And what Andrew said -  
7 people's concept back in those times was when they talked  
8 about waiting lists, they talked about waiting lists or  
9 waiting times for elective surgery. There was not the  
10 concept anywhere near as well developed or well understood,  
11 as well politicised, as waiting times for outpatient  
12 services.

13  
14 MR MUSTON: I think that brings me back to my earlier  
15 question.

16  
17 PROFESSOR WILSON: Yes, so coming to your question about,  
18 you know, the policy settings, et cetera. I mean, if you  
19 have a system, which all states and territories in  
20 Australia have, where there is, essentially, a health  
21 budget, and the Ministry of Health is expected to manage  
22 within that and its provider units are provided an amount  
23 of money to operate within that, then they've got to work  
24 out how they're going to manage to meet as much demand as  
25 they can within the system, within that system.

26  
27 So, you know, broadly, what are the things that they  
28 can do to do that? Well, yesterday we spoke a bit about  
29 prevention and we talk about the sort of issues that, you  
30 know - while we may be able to prevent some of this, it  
31 doesn't necessarily lead to a massive reduction in demand,  
32 but it may free up capacity to meet some other demands.

33  
34 More broadly, then, you've got to either aim to - you  
35 are going to try to manage that resource in there, so the  
36 other way of managing that resource is through waiting  
37 times, and so you've only got a certain number of people  
38 that you can put through, through a period of time. So for  
39 those things where, from a clinical point of view, you may  
40 be able to - there may not be as much urgency, then you'll  
41 have some sort of delays built into the system to meet with  
42 that demand.

43  
44 Or you can try and improve the efficiency of the  
45 system, and we talked about, and you've just given a nice  
46 example, where you try and reduce the length of stay and,  
47 therefore, you can increase the number of people going

1 through, recognising, however, that if you do that, there  
2 is actually an additional cost to it, but at least under  
3 activity for - at least under the NHRA part of that, you're  
4 getting 45 per cent of that back from the Commonwealth so  
5 it's not as much of a hit as it could be in that regard.  
6

7 Then you can also look at whether or not there are  
8 cheaper ways of doing things, more efficient, from that  
9 perspective, so not only just keeping people in hospital  
10 for the minimum clinically necessary period of time, but  
11 also whether or not you can actually manage them in other  
12 settings, whether you can use virtual care to provide  
13 services - those sorts of things are another way of  
14 reducing the cost of your services in that regard.  
15

16 Then, the other thing you can do is that you can look  
17 at, well, where can we share this cost? So if you can move  
18 services out of the public system into some other, into the  
19 MBS billing system, then, you know, you achieve the same  
20 end of managing within the budget you've got. So there are  
21 large incentives for managers in the health system to use  
22 all of those strategies to try and meet demand.  
23

24 MR MUSTON: In terms of the extent to which the current  
25 system and its workforce has the capacity to meet that  
26 demand, have we, for perhaps largely historical reasons,  
27 unwittingly prioritised the demand for surgical services  
28 over the demand for other forms of services, by, say,  
29 measuring wait times for elective surgery because they're  
30 easy to measure, and holding ourselves strictly to account  
31 if we --  
32

33 PROFESSOR WILSON: I'm a physician by background, so  
34 I couldn't possibly comment on that.  
35

36 MR MUSTON: I'm going to ask you to anyway.  
37

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

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

5  
6 MR MUSTON: In terms of what matters to the population, or  
7 at least a government's perception of what matters to the  
8 population - this is a little bit off topic when it comes  
9 to funding - the government, in a way, has potentially got  
10 a capacity to shape that, doesn't it, by determining what  
11 it reports on or what it invites, say, the BHI to report  
12 on, and the data that it insists its practitioners and its  
13 local health districts collect and report on?

14  
15 PROFESSOR WILSON: And I think that has been recognised,  
16 and Mick can comment on this better than I. It has been  
17 recognised at ministerial level and senior levels, that,  
18 you know, we do need to measure a broader range of issues  
19 in - a broader range of areas within the health system for  
20 exactly that reason. But Mick might want to comment.

21  
22 MR MUSTON: Mr Reid?

23  
24 MR REID: I would just support the comment of Andrew.  
25 I think governments, particularly over the past five to six  
26 years, have very much gone back and looked at some of the  
27 waiting times for outpatient services. Sometimes they're  
28 up to four or five years, existing then, and there has been  
29 an endeavour to do that, but there is no doubt there is  
30 still - you could argue that that has not received the same  
31 political attention as the political attention on elective  
32 surgery waiting times, and that still predominates, and  
33 I think the physicians who work in hospitals would argue  
34 that often they feel disadvantaged by the change in bed  
35 availability, access to theatres, access to other - focus  
36 in elective surgery rather than other activities of the  
37 hospital, to the detriment of patient care.

38  
39 So I think there would be a view around what you've  
40 said is true, but I do think there has been considerably  
41 more attention to those aspects of hospital care more  
42 recently.

43  
44 MR MUSTON: But to test the foundation, we've been told  
45 that there is a sound evidence base for the proposition  
46 that a delay in receiving your elective surgery - if you've  
47 been screened by a surgeon and it's been determined that

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

6  
7 THE COMMISSIONER: There are periods beyond which where it  
8 starts to become clinically significant.

9  
10 MR MUSTON: Let me put it another way. The thresholds  
11 that we hold ourselves to in times to surgery for elective  
12 surgery undoubtedly have an evidentiary basis?

13  
14 PROFESSOR WILSON: Look, I think in general, if you've got  
15 a disease or condition which is likely to be progressive,  
16 then the longer you wait, then the less desirable it is.

17  
18 MR REID: And we have a categorisation, Andrew, of  
19 elective surgery which has an evidence base.

20  
21 PROFESSOR WILSON: Yes. But, you know, not all conditions  
22 are the same in terms of their propensity to either shorten  
23 your life or lead to disability. So the system has  
24 a system for categorising the need to do that, and it is  
25 based on evidence, on clinical input into what would work  
26 to create those different categories for it.

27  
28 If you are a patient, sometimes that doesn't seem very  
29 fair, that you are categorised into a lower need category  
30 than others. But it is part of that way of managing  
31 demand.

32  
33 MR MUSTON: Whilst equally imprecise no doubt, an  
34 equivalent evidence based categorisation could no doubt be  
35 created for all manner of outpatient care? For example, an  
36 example we've used many times here, the paediatric  
37 intervention where a child is identified as requiring  
38 paediatric intervention, there would undoubtedly be some  
39 evidentiary basis that could be found out there to support  
40 the proposition that if they get it before they start  
41 school, the outcome will be better both in terms of health  
42 and life, than if they get it in year 4, for example?

43  
44 PROFESSOR WILSON: Yes, my understanding is that there is  
45 a triaging process for public outpatients as well and  
46 people are assessed as to their need.



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

7  
8           So I think that sort of earlier triaging is more  
9 complicated, but it is, and as far as possible, it is  
10 based on an evidentiary approach where there's some  
11 assessment of the referral letter that comes from the  
12 general practitioner, you know, in terms of, you know, why  
13 is this - what's the urgency in this particular referral.

14  
15 THE COMMISSIONER: I think that's right. I mean, that's  
16 what we've been told in our travels. But when we're told  
17 about paediatric wait lists, say, at John Hunter, for which  
18 the range was given two to five years, with a question:  
19 "How could the wait list extend to five years?" The answer  
20 is, "Because we do triage and the really critically urgent  
21 cases keep bumping back those that are at a different  
22 triage level." But that doesn't mean that waiting three,  
23 four, five years when you're three years old or four years  
24 old or five years old isn't hugely clinically significant  
25 in a bad way.

26  
27 PROFESSOR WILSON: Yes, I couldn't disagree with you,  
28 Commissioner. It is a problem. I can't speak specifically  
29 for paediatric wait lists but --

30  
31 THE COMMISSIONER: Well, getting data about --

32  
33 PROFESSOR WILSON: -- I certainly know that, you know,  
34 you've got things like developmental delay - what does that  
35 mean, for a start; and then triaging that is quite  
36 problematic. And then getting the treatment - getting to  
37 get the right assessment and then getting a comprehensive  
38 response to that is, you know, quite complex. It's  
39 certainly, potentially, a lot more complex than, you know,  
40 a waiting list for a hip replacement.

41  
42 THE COMMISSIONER: Sure, of course.

43  
44 MR MUSTON: Accepting it's more complex, though, it's not  
45 beyond the capacity of the system and the many very clever  
46 people who contribute to it to create at least some sort of  
47 a guideline as to when, informed by an evidence base,

1 someone who presents with a particular condition or is  
2 referred to a particular type of specialist to be assessed  
3 or offered some treatment --  
4

5 PROFESSOR WILSON: I'm feeling a little nervous here  
6 because you're taking me into some areas of, you know,  
7 specificity in terms of the health system, and I'm just  
8 conscious that I don't want to mislead you in terms of some  
9 of these things here. So I think some of the questions you  
10 ask are better targeted to people who deal very  
11 specifically with the sorts of areas that you are dealing -  
12 you know, that you're asking about. But in general, you  
13 know, I think this is, I feel, one of the areas that  
14 requires a lot more attention within our system across  
15 Australia. It is an area that's problematic.  
16

17 MR MUSTON: Without descending into the specifics of how  
18 long one might need to wait for a paediatrician or whether  
19 you could, in fact, set a guideline for that as opposed to  
20 a rheumatologist and the like, to the extent that it is  
21 possible to do that - it may not be but to the extent that  
22 it is possible - it's not something we're doing at the  
23 moment in holding ourselves to account as a health system  
24 in terms of our performance?  
25

26 PROFESSOR WILSON: I would say I'm nervous here because  
27 I don't know. I think you would need to ask - I would be  
28 surprised if there isn't some attempt to do that at the  
29 moment, to do - to base - to use an evidence base and  
30 guidelines to do that, but in the particular setting you're  
31 talking about I'm not - I don't know.  
32

33 MR MUSTON: Mr Reid, you might know. Are you aware of  
34 whether the BHI, for example, routinely publishes data on  
35 how long people wait to receive care through specialist  
36 outpatient clinics where it's been determined that they  
37 require it as opposed to those statistics that we see on  
38 the front page of the newspaper so routinely, for waiting  
39 times in emergency and waiting times for elective surgery?  
40

41 MR REID: We clearly, as you know, publish quite detailed  
42 information on the latter, so you're right in the sense  
43 there's the sin of omission that occurs there that we don't  
44 publish the same detail outside elective surgery for  
45 waiting times.  
46

47 There are some KPIs in the service level agreement at

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

9  
10 MR MUSTON: Or maybe more - may have a more deleterious --

11  
12 MR REID: Yes, that's what I'm saying.

13  
14 MR MUSTON: -- consequence?

15  
16 MR REID: Yes.

17  
18 MR MUSTON: As a results of the things that we're  
19 measuring and the things that we're reporting on, and those  
20 failings within the system that we're calling out - namely,  
21 a failure to meet a particular time frame with respect to  
22 elective surgery or waiting time in an emergency  
23 department - we're, in effect, prioritising those things  
24 over what might potentially be equal or even greater  
25 failings in other aspects of the public health system,  
26 because we're not measuring them and we're not calling out  
27 our failures and so the system is not incentivised to fix  
28 them, at least until they have fixed those other things  
29 that we are reporting on. Would that be a fair comment, do  
30 you think? Mr Reid, you are probably best placed.

31  
32 MR REID: My response is I think yes, what you say is  
33 correct.

34  
35 Do remember what Andrew said. I mean, this is no way  
36 to excuse it, but what Andrew said at the start is pretty  
37 critical, that the entree into elective surgery waiting  
38 times has a capacity of assessing the problem prior to  
39 getting on the waiting list in some ways, and there's a  
40 difficulty in many of the outpatient services that the  
41 problem is identified and assessed once the meeting takes  
42 place. So that element of how you prioritise has some  
43 complexities, but that doesn't mean it cannot be done or  
44 shouldn't be done, but it does have additional complexities  
45 to it.

46  
47 THE COMMISSIONER: Is there any reason, though - accepting

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

8

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

12

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

15

16 MR REID: Yes.

17

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

29

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

32

33 MR MUSTON: Yes.

34

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

41

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

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

3  
4 MR REID: Commissioner, I think - and this is a very  
5 difficult area and I'm not trying to justify it in any way,  
6 shape or form - the interface between the primary care  
7 sector and the acute care sector often plays itself out in  
8 the outpatient area in the main, so that, in some degree,  
9 just like emergency departments, it is, in some degree,  
10 a last resort or a place of alternative going for these  
11 services when there's a combination of public and private  
12 service provision for them.

13  
14 That has always been, I think - and I'm just trying to  
15 reflect upon the history of health, but it has been  
16 probably partly a determinant why there might be a far  
17 greater - a stronger focus on elective surgery waiting  
18 time, which is clearly a function of the hospital system in  
19 the public sector, as distinct from waiting times where, if  
20 you get them down considerably in the outpatient services,  
21 you might have, you know, additional demand brought about  
22 by those reduced waiting times. It's not to justify it in  
23 any way, shape or form but it might be a reality.

24  
25 MR MUSTON: But that would be because, in the particular  
26 community that is served by that local health district, the  
27 need might be greatest in that latter area, namely, the  
28 need for those outpatient services.

29  
30 MR REID: That's correct.

31  
32 PROFESSOR WILSON: Certainly I think that is one of the  
33 issues, the equity issues, that specialists are not evenly  
34 distributed, of any type, throughout the community. And  
35 particularly once you get outside of the metropolitan  
36 areas, the number of specialists falls off rapidly and so,  
37 you know, access to those services becomes much more  
38 problematic, but in exactly the same setting or situations,  
39 the availability of clinics which don't require  
40 out-of-pocket payments becomes - or access without  
41 out-of-pocket payments falls off almost in the same way.  
42 So you get the sort of double inequity there: you get an  
43 inequity of access but you also then get an inequity of  
44 also having to pay for the services anyway. So it's  
45 problematic.

46  
47 Can I just perhaps reverse the discussion slightly.

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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 if 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

1 or potentially gets them started on a treatment program  
2 earlier.

3  
4 So you have to sort of think about the whole - in  
5 changing this, you have to sort of think about the whole -  
6 what you're trying to achieve and then we can say to you,  
7 "Well, look, here are the things which will and won't work  
8 within the existing funding system to achieve what you want  
9 to achieve in that regard."

10  
11 THE COMMISSIONER: Well, if we've achieved not perfect,  
12 but a high level of, technical efficiency, which I think  
13 everyone says we have, then we want to achieve something  
14 else, and equity would be a big thing, for many reasons.  
15 Throughout our travels, particularly to the regions, but it  
16 also exists even in metropolitan areas, there is a lack of  
17 equity. So that's a big thing that would be good to  
18 achieve.

19  
20 PROFESSOR WILSON: Yes, and I think in the paper, we've  
21 sort of pointed towards some of the things which can help.  
22 Mick has his hand up.

23  
24 MR REID: Just reinforcing what was already said.  
25 I think, to go to Andrew's point, if the sole  
26 responsibility of the funding other than the NHRA is for  
27 the states to run the hospital system, then the only issue  
28 is, you know, do you put additional money in terms of  
29 keeping people out of hospitals doing that? But the  
30 funding model is really a service delivery model, as you  
31 well understand.

32  
33 And then if we have a responsibility for the health of  
34 the population, that has that fairness element, which you  
35 have just mentioned, Commissioner, coming into it, as to  
36 how that's done, and in having that, that's where we go to  
37 that discussion where we have the various options of how  
38 you balance up measurements of technical versus allocative  
39 efficiency and how do you bring them into play in a new  
40 funding model.

41  
42 But I think we would argue, probably the people on  
43 this call, and we argued in the paper, that there has been  
44 a strong focus over time which has been quite beneficial in  
45 where we got to on technical efficiency but we have  
46 probably lost some of the ground on whether we're  
47 delivering services in a fair way.

1  
2           The only problem is there to be careful we're not  
3 delivering them as a back-fill against it. How do we  
4 address the issue of whether we deliver them as a back-fill  
5 to Commonwealth absence of services, and how well do we  
6 deliver them just in terms of the use of the state funding  
7 in that, which I presume we'll come to a discussion on  
8 later.

9  
10 THE COMMISSIONER: Sure. There is a statutory obligation  
11 on the LHDs for population health that clearly extends  
12 beyond what happens in the public hospitals, where most of  
13 the focus is.

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

20  
21           We heard some evidence from Professor Eagar to the  
22 effect that New South Wales made a choice, at that point,  
23 to apply the ABF funding model as the mechanism for making  
24 funding decisions as between the ministry and local health  
25 districts, in circumstances where it did not need to do  
26 that, and I think, to summarise her view, it ought not to  
27 have done that.

28  
29           Do any of you have a view on whether a shift to an ABF  
30 model as opposed to the two-tiered model that existed  
31 before that was (a) an essential decision and, if not (b)  
32 was it a wise decision? I might ask (c): Could you  
33 practically reverse it now, even if you wanted to?

34  
35 PROFESSOR WILSON: Again, we would have some views, and  
36 I think you can probably read that into the paper. But  
37 I would caution it by saying: what is it that you want to  
38 achieve? You know. I think in the paper here we are  
39 probably saying something which keeps the benefits of  
40 activity based funding, of set pricing arrangements,  
41 et cetera, as a core element of it, is important. But you  
42 also want to provide more flexibility to respond to  
43 population need; you want to be able to address the issues  
44 of equity, and sometimes that will mean that you will not  
45 be working with the most efficient - the national efficient  
46 price, although that might be the basis under which you  
47 then - you use from and then change for that.



1  
2           So, yes, I guess we're pointing that there's probably  
3 some hybrid between what we have at the moment and other  
4 approaches need to be thought about. Yes.

5  
6 MR REID: I would add to Andrew that yes, we did have  
7 a two-tiered model which led to a decision to move to  
8 activity based funding and we've lost some of that emphasis  
9 on population based analysis, but the funding model of  
10 activity was nowhere near the sophistication as it is now  
11 under ABF.

12  
13           So we've gained a lot under ABF in getting a much  
14 better technical understanding of the service delivery, of  
15 how a hospital operates, et cetera, but I think, as Andrew  
16 said, and I think the whole team would agree, we feel we  
17 need to rebalance that in one or two ways which are  
18 suggested in the paper further on with how we retain the  
19 elements of the ABF and the technical efficiency with a new  
20 focus on - with a revitalised focus on population.

21  
22 MR MUSTON: Would it be right that a resource distribution  
23 model which, in and of itself, is going to have to be based  
24 on some formula that makes assumptions about what is to be  
25 prioritised and what's important within particular  
26 communities, is of itself not necessarily a safe mechanism  
27 to ensure you get genuine equity in the delivery of health  
28 services across a wide population?

29  
30 MR REID: Again going to the point of what you mean by  
31 "equity", but if you mean "equity" in terms of, you know,  
32 distribution on a per capita basis, weighted in some way in  
33 terms of how we utilise the funds, yes, we'll move towards  
34 that. But there is still an essential element of that,  
35 that the vast majority of our money goes into running the  
36 hospital system and we have to work out how to do that in  
37 the most efficient and effective way possible.

38  
39 PROFESSOR WILSON: Let's just say that, you know, you move  
40 to a system whereby you distributed whatever the government  
41 gave to the ministry each year on the basis of some  
42 population weighted index for each local health district.  
43 That would, at one level, at least improve the equity in  
44 terms of the distribution, but it won't address issues of  
45 the equity in the maldistribution of health workforce and  
46 accessibility to health care, because we know that if you  
47 look at, for example, the MBS data, the amount of billings

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

9  
10 But if you're going to do that, you really need to  
11 have the Commonwealth at the table to be able to say,  
12 "Well, look, you're actually underpaying for these areas" -  
13 sorry - "under-contributing for these areas. We need to  
14 have an agreement about how we have an equitable share of  
15 the health dollar in combination that goes to those  
16 communities".

17  
18 I don't think that's an implausible position to reach  
19 to. It's not going to occur instantaneously, but we have -  
20 you know, Commonwealth, through the ABF, has come to a more  
21 equitable share, I believe, in relation to public health  
22 activity, and maybe the next step is that there is an  
23 agreement in the next NHRA which is around an equitable  
24 share for those communities which are under-provisioned.

25  
26 THE COMMISSIONER: Let me ask an impossibly general  
27 question. If the focus is "What do you want to achieve",  
28 and accepting that we're always going to need public  
29 hospitals to provide acute care, and that's just a given,  
30 and that elective surgery lists have to be dealt with and  
31 all those sorts of things in terms of traumatic injury,  
32 elective surgery services and disease that's acute, but -  
33 and we also want an equitable system which isn't just value  
34 for money but has, at least in my mind, some form of  
35 justice, beyond that, what is the most significant thing we  
36 want to achieve?

37  
38 Is it that, in a more general way - because chronic  
39 disease is so important, is it that we provide services,  
40 and perform actions, some of which can't be only from  
41 health, picking up yesterday on prevention, that narrow the  
42 number of years that the population generally has in ill  
43 health, on the basis that it seems that the most amount of  
44 money we spend in the system is on the elderly that are  
45 unwell? Or is there some other thing we should be aiming  
46 for? This is a question for all of you.

47

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

3  
4 THE COMMISSIONER: Yes. I said it was an impossibly broad  
5 general question.

6  
7 PROFESSOR WILSON: The first thing I would just say, it  
8 always concerns me a little bit when people start to sort  
9 of focus on the fact that so much expenditure goes on in  
10 the last years of life. Of course it does, because that's  
11 when people get sick. So, you know, while we can more -  
12 I think we don't necessarily use the - we could use the  
13 money better in that period in those last couple of years  
14 of life, in that regard, that there's, I think, a lot of  
15 low-value care which is provided in that period of time, it  
16 is inevitable that there will be more money - that the  
17 healthcare system will be spending more on that group than  
18 it will on others.

19  
20 I think my view is that what we're aiming to do is,  
21 with any finite amount of money that we have, what are the  
22 best options in respect of investment across all the things  
23 that we can do to achieve optimal health outcomes for the  
24 community and address issues in inequity in health outcomes  
25 which exist at the present time, and, sorry, in health  
26 outcomes but also in health more generally in that regard.  
27 That's just a philosophical basis under which I work in  
28 trying to achieve that.

29  
30 Now, we are stuck with a system which has, you know,  
31 bodies which - as you quite rightly said, we need to have  
32 those hospitals there, they have a fixed cost and, you  
33 know, we've got to live with that because they provide it.

34  
35 Then it becomes, well, actually, how do we efficiently  
36 utilise that resource in that, whilst still trying to meet  
37 the other objectives - the broader population health  
38 objectives and trying to balance out in those areas.  
39 That's why that focus on efficiency and that particular  
40 parameter, I think, is exceedingly important, because it  
41 consumes a very large - they are expensive to run and so we  
42 need to be absolutely clear that they are being run as  
43 efficiently as possible and being used as appropriately as  
44 possible, because they are just about the most expensive  
45 thing that we have in the health system to achieve that.

46  
47 So I think there are good reasons why we should focus

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

7  
8 MR MUSTON: Could I ask, when you use the term  
9 "appropriateness of care" in that hospital setting, what  
10 you have in mind?

11  
12 PROFESSOR WILSON: So we don't want people being admitted  
13 to hospital when they could be managed in an equally  
14 effective way in a less expensive environment. Note I said  
15 "equally effective" environment. So, for example, it used  
16 to be, when I started in medicine, quite normal for people  
17 to be admitted to hospital for back pain; right? Now, we  
18 know that, in fact, there is good evidence to suggest  
19 that's not how you should manage back pain. There should  
20 be a minimum number of people. There will always be some  
21 people who will need to be in hospital for that condition,  
22 but most people can be managed outside of that. So that's  
23 sort of an example of what I'm talking about.

24  
25 MR MUSTON: In terms of the appropriateness of what is  
26 offered in hospitals, is there also a need, perhaps, for  
27 there to be closer consideration given - in a system-wide  
28 level - to what is offered where? And so, for example,  
29 ear, nose and throat surgery, just as an example. Each  
30 local health district might be seeking to offer that  
31 surgery in each location they think they can find an ear,  
32 nose and throat surgeon who will deliver it. Maybe that's  
33 legitimate and justified having regard to population need,  
34 maybe it is not. But does there need to be some  
35 consideration given to the rationalisation of the way in  
36 which certain care is delivered through our hospitals so,  
37 as part of an overarching prioritisation of what is it  
38 we're going to do with this limited budgetary envelope,  
39 we're not spreading it too thin and trying to do everything  
40 for everyone but not really doing all of it as well as we  
41 possibly could?

42  
43 PROFESSOR WILSON: Again, there are different elements in  
44 terms of what you're saying there. There have been -  
45 people have made the case, and there have been experiments  
46 of saying, "Okay, there are certain types of procedural  
47 medicine that you can most efficiently do if you actually

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

7  
8 But almost always, when you do that, you're  
9 centralising that service in some way, so you're  
10 disadvantaging people in rural and remote areas, or  
11 regional centres, if you're really going to the sort of  
12 high-volume set-ups in relation to it.

13  
14 There is also a question around whether that  
15 unbundling of different - sorry, of teasing apart different  
16 types of surgical or procedural services leads to different  
17 types of care being provided in different settings. That  
18 may or may not be appropriate.

19  
20 The others may want to comment on that as well.

21  
22 DR McNAMARA: Can we just go back to the Commissioner's  
23 question a few moments ago.

24  
25 MR MUSTON: Before we come back to that question, can  
26 I just finish on --

27  
28 THE COMMISSIONER: I wanted to go back to it, but we'll  
29 get there.

30  
31 MR MUSTON: We will go back to it. I assure you we will  
32 go back to it.

33  
34 Just on the issue, for example, of the cataract  
35 surgery that you referred to, with the level of  
36 centralisation, you say, you will always disadvantage  
37 people in more rural and remote areas, that's because they  
38 will need to travel to obtain that procedure, whereas  
39 someone who might serendipitously live in the centre where  
40 it's being provided will not need to travel.

41  
42 PROFESSOR WILSON: Yes, it is a trade-off, basically, in  
43 terms of, you know, what happens in relation to that.

44  
45 I mean, the other reason you centralise things is  
46 where you can demonstrate that volume is related to  
47 outcomes. It's not - it's frequently quoted but in actual

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

8  
9 For those sorts of things, I do sort of question  
10 whether or not it is actually appropriate to provide those  
11 things in places in which you are doing low volumes because  
12 you are probably disadvantaging the patient, the person  
13 with the condition, when you do that.

14  
15 MR MUSTON: Higher volumes also have the capacity,  
16 potentially, to produce efficiencies which might not be  
17 able to be captured if you're doing smaller volumes of the  
18 same procedure in an array of different locations.

19  
20 PROFESSOR WILSON: Yes, you might have models of doing it  
21 which are more efficient.

22  
23 MR MUSTON: In the context of a limited budgetary  
24 envelope, for every winner, there's going to be a loser in  
25 the health system, in a sense, that if you, say,  
26 centralised, perhaps not to a single centre, but if you  
27 created hubs across the state that did, hypothetically,  
28 this cataract surgery and you provided - well, let me take  
29 it in steps.

30  
31 To create hubs that provide our hypothetical cataract  
32 surgery, in order for that to remain accessible to everyone  
33 and create that equity that is required, you would need to  
34 ensure that there was appropriate patient transport.

35  
36 PROFESSOR WILSON: People could get there. Transport  
37 there and accommodation while they're there and  
38 recognising, you know, for some people that will be  
39 problematic. Cataract surgery is probably not a good  
40 example. It is pretty easy.

41  
42 MR MUSTON: Day surgery.

43  
44 MR REID: Radiation therapy would be a good example of  
45 that, I think

46  
47 PROFESSOR WILSON: Well, yes. In part that's driven

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

3  
4 I mean, radiation therapy is an interesting example of  
5 a successful government program, in that we had highly  
6 centralised, highly centralised, radiation services.  
7 Queensland was - there were two places in Queensland you  
8 could get radiation therapy when I was training. New South  
9 Wales was somewhat better when I first came here, but it  
10 was still highly centralised.

11  
12 We now provide radiation therapy, it's available in  
13 most regional centres in New South Wales, and other  
14 services are continuing to open up. Now, some of that has  
15 been about technology improvements, but a lot of it has  
16 been about the funding model which has promoted the  
17 proliferation, you know, of these services, and they are  
18 closer to home so people haven't had to travel as much for  
19 their therapy.

20  
21 It is also an interesting example of the issues around  
22 co-payments and equity issues, because most of that  
23 proliferation has actually occurred in the private sector  
24 and that means that many patients haven't - you know, are  
25 being charged co-payments for access to it, and that can be  
26 problematic.

27  
28 MR MUSTON: From an equity and accessibility point of  
29 view, decision-making around what could be centralised and  
30 delivered through a hub or what should be delivered in a  
31 more disparate array of locations will, of course, be  
32 informed by a range of factors including how often you need  
33 to get it.

34  
35 PROFESSOR WILSON: The other aspect of this is, if we want  
36 to maintain services in regional centres, some of these  
37 less complex things are an essential part of the business  
38 model for proceduralists there. So, you know, if you say,  
39 "We're going to do all our cataracts in Newcastle for the  
40 Hunter New England area", that's a problem for those  
41 regional centres if they want to try to keep ophthalmology  
42 services locally, because that's basically what is bread  
43 and butter for ophthalmologists. So you do have to think.  
44 Sometimes you can have perverse consequences for what it  
45 seems may improve patient access - may improve patient  
46 access - but it may actually lead to, you know, loss of  
47 other services because they are tied to that. So it's not

1 straightforward.

2

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

5

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

19

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

30

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

38

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

45

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



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

6  
7 MR REID: I can't see Andrew, so I don't know if he is  
8 responding, Commissioner.

9  
10 THE COMMISSIONER: He was nodding vaguely, I think.

11  
12 MR REID: That would be right. Look, I will put my two  
13 bobs' worth in. It is a very complex question, but I would  
14 have thought that this Commission of Inquiry - I presume,  
15 Commissioner, that you are not recommending significantly  
16 greater or less determination by government as to what  
17 occurs into the health budget and --

18  
19 THE COMMISSIONER: Well, I don't think it's up to an  
20 inquiry like this to start talking dollars.

21  
22 MR REID: No, and that's what you said --

23  
24 THE COMMISSIONER: You know, that really is a matter for  
25 executive government as to what they spend.

26  
27 MR REID: Exactly.

28  
29 THE COMMISSIONER: You can say, "You should do this  
30 service, you should do this in prevention", and that might  
31 mean money has to be spent on that if they adopt the  
32 recommendation, but I certainly don't think it is part of  
33 this Inquiry to say, "The health budget should be  
34 40 per cent, not 33 per cent" --

35  
36 MR REID: Correct.

37  
38 THE COMMISSIONER: -- "or X dollars" - you know (a) we're  
39 not set up to do that; but (b) I just don't think it is  
40 appropriate.

41  
42 MR REID: Yes. And so the answer to your question as to  
43 what we can do, you're doing it within the envelope of  
44 whatever budget is determined by the government of the day  
45 and the contribution of the Feds to what constitutes that  
46 health budget, and we know that currently, you know,  
47 globally, it's running mid-level OECD; globally, it's not

1 changing too much in that pathway, where it sits as  
2 a percentage of Australia's budget that goes into health.  
3 But I think the pathway you are going - and this is not  
4 meant to be gratuitous advice, but I think the pathway  
5 you're going in terms of can we expend the existing amount  
6 of money in a way that fulfills the requirements of the  
7 legislation as to what NSW Health is about, maybe creates  
8 greater incentives on prevention and health promotion and  
9 ways of keeping people out of hospital, and at the same  
10 time, shows that the way we're distributing these funds  
11 moves to greater or lesser fairness in the allocation of  
12 money, seems to be the end game of where you are heading.  
13

14 I think there's a whole array of other things. There  
15 are things about whether you can achieve greater  
16 efficiencies through greater centralisation of some of the  
17 clinical services. I'm not too sure, you know, the pain is  
18 going to be worth the gain in a lot of those areas and much  
19 of that might go against the notion of equity as well,  
20 because, as Andrew said, you want to build up those  
21 regional centres that might be marginal, some of them, not  
22 the high-level tertiary services that will always be, you  
23 know, in a major tertiary hospital, but you want to build  
24 up that full scope of practice for clinicians working in  
25 regional centres in order to promote equity.  
26

27 So I think, you know, it's a complex question, but if  
28 your answer is not to determine the budget, I think the  
29 answer is to determine how can you best use the existing  
30 budget in a way that takes the pressure off some of the  
31 health systems in ways that's probably not being done as  
32 well as possible at the moment.  
33

34 DR McNAMARA: Commissioner, I just want to flag, there's  
35 a connection back to the discussion on Tuesday here as  
36 well, I think, about how well this system is equipped to  
37 innovate and drive change at a sort of local level as well,  
38 and what support structures need to be available to do that  
39 better. Because a lot of what we've talked about today  
40 is --  
41

42 THE COMMISSIONER: I think there is a link between that  
43 and I think there is a link between yesterday to today,  
44 yes.  
45

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

1  
2 A/PROF HUCKEL SCHNEIDER: I would contribute and emphasise  
3 that we obviously - moving towards the goal of equity so  
4 that more people can live longer, and larger parts of their  
5 lives that are healthy, and most certainly there is - you  
6 know, there's the broader contextual reasons for what are  
7 the determinants of health and then you move into realms  
8 like we're talking about here, that range from the health  
9 promotion and the prevention and the screening type  
10 activities. But there's a large chunk in the middle  
11 between the prevention, screening, promotion and the acute  
12 care, which is ensuring that people get access to care  
13 early.

14  
15 I actually think the discussion we were having right  
16 at the start of this session went to the heart of that,  
17 which is getting access to that next step after a primary  
18 care visit or a screening. That is where we have this  
19 complex middle between Medicare benefits schedule funded  
20 services and those that are then serviced through various  
21 different financing models as outpatient services. We do  
22 have a lot of people that still find it difficult to  
23 navigate that pathway between the different types of  
24 services that are offered in different locations under  
25 different models, and ultimately funded through different  
26 modes within our health system.

27  
28 Being able to enable access in a way that makes sense  
29 to people, in a way that they are comfortable with and  
30 a way that they can navigate and in a way that they can  
31 afford, shifts care to the early detection, early  
32 management, links, then, to prevention, and links in to  
33 being able to watch and monitor individuals as their health  
34 changes over time, with the goal of having a much later  
35 stage in life when they might be having those acute care  
36 needs.

37  
38 That does require that ability to be able to innovate  
39 and shift to ensure that that access is available, and it  
40 comes back to several things that we wrote in the paper  
41 about it being necessary to identify in various different  
42 local regions where is the capacity to make sure that there  
43 are no gaps in that journey, where are there additional  
44 needs to be able to close those gaps in that journey? And  
45 that's where the thought to moving towards a system that,  
46 firstly, maps but then also recognises and then takes steps  
47 towards equity to make up for where that gap between those

1 services actually needs to be closed.

2  
3 PROFESSOR WILSON: I think all state and territory  
4 governments are concerned, actually, that the proportion of  
5 their money, of their funds, which are going on health is  
6 actually increasing as a proportion, and as you quite  
7 rightly point out, that's going to be at the consequences  
8 of other service areas, and so what's the broader  
9 expression of what that's about?

10  
11 I mean, I think in thinking about - one also needs to  
12 recognise that health infrastructure and health services  
13 have a broader implication in the communities where they  
14 are.

15  
16 I've had the unpleasant experience of having to tell  
17 a small community that we were going to close their  
18 hospital, and the consequence of closing that hospital was  
19 that we'll probably lose the bakery, because they were  
20 providing that - the butcher and other employment  
21 positions. This was in a situation where we had already  
22 established other health services which were going to meet,  
23 you know, most of the local needs.

24  
25 So there is a question here, a broader sort of social  
26 infrastructure support that health and health care brings  
27 to communities, that are also part of thinking about what  
28 we do and how we do it, which goes beyond just providing  
29 the healthcare services itself.

30  
31 I can see Kees has his hand up there, Commissioner.

32  
33 PROFESSOR VAN GOOL: Yes, so I was just going back to your  
34 question, Commissioner, about the more general efficiency  
35 questions. I think, you know, Australia is no different to  
36 anywhere else, but we tend to sort of, in health care, find  
37 the institution and then find ways to fund it. And there  
38 are, you know, really strong evidence bases, data and  
39 governance structures, as Andrew, everybody knows, around  
40 the PBS and around the MBS and around the NHRA and hospital  
41 funding, whereas that systematic way of thinking about it  
42 in terms of prevention is perhaps a little bit lacking in  
43 that sense.

44  
45 So without that sort of institutional kind of backing  
46 that comes alongside the evidence and the data, prevention  
47 might always fall a little bit behind because of those

1 different - the disparity in those institutional factors.

2

3 THE COMMISSIONER: Yes.

4

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

15

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

23

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

36

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

45

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

1 reason because they've become - you know, their behaviour  
2 has become problematic or some other reason, or they got  
3 unwell.  
4

5 MR MUSTON: What is the real impediment there? The first  
6 point is there's, in terms of the funding as between the  
7 state and the Commonwealth, an array of different ways in  
8 which that's delivered, so we've got ABF funding through  
9 the NHRA, there's some block funding through the NHRA,  
10 there's MBS funding, there's potential aged care funding  
11 through that system, and then you've got other grants and  
12 general GST, Grants Commission money. Is that one of the  
13 impediments, just the complex and disparate array of ways  
14 in which what is essentially the same bucket of money is  
15 passed from the Commonwealth to the state?  
16

17 PROFESSOR WILSON: Yes, and, you know, the more sort of  
18 different streams you have, the more problematic it is to  
19 manage them, the more inefficiencies you see.  
20

21 I mean, the Aboriginal controlled medical services  
22 have had this problem for a long period of time, that  
23 they've had these streams of funding coming from different  
24 sources, and they're a fantastic example of how you manage  
25 under those sorts of streams - so bringing these funds  
26 together for the best outcomes for it. I mean, they're  
27 a model for what --  
28

29 THE COMMISSIONER: Not without struggle, though.  
30

31 PROFESSOR WILSON: They're a model for what primary health  
32 care could be like if we had a better integrated approach  
33 to allowing the pooling of these funds once they reach  
34 a particular point.  
35

36 There are some examples of that being done between the  
37 Commonwealth and the state in different locations, and what  
38 we now need to try and see is a bit more scaling up of  
39 that.  
40

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

1 is part of the strength of that model.

2

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

5

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

10

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

21

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

27

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

43

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

47

1 THE COMMISSIONER: Last resort.

2

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

5

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

11

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

24

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

36

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



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

7  
8 PROFESSOR WILSON: I think it would be useful to ask  
9 Carmen to comment a little bit on the work that she has  
10 been involved in commissioning, which is another way of  
11 addressing this, but before I ask her to do that, if you  
12 don't mind, I just want to address that last question,  
13 because it was on my list of things to say --

14  
15 MR MUSTON: Yes, please do.

16  
17 PROFESSOR WILSON: -- because it comes back to our earlier  
18 discussion about specialist clinics. You've heard a lot of  
19 testimony about patients being seen in emergency  
20 departments who really should be seen in general practice,  
21 and you've heard the tension there is with the emergency  
22 physicians who say, "Well, that's nonsense, these patients,  
23 you know, are complex patients, they need the sort of care  
24 that we can provide here. They're never going to be  
25 managed", and that. We have the urgent care clinics that  
26 will address some of those patients - whether it impacts on  
27 emergency waiting times I don't know. But what I do feel  
28 is that some of those complex patients that they're talking  
29 about, if they were being properly managed in ambulatory  
30 specialist services, that you could actually do a lot more  
31 about keeping them away from emergency departments.

32  
33 So they may not be preventible in the sense that GPs  
34 can do something about it, but I think if they're getting  
35 good care from the right specialist, whether it's  
36 a geriatrician or whether it's a general physician or  
37 other, depending on their condition, then I think there is  
38 a lot more that could be done to keep some of those  
39 patients out. So I do think there is this link which  
40 hasn't been well identified in relation to that particular  
41 aspect of demand.

42  
43 MR MUSTON: Your observation that urgent care clinics  
44 might not be doing much in terms of waiting times, can  
45 I just quickly unpack that?

46  
47 In terms of the waiting times which are published --

1  
2 PROFESSOR WILSON: I didn't say that. I don't know the  
3 answer to that. I don't think we know the answer yet  
4 because there hasn't been an evaluation of the urgent care  
5 clinics. They are certainly going to - they're certainly  
6 looking popular, they're certainly meeting a need. Whether  
7 they're meeting a need which is patients who would have  
8 otherwise gone to hospital, I don't know yet. The  
9 evaluation is not there.

10  
11 MR MUSTON: I think, Professor Huckel Schneider, we were  
12 going to come to you, but before we do, I just note the  
13 time.

14  
15 THE COMMISSIONER: Yes, we might have a break.

16  
17 To those of you online, I think it's easier to stay on  
18 the link, but we'll take a break until 12. So go and have  
19 a cup of tea or coffee or whatever you want. We'll come  
20 back at 12. So we'll adjourn until then.

21  
22 MR MUSTON: The individuals who you can't see who are  
23 frantically typing down everything that we say very  
24 quickly, for their physical health and sanity, need to be  
25 given the opportunity to have a break.

26  
27 THE COMMISSIONER: All right. We'll come back at 12.

28  
29 **SHORT ADJOURNMENT**

30  
31 MR MUSTON: Associate Professor Huckel Schneider, I think  
32 you were about to tell us about some work that you've been  
33 doing which feeds in to the matters that we were discussing  
34 before the adjournment.

35  
36 A/PROF HUCKEL SCHNEIDER: Thanks. Yes, I think this is,  
37 in part, a reflection on some evaluative work that we've  
38 been doing looking at the regions. We were talking earlier  
39 about the challenges of the health system for people in it  
40 navigating that space between primary care and Medicare  
41 benefit services, and those that are provided through the  
42 hospital networks.

43  
44 What we see is that in order to be able to put the  
45 focus on living healthier longer, and trying to reduce the  
46 extent to which people end up with acute care needs earlier  
47 in life than they really should be, we often have

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

10  
11 So these barriers can be distance barriers; these  
12 barriers can be simply availability because all of those  
13 services are full up and have waiting lists themselves or  
14 have closed their books; they can be cost barriers; and  
15 they can also be knowledge barriers, because the system can  
16 be very complex and it's difficult to know exactly what  
17 services are available for any individual when the need  
18 particularly arises.

19  
20 The extent to which there are both needs for those  
21 kinds of services and to which there are barriers to those  
22 kinds of services, so, you know, accessing spirometry, for  
23 example, or getting access to a cardiologist -  
24 paediatrician is another one that is often cited, diabetes  
25 educators is another one that's often cited,  
26 endocrinologist is another one that's often cited - is  
27 often hidden, certainly hidden at a broader planning level  
28 but is often even hidden within local areas and local  
29 systems.

30  
31 This is why one of the - a couple of the points that  
32 we made in the paper really emphasise considering the  
33 possibility of better mapping and allocating according to  
34 need, but also consideration of decision-making shifting to  
35 local levels, where there is joint decision-making, joint  
36 mapping and joint identification of what are not only the  
37 needs of the population of each region but what are the  
38 specific gaps and barriers to accessing that point between  
39 primary care and hospital care.

40  
41 There are a range of different - you know, there have  
42 been some experiments done in developing local joint  
43 decision-making mapping and review, and a range of  
44 different solutions that have been sort of born out of  
45 these kinds of experiments. They include things along the  
46 lines of lifting primary care to top of scope with capacity  
47 building that can come through a range of different ways,

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

7  
8 Also, various different embedding models, where  
9 various different wrap-around services would be embedded,  
10 potentially as an outreach type of service, into  
11 multipurpose services or into primary care clinics.

12  
13 So we do see that there is sort of a lot of different  
14 locally - local-level modes to try and fill that kind of  
15 gap through various different arrangements. The way that  
16 they emerge I think is a bit of an indicator of what are  
17 the barriers that need to be worked around. So that  
18 includes, you know, the time, the distance, the  
19 willingness, but also the knowledge of the gaps so that  
20 there can be some joint decision-making at local levels  
21 about which gaps need to be closed - service-type gaps  
22 needs to be closed. And then how that is arranged in terms  
23 of funding and financing is often very much a product of  
24 what is available, what would be acceptable to largely  
25 private providers in order to be - to move into an  
26 arrangement for payment, whether that be as a VMO in an  
27 outpatient clinic or whether that be having an ease of  
28 arrangements so that it's efficient to tap into MBS  
29 schedule funding for services, and they're always the  
30 backdrop of these local-level solutions.

31  
32 MR MUSTON: Does that really point to a need for  
33 a somewhat wider scope of needs assessment and planning  
34 than what might be a somewhat facility-focused approach  
35 currently taken, at least in some local health districts?

36  
37 A/PROF HUCKEL SCHNEIDER: So I would say it certainly  
38 points to a need for a broader needs assessment that  
39 includes not only population characteristics but also the  
40 mix of availability of services and professions across not  
41 just those within hospital network realm but also those  
42 that are more broadly available across primary care, but  
43 also specialist care. And so much now of which doesn't  
44 neatly fit into primary, specialist or hospital care, as we  
45 have people with complex needs and we're becoming more  
46 aware of broader determinants, and that includes mental  
47 health, it includes drug and alcohol, it includes domestic

1 violence services, it includes family and children  
2 services, it includes allied health and physical therapy  
3 types of services.  
4

5 So a more comprehensive mapping would look at that  
6 broad array and I think that there are structural  
7 challenges to doing that because we have, effectively,  
8 these split systems.  
9

10 MR MUSTON: So if we start from the mapping, we're talking  
11 about, essentially, identifying as a starting point the  
12 populations within a particular catchment's need for health  
13 services, and I gather from what you tell us that that's  
14 something first best done at a local level. Would that be  
15 right?  
16

17 A/PROF HUCKEL SCHNEIDER: Yes, so I would say there would  
18 be a need for a mix. So we get data about our health  
19 system and data about our population and its needs from  
20 a lot of different sources, and so the data collection  
21 capacity, purely at a local level, I would say, would be  
22 partly limited, but there are also a lot of insights around  
23 actual service patterns and availability and ways of  
24 working that would only be captured at a local level, which  
25 would supplement broader population level data.  
26

27 MR MUSTON: So going back to a comment you made earlier  
28 about hidden need, you can have your more centralised data  
29 collection around demographic data, census data, service  
30 use data across the spectrum, which will give you some  
31 picture of need, but that won't necessarily tell you about  
32 the need that might be out there that's not being picked up  
33 because people are not filling out their census or they're  
34 not accessing health services when they should be, for  
35 example?  
36

37 A/PROF HUCKEL SCHNEIDER: Yes, that's right. I think it  
38 can be very difficult to capture from the broad data, for  
39 example, on service use, reasons why the service use  
40 patterns are the way that they are.  
41

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

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

14  
15 PROFESSOR WILSON: Yes, so there is the identification of  
16 need, and some of the health districts have done this very  
17 well, doing exactly what you say, bringing together those  
18 different datasets to give a mapping of what's there. Then  
19 there is the process of priority setting within those  
20 needs. At the moment, that's really a fairly obscure  
21 process.

22  
23 MR MUSTON: Can I come back to the first point, just  
24 before we move to the priority setting? That sophisticated  
25 collaborative identification of the need, which you say  
26 some local health districts are doing well, that's  
27 fundamental to planning a health system which delivers on  
28 anything.

29  
30 PROFESSOR WILSON: It is fundamental to population health  
31 planning. You have to do that, you have to understand your  
32 population health need before you can do population health  
33 planning of health services.

34  
35 MR MUSTON: Because we're about to move to the next step,  
36 I use the word "prioritisation": it's not possible, in any  
37 meaningful or sensible way, to prioritise the delivery of  
38 health services if you don't have that core understanding  
39 of what the underlying need is that you are seeking to meet  
40 through the exercise of prioritisation.

41  
42 PROFESSOR WILSON: And those priorities - they're not just  
43 driven by some metric of health need, they're also  
44 recognising other needs that a community have like, you  
45 know, having emergency services available, right? It may  
46 not actually - if you measured it, it may not actually look  
47 like it's a high need, but clearly, every community wants

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

3  
4 MR MUSTON: Just sticking with step one momentarily, is  
5 there anything about the existing funding arrangements or  
6 structural arrangements within the public health system in  
7 New South Wales which inhibits that needs assessment, the  
8 collaborative needs assessment, which ideally, in  
9 fact almost essentially, needs to take place?

10  
11 PROFESSOR WILSON: I think Mick wants to say something.

12  
13 MR MUSTON: Mr Reid?

14  
15 MR REID: To answer the question, I think it is variable.  
16 Ideally, this is done between PHNs and LHDs. New South  
17 Wales is very blessed to have its boundaries of PHNs  
18 somewhat conterminous with the LHDs. It varies from LHD to  
19 LHD and PHN to PHN as to how collaborative that approach  
20 is.

21  
22 MR MUSTON: Why is that?

23  
24 MR REID: There might be a boundary issue or it might be  
25 an issue of the personalities involved or it might be an  
26 issue of some LHDs are almost exclusively focused on their  
27 hospital system, understandably, for the reasons that  
28 Andrew spoke about earlier, you know, in terms of the  
29 quantum and volume.

30  
31 MR MUSTON: Having regard to the fundamental importance of  
32 this mapping exercise to the delivery of a health service  
33 which adequately and equitably meets the needs of  
34 a population, is there anything that could or should be  
35 changed about either the funding structures or the  
36 governance structures within NSW Health that would enable,  
37 if not require, that to occur?

38  
39 MR REID: I think there is an agreement now between  
40 NSW Health and the PHN collective in New South Wales that  
41 will move to much more developed conjoint planning  
42 processes, but I do think it would benefit from a push into  
43 how that is done. And there are still some barriers in  
44 terms of access to Commonwealth data around some of those  
45 issues, around MBS, et cetera, and the use of marrying that  
46 into the needs collection. But fundamentally, there is  
47 absolutely no reason why there couldn't be conjoint PHNs,

1 LHDs, health needs assessments done from the existing  
2 datasets.  
3  
4 MR MUSTON: Would you accept that whilst PHNs and LHDs are  
5 probably some of the key players in that process, there's  
6 a critical role to be played from one community to another  
7 by a range of other providers or observers of the health of  
8 a population, including, for example, Aboriginal community  
9 controlled health organisations?  
10  
11 MR REID: Correct.  
12  
13 MR MUSTON: Aged care providers within a region,  
14 et cetera?  
15  
16 MR REID: Correct.  
17  
18 PROFESSOR WILSON: And local councils are important, you  
19 know.  
20  
21 MR REID: All of those. Yes.  
22  
23 MR MUSTON: So step one, if we get that right, we get our  
24 identification of the needs of the population - sorry,  
25 Professor Van Gool, did you want to contribute in relation  
26 to that - the needs assessment step?  
27  
28 PROFESSOR VAN GOOL: No, I think just to your question  
29 about whether there are current funding barriers to doing  
30 that.  
31  
32 MR MUSTON: Yes.  
33  
34 PROFESSOR VAN GOOL: I think the Commonwealth and state  
35 aspects still are a driver here as well. Under the NHRA,  
36 it's 45 per cent contribution from Commonwealth, whereas  
37 it's 100 per cent under the MBS. So there is still that  
38 discrepancy between funding sources, depending on where you  
39 can shift your costs to, in particular in the non-admitted  
40 space.  
41  
42 PROFESSOR WILSON: But I think your question is: are  
43 there any financial barriers to doing the joint planning?  
44  
45 MR MUSTON: Yes.  
46  
47 PROFESSOR VAN GOOL: No.



1  
2 PROFESSOR WILSON: There are no financial barriers to  
3 doing that, and local health districts are encouraged to do  
4 so, and there is increasingly infrastructure in New South  
5 Wales to achieve that. There is a new data system which is  
6 being developed jointly with PHNs which will produce unique  
7 data - which is producing unique data on what is happening  
8 in PHN, in primary care and particularly general practice  
9 relative - you know, which is not available elsewhere.

10  
11 MR MUSTON: Just picking up on an observation you made  
12 earlier, Professor Wilson, in relation to the role that  
13 local government might have in that planning, is it right  
14 for me to read into that that local government, as in  
15 effect a representative of the community that's being  
16 served by the health services within a particular area, is  
17 a key conduit which would enable the community to be part  
18 of this needs analysis as well as, and perhaps moving into  
19 the planning part, but --

20  
21 PROFESSOR WILSON: I think this comes to my earlier  
22 comment about health care. Health services have other  
23 implications for communities but, you know, I think they  
24 are locally elected officials who, you know, represent  
25 views within their communities and I think that they're an  
26 important part of it. But also, you know, when you go -  
27 I don't want to revisit yesterday's discussions, but in the  
28 prevention space, they can be very important partners in  
29 prevention.

30  
31 MR MUSTON: It might sound a bit glib, but particularly in  
32 relation to something as important as the delivery of  
33 health care, doing that, performing that exercise with the  
34 community that's being served as opposed to doing something  
35 to the community or for the community that's being served  
36 is a subtle but fairly important one?

37  
38 PROFESSOR WILSON: It can be quite - look, I think they  
39 have to be seen as part of the stakeholders and need to be  
40 involved in the planning process. I mean, I think  
41 sometimes that can actually add a level of complexity, but  
42 I don't think they can be ignored.

43  
44 MR MUSTON: Associate Professor Huckel Schneider, before  
45 we get into the planning and prioritisation --

46  
47 A/PROF HUCKEL SCHNEIDER: Yes. I just wanted to emphasise

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

7  
8 There's a big difference between what LHDs can know  
9 about services that they offer, because they are part of  
10 the health district and they come under one umbrella. It  
11 is more challenging to be able to map services that are,  
12 effectively, in the community sector, and it can be very  
13 consequential when there are changes in even just the  
14 offerings of a few services, particularly in rural and  
15 remote locations.

16  
17 The closing of an allied health centre can  
18 dramatically change the available services, or the closing  
19 of a cardiology service or a respiratory physician leaving  
20 a district, for example, can actually hugely change the  
21 landscape of service availability.

22  
23 So while, you know, there is already a lot of work  
24 being done working together between PHNs and LHDs in  
25 understanding population needs, it is actually quite  
26 difficult and needs a really good local knowledge to  
27 understand what kinds of clinics are offering what kinds of  
28 services and who has books open and who has what kinds of  
29 wait lists, if we're going to then take that equity lens to  
30 be able to think about filling the gaps that do exist.

31  
32 MR MUSTON: So complex as an exercise to start with;  
33 dynamic, because things constantly change, for reasons  
34 including those that you've just alluded to, people  
35 retiring, people moving; and inherently place based. Would  
36 that right?

37  
38 MR REID: Yes. Commissioner, just one other thing, if the  
39 outcome of the Commission's Inquiry is to emphasise the  
40 role and responsibilities of LHDs in population health,  
41 that's a strong incentive for the LHDs being stronger  
42 involved in a needs assessment of the population base and  
43 the sequelae of that.

44  
45 MR MUSTON: That complex and local task, to be done  
46 properly, requires FTE locally, as in warm bodies who are  
47 local and actually actively and perhaps constantly engaged

1 in the process of assessing, monitoring and mapping the  
2 needs that a particular community has from one day to the  
3 next, in respect of its health; is that right?  
4

5 PROFESSOR WILSON: It has to be recognised that it has  
6 a resource consequence if you're going to do it and if  
7 you're going to do it properly but, you know, as I say,  
8 most local health districts are doing some level of  
9 planning and in some cases quite sophisticated  
10 arrangements. I mean, as Carmen's flagged, it can be quite  
11 complicated - it can be quite complicated to capture what  
12 actually - so having a service or a specialist or something  
13 present is quite different to what service is that able to  
14 actually address, if it doesn't --  
15

16 MR MUSTON: And for whom?  
17

18 PROFESSOR WILSON: If it is a specialist who doesn't  
19 bulk-bill, immediately there is a barrier in terms of what  
20 service level they might do. But that doesn't stop you  
21 from planning and recognising that gap in that regard.  
22

23 MR MUSTON: But from a resourcing point of view, that  
24 person or group of people who are involved in that task are  
25 not generating any activity which might be captured by more  
26 traditional activity targets that are set out or  
27 established under service level agreements or the NHRA,  
28 I assume - there is no NWAU for planning?  
29

30 PROFESSOR WILSON: I mean, the districts don't have to do  
31 it alone. There is capacity within New South Wales, very  
32 good capacity, to help with that planning, you know, to  
33 provide some of the technical support and expertise, and it  
34 is probably better provided in that way in the same way as  
35 we are talking about efficient use of resources. Some  
36 aspects of it will probably be better done through the  
37 ministry, supporting the local health districts in that  
38 planning task.  
39

40 MR MUSTON: So done perfectly, it requires some allocation  
41 of resources to the planning exercise, both centrally and  
42 locally, and as to which of those two branches does what  
43 most of efficiently, that's going to depend on what  
44 information is available to them respectively and best  
45 placed to know that are those people who sit in those two  
46 locations.  
47

1 PROFESSOR WILSON: Yep. That's my view.

2

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

13

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

29

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

41

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

1 component.

2

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

15

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

21

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

26

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

36

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

44

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

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

13

14 MR MUSTON: We visited the vRGS.

15

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

26

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

35

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

40

41 MR MUSTON: In what respect?

42

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

46

47 MR MUSTON: What inhibits that transparency at the moment?

1  
2 PROFESSOR WILSON: So sometimes, it's because you don't  
3 know yourself what money's going to come, because, you  
4 know, you go from year to year in terms of dollars and it  
5 goes up and down in terms of what you can do in that space.  
6 Sometimes it's because there's a desire on the part of  
7 government not to create expectations. I mean, it's  
8 a reasonable concern, but it does make it much harder to do  
9 that, if you are not prepared to be transparent about what  
10 you can and can't do. Clearly, you know, you don't want to  
11 alarm a community that you might be going to change  
12 services unnecessarily.

13  
14 MR MUSTON: But whilst they might be alarmed by it, in  
15 order to get that community buy-in and shared  
16 decision-making around what services should be delivered,  
17 what should be disinvested, you've got to tell them before  
18 you make the decision, so it's hard to avoid that, isn't  
19 it?

20  
21 PROFESSOR WILSON: Yes.

22  
23 MR MUSTON: And the consequence, whilst it might be  
24 distressing for them to think that something's going to be  
25 disinvested, of not telling them and sharing with them the  
26 potential enhancements that might flow if that happens is  
27 you're telling them after the decision's been made, and  
28 that's --

29  
30 PROFESSOR WILSON: And unfortunately, that is not  
31 infrequent.

32  
33 MR MUSTON: I think we've seen some evidence of that  
34 around the state as well.

35  
36 The next thing, in terms of that planning process  
37 where you're mapping out the extent to which the unmet need  
38 of the population is to be delivered as part of the public  
39 health system, would it be right to assume that that  
40 process, as a piece of good planning, should not be seeking  
41 to divide up what might historically have been Commonwealth  
42 funded activities and state funded activities; they're all  
43 health needs of the community, so primary care, for  
44 example, should be in the mix in terms of at least  
45 determining whether or not there is an unmet need for  
46 primary care and making decisions around how it should be  
47 met, if your prioritisation exercise determines that that's

1 something that should be given a high priority?

2

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

12

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

20

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

28

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

38

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

46

47 MR MUSTON: That would also extend, in the current



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

10  
11 PROFESSOR WILSON: Yes. I mean, we have an aspiration in  
12 our approach to ageing, ageing in place, trying to keep  
13 people at home for as long as possible, and it's certainly  
14 I'm sure what most of us would want, but delivering that in  
15 a rural community can be very, very difficult. To actually  
16 provide services into somebody's homes can be very, very  
17 difficult aspiration to actually provide.

18  
19 MR REID: It's both a difficult aspiration but - not  
20 "but", it bounces up against the funding process where the  
21 state feels they're being drawn into a provision of  
22 services where the Commonwealth are taking inadequate  
23 response to provide those services.

24  
25 Yes, we could argue that they should be the provider  
26 of last resort, but my view is that that should be  
27 accompanied by a funding agreement with the Commonwealth  
28 that that will be funded as a state-based service even  
29 though it's primarily a Commonwealth responsibility.

30  
31 THE COMMISSIONER: On the basis that aged care funding is  
32 a Commonwealth responsibility?

33  
34 MR REID: On the basis that aged care - I mean, one of the  
35 LHDs is currently looking at establishing an aged care  
36 service to accommodate the large number of aged care  
37 patients they have in their hospital at the moment,  
38 actually setting it up and funding it and running it, as  
39 they are in other jurisdictions, but they're clearly  
40 driving to long conversations with the Commonwealth about  
41 it providing the funding at least for those patients who  
42 would have been previously being funded in the local LHD  
43 aged care services, which are not.

44  
45 So the concurrent arrangements doing the planning and  
46 establishing a service of last resort still have to  
47 accommodate the funding model which the states currently

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

2

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

5

6 PROFESSOR WILSON: Critical.

7

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

20

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

30

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

37

38 MR REID: "We" being the state?

39

40 MR MUSTON: The state, yes.

41

42 MR REID: Yes, correct.

43

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

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

7  
8 MR REID: And the prioritisation of the need.

9  
10 MR MUSTON: Yes.

11  
12 MR REID: Correct.

13  
14 PROFESSOR WILSON: Yes, and as you have said previously,  
15 there are always lots of compromises between different  
16 elements of this.

17  
18 MR MUSTON: An important driver for that assessment of  
19 priorities and decision-making around compromises is going  
20 to be the local health district, informed by that local  
21 understanding of the health needs, which, in turn, will  
22 have perhaps more central information filtered into it -  
23 would that be right? That is to say, there is value in  
24 having the local health districts with their local  
25 knowledge as a driver of that prioritisation and planning?

26  
27 PROFESSOR WILSON: Well, I've not seen a model anywhere  
28 that successfully does that unless it has some sort of  
29 regional basis for doing it. There may be, but I've never  
30 seen a model which - where there is a sense that the  
31 communities are involved in that decision-making that  
32 doesn't involve some sort of sub-unit. I mean it probably  
33 doesn't matter a lot what size - there are other reasons,  
34 factors, that influence what the size of that might be, but  
35 to get it, you need to define a population, basically.

36  
37 MR MUSTON: But there is a role for the centre, isn't  
38 there, in that planning process, because only the centre  
39 has that overarching, system-wide view which might enable  
40 decision-making to be informed not only by the needs of the  
41 population within the local health district's catchment and  
42 the services which are currently being delivered there, but  
43 also what is being delivered elsewhere and the extent to  
44 which what's being delivered elsewhere might actually be,  
45 as part of that grand compromise, called upon to meet some  
46 of the health needs of a local health district's community?

47

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

13

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

20

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

34

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

43

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

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

8  
9 MR MUSTON: But part of that system-wide planning might  
10 also involve, to pick up an example that we touched on  
11 earlier, your cataract surgery, even if there might be  
12 a reasonably high demand for it within a local health  
13 district, if you can travel to an adjacent local health  
14 district because there is a centre where that is being  
15 provided effectively and perhaps more efficiently, that, by  
16 disinvesting in that service in the other local health  
17 district, you might free up some funding to enable the  
18 delivery of some primary care in communities that don't  
19 have it.

20  
21 PROFESSOR WILSON: The dollar has to follow the activity,  
22 so yes, you might, because there might be some  
23 infrastructural costs associated with providing that  
24 service, but a significant proportion of the dollar is  
25 actually going to have to follow the patient.

26  
27 MR MUSTON: But to the extent that efficiencies can be  
28 found within the system, those efficiencies are able to  
29 be - will produce dollars which can be perhaps better  
30 utilised to meet aspects of the unmet health needs in other  
31 facets of the health system?

32  
33 PROFESSOR WILSON: Yes, and, you know, there's an adage in  
34 health care about cost savings, that the only time you  
35 truly see it is when you close a hospital bed.

36  
37 MR REID: A group of hospital beds, Andrew. Not just one.  
38 A group.

39  
40 PROFESSOR WILSON: That's the only time you really, you  
41 know, see that sort of thing. And that, of course, has  
42 significant implications once you do that.

43  
44 MR MUSTON: Professor Van Gool, I think you had raised  
45 your hand.

46  
47 PROFESSOR VAN GOOL: I was just going to say that in that

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

9  
10 MR MUSTON: But, of course, the centralisation also has  
11 the potential to create benefits that are not solely  
12 financial. It might overcome a workforce challenge. If  
13 you have a centre for excellence in cataract surgery in  
14 Dubbo, for example, that might mean that challenges in  
15 attracting clinicians to deliver that sort of surgery in a  
16 number of other regional centres can be avoided or  
17 mitigated.

18  
19 PROFESSOR WILSON: There may be, yes. But I think Kees is  
20 wisely saying we've just got to make sure you consider the  
21 whole cost. So, you know, for example, with an evaluation  
22 of the virtual services, one of the things that we've been  
23 looking at is carbon footprint saving, you know, and it is  
24 actually quite - it is quite amazing, even having virtual  
25 services within Sydney, what carbon footprint reductions  
26 you can get through virtual services.

27  
28 MR MUSTON: But from an access point of view, perhaps  
29 picking up on the carbon footprint, if you do centralise a  
30 service, or move a service further away from people's  
31 homes, the health system, in order to maintain access to  
32 that service so it is still capable of delivering on all  
33 the health needs of the people in the region, needs to work  
34 out a way of getting those patients to the service and  
35 back, it's not sufficient --

36  
37 PROFESSOR WILSON: Yes, I just think, in doing that, we  
38 have to be mindful of those broader implications. You  
39 know, birthing services is one that comes up quite  
40 regularly. For Indigenous people, it is important to birth  
41 on land. There are real issues in trying to maintain the  
42 safe and accessible services, birthing services, in smaller  
43 communities. You know, it would be very easy, and we've  
44 sort of done it almost by default, to keep on concentrating  
45 these things in areas but, you know, there are other social  
46 goods that we need to think about in doing what might seem  
47 to be the most sensible, safe and effective and efficient

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

3  
4 MR MUSTON: The best way to strike that balance is through  
5 a meaningful collaboration between the local, by which  
6 I mean not only the local health district but also those  
7 other collaborators in the delivery of health care within  
8 a local area on the one hand, the community, on the other,  
9 and central governance of the health system, which probably  
10 has a better capacity to identify system efficiencies,  
11 workforce - solutions to workforce challenges, et cetera.

12  
13 PROFESSOR WILSON: Yes and this is where that local  
14 element becomes so important. There is a fantastic example  
15 in Western New South Wales where the local health service  
16 and the AMS, et cetera, have worked with the community and  
17 the community has developed a model for supporting  
18 Indigenous mothers, Aboriginal mothers. In that period of  
19 time, they spend as minimum time off land as possible  
20 during that period of time, they've got support, and they  
21 feel like they still remain part of the community, and then  
22 when they come back - you know, come back to land or  
23 whatever, it's very --

24  
25 MR MUSTON: I think we've heard some evidence from --

26  
27 PROFESSOR WILSON: It was developed locally. It was  
28 a local initiative to achieve that.

29  
30 MR MUSTON: We've heard some equivalent evidence, I think,  
31 from the Aboriginal Medical Service in Nowra, Waminda.  
32 They do have an excellent birthing on country program.

33  
34 So bringing us back to funding, we've identified  
35 potentially a system whereby, through identifying the need  
36 and engaging in a proper and collaborative process for  
37 prioritising the way in which that need might be met by the  
38 public health system and divvying up the limited budgetary  
39 envelope available to the public health system in a way  
40 which enables that to be delivered, is the next real  
41 challenge.

42  
43 How do we, from a funding point of view, create  
44 structures that enable those mapping and planning processes  
45 to actually be converted into the actual hard and fast  
46 delivery of healthcare services in a way which ensures that  
47 they are sufficiently funded for them to be real?

1  
2 PROFESSOR WILSON: Carmen has her hand up. I don't know  
3 whether she wanted to answer that question.  
4

5 MR MUSTON: If not, you can answer another one and we'll  
6 come back to it.  
7

8 A/PROF HUCKEL SCHNEIDER: Yes, just directly on that, what  
9 we're, effectively, reaching when we get to this point is  
10 how to implement services that have been identified as not  
11 being met, for whatever reason. So when we've reached that  
12 point, we're trying to overcome all of those challenges and  
13 barriers that were the reasons why there were those gaps in  
14 services in the first place, and that's what makes it - so  
15 the availability, the time, the clinicians and workforce  
16 that are available.  
17

18 The injection of funding, through whatever mechanism  
19 at that point, needs to identify alternative solutions,  
20 because saying, "We're going to get another primary care  
21 clinic there", or "We're going to get another allied health  
22 clinic there", will still face those initial barriers that  
23 were the reason why it wasn't there serving the community  
24 in the first place. So it is about identifying alternative  
25 solutions to either incentivise more activity there, to  
26 fill those identified gaps and meet those priorities, or  
27 find alternative ways to provide those services and fill  
28 those gaps.  
29

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



1 hybrid model of funding for other types of services, like  
2 bundled costing, et cetera, that that would give you  
3 a mixed model but where you retain the benefits of the  
4 activity based funding model but you actually have a more  
5 transparent distribution of the funds.  
6

7 What it doesn't do is address the issues - it doesn't  
8 necessarily address some of the - while it equitably  
9 distributes the funds, that doesn't mean it addresses  
10 issues of equity of health outcomes within that area.  
11 That's a slightly different question to the equitable  
12 distribution of the funds, and I think Kees has his hand up  
13 there.  
14

15 PROFESSOR VAN GOOL: I did, but you said exactly what  
16 I was going to say. All I would add to that is, yes, the  
17 bundling payment is an innovative way of paying for  
18 healthcare services. The innovative aspect of it is to try  
19 and coordinate different types of services across sectors  
20 over time, and the other aspect that is innovative is that  
21 it might then also start a discussion between all different  
22 payers on how they can contribute to that bundle, rather  
23 than it becoming still, you know, a point of contention  
24 between different levels of funding.  
25

26 MR MUSTON: For example --  
27

28 MR REID: The - sorry --  
29

30 MR MUSTON: I'll come back to you, Mr Reid.  
31

32 THE COMMISSIONER: Go ahead, Mr Reid.  
33

34 MR MUSTON: You go ahead.  
35

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

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

3  
4 Then it also goes to a fundamental question as to  
5 whether the activity based funding, as it currently stands,  
6 is appropriate, and this goes to the new arrangements for  
7 aged care funding which are now in place, which more goes  
8 to a fixed and variable component and which is, in a sense  
9 what Kathy Eagar has argued to you in some way, shape or  
10 form, and then you go to the other components as to whether  
11 you start to adjust your weightings in whatever you retain  
12 in the hospital system to reflect differential costs of  
13 providing the same services within that hospital or group  
14 of hospitals, which many of the submissions have argued to  
15 you, on the basis of ethnicity or chronic and complex  
16 conditions being more prevalent in the community there.  
17 That's a slightly different argument to at least having  
18 something which has a demonstration of what the overall  
19 population based allocation is.

20  
21 In that overall population based allocation, the first  
22 one, we would argue that Commonwealth money should be  
23 included in that so you understand the totality of health  
24 funding but be differentiated within it, so you understand  
25 what the state funding is and the Commonwealth funding.

26  
27 THE COMMISSIONER: And this is the distinction between  
28 what you've called opportunity 4, which we were discussing  
29 I think slightly beforehand --

30  
31 MR REID: Correct.

32  
33 THE COMMISSIONER: -- and what you have just focused on,  
34 which is opportunity 5?

35  
36 MR REID: Correct. That's correct.

37  
38 THE COMMISSIONER: I interrupted you, Mr Muston, I think.  
39 Sorry.

40  
41 PROFESSOR WILSON: And given that you can't fix the  
42 Commonwealth/state funding arrangements.

43  
44 THE COMMISSIONER: You can have a crack, but it would be  
45 hard.

46  
47 PROFESSOR WILSON: At least if that was reflected in what

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

5  
6 MR REID: And the notion of fairness should not  
7 differentiate the state/Commonwealth arrangements. There  
8 should be fairness of accessing health dollars regardless  
9 of which government it comes from.

10  
11 PROFESSOR WILSON: And sorry, just to be clear, because  
12 we've sort of belatedly introduced the issue of bundled  
13 payments in the discussion, by that we mean where you have  
14 some mechanism for estimating the total cost of care in  
15 particular sorts of circumstances, and there is an  
16 allocation in the same way as an activity unit, you know,  
17 is focused on a particular narrow area, this would be  
18 a broader type of service.

19  
20 An example of that might be mother and child, the  
21 first 2000 days. There might be a bundled payment for that  
22 period of time - sorry, for the services that you would  
23 expect to provide in that area, and that would go to, you  
24 know, the district on that basis, as opposed to the  
25 activity based funding.

26  
27 MR MUSTON: I think you have answered the question that  
28 I was going to ask Professor Van Gool when we changed tack  
29 slightly, but just to make sure I have understood it,  
30 I will ask either you or Professor Van Gool to tell me if  
31 I'm wrong: a bundled payment in the context of, say,  
32 primary care, might make an assessment of what, if, as  
33 a matter of prioritisation of the meeting of health needs,  
34 a local health district determines the primary care  
35 service, say, co-located with an MPS facility is something  
36 that would be of use to a community and the best use of  
37 health dollars in that community, a bundled payment might  
38 say, "We've worked out roughly what the workforce for that  
39 sort of service would be in terms of the mix of different  
40 types of clinicians", it no doubt will have been worked out  
41 in the background what sort of money might be generated  
42 through a 19(2) exemption if one were able to be secured.  
43 From the LHD's perspective, other than making sure that it  
44 clicks the Medicare card every time it provides a service  
45 to ensure that funding stream flows, it gets given a bundle  
46 of money which is what is anticipated to be or estimated to  
47 be the cost of delivering good primary care to a community

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

7  
8 PROFESSOR WILSON: And the district, as part of its  
9 planning process, would make decisions about how that could  
10 be most efficiently and effectively provided for  
11 a particular setting, so that might mean an arrangement  
12 with the local - working with the local GP and whatever, to  
13 provide that service; in other situations, it might be  
14 using a nurse practitioner; and in another setting it might  
15 be using some other sort of provider appropriate to the  
16 type of support and care that is necessary.

17  
18 It could be any mix of traditional approaches and  
19 virtual approaches, et cetera, but the expectation is that  
20 they will deliver a package of care meeting a certain  
21 standard and a certain evidenced requirement for what was  
22 required in that space.

23  
24 MR MUSTON: It might, in some instances, include providing  
25 funding in a bundled way to the local Aboriginal community  
26 controlled health organisation to provide that primary care  
27 across the full population of a town.

28  
29 PROFESSOR WILSON: Yes, absolutely.

30  
31 THE COMMISSIONER: Can I ask you a question, you are not  
32 under any time pressure, other than a date of April and  
33 neither am I, but the witnesses might be. Do you have  
34 a feeling for how much longer, and then I will ask the  
35 witnesses what their --

36  
37 MR MUSTON: I can probably be finished within half an  
38 hour, 15 minutes.

39  
40 THE COMMISSIONER: Right. Can I just ask the five of you,  
41 do you have any time constraints after 2 o'clock?

42  
43 PROFESSOR WILSON: I do have time constraints after --

44  
45 MR REID: And I do also.

46  
47 THE COMMISSIONER: If it's okay with the icourts people,

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

5  
6 MR MUSTON: Certainly. I'll try to compress it.

7  
8 Could I come directly to the opportunities that you  
9 have identified at the end of the report, commencing at  
10 paragraph 72, what you've described as "Opportunity 1". At  
11 paragraph 73 you refer to the potential use of some of the  
12 more traditional bases upon which funding was divided up as  
13 a monitoring guide.

14  
15 Do I understand that to essentially be you saying that  
16 some of those population based assessments of need and  
17 population based means by which health funding has  
18 traditionally, in some places, been divided up, whilst you  
19 might not use that as the driver for the funding decisions  
20 that you are making, it nevertheless might remain a useful  
21 tool in terms of just checking to see whether the funding  
22 model that you are using is producing outcomes which are  
23 wildly at odds with what that more population based/needs  
24 based funding approach would suggest they should be?

25  
26 MR REID: This suggestion was based on how do you bring on  
27 to the table something which looks at a population based  
28 understanding, to understand where there's different areas  
29 of need across different geographies. This suggestion was  
30 put on the table more as, as you said, as a monitoring  
31 guide, but it was akin to what was in place, as Carmen  
32 said, in New South Wales prior to the 2011 agreement with  
33 the Commonwealth and states, and it was published by - it  
34 was done every year, published by the health minister to  
35 demonstrate where there was inequities between LHDs,  
36 whether they were being rectified by the funding model and  
37 how they were being changed by the funding model over time.  
38 They were also trying to be very transparent, or much more  
39 transparent, to differential population growths which  
40 occurred between LHDs which had then had different need  
41 bases.

42  
43 When it was in place, it demonstrated over a six-year  
44 period that there was a movement to greater equity between  
45 populations across all the LHDs. So it was used as a way  
46 of going - a public document which went out, which people  
47 could see, that however those moneys went out in activity

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

14  
15 PROFESSOR WILSON: And back to what we were talking about  
16 yesterday about ratcheting up, you know, if you were to  
17 suddenly tomorrow say, "We're going to distribute this  
18 according to a formula", and you suddenly had to shift  
19 \$100 million from one district to another district, the  
20 disruption that that would cause would be - it just would  
21 be intolerable at a whole range of levels. You just  
22 couldn't do it.

23  
24 So even if you introduce - even if you decide to move  
25 to a more equitable distribution of the funds, it's not  
26 going to occur - it's going to occur progressively, and it  
27 may well be largely due to an uneven distribution of the  
28 new funds coming into the system, in other words, rather  
29 than focusing too much on the money which is already tied  
30 up; when there is new growth funding in the system it  
31 differentially goes to one of those areas which are - it  
32 took 20 years, I think, Mick, something like that, under  
33 the previous formula to move things closer to RFD.

34  
35 The Garling Inquiry - I found a section in the Garling  
36 Inquiry which said, you know, that it had moved within  
37 I think - it was something like I think the figure was  
38 20 per cent or something of equitable share between the  
39 districts at the point when the Garling Inquiry was held.  
40 So I don't know where it ended up eventually in relation to  
41 that. The ministry almost certainly knows. But, you know,  
42 it is a progressive process.

43  
44 MR MUSTON: Whatever model you use as your underlying  
45 funding driver, if you are monitoring the extent to which,  
46 at this population level, the funds are being distributed  
47 equitably, and you are publishing that, that introduces

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

5  
6 MR REID: The reality is, Commissioner, that the shift to  
7 greater equity comes, as Andrew said, with the additional  
8 funds that come in year on year, rather than fundamental  
9 changes or closures of hospitals or those types of things,  
10 which aren't going to occur anyway. So it just provides  
11 that transparency and something that could be done  
12 relatively quickly off existing datasets that New South  
13 Wales currently has, that just requires that transparency  
14 in publishing and undertaking the exercise.

15  
16 MR MUSTON: Can I take you to opportunity 3.

17  
18 MR REID: So this opportunity which we talked about,  
19 Commissioner, was really saying if we're going to retain an  
20 activity based funding arrangement or some arrangement for  
21 funding inpatient hospital care and outpatient care, and we  
22 recognise that many of the drivers to get a more efficient  
23 hospital system are still funding sources that go outside  
24 the hospital and, as Carmen said, they're not just right  
25 out in the prevention, the other side, but there's a whole  
26 range of other areas which are not picked up in ABF funding  
27 at the moment - that if you retain some form of activity  
28 based funding, and going back to your very first comments  
29 about the legislative role of what the Department of Health  
30 does, then the funding model doesn't very well accommodate  
31 that legislative role, and you would argue in that that  
32 then - and there is some funding which does go to various  
33 forms of community based activity at the moment, but it is  
34 difficult to assess in a transparent fashion how useful -  
35 whether it goes in an appropriate way.

36  
37 This is more identifying a much more significant  
38 envelope of non-activity based funded services which would  
39 be funded where their role is health promotion, health  
40 prevention, keeping people - reducing lengths of stay, and  
41 could also pick up other issues around health literacy in  
42 hospitals, et cetera, in health care. But it's setting  
43 a pool of money aside which would be for that primary  
44 care/community based services.

45  
46 MR MUSTON: How do we measure the extent to which those  
47 funds are directed at addressing equity in the sense you

1 contemplate in paragraph 80? How is that measured?

2

3 PROFESSOR WILSON: Addressing equity?

4

5 MR MUSTON: Addressing inequity.

6

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

15

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

19

20 MR REID: Correct.

21

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

26

27 PROFESSOR WILSON: Yes.

28

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

33

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

39

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



1 the proposition here is that you categorise hospitals  
2 according to their tiers, which currently NSW Health has in  
3 place, so the smaller hospitals would get a much higher  
4 proportion of a fixed budget and a smaller variable  
5 activity based funding, and the bigger hospitals would have  
6 a much smaller fixed component, bigger activity based  
7 funding, and there would be variations between the  
8 gradations of hospitals as to what the ABF was.  
9

10 It picks up very much on the aged care funding which  
11 the Commonwealth now has place.  
12

13 MR MUSTON: Professor Van Gool?  
14

15 PROFESSOR VAN GOOL: It's just to add to Mick's comments,  
16 that in the NEC - the national efficient cost - model for  
17 smaller rural hospitals, that already exists, but of  
18 course, essentially it cuts out at 3,500 NWAU, and I think  
19 what the proposition here is is to extend that and look at  
20 hospitals that just sort of fit on the other side of 3,500,  
21 so that you have a broader --  
22

23 MR REID: I think if the Commission had an interest in  
24 this, Commissioner, it's something you would recommend be  
25 further developed to assess its viability rather than jump  
26 into it, because it does need a lot of work, which was  
27 quite beyond Martin's brief in terms of how you would get  
28 to it. But it is something that has been advocated in a  
29 number of the submissions that have come to you.  
30

31 THE COMMISSIONER: Sure.  
32

33 MR MUSTON: This perhaps is a question best directed to  
34 you, Professor Van Gool. The starting proposition is  
35 activity is based and funded through the national efficient  
36 price, at least at the IHACPA level. Once the state gets  
37 that money, it, as we understand the system currently,  
38 creates a state efficient price, which is the price that  
39 New South Wales feels, based on its data, it's able to  
40 deliver efficiently the care through hospitals.  
41

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

1 funding - for those medium sized hospitals you either have  
2 a fixed cost block that covers turning on the lights and  
3 opening the doors with a top-up through some activity which  
4 continues to drive efficiency through that hospital but  
5 guarantees that there will always be a sufficient funding  
6 envelope available to operate the hospital and the services  
7 that it needs. That's one potential adjustment to the  
8 existing arrangement. Have I understood that correctly?  
9

10 PROFESSOR VAN GOOL: Yes. So the national efficient price  
11 is obviously allocated to ABF hospitals, but then there is  
12 the national efficient cost for smaller hospitals that  
13 produce less than 3,500 NWAU per year.  
14

15 MR MUSTON: Yes.  
16

17 PROFESSOR VAN GOOL: Those hospitals are funded on a fixed  
18 and variable component. So still block funded, so it is  
19 a little bit retrospective, but still fixed and block - so  
20 if you are a very small hospital, something like less than  
21 200 NWAU per year, essentially, you are all block funded;  
22 there's just a fixed component.  
23

24 As you expand your activity, there's a reward for that  
25 expansion of activity and your block funding reduces. That  
26 block funding, I must say, or should add, goes to the  
27 state, it doesn't go to the LHD, and so it's up to the  
28 state to redistribute --  
29

30 MR REID: The Commissioner is right, in a sense, Kees,  
31 that this is a state activity of how we would fund it once  
32 we got the Commonwealth dollars.  
33

34 PROFESSOR VAN GOOL: Absolutely. Yes, I'm sorry. I'm  
35 purely referring to what the Commonwealth contribution does  
36 here, yes.  
37

38 PROFESSOR WILSON: Just to put that in the context, we're  
39 talking something which means you've got 10 services a day  
40 which are doing that, so there would be 10 patients in  
41 hospital a day, so we're talking pretty small hospitals,  
42 10 or less than 10, because it's 10 activity units. So  
43 it's not necessarily a patient in a hospital for a day, but  
44 we're talking - at the moment, that cuts off at some very  
45 small hospitals.  
46

47 MR MUSTON: The small facilities with one or two acute

1 beds in the emergency department.

2

3 PROFESSOR WILSON: Yes.

4

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

14

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

27

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

41

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

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

3  
4 MR REID: I think I agree with Andrew. The only slightly  
5 contrary point is that I think if one doesn't establish  
6 a clear non-hospital based funding block of money, the  
7 historical trend is that that tends to be drawn back into  
8 acute care service provision over time, by whatever  
9 rationale of politics, waiting times, whatever it might be.

10  
11 MR MUSTON: I have no further questions for these  
12 witnesses, Commissioner.

13  
14 THE COMMISSIONER: All right. To all five of you, but  
15 starting with those in the hearing room, is there any  
16 aspect of your report or the opportunities identified in it  
17 that you don't feel we've sufficiently covered or you want  
18 to add something to? I will start with Professor Wilson.

19  
20 PROFESSOR WILSON: Look, I just go back to the comment  
21 I made midway through the morning that a funding model  
22 should be designed to achieve the objectives of what you  
23 want to achieve from it, and there are wrong funding models  
24 but there are no right funding models, in that essence. So  
25 I think as you start to formulate your recommendations and  
26 are clearer about things that you really want to see  
27 happen, then we can probably help give you some better  
28 advice about which of the funding models would achieve that  
29 and which are feasible within the structures that are  
30 currently in place.

31  
32 THE COMMISSIONER: We might hold you to that offer.  
33 Dr McNamara, is there anything you --

34  
35 DR McNAMARA: Nothing from me, thanks.

36  
37 THE COMMISSIONER: Professor Van Gool, is there anything  
38 further?

39  
40 PROFESSOR VAN GOOL: I'm all good, thank you.

41  
42 THE COMMISSIONER: Mr Reid?

43  
44 MR REID: All good, thank you very much, Commissioner.

45  
46 THE COMMISSIONER: And Professor Huckel Schneider, is  
47 there anything further from you?

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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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