CORRECTED

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO QUALITY OF CARE FOR PUBLIC PATIENTS AND VALUE FOR MONEY IN MAJOR NON-METROPOLITAN HOSPITALS THROUGHOUT NEW SOUTH WALES

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At Sydney on Tuesday, 12 February 2002

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The Committee met at 10.00 a.m.

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PRESENT

The Hon Dr B P V Pezzutti (Chair)

The Hon Dr A Chesterfield-Evans
The Hon R D Dyer
The Hon H S Tsang

WILLIAM KILPATRICK HUNTER, Visiting Medical Officer at Moree Hospital, General Surgeon, Medical Centre, 342 Frome Street, Moree,

ROBERT GILBERT BOSSHARD, Bio-medical Engineer, Adviser to the Project of Mobile Surgery, 25 Sherwood Street, Kurrajong, and

STUART PETER GOWLAND, Urological Surgeon, Developer of Share Mobile Concept, 52 Holmwood Road, Fendleton, Christchurch, New Zealand sworn and examined:

CHAIR: If any of you should consider at any stage during the evidence that in the public interest certain evidence or documents you may wish to present should be heard and seen only by the Committee, the Committee would be willing to accede to your request. If we do go into camera, that evidence will remain confidential except it may have to be disclosed if there is a vote of the House, which I am not aware has ever happened, but it is a possibility. That goes also for commercial reasons, if we ask some commercially secret sorts of things then we can always divulge.

What we really want to hear today is your presentation on what this offers and what benefits it could offer the people of New South Wales, particularly in regional areas.

Dr GOWLAND: What I hope is we can engage you in debate on a whole range of issues that I am going to raise today. I think my initial presentation, Ministry of Health style, is probably only about 25 or 30 minutes. We have a live data base running on New South Wales Health that they have given us over the years and, if I may just introduce, other than the formal sort of introduction, who we really are: I am a surgeon but I am really a kind of corporate miniscule because the project as it developed in New Zealand, while it looks really "corporately", is basically a group of rather amateurish doctors and nurses who have got together and put together something they thought would be a good idea for the health system.

We started off with a very generous grant from one of New Zealand's benefactors to get it rolling and then the Government picked up and gave us a $25 million contract over five years to run mobile services in New Zealand as a pilot and that starts on 4 March doing its first commissioning patients in hospital and then it just starts on a circuit around there.

My background is that I am a urologist and I wound up spearheading the development of the mobile lithotryptor. Again, these were machines that some will remember from Sydney in the old days cost two to three million dollars each when Sydney got its first one – they are now down to about one million. When we bought ours for New Zealand we paid 1.5. In the normal hurly burly of hospitals where everyone grabs for it, as exactly has happened in Sydney, we would probably have about six of them in New Zealand at $2 million each for the projects - $12 million. We have got by with just one and the reason we have got by is because it visits everyone's town, everyone can get a chance to use it, the patients get treated in their own towns; and so I wound up getting approached: would I look at some other projects of a similar sort of nature to what has been quite a successful project.

It has no garage. It just goes around and around the country all the time. It is not like Thunderbirds. Of course, Americans developed mobile techniques long before anyone, they have always had fancy trailers for their generals and they just moved on from there really.

Bob Bosshard I have known for many years. He was the electronics project manager on my surgical project here when I was working as a tyro at the Prince of Wales University and Prince Henry, with a colony of 35 monkeys in those days, and we have kept in touch over the years and he brought a lot of engineering expertise and knowledge for me.

Bill Hunter we have come to know over the last year or two, along with a number of other nurses and surgeons in New South Wales who have helped us sort of flesh out in our own minds the practical sort of aspects of what goes on. As you well know, health is an unbelievably perversely incentivised industry and it is hard to figure out just what the incentives are in a lot of areas in my country, as well as yours.

There are clearly major differences between our two countries - you can play cricket and rugby, which we can't – but there are a lot of similarities as well and I think probably the similarities outweigh the others.

I will just go forward then to looking about this whole idea of sharing things because the two biggies in health are the pharmaceutical bill – that probably in the end of the day has to be dealt by levering companies down and it is a very hard thing to do, as you well know, because the pharmaceutical companies are very smart. As far as high cost technology is concerned, we think this offers an option. Instead of buying machines for everyone you buy a far fewer

number and you share them around; but if they get cheaper there is no reason why they can't ultimately roll out and be owned by the hospitals, but you give them that choice.

So, there is just a little rather cheeky vignette about health from a guy who has been in it for 25 years or so. Quality of care and value for money, which is what this Committee is about, are absolutely inextricably linked. Bad quality costs more and good quality generally in my experience costs less, so they are very closely linked.

I think the biggest single determinant is not threats or documents, or legal sort of bound memoranda, but in fact the culture of a hospital, if we are talking about hospitals, and I think the culture of public hospitals here, the UK and in my country often is rather lacking in instilling those cultural aspects, and you have seen that and guys have walked away over the road to the private hospital, things like that, and you might well say: why have a public system anyway? My view, having talked to lots of politicians over the years and my colleagues, is that a major credibility for both of us comes of having an acceptably good public hospital system. I am a private practitioner myself. So I think there is a feeling and a need in fact for us to have a good public system. We have just got to make it work.

The Hon RON DYER: Can you identify what negative aspects of the culture of the public hospital you might be referring to?

Dr GOWLAND: I think probably the poor communications between management and the staff really – and by "staff" I just don't mean surgeons who are reasonably robust; I am talking about nurses perhaps in particular, which are often 50 per cent of the work force and generally I have felt have been rather undervalued in the broadest sense. I do not know about here and the money, in New Zealand it has been money as well, but basically they have been undervalued. I think in places where the orthopaedic surgeons have exited from a lot of hospitals - the robust and rugged nature that they are – I think rather than paying more, which is what would be the initial solution, if they were allowed to participate actively in the management of their unit and run it, you would probably get them back for the same money; but management has never been prepared to let clinicians do that. You have to be accountable. You can't just have open slather, but I think there are a lot of clinicians more than happy to take over that role where they apply the same accountability that they have to their patients to the financial system.

CHAIR: While you are here it might be worthwhile going to speak to the department because the Minister has introduced what is called clinical governance, which is a shared responsibility for clinical care and the responsibility lying with the people who run the place, but he has also instituted a large number of clinical councils which is really the doctors and nurses taking over the system again; which is encouraging. We have not seen it flower just yet, but it is encouraging.

Dr GOWLAND: I am quite cynical and you will know what the Lismore situation is, but my impression is generally they are sort of weasel words. I mean you actually have to develop a budget to a unit and you have to say: you're out of here if you can't make it work, but if you do make it work there is an incentive. I will talk about incentives in a minute, because this is another mantra that goes round, the hubs and spokes, and I would put to you as a slightly cheeky comment that the hubs and spokes relationships between base hospitals and district hospitals tends to ensure the demise of the spoke. I would say the hubs of today are actually the spokes of tomorrow and that is why there is great nervousness in this sort of feeding chain of health that we have actually developed, because I don't think it is sustainable. You could have a situation where if we had one to two hour transport across the Pacific someone says: well, shucks, don't have your operation in Sydney, you need to go to LA. This sort of thing could happen with all sorts of technologies that are in the wings in the future.

Dr HUNTER: That is one of the negatives that we experience in hospitals, when nurses and people see these services being left out of their hospital they say: well, why should we bother?

The Hon RON DYER: The spokes are the district hospitals, are they?

Dr GOWLAND: The spokes are the district hospitals.

The Hon RON DYER: Why is their demise ensured?

Dr GOWLAND: What actually happens is the spoke idea means that a surgeon – let's take a surgeon because I am one – he goes out to a small hospital, it could be Narrandera from Wagga, and it's all sort of innovative and especially he's been forced to do it when he first gets his employment contract, he does it, but it starts to wear thin, the people aren't quite as well trained as the ones he's used to, the equipment is not quite as good, and in the end he will find some excuse. This could happen in your metropolitan process where you have talked about people at PA also

being on in that place up the coast, Mona Vale – I talked to Bruce Barraclough about this – we would put surgeons on at Mona Vale and we would put them on at PA. As soon as it starts wearing thin they will say, "It is not as safe as it should be" and if you start spitting those words around the place it is very hard to keep it going; so I would say the outreach programme is not a sustainable option.

What is probably far better is for the little communities to generate a job that is genuinely valid for people to visit.

The final thing, a little cheeky sort of quirk is to say: At a hospital negotiating funding with the area health service or simply management with their staff, healthy incentives are probably the only way to make it work. We are not talking about incentives as cash; we are talking about incentives where you let units keep some of their own money to reinvest in their own unit. I think the public would accept those kinds of options. As you know, when you do not have those, you will have governments and area health services run sinking lead policies through mutual distrust and you will have area health services also run with sinking lead type projects.

Let us leave that wishy-washy stuff alone for the moment, and talk about what we are here to talk about, to put it in a nutshell, Bill, I want you to talk a lot when we have the data base up, to interrupt at any of time, and of course the members of the Committee.

This is a mobile surgical unit to re-establish high quality day surgery in a selection of New South Wales district hospitals; to configure that same vehicle with some new generation style communication links, to enable base hospitals, also who have their own problems, to teleport in surgeons from their own countries or around the world to help with unusual cases or cases where there has been some new technique developed. They are teleported in as a life-size person, as if they are right in the operating theatre, and they work together.

We want to encourage people to visit these places, we want to encourage residents to exchange we want to encourage our people to have a chance to visit overseas centres.

The Hon RON DYER: Teleport means a video link?

Dr GOWLAND: It does, yes. It is a high band or broadband video link, which gives you good quality. We trialled that, as I will mention. If you are a surgeon in New York at Memorial Sun Institution, New Manhattan, one of the groups which is going to link with us on this, what you have to know is what you can see on the end of that link-up is far higher quality than normal quality.

Where have we come from? We have a management team, engineers, computer people, managers, project people; we have an advisors boards of general practitioners. I will mention the role of general practitioners in this mobile surgery later. We have surgeons and rural surgeons. We have divided sharing resources into two broad areas: Sharing expensive medical technology using mobile units and sharing knowledge with new generation computer technology. I am going to keep focusing on those two areas.

So we dreamt up this device, which had an operating theatre, recovery, a tearoom, and we came up with a concept diagram. I guess as we show this around our country and yours, people have thought: Well, here is another mad group of wallies – and they could have been right. Having done that, in November last year we launched the mobile surgery. While I had realised we could not build our own truck unit without going to huge expense, I think the graphics people got fairly close to what we set. This is a Kara kea, or a welcoming to a Maori Murri (referred to PowerPoint), which was preferred to an opening at the truck yard where they built the vehicle. It was absolutely wet. We had a ceremony, where the Maori Bishop gave a very humorous speech on Leicester

Let us look at the expensive technology sharing. Mobile CAT scanners, there is no place for those now, but if you went back to 1980 CT's were having a sing. If you had shared mobiles may be you would have got away at considerably less expense instituting this technology.

The Hon RON DYER: Why do you say there is no place for them now? There are too many around?

Dr GOWLAND: I think it is hard, if someone has an MRI, you are not going to change them around, except they will want newer ones, of course. That is another option. To do that you have to have someone on a budget that is incentivised because if you share – just like at home budgeting, and farmers too – and you share the equipment instead of owning it, it has to be in a proper budget. These surgeons probably find at the moment in their hospitals they can screw harder for the new device than to look at an option like this because think they will lose all the other

money. They would like to spend it on something else. The share mobile still needs a slight change in thinking on hospitals and how you budget.

There is a CAT scanner from 1980; they really have been around for a long, long time. Mobile MRI's – you are pretty well flush with MRI's, I suspect. All the time new models are coming out. The new, fast generation MRI's mean everything is going to have to change again, may mean you have to think about, you have a fixed budget here, buy the new MRI? You cannot afford something else. Mercedes in the left side of the garage, it is only a Volkswagen in the right. That is hard budgeting and may be that is what hospitals have to start doing. There are three or four hundred of those in America (referred to PowerPoint).

Mobile lithotripsy is where I started. Six or seven years ago we built a futuristic model of the vehicle. It has been fairly successful. It has enabled a whole range of our hospitals, even our urologists to have access to a $1.5m machine for treatment of patients with kidney stones, in their towns by their own doctors.

Carrying on the share expense, we are talking about a mobile operating theatre. An archivist sent this to me (referred to PowerPoint), this was taken in 1895. It was a mobile theatre, it didn't have a Satcom positioned on the roof, but it did have a lot of other things. That seems to be a type of air-supply arrangement. That is our vehicle's launch and we will show you more pictures later.

Around the corner people are going to want laparoscopic surgery, or keyhole surgery, which costs more; but people are going to want, and generally they wind up getting it. The big draw back to keyhole surgery is that it is quite slow. If we are going to start doing better operations, it has to be faster. One way that has been developed around that is intuitive robotics. Like your Palm Pilot, as you start the word, it finishes it. You start tying the knot and it finishes it for you. You start doing the suture line and it will finish it for you. That will enable keyhole surgery to be faster. $US1.4 for one set of robotics, which would probably need to be duplicated, $US2.8.

How are you going to do it? If Pat gave some money to Denise or someone else gives it, they get an edge on everyone else; but you have to look at how a whole State copes with this. It is a different deal. May be sharing mobiles, especially when it is expensive, doling out to individual hospitals when it gets cheaper.

Just to let you know the sort of thing that can happen, this was Brussels two years ago (referred to PowerPoint) and this man is having eye surgery using intuitive robotics. There was grandstanding from Paris to New York recently, where they operated from New York to Paris, because theatre is about communicating with patients. That is the man who is going to be heading the unit in Australia about to have an operation – I cannot see that happening in the foreseeable future, but robotics I can.

A man will be sitting in the corner of a theatre watching a 3D television, programmed with image stabilisation technology. This is a version of your home video camera that stabilises, you can still the heart with computers so on a screen it is still but it is actually beating. The instruments are going up and down. What is the advantage of that? No sternal split, no bypass. You are looking at patients who have had intensive cardiac revasculisation going home the next day. You might say cardiac revaculisation might not be needed, it may be one of a number of techniques, but here is one of the sort of things that might happen in the future.

We have looked at PET scanning. I think it is too expensive. You have one in Sydney, the biggest advantage is the cyclotrons have become relatively small, 40 tonnes instead of a whole hillside but I think MRI technology is going to usurp its role in determining the spread of cancer. I think that is not a go.

The Hon RON DYER: What is PET technology?

Dr GOWLAND: PET is an isotope technology. It can be used for a number of things but one of them is, if you have cancer that his spread, it is the most sensitive way to show it has spread. It means it saves surgery.

We have talked about sharing in the sense of medical technology. I now want to introduce sharing knowledge. I know a lot of money has been spent by this Government on video communication around the State and Australia. It is regarded as a hugely important item. I have to say that video conferencing has turned out, at it's first cut to be not that good. I go around boardrooms in New Zealand they have all got the eye in the sky at the end table - with dust covers. I have gone around little hospitals where the same thing has happened.

If you get a group of medical students, you have a captive audience; they will sit in front of it and do it. If you have visiting firemen, they will do it; or they will sit an exam or doing distance learning. If is part of your weekly

culture, you just want to chat to the guys, it is not good enough quality. The reason they haven't made good quality is that Telstra have not got the lines in the State. They have not been willing to do it unless they charge you a lot of money. I think we should be getting together, Australia, New Zealand, Pacific and others, because one thing they understand is volume.

The Hon RON DYER: Where the technology is installed, why is it unattractive?

Dr GOWLAND: It is the bandwidth that does not allow good enough pictures. I am going to talk about that in a minute. The areas of sharing I think important are the new generation video communications, so we will go over your point; virtual surgery simulation – this has been developed by the CSIRO in Canberra and other places in the world. I think in five years you will be able to put surgeons into a pilot type environment with realistic pictures of surgery. If you, say, come from Leeton in New South Wales and you only do two of these cases a year, you know we are going to say it is not safe to be doing it. There might be another way around it. There might be a way that says – we will give you 20 hours on a simulator and you can do that.

There might be a few solutions out there.

Finally, the dreaded computers that have been such a disaster to health over the last few years, I think it is time to start making them work.

I will show you another live database, with a whole country's lithotripsy on a database with their x-rays before and after the treatment. It is a massive project. Very easy to do. We use clerical people to make sure everything happens as we go. There is no mass of Registrars working frantically on weekends trying to get everything together before the meeting next week. It is there all the time. There are exciting developments there, even though health has had such a disastrous record with computers.

Looking at broadband, we are calling it a virtual attendee program. This means that you imagine you are at the meeting. It is not stiff picture of the head and shoulders of the person, you actually take a seat and a little device will sit where your seat night normally be, you can look around, see who is giving you the raspberry, and things like that.

To do that you cannot use telephone lines. You have to use either microwave communications – which we did in this example, fibre optics or satellites. We did an example of this with our previous Government, we took a kidney stone bus up to the dreaded beehive we hooked in a laparoscopic gall bladder, the then Minister for Health, had had one of these operations about three months before, then we showed him a close-up of the gall bladder, he is in the Canterbury Crusaders colours, as you can see, also about two feet high, we thought he started looking a little nervous then, of course coming from the north island. That is the kind of technology you need to get broadband, fibre optics cables, which you are putting around the country at the moment, satellites and microwave, which you have also got.

Virtual surgical assistance is what the buses offer. I gave a demonstration of how that could work; the Cook Islands Government invited me recently. I was supposed to spend six days on the beach and one day doing the demonstration. About six of those days were spent getting the satellite communications to work properly, but we did. Although some nefarious people from Fiji bet a case of beer that the link would not work, we actually did make it work.

This is an urologist helping a well-known general surgeon.

The Hon RON DYER: This is Moree?

Dr GOWLAND: No, this is in New Zealand. This is the gas plasma. We were using a robotic arm, a simple device, to act as a pointer. It is not particularly made for that application. This could be Bill chatting with someone in Manhattan or Sydney about how to carry out a particular procedure.

That is the sort of thing we are looking at. There are little cameras in the light, cameras on the surgeon and at the other side of the world, there is a brief case device, they can switch between cameras, pan and zoom. We are starting off with our friends around the world, but basically we will introduce research surgeons to help us. They are not teaching them to be surgeons. There are all sorts of wrinkles that occur in surgery. As much of what did not work does not get published, no one publishes anything that did not work, and they would bring that knowledge. This technical knowledge can link our surgical teams, and by that I do mean teams, beyond the northern hemisphere electronically, instead of the 24-hour flight, the alcohol, the jet lag, the frustration that in the end we all try and avoid. If the surgeon goes there, only he goes. This way anaesthetists, nurses, anaesthetic technicians, everyone is part of the

knowledge increase.

Virtual x-ray session – and this again was done in Raratonga - so you are joining a meeting and you are going to take a seat up here somewhere and so there you are, you're sitting back there looking at the x-rays that they are showing, and this could be done at Moree. Do you have a weekly x-ray session with the guys?

Dr HUNTER: Not weekly, but we have sessions.

Dr GOWLAND: Well, you might say amongst the three of you: well, it would be quite nice to hook into Sydney somewhere and join their x-ray session once a week as long as we can see their x-rays and they can see ours; and we have figured out ways to do that, so you can zoom up just like you can with your eyes – this was looking at a bowel cancer they were actually showing us and then we showed them our x-ray, which was this chest x-ray, so they were having a look at that, to see what they thought about it, they made some comments about it and they were talking about it here. In fact we gave them a trick diagnosis to see whether they could actually get it, but they did, so that was fun.

Let's just look at other things though. Cytology: we have had a huge investigation in New Zealand into a pathologist – now this could happen here – who erroneously diagnosed or misdiagnosed cancer and a whole lot of cervical cytology, I think we spent $5 million on it. What if that guy, who got busy in his practice and started isolating himself from the young guys - and there was no one else he could easily talk to in his own area anyway – had been able to link with someone else? What say he was at Griffith Base Hospital on his own and he was able to link regularly to everyone, it might be Wagga, but it also might be Sydney or somewhere further, and just be part of their x-ray sessions, their cytology review sessions? So, here's normal cytology, here's patently abnormal, very indicative of cancer and in fact this would be held in that cytology review thing, different from that x-ray one, where the main tool you have is a little microscope that's got a TV camera on it. So we sent that also from Christchurch to Raratonga and they reviewed it for us and I think we proved the point, that you can be a virtual attendee; and that would apply to almost anyone in hospitals. They might be laboratory people, they might be surgeons, they might be nurses, they might be whatever.

The Hon RON DYER: How acceptable to an oncologist is the sort of methodology that you are describing?

Dr GOWLAND: Fine. There's no problem with this.

CHAIR: The biggest issue is that the cost of maintaining your continuing medical education is the cost of hotels and travel. If you go to a meeting, the clinical meeting doesn't cost very much or the presenters don't get paid a lot and so on, but their costs of hiring the hall, the cost of their accommodation, beer and skittles is all terrific and you get a lot of feedback, but the costs of continuing education are the costs of the hotels and accommodation.

Dr GOWLAND: And as we found the cost of not doing it was $5 million in this case; so these are the things that governments have to think seriously about, but one thing I would say is if you can get volume load, that is, get everyone together, you can deal to the telcos. That's what business people respond to: high volume, they'll bring the price down.

CHAIR: New South Wales Health has a number of, all of its major regional hospitals have a video feed, they have these regular meetings - my wife goes to them, the GPs, the surgeons and so on – of issues that are real issues within the system.

Dr GOWLAND: They are doing it for a special item, but I am saying this needs to be part of your weekly culture and then the requirements are slightly higher, because you're not prepared to put up with the poor pictures.

The next one is a standard Power Point presentation and we are talking about PSA here again. This is one of my colleagues in Christchurch; abnormal PSA levels and this kind of stuff. That was the Prime Minister there who asked a question. A very rude Fijian colleague of mine who is an orthopaedic surgeon mentioned where he wouldn't allow me to put my finger in terms of diagnosing his prostate, and there were a lot of laughs, it was a fun meeting and I think we proved the point about these things being fun. It was pretty cold in Christchurch, that was in July last year and we couldn't resist just letting them know that while we were doing all this kind of God's work type of stuff we were in fact on the day before catching a rather large Wahu fish, which is quite a giant, a few kilometres offshore from where we were having the meeting.

Virtual surgery simulation: the CSIRO, I was there about three or four months ago and I'm going to go back again, because I really think they're on to something. Because they are not surgeons, I don't think they realise quite

how close they are to actually cracking it. What they have done is you sit there with your stereo goggles and things like that – this is me operation on what is clearly a model type gall bladder and liver, but again with fast MRIs you will be able to convert that into real scenery, real anatomy.

The thing about the haptic workbench as developed by your CSIRO is that normally when you use computers when you pull up something you can't feel it tug, so you've got no feedback, tactile feedback into your hands, when you cut something with a knife you can't feel it. With this they developed the actual feel. They got me to put an intravenous into the hand, which I hadn't done for years, because my boys always do it. Needless to say, I fluffed it and I got "Ouch" in surround sound.

I was very impressed with this and I think that, along the lines I was talking about, if you're talking about how do we support surgery and techniques, how would we have robotic surgery say at Dubbo Base Hospital, if that's going to the new way of doing it, when they might not do a lot? Well, this is one of the solutions and, you see, you don't have to buy it. This will probably be put in the very big pipelines – you were talking about your video pipelines that may be 30 megabytes a second at the moment – these might need 10 gigabytes a second pipelines, but that's the way the world is going. Very exciting.

The Hon RON DYER: What does the term "Haptic" mean?

Dr GOWLAND: Haptic relates to the tugging feeling, the feedback through your hands. Finally, information technology – and I have seen we have such a terrible record in health with computers, it's hard to imagine we could ever rescue it, but let's look first of all and our principal sorts of things are that we must have live data bases that give you everything straight away. This idea that someone is going to enter data and X months later you are going to get it when everyone has forgotten about it isn't really good enough, so it must run live. This is on our lithotrypter bus and as the patients come on all the identification data has been put in by the office and then telemetered to the bus, they just add the treatment as they go, so there is no retrofitting of stuff which is very expensive of time and energy. Then data acquisition and I know, as a surgeon, we are absolutely hopeless at gathering data and I think 40 surgeons use that lithotrypter bus in New Zealand. I can get about 50 per cent replying, with faxes and e-mails and things when they see them, then it sort of sags down to 20.

We employ data retrieval nurses who work from home who have access to the office computers. They work out who needs to be followed up that hasn't been and ring them. You may say well, there's privacy issues here and I'm sure there are, but these patients really enjoy someone just taking the time of day to talk to them and because they're actually – as you can see, there's the office, it's the same picture and the same picture on the person operating from home, they'll ask medical type questions, which they get very good at answering. There's often closed loops that aren't closed when they leave and all this sort of stuff, they can tidy all that sort of stuff up. And they get the data. So we have something like 90 per cent data on six years of lithotrypsy, it's very high, 92 per cent I think it is. It's pretty good, and we don't have to worry about it because it just happens because nurses are good at that sort of stuff.

Evidence gathering for audit but also for surgeons' information: this is actually very important because you will have heard this word audit bandied around all over the place. It's a rather boring technology and the best you can do is get up to the bar. We should be providing for our surgical teams and other medical teams as well some way where they can actually look at the stuff they have done and figure out better ways to do it. That's a far healthier way to sort of look at how we manage ourselves in the future.

What I wanted to show you is here we have Auckland up here, which does lithotrypsy and way, way down at the backside of New Zealand there's a little place called Invercargill. I'm going to run into our database here, so it's going to just look the same and I'm now going to show you the treatment. I think we have done about 4,000 cases on this which are all in the database. This is just looking at Auckland – it's not easy to see the numbers with the light on, but it's about 600 cases over the last four years. They've all got their x-rays. This just happened to be number one. If I went here, you would have seen last week's x-rays done on the bus there. In the early days I used to keep real track of this, now I don't bother, but it just happens so it's not a problem. So we're going to compare Auckland with the little place called Invercargill right down the bottom here. I am going to make the point that here Auckland is 66 per cent success rate and Invercargill is actually 76 per cent, so the little guys are doing better than the big guys.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Do you have different drivers of this technology, do you?

Dr GOWLAND: Yes. It always uses the people in the local area.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: The bus doesn't have the same surgeon sleeping in the front?

Dr GOWLAND: No, no, you would be schizophrenic to want to do that. No, it very much uses the people that are in the local area. I am not sure whether this remote will allow me to do it, but you can quickly analyse this, you just click on there, and we will click on here. What that automatically does for it, it runs a mathematical test called Kai Square, instantly. A lot of statistics can be done. Normally you send it down to the lab and some guy mulls over it for a month and then he comes back with an answer. Unfortunately for the Invercargill guys the numbers aren't big enough to be statistically significant, but they still feel god about it and what they're really saying is: "yeah, we can do it". Can you imagine if you installed that in your rural communities, that kind of feeling that "We're little but we're better". That's a very healthy way of encouraging people to help themselves because actually in health the only way to make any of our health systems work is for people to help themselves. There's just not enough money around.

The Hon RON DYER: Are you indicating there, there is no statistically significant difference between Auckland and Invercargill?

Dr GOWLAND: Yes, although there is a trend that Invercargill is doing better, but it's not proven yet. I just wanted to make the point though that when you have this kind of data you don't have to send this off to a specialist, you can actually do some quite simple, in fact some quite complicated statistical analysis as you go.

CHAIR: But the good thing is that, as we heard from Tridgil, you can identify outliers and it is the outliers you are interested in, so that Tridgil sits in Sydney and measures what's happening at Dubbo and feeds back to Dubbo what's happening with their various forms of surgery, but this gives you an instant audit this is continuous and updateable, which is fantastic.

Dr GOWLAND: Yes. That's the key thing. That is absolutely the key thing, but the point we're making is that having gone through the process for the Auckland guys, who might think, "Why aren't we doing as well?", they've got to have a mechanism to look around and find why; and ultimately in kidney stones you have got to go back to the x-rays of the kidney stones.

CHAIR: The other good thing is it tells the people at Gisbon they really don't have to travel to Auckland, Auckland is not better, so therefore the thrill of leaving town is not there, the need to.

Dr GOWLAND: Yes. So on the new bus, because it's rigged out like a broadcast studio for this tele-stuff, we're actually going to do surgical weigh points of the surgery and the surgeon will get for his patients a DVD, as he walks off the bus he will have the day's surgery plus the surgical weigh points of all the other cases he ever did. Why I say that, you saw me put that blue matrix up that showed all these results and things; he will be able to click on the ones that didn't do as well and actually revisit the operation, "Is there something in there that wasn't as good, that I didn't do as well?" or probably more likely a sort of case selection factor, a little shrivelled up gall bladder.

If I show you this, this is a gall bladder and one of the things I can tell you about that gall bladder is that is in pretty good nick, but often they're very scarred. So the surgeon would have probably six little 20-second weigh points in that surgery that would enable him to revisit it and if he" got 10 cases out of 100 that didn't do as well, he can look at the 10; so that's the level we want to take databases to in the future, so that's not just audit. On lithotrypsy there's 20 things you would audit, you press a button, they all come up. That's just nothing. This is far more interesting and a more healthy way to stimulate people to look at their own results.

The Hon RON DYER: This technology relates to major city hospitals, base hospitals, district hospitals.

Dr GOWLAND: They can all participate.

The Hon RON DYER: Everyone?

Dr GOWLAND: Yes. This is on my whole database for urology.

The Hon RON DYER: The technology that you are describing has a universal application?

Dr GOWLAND: Yes, absolutely. It is the philosophy of what you're really trying to get and this is where computing stuff goes wrong.

CHAIR: This is where the Minister's new movement into what's called the new incident reporting system, called the Management of Complaint or Concern about a Clinician is heading.

Dr GOWLAND: That's the kind of thing that's being driven by the whip a little bit, which I think is sad. I would like to think we should give the surgical teams a chance to initiate themselves, just the sheer interest of trying to figure out what they're doing and how well they're doing, which has been stimulating it from that end.

CHAIR: The stimulus for the Minister is coming from the fact that he has now accepted the responsibility for the payment to the Treasury managed fund for all incidents associated with public hospital treatment, so he has to put in place a risk management strategy, therefore an investigative strategy.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: You are going to Woop Woop General here and you're assuming that the surgeon at Woop Woop General goes into this – the pantechnicon drives up.

Dr GOWLAND: The surgeon anaesthetist from Woop Woop General would be mucho scared of all this kind of stuff.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: One would have thought so.

Dr GOWLAND: And we have people on the bus that will massage them through it.

The Hon RON DYER: You are saying this is a risk management strategy?

Dr GOWLAND: It is, yes. In its own way it is exactly that.

Dr HUNTER: The thing is that surgery that's performed in Moree, whether it's a breast lump or whatever it is, has to be performed to the same standard as if it's done in PA.

Dr GOWLAND: Or better than. Or better. Never forget that.

Dr HUNTER: At the moment the surgeons out there, the GP surgeons, the rural surgeons are more isolated, they're not hooked into all this sort of stuff at the moment. They can only look at themselves, or they link up with their colleagues from other towns and so on, but not at this level.

Dr GOWLAND: The computer is no big deal. It is the data gathering. It has always been the case that is critical. People must be absolutely clear on what they want, and then employ the people to do the gathering. The final bit about databases is integrating them with normal patient management. Again we had a disastrous record in health, but clearly schedules can be connected there, all different outcomes, reports and things like that can be there.

I want to tell you about an interesting anaesthetic program. Here is our anaesthetic machine, Datex Activa, and it has some software called Idas. A colleague of ours has only just developed it. Basically it means when the patient comes into theatre with they have an implement like a supermarket bar coder and drugs you purchase from a manufacturer who takes account of putting the correct bar code on, but the names of course, and you run it past the bar code and it gives you voice recognition, something like that. Using another bar code you put in the dose and that becomes part of patient's record. It is a safety net.

Once you have started doing that for all the drugs you use, and you have a hand-held bar coder – we have put a keyboard on that there (referred to PowerPoint), you can seek a page and the bar code for the things you actually want, so that is a great help.

You can do better things than that. We see patient that pre-admission clinics and we record this kind of data. If someone is allergic to penicillin, that gets entered into the record. If Idas picks up: penicillin has gone to the bar code – boom, boom, boom; warning, warning, warning. This is what I am talking about, using databases to become part of your daily life, integrating them and creating a much higher level of safety. As we develop Idas even further, it will be a very interesting addition.

That is a record from a cardiac patient each showing the things we have done. A lot of that is done by hand. The advantage of that is, it is always searchable in the future. How many patients did ideas such and such drug to? Up they come. You can look at their records.

In summary, we are talking about a slightly different way of improving and reducing the variability of quality health care. We have done it in a different way than perhaps you have been looking at. We have done it with two things: sharing expensive technology, sharing knowledge with new generation video communications. The first approach we chose to start this off was a mobile surgical unit, which is very expensive, the unit cost about $2 million for the trailer and truck and about $1.5 million for equipment.

As we go into the database for New South Wales, you will note there are some classic examples Walgett, West Wyalong, there are a whole lot of issues.

Where sharing knowledge with new technology and telepresence. The bus straddles those two things. There is the bus (referred PowerPoint); it has steerable rear axles, it drives into hospitals and the more complex hospitals and has GTS tracking. The bus can steer in reverse. It has five television cameras around it, so you can see the crash as well as hear it.

This was a display at a recent International Commonwealth Health Ministers Conference. That is the inside; I will not show you that. Suffice to say, you could go to Moree with the latest generation operating microscope for ophthalmology for cataracts, you could go to Leeton and do the same thing. Because it is shared across the country it has the ability of upgrading all the time, which is the only chance of keeping up with new technology.

It is an operating theatre that does not look too different from the operating theatres we have already, even though it is on wheels. These are the plasma screens (referred to PowerPoint) and the teleprinter we may get a chance to talk about. That is an example of a New Zealand rural hospital it is going to visit. It will park there. You can see these are not exactly flash hospitals. They are cottage type places.

The parent hospital for this, which is equivalent to your base hospital, went on the media and said the nurses were not good enough. The nurse that I employ ran a dozen metropolitan operating theatres, hiring and firing all the time, said they were one of the best groups of nurses in the world because they are so enthusiastic. This is like the cavalry coming, that is the signal it sends, actually way beyond the surgery that it will do.

So, for 18 months what have we done? What does New Zealand know about Australia? We have talked to a lot of people. We are here because we looked at a group in North Sydney who might have been able to build our bus originally. They said, “Why don't you expand it over here?" We started talking to the few people and that is what got us going here.

These are the hospitals we are talking about, the base hospitals and what we think are the potential appropriate hospitals that might be able to do surgery. This is the travel log of what we have done. People say the roads are hopelessly New South Wales; they might be once you are a long way out but basically the roads are good. We have flown a long way out, we have met a lot of people, Dubbo, Peak Hill, Grenfell Hospital, not big enough to entertain doing surgery. We haven't ruled out a lot of places.

Condobolin is on the edge I would say but could in fact be doing it.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Are you not running a business where as a long as the patients come in and go out, it does not matter how big the hospital is?

Dr GOWLAND: No, it was really the volume I was thinking of.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: They are going to go a certain distance. Do you mean how many patients per month are generated?

Dr GOWLAND: Yes, we have that data, what the cases were and what treatments were performed. We would look at Condobolin and the catchment of Condobolin. We would say: 70 were done at Condobolin but 220 went to Parkes, Forbes and all those sorts of places. We might say the catchment is 290. Leeton is definitely another one that needs supporting. Harry Hancock is a GP surgeon in that area.

We travelled from Leeton up to Bourke. Bourke were very suspicious. They want new theatres in their hospital. It looked like the government might welsh by giving them a mobile that they can wheel in and wheel away. There are all those sorts of insecurities you are likely to find in some of those places.

Ultimately the way you can sell this is to show: If you are prepared to share you can have a lot more than if you

are not. That is a fairly simple sort of thing. The Bourke people were not a welcoming group. We know it is very out of character.

We went to Walgett. That is Vlad Maddock, a Serbian freedom fighter and he got permission for the hospital to be built ten years ago. There is Bill's place. The only snapshot that we got was as we were driving out car park. This was back at Tamworth Base Hospital doing a presentation, then back to Sydney overnight.

We have been at the meetings for our nurses to meet your nurses. Generally there has been massive approval for the concept we are talking about. The surgeons would be 50-50 a lot are threatened. There will be surgeons in Albury who will think: We have just opened up a private hospital, is this going to take all the work away to Deniliquin? In a way you just have to work through that, because they have two look at the way they are going if they do not change the way they do things.

We started thinking where we were going. We drew up maps on the computers. That is Tridgil, he has been very helpful, and Bob, and we have got their permission for the initial circuit arrangement. We are looking here at the circuit. We had to assign postcodes to the hospitals. It was a lot of work to get it done.

This is the start of the database. We looked at the database and asked: What is the story in area health? We found the intervention rates for day surgery comparing them amongst themselves. Let us look at the midwest, which I think has one of the highest, here are the day cases for 1998/99, this is 1999/2000 and we now have 2001. There were 38 cases of day surgery per thousand that year and 39 the year after. We have the ability for the 1998/99-year to add the private impact. You put in "private" it goes up 55, quite significant. A lot of private has been done in a lot of those areas, although there are mismatches.

The classic example of the mismatch is if we go to North Sydney, we find it is only 14 per thousand-intervention rate for day surgery. If we add the private, and this is nearly all North Shore, it goes up to 45, quite a significant increase. By far the bulk is being done there privately. I don't know what the politicians think about that. I mean I am a private surgeon. Is it the cheapest away to run a health service to do it all privately? That is something you have to wrestle with.

I have to come back to saying: Whether you are a private or public surgeon or both, credibility is basically maintained by a good public health system. Most have walked away from it not because of the money but because they get sick of not being able to run their own show. I believe they could, if they agree to be accountable, which I think most of them would.

CHAIR: The private doctors, of course, still do a lot of sharing?

Dr GOWLAND: Yes.

The Hon RON DYER: It seems to me there is a degree of the medical politics involved in this. You are referring to what surgeons at Albury might feel?

Dr GOWLAND: Yes massive medical politics, massive. All these things we are talking about have a bigger advantage to give you. An example I use is when hanging on to a ladder two rungs up, someone starts to pull you off, do you hang on tighter, or do you turn around and walk towards the pullee? That is the choice. We are a conservative group. In some ways we get credibility because we are so conservative. In other ways, it is a real difficulty.

We wanted to look at this is information as to what we could actually show in that area. We can pull up any DRG code. Let us go to the most common, gastroscopy and colonoscopy are the most common, then shortly after that there is the major lens procedure, which is cataracts. We can click on that, the numbers will change, and that shows where all the cataracts are being done in New South Wales. We use that to see where procedures are being done.

CHAIR: Is that Lismore, 900 and something?

Dr GOWLAND: No, Lismore is not on it actually. We have Lismore's data, but I have not included the numbers. If we go to "hospitals", we wanted to know what was actually happening –

The Hon Dr ARTHUR CHESTERFIELD-EVANS: This all came from Tridgil?

Dr GOWLAND: Tridgil gave us the discs; we formatted them so we could get the information that was

useful.

Mr BOSSHARD: He gave us the raw data.

Dr GOWLAND: We have the ability here to look at the intervention rate, say for the year 2000, and we could change that by putting in 35, because we think 35 is probably the intervention rate, and the ones that have the intervention rates light up in yellow, less than 35 in their local hospitals.

That then formed a basis of studying exactly what was going on, so let's look at some of the things that are going on. Here's Leeton Hospital. They only do 50 or 70 day cases a year, which seems pretty low, GP surgeon, with an English fellowship; so that seems quite low, so we said: what about the Leeton people? What are they getting done? 330, that's a lot of people leaving town. So we then said, well, look, what are the things that are leaving town and could that surgeon – let's just see what he's doing and see if there's other things he could be trained to do. This is going to be hopeless if it's not big enough for you to see, but I am now going to rank what they are actually doing in Leeton by volume, so that the highest ones are there – and it's not a heck of a lot of stuff. Why? Well, what's going out?

The Hon RON DYER: Where would they leave town to go to?

Dr GOWLAND: We will show you that. We have the colonoscopies and all that kind of stuff. Let's look at major lens procedures. Thirty-three go somewhere. Where? Double click – I know you can't see that well, but 29 of them go to Griffith. If we just look, you all know where Griffith is obviously but let's just see there.

The Hon RON DYER: How much of a problem is that though, if X number of patients go from Leeton to Griffith?

Dr GOWLAND: What we're saying is: Is there a case to be made for supporting Leeton Hospital? There's Griffith, there's Leeton, and it's an hour's drive. Why doesn't the Griffith guy do them in Leeton? Well, he says, the nurses are no good because they don't know what I'm doing, the equipment is no good, they don't have an operating microscope, why should I go?

CHAIR: They don't and they won't.

Dr GOWLAND: They won't, exactly. We're providing a potential option here and the key thing you are really doing as politicians is you are saying to a community: We're prepared to put in a logical idea, share – everyone will understand that – probably the onus is on you to prove to us that it works and because we're not putting down foundations we can wheel it away if you don't make it work.

CHAIR: Or you keep it updated, and in fact why would you bother? How many do they do in Griffith a year?

Dr GOWLAND: About 150.

CHAIR: Again, with the huge expense of putting in a whole operating complex, for 150 you would never do it.

Dr GOWLAND: Exactly, but what we learnt going around New Zealand was if you start letting Leeton take responsibility for some of its own things, you start making a community feel that health is worthwhile, it hasn't got the axe over it all the time, the service organisations will support funding it and all this kind of stuff, and you are quite justified as a government, I reckon, to say to them: Guys, we'll do 50/50 deals with you, you do half, we'll do half. You know, a lot more of those kinds of ratio arrangements.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: If you said, OK, we are going to take your thing to Griffith or Leeton and we're going to do a week of, you know, day only stuff.

Dr GOWLAND: It doesn't go for a week, it only comes for a day.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: A day, all right, well, however long, a period of time. Anyway you're going to put all your surgery through in that time and your local surgeon is going to do it, you beauty, he's so excited, he's all keyed up. What does he do the other 365 days of the year?

Dr GOWLAND: No, the local surgeon isn't going to do the eyes. The eye guy will come from the nearest eye guy, which is Griffith. Why would he do it? Because his volume will go up slightly.

CHAIR: The thing will come to Griffith one day and to Leeton once a fortnight, or once a month.

Dr GOWLAND: It's a pilot also.

CHAIR: What you do is you close down Griffith's eye surgery.

Dr GOWLAND: I've got it doing 150 anyway.

CHAIR: But there's three a week. Why would you bother having a vitrectomy machine, laser, the whole box and dice, for 150? It's not worth it.

Dr GOWLAND: You will know better on that than me.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Why would the surgeon stay in the country? You're going to have young guns who say, "Right mate, you haven't got a hospital appointment, sleep on the front couch for a year".

Dr GOWLAND: Why wouldn't you have a hospital appointment?

The Hon Dr ARTHUR CHESTERFIELD-EVANS: If you assume that the surgeons are going to go there, what are they going to do when the thing isn't there?

Dr HUNTER: You mean the local surgeon?

The Hon Dr ARTHUR CHESTERFIELD-EVANS: The local surgeon. The hospital is going to implode if what work is done is done in your truck. When the truck isn't there what's the surgeon going to do, twiddle your thumbs until you come back?

Dr GOWLAND: No, the truck only goes to those areas when it's a question of providing a resource that they can't afford to have, so they can do appendix operations and things like that, then they just keep on doing them in the hospital. That's fine. This is only adding to it.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: There are more and more things that the hospital doesn't do.

Dr GOWLAND: You come down to: do we close it or do we look at an innovative way to keep it going, if it's genuine? To artificially keep it going, like building theatres in Wyalong, silly; but in fact to genuinely do it, allowing them to share – the Griffith guy still has a job, he's still based at Griffith, but he'll travel to do these and he'll do it because his volume might go up a bit; and he will also do it because, while it's not the latest "top con" microscope now with all the bells and whistles, in five years when that's out of date he knows the latest one will be forgotten.

CHAIR: The best example, Dr Cottee has a practice in Lismore, she visits Maclean. She visits Maclean and she sees patients with a slit lamp and then if they need surgery they go to Lismore. This way Dr Cottee goes to Maclean two days a week and on one day a fortnight she does an operating theatre list with this machine with the proper-you beaut-fantastic eye surgical equipment in Maclean and then she does her consulting in the afternoon and goes home. That's how it works.

Dr HUNTER: The district hospitals that we have been looking at on this rural health implementation consultative group that the Minister set up, we have been looking at district hospitals, we have subdivided them into those – see, it's all linked – that provide obstetric services and surgical services and those that provide surgical services alone. They are the things that keep them going. If you've got an obstetric service you must have a surgical service as well; so you've got all those things going on in your town. The trouble is that they may only have their theatres working three days a week, two days a week or whatever. It's sort of iffy as to whether you keep it going. These places need surgical services. If you didn't have surgical services for the obstetrics you would have 6,000 deliveries that would have to move from district to base hospitals or city or somewhere.

Adding these extra services is the key to keeping those things going. We are now funded by the services we

provide, so that, as you know, the funding follows the patient now; so if the patient moves from Leeton to have their surgery in Griffith, the money will eventually go to Griffith Hospital, not to Leeton.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: So presumably if this truck arrives, you will have a deal where you get a percentage, 50 per cent or whatever, so presumably you have to pay for the truck.

Dr HUNTER: No, I am talking about the funding of the local hospital, not the funding to me or anybody else, but the funding of the local hospital, is determined by what services you provide and the more services that you do in your town, the better your hospital will survive. It's now entrepreneurial. If you don't create services your hospital sinks; and the problem is if you want to create a new service you've got to have money to do it. We wanted to have a visiting gynaecologist come and the management said, "Yes, he can come, as long as it doesn't cost us any money"; but of course he has to do some surgery in the hospital and that's going to cost money for the hospital to do, even though that down the track they're going to get more funding, they can't see themselves putting the money into it.

CHAIR: It's capital front-end loading.

Dr HUNTER: Yes. If his equipment came in a bus he could come and visit the town and provide the service there.

CHAIR: This is the new service like hysteroscopy and so on.

Dr HUNTER: Yes.

Dr GOWLAND: The other thing is we're talking about the surgeon twiddling his thumbs. Basically the bus doesn't do things he's already doing, the bus only does new things, so he's still doing the old things, but there's some things he should be doing. He should be trained to do colonoscopy and gastroscopy, the surgeons can do that, and in fact there's 60 a year colonoscopies and 59 gastroscopies. So why aren't we training them to do it? That's what I said – you weren't at the meeting – to your executive. Why don't we train this guy to do this stuff so more can be done in his own town. He probably just hadn't thought of it or something.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: He probably can't afford the equipment for the volume he would do.

Dr GOWLAND: No, no, no, you see, that's the thing. The equipment comes with the bus.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: That's why he's not doing them now.

Dr GOWLAND: That's exactly the reason he doesn't do them now. So it's easy for us to have the latest safety washer for these scopes, the latest video scopes.

CHAIR: The thing is you can check whether he's actually learnt it and whether his quality controls are as good as other people, because it doesn't matter if he says he's doing it and he does it and the results are so awful you don't want him to do it – what's the point in having it done locally if it's a botch job.

Dr GOWLAND: Yes. So part of this is you must have good telemetry, good data and that's your quality assurance kind of programme that runs on that; but it's very ease, I mean, I occasionally go around and talk to my guys, probably twice a year, give them their reports and then say, "You're not doing as well as the rest of the country, here's the reasons". It's usually because they've taken on stones that are too big and with surgery it would be a similar kind of thing.

The Hon RON DYER: Why does the Government give this a big tick from a health economics point of view?

Dr GOWLAND: Because from a health economise point of view what you have to accept is – and I said this right at the start – the biggest single thing that will influence whether you can make health work here or not isn't the money you pour in, which you are asked to put the dollops in; it's actually the energy of the work force, which I have to admit is pretty low at the moment, but if in fact you can capture that, you can unleash power that you just wouldn't believe and the beaurocrats will never tell you that, they don't understand it themselves. You can.

This is partly about unleashing power. This is partly about the Leeton guys saying: "Our cataracts did better

and we really tried", about the Lions Club getting together and supporting buying something else that they want to fit with it, and all that kind of stuff.

The Hon RON DYER: What if the Government says for the sake of argument in that case, "What is wrong with a patient who needs X procedure going from Leeton one hour to Griffith Base Hospital?

Dr GOWLAND: Exactly, and that's part of the story. Now remember, if he goes there for his cataracts does he stay, does he come back to Leeton that night or do they stay in the local motel overnight? I bet they stay in the local motel.

CHAIR: It is not just that. If Leeton is only operating three days a week, that means they have got theatre nurses who have to work in other areas which they hate, doing ordinary nursing rather than doing theatre nursing back up there doing theatre nursing four days a week and that keeps them interested and keeps them in town, which means they can be on a roster for after hours for emergency cases they do at Leeton. So you have a team of people who are occupied not two days a week doing nothing but cleaning and ticking boxes, or if they get busy in the maternity or busy somewhere else and they flog the theatre nurses out of there. But it's about maintaining the skills or the skill levels in the district hospitals for those periods of times and doing it economically.

Dr HUNTER: There is another factor too, that local communities do want their hospitals to be there when they need them in a hurry. They will go three hours to get their ingrown toenails operated on by a surgeon they think is better than the one in town, but they crush their hand or have chest pain in the middle of the night, they want a hospital there. When we have gone out and raised money for our local hospital for laparoscopic equipment, the most enthusiastic people were the people who would normally go to St Vincent's, because they know that if they get an injury on their farm Moree Hospital is the place that they are going to be and they will fight for that hospital tooth and nail.

Dr GOWLAND: There is another point about this truck that I haven't mentioned yet and that is what we call a camel function. That is, if you have an infrastructure travelling around – and, remember, the Government is supporting this as a pilot in New Zealand, centrally funded. It would be absolutely impossible to go to base hospitals to try and get funding for this sort of thing, because they've all been nervous about it and "It's just going to take work away from us". You can see the politics immediately of what happens.

Our Government is certainly prepared to go to either three or four buses, they think, when the pilot works out well, and that's the challenge for us obviously. They are also prepared to look at all these other technologies that we're talking about. Once you have got an infrastructure of one bus going around you can actually take stuff out into the communities and we're looking at things like digital renal cameras. There's guys that come up to me and have said, "We've got a bone densitometer, could that go out?" The idea would be you would offload those to the hospitals or the local GPs or nurses and they would know it's coming because the schedule rolls ahead a year always, so they know exactly when it's coming and they will actually book it, they're going to book a year in front of me, and so you can actually give in the hands of rural GPs the latest technology that their metropolitan counterparts don't have.

Rightly or wrongly, technology sends its powerful signal. That's why the toenail guy goes to Sydney, because he thinks they haven't got all the equipment.

Dr HUNTER: That's right.

Dr GOWLAND: So we can't get away from it, it's a neon sign. But then shouldn't our GPs – I mean, the biggest single cause of admissions to your hospitals are medical admissions involving heart failure.

The cardiologists keep fairly close echocardiography, but eco units are coming out now that only have to do simple functions that can teach a general practitioner, operating himself, no ecotech or anything, what the patient's ventricular function is in terms of managing drugs. I am told by my cardiology friends that often will result in stopping them taking some of these expensive cardiological drugs. Some will have to go on them, but it costs my hospital, which drains $500,000, something like $5 million a year treating heart failure. Our guys reckon we can cut that in half, if pre-emptively they were treated in the community. So the trouble with communities is you can't get the kit there. The classic is in Condobolin they said, "Oh gee, there's an ultrasound outfit offered to come round and do ultrasounds". So they come the first time, there's eight people there, there's flags set up, the Mayor turns up, and then the next time there's only six and the next time there's four and the guys say, "Oh, should we miss this one and come the next one?" and then the corner store is not open any more and it just trickles down and it dies. So it is just a natural sort of thing. Here, if you have an infrastructure, it does not matter whether they are going to use it or not, it is

just there.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: You are going to change your timetable if customers do not come?

Dr GOWLAND: Yes, of course you are.

CHAIR: Once GP's get more used to it, there is a woman who has been training army people to use the handheld, very transportable ultrasound machine, which costs about $4000 or $5000, and the idea would be to use those standard for diagnostic surgeons.

Dr HUNTER: We have had to learn ultrasound. That may be in the bus but if you only use it for four patients that time, so what, you are using the other equipment in the bus and the other technology.

Dr GOWLAND: A totally different function from the surgery.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: You have amortised your cost?

Dr GOWLAND: Yes, it is just an add-on.

The Hon RON DYER: What sort of response are you getting from New South Wales Health?

Dr GOWLAND: I have met them twice. I am told that quite enthusiastic but I do not sense that.

Dr HUNTER: I think I can quote Debbie Piccone, who I spoke to yesterday about it; she is quite excited about the concept.

Dr GOWLAND: I am quite used to it now. I am reasonably thick skinned. My own Ministry did not want to do this. Now it has been displayed at the International Health Ministers meeting they are coming on board and I am prepared to let the water flow under the bridge. Left to their own devices they would not have done it. It took the politicians to actually crunch it through. The words were: but Minister, there is no money; well, find some; but Minister, it is not one of our priorities; well, make it so. As I was told, there was a fairly acerbic discussion that day to make it all happen. They have changed. They have come on board.

CHAIR: The good thing about both New Zealand and New South Wales is that they both have good financial arrangements for picking out and amortising costs to the various health services. It is not like the old days where it was all smoke and mirrors.

Dr GOWLAND: A lot of the savings that come out of starting to rebreathe life into rural communities comes back in the social area, not only in health. That is an important thing to remember. I talked about the people who have day surgery but they really have to go the night before because the surgery is first thing in the morning, and they really have to stay the night after because it is Johnny's tonsils, mum and dad both go, so they both take time off work.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: It costs a lot of expense.

Dr GOWLAND: We know that is not a health bill at the moment.

CHAIR: All our hospitals have very healthy bed and breakfast establishments for around in Lismore there are four major B and B's that cater for people who come from all over the place to have their cataracts treated.

Dr GOWLAND: I am going to look at the West Wyalong story. I understand three years ago there was a theatre built under a lot of pressure from the town. In those two years there were zero cases and one case. What happens to those people? We can look at the catchment of West Wyalong, about 330 or 340 day surgical cases go out of town and around 300 multi days. We can see where they go.

The Hon RON DYER: Is there any surgeon there?

Dr GOWLAND: No, no one wants to go.

Dr HUNTER: They had two surgeons and an obstetrician and they lost all three of them because of health

service management. They had their theatre time restricted, then they lost their pathology, it was a slow decline. Then they lost all their doctors, three of the best GPs you could possibly get.

The Hon RON DYER: There is an operating theatre there; it is like a hospital with no patients?

Dr GOWLAND: Normally a theatre costs $1 million to build.

CHAIR: There are 600 people moving out of town to go somewhere else from West Wyalong? How far do you travel to the closest hospital?

Dr BOSSHARD: If you have a bus you just move it to another town, you do not waste all that equipment.

CHAIR: How far is West Wyalong from the nearest hospital?

Dr GOWLAND: There is Temora, Griffith, Parkes, Forbes and Orange.

Dr HUNTER: Probably Orange.

CHAIR: It is not a straight line either.

Dr HUNTER: They might go to Griffith.

Dr GOWLAND: Some of the eyes go to Griffith. We spent $2 million on a trailer and $1.5 million on equipment to fit out. Those are the sorts of ratios. That is a fancy trailer because it is mobile. Let us say a theatre costs $1 million and $1.5 million to equip it properly. It is a big deal. They built a theatre in West Wyalong, which has the bricks, mortar and geography anatomically correct, but it is basically useless.

CHAIR: They cost as much as your truck, but your truck is movable.

The Hon RON DYER: You are saying it would be better to have an investment in this mobile facility than, for the sake of argument, having separate, unused operating theatres at West Wyalong, Forbes and Condobolin?

Dr GOWLAND: Exactly.

CHAIR: A place like Griffith where you have a good operating theatre, you might maintain it to a high-level for general surgery but not to any level for eye surgery except emergency eye surgery but not for the high-class intraocular procedures.

Dr GOWLAND: It is designed to complement many of the places that are more advanced but there are some that are falling off the edge - and some should fall off the edge, there is no argument about that. There are some that are teetering but maybe if you supported them you have a much better and easier solution than closing them down.

Dr HUNTER: Because we are getting a decline in the proceduralists in those areas, it is an incentive to get someone there, it is the closest thing to operating so many days a week and when there is a bus coming that will provide that service, it will give enthusiasm to someone to say: I wouldn't mind going to that place and trying that service.

The Hon RON DYER: In your view would you get someone travelling from Dubbo to Orange for a procedure?

Dr HUNTER: For the eye, ENT and that sort of thing, yes. The ultimate would be to have a surgeon on site who can do the emergency work. That is what you want a hospital there for as well; emergency work that is done when the bus is not there, but he could do the extra things like laparoscopic surgery.

The Hon RON DYER: We know there is no such person in West Wyalong.

Dr HUNTER: Or Coonabarabran and but they should have it. Coonabarabran I know better than West Wyalong, this gives them a three-hour trip to Tamworth and Dubbo. Now they have to go to Dubbo to have their babies.

The Hon RON DYER: You say they should have it but they are not going to have it except on a visiting basis when the bus is there, are they?

Dr HUNTER: No I am saying if you try to advertise for a surgeon to go there, he would be dubious he would think: I am going to go to this place, with the amount of surgery there it is going to take me a year so to get up to speed. If part of the deal was: You are going to have that this bus to provide laparoscopic gear that you have not got and to provide colonoscopic gear that you have not yet got, it would give encouragement to the surgeon to say: I am going to try this out.

The Hon RON DYER: It is hard enough to get GPs to locate in small communities.

Dr GOWLAND: We have a budget to reimburse GPs to go and do the really old fashioned thing, to come and assist at surgery on their patients. Part of that will be getting to know the surgeon, part of that will be the anaesthetist, which may be more important because it is airway management. There is a pacuten, people who run computer models for safety with emergency medical care. That team want to join us and follow us around the country at the same time. They will be on the bus at the same time bringing that level of skill to the doctors and nurses in those regional areas.

The modern GPs week might be: On Monday morning he might do a clinic, on Monday afternoon he might see all his home care patients, Tuesday morning he has clinics, Tuesday afternoon he attends one of these virtual attendee sessions because he is interested in something in Sydney and he joins it, Wednesday he looks at x-rays from the previous week for patients and shares those, Thursday he may have a new birth technology lad or someone like that who visits. There is a range of things you can do to make their life better than just the drudgery of day-to-day clinic, morning and afternoon. You cannot baulk at the money. You have to make the job right or the money thing comes back to bite you.

CHAIR: If he is in West Wyalong, even if it is a place he is visiting, if there is a surgeon and anaesthetist visiting that town at least two days a week then the GPs feel a lot better supported because at least two days a week someone is coming to town who the patient may need to see.

Dr GOWLAND: I would like to add to that, if you take the case of a GP in a town without a surgeon, someone gets a tummy pain -- and there has been a case brought to the medical Council where a GP did the wrong thing -- it is very easy for him to, say, shovel it on. It may take two, three hours to the next place but he does not care because he just shovels it on. If he knows the surgeon, because he assists with him every few weeks, then both of them can risk share together because most of those little tummy pains will settle down overnight, but the surgeon has to know when he gets asked: Do I trust this guy? The GP has to know: Do I trust this surgeon not to let me down in the unlikely event something goes wrong?

If you do those two things, little Johnny for a $30 or $50 consultation, saves going to hospital where he has to be admitted to the base hospital, which will never send him home because once you are in it is hard to get out. It takes three days. I think you turn the $30 or $50 consultation into a $2000 extravaganza while he gets tested before he gets back out again. That never appears on any health economics book, but it is the reality of practical practice. That is the importance of people getting together and understanding what is going on.

You do not want your GPs putting their first to down someone's throat who has had a bad car accident and cannot breathe, in the pouring rain in winter, with the gloves on in Moree, you do not want him doing that for the first time in years in those conditions with a torch, you want him to have been up-skilled regularly on that sort of procedure.

Part of our program has a GP Education Program that goes with the Nursing Education Program, which all fits with the bus program. We would like to help them with recruitment of GPs, if we can put technology in their hands that is better than the metro guys then you have the spark of enthusiasm and competition and all the things that make things work.

CHAIR: The best example is the mobile mammogram machines. The Northern Rivers owns two or three, three large semi-trailers. It is the only way you can get patients to go to have their mammograms to fit with the national aim of getting mammography to the people out of Sydney, to take them to the town and have them sitting in the town.

That technology of travelling radiographers, with very high-quality x-ray machines which are read digitally, as is a

fact of life, the one in Lismore cost almost $3/4 of one million each to put together. They are moving around constantly doing 70,000 mammograms per year.

Dr GOWLAND: That has been a very successful program and the same in New Zealand.

The Hon RON DYER: Am I right in thinking that if you introduce the mobile resource you will not do away with the operating theatre in a small, outlying hospital because they will need it for heart attacks and car accidents?

Dr GOWLAND: That is exactly it. That is the sensitivity. There is a town of Omaroo where are we were going to do our second surgery, a year ago their hospital closed and the government agreed to build a fancier medical centre. If we had gone down when the government said the, "We are closing your hospital", we would have been do the out-of-town. We would have been seen as a mobile inferior option. When we went there after they lost their hospital and said, "Here is a way to restart it", it has been red carpet treatment. It is as sensitive as that.

One of the issues that clearly has to be worked through here is that there just is not an excuse to shut you down, put you on wheels then wheel you away if they do not think you are any good. I think your communities would take the challenge, if you are offering them state of the art equipment, and always use regional surgeons, that is a critically important thing, these are base hospital surgeons in the local area who would often normally be doing clinics anyway so we are just adding surgery to what they do; a regular up-skilling program for the nurses, it is part of our arrangement that we train them nationally we bring them all together, and they are suddenly talking to rural nurses from the little places and they said: Well, when we go to the towns we are usually the little guys and no one wants to talk to us, suddenly we have all the same issues to sort out, because we are all small and we understand it.

So those are the sorts of downstream benefits from what is really in its own right a little bit of an icon – and remember, I am only talking about this as the front end of a series of ways to change the way we do things. This, if you like, is a sort of flagship. I thought the lithotrypter bus in New Zealand would be a flagship, but what doctors tend to do is say, "Oh, that's urology, the blue bus is urology, that's nothing to do with us". This transcends everyone and therefore everyone has to be involved. No one gave any flack when the lithotrypter – well, they did give a little bit, but not a lot. There has been quite a bit of flack from nervous people about this, but most of them are shifting around once they see how it's going to work.

CHAIR: The problem with the area health service – a lithotrypter machine on a truck went to Lismore and Brisbane.

Dr GOWLAND: I know.

CHAIR: And that's hard because the local area health service point blank refused to be part of a deal where they paid a fee for service for that. Instead of that they'd send them all to Brisbane.

Dr GOWLAND: They had a guy who would drive this little thing around and who's a bit of a madman because he'd work 24 hours a day driving this huge long haul kind of thing. Is that how it finally wound up?

CHAIR: It failed because the area health service refused to pay what was basically one or two people a month. Most of them were private, of course.

Dr GOWLAND: We think that you have to always see this theatre as an adjunct to the theatre that's needed anyway, isn't it?

Dr HUNTER: Yes, I see it as an incentive to those towns to get GPs. One of the disincentives for GP proceduralists coming to replace the rest of us that are there is that they are worried about being left on their own, like Stuart was saying with that case. If they know they are getting this sort of service as well it's an incentive to come to the town. It's the same for the surgeon who's in the town.

The Hon RON DYER: There seems to be a larger problem than that though in my view. It's easy to understand how it is difficult to attract a GP to a small or medium size country town perhaps, but my understanding is that it's difficult to attract enough GPs to major towns such as Dubbo or Coffs Harbour.

Dr HUNTER: Different thing altogether. The GPs in Dubbo and Coffs Harbour are not proceduralists. I am talking about the smaller towns. That is a slightly different issue. This is m ore to do with the providing the procedural services in that community and the College of Surgeons to which I belong acknowledges that there are

towns that will never have enough population or need to have a full-time surgeon in their town. I am fortunate that I have two other specialist surgeons in the town and we all do a little bit of GP work, but it would support one and a half full-time surgeons, but then the surgeon would never get time off. I am only here because there is someone else at home looking after my work.

Our worry is that we're only using our operating theatre for routine stuff four days a week. We're in the theatre an average of three and a half nights a week with emergencies, but that extra theatre time is what's bringing our hospital down. We have got a visiting ophthalmologist.

CHAIR: But the cost per case looks very high.

Dr HUNTER: Yes, that's right and when the bean counters look at it they say "We'd better split the money into Tamworth. We've got an ophthalmologist who comes to the town every week, but he doesn't do any operations there because there's no gear. If we had this sort of gear there, he would, and the same with the gynaecologist I was talking about. We have a visiting urologist, he comes once every two months.

CHAIR: If you could operate on those patients in Tamworth you could operate on them in Moree and therefore you would be in Moree two days a week.

Dr HUNTER: The other thing is the waiting list in Tamworth is so big, you have to wait so long, whereas if we had it in Moree our waiting list would not be so big.

CHAIR: Well, it may not be, but it would be the same number of dollars allocated for the surgery, but at least he would be there consulting, charging the Commonwealth.

Dr HUNTER: Yes.

CHAIR: For consulting in Moree, rather than the patients having to drive. Unless they can see him on the one day he's in Moree, or wait for a long time to see him, because he would have a long waiting list, you said they would travel to Tamworth to see him and that's a long drive, so there's a lot of added incentives. The Commonwealth is going to pay whether they see him in Moree or in Tamworth, the same dollar. The difference is for the patient it is another $150 to drive down and back again.

Dr HUNTER: Yes.

Dr GOWLAND: You have talked about the GPs you can't get to go to the bigger places and I again see some of these other ideas as applying to them, that is, they will be able to – they might have an interest in some gynaecological thing as it affects general practice; they will be able to look on the net in the future and find this week there's these PowerPoint presentations or whatever going on around the world, you pick the right language, the right time zone and hook in and if you do that you combine with giving them access to technology on a share sort of basis, which the base hospitals could maybe participate in, then I think you've got a recipe which doesn't involve paying them heaps of money, I think you are working on the interest of the job and I think there's a whole heap of people there that are sick of paying metropolitan rates for accommodation and all the other hassles of big towns, but isolation, professional isolation is the first thing that worries them about putting a foot out and testing the water in a small place.

Dr HUNTER: It is too. We are also looking, on this Committee, at increasing the networking that goes on, so that the GP proceduralist I think should be the department of whatever it is he's interested in, surgery or obstetrics or anaesthetics, for that particular area and he gets involved in the teaching, the quality assurance that's going on in that region.

CHAIR: The College of Nursing put a proposal to the New South Wales Health, I don't know whether they got funds or not, to take a caravan, a trailer around for updated nursing skills through country New South Wales. I don't know whether they got the funding for it, but that's their approach, you have to take the education to Moree, to Narrabri, to Dubbo, you can't expect the nurses to travel to Sydney because it costs the area health service not only just the loss of their time, but really big dollars to accommodate them.

Dr GOWLAND: Part of our contract is to do exactly that, provide nursing training, apart from the GP as well. We just found them excellent people to work with, because they have got enthusiasm, that makes the difference, but I think in the end, because one of the things I suppose you might wonder is – this has to be a capped budget thing – I know if I want to by the next day exactly what cases were done on the kidney stone machine and I can see their x-rays at

home if I can be bothered, and I used to in the old days, and I can check if the guy is doing the right kind of cases. As long as everyone knows those sorts of things are happening, a whole lot of stuff never causes trouble, just because they know that it's under control. Part of that is the telemetry of stuff that we've talked about before, that's actually a very important part of this particular project.

Again, I come back to something I said right at the start. The real enhancement for health – and it might sound wishy washy, but I'm sure it's true - is empowering and enhancing the people in the workforce at every kind of level. It must be very depressing to live in one of these places where the axe is sort of sitting over it all the time. How can anyone be creative in that sort of environment? Everyone gives up.

CHAIR: But if you are a funder of health services, what is the point of having somebody's toenail done at Royal Prince Alfred Hospital where you put all of the big dollars in for the high tech stuff and you're doing something which really could be done almost in a GP's surgery; and that's what really bugs me as a funder, to see inappropriate stuff being done, abusing the high tech capital input you put into the place.

Dr HUNTER: I would agree.

The Hon RON DYER: I can see the benefit of this from the point of view of professional development that you have been describing on the way through. Just looking at it from the point of view of the Treasury, shall we say, the funding aspect.

Dr GOWLAND: Yes, who I have to say was my biggest supporter in New Zealand, the Treasury. The guys are always seen as the bad guys.

The Hon RON DYER: You having said that, why was the Treasury in New Zealand a supporter?

Dr GOWLAND: Because I said to those guys, "You're going to have to stop going through three sets of locks to get into your building, which totally isolates you from the world, and get out and see what the real world is about and they were a bit nonplussed by that, but they did. I took them to some of the places to see what actually happened and I think I convinced them – I regard this as like a seed funding of a community to enable them to help themselves because they feel good about what they are doing and then people will actually dream up other ways to do good things. They might still argue with you for money and stuff like that, but you've actually got a community wanting to do it. I was told in rural New Zealand the service organisations stopped funding all the stuff for the hospitals, which they used to do, because: "It might close, will it close, won't it?"

The Hon Dr ARTHUR CHESTERFIELD-EVANS: It gets stolen. If they buy it for their little hospital, it gets taken away to the base hospital and the Rotary Club said, "Well, bugger that, we'll put it in the local pub".

Dr GOWLAND: You have to convince the Treasury that you are seed funding something that actually is basically designed to be a catalyst for a whole range of other activity that works in favour of health.

The Hon RON DYER: But if, say, at Gulargambone if they have a hospital.

CHAIR: They certainly do.

The Hon RON DYER: We are not going to stop the residents of Gulargambone wanting an operating theatre funded at that town.

Dr GOWLAND: One of the things I showed you was the hospitals that we thought weren't appropriate. It's not actually that hard a decision to make, just going round. These are obvious ones that are too small. There's another group, the grey area ones, where sometimes your better solution is to say, "Well, we'll let you have it, because we're not building anything and it's not going to be there forever and we'll wheel it in and if you can make use of it and it works out all right, then we'll look seriously at keeping it there"; but you have got the ability to not make it go as often or not go at all or skew the specialties that use it. There's all sorts of different ways you can flexibly use it, including stopping it going there, if they're not performing.

Dr HUNTER: Ultimately it's the consumer who determines all this, I feel. If the community says, "I don't mind travelling somewhere else to have my eye surgery done", that's what will happen, but if you can make it attractive in your town and it helps other services, and they believe that the quality of the service, in other words the end result, is as good as they're going to get somewhere else, they'll use it.

The Hon RON DYER: There's an old saying: all politics is local.

Dr HUNTER: It is.

The Hon RON DYER: The people in Gulargambone or West Wyalong, Peak Hill, wherever it is, they're still going to want an operating theatre in their town and the visiting facility, if that becomes a reality.

Dr GOWLAND: There's all sorts of halfway houses between that, but I agree with you, they may want the operating theatre. It doesn't mean they necessarily achieve the new one, but remember the operating theatre may not cost as much as what you have got to put in it to make it work. You are always going to have to ration as politicians, you can't get around that. That's life, but I think this might be a way of rationing where you are allowing them to take a lot more control of what actually happens and if they can't front up, you might say, "You guys have got to convince the surgeons to come and all that kind of stuff; and if you can do all that, we'll look at it but if you can't, don't hassle us".

CHAIR: The one thing I can tell you is that consumers know absolutely nothing about the cost of providing the service. You can bet your boots that they have got no idea what the cost is, absolutely none.

The Hon RON DYER: That's right. They have votes though.

CHAIR: They do have votes. Nobody is going to rush in and provide an artificial service at Peak Hill for surgery. They have not had surgery for a long time, it's fine, not going to have it, there's not enough throughput; but the places who are doing three days a week, like Leeton – not like Leeton, but even Griffith is under-utilised for what it's got. What's the point of operating four operating theatres with all the super specialty stuff there, when you're simply not going to use it? And therefore it gets old, and you can't have the most modern stuff so your orthopaedic stuff goes right off.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: But in historic time you've got hugely increased technology costs, haven't you? In this, from a budget point of view you're getting immensely better utilisation for your capital. That's really your key winner, isn't it, in terms of Treasury?

Dr GOWLAND: Total project, a little place gets a $5 million operating suite and there's no way they could afford a $5 million operating suite.

Dr HUNTER: I think the arguments will come down to community arguments as to whether it goes to Forbes or Parkes.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Yes, where's it going to park?

Dr HUNTER: Those hospitals like Peak Hill and so on all grew up when the travelling time was greater. Now people can whiz down the road, but especially in the mid-west and the southwest you've got a whole lot of little hospitals that are very close together. Somebody is going to have to decide, and I would suggest it would be the communities themselves in the first place, where the surgical obstetrics facility is going to be and do you have to travel from Forbes to Parkes to have your baby or Parkes to Forbes to have your baby. That's what it's going to come down to.

CHAIR: Because otherwise you would close both.

Dr HUNTER: Or otherwise you would close both, they lose it altogether, so you have to choose one.

CHAIR: Unless you are doing 60 deliveries a year the department will close your hospital for obstetrics and if you haven't got a surgical capability, which is 24 hours a day availability you simply cannot offer an obstetric service.

Dr HUNTER: You can't do it, so they are the hard questions.

CHAIR: Surgeon leaves town, no more obstetrics, simple.

Dr HUNTER: That's what happened in Coonabarabran.. The surgeon went to Grafton and it all went down from there. The procedural GP then left.

Dr GOWLAND: We would like to think in the future that it's just a quirk of fate where you live, because you're in the world. I haven't really talked to you much about teleprinting surgery today, but we actually think most hospitals will have a telesweep built in, they won't need to come to the car park into a bus, they'll build their own one, and that will just be a part of everyday life. Our phones by the end of this year will be able to have high quality video on them, which means if someone consults me from the west coast they will be able to show me my patients for the renal cholic's x-rays, where the stone is, that kind of stuff. That's all coming, it's not Dreamtime any more. It's going to happen.

CHAIR: I was really excited by this proposal because I have been given more and more evidence from the UK about its usefulness. One might think: Why would you bother in the UK? It is complimentary. It saves huge amounts of capital gear in twenty different places. You are not talking about just little places, you are talking big places that cannot afford to upgrade. It is all paid for by the State and by the area health service trusts, which are individually funded a bit like in New Zealand.

The incentives are there. They either have last year's equipment, which is falling apart, or they share something that is up-to-date. The doctors are saying we will not operate. We are having that problem in Lismore at the moment, one of the ENT surgeons, the third in a row to quit, has said, "I will not operate in this hospital because the equipment is not safe and not adequate for me to do ear surgery." That is Stephen Prince who is having the problem.

Go to Casino, a small place, but the community has bought in all this beautiful gear. They will not let the equipment travel to the Lismore Base Hospital because the local community bought it and every time it goes to the base it gets stolen.

Dr HUNTER: You have actually raised another issue of the role of the hospital; I always thought community hospitals were in the shadow of a base hospital, in fact Tamworth takes minor surgery like arthroscopies to Gunnedah.

CHAIR: Like Prince Alfred does to North Strathfield Private?

Dr HUNTER: Yes, the same thing.

CHAIR: Canterbury Hospital has its operating theatres closed everyday, four operating theatres meant to do routine procedures; all the routine procedures have been brought back to Royal Prince Alfred, thank you very much we got too busy, and is a closed down the operating theatres at Canterbury. What a waste of money and nursing staff.

Dr GOWLAND: The secret to their success is in fact that PA has the single biggest multi-million dollar surgeries in the whole of the State but for day surgery it is one of the lowest.

CHAIR: It is one of the poorest. If you asked the RPA: Do you really think there is a place for any other hospitals in Sydney? They will say: No. Do you think there should be a one, two square kilometre hospital in New South Wales, ask that of the RPA, and they will say: Yes, that is very sensible.

When asked that question in this very room with a previous Minister for Health, 20 doctors from RPA actually thought about it, "Is that possible? "As they closed down South Sydney, Rachel Foster and so on.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: It was not a rhetorical question for them.

CHAIR: This is what you have to worry about. It is not good and it is not sensible. Would you be able to leave us a copy of your PowerPoint presentation?

Dr GOWLAND: We will send you a copy.

(The witnesses withdrew)

(Short adjournment)

GARY THEODORE ECKSTEIN, Demographer, 18 Kendall Road, Castle Cove, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee?

Dr ECKSTEIN: As an expert witness.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Dr ECKSTEIN: I have seen the information you sent me.

CHAIR: The reason we asked you to come along is that we have struggled in terms of whether each area is getting its fair shake off the stick in terms of dollars. We have heard evidence from the Director General and Dr Trigil about quality and quality measures. At the end of the day the Resource Distribution Formula guides funding.

We have been given a copy of the technical paper on that, which is no secret; it is a public document, the 1998/99 revision. I am aware the department continuously upgrades this, more importantly they are going through a major upgrade at the minute. It has been brought to my attention you have been doing the work for the major health area CEOs. As you have been with this since it was born, you may be in a good position to give us some advice on how the Resource Distribution Formula is made up, how it was developed and whether it was a useful delivery, given it was fully funded to the level which the formula indicates to area health services, whether that would be fair to the area health services?

Dr ECKSTEIN: I think I should begin by saying the RDF is a genuine attempt to be fair. All of the people involved in the work are committed to attempting to deliver quality to the health services in New South Wales. Having said that, it is a very complex document, as I am sure you have discovered reading through it. It is made up of lots of parts and within those parts there are a lot of subparts. My colleagues and I will necessarily disagree in certain aspects of it is to whether it fairly is delivering equity, if it was to be funded exactly according to its specifications.

I have argued in terms of the Far West Area Health Service which demonstrably cannot do that and the department has accepted that advice that I have tried to put to it. I understand the Far West Area Health Service has been removed from the RDF.

CHAIR: We are not interested in the Far West because it is not one of the hospitals that are part of the inquiry - not to ignore it, but to that extent it is not part of our concern.

The Hon RON DYER: Why is it impossible to do equity out there?

Dr ECKSTEIN: It is a huge size, the style of health service it offers, and it does not have a Regional Health Service within its boundaries. Statistically it is so different from the rest of the State we argued it should be deleted from the rest of the State.

CHAIR: The demography out there is so bizarre.

Dr ECKSTEIN: Well it is so different and there are a very high number of aboriginal people.

CHAIR: How do you want to approach this?

Dr ECKSTEIN: I can try, as I often do, to give a short general overview and you could interrupt me. I was engaged a couple of months ago by the Rural Chief Executives to prepare a document suitable for their boards to explain the RDF and also to put forward the arguments that could be used for the rural areas in general to put a case to the department that the RDF is not offering fair value for rural New South Wales. I prepared a paper on that. I believe it has been circulated amongst rural CEOs.

CHAIR: Has that document being used by the department in its ongoing review?

Dr ECKSTEIN: Not to my knowledge.

The Hon RON DYER: You said the RDF attempts to give equity. In what respect to do you think it fails, if at all?

Dr ECKSTEIN: Simply because its complexities are so great and there are certain issues within it that are very difficult to quantify. I can mention a view of those, there will necessarily be disagreement even amongst people of goodwill. There are members of the RDF committee who probably see their role more as representational rather than technical and they would see it that they should put forward the case for their particular location.

Other members of the committee are seen to have no particular battle to win and try and put forward an equity case. We do not always agree amongst ourselves, although we tend to agree more with each other than with representational members.

CHAIR: Are there other countries in the world that do population based funding?

Dr ECKSTEIN: Britain has done so for many years, New Zealand experimented with it; those countries for which we have been provided the splits almost necessarily have to concern themselves with population. Probably there are more countries that do not than do. Those countries that are committed to case mix based funding or even jurisdictions, let us say Victoria which some years ago was certainly almost totally committed to case mix based funding, has now mellowed in terms of where they see difficulties with that.

If you are going to fund every hospital according to some case mix model, you do not need to worry about population, except you probably have to put in some form of restriction to make sure you do not get total over servicing to build up your case mix base.

CHAIR: You can reasonably describe New South Wales as a resource distribution or population based funded model, guided or supervised by case mix based funding to check on their expenditure?

Dr ECKSTEIN: That is a fair comment. New South Wales has been looking at episode based funding, primarily it is case mix based, to do exactly what you say.

CHAIR: That is only doing what we are trying to do, compare base hospitals, not compare Lismore Base Hospital with Royal Prince Alfred.

Dr ECKSTEIN: Yes.

CHAIR: And to compare Casino with, say something of the same size, Coonabarabran or something?

Dr ECKSTEIN: Yes.

CHAIR: So, having got that out of the way, could you now go through the RDF and what it means and what it doesn't mean.

Dr ECKSTEIN: Notionally the RDF distributes virtually the whole of the New South Wales health budget that is delivered to areas. There are a few exceptions to that, so that Aboriginal Health Services is excluded, there are some nationally funded centres that are excluded because the money comes from the Commonwealth, but by and large you can say the great majority of the funds that are delivered to areas are notionally distributed by the RDF.

It is divided into the programme budgets that are used by New South Wales Health. There are nine of those, I think, of which the largest is acute in-patient care, so that many people when they talk about the RDF actually are talking about the acute in-patient RDF, but in fact the RDF is nine RDFs, each one of them with its own model, so there's an emergency RDF, a primary and community care RDF and so on. Within each one of those, and let's take acute in-patients as an example, there are a large number of components, but the most important is that the population is weighted for age and needs and the attempt to deliver a weighting for needs involves a fairly substantial statistical component; but then there are a number of other additions and subtractions so that, for instance, a proportion of people who live in a particular area health service and are treated at private hospitals are discounted because the private hospital is providing the service and thee are discussions about what that proportion should be.

CHAIR: Is the model for that, the mechanism for working that out, fairly robust or is it still experimental?

Dr ECKSTEIN: No, no, it's fairly robust. The difficulty I think is that parts of it are much easier to quantify than other parts, so that for instance the part that I probably personally have the greatest concern about is what is called the severity mixed product, which is a funding of $200 million which is delivered to the major referral hospitals on the

basis that the patients seen at those hospitals are sicker than a case mix system can describe and, in addition to that, these major referral hospitals have additional expenses involved with the training of medical staff, which other hospitals don't have to meet. The figure of $200 million is in my view difficult to justify. I would accept a figure, but one of the difficulties I have with the RDF is in my view the $200 million is excessive.

CHAIR: Historically more and more medical personnel are being trained in our major regionals.

Dr ECKSTEIN: Correct.

CHAIR: And in places like Sutherland and Hornsby and so on.

Dr ECKSTEIN: Yes, and also as case mix becomes better quantified – we have gone through a number of iterations of case mix funding – that loading should in my view be lessening, because case mix should be describing better the increase in severity that may be seen by patients at the major referral hospitals.

The Hon RON DYER: Why do you say that the $200 million figure that you mentioned is excessive?

Dr ECKSTEIN: It's one of these things that's very hard, because you can't put a label on it. The $200 million basically comes from an assumption that within themselves the teaching hospitals are equally efficient with, let's say, the rural referral hospitals and therefore the cost per weighted unit, per weighted case mix unit, reflects the true difference in the additional loading that is required by that group of hospitals. I find that argument somewhat difficult to accept.

CHAIR: Some of the funding that central Sydney gets is for state-wide services and that is therefore excluded from the RDF, like the PET scanner and things like that.

Dr ECKSTEIN: It's not excluded from the RDF, it's taken as a component of the RDF, so if it's a state-wide service it is funded off the top if you like; so, yes, it is in the RDF but it is not part of the apportionment.

CHAIR: When you look at numbers of, say, the most important thing is the population weight for various things.

Dr ECKSTEIN: Yes, that's the largest component of the RDF.

CHAIR: Is it possible that some of the area health services are too small to accurately do the allocation of funding on the weighting for population? For example, it is easy statistically to be fair as though more or less you are dealing with biggish numbers. When we had district health services, some of them were too small to be statistically appropriately dealt with with weightings and so on. Are all of the area health services of sufficient size to be accurate with the RDF?

Dr ECKSTEIN: Far West is not.

CHAIR: We have excluded that.

Dr ECKSTEIN: Yes, we have excluded that. Part of the needs is a loading for what we call rurality, so the more rural you are you get a higher loading, so that of the remaining area health services Macquarie receives the highest loading because it is the most rural of these areas. The issue, I think, probably is what size that loading should take and this has been the subject of considerable discussion within the technical committee, but a rural loading does exist.

CHAIR: Some of these things, for example, just looking at the guiding principles, some of them take into account such funding things as superannuation and some don't. I mean, it really is a bit surprising what is included and what is not included in terms of the recurrent funding that comes by resource distribution. For example, the cost of insurance, whether it be from a Treasury managed fund or an allowance within the Treasury managed fund, for workers' compensation and for professional indemnity insurance. It is difficult to know whether they are included or not; and superannuation payments, long service leave is included but superannuation not included. How does that work?

Dr ECKSTEIN: Advice is taken from the finance branch of the department. There are no specifics as to what each component might be built up towards, so that freight for instance is recognised as a more expensive component, but there is no direct recognition of freight in the model. It's just part of the build-up by which a total figure is arrived at and in the end I suppose you come up with a sense of saying, well, this should be a reasonable sort of figure for the

additional costs, be it superannuation, freight. The one that comes to me all the time is locums, and that has not been dealt with and I think should be dealt with because it is increasing to such a degree.

CHAIR: Is the funding we see for health, say the $8.1 billion now, or it is meant to be next year, does that include fully the cost of operating - exclude capital, for the moment?

Dr ECKSTEIN: Yes, it is. I have actually been asked to develop a capital charging RDF.

CHAIR: We have got that paper, that technical paper, a draft technical paper has been given to us, the capital RDF; but excluding capital, and depreciation, which is included in the costs – does that include all of these costs, like superannuation and long service leave and the Treasury managed fund payments?

Dr ECKSTEIN: Not exclusively.

CHAIR: So in other words the cost of running health in New South Wales is substantially more than $8.1 billion if you took all of the costs into account, excluding capital for the moment, the other costs, like the superannuation and the Treasury managed fund payments?

Dr ECKSTEIN: I am not qualified to answer whether it would be more than $8.1 billion. You would need to refer that to someone with a better knowledge of the financial structures in New South Wales.

The Hon RON DYER: You said earlier you are a demographer?

Dr ECKSTEIN: Yes.

The Hon RON DYER: Age weighting as part of the formula, is that appropriately and accurately applied?

Dr ECKSTEIN: I believe so and the department tends to take my advice on that, so I hope so.

CHAIR: How do you validate that?

Dr ECKSTEIN: You validate that against the actual cost weighted admission rates by various age groups. You say that a particular age sex group uses hospitals or uses acute hospitals, if you are talking about the acute hospital RDF, to a certain degree; and that is taken state-wide and it is then looked against your previous year, so we have now for about twenty years a running series of age weights.

CHAIR: But again say, for example, the hospitals as they have done for the last two years cut back on, the share that is allocated to acute overnight has been reduced out of the whole RDF. You will see that.

Dr ECKSTEIN: I accept that.

CHAIR: That means that, for example, the waiting time for hip surgery and knee surgery has blown out, sometimes now many people waiting twelve months.

Dr ECKSTEIN: Yes.

CHAIR: Therefore they will not be accessing the service.

Dr ECKSTEIN: Correct.

CHAIR: Therefore the question about age weighted service needs will be skewed by the application of how much the system is prepared for those acute overnights.

Dr ECKSTEIN: Correct.

CHAIR: Until the system gets stable - and they are continuing to grow at the minute, the waiting times, waiting lists – until the system gets stable, then that could skew the age weighted needs out there to what the department is prepared to provide.

Dr ECKSTEIN: it has not to a large degree, I think because the elective surgery that you are referring to is a

relatively small component of the total age sex weight. We have had it fairly robust. However, I accept the point that children, for instance, receive services more immediately than older people do and therefore we probably will weight more heavily towards children.

CHAIR: But that is fair across the system though.

Dr ECKSTEIN: Yes.

CHAIR: While we might talk about what is fair within an area health service, across the system that inequality if you like is equally applied.

Dr ECKSTEIN: Yes.

CHAIR: Unless you have got a population which has got a lot more kids than another population.

Dr ECKSTEIN: Yes, so that the population with very large numbers of kids, the area health services with very large numbers of kids, say south western Sydney, you might be able to argue, but I think it would be marginal, that they are being advantaged by the fact that they have large numbers of kids.

CHAIR: Did they have to provide the services?

Dr ECKSTEIN: Absolutely.

CHAIR: Which are not cheap?

Dr ECKSTEIN: Yes.

The Hon RON DYER: On the other hand, an area such as the mid-North Coast might have a higher age profile.

Dr ECKSTEIN: It does.

The Hon RON DYER: That would be taken into account?

Dr ECKSTEIN: Correct, so when the age weight of the area health service of the mid-North Coast gets a high weight, South-western Sydney gets a low weight because of the relative proportion of older and younger people.

CHAIR: That does include the real cost of providing those services?

Dr ECKSTEIN: Provided the costing models for the case weight adjustments are correct. I am not directly involved in that. I believe they are, that is giving you a relatively accurate picture.

CHAIR: For example, children might require more technological implements and more staff per day, but they are only in there for three days?

Dr ECKSTEIN: Correct.

CHAIR: Whereas for an older person there is less intensity but a longer stay?

Dr ECKSTEIN: The costing studies are supposed to pick that sort of thing up very well. I am probably a little more concerned about prostheses and how well they are picked up. Probably the actual cost in most the DRG's are not too great, cochlear implant is an example where there may be a problem but in the overall structure of things it is so small it will not matter in the global allocations.

CHAIR: It does matter to the area health services where they are used?

Dr ECKSTEIN: Yes. I have some concerns about prostheses.

The Hon RON DYER: Why might be cost of those not be picked up?

Dr ECKSTEIN: The way in which the costing works for prostheses is perhaps less accurate than the way in which the costing works for the areas Dr Pezzutti was referring to, where I think the models are doing a pretty good job.

CHAIR: In the old days the costing for cardiac pacemakers was a State funded exercise where there was a certain pool of money that the Commonwealth used, they would put 2001 in and they would accept one, but now they get allocated a full budget and there are no little pools of money. When RPA puts in a heart pacemaker it has to come out of its current budget.

The same for Lismore, whereas there used to be a separately held little pool for pacemakers, and Lismore, Wagga or Royal Prince Alfred could use one, now they are included in the budget. For the small area health service, this is a big in-cost; the bigger area health services less but then they use more.

Dr ECKSTEIN: I think that is fair comment.

The Hon RON DYER: How about aboriginality?

Dr ECKSTEIN: It is included in the model and I think it is reflected well. It was new with the 1998/99 Revision. The reason it was not there before was because aboriginality was reasonably well included in socio-economic status and morality. Our feelings were there were still differences, let us say in Bourke there were still differences between aboriginal and non-aboriginal community regardless of socio-economic status. It is now included in the model and I think that is an improvement.

CHAIR: From this document, in relation to growing health services and those declining, rather than those remaining relatively static, are they disadvantaged?

Dr ECKSTEIN: You have picked on one of the areas that I am particularly concerned about. I think the growing areas are okay. The declining areas I am really worried about. The RDF I do not think is equipped to deal with declining populations, whereas you could incrementally provide additional services to growing populations, if you assessed their population growth correctly, you cannot incrementally remove services so easily from a declining populations.

The Hon RON DYER: Why do you say that? As a matter of politics?

Dr ECKSTEIN: No, it is a question that if you have certain services in place, sometimes those services are at the level where you cannot just pull a piece of it out, you have an area of so many kilometres being covered by one speech therapist, you cannot say: Well the speech therapist can now cover an area three times as large. This then creates problems. Whereas in the example of the growing population, you can say: We can now split this one speech therapist who is now overloaded into two speech therapists.

CHAIR: Is that one of the reasons the Greater Murray keeps running into trouble?

Dr ECKSTEIN: Yes, I think it is. Declining populations are something we are not used to. In the area health services we have always had a movement from the smaller commercial centres to the larger. It is only recently, particularly in New England, we are getting a total movement out of the area health service, so population in the whole area is in decline, Tamworth is no longer growing and the rest of New England is declining. The position for New England as a whole is more difficult than the RDF describes.

CHAIR: Those areas have the advantage of the soaked cities where the Department has been able to provide services much more efficiently because the patients have centralised themselves, so the provision of more centralised services has been more efficient, but now they are losing their population, trying to work within their RDF share is not working.

Dr ECKSTEIN: Yes, I agree. Declining populations are something the department needs to look at more seriously. We now have the situation where in initial population projections everything in inland areas of New South Wales has a declining population.

The Hon RON DYER: It could be said failure to adjust negatively for a declining population could be inequitable in terms of a neighbouring growing area?

Dr ECKSTEIN: That could be so.

CHAIR: The department say that they continue to fund using the RDF, they continue to give them their fair share in dollar terms of and while ever the health budget continues to grow, if Greater Murray stays on the same real dollars that they have got this year, then the places to have the growth like mid-North Coast and mid-Northern Rivers get the growth money, they get what they got last year in real terms plus more; but Greater Murray sits there getting the same real dollars as their population declines. Does this still make disadvantage for Greater Murray?

Dr ECKSTEIN: If the department is holding their budget at the same level, probably not. Their costs are going up.

CHAIR: That is the point, you have new technology.

Dr ECKSTEIN: Yes, on the other hand they have less people they have to provide services for. I think a lot of the rural areas are now having to focus more seriously on the role of their hospitals because in a time of declining population I think we are reaching the stage where the role of hospitals and the importance those hospitals hold in small communities needs to be reviewed more actively.

CHAIR: Socially they are the biggest employer in any town.

Dr ECKSTEIN: Absolutely.

CHAIR: They are relatively highly paid jobs to.

Dr ECKSTEIN: Yes, we get very glib statements from metropolitan areas saying to rural areas: Well, all you have to do is close those inefficient hospitals; but given the real situation and the importance of the health service in communities it is something that really, in my view, has to be dealt with, with the community as a whole.

CHAIR: The Central Area Health Services have led by that. They have closed a stack of small hospitals in the city, Western Suburbs, South Sydney, and Marrickville.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: It is the distance travelled. The problem is different I think.

CHAIR: I understand that.

Dr ECKSTEIN: I tend to use the example of Orange where we have four small hospitals within half an hour of Orange. One could say on efficiency grounds we do not need four community hospitals situated within 30 minutes of Orange Base. However, those hospitals are playing central roles in their communities.

CHAIR: It depends how the area health service uses them. Central Sydney, having closed all those small hospitals, now is doing minor surgery in high-quality, high cost real estate. It is crazy.

Dr ECKSTEIN: I agree.

CHAIR: Then they want more money to do it.

The Hon RON DYER: When you say those hospitals in smaller communities are playing central roles, do you mean a central economic role or a central medical role?

Dr ECKSTEIN: No, I don't mean a central medical role, I don't believe they are part of that. They have important roles medically in aged care and certain other fields. No, I was talking about the economic roles within larger towns. I do not believe Molong Hospital needs to exist on medical grounds, given the state of the highway and proximity to Orange. People in Molong do their shopping in Orange. The question of Molong Hospital is about the role it plays for the community.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: When there's declining population areas, though, you've got increasing transport problem, presumably with an ageing population and also increasing demand. Presumably the RDF takes into account the increase in age in the population.

Dr ECKSTEIN: It does.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: But the transport is harder to measure, presumably, because if you have acute needs in older people who have bad transport problems, you have then got, as you said, in terms of service delivery you need those hospitals socially.

Dr ECKSTEIN: Yes. Transport is considered. Probably it is more difficult again to quantify well, and I think what you are saying is correct, but the increasing need for aged care services is addressed in the RDF and particularly in what's called the rehab and extended care model of the RDF and I think that's done fairly well. Also we are working, or I have another contract with the Ageing Disability and Home Care Department and the models that we are developing in that department are being integrated within New South Wales Health under a memorandum of understanding.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Would you be familiar with that transport study that was done by Endcost on rural transport?

Dr ECKSTEIN: I have read it. It is not something I have directly been involved with. I know whenever I go to these areas transport is usually a number one issue.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Is there any way that feeds into your discussions on the RDF?

Dr ECKSTEIN: Yes, it does, because this is always brought forward as an important issue. In small communities there is a loading which is reflected in that. Whether it is sufficient is probably another matter.

CHAIR: Why is the New Children's Hospital excluded before they allocate area health service funding?

Dr ECKSTEIN: I wish I knew.

CHAIR: The Sydney Children's Hospital is exactly the same in its complexity, its set-up, its style and the way in which it manages its business, how it trains people, as the New Children's Hospital. Why isn't the New Children's Hospital just treated as part of Western Sydney and flows via the accounting factor?

Dr ECKSTEIN: I wish I knew. I agree with you totally. I have raised that. Other people have raised that.

CHAIR: Because they simply get historical funding on what they can bash out of the Government.

Dr ECKSTEIN: I think you have to ask the Director General that question. I have no idea.

CHAIR: There is no rationale.

Dr ECKSTEIN: There is no rationale in logic for it.

The Hon RON DYER: Have you received any other credible or other explanation?

Dr ECKSTEIN: No. We are merely informed that the Children's Hospital is excluded.

CHAIR: You are a demographer, I know. It may not be the right question – just simply say no. The way in which the funding for hospitals is made up using the RDF as part of it but then the whole patient fee thing comes into it and what is raised from the special funds and so on.

Dr ECKSTEIN: The special purpose and trust funds are excluded. Finance wants revenue included. I have resisted it personally, because I don't believe that you can have an RDF for revenue.

CHAIR: Well, they have, they do.

Dr ECKSTEIN: Yes, I know.

CHAIR: And the same goes for the special purpose funds. If you live in a wealthy area, for example, the Royal North Shore, then you are more likely to get bequests from people who are public spirited and who have got money to follow it up.

Dr ECKSTEIN: Especially if you are a children's hospital.

CHAIR: Exactly, so why wouldn't those, where they are successful – when the New Children's Hospital was built I know that we put $200 million into it, I think, and I think the community fund raising across New South Wales was another $40 million for the capital to build the place, to put bits into it, and that was across the state. Why are the special purpose funds excluded, especially for some things like capital?

Dr ECKSTEIN: The argument that is used is that they are excluded because if the community efforts made in creating a larger pool for special purpose and trust funds were incorporated within the RDF, then those efforts might be diminished.

CHAIR: But if that were true then the needs based part of the formula for adjusting the population should sort of counterbalance that a bit, shouldn't it?

Dr ECKSTEIN: Look, I agree with you.

CHAIR: You do it for the private patients.

Dr ECKSTEIN: Yes.

CHAIR: For the services by private hospitals, but not for this.

Dr ECKSTEIN: To me the analogy was the Home and Community Care budget. That is outside the control of New South Wales Health. One could have argued that it should be outside the RDF. I argued at the time it should not be outside the RDF for exactly the same reason, that they are special purpose and trust funds. If you are getting a lot of money under Home and Community Care, well then you do not have to spend it in your own aged care services; and that argument was carried, so Home and Community Care is included but special purpose and trust funds are excluded.

CHAIR: I am surprised again to find the excluding of things like the payments of the Treasury managed fund and so on. I cannot see why they would be excluded because they would be on the basis of the number of people employed locally. It just seems extraordinary.

Dr ECKSTEIN: I can't answer that, I am sorry.

CHAIR; Again, the funding to non-government organisations is again excluded.

Dr ECKSTEIN: Yes. This was very similar. I again argued that it should be included. In fact at one time, I don't know if that's still true, the non-government organisations that were funded through area health services were included and it was only the statewide non-government organisations that were excluded. I think at a later date it was decided outside the Committee that all non-government organisations –

CHAIR: That is particularly important for the RDF for mental health, isn't it?

Dr ECKSTEIN: The RDF for mental health does not exist at the moment.

CHAIR: It is being developed, but that will become one of the complicating factors, because quite a lot of area health services have supported accommodation and so on, which comes under NGOs.

Dr ECKSTEIN: Yes.

CHAIR: And therefore you would want to know how much there was.

Dr ECKSTEIN: You would.

CHAIR: That is a hidden benefit, I suppose, or a hidden amount of money which has been provided by the state.

Dr ECKSTEIN: There have been very great difficulties in developing an RDF for mental health and that is

one of the issues. There are a number of others where I particularly have concerns, so we just have to wait and see what the department does.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: Is this because it is difficult to quantify the degree of mental health disability in the community in that it seems to absorb whatever services you put in, it is elastic?

Dr ECKSTEIN: No, it is not the reason. The reason - I believe I can speak openly, can't I – is that there is friction between the mental health directorate within New South Wales Health and the RDF in terms of the role of the RDF, so that there are certain decisions taken by the Centre for Mental Health in what they would like to see the mental health RDF as being, which I and most other members of the Committee see as not being part of principles of equity.

CHAIR: is part of the problem that the amount allocated out of the budget that's remaining for spending on recurrent health services, that mental health is not allocated enough of the share compared with say acute overnight or mental health?

Dr ECKSTEIN: That could be, but it is not the reason that we're having difficulties with the model.

CHAIR: Because again you would work on some sort of needs base, work on the predominance of certain illnesses in certain communities?

Dr ECKSTEIN: Yes.

CHAIR: Because that is published every year?

Dr ECKSTEIN: Yes. It may well be true. The way in which the RDF works is that the quantum of funding for each of the programmes is itself decided independently, so that the amount for mental health of $500 million, or whatever it is, is decided by the department, not by the Technical Committee of the RDF.

CHAIR: There is a difference. For example, we have just got evidence that the amount of money for community based services has been increasing dramatically over the last three years.

Dr ECKSTEIN: Correct.

CHAIR: And of course acute overnights have fallen a little bit off.

Dr ECKSTEIN: Yes.

CHAIR: But given that acute overnight is billions and community health services is millions, then you get big improvements in services for a small loss at the top.

Dr ECKSTEIN: And decisions have been taken to move particular procedures out of acute inpatient care and into outpatient care, so that dialysis, for instance, is no longer being regarded as an acute inpatient service, so that there is a bit of definitional reasons as well.

CHAIR: Why don't the areas get that right? That is one of the reasons we have for Greater Murray having failures and wins or whatever, because they did not get their accounting right.

Dr ECKSTEIN: I don't know why. I think perhaps the finance people in the areas may not understand the importance of it. I am particularly worried about teaching and research, because the figures that come in from the area health services don't make a lot of sense to me and I am sure that the accounting principles are different.

CHAIR: Do you mean if they sharpen themselves up they would be able to get a fairer shake of the crack?

Dr ECKSTEIN: Probably, and while I think guidelines are given to the area health services, I am less sure that the finance people fully follow those guidelines. Certainly in terms of direct teaching and research; indirect is a completely different matter, but in terms of direct teaching and research the reported expenditures by the areas don't seem to match up to what one would intuitively expect.

The Hon RON DYER: You said earlier that the resource distribution formula is undoubtedly complex. I suppose it is always possible to argue the rights and wrongs of a complex formula or system. Intuitively or, better than

that, on the basis of your professional expertise, what is your view regarding the resources distribution formula? Is it overall equitable? Is it failing?

Dr ECKSTEIN: No, I think overall it's fairly good. I suppose I am biased because, as Dr Pezzutti said, I have been involved from the beginning. I know it's genuine, it's a genuine attempt. It is necessarily complex, because people are always introducing new issues which they wish to be incorporated in the formula; so that for instance let's take the example of Greater Murray. There was an argument put forward to us that itinerant workers are so important in terms of the health care needed in Greater Murray that this needs to be incorporated in the RDF.

The Hon RON DYER: There should be some element of safety, should there not, in the willingness to consider new factors?

Dr ECKSTEIN: Yes, and it has to be significant at least to the second decimal point. That is the sort of process. If it is not significant to the second decimal point, look, it's just adding to the complexity.

CHAIR: Once you allowed flows and then that overcame many problems from a tourism point of view except for interstate flows, and the same goes for itinerant workers, it doesn't really matter if somebody from Lismore goes and works at Wagga, because you can allocate the funding against Lismore because that is a flow, but if they come from Victoria, it is very difficult to screw the Victorian Government for the dough, they won't pay.

Dr ECKSTEIN: Correct. Absolutely.

The Hon RON DYER: Except where there is a defined agreement as between Albury and Wodonga.

Dr ECKSTEIN: For inpatients. Yes, for inpatients there are defined agreements, but not for outpatients, except for the ACT who insisted that they receive funding for outpatients.

CHAIR: With the formula, again where it does take into account revenue, this statement says:

Whilst there is strong equity argument to add revenue together with the department's contribution to areas to create a pool which represents the resources for health services available to areas, there is also the argument that treatment of revenue in a resource distribution formula should not distort the department's policy that creates incentives to collect revenue.

In other words, if you spend a fair bit of effort collecting revenue and you get it, then all you'll do is the Government says, "Well, you got $20 million, we're going to give you $20 million less".

Dr ECKSTEIN: Yes, precisely.

CHAIR: And if you get more, because you are able to, because your area health service has got more people who are chargeable or more big factories where there is workers' compensation involved or whatever, or more accidents, how does the department not distort?

Dr ECKSTEIN: It has to distort, in my view. The question of revenue has been difficult because I think equitable treatment is too elusive, for the reasons you have mentioned. I would have preferred revenue to have been left to a different mechanism rather than incorporated in the RDF. I do understand why it was introduced, but I don't believe that we really have been able to come up with a mechanism which equitably treats the revenue raising.

CHAIR: The department said they were going to review it in 1998/99.

Dr ECKSTEIN: Yes.

CHAIR: Have you any idea what happened as a result of that review?

Dr ECKSTEIN: I am unaware of any review that took place. It's a question you would need to ask the department. I certainly do know that it hasn't been raised subsequently in the Technical Committee of the RDF.

CHAIR: Again, it is interesting when you look at the components that go into – you see all these components, there is population, health, non inpatient services, then you have oral, primary, outpatients, etc. Suddenly the treatment of HIV Aids is shoved into outpatients.

Dr ECKSTEIN: Yes. The reason it was shoved into outpatients was that it was looked after by one area of the department and they found it difficult to subdivide it, so for convenience sake the whole of it was put into outpatients. I don't think it caused a distortion.

CHAIR: There's only small amounts of money, but where you're talking the Northern Rivers Area Health Service with a budget of only $200 million, versus Central Sydney which might have more than $1.3 billion, the same number of patients with HIV AIDS, you can see that there could be a distortion.

Dr ECKSTEIN: Look, it's possible. I don't think it really could cause a main difficulty. The alternative would be to declare HIV AIDS a programme in its own right, like mental health is, and then we would have another programme.

CHAIR: Then you run the risk of it being subject to great political influence from outside.

Dr ECKSTEIN: I think pragmatically, putting it together in the one - I was involved in these discussions. The feeling was outpatients is probably a better place for it than in-patients, since we had to use the total information that came from the HIV branch of the department, that is what was done.

CHAIR: In all those areas there are programs. Some of those programs cannot be interfered with, like mental health is not meant to be scavenged from by other parts of the budget although areas do try to make it very fine from time to time -- but in all other areas of health funding for population, health and so one, whilst each area gets a national global budget based on -- and the formula of what they should get for the year is made up of all these little RDF's which work up to the big RDF -- the Northern Rivers may get four percent of the funding for mental health from the whole State and the whole State provides eight percent of its whole money into mental health. That cannot be plundered.

Dr ECKSTEIN: Yes, it is quarantined.

CHAIR: That cannot be plundered for something legitimately. For example, outpatients gets 10 percent of the State budget but you can plunder all of that. While Northern Rivers might get 9 percent of that RDF they can spend the whole of that on anything they like. What control is there over that sort of movement?

Dr ECKSTEIN: I am not aware of any policing that goes on directly with area health. The argument is that if we are going to set up regional management we should let them manage. I think probably they would find it difficult to justify extreme positions where they would say: Oh, look we are not going to spend any money on outpatients, we do not believe outpatient services are any good. We are going to spend all this money on in patient care. I think they would find that difficult to justify.

CHAIR: If Northern Rivers makes the decision to move $15 million out of its acute overnight services, into community-based services because that is the view of what they think they need, they will tolerate an increase in their waiting lists, they will report that to the Department but that is the manager's managing.

Dr ECKSTEIN: Correct. That is my understanding. I am not privy to discussions that take place between the Director-General and the area health services about the way in which they are delivering services. I assume that there are some discussions.

CHAIR: The clinicians will say: You have all these beds closed because you have cut back on the funding for acute overnight and they blame the State Government, when it may well be they have to look at their own area management who have made strategic decisions about what to fund. Is that the case?

Dr ECKSTEIN: That is correct. The first place they should look, from the clinician's point of view, would be the area health service because they have decided how the global budget is to be expended and they are responsible for taking those decisions.

CHAIR: This budget this year is meant to deliver the fair share using the current formula for each area health service plus or minus two percent.

Dr ECKSTEIN: Yes.

CHAIR: That is a four percent variation.

Dr ECKSTEIN: It is.

CHAIR: Northern Rivers might have a budget of $200 million; you are talking about whether they get 202 or 198?

Dr ECKSTEIN: Yes.

CHAIR: Since Northern Rivers and mid North Coast are well behind on the RDF, these are significant numbers.

Dr ECKSTEIN: They are.

CHAIR: Is it reasonable for the Department to go plus or minus two percent given they are taking small dollars for them, $8.4 billion, but bigger dollars for Greater Murray, which might have 198?

Dr ECKSTEIN: I am not a great believer in funding totally by formula. I believe the formula is a useful device and decision-making on the actual allocations should be well guided by it. I would hope that in cases of areas where two percent will make a big difference, serious consideration would be given as to why it is going to be plus or minus two percent; but I do support the concept of a leeway, of an ability to be able to say: We will provide you with more but that means someone else might have to get somewhat less than the RDF share would allow.

CHAIR: If New England is two percent over their RDF and mid-North Coast and Northern Rivers are two percent under, the department has said by the 2002/2003 budget we will have a fair share of funding. That is what they said.

Dr ECKSTEIN: That is what they say.

CHAIR: Then they come along with a plus or minus two percent. Surely the department in its ability to be fair should be prepared to come out and say: we are funding New England two percent because of these seven reasons, therefore mid North Coast is getting less than two percent of their fair share for these four reasons. It is not the government. The Minister will not say: I want you to increase it by $3 million there or $2 million unless there is a reason. The department does not like that interference.

If the Government's policy is two percent, they are going to be spot on, plus or minus a bit, surely the department and the Minister should be prepared to say why Greater Murray got two percent more?

Dr ECKSTEIN: Absolutely. I think the department, certainly the Minister would be conscious of the problems. When the current Government was first elected they decided they would fund absolutely by the RDF and they changed the name from the RAF to the RDF -- and as I am sure the Committee is aware that lead to certain difficulties. My own view at the time was that funding so prescriptively does not allow some level of flexibility. Somewhere you have to draw the line and say: We will be within a certain limit. Again I'm probably not qualified, but two percent does not sound unreasonable.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: You would argue there should be a transparency as to what the formula is and why it has blown out?

Dr ECKSTEIN: Yes.

The Hon Dr ARTHUR CHESTERFIELD-EVANS: These data should be available.

Dr ECKSTEIN: In Dr. Pezzutti's area we are having a large redevelopment at Tweed which will necessarily require a jump in recurrent expenditure when that comes on board and it is possible that will affect the total Northern Rivers allocation to account for the fact a major capital works has come on stream.

CHAIR: It may put pressure on Northern Rivers to rationalise what is happening in the Tweed Valley, where it has changed what was happening at Murwillumbah because of the new facility at Tweed, but that might also bring money back to them because they will be providing more services across the border.

Dr ECKSTEIN: In the planning that should be occurring.

The Hon RON DYER: To the extent plus or minus two percent is available, does that not mean central administration is able to better take account of new developments such as that?

Dr ECKSTEIN: I agree.

CHAIR: It also gives them something to hide behind if they do not want to bite the bullet.

Dr ECKSTEIN: That is true.

CHAIR: There are questions that have been prepared by the staff. Would you be prepared to answer some of those in writing? The answers do not have to be lengthy.

Is it a commercial secret what you told the area health services about what they should be looking for when the whole thing was reviewed?

Dr ECKSTEIN: I do not believe it is a commercial secret. I am a private consultant. I was contracted by that area to produce a document for them. I cannot see any reason why that should be commercially restricted. I would be happy to make it available to you. Probably it would be appropriate if they gave me a release.

CHAIR: Would you mind checking that? If there is a problem, I understand. It is a commercial contract. If you have given them the arguments used to the department, we will be able to add more weight to it, only if they are happy.

Dr ECKSTEIN: I have no problem requesting that.

CHAIR: If there is a problem, or they want certain parts excluded -- even what parts you can. This is fitting into the department's review of the RDF, so the RDF we see in two years might have a different complexion, but then we have to go through the process. We have taken since 1988 to get to the stage of being plus or minus two percent. If they move the goalposts with the RDF, how long is it going to take for the result of this to settle -- three years, four year, five years?

Dr ECKSTEIN: It should not be more than two or three years. I have been surprised it has taken as long as it has for the Department to produce the next revision. I understand it will be this year. I am a little surprised that is before the census results will be released in July because that will affect the population base. My understanding is that the Department intends to produce the next revision before the census results are available. So, still using the estimated resident population before June 2000, that will be corrected when the census results come out.

The Hon RON DYER: In a sense the goalposts regarding RDF do move however slightly from time to time?

Dr ECKSTEIN: Yes.

The Hon RON DYER: Is it not inherently the case that would be so, given the criteria within the RDF are under regular review?

Dr ECKSTEIN: Particularly the needs index was extensively reviewed and has been circulated for discussion. While there has been fairly extensive discussion I believe that has been accepted. The Health Services Research Group at Newcastle University found that, and I am associated with that group. That has meant the loading for rural areas has increased, which I personally have supported the scores; not all my colleagues believe that is appropriate.

The Hon RON DYER: Does the socio-economic aspect of the RDF work effectively?

Dr ECKSTEIN: I believe that is so.

CHAIR: In terms of flows, Central Sydney sets up a bone and joint institute and sends a letter to all GPs stating: If you have a patient needing their hip or their knee treated, here we are, a place of excellence, specially built, fantastic, on Missenden Road and we will deal with them for you. Of course they are waiting away in Lismore. What is the disincentive the department operates to stop every patient waiting six months or a year at Port Macquarie to get in a

car, drive down and be referred by their general practitioner to the bone and joint unit at Royal Prince Alfred and therefore have mid North Coast Area Health Service pay Central Sydney?

Dr ECKSTEIN: There is no disincentive. I suppose it depends on the contractual arrangements in place between central Sydney and mid North Coast.But it is intended that that be the case.

CHAIR: There are none, and they are not proposed as far as I can tell from the Director-General that there be contracts, otherwise Mid North Coast would say to the GP "You can send them to Sydney to have their hip done, but only if they go to Prince Alfred" and they are not allowed to do that.

Dr ECKSTEIN: Yes, I'm not directly involved with it but my understanding was that following the decision -

CHAIR: But, sorry, the only reason for pointing that out, that would be an aberration, that would be a new aberration, something quite new from what's been happening in the past, wouldn't it?

Dr ECKSTEIN: Yes, the flows are fairly reliable and in fact most area health services have reversed some of their flows. I am more concerned about the flows from the border areas interstate, because that's funded under the Medicare agreement and it goes through central office.

CHAIR: Not any more. Now that money is given to the area health services in their budget.

Dr ECKSTEIN: Yes, but at interstate prices. My understanding is that the areas on the borders are not expected to meet the costs of those interstate flows at inter area rates, that they receive funding for interstate rates.

CHAIR: Yes, they do. The difference, say Northern Rivers there's $19 million costs going out, $11 million income coming in, and that flow correction appeared in last year's budget.

Dr ECKSTEIN: I am talking about the price paid per DRG, which is higher.

CHAIR: We are talking dollars.

Dr ECKSTEIN: We are talking dollars.

CHAIR: $19 million versus $11 million. Not patients, we are talking $19 million.

Dr ECKSTEIN: Yes, but the price per patient that's worked out under the Medicare agreement is a higher price.

CHAIR: Absolutely. That's covered in the RDF document though.

Dr ECKSTEIN: Yes.

CHAIR: Because those prices, those are cost weighted separations.

Dr ECKSTEIN: Yes, nationally cost weighted.

CHAIR: Aren't they the figures that Victoria substantially pays?

Dr ECKSTEIN: Yes. Yes, but within New South Wales the notional figure for inter area flows is a lower figure.

CHAIR: If there's any further questions that we think of, because we're about to put a discussion paper out, then we're going to get feedback from the community. We have put out the technical paper with the discussion paper so they can look at that. If there is any questions that come up as a result of that which people have difficulty with, is it possible for us to be in touch.

Dr ECKSTEIN: Certainly, I can leave my card.

CHAIR: Thank you very much. These are the questions that the staff have worked out and if you think they

have been answered today don't cover them, but if we could have the answers say within a month that would be helpful because we won't get back to this issue until we start talking to the people out there in the community and it would be helpful if we have some answers to their questions.

Dr ECKSTEIN: In the meantime I will talk to the rural CEOs about releasing that.

(The witness withdrew)

(The Committee adjourned at 1.20 p.m.)