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 Monday 3 December 2001

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The Committee met at 2.30 p.m.

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PRESENT

The Hon. Dr B.P.V. Pezzutti (Chair)
The Hon. Dr A. Chesterfield-Evans (Dep. Chair)

The Hon. R.D. Dyer
The Hon. D.F. Moppett
The Hon. Janelle Saffin
The Hon. H.S. Tsang

KENNETH REGINALD BARKER, General Manager, Financial Commercial Services, New South Wales Department of Health, Locked Mail Bag 961, North Sydney, sworn and examined:

EDWIN JAMES PEARSE, Director of Funding and Systems Policy, New South Wales Health Department, Level 9, 73 Miller Street, North Sydney, affirmed and examined:

Mr PEARSE: Thank you for the opportunity to present some further information to you today about the Resource Distribution Formula. I understand the Director-General has already given evidence concerning the formula and my role is to provide more detailed information on how the formula operates. Ken Barker will be able to answer questions about the budget process, including some of the issues about how the formula is used in shaping budgets. I want to start by just addressing a couple of questions about what the Resource Distribution Formula is about. It provides a basis for guiding how available funds are allocated between our regionally based area health services.

At its core the formula is essentially population based, that is, its approach to distributing funds is to try to reflect where people live across New South Wales, take account of their health needs and the costs of delivering services to those populations. There are some components in the formula that are not directly related to populations but these form a minor aspect of the formula. I should emphasis the formula provides a guide to the distribution of funds rather than a basis for determining precise budgets.

The Hon. RONALD DYER: Pardon me, before you proceed, what are the non-population bases for criteria that are built into the formula, albeit, as you say, your minor factors?

Mr PEARSE: A few issues like teaching and research functions are not necessarily related directly to population. There are a number of programs where the populations that drive the allocation formulas really are not the core population of the state. Rather, they might be a specific population group in the state. So I will talk about some of those non-populations elements later. The key principle guiding the development of the formula is to enable the various geographical areas of New South Wales to have comparable access to services given their health needs and the costs of delivering services. I should emphasise that the formula is a relative share model. It does not seek to identify absolute levels of resources required, rather it seeks to provide guidance on the appropriate share of resources that are available.

I would like to give a brief overview of the process involved in determining the Resource Distribution Formula targets and then talk about each step in a little more detail. The initial starting point is to determine the resource distribution pool to which the formula is applied. Separate consideration is then given to a number of components and, Mr Chairman, that relates to an earlier issue you were raising with me here. These components are aligned to the New South Wales health programs although there are some minor differences. Oral health for example is considered as a separate component. Acute in-patient services are considered as one component rather than looking at overnight and same day services together, although what we do, is look at maternity services separate to other acute services. For each component-

The Hon. RONALD DYER: I notice mental is not there.

Mr PEARSE: At the moment mental health is being dealt with as a separate process for developing a formula there. The formula for mental health has not been finalised. We have really tried to deal with that separate to the main body of the RDF. At this point, once we have looked at the different components we look at the range of factors that might affect need and cost of service delivery. By aggregating these we then aggregate these effects together and then look at the impact of patient flows across boundaries, both within the state across area health service boundaries and also interstate. I want to now describe these steps in more detail. The formula applies to all expenditure areas other than a limited set of services such as corrections health, ambulance services, State Government nursing homes, grants to non-Government organisations, programs with a specific focus, special purpose and trust funds. As you mentioned, mental health is actually dealt with separately although the intention is to have an RDF style process for those services.

The Hon. RONALD DYER: So that slide should be changed, should it not, because it does not refer to all expenditure areas other than a limited set--"Except for mental health and those."

CHAIR: There is a Resource Distribution Formula that is being developed for mental health, not as a separate process, yes.

The Hon. RONALD DYER: Is a question of social disadvantage input to the RDF?

Mr PEARSE: Yes it is and I will talk further about how we do take that into account. In this slide I have provided an idea of how funds within the RDF pool are distributed across those components. I actually did include mental health in this slide, but then it is taken out and as I said, dealt with separately.

CHAIR: In other words you allocate it as a percentage of the expenditure budget at 8.3 per cent, although I think the Minister's move in that percentage is lucrative, but the way in which the RDF is dealt with separately?

Mr PEARSE: That is right, yes, that is right.

CHAIR: I think people should understand that. It used to be dealt with in the same way but they are not going to get close to mental health distribution fairly until four years time and developing a new formula. I think that is not overstepping the mark, is it, what I said?

Mr PEARSE: Mental health was never officially part of the Resource Distribution Formula but it has been dealt with separately for a number of years. It has not really been finalised in terms of the Resource Distribution Formula for mental health but as I said we are dealing with that separately, yes.

CHAIR: So by the year 2003 what percentage will it be? Will it still be 8.3?

Mr PEARSE: I could not answer that question. Ken might have a better idea of that.

CHAIR: Isn't it growing a little bit?

Mr BARKER: It is growing. The Minister has said--there is definitely extra money has been allocated to health services specifically for mental health. Mental health is a protected program in terms of the budget programs. Some areas will add to that but they cannot take money out of that pool and I guess the issue is relative to the dollars in the other program but I think he has announced it was about 75 million going into it over a three year period.

CHAIR: I am not sure but I think it was 187.

Mr BARKER: No, it was 107 million I think was the figure that was quoted back--I have got the figure here and I will check that out for you.

CHAIR: But that might change, that percentage, from 8.3.

Mr BARKER: Yes, it could, and the real dollars is extra real dollars--

CHAIR: Yes, that's right.

Mr PEARSE: I want to talk now about the sorts of factors that we take into account in relation to each of those components of expenditure. This is a list of the types of considerations that we look at. First of all there is the population of the area health service and that in reality is the most important factor, the number of people residing within an area health service. We then consider the impact of the age and sex composition of an area, is there evidence that those demographic factors have an impact on the level of demand for a particular component of health expenditure.

CHAIR: I think, for the other members of the Committee, you might explain why that is important. You have got another slide?

Mr PEARSE: I have got another slide which should illustrate that. We then look at other factors over and above these, that impact on our assessment of the needs of the population, other factors above the demographic composition and this is where the question of social disadvantage often comes into consideration.

CHAIR: And dispersed populations?

The Hon. DOUGLAS MOPPETT: And dispersed populations, particularly.

CHAIR: Aboriginality--

Mr PEARSE: On the need side and on the cost side. We look at the use of private sector services, to what extent are they providing substitutable style services for what is being provided in the public sector. We attempt to understand and assess the impact of unavoidable costs of delivering services and we look at the range of State-wide and special services.

CHAIR: The unavoidable costs, is that like a base cost you are going to have to pay no matter what you do?

Mr PEARSE: No, they are more--I will talk about this but, for example, the effect of delivering services to a more disperse population, to what extent it will have driving costs up.

The Hon. RONALD DYER: Is the consideration of the use of private sector services the methodology you use to import social disadvantage?

Mr PEARSE: Not really. That comes in more in the assessment of need but there certainly a correlation between social disadvantage and the extent to which people have health insurance and access to the private sector. So there is some element of those factors working together. Hopefully, I will explain that a little better. I want to just quickly talk about the population side. It may seem to be non-controversial but sometimes there are issues about getting this right. We use the latest official sources of information regarding population distributions adjusted to our area health services. For example, we use the latest census or the latest estimate resident populations as released by the Australian Bureau of Statistics. In terms of projections we use the projections we use the official projections provided by the Department of Urban Affairs and Planning.

CHAIR: That is where it gets quite controversial, is it not?

Mr PEARSE: It does sometimes.

CHAIR: There is a department in Grafton that was releasing population figures which were quite different from the Department of Urban Affairs and Planning centrally and they do it every year with a disclaimer but they have been more accurate than the department in Sydney for many, many years. They used to be fixed because of Government policy in using the official department views.

Mr PEARSE: I could not comment on that. The approach we take is to use the official projections from Urban Affairs and Planning. They update those periodically obviously and they will be updating them again towards the end of next year as the latest census taken becomes available. We talked about the impact of age and sex in the formula and this plot is intended to illustrate how age and sex have an important impact on the use of health services. Here I have looked at acute hospital services. What I am presenting weighted separations per capita, broken up by various age groups. Across the bottom we are going from zero to four years up to 85 years plus and what we find is whilst there is a little peak for very young children, as the population gets older there is a higher use of hospital services.

The big issue for us is that the different areas have quite different age structures mostly they are slightly different in terms of the male/female ratios. Generally that makes very little difference but the age structure does vary quite considerably between Areas. We try to take the impact that might have in terms of the demand for health services by looking at these sorts of rates and incorporating them into our formula.

CHAIR: That is why I asked the question before. Obviously that is for acute care which is acute overnight and emergency day surgery and so on, but that might be quite different from the weights that you have to apply for community based care or dental or whatever.

Mr PEARSE: Yes, and for those other programs we have to use what is the best available data. Often it is less comprehensive than the data we have for acute care but generally they are reasonably good sources of data that give us an idea of what age impacts there might have been. I should point out that this plot excludes maternity services. For maternity services we take a slightly different approach and that is mostly related to the fertility rate of the area health service. One of the most difficult areas in terms of modelling the impacts of need over and above

age and sex effects and we have a long history of working with the Health Services Research Group at the University of Newcastle in developing a health need index for New South Wales.

The basic approach that has been taken by the Health Services Research Group in collaboration with the Department is to attempt to analyse the statistical local area variations in the use of hospital services. The question we are trying to address in this sort of analysis is what characteristics of the community other than age and sex-so we are controlling for those-influence the use of hospital services for each, statistical local area. When we do that we want to control for the supply of health services because sometimes supply can influence the use. So we are trying to abstract outside of what the impact of supply is.

The current need index that we are working on at the moment at with the University of Newcastle group has four factors that are taken into account. Standardised mortality ratios for people under 70 years. What this ratio basically looks at is the extent to which a particular population for a statistical local area has higher or lower death rates for people who are under 70 years. We also look a measure of socio-economic status and for this we use the Australia Bureau of Statistics' index of education and occupation.

CHAIR: Are they the only two you use?

Mr PEARSE: We then use two others, the rurality measure--

CHAIR: No, no, no, you do not use whether they are single mums or--

Mr PEARSE: No.

CHAIR: I have often wondered about that. Only education and occupation?

Mr PEARSE: There are a few reasons why we and the University of Newcastle group have argued that this index is a better index for hospital services at least. This is not to say there are not relevant points to make in relation to other services. The first point is that it is a comprehensive index and the ABS produces a range of indices of socio-economic advantage and disadvantage.

CHAIR: Some of them in income. Income is not in there.

Mr PEARSE: Income is in there indirectly. There are very, very strong relationships between the level of education, for example people with tertiary education, the type of occupation people have and their level of income. One of the rationales for taking this index versus other indices is that other indices do no pick up the impacts of the relative distribution of wealth. They pick up income but they do not pick up wealth, for example, assets, and these indices do not really work very well, particularly for elderly populations where incomes are very low and assets may be very high. This is one of the rationales for taking this particular index, the index of Education and Occupation. We have found in modelling since the early nineties that this is probably a better measure of socio-economic status. It is a single index. I should point out it is not a separate index for the level of education and occupation. It is a single index.

CHAIR: It is a modifier.

Mr PEARSE: Yes. The third measure that we include in the health need index is a measure of rurality and this is the Commonwealth Government's Accessibility in Remoteness Index for Australia, ARIA. This score is derived by scoring populations and localities in terms of their road distance to various service centres of different sizes. I think they have four different population centre sizes and they look at a particular locality and they attempt to see what is the road distance from this locality to these different service centres.

The final measure that we include in the need index at the moment is the percentage of the population which is indigenous.

The percentage of the population which is indigenous is the new factor that has been introduced into the need index with the recent model. Previously we had measures of rurality and the other measures, but the latest modelling is suggested very strongly that this new factor ought to be part of the need index.

The Hon. HENRY TSANG: Question, Chair. Is there a need for measuring ethnicity?

Mr PEARSE: We do take into account ethnicity in relation to interpreter services and ethnic affairs workers but the modelling to date has not supported bringing it into the broader need index.

CHAIR: That might be picked up with education and occupation.

Mr PEARSE: Indirectly, exactly. In fact there are very strong correlations in terms of those sorts of indicators and ethnicity as well. I just wanted to make one final point about the ARIA index, so here I have just provided you with the information of what the average score for an area health service is for each of these indicators and what the need index is in the final column. The analysis is actually undertaken at a lower level of analysis, statistical local areas and then built up to the area health service level. The point I wanted to make about ARIA is, we are not entirely sure that this always reflects the health experience of the population. We think some of it is the health experience, but what we believe is that some aspect of it really has to do with lower levels of availability of community-based general practice and specialist services in the community, leading to a greater use of hospital services. In an indirect way it may be compensated for the levels of medical benefits paid within rural amenities.

CHAIR: Can I just draw your attention to the difference in northern rivers and central Sydney? The Education Occupation, I presume a higher figure there means more highly educated and more employed?

Mr PEARSE: It does yes.

CHAIR: And they have therefore no distance problems, their standardised mortality rate, it says there, they have a higher population of older people than the northern rivers. I find that very difficult.

Mr PEARSE: No, what that is saying is, they have got a higher rate of mortality experience for people under 70. It means they--

CHAIR: If you are a 70-year-old you have got a higher chance of being dead?

Mr PEARSE: Under 70.

CHAIR: Under 70.

Mr PEARSE: You have a 10 per cent greater number of deaths.

CHAIR: I am just interested, and then you can ask about the north west and the far west if you like, but I am interested that that is where you have a population which is very old, like the northern rivers, and you are only looking at the people under 70. I have got an uncle who is 104. He is not represented there and the needs climb when you get past 85 don't they, and that is not even reflected in the figures.

Mr PEARSE: Remember this is on top of age effects, so we have already taken into account the age structure of the population, so if you have got an older population you are getting additional weightings there.

CHAIR: It does not standardise for mortality rates above that. If I understand Doug's problem, you are talking about people who are 30 who die are far less--

Mr PEARSE: Yes.

CHAIR: --and the disease processes in that.

Mr PEARSE: Yes.

The Hon. HENRY TSANG: I live on the north of Sydney so I do not need as much help--

Mr PEARSE: That was basically--

The Hon. HENRY TSANG: --so I would not get the fair share of distribution of the money or help for my old age.

Mr PEARSE: You would get your fair share according to need. That is the objective, is to try to provide equivalent access according to health needs.

CHAIR: You also miss out on the northern suburbs. Henry, you also miss out because they take money off because you have got more private hospitals up there. I mean, even so, even the difference between central Sydney and northern rivers, and central Sydney and far west, the great difference with far west, the modifier--

The Hon. DONALD DYER: The need index shows 142.5, with the greatest contributors to that being the level of indigenous population and distance factors.

Mr PEARSE: The far west is really an outlier, because it is at the extreme of all the measures. It has the highest mortality ratios, the lowest level, in terms of the socio-economic measure, it is the most dispersed, and it has got the highest percentage of population which is indigenous. So each of those contribute to its need index. One of the challenges of modelling this, and this is where we do need the expertise of people from the University of Newcastle, is that a lot of these measures do move together, that is, there is closer relationships and the technical challenge is to try to avoid having double counting effects of these measures.

CHAIR And these will have the same impact on that contributing factor, although sometimes they are squared and sometimes they are halved and sometimes they have got factors in front of them.

Mr PEARSE: We do not get that sophisticated, but we sometimes--

CHAIR: There is a formula which is very sophisticated, which drives us. It is not something you pick out of the air. Having got those figures which are worked out on a formula but it still amazes me it does not take into account the standardised mortality rate for people over 70, when that is a bigger and bigger of percentage of our populations.

Mr PEARSE: The argument is that basically when you look at the older populations, the mortality experience for older populations is, there is very little variation after you have standardised for age. With this particular measure, where we are looking at premature mortality, we are actually picking up the effects of high mortality in younger groups, whereas the age adjustments are more or less adjusting reasonably well for mortality experience for the older groups. I will talk a little later about the approach taken internationally, and a similar sort of argument is being run. I should point out that the index that we have been looking at is the one for acute health care. We do employ this index for population health, primary and community-based services, out-patients and emergency departments. At the moment we really do not have a good basis for directly developing need industries for those areas.

CHAIR: It does apply to in-patient care, does it not?

Mr PEARSE: In-patient, yes.

CHAIR: It does not say that.

Mr PEARSE: In addition to?

CHAIR: I see. In addition to in-patient care, I suppose, but it does not apply to maternity, oral, rehab and mental.

Mr PEARSE: And mental, you are right, and we have alternative approaches to an estimating need for those components.

The Hon. JANELLE SAFFIN: Why don't you agree?

Mr PEARSE: In terms of maternity services the view has been a better measure of need is fertility rate, that is, the number of people, basically reflecting the number of births that are occurring per population, so we are trying to reflect that.

CHAIR: Even if you are in the far west where you have got Aboriginal women delivering, aged 15, with all sorts of illnesses, the cost of providing the multiple services that they need, as they do not go to antenatal classes and so on, it must be much higher. So, there must be a modifier for--

Mr PEARSE: We do try to take them into account on the cost side and I will talk about that later.

CHAIR: So you have got a set formula for that?

Mr PEARSE: For oral health services we looked at, for example, people with health care cards or basically the eligible population for the adult oral health services. For children's oral health services, we look at the population of the target group and then take into account, differences in the oral health status of those populations.

CHAIR: Have you got a set formula for that, for oral health?

Mr PEARSE: Yes, as a component.

CHAIR: But because this index and therefore the RDF calculation apply only to the ones at the top, there is an alternative index for maternal services, oral health, rehab and mental health. It therefore must be a different calculation method, which we should be transferring to the community. I accept that there are more kids per head of population on the north coast, more kids per head of population in the far west, not very many in the old age group in the far west. A lot of them in the age group in the north coast, a lot in the middle who are very dependent in the far west, so very different categories. There are not many people going to rehab and extended care in the far west, I would not think. An awful lot up on the north coast and in Macquarie, but the maternal services not so much up our way, many more out west. I mean, these are different formulas.

The Hon. JANELLE SAFFIN: How do you factor them into the RDF, the differentials?

Mr PEARSE: What we tried to do is, we would look at each of these component separately, look at what the age effects might be and then look at what might be an appropriate need adjustment. I mentioned the maternity services one, the oral health services one, where you have an extended care index. The needs area--

The Hon. JANELLE SAFFIN: However you look at it, how do you factor it into the RDF?

The Hon. RONALD DYER: Aren't they outside the RDF?

CHAIR: They are. If you go back to the slide where you have got each percentage, from each budget they had a formula--before you got here Janelle--you had a list of what each type of care gets, like mental is 8.3 and acute overnight is 5.1. So, then they get, of that 83, this is a different formula. 8.3 for mental health, than there is for acute services. It has always got at the top there, acute index, this whole formula we dealt with before, only applies to the RDF for those services which add up to 70 per cent isn't it?

The Hon. JANELLE SAFFIN: Okay.

Mr PEARSE: That is about right, I could not say off the top of my head what it is, but it would be the vast majority of the-

CHAIR: You have decided centrally you are going to put 8.3 into this and 2.1 into that and so much into that, 51.3 into that.

Mr BARKER: No, I think we should just clarify one point there, that the areas get a general, what you would call budget, and then the areas in line with the legislative requirements to address the needs of their population. We have figured that across various programs. In addition to that, the Minister, from time to time, will allocate specific money for specific purpose. I guess, in terms of the discussion we have just had, two examples that in the last two budgets, the emphasis has been specific growth money allocated to mental health and specific growth funds allocated to oral health, to address, what he believed were recommendations put to him. When we get that money, we have got to put that on top of what their current share is of what their internal allocation is for either mental health, in the two examples, or for oral health and then that builds that up. They do not actually get allocated a specific dollars or percentage for those various budgets on the earlier slide from Jim's. Those numbers is the sum result of what, between their advice to us and other things, we have got. The department, we believe will be spent in that particular year on that program.

CHAIR: To be perfectly frank, if I was sitting in Orange, I could work out whether I was getting my fair share of acute services, which adds up to 51.4, plus the emergency department, plus the primary, plus , and that is all part of the RDF for that 60 per cent of the budget. Then I could work out whether I was getting my fair share of the oral budget, by adding in a lump. The fact that you only allocate a certain budget to--

Mr BARKER: Total budget.

CHAIR: --your total budget, I could then sit down and say, am I getting my fair share working out what my fair share of the various components are.

Mr BARKER: I would have to say I do not disagree with that comment as a general statement, but I think the department is slightly aware of that practise, because what we have been doing with the Episode Funding Concept, they are now getting episode funding for their acute in-patient services, so we are now lined up at the bench mark, there is a funding model out for the emergency department, there is a funding model out for ICU. The Centre for Mental Health is looking at a way to better match the dollars, what value for money that is being delivered in the mental health area, and we are working through those various pockets to be on top of areas who, for want of a better word, are moving money around, to give them a certain result, which may give them inappropriate access to funds.

CHAIR: If we are going to ask the people to see whether they are getting their fair share or not, what you are saying is, the RDF, looking at them one at a time, population health, primary and community based, outpatients, emergency, acute overnight. They are the only bits that the RDF applies to.

Mr BARKER: That is not true.

CHAIR: There are different formulas of the RDF, the different things taken into account for mental health, oral health, and maternity services. In other words, that is to be fair, you have got to take different formulas and account for those amounts of the budget, which turn out in different percentages of the total budget. I mean, this is what people have got to look at, to see if they are getting their fair shake of the cake, but it is not just worked on--

The Hon. RONALD DYER: Mr Chairman, with due respect, could I have a point of order? Are you giving evidence here or is the witness giving evidence?

CHAIR: No. I am asking the question, because this is what people are going to see, when they get this document that we are going to put out.

Mr BARKER: There is oral health indicators that say, with the money that has now been allocated for oral health, there is expectations in exchange for the amount of money that is being provided; how many services are going to be provided and then as I understand it from what Jim said, there is a formula which assists in how much of the oral health share each health service should have, to provide oral health services to the relevant community they have got to provide with those services, and there is that process occurring throughout the total $7.7 billion of budget that we have got out there.

CHAIR: This is a formula that says, say far west should get 3 per cent of the oral health budget for the State, all right?

Mr BARKER: Yes.

CHAIR: Then we should be able to find out if they are getting 3 per cent of the budget for the State for oral health.

Mr BARKER: This will be something we will fit in. This is what is coming out of our peak performance indicator exercise.

CHAIR: That is what I am saying. When we publish the document we are publishing, if it should say yes, far west should get 3 per cent and yes, we are. Or they should get so much of the percentage of the State budget for acute services and, yes we are. We should get so much for mental health services, we are not getting it yet, but we will in three or four years' time. That is the reason for the presentation, so that we can get it clear, so that people out there in the community can start to understand a bit more clearly whether they are getting a fair shake of the whip, which is what our terms of references are, okay? So, we basically have four different RDFs as far as I can see. One, for acute services; one, which is worked out on a slightly different basis, I am not critical of it, and I can understand why, for rehab; slightly different basis for mental health and slightly different basis for oral, because they have got slightly different population targets, if you like.

Mr PEARSE: I should point out really, each of these components has a formula behind it. As I said, mental health is really being dealt with separately by the Centre for Mental Health, but each of these components have slightly different issues that you need to take into account, either in need or in cost, or in specific sorts of services, that you need to take into account.

CHAIR: Once an area gets it I know they can allocate it however they like, except for mental and dental, and they can fiddle around with it internally, I can understand that, but you allocate it fairly as you can from your central point of view.

Mr PEARSE: I will just go on if that is all right, to talk about the issue that has been raised, about the use of the private sector and this really mainly refers to the issue of private hospital services, and the key question we have here is, whilst we try to assess need in a holistic way, looking at what characteristics the population would lead to greater or lesser use of hospital services, we then need to take into account the fact that some of that need is being met by the private sector. The question we try to get at is what the private sector activity is effectively substitutable for public hospital services. It is fairly tricky and difficult sort of question to answer. We really know that not all of it is directly substitutable, but then some of it is, and currently our methods lead us to conclude that about 70 per cent of what is undertaken in the private sector, is effectively substitutable for the public sector. So we take that into account. This applies to acute service: We take it into account, once we have determined what the level of need might be for the population.

CHAIR: How is that done.

The Hon. DOUGLAS MOPPETT: Does this sort of consideration apply to the - I am not sure of the other centres, but I know in Dubbo, the complaint is that this is a lack of GPs. The New South Wales health has to supply and substitute for GPs, the fact that its emergency department, where there are very big clinics.

Mr PEARSE: It is not directly taken into account in terms of the GP or community based specialist. Although we believe some of that need index, particularly related to ARIA is picking up some of those effects. That is, people are using hospitals more in rural areas--

The Hon. DOUGLAS MOPPET: They do not see the doctor.

Mr PEARSE: Yes, because they do not have the alternatives. But this one is more really the admitted patient services have been dealt with by health services.

CHAIR: So how do you then take into account when we now get a directive, which I have actually seen from northern rivers, Doug, I am sorry we haven't seen such a request from western New South Wales, the request to improve the budget aspiration or income for private sector patients in our public hospitals.

Mr PEARSE: It is not quite relevant to this particular issue, because we are really dealing with the issue of the use of private hospital services, rather than private patients in our public health services.

CHAIR: You do not see that as a sort of--

Mr BARKER: This point here relates back to the earlier comment about north of city, so the access the population makes to private hospitals, that is an alternative way for them to have access to acute services, as opposed to going to the public sector. So you recall that discussion earlier on about why northern Sydney gets marked down, that is because of this component here. The other component is about I guess our revenue best practice policy, about northern rivers and for a number of years now, we have been encouraging health services to maximise their revenue potential. That has gone out in a number of different letters, areas there, areas or other, 100 per cent revenue incentive scheme and every dollar in revenue they can generate, they keep. There is no revenue comes back to the department and no revenue goes back to Treasury, so within the constraints of Commonwealth or State policy, if they can generate revenue they compete with them. That allows them, in our view, to provide a greater range and breadth of services spanned. There was a disincentive policy in place, where the money was either taken by the department or taken by Treasury and therefore they have not got the incentive to--

CHAIR: Summing up successful and the private hospital ward is empty and the base hospital is continuously full and we have got lots of private patients, would there be an adjustment to the formula? I can see if there were more closed, there would not be access and you would have to adjust the formula.

Mr PEARSE: In the long run there would. The approach we are looking at, at the moment, is we are trying to look at what is happening over a five year period, to make that sort of adjustment, but in the long run if there are no private hospitals providing services in that particular locality it would flow through in the formula, that is, we would not be making the judgment that part of the need of that population has been dealt with by providing--

CHAIR: How do we find out for the people, so that they can see how you make that adjustment for private sector substitution? Is there a formula published or a methodology available or what, or is it just a best guess?

Mr PEARSE: There was a technical paper that was issued in 1998/1999 that describes the method. It describes the details of the RDF, it is a public document.

The Hon. RONALD DYER: What is the overriding principle around which you determine whether activity in the private sector is substitutable for public hospital services?

Mr PEARSE: What we attempt to do really, is look at the type of activity that is being undertaken in the private hospital sector, to see whether that activity is actually being undertaken in the public sector as well. So, part of the public/private mix for, say a particular procedure in a given locality and across the State as a whole, whether that tells us information about whether it is really something that we would ever do in the public sector. I can give you one example, dental extractions are a fairly big set of separations in the private hospital sector, but whilst we have some in the public sector and they are mostly non-admitted services being provided through the dental and oral health program. They are not significant in the public sector. We more or less say that sort of service really would not be substitutable for what has happened in the public sector. Another extreme would be a birth. The birth happens in the private hospital. In that way we have avoided having to deal with it in the public sector.

The Hon. RONALD DYER: Somehow you have arrived at a percentage of 70 per cent overall. You go on to say that percentage is currently under review. Why is it under review?

Mr PEARSE: There has been substantial change in what is going on in the private sector. The last time we looked at it was 1998. The private sector has grown, the nature of the procedures being undertaken in the private sector has changed as well. A range of other issues that are relevant, and we have better information in trying to judge this issue.

CHAIR: Emergency departments were not available in the private sector until 1997? So that was the first time that you were allowed to operate an emergency department at a number of private hospitals. Not everyone has still got them, but there are a number of private hospitals now that have proper emergency departments and they scaled them, they were not available before.

Mr BARKER: I think the other thing you would have to say too, in the last five years or so the number of private hospitals and their size has changed because a lot of the smaller operators have now been collapsed into larger provided services and the Federal Government's reforms have come in as well, in terms of how private health insurance works, which has an impact on the volume of services being provided, and how that works.

CHAIR: Intensive care is another area.

Mr BARKER: They have some of the worry--

CHAIR: There is a methodology which can be looked at to see whether it is fair or not.

Mr PEARSE: So then we go to look at the issue of unavoidable costs and this is where one of the issues that we look at is the impact of the dispersion on the population on the per capita costs and delivering services. For that particular issue we have taken the approach that is based on the work of the Commonwealth Grants Commission. We look at certain types of costs and try to see what impact is evident in our data on the influence of dispersion on those costs. That has been built into the assessment of the requirements for particular area health service.

Other examples of these sorts of services are ambulance costs met by the health services and here we realise that the rural services tend to have a greater demand so we need a more appropriate way of sort of understanding that the cost impost there. We have used a rurality index to say what would be the fair way we distribute those funds. Nursing home type patients has been a big issue and we have been surveying recently the number of non-acute patients in our public hospitals who could be dealt with by the residential care sector. In the formula over the

years we have taken account of the additional impost that those patients have on our public hospital system. The intention there is that we should recognise that these are in many instances are costs that can not be avoided in the short term at least and certainly we are looking in the long term to try to get some structural solutions to these problems.

The Hon. RONALD DYER: That presumably is a greater problem in rural areas.

Mr PEARSE: It applies almost exclusively to rural areas. It does apply in the metropolitan areas but the vast majority of the problem is a rural area problem.

CHAIR: I mean there are problems. I mean, if somebody goes to Blacktown Hospital while they are awaiting placement they could be there for a month and a half but again you do fund out of the health budget a large number of aged care beds which are owned by New South Wales, don't you?

Mr PEARSE: Yes. They are the residential care or what I refer to as the State Government--

CHAIR: They are in the Hunter and substantially south east Sydney as far as I know?

Mr PEARSE: No, Garrawarra in South Eastern Sydney, but they are spread over a number of different area health services.

CHAIR: None of them are in the country I do not think, are there?

Mr PEARSE: Yes, I think there are.

Mr BARKER: Yes, there is a big one at Maitland.

CHAIR: That is the Hunter?

Mr PEARSE: There is one at Young.

CHAIR: Yes.

Mr PEARSE: There is a list of them because the beds are actually counted but there is a number around and--

CHAIR: Now that is covered by the Commonwealth under the Medicare agreement is it not?

Mr PEARSE: That is right.

CHAIR: So when the minister keeps talking about the $100 million to look after old people, that is actually covered by the Medicare agreement is it not?

Mr BARKER: No, the issue there is that there is nursing home type patients which are in acute care facilities and we can only charge the patient a percentage of their pension for their accommodation rather than get reimbursed as a proper nursing home patient in an approved bed. So it is an issue of getting the approved bed license in which case you can then charge the relevant Commonwealth authority the appropriate nursing home fee. So that is the particular issue of that matter.

Mr PEARSE: Another issue that is dealt with under this category is the impact of severity that is not picked up in the flow adjustments. What I mean by this are the referral patterns into principal referral hospitals, in case these hospitals tend to deal with the most severely ill of patients and that is not quite adequately adjusted for in the case weighting adjustments that we use for the flows. There is also an impact of the indirect costs associated with delivering a teaching and research role.

CHAIR: You mean like paying lecturers and researching professors and the like?

Mr PEARSE: It is more like the--a good example is the additional pathology tests that might be ordered when somebody is in training versus somebody who has gone through their training. There is a separate set of allowance for direct costs which I will talk about in the next--

CHAIR: And this would identify say for example in each budget, let us say Prince Alfred gets, you know, the place down the road, how much they get for severity in teaching and research? There is a set amount that is allocated under the Prince Alfred central Sydney budget?

Mr BARKER: We do identify at the area health service level the amount that is made for this adjustment and that is derived from our analysis of the costs of hospitals so we can--and we can take it back to the cost of--it is not part of the budget where there is a specific allocation.

CHAIR: There is not a specific allocation? So would any of the regional hospitals that we are interested in here get any money under that process?

Mr BARKER: Currently they do not get money under this process.

CHAIR: So that will be one of the areas which will receive a lot of conflict.

Mr BARKER: Yes.

CHAIR: Well that is going to pay for nobody--nobody in the country, none of the hospitals that are all teaching, Wagga, Albury, Lismore, Tamworth, all do teaching, all have--

Mr BARKER: There is an adjustment-

CHAIR: They are all trauma hospitals, every one of these places are trauma hospitals.

Mr BARKER: They do identify at an area health service level expense from budget in teaching and research. Whether it is as specific as what you have said I could not comment upon but there is an allocation for that program but what they put in to it is something we will be working out with them over the next couple of years as we refine the budget--

CHAIR: When we did the last inquiry which I think I am the only one left on this process. That was identified as one of the line items which were identified. We know that the country areas did very poorly out of that.

The Hon. JANELLE SAFFIN: Which one?

CHAIR: This research-the indirect teaching and research countered the outer severity. There was the background cost of actually providing those services and the country areas just did very badly out of that. Any way that is my comment. That is editorial comment.

Mr PEARSE: Part of the process of that is that what we are trying to do is look at what are the differences in the costs of the principal referral versus other hospitals. So in a way that is how the factor has been defined. There have been issues and we are aware of those we are looking at that, about whether the factor ought to be distributed in a slightly different way. As Ken pointed out direct teaching and research is spread across all area health services including the hospitals that you are investigating. There are a number of state wide and special services that are built in to the formula. The isolated patients travel and accommodation assistance scheme IPTAAS, has an allowance and that only applies to people who are in eligible populations. Another example is adjustments for HIV AIDS where the distribution of people with HIV AIDS is quite different across the population. We need a better way of allocating that. Other examples of state-wide adjustments include radiotherapy, spinal and brain injury.

CHAIR: Well, that is again identified, is it not?

Mr PEARSE: Yes. We should point out that up to this point what we have done is we tried to take into account population, need and some cost factors. Once we have done that the per capita sort of expenditures implied by the methodology suggest that rural areas on average would have about 30 per cent higher per capita requirement than metropolitan New South Wales in the formula to that point.

CHAIR: Excluding State-wide services and--

Mr PEARSE: No, including State-wide services and all those things, if we add all those things together.

CHAIR: You mean, somebody in central Sydney area health service, living in central Sydney, gets 40 per cent less than somebody living at Dubbo, per head of population?

Mr PEARSE: Probably not, but on average what I am saying is that people living in the metropolitan areas of Sydney, Hunter and Illawarra, under this formula would have 30 per cent less than the average of the rural areas. Now, each area will have a different factor, for example--

CHAIR: Hang on. Let us clarify this, because it is important. What you are saying is that if I take Sydney, Newcastle, Wollongong out of the picture and just leave the country, the country is currently about 30 per cent of the population. You are saying they are getting about 43 per cent of the funding of all health funding?

Mr PEARSE: I did not say 43 per cent.

CHAIR: You said 30 per cent more.

Mr PEARSE: Per capita.

CHAIR: Per capita. If you go 30 per cent more than 30 per cent is another 10 per cent which 40 per cent. Then there is the--if they do the State budget for health, I have got to take 40 per cent and that is what the country is getting?

Mr PEARSE: Yes.

CHAIR: I do not thing that is true. Not even close actually.

Mr PEARSE: No. What I am saying is that in the assessment of the formula at this point, once we take in to account all those factors that are need and population and cost factors and the State-wide services and we calculate what the formula is saying--I am not talking about budget allocations necessarily I am saying what the formula is suggesting--on per capita terms if we compare the metropolitan areas as a whole to the rural areas as a whole, the rural areas would be 30 per cent higher than the metropolitan areas.

The Hon. RONALD DYER: But some of these special services might be concentrated in the metropolitan areas.

Mr PEARSE: In fact that is absolutely true. A lot of the special services are.

CHAIR: I notice that it took away the State-wide services and some other special things, that it would cost more to provide an equal level of services in the country than it does to provide an equal level of services in the city.

Mr PEARSE: Yes.

CHAIR: So to say blandly that people in the country are getting-funding in the country is 30 per cent more per head of population is simply nonsense.

Mr PEARSE: I am not saying that they are necessarily getting that. I am just saying in terms of where the formula is at this point. This is before, remember, we are taking into account adjustments for flows, that that is the impact of the formula.

CHAIR: You mean before all those formulas we would end up with that, what you said, but Mr Barker is not giving them that money at the moment?

Mr PEARSE: As I said the formula is a guide to how allocations occur and we can talk later about how that impacts into the budget process. Having assessed these population need and cost factors we then look at the impact of patient flows across boundaries and I've mentioned these before but the-in terms of acute flows what we're looking at are the flows of patient's across the area boundaries but also to Westmead Children's Hospital and in terms of interstate flows we're looking at the flows out of this state. So what we are trying to do is take an account of the net effect of those flows after we judge what a population's requirement would be in the formula. Flows for other programs are also estimated. I just wanted to point out that we--

CHAIR: Mental health is not there?

Mr PEARSE: No. In terms of updating the formula, there are several reasons why we are frequently looking at improving our approaches. As I mentioned, population data is being updated annually by the Australian Bureau of Statistics. We are looking at better ways of modelling need constantly and I have reflected some of the latest modelling of need in my previous talk. We are looking at better approaches to understanding the costs including the specific sort of requirements for rural communities. I was asked to talk a little bit about international comparisons of our formula with-or our approach with what is being done internationally.

I refer you to a recent review by two health economists from the University of York, Nigel Rice and Peter Smith. This report compares the approaches of different countries and provinces and states within countries to allocating payments-allocating funds to health authorities or plans within their arrangements. It compares 20 countries or large regional governments within those countries and New South Wales is included in the comparison. The focus of the paper is to understand what sort of factors do they take into account in adjusting for health need. I should point out that not all countries do have formulas like ours, but a lot do. In this light I have given a comparison of a number of countries that have similar arrangements.

The Alberta and Sweden examples are really provincial governments. Just pointing out the types of factors that they are taking into account in the sorts of adjustments, age and sex, composition, standardised mortality, comparing them to how the socio-economic measures, locational measures and other sorts of measures they use in terms of assessing needs and then what sort of cost factors are brought in to consideration. What we find is that all countries use similar sorts of measures of need to what we do but none of them use them in precisely the same ways that we do. Probably reflecting the nature of our health system and the nature of the demographic and geographical features of our country.

CHAIR: Scotland is almost the same because everybody in Scotland is poor. There is only one nationality. Otherwise they are exactly the same as us.

Mr PEARSE: Well, they have got quite a remote population there too. The modelling that is undertaken in England is very similar to the type of modelling that we have undertaken with the Health Services Research Group at the University of Newcastle.

The Hon. RONALD DYER: I see in England that living alone is a factor?

Mr PEARSE: Yes, that is right. They actually do have some better data on morbidity from their census compared to what is available in Australia but morbidity, complicity and living alone are factors that were picked up as being important that we have not yet incorporated. Although I should point out that we did test a range of all those other factors when we were doing the modelling. So the main point here is that what the work that we do in New South Wales is quite comparable with some of the best that is occurring in the world. We do have areas in which we can certainly improve the way we are approaching these areas. The issue in trying to assess need and cost--

CHAIR: So do you agree with this particular total yourself, because the stuff we got from Dr Peacock was-was Dr Peacock the guy from Melbourne? He came up fairly early in the piece?

Mr PEARSE: Yes.

CHAIR: I did not think he thought that England was allocated on a population--

Mr PEARSE: I did read the transcripts and what he said was up to the point at which he came to Australia it was done and he had not kept touch with it but I actually did work in the English National Health Service in 1998 and basically this is the same framework.

CHAIR: They have now come on to what we have been doing for some years.

Mr PEARSE: No, I think they have of led in some ways and in some ways we have caught up. In other areas the modelling that Bob Gibberd did for us was some of the impetus for some of their more recent research. I do know that there is some sort of interchange.

CHAIR: Yes, Peacock made the point that he felt that the population base that he used here was a very fair one.

Mr PEARSE: Yes.

CHAIR: That was his point, wasn't it? Was that the point of his--

Mr PEARSE: I believe so. The development that has occurred in England is that they have now put all their health resources in to this pot. All the GP and other resources as well and tried to distribute that according to this formula. Of course in Australia we are dealing with just State health services. I was also asked just to reflect briefly on what is happening interstate and I do not really have a lot of detail right here but I should point out that at least three other states really have basically throughput models. That is, they are trying to fund, particularly their hospital services on the basis of the target level of activity.

The Hon. DOUGLAS MOPPETT: Target rather than historical?

Mr PEARSE: Well, often that reflects history and that is one of the issues with throughput based models where, what is your starting point and what is guiding what your target ought to be. New South Wales and Western Australia, as I understand it, are the two states that do have strong population elements in their models but I shall leave it at that.

CHAIR: Is there any formula for capital allocation?

Mr BARKER: To date capital has been done by a process of proposals coming forward, prioritised by their minister, going to the budget committee of Cabinet, and then they make a determination on the allocation and then there is a process of negotiation which determines which priorities will get up or will not get up--

CHAIR: It does not matter so much in New South Wales, which is a population-based formula for funding with cost flows now being taken into account, but in other areas where it depends upon what you have got built is what you can do to make any difference.

Mr BARKER: So that is how the capital process has existed for many, many years where the minute we have released a capital charge-in regime which we want to introduce commencing the 1st of July 2001. It will be shadowed for two years and under that we are going to use the operating RDF as a basis. We will then do some adjustments to that and we are going to engage a person to go away and do some modelling on that and then we will be using that to set what you would call a capital RDF. We will then compare to that a charge for health service, the assets they do have.

We intend then to implement that over probably five years and during that process there will be a number of reviews and we will have a process involving areas, treasury, the department to review this process. It is a brand new reform within New South Wales. It has not been done as yet. So treasury is keen to see how we work and as an agency we are very well positioned to do it because we have this RDF approach to how we allocate operating funds so we can use that sort of concept in terms of the capital assigned.

CHAIR: Mr Barker, say for example you have had an area health service that had 5 per cent of the State's budget, well 5 percent of the population, ignore the adjusting business, the 5 percent--obviously if they did not get any capital investment then their buildings and their facilities would fall backwards and therefore cost more per given service. It would therefore seem fair to allocate that 5 per cent of the capital budget over, it might be a 10 year time frame you have to do it, to allow each of the area health services to maintain an equity or an even playing field in terms of their infrastructure.

Mr BARKER: Yes. The capital charge will not allocate the capital budget for building new buildings. What we are going to be doing is saying to those areas using the example you quoted. You will most probably find their charge is a lot less than their budget because they got less than their fair share so therefore they would get a benefit which they could then put in to upgrading and maintaining those buildings in a more-a quicker manner than what they can at present.

CHAIR: You mean a bit like a facility fee? They will be charged a facility fee for the capital buildings that they own?

Mr BARKER: Correct.

CHAIR: Like that access you pay for Macquarie?

Mr BARKER: No, different to that but they will be charged a fee with a budget and under the policy it is shadowed so in the first two years there is no effect except they understand what it is going to mean as it starts to be phased in from year three.

CHAIR: It would have to go on some sort of valuer--

Mr BARKER: We are working now to come up with a standard valuation. Assets have got to be re-valued each five years. We want to have a standard approach. It is no good us having different approaches in different health services because that will create the wrong incentives. So we will have a standard way things are valued, define what the policy will apply to, and we will then go through the process and see how it unfolds and it is a process we have got to keep reviewed and monitored because it is sort of a new way of doing things within New South Wales Health to make sure that we go down the path in a sensible direction.

CHAIR: So then the whole budget then, capital and the cut, will become one budget?

Mr BARKER: No, you will still have a separate capital budget unless the legislation gets changed because that is a different set of appropriations where the Parliament appropriates moneys to build things. This is a way we have got health services managers to focus upon what they have got is appropriately being used and with the charge regime is there a better way they can use it or when they come to argue and bid for new capital works what is to come up with a better fit than what you have had.

CHAIR: But with a building they cannot just walk away from it and say, you are going to charge the same as--

Mr BARKER: No the policy has got--what we have defined as new assets. They will be charged 100 per cent for instance in assets. We have got a 75 per cent factor in there which recognises with some things they cannot do anything with and they will have to work without them. This will not be something that can be-it can not be turned around in 12 months. It will take a long while because of the way the capital program works.

CHAIR: And this will go out for discussion.

Mr BARKER: It has already gone out to the areas. It was alluded to in the--

CHAIR: Will ordinary people be given access to comment on that?

Mr BARKER: It is out in health services now. There is a steering committee which was seeking some nominations from areas to participate in and it has been sent out to areas. It is public information.

CHAIR: Is that possible for us to get a copy of that?

Mr BARKER: Yes, we can organise to get a copy of that over to you.

CHAIR: Mr Barker might just give us a rough outline of how the budget is put together because it is no longer historical. There is a huge number of controls on the budgetary allocation process.

Mr BARKER: Before I do that if I just correct that mental health information that we spoke about earlier on, that the Minister, back in April 2000, made references to a couple of numbers. He said that expenditure will go up to 107.5 over the next three years. This year it has gone up by 28 million on last year's budget and this figure is derived at the 1999/2000 budget. We are still of the view that that figure will be achieved. And the other figure that was referred to in our earlier discussion was 45 and there we said that overall expenditure in regional mental health services will grow by 45 million or 28.6 per cent and that 45 covers the Hunter and Illawarra plus the eight rural health services. So that I think clarifies those numbers we were talking about before.

CHAIR: But he has also said at the Estimates Committee that the RDF, in other words, fair funding across the State for their dependency is not going to happen for four years, will not be finalised for four years, whereas the RDF for other services should be finalised in next year's budget. It is plus or minus 2 per cent I think.

Mr BARKER: Plus or minus 2 per cent. In terms of how the process works is that when the announcements were made in March 2000 we looked at what health services had then compared to their RDF entitlements, taking into account four factors that Jim has explained and then with the three year certainty process and growth money we then applied growth money to all areas, so all areas in the state are getting growth money, but what we have done we have biased the greatest amount of growth in percentage terms to those health services which under the RDF were the furthest away from their percentage share and therefore that process went out, as I said, in March.

Areas were given advice then of what their three year forward budgets were and they have developed proposals for--of course last year has gone, they have had additional money this year. A number of those announcements were announced around budget time or since that time and that money is going out to areas so that in terms of the inquiry the greatest range of growth money is going to mid north coast and northern rivers because under the RDF approach they were the two most under-resourced rural health services.

So they are moving up to be--on the information we had when we did this modelling back in late 1999, early 2000--within two percentage points of their RDF share, and that same approach has been followed with urban health services. So we are going to get them all within 2 percentage points. There is three exceptions to that, on the modelling that was done at that time, Far West, Mid West and Macquarie were shown to be greater than 2 percentage points over. However, no adjustments had been made to bring them down. So we are not taking money off those health services to bring them within the 2 per cent point.

CHAIR: Just everybody else is catching up to them.

Mr BARKER: There is undoubtedly historical reasons and we have used the historical budgets that they had so they were all still getting funded for normal movements but the growth money has been directed towards the areas where the formula is saying they are definitely under-funded, to bring them all up. So that is in terms of how the money is going out. The same has occurred in the mental health growth money.

CHAIR: So, for general money, this year's budget everybody should be plus or minus 2 per cent.

Mr BARKER: Next year's budget, 2002/2003.

CHAIR: Yes, 2002/2003, the one that is coming that is the one we are concerned about.

Mr BARKER: Based upon the RDF formulas and numbers that existed in 1999 and 2000.

CHAIR: Yes, not this budget 2001/2002.

Mr BARKER: 2002/2003.

CHAIR: The one that you were talking about, the one after that?

Mr BARKER: Yes, 2002/2003.

CHAIR: So when we get to 2002/2003 everybody should get a fair trade, plus or minus 2 per cent. I accept that.

Mr BARKER: I guess I should explain to the Committee that when we did the modelling we were using 1999/2000 budgets--and Jim will correct me--it was either a 1998/1999 or an early 1999/2000 statistical set that went into the RDF. Of course, over a period of time the statistics will move for some of the reasons we have already discussed and some of the budgets also move for things outside of just pure growth. So what we are now in the process of doing is reviewing the RDF and we can review there we know where their budgets are--reviewing all that to see, if for 2003/2004, how they are all then sitting for the forward year's allocations and months.

CHAIR: So you are using the same RDF formula and the old statistical numbers, the old population that was done--

Mr BARKER: No, I think Jim made a comment that one of which was indicated new set standards come in, the indigenous one, was one of--

Mr PEARSE: Yes, there will be the new--

CHAIR: Aboriginality has been there for a couple of years actually.

Mr PEARSE: An aspect of Aboriginality has been there but this will be a new factor in the--

CHAIR: When you do that, that will be so that by 2002 and 2003 there should be pretty fair funding except for mental and then of course for dental it is a little bit different again because that is done on a dependency base, number of kids, number of health card carriers. I understand that. I am not arguing about it.

Mr BARKER: When the growth in mental health was announced there was four million last year a further five this year to give us an extra nine per annum and then it goes up next year by a further eleven. The distribution of that twenty million per annum which will be going up next year, as I understand it, was allocated using those service priority areas in terms of where it should go.

CHAIR: It is a slightly different formula.

Mr BARKER: Slightly different formula.

CHAIR: But again that is also relatively fair across the State.

Mr BARKER: The mental health money is used, yes, that same sort of fairness approach in how it goes out.

CHAIR: To try and get to it, but the Minister said that we would not get to that for at least four years--the fairness. In other words there is gong to be further announcements about mental health so that by--I do not know whether it was 2006 or 2007, the Minister indicated that it should be again relatively fair across the State. The bit I am coming to is, that includes cross-flows now, does it not?

Mr BARKER: I will talk about flows now if you like. With the flows there are two components that are in an areas budget. There is the inter area which Jim explained, so that is where if you are a resident say of mid north coast and you go to Hunter to have your services provided, we call that an inter area because it is within the State of New South Wales. We have flagged in their budgets what the value of them is but we have got no cash. We have just put that in for notional purposes. The exception to that is for around five or six urban health services: Hunter, Central Coast, Northern Sydney, South East and Central Sydney, South West and Wentworth, Western Sydney and Illawarra, the nine urban health services. The Director-General struck agreements with those CEOs about reversing certain minor specialist flows between those health services and so what the department has done there, we have taken the money off the in-flow area, we are holding that sort of on trust and the out-flow area has got to reverse the flows that previously reversed it and then if they can reverse that they will get the money.

That is only affecting those nine urban areas. It is not affecting the rural sector at all although in the way their budgets have built up we have reflected it as we do in their financial statements so they, in a public sense, are aware of what the value of health service's in aggregate their community is accessing. We thought it was important to do that so that when they look at how much is spent on, say, the community of the mid north coast, no matter where they get their services provided, they know what we are spending to have those services provided to them. In terms of interstate flows it is slightly different.

CHAIR: Stay on the intra-regionals. With the three-year budgetary certainty process the Minister has given and with the growth money, the mid north coast for example could decide, "Look, we are spending a lot of this money on cross-flows to Hunter for renal services, we will rehabilitate those back" and they can plan to do so with your agreement. The difference between this and the inner city group is that you are proactively managing that process, whereas you are not proactively managing it as far as what I can tell from what you said for, say, mid north coast and, say, Orange, for example.

Mr BARKER: No, it is not been proactive managed for the rural, that is true, but if they started to show that they were reversing flows, which could happen in an area like Mid North Coast, that then gets picked up in Jim's formula when he looks at the value of flows that is going in between, say, mid north coast and Hunter. The issue--the areas raise is, "Well, we do things but it takes some period of time for that to flow through because you cannot instantly work out how quickly--

CHAIR: But for the same way, to move people out of the central Sydney services into south west you are proactively assisting south west to actually rehabilitate. You are not assisting the country areas to rehabilitate.

Mr BARKER: Well, the position we have taken is that this year being the first year of doing that we wanted to try it in a small way and I think the aggregate value of all those flow reverses I spoke about is about four million dollars. So it is not a great amount of money in terms of their budgets, so we have not given a major exposure in terms of risk because the risk with this sort of area is that the flow reversal area will reverse the flow and the in-flow area will still continue to do other work, so you are trying to spend the same quantum of dollars twice which you cannot do. So that is why we have picked up little small buckets which we think are generally manageable.

CHAIR: When you get to the interstate flows of course you are aggressively managing those, aren't you?

Mr BARKER: That is a bit different. What is happening with the interstate flows is that part of Jim's area is doing various negotiations with the other jurisdictions which is the other states and territories, especially the ACT, Victoria and Queensland and--

CHAIR: South Australia.

Mr BARKER: And South Australia because a lot of those jurisdictions get their residents from virtually one health service. They get it from others as well but their main routine flows either come out of northern rivers in the case of Queensland, they go to South Australia from far west, they go into Victoria from Greater Murray and they go into the ACT from southern.

The Hon. RONALD DYER: But that is sometimes by agreement. In Albury, for example, the mothers are having their babies at Wodonga by arrangement.

Mr BARKER: That is true and we are aware that is--

CHAIR: Yes, but all of the other states are leaching off New South Wales at the moment, aren't they?

Mr BARKER: I would not disagree with that comment but others might.

CHAIR: We are paying out more.

Mr BARKER: We are paying out more. The net cost to New South Wales is around 80 to 85 million a year for New South Welsh people to be treated in these eight estate hospitals under various agreements and so what we are trying to work out is a way where we can have some certainty over the process rather than they just taking New South Wales residents which is a bit outside of our area health service charter so what we are doing--

CHAIR: Do people from New South Wales get a better deal than people in the other states? Say, for example, we are buying a service from northern rivers into Queensland, are we doing it at New South Wales access rates or Queensland access rates?

Mr BARKER: I do not know about the access but we pay--the benchmark is national average price which we--

CHAIR: Yes, but, sorry, what I am saying is that I think that New South Wales people have a higher access rate for their public health services than, certainly than Victoria and probably also Queensland.

Mr BARKER: It was an issue at one stage I know in Victoria because there was some allegations being made that they were not getting the access that they thought they should be. I really have not got the information.

CHAIR: I thought New South Wales was getting a better deal out of it, I mean, New South Wales people, not the State Government that was paying for it.

Mr BARKER: I could not say whether that is true or not but we do pay national average price. That is the bottom line price and we would argue against that because those four jurisdictions have a lot of work from us and we would argue that it should be more of a marginal note than a national average price. So the health services that we have spoken about will be working with the department in terms of negotiating a better price and more certainty

over flows and in the allocation that it would set some benchmarks on how we want to manage that--not benchmarks, base lines, so that the areas do start to be more involved in their flows from New South Wales to the other jurisdictions.

CHAIR: Are you helping in the same way to improve some reverse flows?

Mr BARKER: We are working actively with northern rivers. The issue at northern rivers is slightly different. They are just going through the re-building and new building at Tweed Heads and in talking to the CEO, Chris Crawford, he is reasonably confident they have started doing some stuff with renal but of course because Tweed Heads Hospital is virtually right on the Queensland border he is comfortably confident that there will be some actual reversals that northern rivers residents in that Tweed area will go to Tweed rather than to Queensland and from where we sit there will be undoubtedly more people from that southern portion of the Gold Coast going to Tweed Heads. So that could have a positive effect. I do not mean overall positive but in terms of the services you can get from Tweed Heads Hospital, we think that will reverse flows into Brisbane and other areas, although tertiaries will still most probably continue.

CHAIR: When he agreed to go to the presentation before, he indicated that those cross-flow dollars are in the budget allocation, which is included in the three year budgets and the increased allocations. Is that the case?

Mr BARKER: No, when the three year budgets were set the flow dollars were not included in those figures. They are in their cash but we do it by way of a journal adjustment because we want to reflect it again into the shadowing principle for this year but there is no cash being given although we are in active discussion with Chris because he is working with us to try and start some things earlier than the others because it is a better position.

CHAIR: I know there is no cash involved but when the Minister announced the amounts of money that were going to go year, by year, by year to northern rivers, the allocation of expenditure money, it was included in those numbers because I checked with Nick Reid the day it came out. So that there is a big bounce this year and that big bounce included the flow moneys, because it is nineteen versus eleven from memory, is it not?

Mr BARKER: For?

CHAIR: Northern rivers. I mean, the in-flow, out-flow business. The difference is about eight or nine million. Previously that was paid from central head office across to Queensland but this year it gets folded in for the first time, from memory.

Mr BARKER: No, it was--interstate is in there but, was in their financial statement last year for the first time.

CHAIR: That is right, but not cash.

Mr BARKER: Not the cash, and we have got it in--yes, it is in their allocations this year but again they do not get the access to the cash. We are now talking to northern rivers.

CHAIR: You are only talking in and out anyway.

Mr BARKER: It is an in and out transaction.

CHAIR: So that is the cross-flows of the budgetary process. How do you conform, once the areas then get this amount of money which you work out as fair, they can then do what they like with it as long as they have got a reasonable argument. They can move money from acute services to rehab if they wish?

Mr BARKER: They cannot move money, as we have said here before, out of mental health. oral health, the Minister is protected, Aboriginal health and community health. They are the ones that bear some caveats

CHAIR: But they can add to them?

Mr BARKER: They can add to them, and with their growth money, their general growth money, as is with their mental health growth money, they have to come back and articulate how they are going to use that money and where appropriate demonstrate additional volume or services they are going to provide and that is all then approved and once that is approved, the cash will flow to allow them to do those types of activities.

The issue that we have spoken about, about the programs, is that we have been--and it has been a matter that has been asked of Estimates Committee about how some of the program movements happen. So we are going through a more vigorous process now to monitor what is happening with program movements and allocations with the areas to try and have more stability in that process than has been there in the past.

That monitoring arrangement will allow us to understand better what the areas are doing so that if they are moving money from one program to another there is a sound reason to it and it is not for something that you might say is not 100 per cent correct and in that process we are looking at overheads, how they allocate overheads. There is advice out how overheads would be determined but that does not mean that there is a consistent way that is done across the State. So we are working down that way as well to make sure that--is it an overhead or is it a direct cost. I can give you an example of what we mean by that. If you are the director of, say, drug and alcohol, you should be allocated directly with the drug and alcohol program. However, because you might not be out there seeing the community--large health service--some people might say, "Well, that is an overhead." That is blatantly wrong. An overhead in our view would be a chief executive officer, people like myself, people who work in the payroll office, those sort of people who provide common services across a range of activities, not someone whose whole job is to run that particular service.

CHAIR: I remember Refshauge and Phillips both had a go. CEOs started putting a little facility fee on the mental health budget, had a bit of a nibble at that and I think both of them reacted quite angrily. It was a good try.

Mr BARKER: And that is part of any big organisation.

CHAIR: The reason I asked the question about the moving is that the Auditor-General recognised last year that northern rivers was moving about 15 million out of its acute overnight to community-based services because that was a judgment that they made--they were quite open about it--the judgment they made that they needed more money in their community-based services than they did in the acute overnight and that is a judgment that then I presume they put through to you, you approve and--

Mr BARKER: They would do that by themselves but we are now going to be coming in as having a greater--we are going to change that around, but to date that has generally happened at a local level and that is the process we want to go back and have a much closer look at, but that approach is an inconsistent with the health council also because the health council made the view that with how medical practice is changing, that if you can put more into the prevention, which is the community health sort of thing, either in terms of prior to your episode of care in the hospital or after, that is going to be a more effective use of resources.

CHAIR: It comes to the issue that Arthur often raises which is the issue that EMPOS has come to us about in terms of the budget. As we do more and more of this acute care, day surgery and day of admission surgery and people are discharged earlier than they were in the old days, not discharged early but earlier than they were in the old days, that puts more effort onto community transport or transport costs for the person and perhaps on community-based services or back to the person themselves. So have you quantified that in any way? As we have become more efficient with the use of our beds or our facilities, have you been able to quantify in any way whether there has been a--what shift of cost has been to community-based services, whether they are NGA, your own, or whether they are the patient's own cost?

Mr BARKER: No, I cannot say that I am aware of any studies where that has been on the--

CHAIR: You have heard the argument before?

Mr BARKER: We have heard the argument and the argument ,as I said, is consistent with the health council's report of providing more in that community-based environment and that is why, if an area did as you--like northern rivers, moving money into that program, it is consistent with that providing how they manage their acute care services, has it reduced the volume instead of services--

CHAIR: It did, it dropped--the waiting list this went up but it was not just the out of hospital because of acute, it was for a whole lot of other reasons, keeping people out of hospital as much as anything.

The Hon. RONALD DYER: Does it not stand to reason if people are discharged on the very day that they undergo the surgery in rural areas, that there will be a greater reliance on, shall we say, district nurses and the like?

Mr BARKER: I am not a clinician but I imagine that would be a matter of clinical judgment for that particular procedure and how it would fit in with that day surgery policy.

The Hon. RONALD DYER: I am not a clinician either but it seems to me that in many cases, not all, we have someone who is discharged earlier than they once were but they are likely to require some follow-up care at home, just as a matter of common sense.

Mr BARKER: Yes, but the health council has been advising about putting more money into the community health and as they can make the--did with their benchmark costs under episode funding, that one of the things we want them to do, when they get down to benchmark, is use any benefits they can get out of that to put it into the community to invest in services there. A personal example, my grandmother when she had a cataract operation, she was in hospital for about 14 days, where these days it is virtually day surgery and you are home in the next--

CHAIR: It is called out-patient surgery now I notice. The department is now calling it out-patient surgery.

Mr BARKER: That is what is happening, as I understand it, across the board and things are changing.

DEP. CHAIR: The surgeons do not know the social situation of the people that they see. Many of the GPs do not either, so it is not much good to say that it is back on the clinicians. It might be back on the clinicians if the clinicians--the thing happening in sausage fashion fact.

Mr BARKER: You would imagine in a consultation process there is some form of discussion with the patient about, "Well, when you go home you are going to be in this particular physical state. Have you got someone to look after you?" if they think it is appropriate, "Have you got someone to care for you" and if the person keeps coming up with negative answers then we have social workers and people who can then come in and try and organise those sort of services.

DEP. CHAIR: They were discussed in your quality workshops where the targets are so enthusiastically followed for day surgery?

CHAIR: The Commonwealth has in fact assisted with cost shifting to itself in this regard, the hospital and the home was a program that the Commonwealth funded which is basically a shift from state-based in-patient services to home-based Commonwealth-based services.

Mr BARKER: We are funding hospital and the home as well.

CHAIR: But if they gave you the money. I know that.

Mr BARKER: I would not say they have given us all the funding.

CHAIR: No, but the fact that some of the people, as Ron has suggested, go home earlier there might be a community service. They might also need to see their GP at home or go to the GP to have their stitches out, et cetera, where they might have stayed in hospital to have their stitches out.

The Hon. RONALD DYER: That is a problem in country areas if you have not got a GP to go to. We have been told, even in a place like Dubbo which is hardly a small rural village, that there is a shortage of GPs and you cannot get onto their books unless you are--if you are coming into the town to live--

CHAIR: That is where Doug already mentioned that they actually use the hospital as their GP which is a big cost.

Mr BARKER: I can understand from talking to the CEO up there on Thursday that one of those reference centres has actually done its capitalisation so it is ready to go. It is now trying to recruit some general practitioners to work out of it to provide-what is most probably a service they have been after for some time.

The Hon. RONALD DYER: That related to Dubbo if that happens. The general point I am making is that it is all very well to talk about people going home quickly and in an appropriate case seeing their GP, but we all know it is notoriously difficult to attract GPs to rural areas in the first place so there might not be a GP to go to.

CHAIR: Of course that then brings on the cost if , say for example, they have got to travel to see the community nurse or the GP, the cost of getting transport is an added cost which they would not have borne if they had stayed in hospital overnight. In a cataract for instance, for example let us say, cataract surgery, I had mine done recently. Sure I got in there at half past 8.00, sure I was done at half past 9.00, sure I was at home at half past 10.00, because that is what it was. But the next morning at half past 7.00 I had to go back in to the hospital to have the first review and that meant that all of the patients for that day who were not Lismore people, would have had to stay overnight in one of the hostels and B and B's around the hospital because there are a number of them, to get up there at 7.30 in the morning before they then went home. So there is a cost to the patient of being admitted or paying for a B and B, bed and breakfast or some accommodation with a rel.

The Hon. DOUGLAS MOPPETT: Perfect example. Early discharge and you have been having dizzy spells ever since.

CHAIR: But you know what I mean, there is of course a cost which has been shifted from the hospital, which is what we have all said, it has shifted from the hospital based service to the community based service or to the individual themselves. But there has been no methodology of trying to work out how much that is.

Mr BARKER: We are at the stage we were doing a range of things in terms as I said investing more money into community type services. They have been funding some community transport options in certain places and there is a whole range of things.

DEP. CHAIR: Since the end cost report or are you saying generally?

Mr BARKER: I am not familiar with when the end cost report came out but there has been a community transport proposal being--

DEP. CHAIR: Less than six months ago.

Mr BARKER: Yes. This has been out before then. Some of what the government calls families first, pretty common some of the families first and (indistinct) a ride also as part of the government action plan to sort of come out of the Health Council.

The Hon. RONALD DYER: I think Dr Chesterfield-Evans is referring to this document.

DEP. CHAIR: Yes, that's correct.

The Hon. RONALD DYER: Transport to Access Health Services in Rural and Remote New South Wales and it appears to be dated July of this year.

Mr BARKER: I would no be aware of the status of the category assessed by--

DEP. CHAIR: Yes, that is right. It is less than six months, that is right.

Mr BARKER: I would imagine one of our policy areas to look at the viability of it and see how it--

CHAIR: There is another one of their documents which is about Sicker and Quicker, Quicker and Sicker, is it not?

DEP. CHAIR: Quicker and Sicker. I gather there was some--

CHAIR: This was on earlier discharge issues paper that they put out which covered the issue that we have been talking about, about they have been charged earlier and the transfer of the provision of services to others, not that that is bad or good, it just happens.

Mr BARKER: My colleague has just gave me a piece of paper that the health related transport program of 800,000 was established in late 1998 with recognition of the need to improve access to health facilities for people not able to access any other form of transport and the minister has now approved for a further two years to 49 community transport organisations and the Aboriginal Medical Service to provide health wide transport. 500,000 will be distributed for a further two years which is a further million in total to 33 of these services located in rural

and remote areas and so there is certainly things happening in that area. I just sometimes lose touch with some of these smaller programs. I am sorry about that.

CHAIR: There is an issue that is in the paper produced by the Director-General to us about strategies to improve management of booked activity. They make the point that it is the effect of changing practices on targets and it goes to the issue on page 11 of advance in medical technology and the management have for many years caused reduction in the average length of stay of in-patients:

> Many previously overnight procedures are now being done on a day only basis. Furthermore, many procedures which were being done on a day only basis are increasingly done on an out-patient or ambulatory basis. It is important to recognise this latter point both in setting targets and in monitoring performance, an area moving to out-patients cystoscopys or cataract removals should not be penalised but encouraged in this care but there are perverse incentives.

So how do you monitor those things as a financial--

Mr BARKER: Did Paul Tritchell come and talk to you?

CHAIR: This is financial stuff. He did not talk to us about the financial stuff. If there is a good reason clinically to arrive at 8.30, cataract at 9.30, home at 10.30, but instead of it being a day only admission you are only sort of an out-patient, there are different costs that you can give to people and therefore you can attract different subsidies from the state government for that sort of service. How do you or your organisation watch that they do not play shufties on you or that you do not inadvertently disadvantage what is good practice?

Mr BARKER: We do not specifically in my area monitor that but there is a performance agreement between the Director-General and each CEO which has a range of requirements in it including day only admissions, non in-patients, not admittable, non occasions of service or non in-patients occasions of service, and so that is then assessed as the year unfolds and at the end of the year and so clearly that if an area was inappropriately coding something for want of a better example, that would be picked up in that process because you would imagine there would be some abnormal numbers or something would not come through. Now most people in a professional position will not give bad data to cover up other deficiencies. I guess if they do they--

CHAIR: So these more detailed big issues are covered by written contractual agreements between the CEO--

Mr BARKER: It is a performance--

CHAIR: They are subject of the Director-General's visits.

Mr BARKER: There is an annual review that occurs and then there is an agreement and we then--I monitor the financial results and there are other areas of activity during the course of the year and areas are then spoken to. They might have a meeting with us, we might go up and see them. There could be correspondence, a whole range of things and that will come out of each area of the department and clearly if an area is not doing the right thing, there will be then a way that that will be taken forward in discussions with the area. There is always going to be--we just monitor those types of things to see how they are going.

CHAIR: Has anybody got any other questions, I have got two more and I thought you had better have your go?

The Hon. RONALD DYER: I just want to clarify one matter. Quite some time ago Mr Barker was referring to episode funding or episodic funding. Could you just clarify what that means. I know what episode or episodic means but within the health economics context?

Mr BARKER: Right. What happened from the Health Council report is that for acute care--and that would include day only--we have got an average what we call benchmark cost for similar hospitals. So in terms of your inquiry we would be expecting that the base hospitals will all have a similar benchmark cost factor and that is then weighted for the procedure, so we use different ratings. So the simple procedure has a number less than 1 where a complex procedure might have a number of might be 2.5 or 2.6. So each one of those procedures they do they get the average cost by that. We then compare what they are going to do for the year using the case weighted number of volumes at the benchmark to what they should do compared to their budget and if there is a difference we then have asked them, starting last year, about how they would intend to come back to benchmark or alternatively if they can justify why they should be maintained over benchmark and justify that.

Last year was the first year and it was a bit of understanding by both the health services and the department. This year we have improved how we are doing things. We have had a number of workshops with the area participants, both last year and this year, so we have had very much a collaborative forum on how we work this process forward. This year we are improving our understanding of what they are doing. They are also improving their understanding and so we will get a better idea this year where they really are. There were some anomalies last year. We would argue that some most probably did not get it as good as what we would have hoped to so we are hoping to improve that result this year and be in a much better position next year to take it forward. We would hope that that process would free up some money as I said before, to go back into the community health programs to provide a greater range of services.

So there is a peer for base hospitals. They are not compared to the teaching hospitals in that exercise. There is a separate benchmark cost for teaching hospitals and it does then lead to the acute care programs are more self sufficient because as I said there is a separate program being trialled this year for emergency departments and are also trialling another process this year of shadowing as we call it, for intensive care.

CHAIR: The last thing, I wonder if you could send us the papers on how you work out each of those formulas so that we can include it as an appendix so that people out there can see how you do it, particularly the adjustment for private hospitals and so on and also how the formulas actually worked to produce the figures.

Mr PEARSE: We can provide you with the public document we referred to which is 1998/99 technical paper, this is a public paper.

CHAIR: That has got the details of how the--

Mr PEARSE: It has got some of the detail.

CHAIR: Just so that people can get it if they want it. They can then work it out themselves. If they have trouble understanding it, well they can go and ask the hospital how they do it.

The Hon. RONALD DYER: But it is not necessarily cast in tablets of stone.

CHAIR: The reason that it is important is that if it is a population based formula it should be a population based formula and it is up then to the government or the department to explain why one area is treated differently from another area if people are meant to be getting a fair shake, and there are reasons.

Mr PEARSE: As I said, there are things that we are updating and looking at at the moment and we have not really come to the point of finalising.

CHAIR: That still gives you a 4 per cent variation between one area which might be 2 per cent up, like Greater Murray, who still cannot live within their budget and northern rivers which is--at the end of the day mid north coast which would be 2 per cent down, a terrific variation of about $8 million between the two. Then they have to explain that to their own taxpayers, not the government.

The Hon. RONALD DYER: I would have thought it was commendable from the point of view of public administration to keep trends under review and if a particular formula is shown to be not working properly to adjust it.

DEP. CHAIR: Brian interrupted you. You said, " I can give you the public document," which I think is 1998/99 and you looked like you were going to say "and there are some working papers since then that are not yet public," but you did not quite get to say that because Brian interrupted you. Can you finish the sentence that you would have said about when you started saying, "I will give you the public documents."

Mr PEARSE: What I was going to say was that a number of the factors as I have mentioned in my presentation are currently under review and we have not finalised that review at the moment. But that was really the public document that shows where the RDF was at that point in time.

DEP. CHAIR: Yes, but the documents since then, they must not surely all be virgins floating around for three years with Draft written on them. There must be some sort of an update that the department has since then?

Mr PEARSE: No, there has not been a formal update since then that has been signed off at some point.

DEP. CHAIR: How close to formal are the informal documents that are floating around?

Mr PEARSE: Not very close in my view. They have not be signed off by, or even seen by the Director-General.

CHAIR: They will not effect the nature of the inquiry which finishes in 2003. Our inquiry finishes in 2003; no change before then will there?

Mr BARKER: No, because there is a three year fixed budget so they are all guaranteed, those services.

Mr PEARSE: They will not affect budgets.

CHAIR: Mr Barker, one final question,. I wonder whether you could give us the way in which you calculate each area health service's budget. In other words, what the dollar figures are and the reason behind them. Say for example you have got the RDF for general and then how you worked out for the mental and so on. Is that easy or hard?

Mr BARKER: It is essentially with the three year budgets they all know now what their growth factors are.

CHAIR: Yes, but the people out there who--

Mr BARKER: You want a plain English version.

CHAIR: The plain English version so that they understand if they live in Coffs Harbour that this is what they get for each area. Whether the area spends the money in that way is their business.

Mr BARKER: I could not give it by Coffs Harbour. We could give it by Mid North Coast.

CHAIR: Yes, Mid North Coast. So it is worked out on these line items get this much and they deserve this much, you get this much, you deserve this much, you get this much. I know there is a variation but people should be mature enough to see that and if the area then does not spend it that way, well that is something for them to explain to their local community, not for the department to explain. I think that is a fair way of doing it. They are public figures but it is just the rationale behind them which I think is what people are going to look at, will want to look at.

Mr BARKER: We will also arrange through the Director-General to send to you some advice on our community re-investment strategy.

CHAIR: Excellent.

Mr BARKER: Which addresses those issues about community health and those kinds of things.

CHAIR: Thank you, that would be very helpful. Any other questions from anybody? Mr Barker and Mr Pearse, thank you very much indeed. I do not think we will have any follow-ups on this at all because I think it has been very good. Thank you.

(The witnesses withdrew)

(The Committee adjourned at 4.27 p.m.)