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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

MONDAY, 30 MAY 2005

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Monday, 30 May 2005

Members: Mr Somlyay *(Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Georganas, Ms Hall, Mr Johnson, Ms King, Mr Turnbull and Mr Vasta

Members in attendance: Mrs Elliot, Mr Georganas, Ms Hall, Ms King, Mr Somlyay, Mr Turnbull, Mr Vasta

Terms of reference for the inquiry:

The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

Committee met at 9.44 am

ADDISON, Ms Linda, Assistant Secretary, Private Health Insurance Branch, Australian Government Department of Health and Ageing

BALMANNO, Ms Rachel, Assistant Secretary (Acting), Strategic Planning Branch, Australian Government Department of Health and Ageing

DAVIES, Mr Philip, Deputy Secretary, Australian Government Department of Health and Ageing

HUXTABLE, Ms Rosemary, First Assistant Secretary (Acting), Acute Care Division, Australian Government Department of Health and Ageing

MASKELL-KNIGHT, Mr Charles, Adviser, Medical Indemnity Branch, Australian Government Department of Health and Ageing

MERSIADES, Mr Nick, First Assistant Secretary, Ageing and Aged Care Division, Australian Government Department of Health and Ageing

ROBERTSON, Ms Samantha, Assistant Secretary (Acting), Medicare Benefits Branch, Australian Government Department of Health and Ageing

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing, for its inquiry into health funding. This is the first public hearing for this important and timely inquiry. During the inquiry, the committee will be exploring how the Australian government can take a leading role in improving the efficiency and quality of the health care system. While Australia's health system is among the best in the world, it is facing ever increasing challenges from rising patient expectations and funding pressures. Current health funding arrangements between the Commonwealth, states and territories, and the private sector are complex and a source of confusion, and this affects the quality of health care services. Today the committee will hear from the Commonwealth Department of Health and Ageing and then from the Australian Divisions of General Practice, representing the doctors. This hearing is open to the public, and a transcript of what is said will be made available via the committee web site. I invite representatives of the Department of Health and Ageing to make a brief introductory statement before we proceed to questions.

Mr Davies—Firstly, I apologise for a somewhat dishevelled time of arrival this morning. I think there was some communication breakdown. We were led to believe that you were starting at 9.45 am, so apologies for that inconvenience. I also thank the committee for the opportunity to participate at this early stage in your inquiry. We certainly welcome the opportunity to be involved in the early stages of your deliberations with the committee. We also appreciated the opportunities we had to meet with you earlier and provide support in the development of the terms of reference, as well as providing a written submission to you. That submission, I hope you will agree, responds to your terms of reference around the roles and responsibilities of different levels of government, funding arrangements, accountability, the private health sector and private health insurance in particular. We hope that submission has given you information on the leadership role of the Australian government and how it works in partnership with states,

territories and the private sector to deliver health services for all Australians. We hope it has explained the current funding arrangements, accountability measures and quality improvement frameworks that are in place to ensure the efficient and effective delivery of health services. We hope it has outlined Australia's strong private health sector, including the relationships within the sector and between the public and private health sectors. We believe it has gone into some detail on issues around private health insurance.

I have a number of officers from the department accompanying me here today. Hopefully they can answer your questions on issues in our submission. We have to acknowledge that it is a very broad subject that you are traversing and this is the first session on the first day. In light of that, it may well be that we have to agree to come back to you on some issues and we will be more than happy, once your deliberations have proceeded, to come back and help you with more specific points of detail, which I am sure will emerge. I would also like to bring to the committee's attention that a number of issues relevant to your inquiry and your terms of reference are on the agenda for consideration by COAG at the end of this week. Given the role of COAG as the premier Commonwealth state forum, it is likely that their consideration of these issues may well be relevant to your work, particularly the term of reference that goes to the roles and responsibilities of the different levels of government. Recognising the stage that you are at, it may well be that you want to consider COAG's deliberations as part of your work, and come back to us subsequent to that. With those comments, we are happy to take your questions.

CHAIR—We certainly would like the states and territories to make submissions to our inquiry, but they have not as yet. Through the secretary they have expressed concerns that the government has the report from the Podger review, and that COAG is examining this issue. Before it goes to COAG, and before they have considered the results of the Podger review, they will not be putting in a submission. I expect that they will after that.

We will not get through all the questions that we want to today. Members of the committee have asked whether you will take questions on notice. We will forward questions to you on any areas we do not cover today and we ask you to respond in writing.

Mr Davies—Yes. We will be happy to take questions on notice and respond to written questions. If the volume reaches such a level that justifies a return visit, we would be happy to do that and help in any way we can.

CHAIR—One of the areas which is of primary concern to us is public hospitals under the Australian health care agreements. Given that there is a royal commission in Queensland regarding the performance of a number of hospitals, could I ask you, to start off this inquiry, what role does the Commonwealth have in determining health care standards and accreditation of public hospitals in the states? We have a role in accrediting private hospitals, but do we have a role in accrediting public hospitals?

Mr Davies—Any role that we have, I think I am right in saying, would be encompassed under the terms of the health care agreements, in terms of the relationship to financing. There is an array of quality assurance mechanisms within the health system. For example, the registration and competence of medical practitioners are largely the responsibility of the state medical boards, in which the Commonwealth government has no direct involvement. But in terms of the actual hospital buildings, facilities and services that are provided in those locations—and I look

to my colleague Ms Huxtable, who is responsible for health care agreements—I think I am right in saying that in the health care agreements there may be some reference to that.

Ms Huxtable—As you would know, the focus of the health care agreements is to provide a significant contribution to assist in the funding of hospitals. The 2003-08 agreements—we are in that period now—have focused on eliciting a range of consistent data in regard to the performance of hospitals. There are probably two foci, actually, and that is one of them. The other is, under the health care agreements, to progress a national health reform agenda, which covers a variety of matters. Health ministers have also given consideration to safety and quality issues. A review of the Australian Council for Safety and Quality in Health Care has been progressing and health ministers considered a number of initiatives at their recent meeting in January this year to look at ways to elicit consistent information about the standard of care being provided. The focus of our attention is predominantly on providing moneys and gathering information so that we can better understand what is happening in hospitals. We can talk at more length about that. I am not sure whether that entirely answers your question.

CHAIR—Within our system of checks and balances and the information that we gather, if one doctor happens to lose 87 patients over an 18-month period, would the Commonwealth have any method to pick that up and say that is out of the norm?

Ms Huxtable—The actual management of the hospital system is very much a state responsibility. Under the health care agreements, what the states agree to in accepting the Commonwealth's contribution is to adhere to some basic principles around Medicare, which is about providing services on the basis of clinical need in appropriate times, and to public patients free of charge. These are the principles that underpin the agreements, but the actual management of the hospital system itself is the responsibility of the states and territories under the agreements.

CHAIR—Do you think what has happened in Bundaberg is consistent with the agreement?

Ms Huxtable—To what are you referring?

CHAIR—I am referring to the Bundaberg hospital, where these 87 patients have died as a result of one surgeon.

Ms Huxtable—I am not aware of the details of the case.

CHAIR—Right.

Mr Davies—You did mention accreditation. I believe I am right in saying—and, again, it is not a direct area of our responsibility—that there is the Australian Council on Healthcare Standards and it may be worth your while talking to them. I do believe they run a scheme for the accreditation of hospitals. We do not have any requirement that public hospitals be accredited. It would be for the state government to make that requirement.

Ms KING—Mr Huxtable, in terms of the information that you collect under the Australian Health Care Agreements—and I also want to refer to the Public Health Outcome Funding Agreements and the indicators in those—what do you do with that information? I guess I have

an impression, from when the Public Health Outcome Funding Agreements were first done, that there was an inordinate amount of information collected on a range of different indicators, but that information then just sat in repositories within the department and very little was done with it. Could you make a comment about that please?

Ms Huxtable—With regard to the PHOFAs, I cannot, but there is an officer here who can speak to that. With regard to the Health Care Agreements, for many years we have collected information on admitted patient services and there certainly has been a challenge in developing tools—

Ms KING—Some of those are about quality, aren't they, in terms of what Mr Somlyay was referring to?

Ms Huxtable—Predominantly those are about length of stay and coding in-patient episodes to diagnosis related groups. So we have a wealth of information on that, as does the AIHW. The challenge over the last 10 to 15 years has been to develop the tools that allow information and coding standards to be consistent. I think that has been a focus of activity in the last 10 years.

However—and I will answer the question around reporting too—the focus of these agreements has been to build on the admitted in-patient information by adding to that the information on outpatient services and emergency department services where the data are not as readily available or as comparable. Also, we are looking at rehabilitation services. So we are broadening the scope of that.

With regard to the reporting arrangements, under the agreements we publish annually *The state of our public hospitals* report. This is the first set of agreements in which this occurred and the last report was published in June 2004. We are on the verge of publishing another, which is currently with the states for comment. That will be published on 30 June 2005. We can make the 2004 report available to you if you wish and then the 2005 report when it becomes available; but it is not quite ready yet.

Ms KING—How regularly do you get information in under the Australian Health Care Agreements? What is the reporting schedule?

Ms Huxtable—I do not know that I know all the detail, and I am not sure if it is a policy issue. I think it is quarterly, isn't it, for most?

Mr Maskell-Knight—There is a mixture of quarterly and annual reporting for different items. If you look at the agreements, one of the schedules at the back actually specifies which data items are reported quarterly and which are reported annually.

Ms KING—Could you provide a copy of one of the agreements for the committee please.

Mr Maskell-Knight—We can do that. They are actually published—

Ms KING—They are published on the internet, I know. I am just being lazy.

Mr Davies—We can perhaps ask Ms Balmanno to speak to you about the information under the PHOFAs if you want. Mindful of the focus on safety and quality, I think the other point I should have made is on the Australian Council for Safety and Quality in Health Care, which Ms Huxtable mentioned. They have made quite a lot of progress in recent years in terms of reporting adverse events and I believe they are now close to agreeing a national sentinel events reporting system, which would obviously give some sort of early warning of where quality problems are emerging.

Ms KING—Thank you.

CHAIR—As a Queenslander, and given that there is a royal commission on at the moment into the events at Bundaberg Hospital, I was asking whether we have any arrangements in place that require certain standards of public hospitals, given our funding? Would we be expected to pick those problems up from the data that they provide to us?

Mr Davies—I think in terms of—

CHAIR—If the answer is no, the answer is no.

Mr Davies—The answer is no. Clearly we are concerned when such issues arise, particularly if they have a detrimental effect on public confidence in the health system and broader health services. But primarily, regarding the operation of hospitals and the employment of hospital staff, although the Australian government makes a sizeable funding contribution, the nature of that funding contribution is not such that we are directly involved in the delivery of those hospital services. So it is primarily a state and territory responsibility in terms of employment, operation and outcome of what goes on in their public hospitals.

Ms HALL—I have a couple of questions I would like to ask you, as I am sure the other members of the committee do. I will be submitting some of my questions in writing at a later time. While we are talking about the agreements, I noted in your submission on page 7 that you talk about the 2003-08 Australian health care agreements. For the first time the minister has allowed the imposition of financial penalties on states and territories if they do not meet the reporting requirements set out in the agreements. Has that been enacted against any state or territory? If so, why and could you provide details?

Ms Huxtable—The first year in which this could have occurred, the one that I have been involved in, is the one just passed. No, there were no penalties imposed. The requirement of the agreements, which are signed by all parties, is that compliance payments can be withheld in the event that a state is deemed to be noncompliant with the agreements. That covers a variety of factors—for example, if there were evidence of systemic failure to comply with the principles which underpin the agreements. The ones I referred to earlier were about patient election, that is, the right of a person to be treated free of charge as a public patient in a public hospital, and treating patients in clinically appropriate ways and within a clinically appropriate time. The other important factor is about compliance with the data requirements about data being received on time and consistent with the requirements of the agreement. So they are the two tranches which we monitor in terms of compliance. As yet no state has been affected by that.

Ms HALL—I would like to refer to the Podger review. Were the department involved in that review? Did they meet with Podger? If so, what kind of issues did they pursue and what were the department's recommendations to that review?

Ms Huxtable—It was probably a less formal process than that sort of process where recommendations are made. We had two officers on the task force which supported the Podger review. That task force was based in the Department of the Prime Minister and Cabinet.

CHAIR—For the benefit of the record, would you run through the process of the Podger review—how and why it was set up?

Ms Huxtable—I will be in part just relying on my memory. Our department was not directly involved. I would not want to mislead in any way. You will probably recall that following the last election, when there was the announcement of ministries et cetera, an announcement was made that there would be a review of health undertaken by Andrew Podger. At that time there was also an announcement by the Prime Minister about the range of issues that Mr Podger would be asked to look at. These were: ensuring optimum efficiency and effectiveness of health service delivery for all Australians across the primary acute rehabilitative and aged care sectors and their interfaces, and in doing so to clarify responsibilities; ensuring best use of the funding that all jurisdictions put into health and improved accountability and transparency of health funding; and identifying barriers to seamless service delivery for patients. The task force was not a public inquiry; it was more like an interdepartmental committee, I suppose. Certainly we, as a department, did provide factual information and had discussions with the task force and with Mr Podger from time to time focused on the reference.

Ms HALL—In what direction did those discussions go?

Ms Huxtable—I am not sure that I can really say much more than that they were focusing on those interface issues—an announcement has been made about the sorts of issues that were being discussed—so discussions were quite wide-ranging.

Ms HALL—Did the department adopt a certain direction, when they were addressing those issues?

Mr Davies—I think our role was more to provide factual information. In answering the sort of questions that were out to us, we were not really setting the direction of the task force. As Miss Huxtable has already said, the task force was based in another department and we were not party to all their deliberations. We were merely providers of information rather than setters of direction.

Ms HALL—So the department did not have an opinion, is that what you are saying? The department did not have an opinion on those terms of reference?

Mr Davies—I think it is fair to say that we were not asked our opinions, as such, on those terms of reference.

Ms Huxtable—No, not the terms of reference themselves.

Mr Davies—We were providing input so that other people could form an opinion; those other people being the task force.

Ms Huxtable—The terms of reference are very wide-ranging—

Ms HALL—They are.

Ms Huxtable—and we have responded to the requests for information across a wide range of matters that were addressed by the standing committee.

Ms HALL—But surely, as a department, you would have an opinion on some of the issues encompassed in those terms of reference?

Mr Davies—It depends on what you are asked.

Ms Huxtable—That is right.

Mr Davies—We have an opinion certainly. Our opinion on the goals defined for the task force and the objectives that they were setting out to meet and advise on, optimum efficiency and effectiveness, would certainly support the pursuit of those goals. But I think the mechanism to achieve those goals was very much the material on which the task force itself concentrated.

Ms HALL—Okay. I do not want to hog the time because I know that everyone has got some questions they want to ask. I have got a number of questions I want to ask on private health insurance, so I will submit those in writing.

Mr Davies—We will be happy to take those and respond.

Ms HALL—One thing I would mention is that in your submission there is really no mention whatsoever of mental health and how the terms of reference relate to that. The only place I saw mental health mentioned was when you were talking about private hospitals, so I believe that we need more information from the department on mental health because that is an area where there is a problem with the interface between—

Mr Davies—It may be helpful, just to avoid duplicative work on our part and also unnecessary concern on yours, there is, in parallel, a Senate inquiry into mental health. The department will be making what I believe is going to be a fairly substantial submission to that inquiry which will certainly go to financing and a whole raft of other issues. I think that will be appearing on the Senate inquiry's web site very shortly. That might be a good first port of call to see if that answers your questions. But, again, if you have particular questions you want put to us on that specific issue—we did not identify that as highlighted by the terms of reference—we are happy to answer them.

Ms HALL—It is part of health.

Mr Davies—Absolutely, a very important part.

Ms HALL—I would ask you to address those answers to the committee. The other quick question relates to aged care and a recommendation in the submission that we have received from the AMA—I have not had time to go through it again this morning. We have all heard of older people in hospitals described as 'bed lockers', for want of a better term—it is a term that I do not like. The AMA make a recommendation that if those people cannot be offered residential care or suitable packages in the community then the Commonwealth should pay the states the equivalent of what they would pay to an aged care facility. I draw your attention to what happens in the UK, where they have introduced a similar sort of scheme. Obviously there are some differences because they do not have the same state and Commonwealth divide with the retribution if a person is not offered the package that they need.

Mr Davies—It is a model that, as you say, exists in the UK. I think the UK stole it from Sweden initially.

Ms HALL—Yes, they do it in Sweden, too.

Mr Davies—And they do have the same jurisdictional issue in the sense that the National Health Service does the hospital care, and the local authorities do the residential care. So there are some analogies.

Ms HALL—The AMA recommended something that fitted the way we operate our health system.

Mr Davies—Mr Mersiades will be able to go into more detail, but it is worth noting that sometimes that judgment as to whether a person is ready to move from hospital into a community setting is not always as crisp and clear as we might expect it to be. Just because someone is elderly and in hospital does not necessarily mean their need for hospital type services is clearly over at any particular point. So I think there are a number of practical considerations that would need to be addressed if one were to pursue that line.

Ms HALL—I have to say my area health service tells me that there is an issue there.

Mr Davies—Yes.

Mr Mersiades—It partly depends on the extent to which there is a problem in public hospitals, and in recent years there have been a number of measures to try and reduce the incidence of people waiting in hospitals. For example, for the first time since about the mid-1990s, the provisional level of aged care places has gone over 100, to 101.6, so that is creating more opportunities—

Ms HALL—I do not wish to be rude, but I just wonder if you could tell me what you think of the AMA's suggestion.

Mr Mersiades—It is well worthy of consideration, but I was suggesting to you that there are two ways of approaching it. The other one is the transition care program, which goes some way towards what has been proposed, where collaboratively the states and the Commonwealth work together to jointly fund a transition care program to cater for these people who are transitioning from hospital into community or residential care. What I am suggesting to you is that there are

number of ways of dealing with this issue. It could be that those measures that we are working on at the moment may see the incidence of that problem diminishing. There is also a move to 108 operational places, so that creates a lot more places out there to take the pressure off the hospitals. So, it is a multifaceted issue.

Mr TURNBULL—On page 11 of your submission, you run through the percentage of funding that is provided through the health care agreements to public non-psychiatric hospitals. You point out there that 49 per cent of funding in the fiscal year 2003 was contributed by the Australian government, 43 per cent by the states and eight per cent by the private sector. We have all seen various people canvass the idea that the federal government should take over the management or responsibility for public hospitals. While the federal government is not providing the majority of funding for private hospitals, it is clearly providing the largest share of that funding. Do you think the administration of public hospitals would be improved if the federal government were to take responsibility for them from the states?

Mr Davies—I think you are asking me to speculate on a hypothetical question there, and I am not sure that that is an appropriate thing for me to do.

Mr TURNBULL—I am asking you a question. Do you think the administration of the public hospital system would be improved if the federal government had responsibility for it, as opposed to its current status where the federal government provides the largest part of funding, but does not actually administer it?

Mr Davies—Again, I am not sure that is something on which officers of the department can comment. It is not currently a government policy.

Mr TURNBULL—It is not government policy to answer questions?

Mr Davies—It is not a government policy to require its officials to speculate on undeveloped policies.

CHAIR—I think the policy is exactly the opposite.

Mr TURNBULL—We are all familiar with what the government policy is, but there is a debate going on out there, and we are just seeking your view.

Mr Davies—I think then the answer would be that it is not an issue on which either I or the department has a view at this point in time.

Mr TURNBULL—That is fine. If you don't have a view then you cannot express one.

Mr Davies—Thank you.

Mr GEORGANAS—My question is about the state and Commonwealth agreements 2003-2008. I know that the question was answered earlier but no fines have been imposed and no states have being penalised thus far. Have all the states been meeting their requirements in accountability on time, quarterly, on a regular basis? If not, how has the Commonwealth worked with them to try to achieve that?

Ms Huxtable—We have a significant collaboration in regard to issues.

Mr GEORGANAS—It would be good to know how many times they have not met those requirements. If they are that is fine but if not, and if it is on an ongoing basis, you may need to have a look to see whether there might be a bit of a problem.

Ms Huxtable—We are working closely with them in regards to some of the data systems because it is not simple to develop some of these systems. Certainly in the area of rehabilitation, for example, where getting information in regards to in-patients is relatively straightforward but capturing the outpatient data is quite difficult, the timetable for that has been developed in close consultation with them to allow the developmental work to be done. We work very closely with them and we provide funding support in that regard.

The other element is in respect of some of the compliance issues around patient election. We certainly investigate instances where there is anything brought to our attention that suggests that the states have not been compliant with the agreements. We write to them and that, at times, has led to some instructions being sent out to hospitals in regard to patient election issues. But there is nothing outstanding in that regard that I am aware of at the moment. We have a dialogue. It is not the sort of agreement where we are here and they are there and every year we say yes, you have met it, or not. It is really an ongoing partnership and dialogue around all of those issues.

Mr GEORGANAS—There are dates that are set down for them to meet those requirements?

Ms Huxtable—Yes.

Mr GEORGANAS—Would be possible to find out if the actual requirements have been met by those dates?

Ms Huxtable—They are being met. I can tell you that.

Mr Davies—I think Rosemary is entirely right to point out that the nature of the relationship at the practical level between offices of the respective departments is a very constructive and collaborative one. It is not as if we sit there waiting for them to get it wrong and then come down on them. We actually work with them to ensure that the reporting requirements are met and if it looks as if a deadline is in danger of not being met we will intervene early. Our job is to help them avoid paying the penalties, not to try to impose the penalties on them.

Mr VASTA—The electorate of Bonner is probably not so different from the other electorates in Australia in the fact that we have got quite an elderly population. We have had the community come to us and say to us, 'Look we want to save the government money by keeping the elderly at home for a longer period.' Meals on Wheels is quite substantial in our electorate. They have gone to the state government and put in a proposal for state and federal funding of a big kitchen so that they can provide stay-at-home facilities for all these elderly patients so they do not then go to an aged care facility where it is going to cost the government more and more. They want some kind of subsidy for the expansion of their kitchen in a professional manner. What would your department think about that kind of proposal? Is there any kind of merit in that? There are increasing numbers of communities coming to their MPs and saying that they want this kind of

organisation to expand so that it does not put so much of a burden on state and federal governments.

Mr Mersiades—The government's overall policy has been to encourage and create the opportunities and the choices for people to age at home for as long as possible and to avoid premature admission to aged care homes. It has done that through a six per cent real increase which has been met by the states and territories in the Home and Community Care program, which includes the Meals on Wheels program. The states are responsible for the day-to-day administration of the Home and Community Care program. The sorts of initiatives you have just mentioned could be considered under those programs. But you would have to look at the cost effectiveness of the proposal and you would have to compare it with a lot of other demands that are on the Home and Community Care program.

Mr VASTA—You will be getting a submission, I think, in the near future from us and there are a few other electorates where we know that this is occurring.

Mr Davies—But again, as a general principle, there is no argument—

Mr VASTA—There is no argument—

Mr Davies—The longer people can live in their own homes, the better. It is both financially and from the point of view of the individual's quality of life a desirable thing, so a lot of work is to support that.

Mrs ELLIOT—My question is also in relation to aged care and the delivery of residential care packages. What I am curious to know is whether you collate any data in terms of, once someone has been assessed by ACAT, how long it then takes for that actual service to be delivered, from the time of assessment to the actual delivery. Also, do you collect data on the number of persons who cannot even get to that stage of being assessed by ACAT because of the large elderly population and the lack of packages available? So it is specifically those two criteria I am after: the people who are turned away and how long they have got to wait, even though they have been assessed as having that need.

Mr Mersiades—Yes, we do collect that data, through an ACAT minimum data set, but I would have to take your question on notice in terms of the precise information. I do not have it with me, but we do collect that information.

Mrs ELLIOT—Could I then access that through you later on to find out specifically—

Mr Mersiades—We will provide you with that data.

Ms KING—I would like to briefly go back to Podger, if I can. I understand that is listed for COAG as an agenda item later this week. Has the paper been made available to states and territories?

Mr Davies—There is an agenda paper for the COAG discussions, yes.

Ms KING—Does it contain the full Podger report or is it an agenda paper that says, 'We're listing this for discussion'?

Mr Davies—The agenda paper, as I understand it, has the topics for discussion and there is some discussion of those topics within the paper itself, which will then be grist to the COAG mill on Friday.

Ms KING—Has it been to health ministers or AHMAC at all, or is it just going straight to COAG?

Mr Davies—No, it is just going straight to COAG.

Ms KING—The GDP percentage figure for expenditure on health that you have provided is the 2002-03 figure. Is there anything available more currently than that? That is on page 4 of your submission. You have got 9.5 as the 2002-03 figure.

Mr Davies—I think I am right in saying that figure is the most recent, although obviously, particularly at this time of the year, new financial year figures do come out. We will check, and if there is anything more recent, we will certainly get it to you.

Ms KING—It would be helpful for me. I would not mind a breakdown, a look back from 1996 to now, in terms of that figure. Also, you have given a breakdown—I think it is in the table—in terms of OECD countries and the mix between private and public. I would like to see that over time as well. We have only got the 2004 OECD health data there. Jill, is that what you were after as well?

Ms HALL—Yes, that is what I was after.

Mr Davies—So, just to be clear, because this is fairly straightforward stuff to give you, you are after the trends in the Australian per cent of GDP, from 1996 to the most recent possible, and, presumably for that same period, the same data for the other OECD countries on this list.

Ms KING—And the private/public mix.

Mr Davies—And the public/private split.

Ms KING—Just on that 9.5 figure we have got, health expenditure was almost stable around 8.5 for quite a substantial period of time—and I assume that that 9.5 figure continues in subsequent financial years—so what has been the main driver of the increase?

Mr Davies—The fastest growing component of government spending is the PBS—the increasing costs of subsidised pharmaceuticals.

Ms KING—And what is driving that? Is it consumer usage or cost of pharmaceuticals?

Mr Davies—It is a combination of price and volume. Again I have got reasonably recent data which is not to hand but which we can produce for you. I think it is roughly two to one—no, I had better not say. We have got a breakdown of how much is price and how much is volume.

Ms KING—In terms of the volume figures, are there particular classes where there has been an explosion? Obviously, the statins was one class that just seemed to take off—everybody was on them for a while there!

Mr Davies—I am not sure we would use the word 'explosion'! But again, I think we can break both the price and the volume down into major therapeutic groups. These are not figures I have with me today, but we can certainly provide them.

Ms KING—It would certainly be helpful information.

Mr Davies—In terms of price, while there are pharmaceuticals coming off patent onto generic—which has typically saved money—there are also more powerful and more costly products coming on patent. Subject to the deliberations of the PBAC, if those are listed they can involve very significant degrees of subsidy. There is no doubt that that increasing sophistication drives a lot of that cost. We will get you the breakdowns, certainly.

Ms KING—Thank you.

Mr TURNBULL—There is a very experienced nursing home operator in my electorate, Ralph Levy. I do not know whether he has been in correspondence with you. He draws attention to a very significant issue that affects every electorate, which is the problem of people in aged care facilities at a distance remote from their children and relatives. Of course they do not get visited very often and it makes their situation particularly miserable. Particularly in my electorate of Wentworth, where property values are high, it is difficult to find large sites within a reasonable proximity for developing facilities of this kind. Mr Levy has advocated that more should be done to promote or enable the construction of smaller facilities—I recognise this runs against the economies of scale—so that there are more beds available in a more diverse, spread out way so that they are more accessible to families. After Mr Davies's response, I would not ask you to express a view on a policy, but you could perhaps discuss whether this issue is something that has ever come across your desk, and if it is something that you are focused on—this issue of maintaining the social connectedness of people in aged care facilities.

Mr Mersiades—It certainly is an issue. It manifests itself the other way as well. There is some evidence that suggests that older people move to where the children are living. In other words they go to the outer suburbs. But you are correct in pointing to the economies of scale.

Mr TURNBULL—That argues the case for having a more diverse spread of these facilities, so that there are possibilities for people moving so that they are close to their kids.

Mr Mersiades—Yes, that is right. Under the planning arrangements we have at the moment we tend to be at a regional level, and we do not dictate the size and location of services. It is a matter for the providers to respond to the market and to what they feel is in demand. You correctly point to the issue of economies of scale. Most of the providers would be looking to build larger homes, because they do allow those economies of scale.

Mr TURNBULL—What is your view on multilevel homes?

Mr Mersiades—Under the building certification arrangements, if they are appropriately designed, they can fulfil a very important need. In some cases they have developed a poor reputation but those are generally older homes that have been adapted, have been there for a long time and are not really suitable for, and have not been appropriately designed for, the standard of aged care that is required today. Fundamentally, there is no problem with them; there is quite a lot being built.

Mr TURNBULL—I have one final question. Have you given any thought to the degree of financial support from the Commonwealth? While it obviously pays attention to the cost of operating a home, it does not have any regard to the capital cost associated with the land value, which varies enormously from place to place.

Mr Mersiades—The Commonwealth contribution does not, you are right. It is a set amount. But there is also a private contribution to the cost of capital, particularly in the case of low care—that is the bond—and that is a variable amount.

Mr TURNBULL—Yes, but the problem in, say, my electorate is that where land values are high it is difficult economically to justify building facilities in that area. As a consequence, people who are going into aged care facilities are having to be placed a very considerable distance from where they have lived and where their families are. I put it to you that there is an air of unreality if you have a degree of government support and funding, which obviously takes into account the cost of operating a home but fails to take into account the land cost. It is clearly discriminating against facilities and, therefore, populations that live in areas where land values are much higher.

Mr Mersiades—The policy is to provide a uniform amount across the country as a capital contribution. It is not tailored to the cost of living in particular geographic areas, be it linked to accommodation or any other costs. A case could be made for differential amounts but where land prices tend to be expensive we are also tending more and more to see extra service being provided.

Mr TURNBULL—Do you mean in-home service?

Mr Mersiades—Yes. They tend to be in higher socio-economic areas as well, not exclusively, but they tend to be there. There is a bit of a response coming that way. There is also a requirement for accessing the residential subsidy. You are required to have a certain number of concessional residents in order to be able to attract a higher level of subsidy. It does reflect in the amount of operational subsidies that you receive. But I take your point about the cost of the land; it varies. There are other ways of dealing with that, as you pointed out. In the city areas you tend to have more multistorey provision of accommodation to deal with the land issue.

Mr Davies—I think there are also arguments that there are many cost drivers of a residential facility. Land is one input, but there is also labour, food and materials. I imagine one could mount a symmetrical argument to say that the cost of running a facility, maybe in terms of other inputs, fuel, food and so on, might be higher in some of the more remote areas. I think there are swings and roundabouts in terms of those cost structures where land and property values are just one input into the economics of running a facility.

CHAIR—The other problem also is there is no land available.

Mr TURNBULL—Yes, that is right. In the inner-city areas there is enormous diversity in the types of dwellings and the income affluence—however you want to describe it—of the population. The outer suburbs of big cities tend to be more homogenous because of the way the land was developed. My electorate is the smallest in Australia, being only 26 square kilometres, but it is extremely diverse in terms of incomes. Some of the aged care facilities that people from Wentworth are using as they get older are now a very long way away from where they have lived and where their families typically are and that is a major problem. Finding an equitable solution is obviously the challenge. I am glad you are aware of the problem.

Ms KING—Are there any moves to look at the formula for allocation of aged care beds? Because we have a regional and rural electorate, we do not have the land price issues but we have similar issues with people being located some distance from a large regional centre that tends to capture and attract most of the aged care beds, whereas some of the smaller and outer metro areas of my electorate do not. There are battles for people in relation to that. It seems to me that the formula for allocation—I do not know the last time it was looked at—is something that causes enormous tension in areas. It seems to make little sense to me.

Mr Mersiades—In its essence it has not changed. It is based on a certain number of places per population over 70 years of age. Changes have been made in increasing the number of places per 1,000 people and also changing the balance. There is greater choice to be able to stay at home longer.

Ms KING—A lot of people have moved out of the western suburbs of Melbourne and into the area and now want to locate their aged parents into that area but they do not get counted in the formula because they are not physically living there. The aged care facilities there have quite large waiting lists. I do not know how you would take into account that sort of shift in elderly people out of the western suburbs of Melbourne into Bacchus Marsh. There seem to be tensions around those sorts of issues in the outer metro areas—

Mr Mersiades—It is very difficult, as you say, to try to predict those moves. The ABS does it to a degree, but understandably you can be a bit behind sometimes with community views and flows.

Ms KING—And it is based on the last census data as well.

Mr Mersiades—They do make some predictions, but, as you say, it is based on current knowledge. It is a bit more difficult. The long and the short of it is that we do not have a capacity to be able to predict where older people are going to move with any certainty. It could be that, in the example you are talking about, there are an awful lot who are moving to the Central Coast, the North Coast and the Gold Coast.

CHAIR—And the Sunshine Coast.

Mr Mersiades—Yes. Those are probably just a little bit easier to predict, but people moving closer to where their children live is a bit more difficult. Canberra has that phenomenon as well.

Ms HALL—Because the current formula is based on a health service collection area in New South Wales it does not pick up maldistribution. In one area you can now have an oversupply; in another area a significant undersupply. It balances itself out, yet there may be great distances between them, particularly in areas like that. Could you come back to us with—

Mr Mersiades—I can give you the answer to that very quickly. Under the regions you talk about, we have aged care planning committees in every state and they look at each region. Under the annual allocation places—one of which is about to go out or has just gone out—there is a capacity to identify areas within regions where preference is given because of undersupply. So the planning arrangement does try to accommodate the fact that certain parts of regions can be under, compared with others.

Ms HALL—But if the bottom line says there are enough beds in that region, when in actual fact there are not, when you break it up—

Mr Mersiades—I think—

Ms HALL—I have got to stop.

CHAIR—I want to move on to another topic, since we only have a few minutes left. In your submission you talk about the levels of responsibility between the Commonwealth and the states and territories. Does the department have any definitive figures which would demonstrate the effects of cost-shifting on Australia's health system? We all know examples of cost-shifting in the public hospital system, from the public hospital to the Commonwealth. Have you any studies to show that that is happening and to what extent it is happening?

Mr Davies—I am not aware of any studies that have been carried out in the department. Whether there are others in the broader literature, I am not sure. I think one would have to acknowledge that part of the very nature of 'cost-shifting' is that one person's cost-shifting is another person's good management. So to actually draw a line around a particular piece of money and say, 'This is a cost that has been shifted,' would in fact be subject, in itself, to quite a degree of debate, ambiguity and alleged subjectivity. To try and quantify cost-shifting, you are probably trying to quantify something that is, in itself, fairly vaguely defined. So I think it would be a difficult thing to do. It is certainly not something that I am aware that we have done—unless any of my colleagues would like to contradict me. Not since 1996, I am told. So we did it in 1996.

CHAIR—What was the outcome then, and what did we do about it? I think that was when I was chairman of the public accounts committee!

Mr Maskell-Knight—I am not sure if it was done in response to your chairmanship. The government decided in 1996 to impose penalties on the states under the former health care agreements in respect of cost-shifting. An exercise was carried out based on looking at trend data under Medicare to try and quantify how much there was and where it was. I cannot remember how much the penalties were. I am sure we could supply that information to you. I think it was of the order of $75 million or $90 million per year.

Ms HALL—That would be really good if you could get that information back to the committee.

Mr Davies—We will certainly see if we can dig that out of the archives.

CHAIR—What about duplication between the Commonwealth and the states? Is there any proof of overlapping services and duplications? Could that be streamlined to save money or more efficiently use health funds?

Mr Davies—Again, as we sit here, I am not conscious of any obvious examples of what might be considered duplication. Certainly it is not something that is frequently brought to our attention. It is not something, through the monitoring we talked about in the early stages of this session, that has come to our attention.

Ms HALL—I note that in your submission you talk about meetings between the Commonwealth and the different state departments. Do you look at issues like this and work out how you can work in partnerships? Could you tell us a little bit about some of the partnership arrangements that are being developed between the Commonwealth and the states, and how this has been attempted to be addressed there?

Mr Davies—It is the Health Reform Agenda Working Group—

Ms Huxtable—That is right.

Mr Davies—which comprises senior officials from jurisdictions working together on a series of specific topics.

CHAIR—Is that associated with COAG?

Mr Davies—No, this is actually a child of AHMAC, I think—health ministers—

Ms Huxtable—Yes, it is health ministers and health officials as opposed to premiers and officials of the Prime Minister.

Mr Davies—So there are examples. In the early stages of that work we have devised a better way of managing pharmaceuticals between the hospital sector and the community or non-hospital sector, which I gather is currently working quite effectively in Victoria. Rosemary probably has other examples of concrete improvements that have come out of that.

Ms Huxtable—We could provide you with something, because there are quite a few areas where we have worked together and there are projects that are occurring now.

Ms HALL—So you could identify the problems that you have come across, the strategies that you have put in place and the result of that.

Mr Davies—We have a number of what might be termed success stories and we are happy to share them with the committee.

Mr GEORGANAS—Have there been any moves by the department to look at how dental care is funded by the states and by the federal government, in terms of dental care being a health issue? People come to see me and say, 'If I break my arm and it is in pain, I get health services to fix that arm, but if I break my tooth and I am in pain, there is nothing there for me.' Dental problems can lead to secondary gum diseases and other issues, but I think it is something that we should be looking at. Has the department looked at anything?

Mr Davies—Our position on this is quite unambiguous, which is that dental health is the responsibility of state and territory governments and has been for a number of years. The federal government does support people's dental health care where they choose to purchase dental health cover as part of ancillary cover under a private health insurance policy. But dental health is a state and territory responsibility.

Mr GEORGANAS—So there is nothing on the agenda that is looking at tackling the issue, or at least finding a solution to the massive waiting lists around the country?

Mr Davies—I think that is a problem that the responsible jurisdictions may wish to tackle.

Mr GEORGANAS—So basically the Commonwealth is wiping its hands of the issue?

Mr Davies—No, it is not something that is on our hands to wipe off. It is a state and territory responsibility, so it is not within our gift to solve the problem.

Ms KING—In 1996 it was, so there have been some changes; I am not asking you to comment on that. One of the other areas that we constantly get questions about is young people in nursing homes. The states are saying that because the Commonwealth is responsible for nursing homes, the Commonwealth should do something. The Commonwealth is saying that it falls under disability services, so it is up to the states. It seems to be completely intractable. Is it on the agenda anywhere to discuss? Have there been any moves to try and find some sort of solution for the under-65s in nursing homes?

Mr Davies—Nick will speak, but I think it is another one where the jurisdictional responsibility is clear.

Ms KING—Both the Commonwealth and the states are saying the same thing, and it is just awful.

Mr Mersiades—There is this difference of opinion, but the CSTDA defines quite clearly where the responsibilities for specialist disability services lie.

Ms KING—Setting up a youth-specific nursing home is a highly costly exercise, and it is not a cheap service to provide. Does the funding within the CSTDA allow a state government to do that, or would it be a matter of shifting money out of other disability services?

Mr Mersiades—I cannot comment on whether the funding under the CSTDA is adequate; it is not within our portfolio. But under the CSTDA, the Commonwealth contributes to the states to run supported accommodation. It does that quite extensively. At the Commonwealth level, we have run a number of innovative pool pilots, which you probably know about. They are

premised on an assumption of where those responsibilities lie, and they build on that in trying to, for example, pilot a Commonwealth contribution to people who age in supported accommodation, so that we combine state and Commonwealth money.

The Commonwealth money is linked to age-related issues. That is being trialled quite successfully in a large number of locations. We are having less success with the piloting of opportunities, or creating alternatives, for younger people currently in nursing homes. There is only the one pilot being undertaken in that.

Ms KING—Where is that?

Mr Mersiades—I think it is called Carnegie—it is targeting multiple sclerosis—it is in one of the Melbourne suburbs.

Ms KING—I have heard about it. In terms of innovative pool pilots, I assume they are running across different sectors of the health system, not just aged care. Obviously there were the former coordinated care trials but are there other programs within the department that we could have a look at that do pool funds, particularly state, Commonwealth and even private, that you could give us? I think there is one listed in there on the interface between hospitals and nursing homes and other aged care facilities. But if there are other things across the department it might be useful for us to have a look.

Mr Davies—The other large one is multipurpose services, mostly in rural communities, which bring together health, aged care and, in some cases, broader community services.

Ms HALL—That is state and Commonwealth too, isn't it?

Mr Davies—Yes.

Ms HALL—They are very good.

Mr Davies—Would you like some more details on that program?

Ms KING—Just a bit more and if there is any early information on those others. I assume there is an evaluation running for them.

Mr Davies—We will see what we can get for the committee. I would like to come back on one point on dental. I did mention that the federal government contribution is through the ancillary private health insurance cover. I am not sure that I made quite clear that, of course, financially that means the 30 per cent rebate is the federal government's financial contribution. I am sure you are aware that from 1 April that rebate is an even higher percentage for elderly Australians. That is how the federal government puts its dollar into dental health.

Mr GEORGANAS—That is only for people with private health cover?

Mr Davies—Yes.

CHAIR—On that note, has the department been looking into how to reduce the cost of rising private health insurance premiums? That is a matter that is very close to the heart of most MPs in every electorate.

Mr Davies—Yes, Ms Addison is probably best placed to give you the state-of-the-art, but the quick answer is yes, and I will give you some more detail.

Ms Addison—In looking at the cost of premiums, there has been a range of reforms made to private health insurance arrangements in recent times. A number of these have been focused on looking at the cost of premiums and helping health funds manage those expenditures. We mentioned before the GDP figures on the overall cost of health expenditure and the rate at which it is increasing and one of the things I have observed is that the rate of increases for private health insurance are in line with those GDP increases, so the pressures that are on private health insurance funds in the health sector are not isolated from the broader health economy.

Most recently a major area of reform was the prostheses reform and legislation was passed earlier this year. We are in the process of finalising the benefit negotiation process to set benefit levels to come out in the new schedule for the prostheses. It is hoped that, through those reforms, we will be able to bring down what had been a growth in the cost of prostheses of around 30 per cent on average. We are hoping to use those reforms to create greater price tension to bring the growth in that expenditure to not quite 30 per cent. The prostheses one was important because it was starting to move into the overall costs, it was looking at being a driver of health premiums of about two per cent. It is a fairly important part of what we have been working on.

Ms HALL—I noticed that the other driver was medical costs. Would you like to touch on that and give us an idea of what you are looking at doing there? Because that was a growth of 10 per cent per annum.

Ms Addison—We are not looking at the medical costs specifically for drivers; we have been looking at the overall system. Prostheses have been fairly important because of the proportion that it was looking at. But in terms of medical costs, we continue to look at how the gap cover arrangements are working and how the takeover gap cover is working. We are expecting to conduct a review of gap cover arrangements in the next year or so and that will give us an opportunity to analyse how those arrangements are working.

CHAIR—Have you analysed where the money from the additional premiums every year is going? The private hospitals tell us that what they are receiving from the increases is below CPI.

Ms Addison—I would be able to provide you with some figures of the break up of the expenditure. Effectively, hospital outlays in total account for the bulk of the outlays and there is growth. While it is correct that their share of the overall slice of the pie has been reducing—things like medical and prostheses costs have been taking some of that up—the bulk of it is in the expenditure that health funds provide to hospitals. Some of the effect is ageing, as you would expect, but the ageing effect has been fairly stable for the last few years. It varies a bit in the impact of price. We can see that prostheses price has had an impact in recent times. But when you look at the costs, if you like, for hospital outlays there are a whole lot of things that feed into that utilisation—wage costs et cetera. We have been looking at it and we constantly monitor it.

Mr Davies—There is a graph and a table on page 20 in my version which give that breakdown. The table also gives the growth rates. As Ms Addison said, fundamental to that is that people are using their private health insurance more.

CHAIR—Any further questions? We have our next lot of people here. We are running out of time. We will definitely get the department back again after we have met with other witnesses. As other organisations appear before us, there will be a need to revisit some of these areas and to touch on other areas that we have not got to in today's session.

Ms HALL—When it comes to private health, there are two problems people come to see me about: premium increases—NIB, a company that is quite big in my local area, just had a massive increase—and the gap. Even though there are no gap arrangements in place, invariably someone will go into hospital and when they come out will have a $2,000 to $3,000 bill. Is the department looking at any strategies to address this?

Mr Davies—Certainly. On your latter question—the gap cover and informed financial consent—there is work under way, and Linda Addison can talk about that. As to premium increases—

Ms HALL—It has been deregulated.

Mr Davies—there is very detailed provision in the legislation to make it easy for people to change funds with no penalty. It is not always easy to compare products between different funds and, obviously, that is something that you might wish to explore with your constituents.

Ms HALL—You highlight that too in the report.

Ms Huxtable—Can I just add to that. I would not want to minimise that issue around the gap; I think it is a very important issue. But since September 2000, when the gap cover arrangements were brought in, until today, the number of medical services being provided without gap has gone from 60 per cent to 80 per cent. Now we have 14.1 million of the in-hospital medical services with no gap and 3.2 million with a gap. However, that having been said, I think it is certainly an area that we are very interested in. We are certainly aware of the feedback that comes through the Private Health Insurance Ombudsman and the other about how this is an issue for people. A lot of it is around the issue of knowing what the gap was; the informed financial consent issue. Our surveys suggest that.

Mr Davies—And we do have work under way on it.

Ms Addison—We certainly do have work under way, particularly on informed financial consent related to the outcomes that people experience with the gap. As Ms Huxtable said, there has been a significant increase in the uptake of the gap cover arrangements and that has addressed a large part of the problem, but people do seem to still experience gaps that they were not aware of. The work that we are doing at the moment highlights that they do not necessarily know where those gaps have come from or what they are related to. It is clearly a concern when the gap arises, if they are not aware of it.

In the latter half of last year we commissioned some consumer perspectives survey work, looking at informed financial consent and the incidences of informed financial consent, to provide a basis for strategies on how we might better deal with some of those issues. There is some advice with the minister at the moment on how we would like to progress those strategies. We would hope to be able to comment further as the committee does its work in the future.

CHAIR—Thank you very much. Thank you for appearing today. We really appreciate the comprehensive paper that you have prepared for us. There are many other areas we wish to explore and when the states, after COAG, finally respond to our terms of reference, we will see you again.

[11.07 am]

CARNELL, Ms Anne Catherine (Kate), Chief Executive Officer, Australian Divisions of General Practice

WELLS, Ms Leanne, Manager, Policy and Development, Australian Divisions of General Practice

WETT, Ms Liesel, Deputy Chief Executive Officer, Australian Divisions of General Practice

CHAIR—Welcome. I am required to say that the committee does not require you to speak under oath, but you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Would you like to make a brief introductory statement before we proceed to questions?

Ms Carnell—Thank you very much. I will make just a very brief statement, because I will not go over any of the issues that we have raised in our submission as I am confident that everyone would have had a look at that already. I would like to scene-set a little, though, and tell you a little bit about where we believe the division network is placed in the primary health care arena. As you can see from our submission, that is really the area we focused on—primary health care funding and the relationship between states, local government, the federal government and of course the private sector.

As members of the committee would be very well aware, the demographics that we are facing in Australia with regard to health generally are a challenge and certainly somewhat concerning, with the ageing of the population and increases in the number of people with chronic diseases that are being managed in the community. The challenges at the primary health care level for health policy are very real.

Where the divisions of general practice fit in that is really important. As you would know, there are 119 divisions covering Australia. Every one of those divisions has its own board and governance structure and therefore has its own capacity to hold funds and to provide services independently of the others. We also have state based organisations which again have their own boards and governance structures, and of course we have the Australian Division of General Practice here in Canberra as the overarching coordinator of the network. The people on the boards of the divisions are a mixture of community representatives, GPs and, in many cases, other allied health professionals. So those entities right around Australia are in a position today to provide, and do provide, primary health care outcomes to general practice and the community.

Today, those divisions, although predominantly funded by the Commonwealth, hold funds and provide services on behalf of local governments, the private sector—in some cases—and of course state governments. Their major role is to work with general practices—and I refer to general practitioners' practices in the broadest sense, so not just GPs—and provide services to general practices to allow them to better fulfil the primary health care needs of the Australian community.

So I suppose the basis of our comment today with regard to health funding is that the division network is already there in Australia and is able to hold funds on behalf of all levels of government—and, again, the private sector as well—and provide a coordinated and focused primary health care set of outcomes for the communities that they service. Those communities they know well—they know the general practices well; they know the allied health professionals in that area. So the services that they can provide can be and are tailored to the needs of their communities. By having one entity that holds funds on behalf of a number of governments, you overcome the silo effects that I am sure you have heard or read a lot about; you get rid of duplication; and, most importantly, you have primary health care delivery that is in line with the needs of the community. I might hand over to Liesel and she can give you some examples of what I am talking about.

Ms Wett—Our submission talks about some key areas where divisions are working together and have bridged that gap that is the state/Commonwealth divide. But one specific example that I would like to bring up today is the north-west division of primary health care in rural Queensland. They are now the provider of choice for allied health. They employ over 60 allied health professionals in their entire region and that is because they have been so successful at engaging with local GPs and other state services to be able to provide services for people on the ground. So that is an example, I suppose, of fund sharing, where there is an outcome for the patient in the long run.

Ms Carnell—And Leanne?

Ms Wells—Probably a similar example is in Victoria, where a division—north-east Victoria—has been working with the state health service to bring together state health funding and federal health funding for allied health service delivery in the mental health area. Basically, the division works through a business MOU with the state health service to offer an integrated service. So funding and services are not being duplicated, but state services for a primary mental health care early intervention service for people with mental illness are being linked up and integrated with a federally funded referral pathway for GPs. So on the ground there is that pooling of funding and service integration straddling those two levels of government.

Ms Carnell—To sum that up, what we do—and can do, I think, even more so in the future with a more aggressive approach to fund-holding—is support the sorts of multidisciplinary teams, the more coordinated approach to primary health care and coordinated care that everyone talks about, but the challenge has always been in how you bring together various levels of funding from different levels of government.

CHAIR—You have outlined the current funding arrangements for the divisions. Do you advocate any changes? Where do you see the future?

Ms Carnell—We see the future of divisions as being significantly more in the fund holding arena. We would like to see in the longer term—and in the shorter term, I have to say—divisions being seen as able to hold funds on behalf of the general practices and the allied health professionals in their areas and to be able to provide a coordinated set of treatment options for people with chronic disease in the community. In other words, we would like to see divisions funded with a set amount of money to be able to provide a coordinated treatment regime for, say, a diabetic in the community. The benefit for government, of course, is that it means that it is not

a straight fee-for-service model; you do end up with a blended payment model that way—with a cap. We believe—and I know that our divisions believe this—that they can provide that coordination at a local level to significantly improve the health funding outcomes—or the health outcomes—and the funding outcomes for those sorts of people.

Ms Wett—We have one division that is looking at diabetes at the moment. It is looking at data and it is working with 100 per cent of their GPs not very far from here, doing exactly that—without the changes to the funding.

Ms Carnell—And it is getting quite significant health outcomes by that more population health approach.

CHAIR—Divisions seem to be run by doctors at the younger end of the age scale. Is it difficult to get older GPs involved in your work?

Ms Wett—No. I worked for two different divisions of general practice in my time. The first one I worked for was in the Kogarah region. That cohort of GPs was a lot older than the ones that I worked with in the Illawarra region, probably by about 10 years. But there was still engagement at all levels. Some GPs that had never turned a computer on were taking up new initiatives. I had one GP in the Illawarra region who was 65 and who taught himself to type. It is not just the 'youngies'; it is a bit of a mix. It is people who want to make a difference.

Ms HALL—The divisions in all our electorates are very proactive and they constantly keep in touch with us. I think that is very useful from a member of parliament's point of view. I notice in your submission you mention private health insurance and ways to make it more sustainable and you look at increasing benefits. An area that you did mention was the gap payment with GPs. Have you got any other suggestions as to expansions—that is one example—and ways that private health insurance can be made more sustainable and premiums be kept down?

Ms Carnell—We would like to see private health insurers engage more definitely with divisions and with us, looking at what we might call 'wellness models' for their members. There are two types of people we will talk about. One is the person who is newly diagnosed with a chronic condition. Rather than wait for that person to go through the system and for the private health insurer to fund on, fundamentally, a fee-for-service base every time they interface with the health system, we would like to see private health funds fund however many thousands of dollars per year to divisions to provide early intervention wellness support for those people. In other words, for a newly diagnosed diabetic to have support from a dietician, some support with regard to an exercise regime, regular testing, knowledge of how to self-manage their condition and the support to do that. At the moment there is no obvious mechanism in place to do that, although we have had discussions with some of the private health insurers along those lines.

Also there is another group of people who are 'potentials'. People who have, say, a family history of diabetes—we use diabetes because we have so far—who may have a number of the risk factors that make them more likely to become diabetic later in life. Of course a health insurer providing whole-of-life coverage cannot not insure those people on the basis of their risk factors. And we think an early intervention approach, where before they are diagnosed those people are given support to stay well, would be a significant step in the right direction. And I would have to say, from a member of a private health fund, I think that sort of support package

would be significantly better than waiting around until you need the hospital or the dialysis or whatever else it might be. It is about stepping back and thinking about what whole-of-life cover really means, and where the money should be spent.

Ms HALL—My next question relates to cost shifting, and I will use GPs as an example. I will give an example where it could be argued that the costs are being shifted to the state because of the shortage of GPs, particularly where doctors are not bulk billing and people are using public hospitals. But then on the other side I can give the example from my area where the after hours service is being complemented by the Commonwealth. So you have a double-edged sword there. Could you give the committee examples of where cost shifting takes place within the health system? How is this cost shifting a barrier to optimal health outcomes, and what strategies do you think should be put in place to address the problem?

Ms Carnell—It is a 'meaning of life' question. I am happy to answer, but it is very hard for me not to think of this from two perspectives.

Ms HALL—I tried to be balanced with the example I gave, because it could be argued both ways. Yes, costs are shifted to the states; yes, they are shifted to the Commonwealth.

Ms Carnell—I made those comments about the divisions being used because they are not owned by any particular government. They are potentially funded by both the Commonwealth and states, and hopefully owned by primary health care deliverers at a local level. This is why I believe that divisions are a good mechanism to manage cost shifting, which does happen—there is no doubt about that. When I said that it is hard for me to make a comment, having run a state/territory health system and having spent a lot of my department's time trying to cost-shift back to the Commonwealth—

CHAIR—But the Commonwealth department told us just a while ago that it does not happen.

Ms Carnell—Well, yes.

Ms Wett—I have an example. One of the examples of cost shifting back to the Commonwealth that we used to see in the Illawarra was early discharge. Patients would be moved out of hospitals and put into the home and there was an expectation that the GP or the GP's practice nurse would pick up the care of the patient. Leanne and I have just returned from New Zealand, where they have spent a lot of time looking at early intervention; picking it up but being funded to do so, and getting better patient outcomes. But they have also looked at pre admissions and what the GPs can do to reduce waiting lists, and all sorts of things. So they are a bit both ways.

Ms HALL—We are interested in both ways, we are not only interested in the Commonwealth we are also interested in ways costs are shifted to the states, and strategies to address that.

CHAIR—We want to see as much of the health dollar go to the patient as possible, and not be wasted in duplication in a process associated with cost shifting.

Ms Wett—In tests, results and pathology.

Ms Carnell—You may have seen in our submission some comments on the shared care programs that exist. That is a good example of how both levels of government have come together and put together programs where people are supported out of the hospital environment into their homes, using not only GPs—funded by the Commonwealth—but also support from the hospital system locally, to look after that patient with a real patient focus.

So I think we have got, from the network, some runs on the board on how it can work, and it can. The problem is: when it does not work is when there is cost shifting. So—and again I will use an ACT perspective because I know about it—if the ACT government goes for shorter lengths of stay in hospital, as every government does, trying to get people back into the community early, it is true that the GP, the general practice, is the first port of call.

The issues surrounding discharge summaries—appropriate discharge information to GPs—are something we all know about, and there is some work certainly that is happening in divisions to try to overcome that gap. We do know that an awful lot of readmissions come because that discharge information does not happen; is not as good as it should be—GPs do not have the information that they need. If and when the shared care approach happens, patients are supported through that, I suppose, hiatus—or what can be a hiatus—and the patient ends up doing better and is not readmitted. To do it, though, you need to have a shared care approach.

CHAIR—So you are saying that when patients are discharged from hospital their doctor does not have their records?

Ms Wett—No, in a lot of cases.

CHAIR—Can they get them?

Ms Wett—In some areas—very few areas!

CHAIR—No, this is serious, because—

Ms Carnell—If there is one issue that causes general practitioners more problems than any other, it is the discharge summary issue.

CHAIR—That is from the public hospital.

Ms Carnell—Yes.

CHAIR—But private hospitals are different.

Ms Wett—They are worse.

CHAIR—They are worse?

Ms Carnell—Because their computerisation is not, on the whole—this is generalisation, I know: obviously there are people who are great, but getting information from the critical care area back to the GP is—

CHAIR—Is a problem.

Ms Carnell—It is a huge problem. So GPs regularly see patients that have been discharged from hospital—as we know now, quite early—with no records, no knowledge of what they have had—

Ms Wells—A couple of pills—

Ms Carnell—A couple of pills in little bottles—and they go and see their GP because they are told to go and see their GP, and it causes problems.

Ms HALL—And there can be a problem in the admission phase too, can't there, with getting the information from the GPs? So it is both ways that there is that problem of communication, isn't it?

Ms Wett—There is, and one of the things that a lot of divisions have tried to work on is some sort of preadmission referral protocol, so that if the patient is going up to A&E they are referred with the information that, for example, they have chest pain and they are on these four medications, so when the patient presents at least there is some information.

Ms Carnell—And they have had this test and that test so that it does not have to be done again.

Mr GEORGANAS—I would just like to clarify this in my own mind: if I go to hospital today with whatever—touch wood—and I am discharged, and my practitioner, my private GP, wants those records, he cannot access them. Is that what you are saying?

Ms Wett—The patient has to give permission. You are lucky; they are not normally electronic—I do not know whether you have ever seen a discharge summary—

Mr GEORGANAS—So if I gave permission to my GP he could then get those records.

Ms Wett—Yes, and the funniest thing is—this is just hilarious—for electronic records, the patient has to give consent and sign on a form to get an electronic version, but if I were a GP—for example, Dr Malcolm French—I could ring up and say, 'It's Malcolm French here; can you please fax me XYZ,' and they would go, 'Sure, Dr French.'

CHAIR—I do not get the significance of that.

Ms Wett—He could be anyone.

Mr GEORGANAS—But earlier you said that they do not get those records?

Ms Wett—No, the patient does not leave with a discharge summary or anything.

CHAIR—What about X-rays from the hospital? Does the patient take those with him to the GP? Or does the GP have to order them again?

Ms Carnell—It depends on the state, the hospital and the IT management system. I know that there has been an extraordinary amount of time, effort and money spent on attempting to get good information management systems operating between public hospitals and GPs, although I have to say that at this moment it is patchy in the extreme. A lot of it is because public hospitals in different states are using different systems; the systems are not standardised. It has not been seen as an issue that has mattered enough.

CHAIR—There has been an enormous amount of duplication in things like pathology and X-rays.

Ms KING—In Victoria, primary care partnerships have been set up—there is a whole section of information on them. Are you seeing any improvement or has it just made things worse?

Ms Wett—From what I understand there are a couple that are working well but they have all focused on different things.

Ms KING—Is there one in Victoria where the information stuff is working really well that we could have a look at?

Ms Carnell—We can get back to you on that. There are a couple of divisions that are doing this quite well and have good relationships.

Ms KING—I was thinking of Ballarat, my home town—

Ms Carnell—That is a good example.

Ms KING—I do not know if they are doing well in terms of information transfer.

Mr VASTA—I raise a different issue: trying to take some of the costs away from the government, say, with these nurses that are fairly skilled. I know that in our local GP area—there are a lot of young families there—patients wait for at least an hour or 1½ hours, and then the doctor says, 'I'm not going to prescribe anything except for you to go home, go to bed and have some Panadol.' Is it possible to have nurses that know a fair bit about the basics like the flu?

Ms Carnell—We believe practice nurses are absolutely fundamental to the practice team approach that we are advocating. About 40 per cent of practices around Australia now have practice nurses. The Australian government gives a subsidy to rural practices to put on a practice nurse. That subsidy is not available in urban practices but we have done quite significant work on business cases for general practices to show that putting on a practice nurse produces a good bottom line, regardless of whether it is in rural or urban areas.

We have certainly been lobbying to have the item numbers for practice nurses extended. Currently, practice nurses can do immunisation and wound management without the doctor standing beside them—under the auspices of the doctor but without the doctor's direct involvement. We would like to see the number of things that practice nurses can do independently extended quite significantly to allow for that exact scenario that you are talking about, particularly wellness checks. When the diabetic I mentioned comes in and just needs a weight check and a bit of a look at them and those sorts of things, there is absolutely no reason

why a practice nurse—or, for that matter, a diabetic educator—cannot manage that patient without GP involvement at all.

Ms Wett—Or even basic things like taking blood pressure, height and weight, peak flow and whatever else—just to have all that data there so that the GP can walk in and review it—and look after the management of the patient.

Ms Carnell—I just need to say a few more things about information management. General practices have moved ahead a huge distance, predominantly because there have been significant government subsidies to put in computers. Now there is the broadband initiative—there is a whole range of things. GPs now, predominantly, have computers on their desks and a very large percentage of them are using them to generate prescriptions. The broadband initiative means that more of them are linking up to broadband. A lot has happened but what is still to happen is a national information strategy that looks at the connectivity between general practices, hospitals, residential aged care facilities and so on, and at what the standards are for that sharing of information.

We perceive the division's roles in population health are very real. That means having good data on how many diabetics we have, the sorts of treatments that are happening and what is working. Being able to give GPs good feedback on what is happening in their own practices is fundamental. But to do that, you have to have the data. To move data you have to overcome some of the issues we were talking about. I did not want to leave a view that nothing had happened in this area—a huge amount has happened; it is just that connectivity between various players is a bit light on.

Mrs ELLIOT—My question focuses primarily on regional areas and issues of the lack of doctors who bulk-bill and the lack of incentives to get doctors to regional areas. These seem to be major issues in other regional areas, not just mine. I am interested in your perspective on that. Also, the RRMA classifications seem to be an issue that comes up. Essentially one area can cover a rural area, but it falls into a slightly urban area as well; therefore, the classification drastically affects what they get in the rural area. I am asking you for your perspective on that. It seems quite outrageous how you can have the different areas under one classification.

Ms Carnell—The RRMA issues are huge. It is a classic domino effect: you change this bit and you have to change this other bit. I am aware that there is a review of the RRMA classifications at the moment. It is certainly true that they cause anomalies. It is all about winners and losers. If you change it over here, you change it over here as well and there will be swings and roundabouts, which is a problem.

In terms of getting doctors and other allied health professionals into rural and regional areas, a lot of it is about being able to give them the sort of support they need for their families, their partners, their kids and so on when they come to those areas. That is one of the major roles that rural divisions play. In those support mechanisms, the rural work force agencies do a lot of the recruiting, but then it is the division's role to make them feel at home and give them what they need to ensure that they have the skill sets required.

Ms Wett—I think the divisions that are successful at recruiting have done a lot of that personal family work. One GP, who worked in a rural area, told me that while everyone was

friendly, no-one was her friend. Divisions can often bridge that gap, bring the families into the community and work hard at doing that sort of thing.

Ms Carnell—It is also important to remember that it is not just personal support that is needed. When a GP goes into rural area, sometimes they can be professionally isolated as well. Maybe the MAHS program is a good—

Ms Wells—I think there are a couple of major areas of support that divisions provide their fundholding to. MAHS, More Allied Health Services, is an example in rural communities. The great majority of divisions have chosen to employ psychologists, but they could be dieticians or podiatrists, to provide that sort of professional support to GPs on the ground. The other comment I would make on support to GPs—in a professional sense that divisions provide—is that divisions are often very active in convening small group learning and peer support networks for GPs. For example, overseas trained doctors, new to a community, get professional support through an informal peer network that is often a safe environment where they can ask questions of their peers around the system and how it works in this community, as well as the sort of family support that Liesel was talking about.

Ms Carnell—I think the reality is, though, looking at all of the AMWAC figures, that there are not going to be enough GPs for rural and regional areas. Every other figure that we know suggests that the problems will continue no matter what we do. That means that getting back to the practice team approach—the practice nurses in rural and regional areas, the other allied health professionals acting as a team with their general practitioner—becomes a no-brainer in how general practice should work. To make that work you have to find a mechanism to fund it. It can be more item numbers, using the fee-for-service model, but we would like to see that brought together with some blended payment approaches—with some block payments for particular outcomes.

CHAIR—In my electorate two things are happening which I have noticed in the last couple of years. There are bulk-billing clinics springing up, mainly run by nondoctors and using salaried doctors. They are springing up quite a lot on the Sunshine Coast. The other thing that we are finding is that doctors are selling their practices and being re-employed by the new owner, working about three or four days a week at the most, and actually making more money than they were in running their practice. One of the big problems with GPs is the cost of running a practice and that the remuneration in relation to the work just does not make it worth while. How do you arrest that trend of GPs leaving prematurely?

Ms Carnell—You are lucky to find a GP that can actually sell their practice, because the practices are not worth much, simply because somebody can open next door without a problem. You can understand why they are not worth a lot. It is certainly true that we do not have an awful lot of GPs who are interested in running small businesses. We have a lot of GPs who are interested in running medical practices and looking after patients and getting better health outcomes, but running businesses is generally not what they wake up in the morning aspiring to do, unfortunately. Unfortunately our younger GPs have that view on life even more so than some of the older GPs, who have always perceived that that is what they did. Again, one of our roles from a division perspective is to be able to provide that business support and that support for the broader general practice—the team based approach, extended care planning and so on. There is a whole range of ways GPs can supplement their fee for service.

CHAIR—These bulk-billing clinics are using foreign doctors.

Ms Carnell—They are.

CHAIR—How do they fit in?

Ms Carnell—They provide a service. We think it would be pretty sad if it was the only service that was available, because it is very different from the team based approach that we are talking about: the patient-centric, chronic disease management approach.

CHAIR—You cannot include these foreign-trained doctors who work in bulk-billing clinics in the team approach?

Ms Carnell—Do you want to make a comment, Liesel, having dealt with—

CHAIR—What, the GPs?

Ms Wett—It depends on who the owner is and what drives them. One of the beauties about innovation in divisions in hard areas like the back of New South Wales is that the division has worked with the local council and the local community to attract people and look at that business model. We have got divisions in Finley and places in western New South Wales actually running practices just to encourage that teams based approach and to make it viable. Then the community has ownership and everyone is sort of in the tent. There is another division in Tasmania that is also looking at taking off that responsibility from their GPs so that the GPs are happier and they stay in the community.

Ms Carnell—In other words, the division runs the practice, provides a—

Ms Wett—The community is feeling comfortable because they have a service that they can access and all that sort of thing, but it depends who is running the show. In the past I have tried to work with some of the big corporates and they are not interested; they think they can do it better.

Ms Carnell—Equally, we have had some interest, just in the last little while, from one of the corporates who was interested to get much closer to divisions, and understands that the future is about more, I suppose, chronic disease management, team based, patient-focused approaches. So those discussions are happening, at least in their early stages.

CHAIR—What is happening in the cities? We do not seem to have anyone from the city here.

Ms KING—Can I ask a question. There seems to be some duplication between some of the work that rural work force agencies are doing and divisions are doing. Rural work force agencies are concerned, I guess, that the divisions want to take them over. Can you comment on that, please.

Ms Carnell—We certainly had those discussions too. I do not think anyone needs to take over anybody. But we really do need to work between the rural work force agency divisions and the regional training providers. There are three regionalised services, general practice based

services, all funded by the Commonwealth and I think it is up to the three of us to ensure that we do not duplicate and that we spend the money where it is supposed to be spent, and that is on actual service delivery not on administration or trying to step into each other's patches. We have certainly had those discussions with both the other entities and I understand that the rural work force agencies are looking at the moment at how to better define what their core role is. The same goes for us and for the regional training providers.

Ms KING—Can I just ask about the regional training providers. Obviously this is still fairly new and a move away from the college training model, are there any problems that are emerging at all, or things that we should be conscious of in relation to training and what that means for distribution of doctors?

Ms Carnell—No.

Ms KING—It is all fantastic and it is the best thing since sliced bread!

Ms Carnell—We do not have an answer. I will immediately put on my other hat as chair of GPET so it is not a conflict of interests. The program has rolled out well. There are 22 regional training providers around Australia, again, all with their own governance structures and their own boards. That means that some doctors are spending more and more time on boards than they might be in their practices which is a bit of an issue for everybody and that is one of the things we need to address.

I will give you an example of the issues surrounding general practice training. This year there were 247 more training places available than there were graduates. The number of training places in all specialties has increased quite significantly. We now have the new sub-specialties that are taking graduates as well, so general practice is competing with a whole range of other specialties which is a bit of a challenge. General practice, of course, may be perceived not to be remunerated quite as well as some of the other specialties, and of course with the requirements for rural placements even the general path registrars have to spend three to seven months in a rural area and potentially six months in an outer suburban area, taking into account that the average age of our registrars is about 35. They often have kids which means it is a challenging requirement. There are some real issues. It is a competitive market and there are not enough graduates to fill the quota.

The training and the model are working well. The colleges still set the curricula. The RACGP sets the exams, so it still has the college involvement, but the regional training providers provide the local support and the local infrastructure for the registrars. This seems to work pretty well; it gives a much more local focus.

Ms KING—I just want to talk about the after-hours service. The Commonwealth has advertised for GPs to take this up, although obviously not in my local newspaper. What do you reckon the take-up is going to be? Are GPs going to be interested in this after-hours service or are they way too busy?

Ms Wett—Potentially yes, some of the criteria are not too stringent, so they might look at extending their service for an hour, or a Saturday morning, or something like that. I think there

will be a largish role that divisions will play in assisting those practices, all those GPs, to put in applications. They are not used to doing that sort of thing.

Ms KING—A bit underwhelmed, I would have to say.

Ms HALL—I think one of the best after-hours models is the Hunter model. I do not know what they are looking at in Ballarat. It sounds like this is just an extension of practice hour operation. Maybe the division should be looking to push more strongly the model that has operated so successfully in the Hunter.

Ms Carnell—Certainly the Hunter urban model is a model that works very well.

Ms HALL—A commitment from all the GPs?

Ms Carnell—Yes. There are also others. There is an after-hours service in Tasmania which appears to be greatly improving the longevity of doctors staying in practices. In Northern Tasmania they do not have to do the seven days a week after-hours stuff. They are staying put. The bit of work that has been done recently tends to show that it is working. There are a number of different models that are working very efficiently around Australia. I suppose the whole point is to have a model that is appropriate to the local doctors and the local community.

Ms HALL—Can the division submit examples of where it is working well?

Ms Carnell—We can do that. We can zip out to the network and ask them. I am sure they will be very happy to provide it.

CHAIR—We have not had a response from the states or territories at this stage. That is because they are all waiting for the outcome of the Podger review et cetera. We expect to hear from them a little later, in which case we might ask you to come back if there is any need to. We thank you for your comprehensive submission and for coming here and giving evidence today. Are you happy to take questions on notice if other members of the committee feel they want to follow up on issues that have been raised here today?

Ms Carnell—Absolutely.

Resolved (on motion by **Ms Hall**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it in the public hearing this day.

CHAIR—I declare this meeting closed. Thank you for your attendance. Thank you Hansard.

Committee adjourned at 11.52 am