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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

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MELBOURNE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 28 June 2005

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

Members in attendance: Mr Georganas, Ms Hall, Ms King and Mr Somlyay

Terms of reference for the inquiry:

To 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 9.34 am

CHAIR (Mr Somlyay)—This is the second public hearing for the committee's important and timely inquiry into health funding. 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 faces ever-increasing challenges from rising patient expectations and funding pressures. Certainly, current health funding arrangements between the Commonwealth, states and territories and the private sector are complex and a source of confusion. This affects the quality of health care services.

Today the committee will hear from five organisations: Orphan Australia, the Rural Doctors Association of Australia, the Municipal Association of Victoria, the Australasian College for Emergency Medicine and the Victorian Health Promotion Foundation. This hearing is open to the public and a transcript of what is said will be made available via the committee's web site. If you would like further details about the inquiry or the transcripts, please ask any of the committee staff at the hearing.

I have some remarks by way of background. We all know that there are a number of inquiries into our health system going on. They are wide and varied, from a royal commission into the public hospitals in Queensland to a committee of officials set up by COAG to examine the relationship between the Commonwealth and the states in how health services are delivered. This inquiry by the House of Representatives Standing Committee on Health and Ageing is very timely because most of the other inquiries are being conducted within the health bureaucracy in Australia, both Commonwealth and state. Our public inquiry gives people involved in the public health sector, the private health sector and organisations representing players the opportunity to put something on record and have an input into all of these other inquiries that are currently drawing the threads together in relation to the Council of Australian Governments. It is very important that private organisations are given a chance to have a say and put that on the public record. We hope that you will use this vehicle for that purpose.

[9.37 am]

YOUNG, Mr Alastair James Fleming, Managing Director, Orphan Australia

CHAIR—Welcome. Although the committee does not require you to speak under oath, 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. Do you want to make a brief introductory statement before we proceed to questions?

Mr Young—Yes, please. Good morning. I would like to thank the committee for the opportunity to present the submission to the health funding inquiry. I would also like to thank those committee members here today for the opportunity to discuss the gap in the current federal orphan drug program. Before that, I would like to take a moment to provide a brief overview of orphan drugs and the orphan drug program. Orphan designated drugs are drugs, vaccines and diagnostics used to treat, prevent or diagnose rare diseases. In Australia a rare or orphan disease affects fewer than 2,000 individuals at any one time and often the number is much smaller. For example, about 50 people in Australia have nephropathic cystinosis, about 510 people have pulmonary arterial hypertension and about 1,200 people have essential thrombocythaemia.

Orphan designated products such as those used to treat these conditions are generally not commercially viable. Pharmaceutical companies tend not to develop and market such products as the financial return is small compared to the cost of development, registration and marketing. The Australian orphan drug program, established in 1998, acknowledges that patients with rare diseases have 'rights to drugs of the same quality, efficacy and safety as those with more common illnesses'. The program encourages sponsors such as Orphan Australia to register these products here by 'reducing the costs through waiving of fees and by providing exclusive approval'.

As managing director and founder of Orphan Australia, I have witnessed the constructive and positive changes this government has made to the Australian health system—in particular, the creation of the federal government orphan drug program. A recent industry publication suggested Orphan Australia was criticising the government's system of pharmaceutical benefits. I can assure you this is far from accurate. The government has made significant improvements in Australian health care. The creation of the orphan drug program has resulted in an increase in orphan drug registrations, and the government is to be commended. This is perhaps not significant to most Australians. However, it is of great importance to the small number of patients in Australia who require treatment for rare life threatening diseases.

The original orphan drug program identified that funding of such drugs would need to be addressed in order to make the program successful. Two important reports have since been brought to the government's attention detailing this gap in the orphan drug program. The Hayes report and the Tambling report both identified this area of deficiency, suggesting that an otherwise successful program is yet to be completed.

Strict efficacy and economic criteria used by the PBAC are important parts of the country's Pharmaceutical Benefits Scheme and help ensure that Australians are getting good value for their

pharmaceuticals. As a taxpayer, I am very pleased that stringent tests are applied to ensure that these drugs are cost effective. Orphan Australia is not disputing the necessity for regulation to ensure that Australians are accessing safe and cost-effective drugs. The gap or deficiency in the orphan drug program, however, lies in the cost-effectiveness data required by the PBAC to list the particular orphan drug. Safety and efficacy is not a question; rather, the criteria relating to cost-effectiveness are simply impractical to apply to an orphan designated drug. The PBAC cost-effectiveness criteria have been specifically developed to deal with large patient populations and significant PBS expenditure. Orphan drugs are therefore at a significant disadvantage purely by virtue of being an orphan drug. There are not sufficient people with the rare and ultra rare diseases in Australia to carry out the tests to satisfy PBAC current criteria.

Orphan Australia is not seeking special consideration. Our submission details the reasons why Orphan Australia is asking the committee to consider alternatives such that the integrity of the evaluation process is not diminished. However, it takes fair and reasonable account of the difficulty orphan drug sponsors have in meeting the PBAC cost-effectiveness criteria.

CHAIR—Thank you. You indicated in your submission that sponsors are often deterred from pursuing registration on the PBS listing as orphan drugs as they are not usually commercially viable. Could you outline generally the funding process for orphan drugs for the record? What is the role of a sponsor?

Mr Young—There are three processes involved in taking an orphan drug through to the market. One is to obtain orphan designation. The orphan drug program introduced in 1998 addressed that very well. You have to prove that there is an incidence of less that 2,000, you make an application and the application is accepted or rejected. If it is accepted, it is listed as an orphan designated drug. You can then make an application for registration. If it is an orphan designated drug, your application for registration is considered and evaluated without the normal evaluation fees. Then it can be registered. However, in order to get reimbursement you still have to follow the process of PBAC review and you have to meet the criteria of the PBAC, which, as I said, are designed for products for a wide range of patients and with high dollar costs. The system as it is now does not take into consideration the nature of these orphan designated products because the incidence is below 2,000 and sufficient data is not typically generated for these types of products to meet the current PBAC criteria.

CHAIR—What do you see as the key changes required to make orphan drugs a more attractive proposition for potential sponsors?

Mr Young—The federal government needs to come up with a system to take into account the special nature of these products. It has already created a successful program—the orphan drug program—in that the products are designated, they can be registered with due consideration, and the evaluation fees can be waived. But there we strike a brick wall: if the product does not get reimbursement, it cannot be used and the patients cannot be treated. The government has introduced a very good program, but the program itself and two subsequent reports indicate that we are almost at a brick wall. It is almost a waste of time having the program if we cannot reimburse the products and give the patients access to these products.

Ms HALL—It seems to me that you have four recommendations—and you might like to expand on them a little: developing specific pharmaceutical benefits cost-effectiveness criteria;

funding orphan drugs through Australian health care agreements; funding orphan drugs through public health outcomes funding agreements; and funding orphan drugs through supplier agreements with governments. Maybe you could give us an idea of how you think that will work, starting with developing specific pharmaceutical benefits cost-effectiveness criteria. How would you do that?

Mr Young—Funding options are very difficult to consider in isolation with one company. The options we have come up with have been considered in terms of what is currently happening—for example, the PBAC system, as the guidelines are currently written, does not take orphan drugs into account.

Ms HALL—I understand that.

Mr Young—So perhaps one way forward is to alter those guidelines or have a second set of guidelines for the orphan designated products.

Ms HALL—I am interested in what you think those guidelines should be.

Mr Young—The guidelines need to take into account the nature of the products. The criteria need to be less strict in terms of the volume of data required, because we are talking about conditions with fewer than 2,000 patients. We cannot provide the volume of data that the guidelines now require. Another option we put forward is to have direct communication between the government and the companies, along the lines of how blood products are now considered. That is perhaps a more simple and straightforward option. The disadvantage of having a second set of criteria through the PBAC system is that it complicates the process. We have outlined other direct funding options which are outside the PBAC process, and perhaps that is the best way to go.

Ms HALL—What sort of criteria do you think should be put in place to determine whether those agreements or arrangements are entered into?

Mr Young—These products are registered; they are safe, efficacious, quality medicines through registration.

Ms HALL—I understand that.

Mr Young—It is difficult to discuss the specific criteria at this hearing. I can only say that the criteria need to be less strict and designed with orphan drug products in mind.

Ms KING—What volume of drugs and what sort of cost are you talking about?

Mr Young—About 90 products have been designated since 1998 when it was introduced.

Ms KING—What is the usage?

Mr Young—I can only speak for our current products. We have six orphan designated products, and they treat around 4,000 patients. If all of those products were reimbursed, the cost on an annual basis would be less than $10 million.

Ms KING—If you relaxed or had a different set of guidelines for orphan drugs, how would you stop a pharmaceutical company somehow trying to argue that its drug was an orphan drug when, potentially, it had mass appeal for something else?

Mr Young—The current regulations cover that. There are mechanisms in place through the current orphan drug program.

Ms KING—Have they worked? Has anything snuck through in the orphan drug program?

Mr Young—No, the criteria are very clear. It certainly worked for us and I have seen no other cases of abuse. The criteria are very clear once the drug is designated. But in terms of either designation or reimbursement the government has now put in place extra criteria for products being listed through the current PBAC system to make sure that the system is not abused. So there are current mechanisms that could be used.

Mr GEORGANAS—We are talking about a figure of 2,000 for it to be a designated orphan drug and to be registered. How strict is that 2,000? If, for example, there were 2,200 or 2,300 people with a requirement for that particular drug, does that then automatically not come under an orphan—

Mr Young—It excludes it and your application.

Mr GEORGANAS—Because those figures of 2,100, 2,200 are still a small number for a drug company to develop, where does the company go? You might not be able to answer that.

Mr Young—That matter was considered, I imagine, when the original program was put in place and the 2,000 figure was decided by the government. You have to decide on a figure, and it is very clear that if your product has an incidence of more than 2,000 it does not get orphan designated; therefore, you have to pay for the registration. That fact must have been considered in the original process. We go out and find products based on doctors' requests. I founded the company specifically for that purpose: to provide products for orphan diseases. In speaking to hospital specialists, it is very rewarding for me to find out that they need these products. They come to me and ask me to find these products. So we are fulfilling a need; we are not pushing a barrow. That is why I started the company. Doctors and specialists come to us and say, 'This product is required: can you find it for us?' In a lot of cases we can.

CHAIR—Along those lines, from the point of view of the patient, when a patient is diagnosed with a problem that a specialist or a medical practitioner can find no traditional treatment for and seeks an orphan drug, what options does that patient have? What happens to the patient? We are talking about the process. Can you tell me what happens from the point of view of the patient? If a patient has a condition treatable by an orphan drug, it can be on the PBS or not be on the PBS. Is that correct?

Mr Young—Yes. I will try to summarise the process quickly. If the doctor is aware of an orphan product, it may be available in some form in Australia. They may come to us, we may find it and say, 'It's available,' and this is what we have to do. We have to get it orphan designated, first of all. We have to get it registered and, for the patient to afford it, they would

have to get it reimbursed. The orphan program is in place. The orphan designation is relatively simple and the registration process is also relatively simple, again because of the good work—

CHAIR—Is it quick?

Mr Young—It is relatively quick and it is as quick as other products. So the orphan designation and registration process works. It has been introduced and the program works.

CHAIR—So if someone is diagnosed today and needs a particular treatment, how long before they can have it?

Mr Young—For a registered product, approximately 18 months, because that is the time it takes to get a product designated and registered.

CHAIR—What happens in the meantime?

Mr Young—It can be made available through the Special Access Scheme. A product that is approved overseas can be made available through the Special Access Scheme before it is registered in Australia. If the doctor takes responsibility for that, then it can be made available. There is no federal government funding for that.

CHAIR—Who pays for that treatment?

Mr Young—If anyone pays, it would be either the patient themselves, if they had the money to do that, or the hospital, if the doctor or the patient convinced the hospital to do that. The hospital in that case would be filling the gap which the program that we would like introduced would eventually cover.

Ms HALL—What would be the average cost to a patient if they had to pay for it themselves?

Mr Young—It is difficult to give an average cost, because some products cost—

Ms HALL—Give us a range, give us a few examples. You have six.

Mr Young—For our products it would be from $900 to $15,000 per annum. Some products are much more expensive than that.

Ms KING—I asked you a question before and you said, 'Around $10 million', but that was for the products that you currently have. Has there been any work done on the cost to government if they looked at a rebate scheme for this?

Mr Young—I am trying to think back to the Hayes report and the Tambling report and whether they estimated the total cost. From memory, I do not believe they did.

Ms KING—So that work would need to be done before there was a chance to convince the government to change public policy?

Mr Young—Yes, perhaps. Out of the 90, we have six designated. A lot of the larger companies have orphan designated products, but it is not their priority. It is our priority because that is why I founded the company. Some of the bigger companies may not be as aggressive as we are.

Ms KING—But, if government are going to do it, the first question they will ask is: 'How much is it going to cost? What do we need to take out of the budget for it?' So that work would certainly need to be done before anything could change.

Mr Young—Yes. The government is already putting in place volume price arrangements with pharmaceutical companies through the normal process. That would be equally applicable to these products, and we would be very willing to do that.

Mr GEORGANAS—You mentioned earlier that a drug takes approximately 18 months to become registered. Once a drug is registered and a patient is diagnosed with a particular illness or disease, how quickly can the patient have access to that drug under the orphan scheme?

Mr Young—If the money is available, you can get it immediately.

CHAIR—If what money is available?

Mr Young—If the funding is available.

CHAIR—From the point of view of the patient being treated and the cost to the patient, once that product is registered and that treatment is prescribed by a doctor, there is no cost to the patient, is there?

Mr Young—Yes, there is. Unless there is a funding mechanism in place, the orphan designation and the registration are wasted. You get to the point where you have it designated and you have it registered, but unless there is a funding mechanism you cannot go any further—unless the patient takes it out of their own pocket or the doctor can persuade the hospital to fund the gap. This is the crux of the problem: you put in place a very good program for orphan designation and recognised the need, which is recognised internationally, but indicated the limitations of that program. Two subsequent committees have done exactly the same, and that gap is still there. You put all that effort into putting a program in place, all that effort into reviewing it twice, and you still have that gap.

CHAIR—What does this mean for the patient?

Mr Young—It means that the patient is not going to get it in the majority of cases. A small percentage of the patients are being treated.

CHAIR—And obviously the condition has to be life-threatening anyway?

Mr Young—Yes. We are talking about serious and life-threatening conditions.

Ms HALL—Could I go back to my first line of questioning. You have identified those four areas. Are there any other possibilities for funding this?

Mr Young—I am sure there are, but in isolation it is difficult to come up with them because we have not talked to the government about them and I am sure they have ideas that we have not thought of. These are four options that we have come up with in isolation, bearing in mind other systems already in place for other types of products, but I am sure there are others.

Ms HALL—I understand your dilemma, because you are treating very rare diseases, and there are very small groups of people with those diseases. You have small numbers that you trial your drugs on, and therefore it is very difficult to establish the criteria that you need to get the PBS—

Mr Young—Yes, the cost-effectiveness criteria.

Ms HALL—Yes, it is very difficult.

Mr Young—The safety, efficacy and quality is clear.

Ms HALL—I have seen at first hand how people who need some of the medications are in the dilemma of not being able to afford them. They have to somehow manage to get the money to have the medications or go without them and face life-threatening situations. I have actually seen where that has happened when people have not been able to afford it.

Mr Young—In most cases they cannot afford it because the products are so expensive. Only the very privileged would be able to afford to pay for these drugs themselves.

Mr GEORGANAS—Mr Young, I do not know whether you can answer this question, but, out of the people who are diagnosed with a certain illness who apply for orphan drugs, how many—as a percentage, if you have it—would not get them because of the costs?

Mr Young—I can give you an approximate figure for our products: 75 per cent of the patients would not have access either through paying for it themselves or through hospitals funding the gap.

Mr GEORGANAS—So 25 per cent would have access either by paying out of their own pocket or by accessing funds from somewhere?

Mr Young—That is right, and that is after a period of time. For the first year after the product was registered, the figure would more likely be 90 per cent, but over a period of time the hospitals fund it a little more. But initially it would be 90 per cent for the first year after the product was funded.

Ms HALL—In line with what Steve is asking: when people are initially diagnosed with these rare diseases, do you as a company often provide the medication for a short period of time, thereby determining its effectiveness in treating that particular patient?

Mr Young—No. Typically the clinical trials are carried out overseas. We bring these products in from overseas—from Europe or North America—and the clinical trials are typically carried out there, although there are some centres in Australia often included in those trials because, as

indicated, the small patient population requires trials to be carried out in a much wider area to get the number of patients.

Ms HALL—Maybe it was a bigger drug company that was supplying this person, but they were prepared to—

Mr Young—They may have been part of the clinical trial for registration. As I say, it might include Australian centres.

CHAIR—Does the fact that these clinical trials are conducted mainly overseas have an impact on their listing under the PBS?

Mr Young—No. The registration criteria for safety, quality and efficacy are international standards that we meet. In addition, the PBAC look into cost-effectiveness criteria, and those studies are not conducted typically by the overseas companies because they are specific to Australian requirements. Only in Australia do they require the specific cost-effectiveness criteria for big products, never mind small orphan products. There is no way you are going to get that data unless it is specifically designed for Australia, and they are only justified to do so for the large products.

Ms KING—What are the companies in Australia that have orphan drugs?

Mr Young—There are a lot of companies—

Ms KING—Do the big ones have them as well?

Mr Young—Most of them have one, two or three—and some small companies do too. There is a range of companies that have orphan drugs.

Ms HALL—It is important for us to remember that the World Health Organisation has designated only 5,000 conditions that can be treated by these orphan drugs, so it is not a very large number of drugs that can be considered to be orphan drugs.

Mr Young—That is right.

CHAIR—Because we are looking at a structural shift in health services away from hospitalisation and surgery towards medicines, which would not only result in a more efficient type of health expenditure but also improve health outcomes, how significant is the contribution of orphan drugs to addressing rare and serious diseases insofar as cost savings in other parts of the health sector if we can keep people out of hospitals?

Mr Young—Products for treatment of rare conditions, like other pharmaceuticals, in many cases keep patients out of hospital, because if patients are not treated they will have relapses and they will be taken into hospital where they may stay one day or one month. But often if they are given orphan products their time in hospital is reduced. That is in addition to extending their life and improving their quality of their life. For example, one of our products for treatment of a liver condition extends the time until liver transplantation is needed. In fact, the liver transplantation may not be required at all. Another product reduces the chances of cardiac problems so that a

person is not taken into the emergency room with heart problems. All of our products when used by patients increase their quality of life and reduce the amount of time in hospital and the expense of hospital treatment.

Ms HALL—I suppose that even if all the people that required orphan drugs were hospitalised, it would not be a great number of people. Your dilemma is that it is a small group of people, the treatment for them is quite costly and government tends to invest in treatments for large groups of people rather than for smaller groups. That is where the cost-effectiveness argument comes in. You can see these people are left out when you are looking at groups of 34 to 56 people as opposed to the numbers of people who are suffering from diabetes.

Mr Young—That is right. It is difficult because there are so few people involved and it is easy because there are so few people involved—it is both.

Ms HALL—Exactly: it is a dilemma.

CHAIR—It is a dilemma for government as well because the cost to the Commonwealth of funding orphan drugs is a saving to the state government through the hospital system. It is not a saving to the Commonwealth, and this is another aspect we are looking at: the relationship between the Commonwealth and the states in funding health services. Maybe there is a mindset at the Commonwealth level that if we fund orphan drugs to a further extent we will make savings in the total health sector, but the savings will accrue to the state governments and not the federal government.

Mr Young—Yes. I understand. The current system is inefficient. First of all, as I said, there is a program in place that is working up to a certain point and is not working from that point onwards. Because of that, the state government is plugging the gap in some cases. After a period of time, perhaps 25 per cent of our patients are being funded by the hospital. That is on a hospital by hospital basis, and almost on a drug committee by drug committee basis. That is a very inefficient process. It has taken four or five years to get to that stage with some of our products, so it is very, very inefficient. They are plugging the gap because there is no federal system.

Ms HALL—Could you clarify that point? Are you saying that the state is providing the orphan medications through the state system?

Mr Young—Some hospitals are funding a small number of patients.

Ms KING—So your recommendation is to fund something through the Australian health care agreements, which would alleviate that. The orphan drug program was not retrospective. Are you saying that there are some drugs on your product list that are caught—that is, they are registered with the TGA but they are not registered as orphan drugs?

Mr Young—That is right, yes.

Ms KING—So that is another problem. It is not affecting a lot of drugs, but a few have been caught in that.

Mr Young—Yes.

Ms KING—Were there any recommendations made in those reports that those drugs should go back and be listed as orphan drugs?

Mr Young—No. They look to the future.

CHAIR—I think the key to health care reforms in the future will be to concentrate on primary health care, and orphan drugs will play their part in primary health care. Do you agree with that proposition? How do you see this keeping people out of hospitals?

Mr Young—Sorry; can you define primary health care?

CHAIR—Primary health care is when a condition is diagnosed and treated without the patient becoming institutionalised.

Mr Young—Yes, absolutely. With our products, the treatment is usually initiated in hospital because the specialists are based in hospital.

CHAIR—Who diagnoses it?

Mr Young—The specialist will diagnose it. The patient will be referred, eventually, to a specialist, and the specialists are based in hospitals. But the patients are typically not in-patients. They are typically outpatients—and that is why it is a federal government responsibility and the hospitals are plugging the gap. So they are diagnosed by the specialist and if they are diagnosed and given the best treatment—in this case the orphan drugs—they will stay out of hospital. But, if they are not diagnosed or if they are not given the best treatment, they will go into the hospital system quicker than if they were given the best treatment available.

CHAIR—As there are no more questions, I thank you very much for giving evidence to us. We have had the Department of Health and Ageing appear before us, and it was very much a general meeting we had with them. We will be meeting with them again and raising issues that different people who have made submissions have raised, so we will certainly raise your issues with the Department of Health and Ageing at a public hearing. Thank you.

[10.19 am]

MACKEY, Dr Ken, Immediate Past President, Rural Doctors Association of Australia

STRATIGOS, Ms Susan, Policy Adviser, Rural Doctors Association of Australia

CHAIR—I welcome representatives of the Rural Doctors Association of Australia to give evidence. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament and giving false or misleading evidence is a serious matter that may be regarded as a contempt of parliament. We really welcome you giving evidence to this committee and taking the trouble to put in a submission.

As you know, there are many wide-ranging inquiries into our health care system going on at present, from a royal commission into public hospitals in Queensland to the other extreme, which I think is the inquiry announced by COAG—I gave you a copy of the COAG communique—and is a committee of senior bureaucrats at Commonwealth and state level to examine the program of reform needed in the health care sector, both private and public. The inquiry that we are having will parallel the inquiry by COAG and will give health care professionals not in the public sector a chance to give evidence before this committee and make sure that what you have to say is taken into account by the COAG inquiry. I ask you to make a brief introductory statement before we go on to questions.

Dr Mackey—Thank you for the opportunity for the Rural Doctors Association to contribute to this inquiry. I hope that you have seen and read our submission. I just need to point out a few of the important things with regard to rural health and those who service rural health, in particular rural doctors but we also pay particular attention to all those others who are providing services in rural areas, such as the nurses, the allied health people and the administration people, who are essential.

The first point to make is that we all should recognise that there is increased morbidity and mortality in rural areas. That serves to give us a focus of why there should be some further attention to rural health issues. From the submission, I think we can make the point that there is inequity as far as the dollars that are spent through the MBS, the PBS and now the private health insurance system. That translates to a contribution to the poor mortality and morbidity statistics that are shown in the rural setting. There are many reasons for that. The work force is the first issue that always comes to mind when we are talking about rural health and rural doctors in particular. That means that there is an access problem for patients to get the services that they need and require. Our submission certainly points out that the quality of services that are delivered in the rural areas is second to none. I think there are some perceptions that that may not be the case. We have much support in statistics that can provide evidence that the services that are out there, struggling as they are with the lack of manpower and other resources, are providing excellent results.

The other part of the recommendations is that fee for service should be maintained as the basic mechanism, but we recognise that there need to be other targeted incentives and initiatives that

will help to improve rural health outcomes for those in particular need. I do not think we need to go into any other subgroups of those that are in particular need, but I think it is obvious that there are some that need more assistance than others.

CHAIR—The term 'rural doctors' is a very broad, sweeping description of something which is far more complex. Do you want to put on the record how you would differentiate them? A regional doctor on the Sunshine Coast in Queensland is different from a doctor at Longreach in the types of services they provide. The types of services provided by a doctor near the beach on the Sunshine Coast are far different from what would be provided 20 kilometres inland, so where would these doctors fit in your definition of rural doctors?

Dr Mackey—There is a set definition of a rural doctor as it applies to our membership and each state has different criteria for membership. In one state, for example, if you want to be a member of the Rural Doctors Association of Australia you need to be in a rural area, RAMA 3 to 7, to be accepted. Others have a definition based on population—an area that has a population below 25,000. But I think all of the state and territory organisations allow anybody to be a member who has a particular interest and involvement in rural health. It is a broad brush and it is not exclusive. It is not trying to exclude people; it is, rather, trying to be inclusive.

Ms Stratigos—Another thing we could say—and I wondered if this was another aspect of your question—is that a rural doctor, by and large, is much more likely to have to provide medical services without a whole series of backups and supports that in many of your electorates would be available to people, even in big regional centres. They are certainly not available to somebody in solo practice in a small town. There is a level of complexity and responsibility that is not able to be shared by a rural GP. Somebody practising in a larger area would have that support system. So we are talking about another difference there as well.

Dr Mackey—One further point is about the number of specialists we have. It is a growing number and they now seem to recognise that they have a commitment and involvement to rural health. Some of the specialists that have joined Rural Doctors may, for instance, reside in a capital city but, as we are seeing, they are providing very valued services on an outreach basis. They have obviously become members as well.

Mr GEORGANAS—That would be someone who practises in the city but visits—

Dr Mackey—One day a week they will go out to a smaller regional area and perform a day of surgery, or an ophthalmologist will fly out.

Mr GEORGANAS—Yes.

CHAIR—We are concentrating on health funding—the distribution of federal health funding. You have outlined in your submission that there is currently an inequitable distribution of federal funding due to Medicare underspending, less access to services and a lower uptake of private health insurance by rural Australians. From your own studies, or research of others, can you outline the degree of health funding differences between rural and urban areas and also within the different rural and remote areas.

Ms Stratigos—That is something that was in our submission but we would have to say that the data is always a couple of years in arrears—it is very hard to get it. If, for example, you look at the per capita spending under Medicare you will see that in a metropolitan area it is about $180 to $190 per person per year, whereas in a remote area that figure goes down to about $80 per person per year. As you would know, that does not relate to the fact that people in remote areas are healthier and so do not need the services. It relates to the fact that the services are not there on the ground for that person to access whereas the person in a metropolitan area can access them. We should say at this point that we are very well aware that the inequity in the system results from unintended effects and that the policies that were put into place were, of course, based on the principles of equity. But how the policies work out is inequitable. If you do not have the doctors to supply a Medicare service to a particular population then they are not having as much Medicare expenditure directed towards them because the services are not there.

It is the same with private health insurance. It is lower in rural areas for two reasons. One is because socioeconomic status is, by and large, much lower in rural and remote parts of Australia—the figures are in the submission. The other reason is that the private sector services which people in metropolitan areas can take up—they can have that choice—are not available to people who live in the country. They do not have private physiotherapists, or they do not have private hospitals, to the same extent as people in the cities. So, again, a subsidy to the taxpayer which is designed to be equal is in fact not equitable. Why would you take up private health insurance when there is no private service that you can use it on? So that again is a disadvantage in fiscal terms, directly related to health funding policy. The same applies to the Australian health care agreements, which I hope we will come to a bit later on.

CHAIR—What would you recommend as a measure to encourage people in rural Australia to use private health insurance? Would you use differential premiums for people in rural Australia?

Ms Stratigos—What would you get?

Mr GEORGANAS—If a service is there.

Ms Stratigos—Yes, if the services are there. Certainly I take your point that, because of the low socioeconomic status, it might be that people in rural and remote areas could benefit from a subsidised premium. But why would they want it at all, if there is no private service to buy?

CHAIR—Where someone in remote or rural Australia needed to travel to a hospital in a capital city for major surgery and they had private health insurance, they would have choice and all the other benefits of private health insurance. Am I right or wrong?

Dr Mackey—It is hard to exercise choice from 500 kilometres away.

CHAIR—I will again use Queensland as an example. If you have to travel 500 kilometres to get treatment in Brisbane, you do have the option of going private or public.

Dr Mackey—Yes.

CHAIR—Is there an incentive for people from remote areas to seek treatment—for example, if someone wanted a heart bypass in Brisbane and they lived at Longreach—in the public system rather than through private health insurance?

Dr Mackey—There has to be a considerably better perception by the community in the rural areas that the service that they will receive on a private basis is substantially better than on a public basis. I would think the perception for such major surgery as you nominated is that the public sector is doing it very well. There are longer waiting lists, which is the main incentive for patients to take up private health insurance in the rural communities—they perceive that they will get a service quicker. But, as far as the standards and quality are concerned, the perception by the majority of community patients is that it would be equivalent. They get that perception by people coming back to the community after having had the operative intervention who are often very happy with that capital city bypass, graft or whatever.

Ms KING—I guess you could also argue that another incentive for people to take out private health insurance is ancillary cover. If you are talking about dental care or getting your glasses done, you can forget about that in terms of private health insurance in rural areas and in some regional areas. Either the service is not there or the private health insurers do not have contracts with the smaller providers in those areas. I think that may be another reason. It is in terms of not just major surgery but also ancillary cover—you get no benefit from that whatsoever.

Dr Mackey—I agree.

Ms Stratigos—And mercifully those are the services that people are more likely to need.

Ms HALL—I have to say that I found your submission an outstanding one in that you have covered so many important areas.

Dr Mackey—Thank you. I will pass that on.

Ms HALL—I would like to concentrate a little bit on the inequity that exists and on some of the solutions or suggestions that you have put forward. Could you expand on ways that you think equity in relation to MBS and private health can be increased for people who live in rural areas? I noticed that you made a suggestion in relation to private health and MBS that might be beneficial to people living in rural areas. Do you think cashing out would work in rural areas? I will throw that in as one of the suggestions that you might like to discuss.

Ms Stratigos—There will be times when cashing out is probably beneficial, and there are examples in North Queensland Indigenous communities and sometimes in specific areas of health care. To follow on from what Ken said before, by and large a fee for service through the MBS system works well because it has clear incentives in it to attract a work force. I guess this comes back to our second major principle, which is that the work force is really the key to this. I think you will find in all the research that the work force is the major input into any health care system and, therefore, the way the work force is funded is the key to a well-oiled system.

We have to have flexibility, and we do have a lot of flexibility in Australia. We would like to say that we think we have a very good health care system, which is not to say that we do not think we could make it better. But let us be quite clear about this: we have not come here to say,

'Doom and gloom, our system is awful.' I think it would be fair to say that rural doctors appreciate that they are working as part of a first-class system, but we have to get on to it and make sure that it changes with the times.

The rural economies and communities have not always experienced lower rates of socioeconomic development compared with the rest of Australia. I am sure that at least some of us in this room are old enough to remember that. What we are saying is that things change over time. We have to look at new models of funding, and that has already started if you look at some of the changes—for example, subsidies to support practice nurses through Medicare. That is very new and is a way of supporting general practice as the hub of primary care. We were very interested in what you said to the previous speaker—10 years ago the idea of a Medicare item number for practice nurses would have had everyone in acute cardiac arrest at the very thought. Now we are looking at flexibility in models, and we need to, but not all of the system is flexible.

Dr Mackey—I would like to point out that one of those models is the Medical Allied Health Services, MAHS, which is funded through the Commonwealth. Essentially, that is a pooled funding system in which the funds go to the division, and the division members then decide among themselves the distribution of those funds—to which towns the dietician or the diabetic educator or other allied health practitioner should go. That is an example that is working by providing much greater access to allied health services around the country. Certainly in my town, for instance, I now have a psychologist, a diabetic educator, an occupational therapist and a dietician available. Previously they were supposed to be available and provided by the state health system. There is a huge difference between what the state will supposedly provide and what is happening on the ground. That service has improved access to many of those one could almost say essential services to keep patients out of hospital and keep them well. It is also a small example of pooled funding at the local level, where the flexibility and the needs can be decided at the local level. I think that is what we would try to emphasise—that rural areas are small and global funding concepts do not always get translated into efficiency and effectiveness. We would be saying that, overall, fee for service is best but some targeted initiatives through some pooled funding are acceptable. We have seen in some small ways that it is working and maybe that should be the basis for some expansion.

Ms HALL—Is there any way that the 30 per cent private health insurance rebate could be better utilised in rural areas?

Ms Stratigos—We have some ideas.

Ms HALL—We would like to hear them.

Ms Stratigos—This brings me back to the Australian health care agreements. Although they are relatively new and, I know, regarded in some states as extraordinarily flexible in their application, I think we have to go right back to that basis of funding for the health system. If we look at rural hospitals, for example, which are closing at such a rate that it surely would be classified as an epidemic if it were a clinical happening, they seem to be starved of the oxygen that should come to them through the Australian health care agreements. So one of the ideas that we would like to see investigated is that of working through the Australian health care agreements for more equitable distribution. But I know the problem with that is that the Commonwealth gives the money to the states, who then use their own judgment and discretion,

subject to their own political pressures, to distribute it. This means that many small rural hospitals are starved of funds, they are downgraded and they close. I do not need to tell anybody here about the closure of maternity units in rural areas: over 120 have been closed in the last 10 years. That does not relate to demand for the services; in fact, fertility rates are slightly higher in rural areas. So, if there were an underspend on Medicare payments and the private health insurance subsidy, if you like—

Dr Mackey—And the PBS.

Ms Stratigos—and the PBS, because the underspend on the PBS of course follows the underspend on Medicare—that would be one way to have funds available to support small rural hospitals. Now, this would be difficult, certainly in political and fiscal terms but not, I understand, in legislative terms. If we could do that, it would overcome the problem that exists in the Australian health care agreements whereby it is possible for the Commonwealth to come down heavily on the states for noncompliance with the terms of the agreements. As you know, under the agreements they are supposed to maintain the same range of services that was available in 1998. Well, it depends on how you define range. They can say, for example, 'We are still providing maternity care to X region,' but it may mean that the women there have to travel 200 kilometres, so we do not see that as the same range of services. But the only comeback the Commonwealth has at the moment is fiscal penalisation: the Commonwealth can cut back some of their money. Of course, this is counterproductive. If your issue is that rural hospitals need more support then cutting back the funding to the states, which is the only punitive response you have, is totally wrong. That would just mean that there was less money for the communities that need it more. We believe that there should be some other way of supporting health care services in rural communities, looking at the hospital as a centre for those services, and that the distribution of funds that are underspent in other areas might be a way to do this.

CHAIR—On that point, obviously we are interested in the debate on the division of responsibility between the Commonwealth and the states and who should run public hospitals. The Minister for Health and Ageing feels that the Commonwealth should have more of an involvement; the Prime Minister is not of that view. Do you have a view?

Dr Mackey—I do not think we have a view.

Ms Stratigos—I do not think we have a political view, if I might say so. I am not a doctor.

CHAIR—I hope we do not have a political view. A practical view would be very good.

Ms Stratigos—Rural doctors are very heads down, tails up. What we want is what is best for the community. If that means the Commonwealth taking over, go for it. If it means the states doing things differently, that is fine, too.

Dr Mackey—A view can be reflected in what I was talking about before with the MAHS system and a better delivery of health services at the local level. Over the last six or seven years, and particularly since the 2000-01 budget, there has been great improvement in the delivery of health services in the rural areas through the GP practices with practice nurses, which were introduced into the rural areas in particular and through MSOAS—Medical Specialist Outreach Assistance Services. Many of those initiatives we see are being sponsored through the

Commonwealth. When we look at what the states are doing to rural doctors, rural communities and rural hospitals in general, we see that they are very negative. So on balance the Commonwealth is taking a more responsible view of rural communities and the patients that need rural health care and we would be supporting that approach. But, as for total control by one or the other, I do not think we have a particular opinion or view.

Ms Stratigos—There is one other form of cooperation between the Commonwealth and the states which certainly works in some cases better than others and that is the multipurpose centres. I know in Queensland there has not been great uptake and there have been issues in New South Wales. But there are other places—Western Australia, for example—where they work extremely well. The formula there is really a tripartite one. It is community direction, very largely, with Commonwealth and state joint funding. That is a form of pooled funding, if you like. Services are tailored to the local community.

Dr Mackey—With flexibility. That is the emphasis there.

Ms Stratigos—It can work and, in places, it does.

Ms HALL—It has worked well in some places in New South Wales as well. There have been some good outcomes.

Dr Mackey—Yes. Particularly the capital improvements are very noticeable.

Ms KING—When you are talking about underspends on the MBS, PBS and private health insurance, you are not talking about program spends, are you? You are talking about the differential spend in rural areas.

Ms Stratigos—Yes.

Ms KING—You are actually not talking about underspends.

Ms Stratigos—No, it is conceptually underspend.

Ms KING—I just wanted to clarify that. Thanks for that. I have other questions but not on that.

Mr GEORGANAS—Just going onto the health work force, one of the things that I have noticed in South Australia is that in some country towns where we do have services in rural areas they are finding it very hard to retain specialised doctors or just ordinary GPs. We are finding that we are getting a lot of overseas doctors. In fact, approximately 30 per cent of the rural medical work force is overseas trained. How do we retain these people? What do we do to keep doctors in rural areas? As an example, just recently in South Australia there was a hospital where the obstetrician got up and said, 'That's it,' and left. They are finding it very hard to draw people into these rural areas. That seems to be one of the biggest problems that we hear about.

Dr Mackey—There is no simple answer to that. There are many inquiries and investigations as to retention and recruitment of doctors, nurses and other professionals in rural areas. We have to contend with the global trend of urbanisation to start with. The first ones that move are

generally professionals, so we are up against it there. There are many issues that have to be taken into account. We have already spoken about the financial incentives that should be there. But that may not in the majority of cases be the most important incentive. Other important things are family, education, professional development opportunities and the commitment that is there from the community to the practitioners that come.

There needs to be a multipronged approach to address each and every one of those issues. When it comes down to an individual there has to be a huge amount of flexibility to say that the incentives can be targeted in one way or another for them, particularly as we are getting more females trained in medicine. Obviously, having some assistance and time out with the upbringing of children needs to be included in any package, in the broad sense, that may be available to those female practitioners. The males are also getting the idea that they need to reduce their hours from the typical 100 hours of a rural doctor down to a more sensible 60 or 80 hours or something. So there are many changes that we are contending with, and there is no simple solution. In the main, it needs to be individually targeted.

CHAIR—How does the age profile of the rural work force compare with the age profile of the urban work force?

Dr Mackey—That is another issue, particularly with the specialist rural work force. I think we had some figures this morning where the average age of the rural obstetricians is 60. Is that right?

Ms Stratigos—It is about 60. The average age of a rural midwife is 54. We are talking about really hard work, with broken sleep et cetera.

Dr Mackey—They have five years to go then there are none, it seems. The replacement rate, particularly for the specialist obstetricians, is low. Then there are those you were referring to, the procedural GPs as we call them, who are doing anaesthetics and occasionally doing surgery and obstetrics—and usually providing the accident and emergency, of course, because all rural doctors have to do that. You need to have those services out there. The question is how they are provided and what incentives are provided. Most of those services, the true emergency services and the procedural work, are provided at the local hospital. That involves them working with the state government, and the interactions there are not always that conducive to keeping the practitioners in the area.

Ms Stratigos—The research says that the major trigger for people leaving rural practice is the pressure of after hours. It is perhaps not the underlying cause but it is certainly the major trigger.

Mr GEORGANAS—Even if we had all these services that are required in rural areas in place, they would be no good if we could not attract the work force, which is what I see happening at the moment—we are just not attracting the work force.

Dr Mackey—An Australian trained work force?

Mr GEORGANAS—Doctors, specialised services et cetera. Would you look at targeting that first?

Dr Mackey—You may do. But the patient who is sick or who has chest pain does not care who is targeted—they want to have a doctor see them, and so they should. That doctor should be available and well trained and the standards should be guaranteed.

Mr GEORGANAS—So we need to get them working in those rural areas. That is one of the key things.

Dr Mackey—Absolutely. The range of conditions is going to stay the same. People are still going to have chest pains, so it is no good trying to just target obstetrics.

Mr GEORGANAS—I am talking across the board.

Ms HALL—In line with Steve's question, you must have some solutions that you think should be implemented.

Ms KING—What do you think of bonding? Most GPs hate it.

Dr Mackey—No; with all those initiatives there have been a lot of incentives that have been implemented through the Commonwealth. They are many and varied, and we are very thankful that they are being brought in. Bonding is one of them. Unfortunately, some people see it as being enslavement. We do not see it that way. I think there has to be some push and there has to be some pull. Unfortunately, we have tried a lot of the pull with all sorts of targeted incentives, including finances. That does not always work with the younger ones, as I have said before. Unfortunately, I think there has to be a little bit of push in there. That has to be done in some way. If that is to be done, as we believe in the association it should be, then bonding is a suitable way of doing it. Having lived in a rural area for a long time, I do not see it as been so negative a thing to do. That is the portrayal and sometimes the perception that is given to young people who are trained by urban doctors or other professionals. They are given the impression, once again, that the services and anything else that are provided in a regional or rural area are substandard or not as good as can be achieved in urban areas.

Ms HALL—Are there other solutions?

CHAIR—Do you agree that someone trained in the bush is more likely to stay in the bush?

Dr Mackey—I certainly agree with that, and the statistics point that out again and again. The new clinical schools that are now springing up around regional areas are a great boon and will provide a lot more rural doctors and other rural professionals. I have seen that particularly in Newcastle. I was in the Hunter in 1986 before the new medical school started there, and I had to refer much of the difficult work to Sydney. Once the new medical school came to Newcastle, it made such a difference to the whole ethos of treating and looking after medical conditions in the whole Hunter Valley and beyond. Having a medical school or even a clinical school is something that brings a whole lot more to a regional centre.

CHAIR—Is it too early to estimate how the James Cook University at Townsville is performing, from that point of view?

Dr Mackey—I have heard great things about it, but I have not seen the actual statistics. The Flinders Medical Centre shows some wonderful figures of young medical students and trainees who have gone from Adelaide to the rural areas. They have improved their marks to greater than they would have if they had stayed in urban areas.

Ms Stratigos—They have worked with rural GPs.

Dr Mackey—It emphasises that they improve their standing within the class by going rural. It really shows that we can provide a lot more services in rural areas, including teaching and training.

Ms Stratigos—I will just come back to the bonding question because perhaps I did not answer it completely. We think that, if bonding is necessary, fine. But, to come back to the principle I was talking about with the Australian health care agreements, one of the things that characterises our funding systems in this country at the moment is that we tend to supplement them by penalties for noncompliance, rather than by incentives for going that extra bit further. We think that bonding is okay, but we think that bonding would be good if it were accompanied by scholarships. It is really a little unfair. Again to show my age, if you go back to the previous bonding systems that existed in Australia—for example, in education departments—which worked very well, you would find were bonded but you also got a scholarship. The problem with the bonding system here in medicine is not the principle but that it should have an incentive in it as well. Maybe the principle that we should be trying to inculcate into fiscal systems is to try more carrots and fewer sticks.

Ms KING—Along that line, one of the comments that you made in relation to bulk-billing and the differential between bulk-billing rates in metro areas and rural areas is that there should be some sort of incentive indexed differently for rural areas. Can you expand on that?

Dr Mackey—We did mention the indexation of the Medicare Benefits Schedule, if that is what you are referring to.

Ms Stratigos—I think the question was in relation to the loading.

Ms KING—Yes, the loading for those in rural areas.

Dr Mackey—The loading is now available for general practitioners who provide a service to a patient with a health care card or who is aged under 16. That loading is greater if it is provided in a rural area than in an urban area. That is in recognition of the fact that there are some increased costs and increased complexities of providing services in rural areas. That has been an incentive to remain for a lot of doctors, and maybe it is a recruitment thing as well.

Ms KING—In terms of some of the other incentives that you have suggested—for example, incentives for the provision of timely health promotion, prevention and early intervention and structured management of chronic diseases—there are programs already that provide incentives for GPs to undertake those things. Why are they not working?

Dr Mackey—There was a restructure as of 1 July of the chronic disease incentives through the MBS. I think that will work better. The major reason why they are not working is red tape and difficulty in doing the paperwork.

Ms KING—It is not just that they are generally not working? You are suggesting that one of the ways to improve the health of rural Australians is through those incentives, but they are there and they have been there for quite some time. There are incentives for MBS items for assessments of over-65-year-olds and over-75-year-olds. A range of different MBS items have been introduced. If they are some of the ways to improve health in rural Australia and they have been in place for a while, why are they not working?

Dr Mackey—It takes time to change rural doctors. It takes time to change anyone, but sometimes doctors more than others.

Ms KING—Is the uptake of those items smaller in rural areas?

Dr Mackey—No, it is actually greater in rural areas. I suppose you could consider it as a tick. One reason why it is better is that practice nurses were introduced into rural areas. This emphasises the team approach that is now really needed to provide the whole broad spectrum of disease management.

Ms KING—So it is not just the incentives; there is something else going on around work force, socioeconomic status and access to services other than just some of the incentives that are here?

Dr Mackey—Yes. For those chronic disease items you need to have the allied health practitioners to use and refer to or the practice nurses. Those things are being taken up. In my instance it was difficult to utilise those services because you needed to have an extra room in the practice. You need to have those issues addressed first. They are not going to change overnight. I think you can see that there has been a gradual and increasing uptake of those incentives.

Ms Stratigos—By the time you get into chronic disease management, though, there is a step further backwards. The Medicare system as it stands at the moment covers very little screening. For example, there is now an item number for practice nurses to do pap smears, but not for the general practitioner who does not have a practice nurse with the training and qualification to do that. Bowel screening, for example, is coming in now under another program, which is not going to work very well in rural and remote areas, incidentally, because once a diagnosis is made there is no provision in the program for the patient to then access in a smooth and affordable way the services that come up from that. We need to go back further and look at some of the ways in which prevention was not built into our Medicare system when it started. That means there are still some gaps in its coverage.

Ms KING—What about the interaction with community health centres? It strikes me that their role has changed dramatically. Certainly in Victoria it has changed dramatically since they were first established. They seem to have dropped off the radar screen in terms of prevention and their interaction, whereas the divisions seem to be rising in that role.

Dr Mackey—This goes back to what I referred to before—the funding is state based for community health centres and it seems to be retracted year in and year out. The one that is taking up the gap is the GP practice. They know that they can provide that service. Lots of rural practices have had practice nurses for many years. So that is a start. As I said, the MAHS initiative—Medical Allied Health Services—is coming in there. Most patients can and will access their GP and the GP occasionally might have to do a home visit.

In a community, if a patient needs a service, that can now all be provided through a well-developed general practice in a rural town and certainly, I suppose, in an urban setting as well. Dressings are now paid for through the Commonwealth, and that was one of the major things that the community health nurses did, as well as other review and home visits. So the capability and the resources are there now, or should be soon, with each and every general practice, to provide most or all of those services that were provided through the community health system. I would go so far as to say that the community health system would be better off being absorbed or taken over through the general practice system—and that may be with the help of the divisions—to provide those services that really are out of hospitals and leave the hospital work to the experts that are there at the hospital.

Ms KING—If you look at the history of community health centres you see that they had a very radical history in terms of their establishment—particularly in New South Wales, where they started. They were not always about the provision directly of allied health services. That was one thing. But what they did too, and certainly in Victoria this has dropped off, was look at collectives of people who were coming in with particular conditions with a broader structural approach to those issues. For example, with occupational health and safety, if they were getting large numbers of people with injuries from a local factory, they would work around those. They worked far more on what people from my era look at as the structural approach to health, promotion and prevention, as opposed to a direct intervention approach. GPs do not do that. They do not do that well.

Dr Mackey—They are doing it more and more.

Ms KING—They are, but they still do not do it well.

Dr Mackey—Okay. It takes some time for GPs to change. I think the incentives are there. Sure, they are financial, but there are also other incentives. I see that there is a positive change going on so that the continuity and the comprehensiveness of care for each and every individual in the community can be provided out of the GP practice. When something seriously goes wrong, they go to hospital and, quickly, they are out of hospital and back into the community where the GP team can provide that comprehensive care. I think that should be a principle to push forward. I think it is better for the patient that they are there—they have that local knowledge and local contact, rather than back in the ivory tower where they sometimes get brief treatment as an outpatient, after having waited for four to six hours.

Ms HALL—How effective do you think the RAMA classification system is? Do you think it is working?

Dr Mackey—Overall, we are happy with the RAMA classification and the system. I think it has been used for well over 10 years now. It has provided a direction for the way that services

and finances can be delivered. There are some problems that do need to be tinkered with at the edge.

Ms HALL—What problems?

Ms Stratigos—There are anomalies, really. There are anomalies in all systems. The best-known one is that Noosa—which even has a private hospital and is very close to Nambour and, actually, is within easy access of Brisbane—is in the same classification as very small towns that are very far away from other centres. We have just made a submission to the Department of Health and Ageing's review of the RAMA classification system in which we propose that it be maintained but that a template which would enable it to be more sensitive to other issues—for example, socioeconomic issues or the demographic profile of a particular community—should be taken into account. I would be very happy to submit this to you.

Ms HALL—We would appreciate that very much.

Ms Stratigos—At the beginning of 2004 we also did a submission on the Strengthening Medicare initiatives, which sets out perhaps more fully some of the things that we have in this submission—for example, about bonding, work force issues and support for GP teaching. If you would permit us, we would be very happy to submit that to you.

Ms HALL—We would appreciate that. I feel we led you a bit on the work force shortages issue. We mentioned bonding, and you did not get on to other kinds of strategies that you think could be put in place to address the work force shortages. This is not only about doctors; this is looking across the board, because there are shortages in all areas.

Dr Mackey—As I related to you, that is very broad ranging and there are all the initiatives that need to be introduced. I do not think we have any summary document that could be easily provided as to particular incentives. But as I related before, you need to think of the practitioner, the midwife or any other health professional—and their families—as coming as a unit. You have got to think of their ongoing education and professional development and the social context in which they wish to reside. Sometimes it has to have a religious basis or whatever. Sometimes there will be a cohort of their own religious believers in an area and that may be the major attraction to a group of doctors. There are many and varied things. Obviously, no-one can influence where even a religious group may go.

Ms HALL—You might think about it a little bit more and send us about a page and a half of some strategies, in point form, that we could look at to encourage the medical work force to be more sustainable in rural areas.

Ms Stratigos—We do have some. For example—and following on from that—it is not only about seeing the medical practitioner and the family as an entity and then providing support and opportunity. The income-earning capacity of the spouse of a medical practitioner is an increasing problem because there are now more women doctors, for example, and their husbands expect job opportunities in a community which may not be able to provide them. The same goes for women, but perhaps we are more easily socialised into thinking that we should change to another profession or something else.

I will go back to the question you asked as to the health work force as a whole. We are very interested in maternity services for rural communities. Those are a real team thing. The midwives cannot practise without the GP proceduralists and they all need somewhere, not necessarily co-located, a specialist obstetrician. One of the things we have been working on, since having a symposium in Alice Springs in March, is looking at team training so that, instead of the midwife going there and the specialist going there and the GP going there, we could have training in teams—and this does not take place very much yet—as well as support for team care delivery, which has been shown to give better health outcomes. It could also raise morale. For example, midwives do not get as many CPD opportunities as medical practitioners do, but if the midwives are not there the GP cannot practise. So I think it is very much about a coordinated integrated approach. We will certainly send you a page and a half on the material that we have thought about. My only proviso would be that none of these is going to be the perfect solution.

Ms HALL—Of course; we will hear from a lot of people and hopefully we can come up with a workable solution. You mentioned contestability in health care funding agreements. Your submission says:

... introducing further contestability into health care funding agreements will not deal with the inequitable distribution of health resources between urban and rural areas.

Would you like to expand on this?

Ms Stratigos—Yes. As your chairman outlined at the beginning, this paper is being discussed and this discussion is taking place in the context of a foment of potential reform in the health care system. From where we sit, we are rather concerned that an overemphasis on private enterprise/private funding systems and so on may disadvantage areas of the country. Health, as with other things, just does not attract the same level of capital investment. If we look at models which work very well, we see that in the UK these huge hospital redevelopments—£60 billion worth—are coming from private financing in some cases.

In New Zealand, a much smaller country, where they are also using private financing, we are concerned about funder-purchaser-provider models, which have already been tried in Australia, particularly in Queensland, and were not done very well at all. There seems to be in the current overall political-cultural environment such an emphasis on private enterprise and user pays as the answer to all our ills. We want to point out that for that funder-purchaser-provider split—which of course has the advantage of introducing competition into a market and so theoretically gives consumer choice and better services as each of the providers aim to provide a better or more distinctive service—the market for rural health care is fairly inelastic. It is not a conventional market and—you do not find this said in your economics textbook—both the demand for medical services and supply is fairly inelastic. And contestability, in which providers in different sectors were measured against each other, is not going to work, especially in more financially disadvantaged environments where the only provider is likely to be the public sector, because the private sector will not touch it. Therefore, that public sector provider may be disadvantaged in a competitive environment and that would severely disadvantage small rural communities.

Ms HALL—That is a very good point.

CHAIR—I think you have answered my question. I was going to ask: how do you get a GP from a bulk-billing clinic in Balmain and send them out to the bush, where they have to perform a totally different range of things? There is a big transition in that. The one thing we have not covered today is the overseas doctors question; they make up over 30 per cent of the work force in rural areas now. Is that working well? We have our problems in Queensland, as you know.

Dr Mackey—Let us just hope that is a one-off, and the evidence is that it is. The bottom line is that there is no alternative at the moment. If you have a chest pain the community wants somebody there. For a whole range of reasons, the Australian trained doctors are not coming out to the rural areas, and we have to accept that at the moment—that is a fact. The alternative is then to search overseas and get the best that we can from overseas. There is now huge international competition with the US, the UK and many other countries for these overseas trained doctors, so we have no alternative.

If we look back a couple of generations there were many that came over from the subcontinent, from the UK and from other countries. Back in the forties and fifties they were overseas trained doctors; we have relied on overseas trained doctors for many decades. The service that they have provided, particularly in some country towns, has been wonderful. Maybe there is a lot more of a push at the moment to bring in overseas trained doctors. Hopefully that is only temporary, but in the main the service that they have provided in many towns for three to four decades has been wonderful. I do not see why that is going to change. There are problems with making sure that their credentialling and standards are satisfactory but that can be overcome with particular attention from the registration boards and from the colleges to make sure that their training is adequate and up to standard.

Ms Stratigos—On that point, I will indicate one concern which is not listed in the submission. This inquiry is about health funding, but if you look at Commonwealth or Australian government policies as a whole you see that there is sometimes a problem in that they can undermine each other. For example, lack of work force undermines regional development strategies. When we look at overseas trained doctors—and the figures are actually 52 per cent in Western Australia and 42 per cent in South Australia—we see that the immigration legislation in some ways undermines the health initiatives to attract more doctors. If you come in as a temporary resident doctor—and you can work here for four years and provide a very good service, often in small rural hospitals—you and your family are not able to access Medicare, even while you are maintaining the health system in the country. In some states—New South Wales, for example—you cannot send your children to a government school without paying the price. For a primary school child of an overseas trained doctor in New South Wales at the moment it is $5,000 a year. So there are ways in which health initiatives could be supported by more coordinated activity at points where different portfolios intersect.

Another area is the HECS repayment system, which supports medical graduates but of course is not run by Health and Ageing. The anomaly in that is that after graduation a medical graduate will work under supervision for some years and get paid. The HECS repayments now cut in at, I think, just over $30,000 a year, and a graduate is likely to be paid over $30,000. After they have been in the country for five years their HECS is forgiven, but before that time they will already have paid it back. I do not think these things are necessarily thought of at the beginning. Maybe looking at those points where the health system touches on other systems would make things easier.

CHAIR—Thank you for that. We have not have that raised with us before. It is a very good point and it was very well made.

Mr GEORGANAS—The HECS fees and the bonding that we spoke about earlier are very interesting issues. Have you looked at ways that the HECS fees could become some sort of incentive in terms of reduction for bonding in rural areas, like we had with the education policy?

Dr Mackey—And how it is taxed.

Ms Stratigos—You can access both, depending on your scholarship. You can also get a scholarship if you are bonded, but you have to get it from another system and so on.

Dr Mackey—It is complex.

Ms Stratigos—It is very complex, particularly because in this case it is not a health initiative; it is an education initiative. One thing I cannot resist saying is that it should possibly be available to other health care professionals—midwives, for example.

CHAIR—Is there anything you wish to add to anything you have said to wind up?

Dr Mackey—I think we have covered and summed up many of the things that we had in our submission.

CHAIR—Thank you very much for making such a comprehensive submission and for giving evidence today. I think every member of the committee learned a lot today, and there are some new areas which we should explore. As I said to the previous witnesses, please keep your eye on the evidence on internet and, if you want to add to anything you have said to us as a consequence of evidence by other witnesses, please do. Thank you very much.

Proceedings suspended from 11.23 am to 11.36 am

HARGREAVES, Ms Clare Lynette, Senior Adviser, Social Policy, Municipal Association of Victoria

JOSE, Mr Gerard Michael Patrick, Director, Community Services, Knox City Council

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these are formal proceedings of the parliament and that the giving of false or misleading evidence is a serious matter which may be regarded as a contempt of parliament. I think that some members of the committee met you at the cost-shifting inquiry conducted by another committee which covered many of the things that are in your submission. I remember them well from the public hearing we had at Warrnambool. I now invite you to make an opening statement.

Ms Hargreaves—Thank you for the opportunity to speak today. As you would probably be aware, the MAV is the peak body for local government in Victoria. We collectively form with the other state associations the Australian Local Government Association, ALGA, who I presume you will be speaking to at some stage during the inquiry. To set the broad context: as you would know, local government has a very broad range of roles that relate to public health generally, environmental health, health promotion, provision of health programs and services, recreation and leisure, and so on. In Victoria we have had a great focus with the councils on their municipal public health planning and have been working with them on the broad social determinants of health. So it goes without saying that, like you, we have a very strong interest in ensuring that health services of a high standard are accessible to all communities in Victoria.

The issues that are looking very positive for local government—I will leave it to the Australian Local Government Association to discuss their submission with you—are around our work on an intergovernmental agreement with the Commonwealth which will look at the role that local government plays and provide a forum for us to talk about the overall financial arrangements following on from the Hawker inquiry. I refer to that because obviously the overall financial position of local government affects enormously our ability to carry out work with you in a number of these areas. It would certainly be the view of local government nationally that we are trying to move as much as possible from an illness focus to one of public health and prevention, bearing in mind that you need both aspects. Local government has a lot of investment in working at the preventative end, because of our often universal contact with the community. Certainly over the last 30 to 35 years local government nationally has increasingly provided human services and health services. This is a particular trend in Victoria where, as many of you would probably be aware, there is a fairly high level of local government involvement in human services. For example, local government in Victoria is the major provider of home and community care services to assist people living independently at home.

We have made presentations to previous inquiries on cost shifting and to the recent Senate inquiry on aged care, but in this submission we have concentrated on three areas of service delivery: home and community care, maternal and child health, and immunisation. We see these working very well in a partnership model with the state and Commonwealth governments, and we are working on the ground with our state colleagues on how the services are delivered in Victoria. We have ongoing concern about the proliferation of a range of programs for different

target groups in some of these areas, particularly in aged services, where we seem to have parallel Commonwealth and state programs and at local government level we end up trying to sort that out on the ground.

We are experiencing difficulty in Victoria in relation to the Home and Community Care program in meeting increasing demand, which is due to population characteristics and an increasingly frail client group. We have played a strong role in immunisation—you would be aware that over many years we have had very high levels of coverage in Victoria—and we have done some particular work, as we outlined in the submission, on the costing in that area. In relation to maternal and child health, we are working in a fifty-fifty partnership arrangement around the funding of that service in Victoria, which may not be particularly relevant to your inquiry except for the fact that I think the model we have in Victoria, where under the Health Act councils are required to follow up all birth notifications and thereby we see just about every family in Victoria through that universal service, is an extremely good model. It works very well.

As we mentioned in the submission, sustainability of funding arrangements into the future is of ongoing concern to local government. But there is a great commitment in Victoria for councils to continue to be involved in these areas and to work in partnership and make joint plans with the state and Commonwealth.

CHAIR—The members of the committee come from different states. Jill is from the Newcastle region of New South Wales, I am from Queensland, Catherine is from Victoria and Steve is from South Australia. I was formerly a minister for local government, so I am aware of these differences, but there are a tremendous range of functions which differ from state to state. There are differences in local government. The electorate of Curtin in Western Australia, which is only about 80 square kilometres, has over 12 local authorities, whereas in Queensland we have one local authority with 140 ratepayers that is bigger than Belgium. So there are extremes of functions that local governments carry out. You have a very clearly defined function regarding the HACC program. Can you tell us, from your knowledge, if other states have the same function with regard to health that Victoria has?

Ms Hargreaves—They probably have the broad roles that we have talked about. They certainly have roles in environmental health, public health and general preventive programs and also in social planning. In fact, the other states, especially New South Wales, are perhaps ahead in terms of the legislative support they have for local government around social planning and health impact assessments and those sorts of functions. Certainly at the level of human services there is great variability. While there is involvement from the other states in something like the Home and Community Care program, it is quite different from Victoria. The additional issue in Victoria, as you know, is that at this stage local government put in about $70 million a year as well, and certainly that would be much higher than anywhere else.

CHAIR—Does that come out of ratepayers' funds?

Mr Jose—Yes, generally it does come out of ratepayers' funds. That is the base that we are operating from.

Ms HALL—For service delivery through local government, I think Victoria is the Rolls Royce model. Coming from New South Wales, I know that we do not have nearly the same level

of intervention from local government. You make a point in your submission about the HACC funding, the contribution made by local government and the fact that there is some duplication of services. Would you like to expand on that for the committee?

Ms Hargreaves—We certainly acknowledge that in fact federal, state and local government in Victoria are putting in additional funds every year in recognition of population changes and so on. Probably the biggest issue we have is around the indexation, and we spoke about this to the Senate inquiry into aged care. Running with the indexation that we have in the program for an hour of service at around two per cent—2.1 or 1.9 or whatever it turns out to be this year—of course does not meet wages growth. It is perhaps hard for people to understand that a service that is provided in people's homes means that the predominant cost is the work force and also, as we would say, a shower is a shower is a shower. If you are actually providing a service to somebody, higher quality could mean that you take more time not less time. So it is a very difficult area in which to be asked to try and increase efficiencies each year. That is an ongoing problem for us in trying to provide additional services to meet the growth in the population, when some money every year from local government has to be used to make up that hour of service.

In terms of fragmentation, we are very supportive of the work that Minister Julie Bishop is looking at, for example, in the home and community care area to try and bring some consolidation of about 17 programs in her area. The trend for the Australian government to target funding to particular needs groups as they arise is something we can understand—a needs group presents with problems in a particular area and so a new program is created—but we do find it enormously wasteful in terms of duplication of administration of programs and the number of providers you then find in a system, albeit you want to continue to work in a competitive environment. When we have small providers, perhaps a residential care organisation, suddenly deciding that they are going to provide aged care packages when they have no history or experience in it and they are going to provide 20 packages across a whole lot of suburbs in Melbourne, this is not particularly helpful from our perspective. Some of this is documented in a report that the MAV was supported to do for the Myer Foundation around the work they have done on the future of this in Australia.

Mr Jose—I would like to add a couple of comments. I think the point about indexation is valid but my view is that, instead of a CPI adjustment, local governments are faced with increases in the cost of governance which do not get picked up by indexation or growth funds. We face increasing demands from ageing populations but we are also facing increasing quality of service provision, which is reflected in the cost of training, the cost of meeting diversity within our communities and the cost of meeting state legislation on occupational health and safety, risk management and manual handling. All those costs impact on the capacity of local government to deliver that service. Whilst we might get a CPI adjustment, it goes nowhere near meeting the cost of recruiting and retaining quality staff. That is what we are coming back to: those costs impact on the cost of governance as opposed to the cost of CPI.

Ms HALL—How does competitive tendering impact on the delivery of HACC services and fragmentation?

Ms Hargreaves—I understand that the Australian government has to deal with the issues of equity across the nation. We in Victoria are certainly finding that the current trend to more or less

a tendering approach in regional conglomerates for a whole range of programs is causing us quite a deal of difficulty both in the health and ageing area and in the family and children's services area. Almost every realignment of a program that comes out seems to be working from a zero base. There is no acknowledgment of the existing expertise that has been built up in the system by organisations that have taken it upon themselves to run these services over the years. We have had examples in the last couple of months of councils that are very effectively running programs at the moment, whether it is respite for carers or inclusion support for children with disabilities, being asked to throw the whole thing up in the air, somehow form a regional grouping and submit as a regional grouping. We have examples for some councils where all of this is for perhaps $14,000 in a program where they are actually providing more of the funds within their municipality already to provide an integrated service to their community.

So there does seem to be very little recognition at the moment of the need to strengthen the service system. With the state in Victoria, it has been accepted that local government is a sphere of government, that we obviously have the public good at the forefront of what we are trying to achieve, that there is no other reason we are in the business and, of course, that all money is used for the service or ploughed back into the service at all times—it is not used for a profit. So I have to say that the sort of approaches that we have got are not sitting very well with us in terms of better integration and service coordination.

Mr Jose—To strengthen that: we are a major contributor to many of those services, both financially and in intellectual resources. I think that is built up with employment, history and knowledge, and it is pretty hard to throw those things into a contestability basket and come back and say, 'Yes, local government, you're picking up 60 per cent of maternal and child health services but we are going to throw that out into the marketplace and still expect you to bid and provide.' I do not think that is a partnership model. They can work against each other, I think.

CHAIR—Do you find that there is mobility? In a regional area where there is competitive tendering and someone else wins a tender, you would expect to lose all that corporate knowledge. Is that corporate knowledge absorbed by the new provider, or is it lost?

Mr Jose—I could not answer with any certainty. I think part of it would be lost, yes. In our area at the moment we have built up staff working with children with special and additional needs. They do not go to the new provider; they will go somewhere else within our service system. So that knowledge, which I think is critical when working on an inclusion model for children, is too vital to the sector to be lost, and quite often it is lost because there is no transmission of business.

Ms Hargreaves—The other thing that particularly the rural and regional councils find is that, because tenders are often assessed by people not familiar with the area, new tenders are often awarded to a central organisation that does not have any base in the particular rural and regional area. We call them absentee case managers. When these programs are awarded, at the end of the day, when there is a problem with a resident in their particular area, they come back to the council anyway because that is who they have the enduring relationship with, especially when the case manager is 200 kilometres away in another town and has very little understanding of the networks. So, as we say, the councils are in a position to seeing the impacts of the various policy directions on the ground and obviously trying to make the best of them, as they do.

Mr Jose—I worked for a while in Campaspe, so that is Echuca, up on the river, and there was the same model there of local government taking a lead role in shaping and influencing thinking and in the assembly of other organisations within the local area, which was crucial. I listened to your previous comments, and I suppose that is working with the community health centres and the divisions of GPs and others within your local area to get the best possible outcome. As Clare said, when all of a sudden a tender is given to someone 100 or 150 kilometres down the road with no ties to the area and no understanding of the service system that exists, it becomes problematic when it does not work as properly as it should.

CHAIR—If it does not work, surely that would show up when the government measures the outcomes. In a competitive tendering process, when a good service is being provided through a council, why would you go to somebody else on the basis of outcomes? All of this is outcome based, isn't it?

Mr Jose—It is. Without talking to the people who are assessing the tender, I would say maybe their outcome measures are very vertically structured instead of horizontally structured—a vertical or silo approach as opposed to an integrated model. Sometimes their outcomes are very discrete; they do not look at the social model of health that Clare was talking about earlier.

Ms KING—In your submission you talked about the forums through the National Public Health Partnership. One of the things that happened when you had the move towards public health outcome funding agreements and then the establishment of the National Public Health Partnership was that they separated out the funding negotiation from the policy reform issues. Local government got—and I assume is still has—a strong place at that National Public Health Partnership table.

There were a few commentators around at the time saying that for health reform you should do exactly the same thing—that is, take the Australian health care agreements as a separate issue and then have a health reform policy area. Has there been any discussion of local government participating in health reform in the same way that it does in the National Public Health Partnership?

Ms Hargreaves—Not to my knowledge, but I think that is probably one to run through with the ALGA at their presentation. I certainly know there was a lot of effort put into making and maintaining a place for local government in the National Public Health Partnership. But, obviously, we would be very happy to consider that proposal.

Ms KING—I would certainly be interested in your view. In terms of the COAG reforms that are happening, I do not know what participation local government has in that through either your association or ALGA.

Mr Jose—I would suggest that it would probably be through ALGA. But there are probably international experiences that might be useful for the committee. I think Denmark, Sweden and now the UK are looking at how they actually strengthen that relationship at the local level in terms of the overall provision of public health services and have a stronger role at the local level. So there are probably some useful models there.

Mr GEORGANAS—The Victorian state is, I suppose, the only state where you guys play a major role in contributing to funding. What is the historical reason behind that?

Ms Hargreaves—I think in some of the areas it goes back to the councils in Victoria picking up services post Second World War on their own initiative, really, around meals and home help and so on. The work in infant mortality and child health goes back to about 1917, I think. It came out of original issues around public health and sewerage and all those things. Then it was looking at infant mortality and what was happening there. So I suppose it was an initiative of local government in Victoria in order to address some of these issues and it then became more formalised over time. We have seen local government develop from involvement with roads, rates and rubbish to involvement in town planning, human services and the environmental areas. Probably the latest is economic development. That is now strong in Victoria as well. It completes the picture, really, in terms of integrated planning and local government seeing that it has a broad role across all of those functions.

Mr Jose—I have only been involved in local government since about 1979—history does not go back that far! A lot of our arrangements in those days and beyond were very much on a shared, true partnership model financially as well as in planning the targets. For Meals on Wheels in those days the cost of the meal was probably almost fully funded by the state. Nowadays we are still getting $1.15, but each meal is probably costing us $11, and in some cases $15. The partnership was there originally in terms of planning, provision and meeting a social need. It is still there—it is just that the costs and balances have shifted.

Ms KING—Can I ask you about immunisation provision. I was under the impression that, when the changes at the Commonwealth level occurred, there was a lot of discussion about local government getting out of immunisation completely and it going over to GPs. Are many local governments still involved in mass immunisation programs? How does that work in with the Commonwealth's GP incentives program for immunisation? I have lots of questions around that, so just talk to me about that.

Ms Hargreaves—I suppose it has been an area of some concern in Victoria given that we had very high immunisation rates before the change. Certainly we accept that now we are in an environment of mixed provision. I think I have a note here saying that we went from 85 per cent of immunisations being delivered by councils in Victoria to just under 50 per cent. From our perspective, we were wondering whether this was going to be an improvement or not. I suppose as well the structural involvement of local government, from our point of view, is a much more effective way of ensuring universal provision. The councils have continued to play a very significant role despite the disparity. In fact, it costs local government less, but also obviously we are being subsidised at a much lower rate.

So, in terms of a cost-effective model, we have a strong view from the public health point of view about local government being able to play a continuous role in terms of awareness of families and follow-up and so on. Because of the close links with the Maternal and Child Health Service, it would be very unfortunate for Victoria if local government exited altogether. Over the last few years we have worked with the division of GPs and so on around making good use of having both the GPs and the councils involved in terms of families they can pick up at various points, particularly ones that might miss out.

Mr Jose—We are still heavily involved. Tonight is our council meeting and, as a backdrop to that, we have immunisations running in the next room, so it makes a very interesting sound backdrop to councillors discussing issues. We continue to participate for a number of reasons. One is that families want our service, because it is an integrated service. It is not just the immunisation; it is access to an array of information that supports families in their local communities. I think we provide a better backup service in terms of follow-up to families, and we have a skill set that is in some ways sometimes better than a GP's and the overarching immunisation program.

Ms KING—Has the provision of immunisation changed? I just want to know the mechanics of it. Do you have a GP who comes in and do they then claim the immunisation payment, or do you have a block?

Mr Jose—We have nurses who provide the immunisations, so we get a funding base which is around the number of immunisations not about the number of jabs that each—

Ms KING—And you get that from the Commonwealth?

Ms Hargreaves—The Commonwealth-state subsidy for preschoolers is $11 and for school aged children it is $8, and local government is receiving it. By all accounts, it is therefore much more cost-effective—

Mr Jose—It is.

Ms Hargreaves—for the numbers of children that we are immunising.

Ms HALL—There is a differential in the cost between what you receive and what it costs you to deliver that service too.

Ms Hargreaves—That is right.

Ms HALL—Council is picking up some of the cost of providing that immunisation service.

Ms Hargreaves—That is right.

Ms HALL—So that is an example of, I suppose, cost shifting and that is cost shifting at a federal level. But, then, if you look at other areas there is cost shifting at a state level too. What strategies, agreements or partnerships need to be entered into so that this cost shifting to local government is stopped? I note that one of your final points is that this needs to be addressed or else the services you provide will no longer be sustainable. To me, it appears that it is at all levels of government and that you are being asked to take up more. Is this just a Victorian phenomenon?

Ms Hargreaves—No, I think it is a national phenomenon—and, I suppose, going back to the discussions that the ALGA are having at the moment following the Hawker inquiry and so on. Certainly we are working in Victorian local government on the idea of cost sharing, trying to move on from cost shifting, in the sense that as a sphere of government we are also making a commitment to remain involved in some of these areas. As long as we can do that on a

reasonable basis in partnership with the state and the Commonwealth, the councils are happy to do so. In the area of maternal and child health we now have a memorandum of understanding where we are saying that we are roughly bearing 50 per cent of the cost each. That is in writing. It is signed up to for the councils via the MAV with the state.

We are also about to sign an agreement around HACC, which is around the broad intent that local government wishes to stay in this area. But in that case we are saying, 'It will be at a level determined by each council within their current revenue base,' and so on, so they may not be able to grow it as much as they were able to in previous years. It is an attempt to raise the sophistication—a bit of a discussion—around the partnership in the areas that local government in Victoria or nationally thinks are important. But, yes, it goes back again to the Hawker inquiry and the overall negotiations that for a number of years were sitting at around four per cent of overall taxation revenue in Australia being held by local government. Often that is something the community do not understand very well in terms of the council's ability to pick up on various service areas when there are shortfalls.

Ms HALL—It says here that the cost of immunisation for the council is $22.70 for preschool age children and $11.60 for school age children, whereas the benefit that you have received for the $22.70 is $11 and for the $11.60 it is $8. Is that sustainable in the long term?

Mr Jose—In addressing one service out of over 200 that we provide, it is hard to say what is sustainable and what is not. We have to look at our shifting priorities. It is cost acceptance that we are in—it is almost cost avoidance for us because we believe that the community benefit is paramount. However, we would obviously like to see those costings shifted.

Ms KING—Using Knox as an example because you are here, how much of the rate increases each year would be because of the health services that you are talking about?

Mr Jose—The health services per se would contribute. Sixty per cent of our budget is rate based.

Ms KING—What was Knox's rate increase this year?

Mr Jose—It was much less than previously. It was 3.9 per cent.

Ms KING—A post-election year.

Mr Jose—We try and analyse service by service, but the cost of all of them would contribute. HACC is probably a major one that will impact on our rates. Maybe not this year, but over the next 10 years it will have a dramatic increase on the rate base. Things like maternal child health increase it as well.

Ms KING—That is an example of cost shifting onto individual ratepayers through local government taxation for services that are funded by the Commonwealth.

Mr GEORGANAS—Have you found that some local governments have wound back the services that they are providing because of the exact same issue that Cathy is talking about?

Mr Jose—I think that you will see continuing responses, depending on the capacity of the councils. We are probably better situated, being an eastern metro council with a stronger rate base than some of our provincial and rural areas that cannot afford the cost increases. But even within our council, we have taken a line saying that we cannot afford to increase our contribution into HACC as much as some of our neighbours who have gone up to 30 per cent or 40 per cent of the cost. We have maintained ours at 20 per cent this year, so we will start waiting lists. They are the sorts of reactions that some of the councils will have to deal with.

Ms KING—I know that in my local government area—we get people coming to my electorate office—they have definitely reduced HACC services and the hours that are provided to people. They have reassessed everybody on HACC services, so we hear the complaints about that. Has the MAV done an assessment of what each council has done in Victoria in response to the HACC funding? Is that part of your submission to the aged care inquiry?

Ms Hargreaves—Yes. There are a whole variety of responses in terms of prioritising demand and so on. We said to the other inquiry that it is like stretching a piece of elastic. Ten years ago, we would perhaps have thought that two hours a week of home care was appropriate for someone with certain needs, and they would be lucky to be getting about three-quarters of an hour a week now. As a generalisation: the overall council response has been to try and maintain some level of service in reducing the amounts, even if it is only providing a delivered meal. By that process, the person has at least had an assessment and is linked into the system. Councils will make a lot of effort to find other supports also, whether they are from Do Care, the Salvation Army or other organisations. The feeling has been that it is better to maintain some contact. We are well aware of where that leads you, in terms of whether you are providing an appropriate quality or amount of service.

Mr Jose—The other aspect is that in the responsiveness capacity of local governments, some have gotten into the situation where they will not even advertise their services for fear of the demand. We are at the stage where we are only servicing 25 per cent of the eligible HACC population base—and that is to say nothing of people with disabilities accessing that. The more you advertise and gear people up, the more concerns you have. I believe that people taking those sorts of measures is only going to increase.

Ms HALL—So that I can get an understanding of your area, what is your population base?

Mr Jose—Knox is about 150,000. Our aged population is about 11,000 or 12,000 at the moment, but it will double over the next few years.

Ms HALL—Which electorate covers your council?

Mr Jose—In terms of?

Ms HALL—Federal.

Mr Jose—I did not bring them with me. Chris Pearce represents us as our local federal member for Aston.

Ms HALL—You would have two, wouldn't you?

Mr Jose—Yes.

Ms HALL—Do you know the other one, Ms King?

Ms KING—Deakin and Aston would be the two. They are both Liberal held seats.

Mr GEORGANAS—Going back to the funding and whether the burden goes on ratepayers and therefore services are being dropped: what I understood was that they are just being spread more thinly and there are less hours provided et cetera. Are there any services that are dropped altogether and, if so, who picks them up?

Mr Jose—We have returned a service to the Commonwealth—I think it was the national respite for carers service—because we felt that we could no longer afford that as a service.

Mr GEORGANAS—Who took that up?

Mr Jose—It has gone back to the Commonwealth.

CHAIR—I refer you to the document that I just passed to you, the communique that came out of the COAG meeting. The section on page 2 where they talk about the Australian health system says:

Ways in which the health system could be improved include:

- simplifying access to care services for the elderly ...
- helping public patients in hospital waiting for nursing homes
- helping younger people with disabilities ...
- improving the supply, flexibility ... of the health workforce;
- increasing the health system's focus on prevention and health promotion;
- accelerating work on a national electronic health records system;

Can you see a role for local government in Victoria in those functions?

Ms Hargreaves—Without a doubt—obviously in some more than others, where we have direct involvement.

CHAIR—Immunisation is a vital part of primary health care.

Ms Hargreaves—That is right. We would intersect with most of those issues at some point. Certainly the relationship between the acute, the residential and the community based sector is something that we are vitally concerned about and interested in. In Victoria we have had programs around hospital admission risk and the acute sector starting to invest in, especially, the higher numbers of older people that they have coming through their emergency departments and how that could be better handled. We very much wish to work closely on that, because they are often people who already are already known to us through the Home and Community Care program, on the best service mix and support to assist them in the community rather than in the more expensive acute system and so on.

We are involved in working with access for people with disabilities. We are doing some work in terms of the health work force and the work forces generally that affect us. For example, at the

moment we are managing a project at the MAV on the maternal and child health work force because of the difficulties of maternal and child health, particularly with relieving services, in rural Victoria. There would be a number of points at which we would intersect with those issues.

Mr Jose—I would add that we work at a regional and subregional level on a primary care partnership model with hospitals, GPs and community health. One of the things we are working on is electronic recording systems. We are getting one between us, which is obviously more efficient, but also means that residents do not have to give their case history five times over to move around the system.

CHAIR—The communique also says:

COAG agreed that Senior Officials would consider these ways to improve Australia's health care system and report back to it in December 2005 on a plan of action to progress these reforms.

Will local government have a say in that committee of officials? I doubt it.

Ms Hargreaves—Again, without speaking to the ALGA, I think local government is not only a lone voice but does not have the infrastructure. The situation between us and the MAV is probably a good example. We have a very small number of staff and we work directly with the councils.

CHAIR—Could we encourage you to speak to the ALGA, look at the COAG proposals and put a submission to this committee? We want to give the rest of the health sector, apart from the senior officials, the opportunity to have a say in this COAG process and to highlight their areas of concern. If the ALGA, and particularly your organisation, has a specific interest, would you come back to us on that?

Ms Hargreaves—Yes, we can certainly do that with the ALGA.

CHAIR—Thank you very much for appearing before us. We appreciate the time you put into doing your submission and look forward to hearing from you again in the context of COAG.

Proceedings suspended from 12.15 pm to 1.22 pm

SINGER, Dr Andrew Harris, President, Australasian College for Emergency Medicine

CHAIR—Dr Singer, welcome to this public hearing today. We appreciate your coming and we appreciate your submission. Anyone who has been in the emergency department of a hospital realises what a fantastic job you people do. I have been there a few times and I can assure you the experience is a real eye-opener. I would recommend to members of the committee that, if you have a spare Saturday afternoon, you go to your local hospital and see what they have to go through. Our inquiry coincides with COAG's recommendations for reforming the health system. COAG set up a working party consisting of senior bureaucrats from the state and federal spheres. In our inquiry, we would like to supplement what COAG is doing by giving the health industry an opportunity to appear before us and put their views on the public record and thereby have some input into the work of COAG on health reform. Having said that, would you like to make a brief introductory statement before we start on questions?

Dr Singer—Thank you. Probably the easiest thing is to briefly state what I put in our submission. The emergency departments are very much at the interface between the different sources of health funding. Public emergency departments are funded through state governments, but we receive patients either directly from the community or referred to us not only by general practice, which of course is federally funded through Medicare and the aged care sector, but also by community health, which is state funded. Being at that interface, we often get to see some of the problems that occur in relation to funding issues. It also means that efforts to change attendance patterns in various parts of the health sector tend to interact with us and, unfortunately, there is usually an element of cost and/or blame shifting as a result. That is certainly one aspect of our submission.

We spoke about two other aspects in our submission. One was, again, in relation to aged care. There are a number of issues in relation to aged care, particularly longer term aged care, which again is federally funded mainly through aged care residency programs. But often we end up providing either episodic care or providing care because of inadequacies in the aged care system either to cope with an acute problem or because a person is waiting to get into that system and has not been able to access it.

Finally, another issue that we feel is worth raising is the issue of private emergency medicine, which is an area that underwent some initial growth but, frankly, has now stalled and is in decline mainly due to issues relating to how it is funded. Part of it is to do with the Commonwealth Medicare benefits schedule, but part of it is also to do with the reactions of the private health funds. The reality in private emergency medicine is that it is not viable by itself compared to other areas. It relies on fairly hefty copayments to be viable, with a result that there are limitations on people who can or will access it. There are also a number of frustrations on the part of not only members of the public but also practitioners because those copayments do present fairly substantial barriers, which are not being addressed by many of the previous or even recent efforts to address some of those issues in other areas.

ACTING CHAIR (Ms Hall)—Thank you for coming along to address the committee today and to answer some of the questions that we have. I would like to start by concentrating on the area of aged care and the issues that that raises for accident and emergency departments. My

understanding is that a significant proportion of the people that present at accident and emergency departments are people who would fit into that aged care category. Can you tell the committee whether the care that older people who present have been receiving in the community is adequate, whether the skills and knowledge level of the people working in accident and emergency to deal with that older population meets their needs and how we can make the system work better than it does at the moment?

Dr Singer—There are a lot of elements to that question.

ACTING CHAIR—There are.

Dr Singer—Remind me if I miss out anything. The proportion tends to relate to the demographics of the area that an emergency department is in.

ACTING CHAIR—Just on that, would the demographics be higher than the percentage of people?

Dr Singer—Yes. The reality is that emergency care essentially has two peaks: a young peak—middle childhood through to teenage years—and then an elderly peak, which probably goes from about the age of 60 onwards. But the reality is that the majority of young adults and middle-aged people certainly consume less emergency department services than is their proportion in the population. Having said that, the proportion of course is skewed, and it is skewed because elderly patients tend to have problems which often are not easy to sort out or, more difficultly, they have several problems that need to be sorted out simultaneously. They are often long-term problems and some of them are relatively insoluble, including dementia and other chronic illnesses for which we have a limited role in providing episodic care.

The other major issue that we often have to face in relation to these patients is not so much that there is an acute problem that is difficult to sort out but that this acute problem, on top of every other issue that they have—including their own frailty and their ability to remain independent in the community—means that they face a crisis point. The purpose of emergency departments is to provide crisis care, so we often end up having to provide that care even though, compared to other conditions that we treat, it is not absolutely necessary for someone to be in an emergency department. An example would be, say, an elderly widow with dementia having a fall and breaking her wrist. If you or I broke our wrist, often the treatment would be relatively straightforward: the arm would put in a cast and sling and then we go home. For an elderly person, if that happens to be their dominant hand and there is no-one at home caring for them, it means they are unable to cook and care for themselves and often means that these people end up needing to be in hospital as a result even though the actual condition that led them to being in hospital did not mean they needed to stay there. There is that aspect.

With regard to expertise, I think it is fair to say that we are not experts in that we are not specialist geriatricians. We are not general practitioners; we are experts in providing episodic care for acute problems. The other level of expertise that we have is that, in the main, we can sort out what needs to be done relatively quickly and easily. Part of that is due to the way emergency departments are structured. They are structured to provide diagnostic services on a fairly expeditious basis and are essentially able to get to the nub of the problem relatively quickly.

Ms HALL—I will stop you there. It has been argued fairly strongly to me by a specialist that works in that area in the Hunter, Kichu Nair, that it would advantage accident and emergency staff if they were given some extra training in the area of caring for aged people, simply because of the high number that present with those problems.

Dr Singer—I know Kichu quite well. I think that is quite a reasonable suggestion. The reality in medicine is that you cannot be an expert in everything, and one of the things about emergency medicine is that, by its very nature, it is a very broad based thing. Therefore, yes, I think extra training would certainly be useful. I think that often what is required is more the extra backup rather than the extra training itself. Through necessity, most emergency departments now have some system set up by which to get some access into the aged care sector. My day job is Director of Emergency Medicine at the Canberra Hospital. We have what is called a link service, which is essentially a nursing liaison service that allows us to get discharge planning started at the very beginning before we have even made our final decision on admission. It also allows us to work out what community services might be required. It gives us access to respite services, if that is what we need. It gives us access to various other community resources which you may not always be able to get at and which, unfortunately, are not always easily accessible from general practice, partly because a lot of this is state funded rather than federally funded and it is not necessarily easy for the two sectors to interact at that level all the time.

Ms KING—Can you clarify that? Why is that?

Dr Singer—There is no bottomless pit; therefore just about every service has to have a gatekeeper involved. As a rule, most of the aged care services would usually have a couple of different levels of gatekeeping. In terms of federal funding, that is based on the central registration process that occurs when someone is classed as an aged care client. In terms of state based services like community nursing, usually these services tend to be accessed through hospital based services. The reality is that there has been a continual decline, apart from emergency department services, in hospital outpatient services. For example, to get a so-called ACAP assessment usually takes several weeks and is entirely dependent on what is available through the hospital.

Ms HALL—Are you saying that the interface between the emergency department and community services and the relationship between the state and Commonwealth are not working so well?

Dr Singer—They do not always work. As I said, there are times when I am sure some general practitioners would prefer if they could access some of these community services directly. It varies between areas, but certainly the reality, say, within the ACT—and certainly in the areas in New South Wales surrounding us—is that it is often difficult for them to do that without the hospital being involved in the first place. In the main, that often falls to us because we are the front door.

Ms HALL—Given the role you play and the fact that you are the interface with the community, in many cases you are the interface between the patient and their GP and you are the interface for residential care facilities when patients are admitted, what general strategies can you put in place to deal with that?

Dr Singer—There are different ways that that could be addressed. One is that the hospital's aged care service beefs itself up to be able to provide something more akin to episodic care. For example, a couple of initiatives have started in terms of training nurse practitioners to provide an outreach role, possibly with the ability to provide some level of crisis management. As I said, a lot of the time the problems themselves are not complex; it is more the combination and the fact that they have occurred at a time when it is difficult to be able to access other services. Another way it has been dealt with, for example, has been at the Gold Coast Hospital, which ended up developing a service they called a 'hospital in the nursing home', where essentially the emergency department provided the outreach service because they found that nursing homes were finding it increasingly difficult to access general practice services or aged care services particularly outside of business hours. By being able to intervene at an early stage, before the patient had left the nursing home or the aged care facility, the patient did not end up having to come to the emergency department and taking up space and resources that are often very much at a premium.

ACTING CHAIR (Ms Hall)—Some of these issues that you have raised come across the boundaries of the cost-shifting issue that we are looking at very strongly. Who pays for it—the Commonwealth or the state? Then you add to that the fact that many people whom you see in accident and emergency wards, even the woman with a broken arm, end up in acute care beds. The dilemma is: is this the kind of patient who should be in a hospital? What sort of solutions have you for us?

Dr Singer—I think part of the issue is accountability. At the moment what we tend to see at the ground level is that often it is easy to say that a particular issue is a state or a federal responsibility without necessarily addressing it. It is not necessarily the case that we have the solutions, but at the moment it is a bit too easy at times to say that it is someone else's problem. For example, the ability for community nursing services to interact with general practice is hampered because of the different funding sources.

It is not necessarily a panacea to have a single funder, because the system is complex anyway and it is still going to be as complex whether you have a single funder or the devolved system that we have at the moment. But it does mean that, when you are evaluating different ways of dealing with it, it would be a bit easier to say, 'We currently pay this amount of money for this service when in fact it may be better provided by spending the money in this area instead,' without having to say, 'This is currently a federal program and this is a state program.' It is almost impossible to be able to shift funds or resources from one area to another. The problem we see is not so much that there is no flexibility but that it is very difficult to progress when that progress tends to be incremental whereas at times it needs to be more radical.

ACTING CHAIR—The AMA's submission to the committee suggested a system whereby if an aged person is using an acute bed in a hospital then that should be paid for in the same way as they would be in the community. In a way that is similar to the system in the UK of retribution, where if a provider cannot offer the service immediately then it has to be paid for. Do you think that is an answer?

Dr Singer—It may be. The only way those kinds of systems tend to work is when the result is that there is a financial incentive for the right sector to get its act together. Certainly there could be an argument for it in my hospital at the moment where, for example, out of 450 beds there are

probably somewhere between 30 and 50 beds taken up by people waiting for an aged care place. There needs to be a way to encourage those people to get out into the aged care sector. At the moment you are right: it is easier to say that the hospital gets the federal component of their funding while they are there. But there is still probably not quite enough incentive for those people to get out. And, yes, often the only way to do that is if there is a financial penalty if you are not able to provide the service for them in the right place. I think it would be helpful in providing an incentive to try to develop more aged care places, because we need them now, not in 20 years time when all the baby boomers are going to be at the right age.

Mr GEORGANAS—You spoke earlier about the woman with the broken wrist as an example. What would be the average stay in hospital for a person like that?

Dr Singer—That was a theoretical scenario.

Mr GEORGANAS—In your hospital, for example, where you might know the figures.

Dr Singer—Assuming that it is a relatively straightforward problem and if, say, the problem is placement, so to speak, then it depends. What it depends on is the level of care that the person needs. If the person only needs to move from their home to a hostel, where essentially they live relatively independently but have their meals done for them and have some nursing services available, that can often be a relatively short stay—a few days. If it is a more extreme situation—say they fall and break their hip instead and so effectively become immobile as a result—then it can take weeks or months and is often dependent on whether the family will accept the care that is being offered. For example, in our hospital we have social workers and nurses whose task it is to essentially find nursing-home placements for patients. At any one stage the family have the right to refuse what is being offered to them. There are a couple of infamous cases within the hospital where there have been several rejections with the result that that person is stuck, taking up an acute care bed—certainly in our view unnecessarily.

Mr GEORGANAS—I have heard stories around Australia that people casually present themselves to a hospital when they cannot find an aged care bed. Are you finding that in your hospital?

Dr Singer—Yes. I am sure that that occurs in every hospital. It has certainly been the case in every hospital that I have ever worked in, and I have worked in about 20 in my time. Yes, that is often the case and that may be due to a combination of factors. It can be due to the fact that it has been identified that this person needs to go to the next level of care but it is unavailable or they are waiting for their ACAT assessment, which has to take place before they get into the federal system. It may be because it is an acute crisis and, even though the crisis itself is relatively minor, that combined with the other problems means that the only way they can access the system is through the emergency department. Please don't get me wrong; I am not saying that we do not want to look after these people. But if the system were working the best way it could—and there are times when we are even able to do this—we could deal with the acute crisis and get someone into respite care or into a system where they get an enhanced level of community care to tide them over. Often that can prevent them from having a hospital admission.

The reality is that once you are admitted to hospital it is very difficult to get anything done as quickly as it could be done through the community or even in the emergency department. A lot of emergency departments, including my own, now have short-stay units, which have the function effectively of reducing length of stay. Because we are geared up to do things quickly and 24 hours a day, we are in a better position for short-term things to get people in, get them sorted out and get them out. If you end up in a hospital bed, the reality is that a lot of the senior medical staff in hospitals only work part time at any particular site and therefore you have to fit in with schedules, you have to fit in with ward rounds et cetera. The advantage we have with our short-stay wards is that we have someone on site 24 hours a day to sort that kind of stuff out and, as a result, we are able to do it more quickly. For example, we have a policy in our department of never sending an elderly patient home after about 9 pm, regardless of the problem, because the risks tend to be too high. We often do not know exactly what their situation is going to be and it is often easier to sort it out in daylight hours rather than trying to do it in the middle of the night. If they get admitted to hospital, it is probably two days before they get home.

Ms KING—How are your short-stay units funded?

Dr Singer—They are funded in the same way as any other public admission, so essentially they are funded through the state system. I believe there are some departments that are able to use things such as workers compensation or the motor vehicle third party system for appropriate conditions. There may even be some emergency departments that are able to set things up to take advantage of private insurance in the way that you can do with any other admission to a public hospital. In the main, the unit in my hospital functions essentially as an extension of the emergency department and therefore an extension of public admission.

Ms KING—So you have your emergency department bucket and this is funded as an admission?

Dr Singer—That is correct.

Ms KING—But as a short stay?

Dr Singer—That is right. For example, to develop the initiative in my hospital we received an extra several hundred thousand dollars, which was mainly related to the extra nursing staff that were required, plus there were some set-up costs: you have got to have space and you have got to set the systems up in order to do the work, which we did not really have.

Ms KING—So how many hospitals have got short-stay units like yours?

Dr Singer—I think you would find that virtually every teaching hospital would now have one. Most of the larger community hospitals do. There is not a lot happening in regional areas yet. That is partly because they have less of a need for such a unit. Also the other the big driver for emergency departments to do this is the issue of a lack of access, of being unable to get patients into in-patient beds. This is a way to provide that care in a way that gets them out quickly enough so that they do not need the in-patient beds in the first place.

Ms KING—We have focused quite a lot on the interface between aged care and the emergency department. I want to ask you to explore the interaction between emergency

departments and GP services—or lack of—particularly GP after-hours services. Have you got any comments to make about that that?

Dr Singer—How long do you have? It is a difficult issue for a number of reasons. Certainly the college and emergency medicine people in general have the strong view that after-hours general practice needs to be supported and that these services need to be available. The reality, though, is that there have been changes to Medicare over the years. I know that there have been some improvements in recent months, though probably they do not quite go far enough to encourage general practitioners to provide after-hours services. But the reality is that the changes in work practices for general practice have already occurred and are probably unlikely to return.

Ms KING—So the horse has bolted?

Dr Singer—Exactly. Obviously that means that emergency departments are often the only places in a position to provide that. The reality is that we have several advantages over general practice in providing some of that care anyway. Most people presenting after hours are presenting because of some kind of acute crisis. They are rarely presenting for routine general practice type care. They say, 'Have I got a broken bone?' or 'I've got vomiting and diarrhoea—give me something to fix it' or 'Am I dying?' or whatever. We are certainly already better set up for that area anyway. There has been a lot of talk in the past—fortunately not so much recently—about these patients being a burden on emergency departments, particularly those patients who you could argue would fit into our lower categories. I do not know if you understand that a five-category priority system is used in emergency departments.

Ms KING—Yes, I do.

Dr Singer—Traditionally categories 4 and 5, which are the lower priorities, have often been classed as general practice patients. The reality is that is not the case. There is no doubt that a subset of those patients are patients that could be seen in general practice if the service were available. The reality is that a large number of the patients are in fact referred to us by general practice anyway for various reasons. As for the solutions, the marginal cost of providing services to these people is actually relatively small. If we take away the staff costs—and the reality is that a proportion of your staff costs has to be counted because some of your staffing is there to service such people; if they were not there you would not require the staff—we are probably talking about a marginal cost of maybe $30 maximum per patient. My department sees 50,000 patients a year. I have a budget of $12 million to $13 million. Of my 50,000 patients, we are probably talking about 7,000 of them. So the marginal cost is pretty low.

Ms KING—Have you seen an increase in category 4 and 5, a subset of whom may be GP patients?

Dr Singer—It is a variable feast; in some places we have seen reductions and in other places we have seen increases.

Ms KING—Is there any correlation with GP availability, bulk-billing rates, affordability or access?

Dr Singer—I cannot tell you about bulk-billing rates because I do not know the geographical distribution of that. I think it is fair to say, though, that in outer urban and regional areas, where there is a shortage of general practice availability, it is definitely the case that more people attend emergency departments. Solutions such as co-located after-hours general practice have been suggested. Unfortunately the report has not come yet, although it should come soon. There are a number of trials in different areas. There are trials in the Hunter, in Canterbury in Sydney, in Melbourne and in Brisbane. The main problem is that most of them are relatively inefficient, in that you are talking about maybe one or two patients an hour for most of these places. While the marginal cost for an emergency department is relatively small, the cost to set up something specifically for that purpose becomes difficult. Mind you, the solutions have often been attractive to state governments on the basis that they provide the infrastructure, which they can do relatively cheaply. The ongoing funding is federal; it is all funded through Medicare. It is obviously cheaper to do that than to employ someone to provide the same service within an emergency department. If there were not that state-federal interface, I believe a lot of those services would be seen for what they are, and the trials probably would never have got very far.

Ms KING—I cannot remember your exact words, but in your opening statement you said something along the lines that private health funds were fairly recalcitrant in relation to private emergency departments. Can you expand on that?

Dr Singer—Essentially, the way that private emergency medicine is funded at the moment is that, as a rule, if you see a doctor in a private emergency department you will be billed the appropriate CMBS item for that consultation. There are issues with that, in that there are three different levels and it depends on whom you see. You will often be charged a facility fee, which is variable, depending on the department, but is anything from $70 to $150, depending on where you go. In the main, that amount is not refundable under any circumstance. The private health funds view their role in private hospitals as relating purely to private hospital admissions, the result being that they are not interested in funding outpatient work, which they regard as essentially the province of Medicare. In some places it is funded. I believe that DVA fund it for their cardholders. That obviously helps one part of the aged care sector, although the reality is that the veteran sector is going to shrink.

The reality is that there is a large copayment. That does not necessarily stop people from attending emergency departments, but it means that we have gone from having probably 25 to 30 private emergency departments in Australia five years ago to having about that half number and there are virtually no new departments opening. Most of the departments that do run usually do it out of another motivation. Sometimes they work as lost leaders in that they bring in admissions, particularly occupying beds during downtime—for example, weekends. A number of private emergency departments operate because of the community or charitable focus an organisation might have. It certainly tends to be the case that a lot of the ones that are still running are those that are run by religious orders or have a strong community focus rather than a more entrepreneurial one. That in itself is a major issue.

Part of the problem is that the decision that was made in relation to the Commonwealth MBS funding for private emergency medicine was that, essentially, it would parallel what is already provided in the general practice streams. There are some anomalies though. For example, if you have vocational registration, as a general practitioner, except for the two highest categories of consultation, you earn more than an emergency specialist.

ACTING CHAIR—I should apologise for the confusion that is going on.

Dr Singer—That is okay.

ACTING CHAIR—We have had an issue that we have had to deal with. That is why people are running in and out all the time. I apologise. It is not that we are not interested.

Dr Singer—That is fine. You called me; I did not ask to be here.

ACTING CHAIR—I know the chair will be particularly interested in the issues you have raised around accessing private sector emergency care. That was one thing that he particularly wanted to raise. You touched on the fact that the system is failing to be patient focused. That may mean that, instead of the system delivering the best service to the patient, the patient is being required to fit in with the system. Would you like to comment on that?

Dr Singer—That was at the end of my submission, wasn't it?

ACTING CHAIR—Yes.

Dr Singer—A part of that is that, at the moment, the system that we work under is, in the main, determined by providers rather than by consumers. It is a reality that, to a certain extent, that has to be the case, particularly in relation to emergency care, because the attitude that most people have around emergency departments is, 'They are nice to watch on TV, but I don't ever want to be there.' Therefore, as we are only providing episodic care as a rule, most people only, if ever, get to consume our services on an occasional basis. And it is usually at a time of crisis and they are usually not particularly interested outside of that.

Across the issues of funding, often the services that are provided are based on where the pot of money is coming from rather than what is necessarily in the best interests of the patient. For example, some of these hospital outreach services are provided because, firstly, there is a need there and, secondly, we think we can save money by providing it out there rather than having to provide it in the hospital. On the other hand, there are a number of services which we have to provide in an emergency department because, even though there is a need there, there is not necessarily the interest to provide the service in the community, whether it be through general practice or another area. That was essentially the gist of what we were trying to say. Again, it is difficult to get around that issue. As I said, changing the funding does not necessarily fix that part of the problem because the reality is that the system is driven by how it is funded and where the funding goes.

It just seems to us working on the interface that if there were ways to streamline the funding so there was less of a division then it would be easier to say, 'This service needs to be done; we can fund it through this mechanism,' rather than 'That means we need to give an extra 0.2 per cent to the states to do it through a hospital,' or, alternatively, 'We need to add an extra 0.3 per cent into Medicare for GPs to provide it' or whatever. It is probably being a bit simplistic and naive in some ways, but you are here to consider health funding issues and we believe that that is an important issue.

ACTING CHAIR—My final question is: what message would you like us to take away? What is the strongest message you would like to give us as a committee for this inquiry?

Dr Singer—The strongest message that we would like to give you is that the current system of health funding is, we believe, very inefficient and there must be a better way to do it. We do not necessarily say that there is a right answer. I think most of us in emergency medicine would think that the deletion of the division between state and federal funding would probably work to a certain extent in our favour, but we are not saying that that is the whole solution and we fully understand the political difficulties in being able to do that.

ACTING CHAIR—As there are no more questions, thank you very much for your time. The evidence you have given us is very useful. Thank you.

Dr Singer—Thank you for having me.

[2.13 pm]

MOODIE, Professor Alan Rob, Chief Executive Officer, Victorian Health Promotion Foundation, VicHealth

SHEEHAN, Ms Caroline, Acting Director, Health Promotion Innovation, Victorian Health Promotion Foundation, VicHealth

ACTING CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament and giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Do you wish to make a brief introductory statement before we proceed to questions?

Prof. Moodie—Yes, I would love to, thank you very much. I will start with a little bit about VicHealth and health promotion and then talk about some of the key points that we think are relevant to the inquiry. The Health Promotion Foundation is a statutory organisation in Victoria established under the state Tobacco Act 1987. It was the first organisation anywhere in the world established by government legislation to use a hypothecated tax on tobacco to promote health through partnerships with sports, arts, cultural bodies and the funding of innovative public health research—and, at that stage, buying out of tobacco sponsorship in sports and the arts. This model has been copied in other states of Australia and internationally—in Switzerland, Thailand and Austria, and it is now being developed in another six countries.

We fund over 1,000 projects a year. We have an annual budget of about $29 million. Our major areas of work are tobacco control, mental health promotion, physical activity, healthy eating and reducing health inequalities. We fund programs such as Quit, SunSmart, the Walking School Bus, Good Sports and Leading the Way. About 30 per cent of our funding has to go, by virtue of our legislation, through to state sporting bodies, so we fund 50 state sporting associations, nine regional sports assemblies, a number of key public health research centres of excellence and over 50 research fellows and scholars.

I want to say a little bit about health promotion. This may not feature greatly in your discussions—and that was one of the reasons why we wanted to be here. It can be a rather fuzzy concept and I want to see if I can explain it—and use as an example where we have come with tobacco. We see health promotion as being actions that change the social, the economic, the cultural and the physical environments so that they improve people's health. If you take the example of tobacco, what we have done so successfully over the last few years are changing the social value of smoking, changing the culture of it, increasing the cost of cigarettes, for example, and regulating against smoking in public places. So the big picture is about changing environments in which people live but also about strengthening the understanding and the skills of individuals in ways that they can improve their health. In this case, it is the quitting skills or how you maintain quitting and those sorts of things. So it is knowing about what to do and being able to do it.

This seems to overlap very much with primary prevention—examples of which might be immunising against communicable diseases and injury prevention. That in turn overlaps with

secondary prevention, which is treating people who have elevated risk factors or who have a disease—for example, treating people with hypertension. I am sure when people have talked about prevention in your discussions they have mostly been clinicians. They would be talking much more about what we would consider secondary prevention—in other words, people have a disease and it is how you manage or treat that more effectively to prevent further complications, which is obviously a very important part of the health care system. But we are trying to talk more about things that we would call 'up stream', so we are in a sense saying that prevention is better than cure.

We need cures but we think we need prevention as well. There are some great examples of this. In Australia in the fifties 75 per cent of men smoked. Last year, the adult rate in Victoria was 16.6 per cent. In 2002, we saw the lowest levels ever in the number of 12- to 15-year-old boys and girls smoking. In 1988, because of that 30 years of work, over 17,000 premature deaths were averted and the estimated total benefits alone in that year were $12.3 billion, made up of lower health care costs, improved status gains and longevity gains of $9.6 billion. That is using a very conservative assumption that public health programs contributed only 10 per cent to the decline in tobacco consumption. I am not sure where the other 90 per cent came from, but it has still been a remarkably successful and very cost-effective intervention.

One of the best examples of good health promotion of public health in our state is in relation to road trauma. In 1971, 1,061 people died on Victorian roads. There are now 700 fewer deaths and 6,000 fewer major injuries every year. In fact, the estimated benefits in terms of reductions in payments have completely outweighed the cost of running the programs in the first place. So here you have a group who is paying for the costs of treatment, paying for the costs of long-term rehabilitation and investing very heavily in prevention because it reduces the bottom line for them. So it makes a lot of economic sense. Obviously another very good example is skin cancer. We have completely changed the culture around the notion of the bronzed Aussie. In 10 years there has been a 60 per cent reduction in sunburn levels in Victoria. The malignant melanoma rate in men and women is plateauing for the first time.

So we think there are tremendous opportunities to improve our work in public health and in health promotion. That is why we are so interested in your inquiry and how the Commonwealth can take a leading role in improving the efficient and effective delivery of high-quality health care. We think that is also about prevention and promotion; it is not just about what happens to people when they go to the general practitioner's office or the hospital.

We hope that the inquiry will focus on the promotion of good health and the prevention of the onset of a range of preventible illnesses. We think the current health care system limits its focus to treating illness and disease and is not in tune with the additional benefits to the health, wellbeing and bottom line of the economy that we think are achievable with a stronger health promotion focus.

Our view at the moment is that the current system focuses on being the ambulance at the bottom of the cliff. We think that far more attention should be paid to reducing loss of life and suffering and to the better use of our economic investments by trying to be much more the fence at the top of the cliff. Obviously, we are not talking about a complete alteration in investments patterns, but we think that at the moment we are not optimising our investments in health and getting the best bang for our health buck. In many ways, we have to satisfy the greater popular

demand for treatment, but that may not be the best way of producing the best health investments. Too few resources are going into population-wide approaches to prevention and too many resources, for example, are going into pharmaceuticals and medical diagnostics.

A good example of where money is going to the wrong intervention is that of physicians who don gloves and masks and follow universal precautions to protect themselves against HIV and other diseases at a cost of something like $2.4 million per life year saved, yet the same physicians often fail to take the time to advise their patients to stop smoking, which is an intervention that, even taking into account poor compliance, only costs about $6,000 per life year saved. Another example is that, in Australia in 2001, we spent about $80 million on Zyban—an anti-anxiety ancillary drug used to help people to quit smoking—and only 20 per cent of people prescribed that drug were reported to have finished their course. Why didn't we spend $10 million on a national tobacco campaign, which we know would have produced 200,000 quitters and averted a thousand deaths? I do not know where the evidence came from to say that we should spend $80 million here but not spend $10 million there, even though we know—and this was the department's evidence—that the latter would be a better intervention.

We know globally—from OECD countries in general, including the US and Australia—that preventable behavioural factors constitute something like 40 to 50 per cent of the causes of premature deaths, but we allocate about thee per cent of our total health expenditure to organised public health and private prevention programs. There are a number of very cost-effective health promotion and public health programs. Savings range from $2 to $9 for every dollar invested. This evidence comes from the Centres for Disease Control in the US. Again, we would advocate that this be included in our look at the health care system, if for no other reason than to optimise our investment in health—that we get a better bang for our health dollar, as I mentioned before.

To finish—thank you very much for your patience—I make one last point. We think certainly that the involvement of the private health sector in the promotion of good health and the prevention of illness and disease—this is the experience in the US—at a community level would be really worth considering, as it seems to be much poorer here than in the US, for example, where Blue Cross and others get involved in local community prevention programs. We would very much welcome the HBAs, the Medibank Privates and others being very much involved in prevention and promotion as well.

ACTING CHAIR—Ms Sheehan, would you like to add anything?

Ms Sheehan—Not at this point, thank you.

ACTING CHAIR—I will start with a couple of questions. Firstly, the COAG meeting in June discussed ways in which the health system could be improved, including increasing the focus on preventative health promotions. Would you like to comment on that?

Prof. Moodie—I was really pleased to see that. Again, regarding interpretation, what is 'prevention'? You may see that prevention is interpreted, in a sense, to be early intervention and prevention in a clinical sense. I am completely supportive of that—it is all part of a spectrum, if you like. But we are convinced that we also need to be doing these prevention programs in the community. There is the whole issue of obesity, for example. We might hang around for an obesity pill but, frankly, we are not going to be able to deal with it unless we can deal with the

economics of it, unless we can deal with the environmental issues around helping people to be more active and to reintegrate exercise into their lives and unless we can change nutrition patterns. It has to happen at a population level; I do not think it will happen by a pill.

ACTING CHAIR—When you are developing your programs, what sort of research goes into the development of those programs? Do you test their effectiveness before they are launched?

Prof. Moodie—Sometimes we do. In a sense, with tobacco, over 30 years that has been a progressive trial and error. The banning of tobacco advertising did not have an evidence base to it. It had a very strong rationale to it, but it had not been tried. In many ways we have to do both: use small pilot programs and look at the effectiveness of those, and sometimes doing and then learning. What I think is very important in all of these really successful health promotion and public health programs is that we have developed a very good capacity for monitoring, surveillance, evaluation and operational research. I know that, for you as decision makers, unless we have been able to say, 'This is the evidence about what works,' or 'This is where we are,' then it does not matter how good the idea is, it generally loses political support after a while if you do not have the evidence.

ACTING CHAIR—What about programs that are designed to address issues in certain communities—disadvantaged communities, Indigenous communities? Some of those communities and groups have the worst health outcomes and it is probably harder to change their behaviours and environments. What sorts of strategies do you have in place to address those issues?

Prof. Moodie—One of our major concerns is health inequality: (a) to know about it and (b) to then do something about it. There are several approaches. On the one hand—and this has happened to a certain extent with tobacco—if you drop the population levels then you also drop the levels within those of those who are not doing very well. On the other hand, sometimes that can increase the gap rather than decrease it. There is a general feeling that you have to, in a sense, work with the population as a whole as well as with groups at risk. But that means you also need to have programs or investments with people, whether it be Indigenous people or people recently arrived in Australia—they are the ones who we are particularly working with—or that are place based. It might be where they live. In general, the inverse care law applies: those who have more get more and those who have less get less. In terms of the amenity provision, in places that have less, they have less recreational facilities, they have less footpaths, and healthy food is more expensive in poorer areas. So you have a whole lot of rather strange paradoxes where in many ways it is a bit harder to be healthier in terms of adopting behavioural change because of the environment in which you are living. So I think interventions have to be place based and they also have to be within the population and by the population that you are dealing with. That is why we try to balance our investments at the population level as a whole, as well as groups at risk or groups with a higher disadvantage.

ACTING CHAIR—In your submission, and also in your evidence here, you have stated that there is more scope for private health providers to be involved. Are there any private health providers who are active in this area? If there are, can you outline the kinds of activities they undertake? And could the Commonwealth government do more to encourage private health providers to engage in health promotion activities?

Prof. Moodie—I think we were stimulated by colleagues in the US who were working through BlueCross and BlueShield and by how much they were involved in local community based health promotion. We have not seen, in my experience, a great deal of it here.

ACTING CHAIR—There is one in Wollongong, I think.

Prof. Moodie—Yes—there are some local ones. But in the sense of them being involved in the population health debate as well as the rebate debate, if I can call it that, it would be very valuable. I know the government is looking for public-private partnerships. But for these partnerships to be effective, in some ways they have got to be able to see it affect their bottom line. So you might not talk about it just from a notion of corporate social responsibility but rather ask, 'How can we look at it from a point where it actually helps them?' That would be like the Transport Accident Commission here—they pay for all the advertising and prevention of injury because it is fundamentally in their bottom line interest. That is a much more closed system; it is much easier for them to do that. But some encouragement from the government to the private health insurers would be a great sign for the rest of the community.

Ms KING—An example of that in my community is that MBF have set up the Positive Choices program. In essence, whilst it is a suicide prevention mental health program using elite sportspeople, it also seems to be a way of recruiting members to sign up with them. Can you give us examples from BlueCross in the US? Are they like that or are they totally removed from getting people to sign up in that way? Obviously it is a completely different system—are they more community focused?

Ms Sheehan—I can answer part of that question, having spoken with our colleague from BlueCross in the States. She was saying that the organisation has two arms. There is certainly one arm of the organisation which is set up as a foundation that provides a range of grants and programs which are not about getting more people in to take out insurance with that organisation. But all those programs that they support have a very strong health promotion focus. They do all sorts of things, from funding localised community groups and participating in activities to promoting fun runs, fun walks and all sorts of things to help people be active and to live a healthier life. So they have one whole arm of their organisation that does that. She was also telling us that that is not uncommon amongst those sorts of organisations in the States.

There is also a part within the organisation that also uses some of their funding for corporate sponsorship, and there is some branding associated with that. But they tend to brand a whole range of healthy activities. So, even if people do not ultimately sign up, they are still supporting a whole range of community based opportunities for people to get along, get involved, participate, lead a healthy lifestyle, and learn more about looking after themselves and their health. She was saying to us that they work with local communities to try to effect change in them—designs of parklands and such things were the examples she gave us. So they seem to be really proactive in how they work in their geographic area.

Prof. Moodie—Which in turn, I think, would enhance their brand. It is not an obvious link.

Mr GEORGANAS—In the last budget—the 2005-06 budget—there were some health initiatives outlined by the federal government. You may be aware of most of them. There was money for the National Illicit Drugs campaign and the anti-smoking campaign. There was $4

million towards the early detection of breast cancer and funding for the Bowel Cancer Screening Program and a whole range of other things. Would you like to comment on this allocated funding and any perceived shortfalls that you see in it?

Prof. Moodie—Again, I am not an expert in this area, but certainly my quick appraisal of it is that, whilst that is welcome, the investment going into that part of the system is around the three per cent area. I again come back to this: I know what the demands on the politicians are. They are: 'I want my treatment now' and 'I want my ambulance when I get sick' but 'I'm not particularly concerned about preventing something that is going to happen to me in 30 years.' There is no waiting list for prevention—we know that. But, on the other hand, there is the example I just quoted of Zyban and the amount that we are spending on pharmaceuticals and the return that we are getting compared to more cost-effective investments in different population health or health promotion projects. That is where I would put my money.

Mr GEORGANAS—So you would say that there could be better ways of allocating money towards preventative health than the way we are currently doing it.

Prof. Moodie—Yes. In most health departments the population health division or the public health division is a small group off to the side. They may or may not even have someone in the departmental executive. They do not necessarily get the issues up through the expenditure review committee or whatever it is. In many ways, if you look at the way that drugs are—

Ms KING—As an aside to that, are there any countries that you think have got the balance right? Is the UK doing any better than us in its focus on this?

Prof. Moodie—The UK have led the way in the last few years, and the reason they have done that is that their treasurer, Gordon Brown, has taken this very seriously. He has said, 'Look at the data and tell me what is going to happen in 30 years if we just leave things as the status quo,' and he has got a guy called Derek Wanless, who is a leading economist and businessman—not a health person, which I thought was great—to actually do the sums. They said that unless we start investing in health promotion and prevention higher up the stream, if you like—or being the fence at the top of the cliff—we are just not going to be able to afford the bills 30 years down the track. As much as I would argue we should do this because we will get a better health outcome and we will reduce suffering, I think the primary driver will probably be economic. But they seem to be doing it better than most. Also, Switzerland is just introducing a prevention bill and the Germans are doing the same. So I think the Europeans are really starting to lead in this area—again, it is probably driven by economics as much as anything else.

Mr GEORGANAS—I suppose what you are saying is that you believe that the way we currently invest in medical technologies and medicines and the way we are going is unsustainable. In what ways? Why do you believe that?

Prof. Moodie—Why do I believe that? It is because it is what the Treasurer says, as much as anything else. Our pharmaceutical budget has been going up 12½ per cent per year over the last three years. It has added an extra billion dollars to our overall budget—but, I would ask, for what health outcomes? Again, it may be satisfying a need. Is that a need of patients, or is it a need of doctors who are prescribing this on the basis of fashion rather than science? I have been a

general practitioner and I know very well the activities of the pharmaceutical companies and the medical technology companies.

We also have to look at the fact that you cannot make money out of public health. It is very hard to make money, so there is no-one behind it, but pharmaceuticals and medical technologies are important businesses. We know very well from the US experience that companies will try to keep their drugs on the list for as long as possible before the generics come in so they can maximise their profits. That is fine, but we have to realise that maybe that is not the best investment of our taxpayer dollar.

Ms KING—What is actually happening in spending in this area from a state and territory point of view and in the Commonwealth? It looks as though the Commonwealth's spending has gone up, but I guess it depends on what you count. I run on an assumption that the states and territories have increased spending but I have no idea. What has happened over the last decade?

Prof. Moodie—It is chronically hard to tell what is counted and what is not counted, but I do not think that the spending has gone up in our state. It was interesting, in the last state budget here, that the only element of the whole budget to go down was public health. Everything else went up. In many ways, public health may not be seen to be direct service provision and health promotion is not seen as direct service provision. Then, when pressure is applied, we as a community apply it as 'We want more services and we want them now.' I really do acknowledge the very difficult nature of this in the political sense but, again, I would always come back to the question: 'Are we really looking at it from the point of view of are we maximising our investments?'

Ms KING—One of the comments that we heard today and started to talk about was that we have seen general practitioners get more involved in not population health but certainly some of the primary prevention and at the same time we have seen, to some extent, the role of community health centres that did have that population base decline into far more of a clinical service provision model, and that is what they are funded for. One of the comments we heard from the Rural Doctors Association was that community health centres are pretty much defunct and that their role should just go to divisions. I obviously had some problems with that. There seems to me to be a general sense that, as we have moved more towards services provision of primary prevention, that broader population stuff has started to disappear or it has lost some of its power. Can you comment on that?

Prof. Moodie—I would agree; I think you are right and I think it is going to be increasingly hard to get this on the agenda—paradoxically. You would think it would be easier, given the pressure on limited resources and that collectively we started to look around for the best investments. But we as individuals and as voters probably act differently, and that is often where the pressure is. I think it makes it harder, but that is why, in a sense, we need government to be able to say, 'We need to slightly differentiate need from want and we need to provide services that give us a better outcome.'

Ms Sheehan—Our experience of a range of those community health centres is that some of them do some fantastic work on the ground in local communities around upstream health promotion and promoting health in their communities. But, with their budgets getting tighter and more demands on their services, because that is not seen as a health service it often gets cut early

on. Even at the grassroots level we know from groups we work with that they would love to do more population based health promotion. They have got some fantastic ideas but, again, they are under the squeeze. So that is the first thing they are pressured to drop off their list of activities and outputs.

Prof. Moodie—A good initiative here has been the primary care partnerships over the last few years, bringing together all those groups that can work on these population health issues collectively. It is terribly hard for the Minister for Health in Victoria to try and encourage small communities to say that maybe they do not need an operating theatre that is funded to operate all year round and yet maybe only operates 10 per cent of the time when that funding could be much better invested at a community health level, where you are preventing diabetes, preventing the complications from it and keeping people out of hospital. It is a really tough ask, but I think we just have to get clever at doing it.

Ms KING—In terms of opportunities in public health, it seems to me that we have had some fantastic wins. When you look at the history of public health, such as SIDS, you see that there are some really large things we have been able to do on a population health basis. Do you think we have exhausted the possibilities and we are now looking mostly at behaviour change, which is the hardest stuff to do, to evaluate and to prove to be working, or do you reckon there is other stuff out there?

Prof. Moodie—Again, I would see those as overlapping anyway. But even if, for example, you said you would invest just in tobacco control, having invested in that much more heavily and got prevalence down to 10 per cent, it would be saving a lot of lives and saving a lot of health care. We know that by getting people to quit not only do they live for longer but also they die quicker. In other words, they are sicker for a much shorter time. That is just one simple case.

In terms of mental health, the biggest issues for the future in Australia are around depression and anxiety—mental ill-health, if you like—and physical inactivity and poor nutrition. I do not think they are going to be solved by pills—even if we want more people on antidepressants. Frankly, I do not think we want 20 per cent of the population on antidepressants. We have to do something about the bullying in schools and in our workplaces which causes the depression in the first place.

The other irony—or it is a paradox, I guess—is that we are presenting to you the fact that it is budgets outside the health care budget which need to be brought into this as well. Whether they are around physical activity or whether they are around mental illness these are whole-of-government approaches that have to work. We have to be smarter in working out what promotes good mental health and physical activity. We are now working on the science of participation. For a long time we have thought that you are either good at getting people to play for your club or you are not good at it. We think there has to be a science about how you get people to participate, how you encourage them and keep them there and particularly how you get the people who are the most disadvantaged involved.

Mr GEORGANAS—You have mentioned Zyban a couple of times. Could you elaborate on how it works in terms of funding? Is it a preventative measure?

Prof. Moodie—It is like nicotine replacement therapy. It is a relatively effective aid for helping people quit. It is an anxiolytic antidepressant so it is useful. But the point of why I raised it is that it got the nod for $80 million to be spent on it because it had gone through the Pharmaceutical Benefits Advisory Committee, which is where the money stream is. In other words, the money flow for pharmaceuticals is much, much bigger than the money flow for public health. That is why they were not looking at what they could do with that $80 million in a national tobacco campaign—a broad public health campaign. That is my point: often we are not comparing the right things. Because we have got the finance system structured in this particular way we are not looking at these other opportunities.

ACTING CHAIR—Given the terms of reference for this inquiry and the fact that we are looking at the division between state and Commonwealth, do you think that one level of government should take a greater responsibility? Do you see a particular lead role for the Commonwealth in this area? I would be very interested in your comments on that.

Prof. Moodie—I definitely do. I have worked at the state level here with the department of health, as it was, on HIV—that is a good example from the late eighties. In every state we all did better because of the Commonwealth leadership, and that continued across governments, whether they were Labor or coalition—it did not matter. I would always welcome national leadership. Federal systems work better—when you get a national policy where states can reinforce each others' work, learn from each other and share with the Commonwealth. In these areas of public health this is always really welcome. Again, the work that has been done on tobacco, for example, has always been enhanced by virtue of having a national approach to it. I was really pleased to see yesterday the announcement of a national sexual health strategy and the fact that there will be a screening and education campaign for chlamydia. That is wonderful news.

ACTING CHAIR—Do you see a role for both levels of government?

Prof. Moodie—I would also see a role for local government. We work with local government a great deal and increasingly respect what they do. But, in terms of the issues around mental health and physical activity, local government is often the provider of all of those amenities that allow people to connect with each other and be physically active.

ACTING CHAIR—Am I right then to take from your comments that you think the best outcomes in the area of preventative health are achieved by the Commonwealth providing the lead role and the three levels of government working together?

Prof. Moodie—Yes, and that obviously involves the other non-government organisations and other players. If you get everybody moving in the same direction, you get a much better outcome. If policy legislation and regulation are all moving in the same direction, the three levels of government are working in the same direction and you get a fairly high consensus or agreement around a national strategy then you are much more likely to get better outcomes. But where everybody is going off in different directions it really weakens the overall impact.

Ms KING—Having been out of the field for a while now, I wish to ask you how the National Public Health Partnership is going. Obviously, when it was set up in the separation of the public health outcome funding agreements there was some talk about using that as an example for the

rest of the health system as to how you might separate the angst around Commonwealth-state relations and funding from policy reform issues. Has it worked or is it on its last legs? I have heard different reports.

Prof. Moodie—I do not know enough to say. I am a strong believer in it. I think these sorts of things can work, but maybe its work needs to be more focused on more achievable outcomes and more specific strategies rather than trying to do everything. I am still of the view that the Commonwealth has a great role in helping the states get together and helping local government come into the act.

Ms Sheehan—I would add something on the business about the mandate it has as well. I know through some of the work we have fed into the National Public Health Partnership that they have been trying to pull together very disparate policies across a range of states. Trying to provide that leadership is fantastic, but I guess it is also about what support there is for states to come on board, follow through or pay attention to that work so that it is not all just done in vain.

ACTING CHAIR—Thank you very much for your evidence and your submission. It has been very interesting. I think we have all learned quite a bit.

Prof. Moodie—Thank you very much. We appreciate it.

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

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

Committee adjourned at 2.53 pm