COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

TUESDAY, 5 JULY 2005

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 5 July 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, Mr Somlyay, Mr Turnbull and Mr Vasta

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.

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Committee met at 10.17 am

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing inquiry into health funding. This is the third public hearing for this important and timely inquiry. During the inquiry the committee will explore how the Australian government can take a leading role in improving the efficiency and the quality of the health care system. While Australia's health care system is among the best in the world, it faces ever-increasing pressures, particularly cost pressures. This in turn can affect the quality of care the patients receive and obliges the public and the private health systems to be as efficient as possible.

Today the committee will hear from the Royal College of Pathologists of Australasia, the Combined Pensioners and Superannuants Association of New South Wales, the Australian Dental Association, the Royal Australian College of General Practitioners, Professor Stephen Leeder and the Australian Council on Healthcare Standards. This hearing is open to the public and a transcript will be made available via the committee's web site.

[10.19 am]

GRAVES, Dr Debra, Chief Executive Officer, Royal College of Pathologists of Australasia

CHAIR—I now call the representative of the Royal College of Pathologists of Australasia to give evidence. Dr Graves, although the committee does not require you to speak under oath, you must understand that these hearings are formal proceedings of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. Do you wish to make a brief introductory statement?

Dr Graves—Yes, I do have a short introductory statement. Thank you on behalf of the Royal College of Pathologists of Australasia for the opportunity to appear before the committee today. The college's submission to the inquiry recommended the investigation of a single funding source for pathology in Australia. This is an option we have proposed in the past, most recently during our pathology agreement negotiations, which were signed in 2004. The college is party to a capped funding agreement with the Commonwealth in relation to funding of pathology.

Current arrangements result in cost shifting between federal and state governments and support inequities between different sectors of pathology, none of which is conducive to the best practice for patient care. A single funding source could improve efficiency and effectiveness of health care delivery by simplifying funding arrangements and clarifying the roles and responsibilities of the different levels of government. However, in order for this to be effective, it is imperative that the introduction of such a funding model is properly planned and involves appropriate consultation.

To illustrate the potential impacts of introducing a single funding source, let me give some examples. There is currently an international crisis in the pathology work force. There is a drastic shortage of pathologists at an international level. The Australian Medical Workforce Advisory Committee has actually recommended that the college needs to put on an extra 100 training positions per year. We have about 260 now, so that is an awful lot more. To date, we have had 10 positions funded through the Commonwealth, which has been fantastic. That has been a new initiative. We have had about 11 through other state governments. There are details in the pack we have provided to the committee in relation to the work force numbers. But we were supposed to be getting 100 per year so we are currently still about 167 short. Our problem is that there is a debate as to who should be funding the training positions. Is it a Commonwealth issue? Is it a state initiative? That is causing a lot of problems.

If we had a single funding source, that may help address those issues and it may be a much better coordinated approach to work force planning and funding. It could reduce barriers within the profession as well, between the public and private sector, fostering much stronger networks among pathology colleagues. This could assist with the recruitment and retention of pathologists and improve pathology support for regional areas. It also could result in flow-on effects from collaborative research and teaching. In contrast, if the introduction of a single funding source was perceived as an excuse for governments to cut pathology funding, this could lead to attrition of pathologists from the work force, which could have a detrimental effect on patient care. So

obviously any introduction of single funding would have to be done very carefully in relation to these sorts of issues.

Pathology lends itself to a single funding source model and it would be an appropriate sector in which to pilot such a system in Australia. However, it must be stressed that the college would only support such a model with a guaranteed no deterioration in the public sector pathology or the private sector pathology, and provided that appropriate support for teaching and research would be provided.

Whilst the college's submission in the inquiry focused on a single funding source for pathology, there are several other issues that I would like to bring to your attention today. Firstly, the college has ongoing concerns in relation to the support for genetic testing in Australia. Whilst the reasons for the gatekeeper role of the Medical Services Advisory Committee with regard to the Medicare schedule is supported—and in fact we feel it is a very appropriate model—the current MSAC process is not able to keep pace with the advances in genetic technologies. The college considers subjecting established tests to rigorous investigations before they can be placed on the schedule is duplicative and requires streamlining. We have made proposals to MSAC in relation to this and we are hopeful that we can make some progress. However, it is a very important issue. Australia only has some six genetic tests on our schedule. The National Health Service, for example, in Britain has some 250. So we are lagging behind in relation to those.

CHAIR—I am sorry; what was that?

Dr Graves—The National Health Service in Britain has some 250 genetic tests available to the public. Through the Commonwealth schedule we currently only have about six. Obviously there is funding available through the state governments but it is another example of inequities between the two systems and an example that sometimes private patients are missing out on important genetic tests because they are not available on the schedule, basically.

Finally, attention must be given to the funding of new information telecommunications technologies. There has historically been an expectation that advances in this regard should be funded from efficiencies derived from other areas of pathology. However, there comes a point when the majority of the efficiencies have been realised yet the costs of these systems continue to grow. If pathology is to continue to drive technological innovation in order to facilitate the coordinated care for patients through interfaces with Medicare, clinicians and hospitals, for example, this needs to be recognised in the approach to funding pathology. I would be happy to answer any questions on behalf of the college.

CHAIR—Could you explain for the lay people, which we are, how pathology differs in private hospitals compared with public hospitals? Is there mobility of the work force between the two?

Dr Graves—In comparison to other areas of medicine, the private sector and the public sector pathologists tend to be more segregated, to be honest. If you work in the private sector you tend to stop in the private sector. There is a small amount of interchange between the two but not a lot. In the public sector, there is a right to private practice for public hospital pathologists, so probably about seven to eight per cent of the Medicare expenditure on pathology is conducted within the public hospital system on private patients within that sector. So there is a little bit of

cross-fertilisation. The services are provided in very much the same way. All the laboratories are accredited within the public sector. Obviously the funding in relation to pathology is based on grants from the state sections whereas in the private sector all the funding comes through the Medicare system.

CHAIR—The first organisation to appear before this inquiry was the Department of Health and Ageing. The departmental witnesses, who gave evidence under the same conditions that you are, in that they did not give evidence under oath, made it very, very plain to the committee that there was no such thing as cost shifting. That surprised me, it surprised other members of the committee and it surprised everybody. The next witness was Kate Carnell, on behalf of the Divisions of General Practice. She talked about her days as chief minister and health minister—how she spent her whole life cost shifting. So there is the perception amongst us that there is cost shifting going on—of course it is. It is rampant, yet the Commonwealth seems to pretend that it does not happen. Can you explain to us how cost shifting happens in pathology, in public hospitals?

Dr Graves—It can happen both ways: cost shifting both from the public to the private and back from the private to the public. Sometimes there has been a line drawn in the sand—in relation to our pathology agreement, for example—to say: 'This has been a practice that has been going on for some time.' So there is not new cost shifting happening, and that is one of the things that we have had discussions about in the past.

It occurs with things such as when public hospital outpatient services are being provided—if they are not being provided within the hospital, the patients are being seen out in Medicare systems and they are obviously getting the pathology testing done that way. It also occurs with pre-op testing in relation to patients going into hospitals, where technically speaking the patient is a public sector patient getting operated on in the public sector; however, the pre-op work-up is done out in the private sector, and the funding for that service is done by the Medicare system. That is something that certainly happens.

CHAIR—Does the public system encourage that to happen?

Dr Graves—Yes.

CHAIR—How?

Dr Graves—I must confess, I was a medical director in a hospital in Victoria many years ago. It is a balancing act in relation to looking at how resources are used. When services are not being provided, particularly when the outpatient sessions are not available in public hospitals, it is often easier for the patient to be seen in the surgeon's rooms. I think it is done for the patient's convenience. It may not be done deliberately but purely so that it can be done while the patient is in the surgeon's rooms. The pathology testing would be appropriately done in the private sector. So that is something that is done.

Other areas where there is concern, for example, are with things like genetic testing and complex testing. There might be a patient being seen in the private sector by a private physician for whom the test might not be available on the Medicare schedule, so that patient is sent to the public sector to get that testing done. Sometimes in that circumstance the public sector will take

up the cost of that test; in some cases they will charge the private laboratories for that test and then pass that cost back to the patient. That is the type of interface where these sorts of things occur in relation to funding problems.

Ms HALL—Is there any cost shifting from the Commonwealth to the states?

Dr Graves—That is perceived to be the case in that circumstance—with the complex testing in particular.

Ms HALL—That is the only area?

Dr Graves—The major areas that we are aware of are complex testing and genetic testing—that is for sure. I am not cognisant of all the arrangements—

Ms HALL—It is important for us to have that made clear.

Dr Graves—but those are areas where the point is constantly raised that the public sector is providing those sorts of services: genetic testing, complex microbiological testing, complex drug testing and those sorts of things that some of the private laboratories do not offer. They are being offered more and more now in the private sector because with the commercialisation of the big laboratories they can offer them; however, there is not a funding stream for them sometimes.

CHAIR—From the point of view of the patient they do not care who is paying for it.

Dr Graves—That is right.

CHAIR—And quite frankly I don't care who is paying for it. But we are concerned, as an inquiry and a committee, about wasting money and duplication in the process of this cost shifting. Is that happening in pathology?

Dr Graves—Yes. One of the examples in relation to possible duplication is that if you are having tests done out in the private sector, if you do go into hospital, there is no necessary communication between the public sector laboratories and the private sector laboratories in relation to duplication, so you might repeat the testing. That sort of thing does cause inefficiencies in relation to processing.

Electronic communications can certainly improve things. Things like HealthConnect that are going on now have great potential to help facilitate that process. But, equally, sometimes some hospitals will not accept the results of one laboratory over another. They want to repeat tests, and that is duplication.

CHAIR—Is that because of professional jealousy or is it for litigation purposes?

Dr Graves—It is probably a combination of concern that they have the right quality controls. It is done with the best of intentions basically to make sure that they have the baseline. In laboratory testing, you do get variations between laboratories in so far as a particular test might be done by a particular kit method or something like that in one laboratory, and it would be done in a different way in another. Then, to have that baseline, it is better to sometimes have that test

done again. There are some reasons for it occasionally, that is for sure—where it is appropriate from a clinical practice point of view.

Ms HALL—In your submission you touched on research. I was wondering whether you would like to expand on that a little bit for us.

Dr Graves—One area of major concern to the college is that currently there is very little research being done in pathology. There are two different types of research: pure pathological research in relation to disease control and those sorts of things; and then there is research which develops and applies tests in a clinical setting.

The way health funding has evolved is that, in the past, a lot used to be done in the public sector. But pathology has probably become more corporatised in the public sector. It is very much run as a business unit in the public sector these days. A lot of the research that used to be funded through things is not being funded currently. The private sector has taken up some research activities—some of the big privates are supporting it—but currently there is not a good, well-defined source of funding for research. Potentially that could draw down the level of what is happening in Australia in relation to pathology.

It is vital that we develop new tests and keep abreast of new things all the time. It is always a risk, if you do not have the funding—and also if you do not have the actual pathologists to do the research, which is one of our concerns at the moment—that you are going to slow down the rate of introduction of new tests that can be diagnosing cancers and getting down to that level. It is critical to keep pushing that envelope in relation to what is available.

Ms HALL—How do these work force issues that you mentioned fit into that?

Dr Graves—It is a huge issue because we are so short of pathologists in Australia. Our guys are the doctors that diagnose all the cancers. For example, when the surgeon takes a piece of tissue out of the body, it is not diagnosed until the pathologist says that it is cancer or not—and they are critical in that role. They are involved with blood products, blood transfusions, leukaemias, infectious diseases and monitoring diabetes. If we have the doctors involved in that, they are working really hard just to provide the service level, and they have very little time left to do any research and push the envelope in relation to new technologies. We are still just keeping there at the moment. We are in a crisis now but if we do not get additional money for registrar positions soon—if we do not get the numbers that we need for the future—it is going to be even worse.

CHAIR—Is pathology attractive as a career?

Dr Graves—It is, very much so. We did a survey last year in the seven disciplines we train in. Anatomical pathology and haematology are our two biggest. Of those two areas, we surveyed the people who applied for jobs and we had 40 really fantastic medical graduates who wanted to do pathology, but we just did not have positions available for them, which was a tragedy. It is quite a popular area of medicine to go into at the moment.

CHAIR—If you have a shortage and you had 40 wanting a job—

Dr Graves—We just do not have the funding. We have a shortage of pathologists that consult. They come to the college once they have finished their medical degree. It is a five-year training course and you have to have a registrar position to become a pathologist. It is very much an apprenticeship model. Those medical graduates applied to the organisations to get training positions, but there is only funding for X number and we had 40 more that would have been really great people to come into the training program.

CHAIR—Who provides the funding for that?

Dr Graves—It has been state governments traditionally. Seventy positions within pathology were cut out of the system over the last 10 years. There was a perception, I think, that we were not going to need trainees because automation and all those sorts of things were happening. Automation has happened but, because of technological advances in areas, the number of pathologists required has dramatically increased. For example, 10 years ago you would look at two slides under the microscope to diagnose a breast cancer; today you would look at about 50 to really individualise a diagnosis. Then you can target the chemotherapy or the radiotherapy or that sort of thing to it. That level of complexity has increased, and having the 70 positions cut out of the system has really caused a major—

CHAIR—When you say 'the system', do you mean the public system?

Dr Graves—Yes.

CHAIR—Who trains people for the private sector?

Dr Graves—Traditionally, the private sector has always got their trainees from the public sector. That is across the board in any area of medicine. However, because of our shortages, prior to our signing the pathology agreement, we had 16 trainees in the private sector. The private guys had put their hands up and said, 'We're going to start training.' They felt that that was about as far as they could go, because the Medicare schedule is not based on training type requirements, so they had that. Part of our pathology agreement negotiations was to try to get more funding for the private sector. There is a lot of capacity in the private sector to train. That is when we did get 10 registrar positions out of the Commonwealth agreement. We would like up to 50, but we are still in discussions with Minister Abbott about that at the moment.

CHAIR—I only know the Queensland system. In Queensland the big two are QML and Sullivan Nicolaides Pathology.

Dr Graves—Yes. They have five private trainees now.

CHAIR—It is very big business, isn't it?

Dr Graves—Yes.

CHAIR—You see the QML and the Sullivan Nicolaides Pathology vehicles going to the GPs, doing their rounds regularly. How big is it as an industry?

Dr Graves—The total Medicare expenditure in pathology is about $1.6 billion a year from the Commonwealth in the private sector. The public sector is thought to be around $1 billion as well.

Mr TURNBULL—Is that $1.6 billion?

Dr Graves—That is right.

Ms HALL—In your presentation, you touched on answering some of those questions Alex directed to you. You said that there is a debate between the states and the Commonwealth over funding these additional positions. Could you explain to us how it is bogged down there?

Dr Graves—As I said, it has traditionally always been the state governments that have funded these positions. We have been lobbying all the state and territory governments to get additional positions. When we have gone to see the state ministers, their arguments have been that they are providing the training for the doctors to then go out into the private sector, which is not necessarily the case. Yes, they are but, in relation to the state-Commonwealth relationship, the public sector has traditionally been responsible for the training of doctors. They have always gone out into the private sector or the public sector. That has been the argument that we have been repeatedly getting when we have gone to the state health ministers. They say: 'We don't think we should be funding any more positions in pathology. There should be a Commonwealth obligation.' I think the Commonwealth did recognise that in its support of 10 training positions, and I think there is interest in going further but, at this stage, there is nothing further on the table in the budget.

Ms HALL—So the Commonwealth is saying that it is a state responsibility.

Dr Graves—They are saying that, because of the drastic shortage, they recognise that we need to do something. They have given us the 10 registrar positions, which is a starting point. That is fantastic. In fact, it is the first time in non-GP medical specialisation that the Commonwealth has supported the funding.

CHAIR—In which states are those training positions?

Dr Graves—There are two in Queensland, four in New South Wales, three in Victoria and one in Western Australia. It is a wonderful collaborative model insofar as it is a partnership between the public and private sector. Because of the types of cases you can see in the private sector, there is a requirement to still have exposure to some of the public sector cases. The set-up has been that the registrars have a five-year training program design. They all spend about two years in the public sector and three years in the private sector, but the private sector is paying. The Commonwealth have provided $75,000 a year and they have to top up the salary to about $100,000 a year for the registrar.

Ms HALL—In your submission and in your evidence today you have said that you favour a single body. Could you share with us what your vision of that single body is?

Dr Graves—The college has been supporting and floating this notion, but we do not have 100 per cent support from every single pathologist. I think the idea has been that it would be based

on a fee-for-service model. That is where the college has been very committed to the model in relation to Medicare.

CHAIR—That would happen in the private sector?

Dr Graves—Yes. Organisations would be funded on the tests that they provide. However, it would be with the proviso that you would need to have some sort of provision for separate, quarantined funding sources for work force, research and teaching of medical students.

That has been the notion that has been put forward. It has not been dealt with in any great detail by the college. It has been something we have spoken about—to that level. There was an acknowledgment, I think, that, in order to proceed with any of this, very detailed costing analyses would need to be done between the public and private sectors to work out level playing fields. While the public sector have a very corporatised model—much more than they ever used to—and they have quite good costing systems, how they actually measure their costs in relation to rentals and those sorts of things are quite different. So it would take quite a lot of work to go through costing models, and we feel that a model would evolve out of looking at those sorts of things in much more detail.

Ms HALL—How do the private and public sectors compare, cost wise?

Dr Graves—Fairly favourably these days. Ten years ago the public sector would have been a lot more inefficient than the private sector, but there has been a big push from commercialisation and those sorts of things. They operate with very efficient models these days.

CHAIR—Do they ever tender out public work to the private sector?

Dr Graves—They do. There are some that are happening in Queensland at the moment because of a shortage of pathologists up there. Also, it has happened in Victoria that the private sector has provided services to places like Frankston and Bendigo. There are some models like that already.

Ms HALL—I have more questions, but I think it is only fair to let the others ask some as well.

Mr VASTA—Dr Graves, you said that there is a shortage of pathologists internationally as well. I just keep seeing these *CSI* TV shows, and others. I think it must be an attractive industry.

Dr Graves—It is very attractive. However, *CSI* is about forensic pathologists. We have 2,000 fellows in Australia, New Zealand, Hong Kong, Singapore and Malaysia, and of those about 27 are forensic pathologists.

Mr VASTA—Are they?

Dr Graves—They are fantastic people and they are really dedicated but forensic pathology is a small component. I think people are unaware of the other side of pathology. In fact, we have given the committee a copy of a magazine we produce called *PathWay* that is going out to medical students and the general community to try to let people know what pathology is about,

because most people do not understand what it is about at all. But, yes, it is attractive. Internationally, shortages are a problem everywhere, and that is why we cannot import the doctors any more. We have sourced them from various places where they have a similar type of training. It is very difficult to get overseas trained specialists in this area with appropriate qualifications to work in Australia.

Mr VASTA—In Queensland there is a great industry coming up—a biotech industry.

Dr Graves—Yes.

Mr VASTA—With the minister, I opened up a new factory on the outskirts of Brisbane. I think Australia has been recognised internationally as having good quality products.

Dr Graves—Absolutely. We have a very good medical system and we train doctors very appropriately here.

Mr TURNBULL—Would the single funding structure that you propose involve the Commonwealth picking up the billion dollars of pathology expenses currently borne—as you said earlier—by the state health systems?

Dr Graves—Obviously there would need to be negotiation in relation to Medicare agreements and those sorts of things. When we have had discussions in the past, that was one of the models considered. If we were going to be continuing with the fee-for-service model, with additional support for training, then it would be like a corporatised entity, I suppose, in relation to the public sector pathology—

Mr TURNBULL—So the public hospitals would become, vis a vis Medicare, the same as private sector pathology companies?

Dr Graves—Yes, that was the suggestion. That was one of the models that was considered.

Mr TURNBULL—Just so we are clear, what you are suggesting is that the Commonwealth pick up another billion dollars of the state governments' collective responsibility for health services?

Dr Graves—When we last discussed it, that was the preferred model, but there are numerous models and we have not definitely said one way or the other—

Mr TURNBULL—That would end cost shifting, of course, because the costs would all be totally shifted to the Commonwealth.

Dr Graves—Yes.

Ms HALL—Did you look at a model where the states would purchase from corporatised—

Dr Graves—We have not got down to that level of understanding. As I have said, it was a concept that we felt could be looked at, but we have not gone down to that level of detail

because initially it was something we raised and they said, 'It is not going to happen.' So we did not put a lot of further work into it at that stage of the game.

Ms HALL—Who said that it was not going to happen?

Dr Graves—We raised it within our Commonwealth pathology agreement negotiations. I think there was interest initially and then people just felt that it was one of those things that needed to be considered. It was stopped. Probably about two or three years ago we were talking about it a lot and then it stopped and they said, 'No, we do not think it is appropriate.' We raised it last year—2004—and there is still interest. It is actually on the agenda of our pathology consultative committee. We are still having dialogue with the Commonwealth about that, at that level of committee.

Mr CADMAN—If it is possible to carve out one profession from public hospitals and fund it separately, surely every profession could be carved out.

Dr Graves—I would not really like to speak on behalf of the other professions, obviously, but I think it comes down to the way pathology has developed in the public sector, in that it has been developed as a separate business unit. Often, even within the public hospital models, pathology providers are working in a type of fee-for-service model where the clinical units get charged for the pathology testing that they have done.

Mr CADMAN—Is it significantly different to, say, the role of a surgeon?

Dr Graves—It is more of a service delivery.

Mr CADMAN—A surgeon does not do that?

Dr Graves—They do, yes. But, looking at the costing structures and the models that are available at the moment in public hospitals, my understanding is that that is what people are saying—that they have the cost structures and costing models done—

Mr CADMAN—I notice in your magazine you talk about the excitement of working with a surgeon. That seems a bit more difficult to define as a fee for service.

Dr Graves—The notion of the actual consultation?

Mr CADMAN—Yes.

Dr Graves—That is difficult in terms of that level of interaction that is described in that magazine. But that is part of the consultation process. A pathologist is there not just to read the slide but also to talk to the surgeon and to provide that clinical advice. Pathologists are not just technicians; they are medical practitioners first. They have an understanding of the disease process. But, when they get a fee for service in the private sector to read a slide, it is part of the consultation service. It is not just processing the slide and reading it.

Mr CADMAN—Why couldn't the fee-for-service approach be done within the state system—

Dr Graves—There is no reason—

Mr CADMAN—rather than entering into the proposal that we move a million dollars onto the Commonwealth budget? Why can't that be retained?

Dr Graves—I must clarify that we have not said that anything should be done one way or the other. We have actually said, 'a single funding source'. But it could be that way or it could be another way. The notion had been fee for service but, you are right: it does not necessarily have to be one way or the other. But it is about providing that fee-for-service type of arrangement.

Mr CADMAN—Is there some financial advantage to go fee for service? It seems to be implied that some of the profession is looking at the private sector and being rather envious of that arrangement.

Dr Graves—I think the reason that the pathologists in particular support fee for service is that it is a recognition of the medical component of pathology—that it is like any other medical specialty in that they provide professional consultative advice. It is not just a service where an automated test is done. There is that element of consultation. It is an important component that they are there, like any other medical service that is provided that way. That is why the college has very much been supportive of making sure that there is that professional content.

Mr CADMAN—So that is a principle. You do not care too much how it is recognised or who it is recognised by?

Dr Graves—No. It is the principle of recognising the medical qualifications of the pathologists in that consultative role, basically.

Mr GEORGANAS—With the discussion earlier of the shortage of pathologists, what is the outcome for patient services? In other areas, we look at surgery et cetera and there are prioritised waiting lists drawn up. Obviously, the shortage is affecting patients in some way. What is the net effect on the patient because of the shortages of pathologists?

Dr Graves—It is twofold, particularly at an anatomical pathology level.

Mr GEORGANAS—For both public and private?

Dr Graves—Yes, in both areas. If you have not got enough pathologists to be diagnosing the cancers, there will be delays. The guys are working really hard to make sure that there are not delays. However, there will be circumstances when pathology results should be available within 24 hours or something like that and they might take a week or so. It does not happen routinely. They really try their best, but sometimes there will be delays because there are just not enough hours in the day to get things processed, particularly if it is a complicated case that needs a lot more research, a lot more consultation and those sorts of things. So, yes, there will be delays like that. The other thing that concerns the college greatly is that, obviously, when people are working harder and faster all the time, particularly when making these sorts of decisions, people may make mistakes. We have excellent quality assurance and accreditation systems in Australia to double-check and those sorts of things, but there is always a risk that, when people are working to their maximum capacity and beyond, mistakes can happen.

Mr TURNBULL—Correct me if I am wrong, Dr Graves, but you said that you felt that pathologists should be remunerated by a fee for service ideally, because that recognises their position as medical professionals?

Dr Graves—Yes.

Mr TURNBULL—Are you saying that medical professionals who are salaried are not being properly recognised?

Dr Graves—No, I would not say that. But from that point of view—

Mr TURNBULL—If you are not saying that, what is the point of the claim? Is a medical practitioner who is salaried in the public health system not as well recognised professionally as somebody who is paid a fee for service?

Dr Graves—It is not the actual payments—

Mr TURNBULL—Can you just answer the question—that is what you said earlier?

Dr Graves—I have to actually answer somewhat differently. Because of the corporatisation of pathology, the majority of pathologists in both the public and private sectors would be on salaries.

Mr TURNBULL—I know that. That is why your comment surprised me.

Dr Graves—What I am saying is that there is a recognition by the bosses that, in relation to where the funding source comes from, there is a requirement or a need to actually have a professional component. They are still like their other medical colleagues from that side of things. It is not about whether they are on a salary but about recognising that the pathologist is actually a very important component in getting revenue in relation to a service. It is not just the technical side of things. The college has had a major concern about making sure that it is not just perceived to be a non-medical entity and that the pathologist component is recognised.

Mr TURNBULL—Can you explain how this would work in a public hospital situation?

Dr Graves—For fee for service?

Mr TURNBULL—Yes. What does it mean for the employed pathologist? What difference does it make to the way he or she is remunerated?

Dr Graves—It is a recognition that a component of the service is actually consultative. It is obviously a philosophical thing—definitely—but it is an important thing to pathologists. It is a recognition that they are providing medical consultation as an added service. In the United States, they have split the technical versus consultative processes and the system does not work particularly well. This is why this would be much better. Providing a test is not just doing the automated side of things; it is a compartmentalised package of automation, talking to clinicians about the patient and actually coming up with an answer. People feel that charging a fee for that

and recognising that it is a revenue-making exercise is a much better way of doing it than lumping things together. That has been the opinion. I am not a pathologist.

Mr TURNBULL—To be honest with you, I do not really understand the point you are making. How does what you are proposing for public hospitals differ from what happens now when pathology companies do a series of tests and send the results back with an invoice? Is that what you mean by fee for service?

Dr Graves—That is what I mean by fee for service, yes.

Mr TURNBULL—But there is no—

Dr Graves—The only reason we are talking about fee for service in the public hospitals is that, if you are going to have a single funding source, you are going to have to have a model of some variety across the board.

Mr TURNBULL—Of course.

Dr Graves—From that side of things, that is where you either have a model like lump funding in relation to the private sector as well and the public system or you have a fee for service model across both. The thing I am saying is that the pathology profession prefers the fee for service model across both areas because they feel that there would be more of a recognition of professional content that way than the other way. It is not a huge deal. But that is why, if you have the two models—lump funding versus a fee for service model—that is the one that the profession has said they would prefer. And that is the case for efficiency reasons, too.

CHAIR—What Mr Turnbull is saying is that funding of pathology by the Commonwealth is done through the health care agreements. If you are going to charge fee for service for pathology, how does the Commonwealth fund that and how does that affect the salaries of people who are paid pathologists? Is that what you are asking?

Mr TURNBULL—Yes. Let me just—

CHAIR—I do not understand, either.

Mr TURNBULL—A pathology company receives a whole series of specimens and requests for tests. There is a schedule. They do their tests, they send their results back and they are paid accordingly.

Dr Graves—Yes.

Mr TURNBULL—I understood that what you were suggesting was—and I think this was your answer to a question earlier—that, under your vision, each public hospital's pathology unit would be treated like a pathology company and would do the tests; there would be a schedule, and the Commonwealth would pick up the tab, as it does with Medicare. Essentially, that is your vision. I can understand all of that, but what I did not understand was when you threw in the stuff about professionalism. I have to say, and I do not know how the rest of the committee feels, that whether a doctor is salaried or is being paid by piecework—that is, per consultation or, if he

or she is a pathologist, per test—or in some other way, I do not think that their professionalism is any different. Their professionalism comes from the fact that they are professionals and they are doing professional work, not from the manner in which they are paid. Are salaried lawyers less professional than lawyers who are paid by the hour? I do not think so.

Dr Graves—I am not saying that they are less professional. It is the notion that they are the ones—

Mr TURNBULL—Well, are they less recognised?

Dr Graves—I suppose it is in relation to the way the model works now for fee for service. The money in relation to Medicare comes into the practice and it is paid to the pathologist and handed over to the actual practice. So the pathologist is the person who actually does the billing in relation to that testing. It does not go to the practice directly. I think, from the point of view of ensuring quality of services and making sure that things are done appropriately in accordance with good medical practice, that is something that is very, very considered in the private sector.

Mr TURNBULL—So what we are saying is that we recognise that in a pathology lab in the process of pathology work there is a series of tests, largely automated nowadays, and then there is an element of professional judgment, which may be greater or smaller depending on the circumstances. Is that right? And are you saying that they should be paid for separately?

Dr Graves—No. They should be paid together. And that is what we are saying.

Mr TURNBULL—But that is exactly what is happening now.

Dr Graves—In the Medicare system now, definitely, they are being paid together. Yes.

Mr TURNBULL—All right.

Dr Graves—We are happy with the system in relation to Medicare—

Mr TURNBULL—I think you have confused us. The professionalism point has confused us! I understand the substance of what you are arguing for; I just did not quite understand the rationale. I still do not.

Dr Graves—The college supports the fee for service arrangements of the Commonwealth, basically, at the moment. We think they are the right way to go.

Mr TURNBULL—Righto.

Ms HALL—Once again on fee for service: how will your fee for service model work with the research component that you believe is so important?

Dr Graves—How would it work?

Ms HALL—Yes.

Dr Graves—It would need to recognise that you need to spend X amount of money on research. So it would have to be an additional funding stream in relation to it, because the Medicare model, in relation to the funding of Medicare services, is purely service delivery at the moment.

Ms HALL—That is right. That is why I—

Dr Graves—And that is what we are saying: we think, if you did it that way, you would have to have quarantined funding for training and research, as an additional sort of thing in relation to it.

Ms HALL—So you would like a new fee structure set up for research?

Dr Graves—That would be right, yes.

Ms HALL—That is very different from anything that exists in any other field of medicine or any other area of research.

Dr Graves—Currently, yes, but that is one of the things that we feel would be very beneficial to the people of Australia—to actually look, identify and say, 'This is what we need to do in this area.'

Ms HALL—How would that impact on the point you made about the concern over genetic testing—the fact that we have only got six recognised in Australia, as opposed to 150 in the UK?

Dr Graves—From the point of view of the funding source, in relation to single sources?

Ms HALL—How would it do anything to improve that?

Dr Graves—It would actually give better access across the board, for public and private patients. We would have to still change the structure of actually getting tests onto the schedule and streamlining a process. So a single funding source is not going to address that, and that is why I did want to bring that out as a separate issue. It needs to be looked at through the MSAC process.

Ms HALL—So you are really recommending a total structural change of the whole way that those services, research and, I suppose, even listing of new tests are brought online?

Dr Graves—Not the listing of tests. That is only in genetic tests, and I think it requires a small adjustment to the MSAC process. The college supports the MSAC process, but it just requires an adjustment in relation to some of the things. We have flagged that with MSAC.

Ms HALL—But with research and funding?

Dr Graves—With research and funding, yes.

Ms HALL—A totally different approach?

Dr Graves—That is one of the things that quite a number of our fellows are supporting, yes.

Ms HALL—And totally different from other areas of medicine.

Dr Graves—We do not comment necessarily on other areas of medicine, but—

Ms HALL—But it is different?

Dr Graves—It would be different, initially. That is right.

Mr CADMAN—It is an interesting concept. I would have to say it seems to me to be a hospital's argument—a provider's argument—rather than a professional argument. I can understand a hospital, for the sake of administration charges and for the sake of perhaps marginally increasing their return, billing patients for a fee for service. As far as the pathologists employed are concerned, they see no difference.

Dr Graves—Pathologists would not see any difference in their remuneration.

Mr CADMAN—It is an administrative process that benefits the hospitals.

Dr Graves—We are not stating it from that side of things.

Mr CADMAN—I know you are not, but that is the fact of the matter.

CHAIR—To put it another way, who would be better off under your model?

Dr Graves—I hope the patient would be better off. That is who we are most concerned about.

Mr CADMAN—Why?

Dr Graves—Why? Because they would be getting better access to rare tests in relation to various issues—

Mr CADMAN—I do not understand that. Do you mean that suddenly the billing process is going to vary the treatment?

Dr Graves—In certain areas it does cause some problems in relation to people getting access to testing.

Mr CADMAN—I would like to see some written identification of that, because unless we get down to detail rather than generalities we are not going to be able to unravel this.

Dr Graves—Okay. We could provide some details to you about that, particularly with regard to genetic testing. There are examples of people who could not get access to the test. They could not afford to pay for the test privately themselves and, because they were a private patient, the probable effect is—

Mr CADMAN—But that falls within the complex issue that you raised previously—that is, cost shifting from the Commonwealth to the state.

Dr Graves—Yes.

Mr CADMAN—But do you need to change the whole system to unravel that complex testing process?

Dr Graves—I think, as we have said in the past, it is a notion that could provide a more level playing field across the public and private sectors in relation to health care delivery. When you have multiple levels of government involved in these sorts of things, there are always—

Mr CADMAN—So is there a drainage out of the public sector into the private sector?

Dr Graves—There is a two-way shift with these sorts of things. It is not one way or the other—and it does cause some inefficiencies.

CHAIR—I think we have covered things quite well. In the course of the inquiry, obviously, pathology will come up in different contexts—public hospitals, private hospitals, health funds and Medicare—and we may invite you at a later time to respond to what others say. Thank you very much for coming today. It was very enlightening, but I think there are still a few questions to answer.

Dr Graves—Yes. I think it is fair to say that the college does not have the answer to this, but it is a concept that we felt was probably worth talking about. It is not an easy one—it is obviously not black and white—but, considering the options, we thought it was an important issue to raise with you.

CHAIR—Thank you.

Dr Graves—Thank you.

Proceedings suspended from 11.03 am to 11.13 am

JAY, Mr Robert Martin, State Secretary, Combined Pensioners and Superannuants Association of New South Wales Inc.

MIFSUD, Mr Mario Charles (Morrie), State President, Combined Pensioners and Superannuants Association of New South Wales Inc.

SKIDMORE, Mr David James, Policy and Information Officer, Combined Pensioners and Superannuants Association of New South Wales Inc.

CHAIR—Welcome. The committee does not require you to give evidence under oath but you should understand that these hearings are formal proceedings of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. I am sure you would not do that but I am required to say that.

As you know, health is a very topical issue at the moment in that the Council of Australian Governments—that is, the state premiers and the Prime Minister—are looking at the reforms that are necessary in the field of health. At its recent meeting, COAG outlined where they think this reform should occur. They have set up a committee of senior officials from the Commonwealth and the states to examine whether the Commonwealth should do certain things that the states do at the moment and vice versa to try to make the system more efficient. This inquiry is giving people who are not senior public officials the opportunity to have a say. You represent people who are users of the health system—consumers—and we want to hear from you as much as we want to hear from the doctors, the private hospitals and the public hospitals. It is very important that your views are given to this inquiry as evidence so that they can be considered when the governments—state and federal—are looking at health care reforms. Would you like to make a brief introductory statement before we proceed to questions?

Mr Skidmore—I am the policy and information officer for CPSA and that involved research for this submission. As you have read this submission I will not go over the whole thing. CPSA is a small community based organisation. It consists of about 15 staff members, mostly part time, and we represent our membership in New South Wales. I have given the details in the submission. We do not quite have the resources of organisations such as the Department of Health and Ageing so bear that in mind in reference to our submission and the evidence that we are going to give.

One of the first points I want to make is about the Australian health care agreements. We have prolonged negotiations with these agreements. In the submission I quote John Deeble. I will read it again. It struck me how AHCAs can often be rather pointless. In part he said:

> ... the legislation provides that even if a state or territory does not accept it—an AHCA—the Commonwealth offer will stand. It was well into the term of the 1998 agreements before Western Australia finally signed.

That has made me think that there has actually got to be a better way of doing things. On the one hand you could have total Commonwealth control of the health system but we thought that would bring in a new bureaucracy. You would have the Commonwealth government as a big deliverer of services as well as a funder of services. You would still have to have branches in

each of the states. Indeed, the existing Department of Health and Ageing also has sections in the states. The minister, Tony Abbott, has put the kybosh on that idea but it might be raised again and we do not think it would be a very satisfactory outcome for the Commonwealth and the states to go down that road. On the other hand, you could leave the system as it is. But the very fact that we are meeting here is an indication that the system for health funding really does need improvement.

A different model—and we can be a bit creative here—would be to have a small bipartisan agency, the job of which would be to formalise health care agreements and deliver them or tell the states to deliver the outcomes based on what happens with the health care agreements at the moment but without that long protracted government negotiation. Such an agency could do its work based on research, data projection and so forth and just administer an act. We do not have all the answers on that particular issue, but that is one of the suggestions.

Looking at the private system and private hospitals, the big question is: is it an efficient service? Certainly, private hospitals do deliver outcomes but, from our point of view—and we represent low-income retirees and pensioners, from age pensioners to people living on disability support pensions—can they afford the private hospital system, even if it is subsidised? They are more likely, we believe, to rely on a public hospital system, and it is in the interests of our organisation to see that the public hospital system is well funded and well provided for.

Regarding private health insurance, we have serious problems with the $2.6 billion a year subsidy that goes towards private health insurance. We do not believe it delivers optimum health outcomes. If you look at the state of dental care, for example, you will see that is one instance where you really need private health insurance, because Medicare does not cover dental health. We see long waiting lists in the somewhat skeletal public dental health system that is administered by the states, and we do not believe that that is the best way of delivering or providing dental services. Indeed, we have said in our submission that we would like to strengthen Medicare, perhaps by raising the levy by even one or two per cent to give it enough capacity, enough funding to cover dental care.

Finally, good health is not a choice in the sense of going off and buying a retail item. Yes, some people do have unhealthy lifestyles and, yes, there is a certain amount of choice around health and the need for health care. But do people choose a disability? Do people choose to have a life-threatening illness? Those questions have to be taken into consideration when we are looking at funding health care. The problem with private health insurance, as we see it, is that it has to operate on the basis of people not needing it. If too many people required private health insurance, it would skyrocket even more than it has and, in the last few years, it has gone way above the CPI. On the other hand, Medicare covers all, and it covers all regardless of your ability to pay.

If we wanted to look at problems where you have a predominantly private health system, we could look at the United States which in fact spends more, as a proportion of GDP, on health than Australia does. A large number of people—over 40 million—miss out on health coverage and they often end up in the acute care system. I found that 18,000 people a year in the United States die as a result of not having health insurance. We are not at that point yet, and we would not like to see our health system go down that road.

CHAIR—Thank you. In your submission you point out the various roles and responsibilities of the Commonwealth and state governments. Do you acknowledge that overlapping between the two is inefficient and we are not getting value for the health dollar? How would you see a realignment of those functions being more efficient? The Commonwealth starting a turf war with the states achieves nothing. We are looking at outcomes: how to get better value for the health dollar.

Mr Skidmore—I would certainly acknowledge that. The turf wars which seem to be part of Australian health care agreements are not the way to go. As I stated before, we raised as an issue of policy—I think this was at our last conference—having some sort of bipartisan agency that could simply formalise those health care agreements based on funding and the services people actually need in all the different states. It is going to be a long, difficult process but I would say there should be a bit of fine-tuning rather than simply delivering health entirely to one government or the other.

CHAIR—We want to abolish somehow the blame game that goes on between the Commonwealth and the states. I quote the example in my electorate of Mrs Smith writing to me and saying, 'I need a hip replacement in the public system but they tell me I've got to wait for five years.' I might write to the Minister for Health and Ageing, Tony Abbott, who might write back to say it is a state issue because the states run the public hospitals. So I might write to the state minister, who might write back to me to say, 'The Commonwealth doesn't give us enough money.' So Mrs Smith gets two letters but she does not get a hip replacement. I want her to get a hip replacement. We want to be efficient in the delivery of services and to stop this blame game that is going on between the Commonwealth and the states. How do we achieve that on behalf of your members? Your members are typically the ones who are not getting the service because of the waiting lists.

Mr Mifsud—I can only state our policy, which has been hard thought out and heavily discussed when we have spoken to our members at annual conferences such as our AGMs. Our policy on this is that we do not want to see funding totally in the hands of the states—and it cannot be in the hands of the states because they are not the fund raisers. We do not want to see, if there is a bringing together on this issue, everything—both funding and administration—in the hands of a federal government, an Australian government. We do not want to see the funding and administration split in the way that it currently is. We are more in favour of a totally non-partisan board being formed, with the federal government funding the health budget after representations from that board at the level necessary—and I will have more to say on this later—and then, through that non-partisan board, the funds being distributed to the states and the states doing the administration. I note that somewhere in our submission there is a statement from one of the government spokesman that he or she—whoever it was who spoke at that time—wanted the funding to remain in the hands of the federal government but not the administration of the hospitals. We still see that division, but the division should be this: a non-partisan board with funding from the national government to the board and then dissemination and administration at the state level. That is what we are in favour of.

CHAIR—I think most of us are quite familiar with your organisation. Its representatives come to see me regularly. We have Alan from New South Wales, Jill from New South Wales, Steve from South Australia, Ross from Queensland and Malcolm from New South Wales—and we have committee members from Victoria as well—so we represent a wide variety of people

and we can see that the system is different in every state from the Commonwealth's point of view. Is it difficult to administer a health system when you have different standards and different requirements at a state level in each state?

Mr Mifsud—The answer to that is obvious. It is not working, is it?

CHAIR—No.

Mr Mifsud—So it is self-evident from our point of view. I have to say that you cannot leave the vagaries and whatever has occurred in the hospital system totally to the states. It is my submission, within the submission, that the federal government has to change the states' funding. This might be the place for me to read my particular plan.

CHAIR—Please go ahead.

Mr Mifsud—On the question of choice, we are very sceptical of the government's contention that through the promotion of private health initiatives the government is creating choice in health. Our scepticism arises from our firmly held belief that the Commonwealth government has sought change in New South Wales, if not in all the states, in terms of funding—and this is important—at the levels necessary for adequate health delivery in the states, particularly in New South Wales, which we are now speaking on behalf of. In CPSA's opinion, the federal government has thus created shortages of all kinds in the public health system and has, in turn, made private health services the only options available in certain cases. In other words, if there is a very specific something you want done to yourself or need to have done to yourself, it has slipped out of the public system and your only choice is the private health system.

As my colleague Mr Skidmore has said, some of our people cannot afford private health insurance, and that has to be realised. People simply cannot afford the peak expenses that are required as a result of the gaps et cetera. Therefore, choice in health matters, as it is being promoted by the federal government, for those citizens who can only choose public health becomes nothing more than a cynical and cruel Hobson's choice, as I have explained earlier. We believe that this situation has been created by the federal government underfunding—apparently quite deliberately—the public health sector whilst financially propping up and promoting private health to the extent that people who cannot afford private health have a Hobson's choice situation on their hands.

ACTING CHAIR (Ms Hall)—I am very interested in your comments about setting up a separate body. Do you envisage that state and federal representatives would make up that body, that some health professionals would be involved in it and that it would look at managing and distributing the health money to hospitals and areas of need? Is that the sort of model you had in mind?

Mr Skidmore—I think so, yes. As I said earlier, we could be a bit creative about this and do some research on a few models that might work. The main point is that it has to have a level of separateness from the state governments and the federal government. The Commonwealth has complaints about how the money is spent. The state governments have complaints about not receiving enough money. To get away from this sort of impasse, we have to look at something separate in order to make sure that money is delivered and the services are delivered on the

ground so that people who need them are in fact getting them. If our suggestion gets up, it will involve a bit of research and bit of creative thinking.

Mr Mifsud—CPSA has not really cogitated on the make-up of this body. However, obviously health professionals would have to be considered, as experts in the field—and not just health professionals but health economists. People like Professor Deeble come to mind immediately, as do others of that ilk. But what we point out very strongly, because our view comes from this area, is that the consumer is always left behind. No matter which committee you talk about, the consumer is always in the minority. In our mind, the consumer should be in the majority. So an adequate mix of those considerations should be sought when or if we proceed to this objective.

ACTING CHAIR—I note that you put forward a recommendation in your submission that the Medicare levy should be increased. You say that that should be used to fund dental health care. Would you like to discuss both the issues of increasing the Medicare levy and the issues surrounding dental health and the people whom you represent?

Mr Mifsud—Before I ask my colleagues I will make a statement. Could you remind me what you were asking about?

ACTING CHAIR—The Medicare levy and dental health.

Mr Mifsud—In popular returns, time and again people have said that they would support an increase in the levy for the purpose of making a universal health care system work. They have said: 'Yes, certainly. This is the one tax increase'—if you can call it that—'that we would support.' Certainly our people, and I speak generally in what I have just said, are quite happy to see a rise in the health care levy for the purposes put before you. I will ask my colleagues to go into detail on what you have asked about.

Mr Skidmore—At the moment, public dental health services are being taken care of by the states. We do not think that they do that adequately. There are long waiting lists. I do not think they are putting the necessary money into dental health that they should be. Many other people are reliant on private health insurance. Some people can afford it but others cannot necessarily afford it, even with the rebate. We have seen considerable increases in private health insurance premiums. NIB, if it comes to mind correctly, went up 16 per cent, or some incredible figure, most recently. Not all of them have gone up by that margin but nonetheless it is acknowledged that there has been an increase. If you are, say, a part-time worker on something like $25,000 a year, you are not going to be eligible for public dental health services, even if you can stand the waiting lists. You are going to have to rely on private health insurance. Although upping the Medicare levy would obviously be a cost to government, one would have to consider—

Mr TURNBULL—It would be a cost to taxpayers, wouldn't it?

Mr Skidmore—Yes, a cost to taxpayers. But what about the cost to taxpayers when you do not fund dental health, when people acquire diseases as a result of having poor dental health and not visiting the dentist when they should as they cannot afford it? That has to be balanced out as well.

Mr GEORGANAS—Earlier you spoke about promotion of choice in health care by the government and said that we have seen some health services slip out of the public system into the private system. Can you give me an example of an area and also the services that are then provided to a public patient in that instance?

Mr Mifsud—I have put two areas in parentheses in my notes. The first is the dental service. The time has got to go by when we think of this as being a separate part of the body. There are cancers that start in the mouth and go into the rest of the body. A massive cost comes out of that by avoiding the thing in the first place. Hip replacement is another one I have in parentheses. We have heard constant stories from our people—I am talking about our own experience, not anything external—telling us that they waited and waited in the public system until they had to go and borrow money, indeed put themselves in hock, to get a hip replacement in another place. Had it not been for the promotion of that alternative, and had the money been wisely spent elsewhere at the necessary level, we may have avoided this. We have also had complaints recently, about which we are attempting to get some answers from appropriate Australian government sources, that hip replacement materials are of a lower standard and, therefore, if you want a better standard, you have to go to the private industry. Those are some of the choices I was referring to.

Mr GEORGANAS—I did not quite understand. You said that if it were not for the promotion of that—

Mr Mifsud—The promotion of private health cover as a choice. It is not really a choice. We are saying to you that that is something of a Hobson's choice, again for the reasons of affordability et cetera. It is just not there for some people; they cannot even aspire to private health cover. If anything, we have to impress upon you the idea that there are people out there who cannot play this game that is being played by the national and state governments. There is no real choice between private and public. For some people, there is only one place they can get their health delivery: the public sector.

Mr TURNBULL—I would like to explore the second recommendation that you made for a single, independent, bipartisan national agency. Mr Skidmore raised it first. I am not sure which of you wishes to answer the question but perhaps you could consider this: do you regard accountability as an important factor in our political system? By that I mean: do you believe it is important that there is a clear recognition on the part of citizens as to which government is responsible for providing which service and which government is raising the taxes to pay for that service? Do you think that accountability is important?

Mr Skidmore—I would say that accountability is important. I would also say that the situation we have at the moment, where we have the states and the Commonwealth blaming each other around health care agreements, makes it really difficult to pinpoint accountability.

Mr TURNBULL—What you have suggested, as I understand it, is a single bipartisan agency. How would you see accountability working there? Let us say that that agency is set up and you have state and federal governments represented on it. Presumably, you would not want the federal government to control that agency?

Mr Skidmore—Neither the states nor the Commonwealth.

Mr TURNBULL—So no-one would be in control of it. How could citizens have any sense of accountability if the health expenditure in this country—probably the most important item of government expenditure—were controlled by no government and therefore no government were accountable for it?

Mr Skidmore—The agency would still be accountable, in the sense that all—

Mr TURNBULL—But the agency does not run for parliament. Let us say there is a failure, a real dissatisfaction. How do voters register their dissatisfaction at the ballot box? They cannot vote for the agency; it is just another collaborative structure that is accountable to nobody.

Mr Skidmore—Government departments are accountable, in a sense. Don't you recognise that? Even though we do not elect government departments—

Mr TURNBULL—There is a very clear point. If a federal government department is failing, it is responsible to its minister and, if voters are unhappy with that minister and the government of which he or she is a part, they can vote for the opposition. I am trying to understand how, if you set up this body which is controlled by no government—it is not controlled by the Commonwealth, which provides by far the bulk of the money—that is consistent with democratic notions of accountability.

Mr Mifsud—I take your point, Mr Turnbull. It is a good point and we have spoken at another level, a state level, on this particular issue: how do you control quangos? That is what you are asking us. As I said earlier, the CPSA has not had the time to cogitate on the make-up et cetera of such a body. However, it is a good point that you raise, and maybe this is a time when we should consider quangos facing the electorate. Maybe that is the answer. That is all I am saying. It needs to be cogitated; it needs to be thought about.

However, on the question of accountability—and this is something close to the heart of the CPSA—the removal of the medical gap fees creates a massive non-accountability situation with you know who. There are many worthwhile health professionals—99 per cent—in our country, but there are a few who will not be accountable to us. I am happy that you raised the question of accountability, because we should make those people accountable. I was fortunate, through my union, to have Canadian people visit us and they clearly told us that the gap is illegal in Canada. To me, that spoke volumes.

CHAIR—We do not have price control in this country.

Mr Mifsud—Unfortunately. That is something we may have to look at.

CHAIR—We have done it before, and the people of Australia have rejected price control in referenda.

Mr CADMAN—You have some interesting ideas. One thing I have seen from where I sit is that, if you encourage more people to insure privately, they generally go to private hospitals and that relieves the burden on state and public hospitals. If that burden on state hospitals is relieved then why is the service falling? You would think they would have more resources and more personnel to better cover the needs of the community. That is one thing I cannot understand.

Mr Skidmore—That line of argument is open to debate. A research note from the parliament of Australia entitled *Public versus private*: *an overview of the debate on private health insurance and pressure on public hospitals* seems to indicate that the jury is out with regard to private hospitals taking the burden away from the public system.

Mr CADMAN—But it is indisputable that the bed rate has risen dramatically at private hospitals.

Mr Mifsud—Are you talking about in New South Wales?

Mr CADMAN—Everywhere, but in New South Wales in particular. We have only to look at hospitals such as The San, Baulkham Hills—areas we both know—Wenty Private and all those. The bed rate is up, pushing 80 per cent.

Mr Mifsud—You are quite correct. That is a fact, and we can only speak on behalf of New South Wales. I do not want to be partisan, but unfortunately I have to be in answering this question. We must not forget that it was a New South Wales government that opened a large numbers of beds—600 on one occasion and 300 on another, if my memory serves me right. So there is an increase in beds. Nonetheless, you say there are problems and you are quite correct. Maybe—and I stress this—that is the carry through from the problems we had. Let us hope that the increase in beds will allay the situation.

Mr CADMAN—I will tell you what I suspect is happening. This is the cost-shifting issue we are trying to get our heads around. As people have moved to private hospitals because of the subsidy, states have closed down or retracted their services. Instead of retaining them at the same level, I think they have probably reduced them. Because they have fewer patients, they are reducing the service they provide. We have to determine that—because why are waiting lists increasing rather than decreasing? You would reckon that, if public hospitals have the same number of people and do not decrease the number of beds, they ought to be able to give better service and take on elective patients more quickly.

Mr Mifsud—There is a point in what you say, but what is the evidence that the states have done just that? While we might suspect they have done that—

Mr CADMAN—There is no evidence. That is what we are trying to find out.

Mr Mifsud—Okay. Unfortunately, no-one on either side of the table here has done any research on that side of things and, as we are all saying, it is still happening. There is no clear assessment of the situation, from our point of view.

Mr CADMAN—What comes through strongly from what you are saying is that the concern of your members is that the Medicare bulk-billed patient is looked after, no matter what system we have.

Mr Mifsud—Absolutely.

Mr Skidmore—Yes, with the best possible health care. They seem to be the ones least likely to be able to afford the private hospital system.

Ms HALL—But you do support a universal system. I think I read in your submission that you feel that if it is a two-tiered system then the people you represent will not get the same quality of service as they would under a universal system.

Mr Mifsud—Absolutely central to everything we say is a universal health care scheme.

Mr CADMAN—What do you mean by 'universal'? Could you explain that?

Mr Mifsud—Yes. A universal one is where Mr Packer or Morrie Mifsud can go in and say, 'I've got an ingrown toenail; can I have it treated?'

Mr CADMAN—You would let Kerry Packer go in for free?

Mr Mifsud—If he pays the appropriate amounts of money and does not go to Jamaica or to a tax-free place to escape tax due in this country—without libelling myself!—then why should he not—

Mr TURNBULL—You are libelling Mr Packer, not yourself!

Mr Skidmore—You are getting us into trouble for libelling Mr Packer!

CHAIR—The good news is you have parliamentary privilege and anything you say will be—

Mr Mifsud—But I am only using the name as an example. A person in that situation, if they pay—

Mr CADMAN—So you would dispense with the public sector altogether on that basis?

Mr Mifsud—No, I would not dispense with the public sector.

Mr Skidmore—Did you mean the private sector?

Mr CADMAN—One or the other. You are going to have a single system—that is what you want?

Mr Mifsud—No. There is nothing wrong with the private system existing, as it was before, as a back-up to the public system. The wrong started to occur when moneys were shifted from the public sector to prop up the private sector.

Mr CADMAN—Okay. But that has made the public sector worse. That is what I am saying.

Mr Mifsud—That is right, and that is what we are saying has made the public sector worse.

Mr CADMAN—But they are getting more money and they have the same number of people, so if they have not cut back on what they are doing then they should be giving better service because there are not so many people wanting to go there.

Mr Mifsud—Now, Mr Cadman, you are cutting right into the rationale behind what we are saying. The point, as quoted in our submission from another person's research, is that, although there have been some increases in funds from the national government to the states, they have not been at a sufficient rate. That is the phrase that I earlier stated was important and I will refer to it again later: 'at a sufficient rate'. Increases can happen but they can be below sufficiency. This is the very central point and I thank you for bringing it up. That is what we are saying and that is why we want a non-politically, non-ideologically committed group to, first of all, say to the federal government, 'This is the amount that is necessary. Give us that,' and then—

Mr CADMAN—Let me put this to you: you have got one quango in the New South Wales government and one in the federal government, and they fight it out and get the best result they can.

Mr Mifsud—Yes.

Mr Cadman—Now why would your committee do any better than that? I assume you are going to have people from the state and people from the Commonwealth on that committee. They are going to come up with the same sorts of problems that we have now.

Mr Mifsud—For the very simple reason that we are convinced there is political bias in what is happening—that is why.

Mr Jay—Mr Cadman, you mentioned that there was a sudden increase in the use of the services provided by private hospitals, particularly in New South Wales. I think that there is general agreement amongst critics that those increases were promoted by elective surgery. People had paid their insurance and had their doctor saying to them: 'Have you got private insurance?' 'Yes, I have.' 'Well, you can have this elective surgery.' And I think that is a critical point about what has happened in the private hospitals since the impact of private insurance subsidies.

Mr CADMAN—But my point is that that has relieved the state hospitals.

CHAIR—There seems to be a perception among you that when this subsidy of 30 per cent came in for private health insurance premiums—

Mr Mifsud—Yes, that is what we are talking about.

CHAIR—that money was taken out of the public sector. It was not. That was money additional to what was in the health care agreements that was given to public hospitals. The health care agreement makes provisions for the necessity for growth. The funding for the private health insurance premiums—for the 30 per cent—was money over and above what went to the public sector. So it was not taking money out of one into the other. But I think you might be arguing that that money would have been better spent in the public sector. Is that what you are arguing?

Mr Mifsud—Exactly. And that is the point. Wherever it came from, as Mr Turnbull would say, it is the taxpayer who provided it. It is our perception that funding is less than is necessary, if we can use that phrase. That funding is, we believe, misspent in that field, and it could have

gone toward helping to allay that hole in the funding. We are not saying that even that would have been the total amount. That is why we are suggesting an increase in the levy itself, which is popular with so many people around this country—the consumer that we represent.

CHAIR—We are not arguing with you. We are here to hear your evidence.

Mr Mifsud—I understand.

CHAIR—We are probing to find out what your ideas are.

Mr Mifsud—We are not arguing. We are putting a stronger case from our side of the view of things.

CHAIR—I would like to thank you for appearing before us today and putting your evidence so strongly. You feel very strongly about the private sector and the public sector, but I know that you do so on behalf of your constituency. Your organisation is represented in all of our electorates. I know that I at least meet with them regularly, and they are telling me things not very different from what you are telling me. So I appreciate you coming along and giving evidence to the inquiry.

Mr Mifsud—Thank you for the opportunity.

[12.05 pm]

O'REILLY, Dr William J (Bill), President, Australian Dental Association

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

Dr O'Reilly—Yes. I would like to thank you for the opportunity to be here today. I believe our submission addresses most of the issues of concern that we have in relation to the terrible state of affairs that exists, particularly with the members of our community who are not able to access dental treatment—whether it is because of their financial circumstances or because of their resident status in rural and remote areas. That has been particularly exacerbated, of course, in Indigenous communities.

Firstly, we feel that the critical issue with dental disease is that, unlike most other illness groups, it is completely preventable, and therefore any impost on the community can be dramatically decreased by the provision of universal fluoride throughout the reticulated water supply in this country. Secondly, I feel that we need to consider having a national approach to oral hygiene education. Both of those initiatives are very cheap in the scheme of things and, given the fact that we are now spending close to $4.4 billion a year on dental services, the cost can be significantly decreased if there is a hygiene, preventive focus placed on the curing of dental disease.

One of the other very critical issues in dentistry is the ageing of the dental work force. After the war years there were very large numbers of dentists graduating from all of the universities. At the University of Sydney, for example, we had close to 400 to 500 dentists coming out every year. At the moment we are down to about 65 or 70 at Sydney university and this simply does not cope with the increased work force needs that we have, particularly in rural and remote areas. We believe that one of the critical issues in driving down costs in dentistry and also providing services to those people who cannot access them—simple supply and demand—is that we need to increase the number of dental graduates who are coming out of this country at the moment.

Another one of the problems we have with the dental work force is that, with the large number of students paying full fees, a significant percentage of students are coming from overseas and they are not staying in this country. To a large extent that is denying places to Australian students and is causing further problems regarding the numbers of people who will stay in this country and will be able to provide dental services in rural and remote areas. That essentially is our submission. I would be very happy to answer any questions. We very warmly embrace the recommendations made by the national AHMAC conference on changes to the dental industry.

CHAIR—Thank you. Is it fair of me to ask you for a historical context of what has happened regarding what you are trying to achieve—as outlined in your submission—over the years? All of us have friends who are dentists, and they all speak to us regularly. Has there been a major

impact in the last 10 years, for instance, because of the increase in the number of people who have private health insurance? How has that affected dentistry?

Dr O'Reilly—We believe there has been an acceptance of the ancillary rebates coming through by the profession generally. My understanding is that the total figure is close to $680 million. That is obviously having an effect on dentists' incomes. The reality, though, is that, given that there are work force issues, and particularly a shortage of dentists, dentists are not dependent upon ancillary insurance rebates for their income.

CHAIR—Different states have different systems. Is there a shortage of dentists in the public sector?

Dr O'Reilly—There is a grave shortage. For example, in Inala in Queensland they have two clinics at the moment with approximately seven chairs. The wait now for a check-up for a concession card holder is approximately 4½ years. Once they get that check-up—in other words, they come off the waiting list—they will be reappointed for fillings or extractions. I think that the critical issue here is that, in the public sector, most of the work which is being done by the practitioners is actually drill and fill and extract. There is absolutely no focus, because of time constraints, on prevention and hygiene. They have the clinical treatment which is required to make them dentally fit—in other words, they are out of pain—or they might have an extraction, but then if they need a denture they are put on another waiting list, so it will take up to two years for them to have the missing teeth replaced. That scenario is prevalent across the whole of the public sector in Australia. There are about 620,000 Australians who hold concession cards waiting for dental treatment in the public sector at the moment. The waiting lists vary between two and five years. If you have a roaring toothache you might be seen within one, two or three days, but then, as I said, you are only going to get relief from pain and then you will go back onto the waiting list for your definitive examination and treatment.

That creates a number of issues with regard to the public sector work force. It is an incredibly frustrating way to practise dentistry. You are putting up with unhappy patients who have been in pain for a long period of time. The dentists in the public sector are often not practising dentistry which embraces all their skills. That usually leads to a fairly high turnover of dentists in the public sector. I think it is fair to say that at the state level—and it is the states' responsibility—the career prospects for dentists in the public sector are very poor. Their salaries are significantly lower than those in private practice. For example, our latest figures show that the average income earned by a dentist across Australia—this is specialists and dentists, so it obviously has that statistical variability—is approximately $113,00 per annum, while that of those who practise in the public sector is around $71,000. Again, with the work force shortages and the lack of dentists going into the work force, there are going to be further pressures in the public sector. It is a major concern.

CHAIR—How do the hours worked compare between the private sector and the public sector?

Dr O'Reilly—I would imagine that they would be less! They are less, and the clinical load is less but different—that is probably unfair. The type of dentistry is completely different. From a state perspective, another concern is that there is no accountability. The type of dentistry done needs to be shown to have a positive effect on the oral health of the patients. That is a twofold

problem. Firstly, it reflects the fact that they cannot do anything that will usually result in better oral hygiene and better oral health outcomes. Secondly, we are concerned that there is no immediately apparent—to us, anyway—transparency of funding from the states and the Commonwealth to the state public sector. It would give us a degree of comfort if we knew that the funding was actually going to the provision of clinical services.

CHAIR—What choices does a patient have who finds himself or herself on this list of 600,000? They can have it done privately if they can afford it; they can take out private health insurance and wait, with a qualifying period. What actually does happen?

Dr O'Reilly—A lot of them will borrow money from friends. A lot of them, I am told, at a state level, will go to public sector clinics and at their triage appointments will say that they have acute dental pain to try and jump the list—which is probably understandable. Or they have to go to the private sector. There is no other choice, and dentistry is an extremely expensive form of treatment. Over all of the services in dentistry approximately 64 per cent of gross income goes on expenses.

Ms HALL—Thank you very much for your submission; it is very interesting. I would like you to comment on those people who are most disadvantaged by the current system. Is it right that there is a socioeconomic factor involved?

Dr O'Reilly—That is correct.

Ms HALL—And many of those people actually do not have the choice to take out private health insurance?

Dr O'Reilly—That is correct.

Ms HALL—You note that people living in Indigenous communities and in rural and remote areas are also particularly disadvantaged.

Dr O'Reilly—That is correct.

Ms HALL—I just wanted to establish that. You talk about private health insurance and the gap payments—the gap between the actual cost of the service and what people receive from their health insurance companies. Would you like to expand on that for us, please?

Dr O'Reilly—The concern that we have is that if people have ancillary cover their premiums will inevitably increase to cover the provision of those particular services. The history, as you have seen in the submission, has been that premiums increase but rebates per service decrease.

Ms HALL—How do dentists feel about the agreements that some private health insurance companies have entered into with various dentists?

Dr O'Reilly—We are implacably opposed to any third party intervention. We see the preferred provider agreements that some health funds have as a way of health funds becoming involved in the determination of what is an appropriate service to be provided to members of the health fund. We have had concerns for a number of years about what results from the preferred

provider types of arrangements. I can give you an example we are involved with at the moment of a practitioner who is working in Adelaide. The particular demographics of his practice mean that his patient base is very elderly. They have a need, therefore, for dentures and for high restorative care—amalgam fillings and crowns. This particular practitioner has a profile which is way out of kilter with what is seen in the rest of South Australia. The practitioner has been asked to show cause why he should remain as a provider for this particular health fund. It is a problem not just in South Australia but across all of the states.

Ms HALL—You also mention in your submission the previous Commonwealth dental health program and how, since that ceased to be in operation, there has been an increase in the number of people who are unable to access dental treatment. Would you like to speak a little bit more about that for us, please?

Dr O'Reilly—The figures that we have show that within a year of that program ceasing there was a 20 per cent increase in the waiting lists across all of the states in this country. That Commonwealth dental health program was good as far as it went. However, there were issues we had as to whether it actually targeted what was really needed. For example, someone with a roaring toothache would have been able to have treatment under that program. But the only treatment would have been—if it was, for example, an abscess on the front tooth—to extract the tooth. Obviously, the options should have been either an extraction and the provision of a denture very quickly or a root canal treatment. The focus there was not to prevent the problem in the first instance but to act as quickly as possible to solve the problem.

Ms HALL—I note that throughout your submission you talk about a leadership role for the Commonwealth in a number of areas. Would you like to expand on that for the committee?

Dr O'Reilly—We feel that the recommendations that have been made in the Oral Health Plan from 2003-04 should be embraced. Parts of that mean that the Commonwealth has an increased role in leadership. One area that we think should be looked at is the fact that at the moment the dental profession has absolutely no input at a Commonwealth level. There is no Commonwealth dental adviser, for example. That to me—and to the association—is extraordinary, given the fact that—

CHAIR—There used to be.

Dr O'Reilly—There used to be, yes. Dental decay is the most common disease in this country and gum disease is the fifth most common, as you have read. It is interesting that we have no input there at all. We would wish to have some input via, for example, a Commonwealth dental officer, who would advise the Commonwealth. We have no representation on the National Health and Medical Research Council. That is an area where we believe the Commonwealth can show some leadership. We recognise the direct—

CHAIR—Does the NHMRC deal with dental issues?

Dr O'Reilly—It does, but the dental input is not there. If you ask me where that comes from, I honestly do not know. To give an example: the initiative with MedicarePlus and the EPC, which is a means of extending dental services to chronically ill members of the community, is a worthwhile initiative. But the truth of the matter is that, while that was bring worked out, we—

that is, me and the CEO—were sitting having a cup of coffee in Parliament House, waiting to meet various ministers, and there was no dental input into it at all. I think that is a shame, because subsequent meetings that we have had, which have all been done in good faith, are now redressing the obvious shortcomings of that particular scheme.

Another aspect to do with national leadership is that for very little cost—we have done some modelling and we believe it would not cost any more than about $10 million—there should be a program to extol the virtues of good oral hygiene. It happens with diabetes, it happens with breast cancer and it happens with pap smears. There is absolutely no reason why that sort of initiative cannot be promoted from a Commonwealth level.

There are many other ways that we believe that the Commonwealth should perhaps show leadership. I find it incredibly frustrating that we have difficulty accessing the minister for health, whose father is, as you all know, an orthodontist. When I was president of the New South Wales branch of the Dental Association, we had the minister for health, in a different role from his role at the moment, doing quite a bit of work for us, opening various initiatives that we had. But we are not able to access the Commonwealth minister for health at this moment in time because of what you were saying before: this blame game where it is a state or it is a federal responsibility. We would like to have some more access there.

CHAIR—On that point, what should be run by the Commonwealth that is presently being run by the states?

Dr O'Reilly—I feel that the model which would work well would be another Commonwealth dental health program, which would cost $110 million to $120 million a year, without the shortcomings of the previous one. But hand in hand with that, there needs to be state accountability in the actual provision of those dental services to ensure that they are being given to dental practitioners and dental hygienists to improve the oral health of those people who most need it. I would see that the Commonwealth would need to have the states meeting various criteria, which I think are on page 19 of our submission. Assuming that that did occur, it would mean a demonstrable improvement in oral health.

Mr GEORGANAS—In your submission, you note that we talk about the OECD countries and the levels that we are at. We are ranked second best on the dental health of children, yet we have one of the worst levels in older Australians. Why is this?

Dr O'Reilly—Fluoride is one the critical factors. I am sad to say, though, that, since that OECD report, research is coming out from Professor Spencer in Adelaide which would indicate that there is, in fact, a decline in the oral health of children.

Mr GEORGANAS—The other question is: why is it historically that we treat dentistry, dental care and dental hygiene differently from other health issues? To me they both seem to be a health issue. I do not know what the views are of other committee members, but there seems to be a difference in the way that we view the two. If you break an arm, for example, you go and get it fixed, and the services are available. But if you break a tooth, it is a completely different ball game. Is there any historical factor in that?

Dr O'Reilly—I do not think breaking a tooth, compared to having a coronary, is as 'sexy', if you like.

Mr GEORGANAS—Yet it might hurt just as much.

Dr O'Reilly—Yes. I feel, as I indicated before, that it is the most prevalent disease group in this country. The connection between oral health and systemic health, as you probably read in our submission, is now well and truly proven. I believe that our profession needs to be a lot more forward in presenting those arguments. I acknowledge that, and we will be doing that in the future. The reality is that it has the seventh largest spend of all the major disease groups in this country and it has a direct effect on the population's health in totality.

Mr GEORGANAS—I have one last question. You mentioned a figure of $120 million per year to bring those waiting list levels down or to ensure that the public receives dental care. The OECD numbers for the oral health of older Australians show that we are nowhere near the standards of other OECD countries. If we were to concentrate on that area of our most vulnerable, those on concession cards et cetera, what would that cost be? Has your organisation done an analysis of that?

Dr O'Reilly—We have not done any modelling on that at all.

Mr GEORGANAS—Would it be substantially less than the $120 million?

Dr O'Reilly—I think that would be pretty close to the mark. It got up to $100 million at the time of the cessation of the CDHP. If it kept on going, the forward estimates for the next year was going to be something like $116 million or $117 million. Given the fact that it was ostensibly targeted to concession card holders, that would be the figure. I would like to put a caveat on all of this. It is dependent on having the work force able to provide those services. That goes to the private and the public sector. It is not a simple fix. For example, the association has been providing rural scholarships for Indigenous Australians to do dentistry. We have been putting a lot of money into programs to take final-year dental students from the University of Sydney, which I have been intimately involved with, out to Broken Hill, for example, to do two-year placements in rural and remote areas of New South Wales. That is all working. But the challenge is to overcome the gender and ethnicity issues, given the make-up of our new graduates. It is a significantly different mix to what it was when I went through dentistry. It is about making sure that those people see an advantage in practising in rural and remote areas. If you can get them out there, it goes to the issue of those members of the public who cannot access clinical work because there are no dentists. There are now two practising in Broken Hill. In places like Nyngan and Walgett it is a disaster.

It is not just in New South Wales but across the whole of the country. We need to address the work force issues as well as providing funding. That comes down to increased funding to the dental schools which, in terms of infrastructure costs, would be about $25 million a year just to increase the number of dental chairs that are required to train more students. We are going to be short about 1,500 dentists in 2010 for this country. Overseas trained dentists are a short-term answer. It is certainly not a long-term answer. If we can flood the market in time with dental practitioners, a lot of these supply and demand issues will go.

Mr VASTA—In America dental care is quite expensive as well, isn't it? The private sector provides access to dental plans to some of its work force, doesn't it?

Dr O'Reilly—Yes.

Mr GEORGANAS—Do you see that having any merit in this country? Do you think that is going to be part of the future?

Dr O'Reilly—Is this managed care or the actual corporate dental plans?

Mr VASTA—It is corporate dental plans.

Dr O'Reilly—My understanding, which is based on a review of literature, is that those plans are becoming more and more expensive all the time. It is my understanding that for providers of those plans—that is, the people who are funding them—it is resulting in—

Mr VASTA—A cost blow-out?

Dr O'Reilly—That is correct.

Mr VASTA—So they are starting to decrease that availability?

Dr O'Reilly—It goes to the benefits payable, the limits and so on. I have not got anything here on that. If you wish, we can—

Mr VASTA—If you could provide that to the committee, we would appreciate it.

Mr TURNBULL—I want to pick up a couple of points you made about training dentists which I found contradictory. You said that post war there were 400 dentists being qualified a year and now it is down to 65 at Sydney university. If the number of dentists that are graduating has declined as markedly as that, why are the facilities inadequate? Presumably the facilities must have been adequate at the time such larger numbers were being produced.

Dr O'Reilly—That is a good question. Facilities have wound back. Dental technology rapidly changes so the equipment that was necessary in the fifties is totally redundant now. The dental technology, chairs, equipment and materials are significantly more expensive than they were many years ago. It is not just the hardware; we also have a problem in the retention and training of academics to train undergraduates.

Mr TURNBULL—Just moving through that, you said that the average remuneration, or average net income, of dentists nationally was $113,000, and in the government sector it was $71,000. That is not an unattractive level of remuneration. Why is there a shortage of dental graduates? Is it a lack of people wanting to train as dentists?

Dr O'Reilly—I think it is the opposite: I think that there is a bottleneck in the number of students being able to get into the faculties. There have also been some changes in a lot of the states. For example, Sydney has gone to a BDent program, where you have to have an undergraduate degree before you get into the Bachelor of Dentistry.

Mr CADMAN—Does the profession recommend that?

Dr O'Reilly—That is a moot point. There was consultation. It was before I became involved with dental politics, if you like. There is, attendant with that change, a focus on problem based learning, which was first used in medicine. That means that the students are now required to come up with a set of solutions—clinical as well as jurisprudential, if necessary, and ethical—to look at a particular patient and the treatment that they would provide that patient, as distinct from when I went through dentistry when it was straight didactic teaching and there was a very strong focus on clinical skills.

Mr TURNBULL—We have a profession which is well rewarded, or has levels of reward that would be regarded as attractive by many people anyway. We have got a shortage of professionals. Why have the universities not provided more places? Why have they not responded to this demand?

Dr O'Reilly—That is an area that we are actively—

Mr TURNBULL—Can you just give us the answer, because we are running out of time. When you go to the universities and ask, 'Why are there not more places for dental students?' what is the answer they give you?

Dr O'Reilly—It costs too much, they say, to train a dentist.

Mr TURNBULL—So they cannot make a buck out of it? Is that what they are saying?

Dr O'Reilly—They are spending more money and they are accepting more overseas undergraduates because they pay full fees and that is diminishing the supply of dentists who will stay in this country.

Mr TURNBULL—Sometimes I have difficulty getting to the core of the point you are making. Are you saying that the universities are saying to you that the remuneration they receive both in HECS contributions and from the Commonwealth in respect of dental places is less than the cost of providing the training for a dentist?

Dr O'Reilly—That is my understanding.

Mr TURNBULL—No, is that what they are saying to you?

Dr O'Reilly—That is my understanding of what is happening.

Mr TURNBULL—But have they said that to you?

Dr O'Reilly—They have not said that.

Mr TURNBULL—So when you ask them the question, which I presume you do, what do they say to you?

Dr O'Reilly—They say that it costs too much to train dentists and that the amount of infrastructure necessary for training them is not there.

Mr TURNBULL—So one thing that this committee should be doing is finding out from the universities exactly what that cost is and how it relates to what they are being paid for providing that training—would you agree?

Dr O'Reilly—That is correct. Part of that would involve—given that a lot of dental students, when they do provide clinical services, are providing clinical services for the state to those patients who cannot access private practice—seeing to what extent there is any cost shifting in that area.

Mr TURNBULL—Okay. You talked about the 'gender mix'. I have no idea of what you are talking about. Are you saying there are more women studying dentistry now or fewer? What is the point that you are making?

Dr O'Reilly—Far more women than when I went through.

Mr TURNBULL—What is the percentage?

Dr O'Reilly—My understanding is that now over 60 per cent of undergraduates are women.

Mr TURNBULL—Is it your observation that, as these women graduate and as many of them become mothers, they are not available to work full time in the profession? Is that your concern?

Dr O'Reilly—No, not at all.

Mr TURNBULL—What is your concern, then, about the gender mix?

Dr O'Reilly—It relates, to an extent, to the ability to attract people into rural and remote areas.

Mr TURNBULL—So women are less likely to move there?

Dr O'Reilly—That is what we have seen.

Mr TURNBULL—But is there an issue—because this is an issue that is raised in other professions—with women professionals, in the years during which they have got children at home, as it were, being more interested in working part time rather than full time?

Dr O'Reilly—That is correct.

Mr TURNBULL—So that is an issue that you have observed?

Dr O'Reilly—It is, but I am not able to give you any figures on that.

CHAIR—You gave us a figure as to the number of trainees in Australia. How many of those are from overseas—or are the overseas ones on top of that?

Dr O'Reilly—No. It is my understanding that at the moment there are about 1,256 dentists under training across the country. I cannot give you the figure as to how many of those are nationals of other countries and therefore will leave this country.

CHAIR—Take the 60 at Sydney University. That is the total number of those being trained now. That includes overseas full fee paying students. How many of those would you expect to return to their original countries?

Dr O'Reilly—I can find out that figure for you. The other aspect is that there are foreign trained dentists who come to this country, also through the Australian Dental Council, and they have to sit exams which are set by the ADC.

Mr CADMAN—You have used different bases on which to present your figures. I have deduced from them that four per cent of dental costs are paid by governments, approximately 30 per cent by insurance and the remainder, which is something over 60 per cent, by individuals. Is that approximately right?

Dr O'Reilly—Yes. My understanding is that the total spend on dentistry is about $4.4 billion and of that approximately $2.96 billion comes from individuals.

Mr CADMAN—However, you make the statement on page 33 that the equivalent of 67 per cent of total dental service expenditure comes from individuals. That is not quite consistent with what you have just said, which is more in line with 50 per cent coming from individuals. I think elsewhere in the paper you talk about roughly 50 per cent coming from insurance and other sources and 50 per cent from individuals. Would you clarify that for us?

Dr O'Reilly—Would you mind if I do not do it today?

Mr CADMAN—Just take it on notice. That will help us get our heads around the issue a little more. It is interesting that you said that within a year of the Commonwealth scheme dropping out there was a 20 per cent increase in the waiting list. That is incredible, because there were no fewer dentists in that period of time. All it would mean is that dentists were doing less work.

Dr O'Reilly—Would you mind repeating that?

Mr CADMAN—You said that, in the year after the Commonwealth dental program dropped off there was a 20 per cent increase in the waiting list. In that one-year period I do not suspect that there was a significant drop in the number of dental practitioners available for the community. It would only mean that dentists were doing less work.

Dr O'Reilly—I am not sure whether there may also have been other factors—for example, whether or not the states changed the criteria for the waiting lists and the type of people who would be eligible. But what we have seen in our figures is that the waiting lists did increase by 20 per cent.

Mr CADMAN—That factor defies logic. The argument has always been that people have not got the money to pay for dentistry. You are saying that the patient availability was there but the work could not be done and that from one year to the next there was a 20 per change. I do not understand why.

Dr O'Reilly—I will get those figures.

CHAIR—When the Commonwealth brought that scheme in, was there an increase in the employment of dentists?

Dr O'Reilly—I do not believe so.

Mr CADMAN—Have you ever explored with the insurance companies the problem of the gap—the concept of 'known gap' or 'no gap' insurance? One of the problems that many of the people whom I come across have with dental treatment is that they are suddenly hit with a bill that they did not expect and, as you say, only about 50 per cent of the cost for dentistry is covered by insurance. Compared with medicine, there is a substantial difference in the patient contribution to dentistry. Therefore, I wonder whether there is scope for a reworking of the insurance arrangements so that some—not all—of the medical processes could be adopted in dentistry whereby patients would be aware of what they were up for before a procedure took place.

Dr O'Reilly—It is our policy that all dentists should inform their patients of what the total cost of the procedure should be. So there should not be any surprise at the end of that procedure.

Mr CADMAN—Good.

Mr GEORGANAS—This question is more for my clarification, I suppose. Earlier we were speaking about places at universities and the way that universities are funded per place et cetera. In relation to the overseas students, were you saying that, because they are paying up-front fees, they are taking the places of students from local areas, who would be trained locally and who would then go back to local areas and work in dentistry?

Dr O'Reilly—That is correct.

Ms HALL—I like the idea that you detailed in your submission about the HECS fees and encouraging dental students or newly qualified dentists to go to rural and remote areas. Would you like to put that on the record?

Dr O'Reilly—Yes. I believe that if there were deferments of HECS for those graduates who went to rural areas of this country that would be an incentive for those practitioners to practise in rural and remote areas of this country. There are practitioners—principal dentists in rural New South Wales, for example, whom I know of—who are paying the HECS fees of their assistant dentists if they stay in their practice for a period of time.

CHAIR—The government has introduced a number of medical schools in regional areas. Are there dental schools in regional areas? It is proven that a doctor who trains in the bush is more likely to stay in the bush. Does that occur in the dental profession?

Dr O'Reilly—We are endeavouring to do that in New South Wales by taking students out into rural areas. That model is also being used in Western Australia and Victoria. Western Australian graduates are going to the Northern Territory and Far North Queensland. As far as a regional dental school goes, there is Griffith University, which started taking students last year.

CHAIR—Where is their campus?

Dr O'Reilly—On the Gold Coast.

CHAIR—And there is a medical school at Townsville?

Dr O'Reilly—Yes. I think that any initiatives to increase the number of dentists and to have campuses in rural areas would be a very positive move.

CHAIR—Thanks very much. We appreciate your submission and your evidence today. Later on in the inquiry we may have occasions where other witnesses may give different evidence. We will refer those to you and ask whether you want to comment further.

Proceedings suspended from 12.51 pm to 1.53 pm

KIDD, Professor Michael Richard, President, Royal Australian College of General Practitioners

PREETHAM, Dr Vasantha, Vice-President and Royal Australian College of General Practitioners Western Australia Faculty Chair, Royal Australian College of General Practitioners

WATTS, Mr Ian Thomas, National Manager, General Practitioner Advocacy and Support, Royal Australian College of General Practitioners

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Dr Preetham—I am a GP in Perth and I am a practice principal.

CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings form part of the proceedings of parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. The inquiry that we are having into health funding is happening at the same time as many discussions on reform in the health sector, particularly on those matters arising out of COAG. You probably saw the COAG communique about a month ago and you would be aware that a senior committee of officials has been set up to look at a range of issues to reform the health industry or sector. We feel that there may be participants in the health industry who will not get a say in that inquiry, and this inquiry, which is running in parallel with what the government is doing, will give people an opportunity to have a say on the record and to make sure that the committee of officials is aware of what various sectors of the health industry have to say. Having said that, I invite you to make an introductory statement before we proceed to questions.

Prof. Kidd—We would like to open our remarks by thanking the committee for providing the Royal Australian College of General Practitioners with this opportunity to speak about important issues of health funding on behalf of general practitioners and Australian general practice. Concern for the wellbeing of our community is paramount for the RACGP. Our college is responsible for setting and maintaining the standards for high-quality clinical care, education and training and research in Australian general practice. We have a strong history—over 50 years—of representing this nation's general practitioners on issues of health care, health promotion, quality and safety and access and of ensuring that Australia's general practitioners can deliver the high-quality care that our communities expect and deserve.

The Royal Australian College of General Practitioners has over 11,600 financial members. This makes us the largest medical college in Australia. We manage the quality assurance and continuing professional development of nearly 22,000 medical practitioners. Over 3,000 of Australia's rural and remote general practitioners are financial members of the RACGP and we have the largest rural membership of any medical college in Australia.

General practice is the cornerstone of Australia's system of health care. Each year there are over 100 million consultations between Australians and their chosen general practitioners, and

each year nearly 90 per cent of all people in Australia consult with a general practitioner. The RACGP strongly supports evidence based policy development and we caution that any changes to health care funding policy should be based on evidence of what works in the context of Australian health care and of what produces improvements in health care outcomes.

In this introduction I would like to focus first on issues affecting Aboriginal and Torres Strait Islander health and then on preventive health care, the needs of rural general practice, safety and quality in primary health care, the use of information technology, general practice teams and primary health care systems. An area of core concern in health funding for the RACGP is that of Aboriginal and Torres Strait Islander health. The health of Aboriginal and Torres Strait Islander people is clearly one of the most pressing health issues facing our nation. This is an area where we believe more effective health funding and cross-jurisdictional coordination can make a significant impact.

The RACGP is concerned that the complexity and lack of definition of the roles of government risk having a particularly negative impact on services for Aboriginal and Torres Strait Islander people. We urge the committee to give particular attention to ways in which health funding can support culturally appropriate models of health care. In particular, the RACGP requests the committee to specifically review mechanisms that will support successful initiatives in Aboriginal and Torres Strait Islander health. The RACGP believes that examples of what will work best in Aboriginal health are best developed in consultation with Aboriginal health organisations.

Much of the discussion about health funding focuses on the supply of health services. The RACGP strongly urges the committee to also focus on health promotion and preventive health care as important means of addressing the demand for health care. It is well recognised that a focus on preventive health care is critical to achieving high-quality health and effective use of available health funding. The RACGP has long believed in the importance of a focus on preventive health care. This is a core activity of quality general practice and has been the driver of considerable work by our college for decades.

All levels of government have a responsibility to fund or support preventive health care activity. The potential health benefits, compared against the costs and weighed against the cost of inaction, compel us to seek ways to improve preventive health care for all people in Australia. We recommend that the committee pay particular attention to ways in which health funding for preventive health care activities can be enhanced and to optimising the roles and responsibilities of the different levels of government in the area of prevention. The RACGP supports the introduction of a preventive health care item within the Medicare Benefits Schedule. Such an item would be based on the evidence presented in the RACGP's *Guidelines for Preventive Activities in General Practice*—our red book.

As I have mentioned, the RACGP has a strong representative and support role in rural general practice. We ask that the committee give consideration to the specific funding issues that impact on the quality and accessibility of health services in rural and remote areas. One important funding issue for rural and regional general practice is the relative inequity of health funding for many rural areas. We advocate that the committee consider this issue closely when deliberating on funding models.

The RACGP sees quality and safety as critical principles of health care. Safety and quality is prominent in our submission to the committee. Information management and information technology provide opportunities and mechanisms for increasing the quality and safety of health care through initiatives such as electronic health records. A shared electronic health record will enable general practitioners to identify where services and investigations have been performed previously by other health providers to prevent duplication in services and funding. Access to information can also be facilitated by improved information management systems. Such information can be critical to providing appropriate, timely and safe care. Our patients are most at risk when they cross the boundaries in our health care system and when critical information fails to travel with them. Electronic health records not only have important benefits for continuity, quality and safety of care but also offer the potential to reduce unnecessary health care costs through reduction in duplication of investigations, identifying health issues and appropriate care needs early, and increasing coordination between health providers. The benefits for patients from these improvements are reaped through better health care, better health care outcomes and reduced personal and financial costs. A targeted and sustained investment in upgrading information technology across the health sector may prove to have substantial benefits in reducing the duplication of health care costs that concern this committee.

Discussion on coordination of health care also brings me to an important area of consideration in health funding—that of general practice teams. General practice teams provide the opportunity to general practitioners to provide comprehensive services to patients through engaging the skills of others, especially general practice nurses and practice managers. A current problem is that incentives to support general practice nurses are not available to all general practices. They are especially not available to inner city general practices working with marginalised populations. Whilst there is potential here for health and cost benefits, we would urge caution that any shift towards general practice teams needs to ensure the maintenance of health care quality and safety. New roles in general practice need to be in line with the competence of the health care professional involved and any relevant registration. We need to be careful that continuity of care is not broken by health care professionals working independently of a person's own general practice. Discussions on the simplification of funding arrangements in health have been occurring over a long time. It is time for us to move forward and begin implementing improvements.

In conclusion, I would like to add a few remarks about primary health care systems. The international literature clearly demonstrates that for any health system to be effective it must be based on a strong integrated primary health care system. Australia lags well behind many other developed countries which have implemented substantial reforms to strengthen primary health care, with general practice at the centre of those reforms. Australia has a fragmented primary health care system based on a strong system of general practice. Australia does not have a national primary health care policy and our national general practice strategy is overdue for review. Our system of primary health care is bedevilled by the split in Commonwealth and state responsibilities and funding streams. One only has to look at the multiple barriers to coordinating care for the aged and the chronically ill to appreciate the health and financial impact of this situation. Until these whole-of-system issues are addressed, the gains that can be made will necessarily be limited. The Royal Australian College of General Practitioners is keen to assist in our role as the national leader in setting and maintaining the standards of quality practice, education and research in Australian general practice. We look forward to making an active contribution to the continuing process of review and reform.

Ms HALL—I will ask you the first few questions. You spent some time talking about Aboriginal and Torres Strait Islander health and the need to look at alternative models. I think that you would be as aware as I am that there have been many inquiries conducted and many recommendations that have been made, yet we still have the same high mortality and morbidity rates within that population in Australia. In line with the terms of reference that we have before us, what action do you think needs to be taken to immediately progress the situation there?

Prof. Kidd—The first issue, which I outlined in the statement, is that if there are going to be alternative models they need to be developed with Aboriginal health organisations.

Ms HALL—That is a very good point.

Prof. Kidd—And there has been progress. We have seen progress in general practice and primary health care in Indigenous health, particularly through the work of NACCHO, and through NACCHO working with organisations like the RACGP in looking at how we can improve standards of quality of care, the development of guidelines for improving preventive care for Aboriginal and Torres Strait Islander people, and the education and training requirements of our health care work force to better meet the needs of Aboriginal and Torres Strait Islander people and to ensure that our health care services are more culturally appropriate. So we are seeing areas of improvement, but it is not enough. As you very rightly point out, it is not happening quickly enough.

Ms HALL—If you were to recommend to the committee any areas, programs or communities where it is working very well, what would they be? Can you give any examples of where they are working poorly?

Prof. Kidd—I would like to take that question on notice and work on it with our staff at the college. We have a unit that works with NACCHO on Aboriginal and Torres Strait Islander health. We would be very happy to provide the committee with some examples of where we believe initiatives are working well. Once again, we do that in concert with NACCHO, which acts as our partner in these areas.

The major area, and other submissions to the committee have brought this forward, is the issue about funding. The funding to Aboriginal and Torres Strait Islander health at the moment is simply not adequate to meet the health care needs of those people.

Ms HALL—Also in your submission you talk about a greater investment in preventive health measures. Last week we visited Victoria and heard from Victorian Health Promotions. They pointed out that savings ranged from $1 to $2 for every $9 that was invested. What role do GPs have in the delivery of preventive programs? How do you see that sitting alongside community health?

Prof. Kidd—Preventive health care is a core part of Australian general practice. It always has been and hopefully always will be. Given that up to 90 per cent of the population visit a general practitioner every year, it provides a wonderful opportunity to address preventive health care issues as well as the acute or chronic health care issues which have led to the person presenting. Our college has produced our evidence based guidelines for preventive health care, which I

mentioned, and we have guidelines on how to effectively deliver preventive health care through general practice.

Unfortunately, one of the biggest challenges that we face is that the funding of general practice through the MBS rebates provides active disincentives to the longer consultations which are required in order to address health promotion and preventive health care issues in addition to the acute problems that people may present with. The current model favours shorter consultations rather than longer consultations. We train our general practice work force to be very proactive in preventive health care. Our general practitioners are very active. Our general practice nurses have a huge role to play in preventive health care as well, as part of the general practice team approach.

Ms HALL—In your submission you talk about the overall investment by all levels of government in the area of preventive health. What role do you see the federal government having in this? How do you think that this can be brought together and coordinated across all levels of government?

Prof. Kidd—The federal government obviously has a role through general practice through the Medicare Benefits Schedule.

Ms HALL—Does it have any other role?

Prof. Kidd—Absolutely. It has a role through developing policy, particularly policy addressing key preventive health interventions. Many of these are rolled out both through our college and through the divisions of general practice at a local level to support preventive health care targeted to different members of community. We mentioned in the introduction our call for an item under the MBS to support preventive health care assessments based on the evidence.

Mr Watts—There are other portfolio areas in the Commonwealth that potentially add value, particularly lifestyle risk factors such as levels of activity and those sorts of issues where the federal government's role in partnering with, for example, local government in local government planning. There are a number of portfolio opportunities across the portfolios outside health. We take a very broad view of health and opportunities to reduce obesity through greater activity do not only come under the health portfolio but come under other areas where local government planning, city planning and other activities are also quite critical.

Ms HALL—What state do you come from?

Mr Watts—I come from Victoria.

Ms HALL—Yes, that was an answer from Victoria. I asked the administration area of my local government yesterday what investment they make in health. I was advised that they allow the state departments to use some of their buildings and that is the level of investment locally. The final question that I was going to ask is: in your presentation you talked about how the system is fragmented, lagging behind and bedevilled by the split between the state and the Commonwealth. Would you like to expand on that and on how it impacts on general practice?

Prof. Kidd—We can certainly provide some practical examples of the difficulties that our patients encounter and that we encounter as general practitioners in trying to coordinate the care for individual patients. One of the areas that we have identified for you in the introduction is talking about aged care and also the care of people with chronic diseases. Trying to assist your patients to navigate their way through a health care system which is not necessarily terribly well coordinated can be a real challenge, particularly for patients on lower incomes who may have difficulty accessing allied health support: services like physiotherapy, podiatry, dieticians, which may not be readily accessible through the state funded system. If they are, patients may not be able to get access to them because of very lengthy delays.

Dr Preetham—I come from WA and I do not know if you have heard of the Reid report, which is supposed to be the blueprint for systemic change to health in WA. There are a few forums through which general practice can feed into this process and that is through the clinical senate, which has clinicians from the hospital system and five general practitioners. There is a group of general practitioners that works with the health reform implementation task force. It is very constructive to have this dialogue with state health—bearing in mind that general practice is federally funded—to look at things like discharge planning, discharge summaries and who looks after the patient when they first come home. Should it be the RMO from the hospital? The bureaucrats may say yes because it is financially a good model. The profession may say, 'Let's look at it. Is it the best thing for the patient?' There are different ways of looking at it.

Ms HALL—What do you think? What is your solution?

Dr Preetham—The solution is that it should be an approach that involves everyone: the profession, the government and the consumer.

Mr CADMAN—I am little bit disappointed with your submission because the only area that really refers to the cost-shifting part of the inquiry seems to be two sentences on page 4 which stated:

There appears to be no single arena in which to consolidate the lessons learned and discuss the implications of these major investments. This appears to be aggravated by the turnover of key staff in all levels of government ...

It is very easy for you to say, 'Keep your public service in place and the problems will be solved.' That does not help this committee very much. Do you have any real examples of where you see cost shifting taking place and ways in which that may be remedied?

Prof. Kidd—We experience, as general practitioners, the effects of cost shifting all the time. Again, it relates to our challenge in assisting our patients to navigate their way through the health care system. An example in this state has been a reduction in public hospital outpatient services.

Mr CADMAN—That is the sort of stuff that we need to know about.

Prof. Kidd—Sure. The difficulty that I now have with patients on low incomes is in assisting them to get to see a specialist in another clinical discipline.

Mr CADMAN—How does that work? I can understand the outpatients. I cannot understand the specialist thing.

Prof. Kidd—Let us say I have an elderly man who I suspect may have prostate cancer, and I wish to send him to a urologist. Previously, I may have been able to send him to my local public hospital, free of charge, to an outpatient urology service. If the public hospital closes that service so that is longer available, I will have to send him to someone privately, which means he may incur a bill.

Ms HALL—Isn't it true, though, that a lot of the urologists have removed themselves from the system? They have not been removed by the state government but urologists are a good example of them walking.

Prof. Kidd—That is something you probably need to approach the College of Surgeons about as to what is happening with individual specialties.

Ms HALL—Yes, that is the reason.

Prof. Kidd—We have seen it in many different disciplines.

Mr TURNBULL—Just finish your answer Mr Cadman's question, because I am interested in hearing it.

Prof. Kidd—The challenge is that I now have to send my patient to see someone privately, and that incurs a bill.

Mr CADMAN—Let me check back so I understand. This is a low income person with a chronic and perhaps fatal disease that needs active diagnosis and treatment. Your normal practice would be to send them to an outpatient service of a public hospital because they would get good treatment and they could afford that treatment, which would generally be free. Is that right?

Prof. Kidd—If that is available. But increasingly those outpatient services are not available to our patients. Therefore, the only option people have is to go to private services where they may incur a bill.

Mr CADMAN—How do they manage that?

Prof. Kidd—They may choose not to do it all, which puts their health at risk.

CHAIR—But you would refer them?

Prof. Kidd—I would refer them but they may choose not to go.

Mr CADMAN—They may not go?

Prof. Kidd—They may not go, and that creates a risk. They may be advised to have certain investigations which they cannot afford and therefore that will not happen either. The cost for the

consultation shifts from having been provided through the state to now being provided through the Medicare benefits schedule due to the rebate that the patient may claim.

Mr CADMAN—That is a good example. Can you think of other ones?

Dr Preetham—Can I give you another example?

Mr CADMAN—Yes, please.

Dr Preetham—Take the example of, say, an 80-year-old lady who goes into the public hospital system with a clot in her leg. The doctor puts her on low dose heparin, which can be given in general practice, and sends her home for her GP or the practice nurse to administer the medication. It is a weekend and she is 80 years old. Is that the best possible treatment? But that is the protocol in the public hospital system, and it is absolutely right because if you look at the case per se, it can be managed at home. So these are the issues.

Mr CADMAN—What is a preferable outcome? If we go back to the 80-year-old lady, what options should be available to her?

Dr Preetham—If she lives at home alone, she should be able to go elsewhere, maybe not to stay in a tertiary hospital.

Mr CADMAN—That is a very good point, because she is not going to be able to get to her GP very easily and she needs supervision. Is that right?

Dr Preetham—Yes.

Mr Watts—So, Vasantha, you are talking about some sort of step down arrangement, for instance.

Dr Preetham—Yes.

Mr CADMAN—Right, so that moves a patient through the public system quickly and probably not with the best medical result.

Dr Preetham—It is probably not a cost-effective measure to keep this lady in a tertiary hospital bed, but it is probably not the optimum solution to send an 80-year-old woman, who lives alone, home on the weekend.

Mr CADMAN—Is there a need then for elderly patients who may be in hospital for treatments for leg ulcers and various things to have an intermediary step before going home?

Dr Preetham—There should be more of that, definitely.

Mr CADMAN—What is that called? Does it have a name?

Mr Watts—After care.

Dr Preetham—After care, respite, non-tertiary hospitals—I am not sure what the grading is.

Mr Watts—'Step down' is one of the ways it is described.

Mr CADMAN—Can you think of any others? Those two examples have started to clarify the issue for me.

Dr Preetham—Can I give you one more example?

Mr CADMAN—Yes.

Dr Preetham—An elderly lady discharged on the weekend needs medication. The hospital pharmacy does not dispense it. She has to come on the weekend to get a prescription from her GP. That happens.

Prof. Kidd—Prescriptions are a real issue, because often we will have people discharged home on expensive medications which may not be available under the Pharmaceutical Benefits Scheme. They are given three days supply and told to then go to their general practitioner to get their continuing medication. They arrive and the doctor says: 'I can write this prescription but it's going to cost you. It's not a free medication.'

Mr CADMAN—As you talked about expensive medicine, I immediately wondered whether this is an area of possible abuse by GPs. Not that any member of yours would do this, but could this be a shifting of the cost from the patient to the state so that the outpatient process and the pharmaceutical dispensing process are abused by more people than necessary using it?

Dr Preetham—In my experience in WA, abuse through the state health system does not occur that much because it is fairly prescriptive in what it give patients when they are released from the hospital system.

Mr CADMAN—Okay.

Ms HALL—We heard from Orphans Australia down in Melbourne and they said that the only way that a lot of people can obtain expensive medication—because they cannot afford it—is by it being prescribed and dispensed through the public hospitals. Some of these medications could cost over $1,000 a month.

Prof. Kidd—There are some services available in different community settings across the country to enable people on very low incomes to access their medications—through community health centres and through some of the Aboriginal medical services.

Ms HALL—You do not necessarily have to be on a low income when you are looking at the type of medications that Orphans Australia deal with.

Mr CADMAN—Those were three good examples. Thank you. If you can think of others, send us an email or something.

CHAIR—That would vary between metropolitan areas and regional areas.

Dr Preetham—Absolutely.

Mr CADMAN—I guess that was my second question—I have had a whole series of questions but this is really the second question. How many of your members have practices in rural or regional Australia? What proportion?

Prof. Kidd—Over a quarter; about a third of our membership. We have over 3,000 rural and remote general practitioners as members.

CHAIR—Am I right in thinking that, in a remote or rural setting, if that happened to a patient and they were discharged by the doctor, it would probably be that doctor who would treat them privately anyway?

Prof. Kidd—Yes.

CHAIR—What happens in that case? Would they issue a script?

Prof. Kidd—In that case there is likely to be greater continuity of care because the person who is providing the care in the hospital is also providing the care outside of the hospital. The GP will be constrained by the policy of the hospital as to how long they can write the prescription for and how much medication is dispensed at the time of discharge.

Mr Watts—Part of the thrust of our submission is that information technology is critically important in knowing what is actually being prescribed or dispensed at the hospital so that you are not duplicating the prescription of a similar drug called by a different name, for example, and running the risk of adverse medicine events. Part of the thrust of our submission is that things like information technology play a critical role in reducing the duplication of health cost.

Dr Preetham—That is not just for medication; it is for pathology as well. If we knew that certain tests have already been done, we would not duplicate them when a patient came to us.

Mr CADMAN—Are there privacy factors here?

Prof. Kidd—There are huge privacy factors when we are talking about the sharing of personal health information between health care providers.

Mr CADMAN—And that is what you are discussing now, isn't it?

Prof. Kidd—Yes, how that information is shared. This occurs every day and it is covered by the national privacy principles and the legislation.

Mr TURNBULL—I want to come back to the issue of cost shifting. We have in the health system overlapping services or similar services which are provided by different agencies and funded by either the state or Commonwealth. As a consequence, if a patient chooses or is directed to one service or another, upon that decision will depend whether the state or Commonwealth pays the cost. Correct?

Prof. Kidd—Yes.

Mr TURNBULL—There is an incentive for, for example, largely state funded agencies to refer patients for services to GPs, where the cost is borne by the Commonwealth. Do you agree with that?

Prof. Kidd—I am sure that often happens.

Mr TURNBULL—While we talk about cost shifting from state to the Commonwealth, is it your view that this overlapping, or duplication as Mr Watts described it, adds to a net increase in the overall taxpayer funded expense of health, and/or does it add to inefficiency? Let us ignore the state-federal division. Let us look at a whole-of-government perspective.

Prof. Kidd—It certainly has huge potential to add to inefficiency. As a general practitioner, I do not particularly think about whether the service that I am referring my patient to is funded by the Commonwealth or by the state. I think about the best service to assist that person whose care I am responsible for.

Mr TURNBULL—Of course you do.

Prof. Kidd—That is part of our role as general practitioners. We are gatekeepers for our patients to the rest of the health sector. We are advocates for our patients. We will become aware of certain parts of the health system where it is easier for patients to get appointments, and they may be the ones we will use. Or we will become aware of services which provide what we may regard as a higher quality care or a safer care, and that is where we will focus. So the issue of cost shifting does not really come into the minds of many general practitioners.

Mr TURNBULL—I am sure it does not. But, focusing on that whole-of-government cost, do you believe that if all these costs that are currently shared between state and federal governments were paid for by one level of government—be it a state or federal government; it does not really matter—there would be a net reduction in health costs and/or an increase in efficiency? And, if so, how?

Prof. Kidd—One of the ways in which you may see a net increase in efficiency is through better coordination of care and better sharing of information across a single health care system. We see duplication of costs particularly where people cross the boundaries in the health system—from hospital to general practice, from private to public and from Commonwealth funded to state funded—and information about what has happened to them does not flow with them. Investigations get repeated, people are prescribed medications which they may have been identified as having an adverse reaction to in another setting, but that information about adverse events or known allergies has not moved across the system with them; therefore you get increased unnecessary hospitalisations, increased adverse events and increased morbidity and mortality for the community, all of which lead to increases in costs.

Mr TURNBULL—But is that a function of Commonwealth-state differential responsibility or is it a function of just poor communication between providers of medical services?

Prof. Kidd—It is something that probably needs a lot closer examination. In my experience—and I will let Vasantha speak to this as well—often the barrier occurs between the community and the public hospital and the difficulty in information transferring across that barrier. People

may be discharged home without necessary information coming to their general practitioner. We see that as a divide between Commonwealth and state, if you like.

Dr Preetham—I think that if the connectivity between federal, state and, in some instances, even local government were better we would work better. The efficiencies will definitely increase. One would think the costs would go down as well. In WA, again, we are beginning to look at this through these two forums that I mentioned previously. I find that a very constructive process. So it will be interesting to see what comes out of it.

CHAIR—Do you have the same problem with pathology? We had the Royal College of Pathologists of Australasia here this morning.

Dr Preetham—Are you referring to the cost shifting?

CHAIR—Yes.

Dr Preetham—It does happen. In my experience, I have seen people who have been to an emergency department and who are then told to go to the GP the next day to have blood tests done. They may not necessarily be a patient of the practice but it is the way the system works.

CHAIR—They might have the blood test in emergency.

Dr Preetham—No, they would not have.

CHAIR—Why not?

Dr Preetham—It may be that the doctor is busy; I do not know. Maybe it is something that could have waited till the next day. So the patient goes to the GP the next day to have the blood test done.

Prof. Kidd—Getting access to results can be quite difficult across the other side of the boundary. That is for radiology and pathology. Investigations are performed within the public hospital setting and the patient returns to their general practitioner. It can be quite a challenge and of course it takes considerable time to chase up results. You may need access to those results out of hours and there is nobody there to look at the computer and find them for you, or you get a barrier because people say, 'We can't release that information under privacy rules.' You say, 'I've got the patient sitting here with me.'

CHAIR—So that would be duplicated under Medicare?

Prof. Kidd—That is highly likely, yes.

Mr CADMAN—Couldn't you provide a number to give you access to that sort of stuff? I would have thought that that is simply a PIN number.

Mr Watts—Part of the cross-jurisdictional problem is that there are different information systems in the public sector and the general practice private sector, and the interests of the two sectors are not necessarily aligned with where to invest in the advancing of the information

systems. So it continues to present this challenge, which may not be just a jurisdictional barrier; it also occurs in private hospitals and private general practice. It is not necessarily a jurisdictional issue. But it does present us with the outcome that we duplicate work or that we cannot work efficiently because we do not have the information at hand.

Mr GEORGANAS—Just going on from Mr Cadman's question about the provider number, obviously there is communication between the different spheres of operators et cetera in the health profession and between public and private. It seems quite odd that today you or I can go to China, put in an EFTPOS card, withdraw X amount of dollars and have it given to us in local currency yet we cannot through a Medicare card get information quite easily. It is only a simple view that I have; I would think that that would be a simple solution. Is there a reason that what to me seems very simple has not been done? What has been preventing it all these years?

Prof. Kidd—We do not have the same level of investment in information technology and information management in our health care system as we do in banking around the world.

Mr GEORGANAS—So that is the single biggest issue, then, if that is the case.

Prof. Kidd—Part of the issue is about not having consistent standards between various parts of the health sector. The Australian government is working with the states and territories through the HealthConnect process and through NEHTA, the National E-Health Transition Authority, to try to overcome some of these problems. This issue is not peculiar to Australia, however, and the same sorts of concerns that you are raising in health care occur in many other developed countries. It is a challenge that many developed countries are facing at the moment.

Mr GEORGANAS—So the biggest issue would be the technology side of things, and then the communication between the different—

Prof. Kidd—Technology standards and communication but also the training of the clinical work force and the ability to incorporate accessing this sort of information electronically as part of your work in providing clinical care to the people who have come to consult you.

Ms HALL—I am pretty sure that cost shifting takes place, both from the Commonwealth to the states and from the states to the Commonwealth. Our state colleagues would say that many acute care beds are taken up with people who really should be in aged care facilities, and that is one area where the Commonwealth shifts to the state. I am probably coming back to Mr Turnbull's question in that I think that there has to be a way of looking at the best and most effective way to deliver health dollars to your patients and to the people that we all represent. I would like to question you a little bit more on how you think that should be done. How can we get around this cost shifting? If I was a state member of parliament, I could sit here and blame the Commonwealth for the problems in the system. A Commonwealth member can sit here and blame the state. What we are about is trying to get in place the kind of system that is going to deliver the health dollars to the people of Australia when they need it. That is one thing I would like you to address.

The other question is in relation to accessing data from hospitals, between public and private and even between doctors. Do you think one recommendation that this committee could make would be to have in place a system that actually facilitates that?

Prof. Kidd—Taking the second part first, yes, I think that would be a very useful outcome for the committee—to advocate for a system to improve the transmission of personal health information across the health sector. That would be very valuable. The other issue was about how we should remove cost shifting. One way of removing cost shifting would be to have a single system of health care, but that is a path that any government would need to be very careful about moving down because—

Ms HALL—Does your college support that?

Prof. Kidd—Our college does not have a specific policy either way. Our college's policy is that any health care policy planning needs to be evidence based and that if we were to engage in such a change, which would be a major change and would cause major disruptions to the Australian health care system, we would want to be darned sure right up front that it was not going to result in problems in the health system and provide us with a health care system that was of a lesser quality, or lead to a problem in retaining our health care work force through their being subjected to major change. So it is not an area which we believe should be engaged in lightly.

Mr CADMAN—Professor Kidd, let us go back to this public-private relationship. What would normally happen to my GP if I came out of hospital? Would the hospital send him a note saying, 'We had Alan Cadman in here and this is what we did to him'? Or would the GP have to ring them up and say, 'Who looked after him and what did you put in his arm or down his throat?' How does that work?

Prof. Kidd—This is very variable and its depends on the individual hospital. In fact, it often depends on the individual unit in the hospital as to what sort of discharge information is provided to the patient's treating general practitioner after someone has been discharged. It is even variable as to whether hospitals record who the patient's chosen general practitioner is, to allow that communication to take place. It is still not uncommon to have a patient presenting to a general practitioner, days after having been in hospital, with the general practitioner unaware that the patient has been in hospital, unaware they have been discharged and unaware of any of the details of what has happened to them. And the patient is quite surprised that the general practitioner does not have all of those details at their fingertips and accessible through the computer system. Having said that, there has been some very concerted effort by a number of centres around the country to improve discharge information and there has been a commitment from many centres to ensure that that sort of critical information gets sent—usually by fax, sometimes by mail, or sometimes handed directly to the patient—so that it gets to the general practitioner straightaway.

Mr CADMAN—Can you give us some examples of best practice in the experience of your members? We will not ask you for the bad institutions; we would like to know the good ones so that we can see where we need to go.

Prof. Kidd—My practice is in Darlinghurst and I provide care to many people with HIV-AIDS. Many of my patients are admitted as in-patients to St Vincent's Hospital. The unit there provides a typewritten discharge summary of exactly what has happened, exactly what investigations have taken place and exactly what the recommendations are for further follow-up.

That provides a fantastic opportunity for me to continue the coordination of care once that person has been discharged.

Ms HALL—How long does it take you to get that, and are you advised when your patient is in hospital?

Prof. Kidd—Some of the hospitals, including some of the hospitals I refer to, send a fax to the general practitioner at the time someone is admitted to hospital and at the time someone is discharged from hospital. Just the details: 'admitted'; 'discharged'—simple information so that you know where your patients are within the health care system. Some of our publicly funded casualty departments are very proactive in providing information, even about someone who just attends for an emergency.

Dr Preetham—Can I also give some examples. In my experience, what Michael says would be pretty much what happens. A lot of hospitals in WA also have a general practice liaison person, who is usually a GP, and that is very useful. If we have difficulties with things like discharge summaries, that is a good person to contact and say, 'The system isn't working; why isn't it working?' For example, a couple of weeks ago all practices in a certain region got a fax from a particular hospital to say that there was no surgical registrar available for two weeks, and to refer acute surgical emergencies elsewhere. That was very useful to know. There are also clinical peer review processes in some hospitals, where there is a GP who also attends, and it is useful to know where the gaps are and where things are falling between the cracks. These are good examples of how the system can work better.

Mr CADMAN—I have an unrelated question: we have had the dentists in here pushing their cause, saying that oral health is the No. 1 problem. Would you see it that way?

Prof. Kidd—Oral health is a very important problem and affects many of our patients, particularly those on low incomes and particularly those with multiple chronic health care problems.

Mr CADMAN—You would not rate it No. 1, but it is very important?

Prof. Kidd—It is important.

Mr GEORGANAS—How do we attract general practitioners to rural areas? There is a great shortage in rural Australia—in country towns et cetera. What do we do to attract more doctors to those places to provide the services needed?

Prof. Kidd—This is a challenge that has been faced over the past decade or so, and we have a number of initiatives under way to support recruitment and retention of our health care work force in rural areas. Our college strongly advocates flexibility for our registrars-in-training, and we have run programs to support our registrars to gain the additional skills that they may feel they need in order to practise safely—particularly in more remote areas where they may be the only medical practitioner available. We need to ensure that we have good incentives to attract people to training and working in rural areas, and we have incentive schemes at the moment. Despite those schemes, we know that a significant number of Australian rural general practices are not viable in the longer term and if they are going to continue to operate they are going to

need considerably more support. The incentives to provide practice nurses for rural general practices have been very welcome. Again, it adds to the health care work force in many of our rural locations.

Mr Watts—We need to expose medical students to rural practice early, because career decision making in general practice is made reasonably early. It is important to provide opportunities for medical students to have rural exposure if they are going to understand the opportunities of rural practice.

Dr Preetham—This is one instance where it is so important to work with local government, with the shire, because one has to cater for the family of the GP. If the family is happy then the retention rate is higher.

CHAIR—Professor Kidd, thank you very much for your submission and for giving us such comprehensive answers to our questions. As the inquiry progresses, issues may arise which you might want to comment on or which we may want to ask you to comment on. If you would be available to do that for us, we would appreciate it.

Prof. Kidd—We would welcome that opportunity.

CHAIR—Thank you.

[2.46 pm]

LEEDER, Professor Stephen Ross, Private capacity

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Leeder—I am both a professor of public health and community medicine at the University of Sydney and director of a small group called the Australian Health Policy Institute, which is within the University of Sydney.

CHAIR—Although the committee does not require you to give evidence under oath, you should understand that these proceedings are proceedings of the parliament and that giving false or misleading evidence is regarded as a contempt of parliament. This inquiry is very broad ranging. There are quite a few inquiries under way at present into reforming the health system. The major one, I suppose, is the one coming out of the recent COAG meeting, involving a senior committee of officials which is addressing the areas that need to be reformed. It concerns me when committee officials bring down reports and make recommendations without perhaps the level of consultation that should occur, so we are trying to ensure that we give people an opportunity to speak about reform in the health sector and we will feed that into the government inquiry that is being conducted at the moment. I invite you to make a brief introductory statement before we proceed to questions.

Prof. Leeder—I think the two big challenges that face the health system, from the point of view of people who use it and people who work in it, are really questions of equity and efficiency. By equity I mean making available to people the services they need when they need them on more or less an equal footing, taking into account where they live, what their income is and their ethnic or other background. By efficiency we are really talking about the wisest use of the health dollar. Those are two really big challenges that face the system.

They provoke some good, robust discussion about the best way to finance health care and what sort of mix we need between private and public, state and Commonwealth, and some good, robust discussion about whether health is a right or a privilege. Is it a commodity? Is it something that you can buy through purchasing health care, or is it something that we should regard as a public good—something for which we should make at least basic provision so that nobody misses out?

An example of a society that operates both inefficiently and inequitably is the United States of America, where there are 50 million people without health insurance, for whom we know there are serious health consequences. Yet it spends a huge amount of its gross national product on health. There is no doubt that, if you want to buy the best health care in the world and you have limitless money, you go to the States. So it is both inefficient and inequitable, but it has pockets of brilliance.

It comes back to the question, most fundamentally: how do we view Australian society? Where do we fit on the spectrum, generally speaking? The poorer a country the less the

government takes responsibility for health care. In sub-Saharan Africa and even in India there is virtually no government responsibility for health care at all. The more wealthy a country the greater the proportion of health care costs that are met from the public purse, because under those circumstances the value of equity is something that we can afford.

My view of Australia is that we are an astonishingly wealthy country compared with the majority of the world. We can afford to provide equitable care, but we cannot afford to do it if we do not pay attention to sources of inefficiency. In my submission I followed the example of Karen Davis from the Commonwealth Fund in the US, who recently provided an inventory of 10 ways in which greater efficiency might occur in the health system, often with improved quality of care, I might say. The best example of that is that if, in the US, there was a system of care for people, say, with chronic heart failure or some other condition, starting with a good family physician and going all the way through to hospital facilities, they could cut back probably on 30 per cent of all hospital admissions, which would save them in the order of $9 billion a year—maybe they would not 'save' it but at least they would have it to spend on something else.

Another area, not mentioned in my submission but certainly an important one and one where I think parliamentary people can provide a kind of reassurance that encourages public debate, is the use of resources for people in extreme conditions, especially towards the end of life. It is often a very hard thing to predict.

Ms HALL—Rationing?

Prof. Leeder—Rationing and rationality have quite a lot in common. I would say it is not so much rationing as being rational about the way in which we use resources and not being profligate. I am not for a moment saying that if someone comes in who is aged 80 we say: 'I'm sorry. You're 80. Your speedo is past the use-by date. You can have nothing.' I think we need a sensitive examination of the way in which we use resources at the moment in looking after people who, by most medical and lay observations, are within months of death, let us say, and of a ripe old age. A great amount of resources go to them. We ration other people to provide the resources to treat them excessively. Because of how we are treating a lot of these people in intensive care units there are not so many resources available for other people. You might ask, 'Why on earth do we do that?' but it is a reflection of the way society thinks.

That is what I mean about the parliamentary contribution to the debate. Just as Daniel Callahan has argued in the United States through the Hastings Centre in New York, which is a great source of interesting material on this topic, we cannot afford a society where everybody has everything just because they want it. There has to be a public acceptance of the fact that people will miss out if we use inefficiently resources in desperate and often futile attempts at rescue for people in extremis by virtue of their age and medical condition. I did not put that in my submission, because it is so easily misunderstood. But I put it to you that one of the important contributions that people such as yourselves can make is to provoke some sort of public discussion around it. I do not mean for you to put your own necks on the chopping block, but could we begin as a society to think about this? There has been movement on this in recent years, which I think is encouraging, but there is still a lot of public debate to be had.

That is far more interesting and actually far more important than saying, 'How many angels can we fit on the point of a state pin versus how many angels we can fit on the point of a

Commonwealth pin?' and 'How in God's name do we get the angels and the pinpoints together?' It is so boring, and does it really matter? Ultimately, does it matter? And it is a fairly harmonious relationship.

Mr TURNBULL—Isn't cost shifting a function of getting the angels to move from one pin to another?

Prof. Leeder—Yes. There is a growth industry there, Malcolm. There are people you meet at a dinner party who, when you ask them, 'What do you do?' say, 'I'm a cost shifter.' You have probably been spared this but let me tell you that when you deal with the medical bureaucracy you meet cost shifters.

Mr TURNBULL—Do people concede that they are cost shifters?

Prof. Leeder—They call it something else, but when you dig down you find that they are busily reallocating something from somewhere else.

Mr TURNBULL—As you are a professor of public health and community medicine and you have a particular expertise in this area, can you tell us a little bit about the types of jobs that professional cost shifters have and how they discharge their functions of cost shifting?

Prof. Leeder—My professional expertise is probably not especially relevant here. But having worked in and around hospitals in the health bureaucracy for a long time, I can say it has to do with processes of care over the purchase or supply of pharmaceuticals. Alan, you were asking about what happens when someone leaves hospital. It used to be the case that if I was your patient you would say to me, 'Well, Steve, here's 10 days supply of tetracycline for your chest infection and make sure you see your GP between now and then.' Nowadays, because if you do that that is a state cost on the state hospital's pharmacy, you give the patient about two tablets and a prescription. The patient has to then hunt around to try to find a pharmacy open at 11 o'clock on a Sunday night when they have just been discharged from hospital. It is hopeless. It sounds trivial but it is really irritating.

Mr TURNBULL—You may have been jesting when you said there were people who introduced themselves at dinner parties as cost shifters, but are there people in the public hospital system whose job is to shift costs on to the Commonwealth?

CHAIR—The answer to that is yes. I can answer that.

Mr TURNBULL—Are you giving evidence, Chair?

CHAIR—It is on the record.

Mr TURNBULL—Good.

Prof. Leeder—There are such people, especially those people working in relation to hospital financing, forms of care, pharmaceuticals and diagnostic procedures. Once upon a time we used to have outpatients in public hospitals. As a respiratory physician, I would see people in public places. I do not do that anymore. When I see them, they come to me in a thing that has been

renamed as a university clinic and I bill them on Medicare. Someone thought that up; it was not me. Someone in the system thought that up. There are other forms of cost shifting that go on that can be equally deleterious. Let me tell you of one, which is the steadily escalating co-payment on pharmaceuticals which comes out with all sorts of rational cotton wool around it but means that ordinary people are paying more for drugs. All that we know about up-front payments in respect of health care suggests that kind of thing will diminish the likelihood that people who are impoverished will make use of those drugs. They are not trivial anymore—we are talking about 20-something dollars a script. That is another cost shifting—someone has thought that up.

Mr TURNBULL—Let us turn to price signals. You have talked about rationing, rationalities and so forth, but the way in which a market economy rations or allocates goods and services is principally by a price.

Prof. Leeder—Sure.

Mr TURNBULL—There are very few price signals to the consumer, the patient, in the health system and obviously that has an impact not simply on whether less necessary services are procured—or whether necessary services are procured in a more or less expensive way—but also on—and you might comment on this; I am asking this as a question—whether people have a lifestyle which is more or less likely to result in them needing medical treatment. If people have to pay more for their medical treatment, for example, would they be less likely to have a lifestyle which led to obesity? We do not know the answer to that. Could you comment a little bit on price signals? I gather that you would have been philosophically sympathetic to there being more clear price signals, yet on the other hand your comments about Medicare and the PBS would suggest that you are looking for fewer price signals.

Prof. Leeder—You make a very important point. If I could massage the question slightly so that I could answer it properly I would say, 'Tell us about demand-side modification of the health system of which price signalling is one method.' If you up the price, you reduce the demand.

Mr TURNBULL—Elasticities.

Prof. Leeder—Yes. The fact is that we do almost nothing by way of demand-side modification, it is nearly all supply side—that is the only tool in the box that we have at the moment. One of the great virtues of Medicare was that it provided a fairly blunt instrument whereby supply side could be kept under moderately good control. Every step we take away from that surrenders that ability. But I think there are areas where price signalling has not been explored. For example, it is perfectly possible to have the philosophy that says, "Health insurance should be universal, but people should know what they are paying for their health insurance.' At the moment, we have no idea. The Medicare levy is a slim fragment of how much you or I pay for public health services in this country. For my money, I would like to be able to say to people, 'We have a very good health care system. Do you realise that, of your tax at the moment, this amount goes to pay for health care?' That would be a very accurate statement of the price of these services. I think where you run into trouble is if you put a price signal at the point of use. The biggest problem I have there is that most use of the health service is not discretionary. This is what makes it such a difficult—

CHAIR—Could you explain that?

Prof. Leeder—Take a painful example from which I have just personally suffered. About three weeks ago, I had a fall. Two weeks ago, I went to see an orthopaedic surgeon and he said, 'You've torn a cartilage. You need to have it removed.' Last Monday, I had it removed. There was nothing discretionary about that whatsoever, so what I paid I had no control over. It just had to be paid. I was not thinking, 'What'll I do next Monday? I think I'll have a cartilage out.' There was no discretion. I suppose I could have hung around for a long time and had it done through some system but orthopaedic surgery is an art form that is really distinctive, as you have probably gathered. That is what I meant. But if the price signal comes to me and it says, 'You're paying this much in taxes on Medicare and you're paying that much for your health insurance,' that at least is bringing me into the economic loop. At the moment I am not in it. I have a rough idea of what I pay for private health insurance and no idea how much of my tax goes to Medicare.

Mr TURNBULL—That is not really a price signal.

Prof. Leeder—I am buying insurance.

Mr TURNBULL—But there is no incentive on the part of either the doctor or the patient to have a procedure or a service, which may deliver the same result, which is more or less expensive.

Prof. Leeder—That is true. I suppose that the best we can do in that regard is look at the variation in prices charged by different practitioners according to their expertise. There is one there. You can choose a really good person who will probably charge a couple of thousand dollars above whatever the fee is. Whether that is sufficient though to actually modify anybody's behaviour is something I do not know. But I think the problem that we run into when we say, 'Let's put a price signal on, say, general practitioners' services above what is already there,' is that, where we do have evidence that suggests that if the price is high—despite and in contradiction to what I said before about the use of health services not being discretionary—in fact, poorer people do not use general practice for necessary things.

There have been some studies done on the interval between Medibank and Medicare in Western Sydney looking at the stage at which poorer parents took their children with middle ear infection to a general practitioner under different financial arrangements. The evidence was there to show that when the price went up the parents thought, 'Let's just put a bit of cotton wool and olive oil in the ear and see how we go,' with the subsequent consequence for the child, which was gone when the price signal was abolished.

I do not mean to simplify this because it is not simple and there is a great deal more to be done, as for example Kaiser Permanente has done in California. We read a little bit about this with Medibank Private this morning in the press—that with judicious help to people to modify their lifestyles and to make them more health-enhancing you can, in fact, reduce demand. That is an incredibly important possibility not to lose sight of when we contemplate a population that is growing older, where there will be more people with these kinds of lifestyle related disorders.

My final comment would be to say it would be wonderful if we could test this out with a few small things so that we were not having this sort of vague, spiritual conversation and we actually had some more facts on the table. I think there is a real need for a bit more experimentation. It is

like the flat tax/progressive tax debate. People say, 'The GST is very inequitable, it's flat,' but, as the *Economist* magazine points out, when you look at what actually happens a flat tax is probably as equitable as a progressive tax system for all sorts of reasons that you would understand better than I would. I would not rule out price signalling at all. I think it is unfortunate that we do not have it on insurance. I think there are some areas where it could be used, as you suggested, to provoke greater awareness of health possibilities and engage in behaviours that are more health-promoting and, one would hope, to reduce demand.

Ms HALL—That would not work for all groups in the population because that is assuming everybody has the choice to modify their behaviour, whereas there are some people whose behaviour is not determined by the fact that they choose to do certain actions but rather that the cost factor in itself is the driving force.

Prof. Leeder—I would go back one step to Mr Turnbull's original question to me about how this fits in with public health. The most effective way of controlling tobacco consumption is to increase the price of tobacco. Who gives it up? The people who you might expect, as you say, are at the bottom of the pile and have the least freedom to move. They are the ones who quit. So price signalling, as a strategy internationally for promoting health, is fantastic. Tobacco tax is the best thing that any government can do to promote better health. I would not worry about anything else, but we have got it in Australia; we have got just about the best international record in regard to tobacco consumption of anybody—17 or 18 per cent. It could be better, but it is fantastic.

Mr TURNBULL—We heard from the Dental Association earlier today, and they made the point that there were now only 65 dentists graduating from Sydney university, whereas in the fifties there were hundreds—400 I think was the figure mentioned.

Mr GEORGANAS—260.

Mr TURNBULL—Yes, 260. We asked Bill O'Reilly why that was so and he speculated that it was because places in dental schools were expensive. We asked whether the university had stated that they could not recover enough from full fee paying students or from HECS students—government plus HECS contributions—to make it a viable proposition. He said they had not said that, but we would be interested in your thoughts about the financials of dentistry. And could you comment on medicine as well, because it appears that there is genuine demand for people to study dentistry but there is a lack of places. It was not very clear to us why there would be such a lack.

Prof. Leeder—It is not entirely clear to me either. I spent last Friday with dentists and dental technicians, looking at the national dental health plan to see what its implications are for New South Wales. It is a very depressed area for some reason. I do not understand why. Public dentistry is one of the casualties where cost shifting has gone in both directions and there is no money left for public dentistry. It is really in very dire straits. The Commonwealth, in 1996 or 1997, withdrew its money, some $90 million or so, from the Commonwealth dental scheme and the states have played a bit of a game and have not really picked it up.

How does that bear upon dentistry training? The fact is that people train for dentistry in the public dental sector. They train in public dental hospitals—at Westmead in New South Wales and

at the dental hospital—or they do not train at all. If that institution is in trouble—as both Westmead and UDH appear to be—then it does not expand and grow. With increasing technological sophistication you can imagine what happens. Whereas once upon a time a dental chair looked like that, with a pair of forceps to yank out the carious teeth, now it looks as if it is capable of putting you in space. It has lasers, suckers and drills and things all over it and fancy everything, so it costs a mint. So the resources that previously covered a roomful of chairs are now down to a relatively small number.

There have been some pretty good efforts to turn dentistry training on its head a bit and make it more contemporary. Sydney now only takes into its course people who are graduates of another course. That does not solve the numbers problem.

Mr TURNBULL—The full fees are about $33,000 per year?

Prof. Leeder—Yes.

Mr TURNBULL—That is what we were quoted. Is that for foreigners?

CHAIR—That is for the HECS debt.

Mr TURNBULL—No, that was the per annum fee.

Prof. Leeder—It is expensive. It is probably the most expensive faculty, according to the figures that I have, in any university.

Mr TURNBULL—I guess what I am asking is: if there is a body of students that are prepared to pay that sort of money then one would assume that the additional chairs are not being provided because the service is being underpriced and the university cannot provide the additional chairs without making a loss—is that so?

Prof. Leeder—What you have to look at here is the fact that the university might claim to teach them all about dentine and that sort of fancy academic stuff but when it comes to learning they do it in the public hospital system, where you will not find, in New South Wales, a truly robust state public dentistry budget—it is infrastructure.

Mr TURNBULL—You think the problem is the lack of resources in the public dental system, not the university?

Prof. Leeder—I do. It goes far beyond training students. The consumer groups and other groups that we had there on Friday were all saying that if you cannot buy it privately you are stuffed. There is a great underclass, particularly of older people and children, who require dental care and who are just not getting it. In New South Wales there is a staggering statistic. We have the highest rate in Australia of children coming into hospital and having general anaesthetics for dental work, largely because it is treatment of last resort.

I do not let the dentists off this hook at all. I think their behaviour, when Medicare was first brought in, in regarding the mouth as some kind of sacred cathedral that should not be funded under Medicare has done everybody a damnable lot of damage, and we still have not recovered.

So there really is no substantial public dental equivalent to what Medicare guarantees for general practice in this country. What you see when you look at the training problems is a fragment of that dysfunctionality.

Having been a dean for six years and manifesting a degree of financial incompetence on my part, I can make judgments about some of my academic colleagues. They are not the best people to ask about the total investment required to fix dental training. They will tell you what they need for people in the university, but that is only a fifth of the total training package. So, from the New Wales government, you would have to get two dental hospitals and you would probably have to build a couple of new wards, quite frankly—and that is a lot of shekels, as we know. So it is going to be a bit of a mess for quite some time; that would be my guess. Private funding for dental students may alleviate some pressure but it will not fix the problem, because the problem does not lie at that level.

Mr GEORGANAS—Professor Leeder, on that issue of dental care, you mentioned that it is regrettable that years ago dentists did not take up the agreement like doctors did with Medicare. Would you say that funding health care through the Medicare system is the best option available?

Prof. Leeder—In my judgment it probably is. I think Medicare is showing a few signs of decrepitude. It is a bit like the shuttle program—panels keep falling off and things happen. But the great principles of universality and a single payer having control over the supply side are being tested internationally and I think come out pretty well. It is not to say that there is not room for improvement; it is not to say that there is not room for experimenting with private providers under a national financing system. We seem to think that private health insurance is the only manifestation of possible cooperation with the private sector—not so. There are lots of things that we could do. We could look at personal health savings accounts and all sorts of things. Lots and lots of things can be done that are not unrelated to what Malcolm was talking about before, such as people taking a greater responsibility for their own health and for the cost of that health care.

Medicare does a pretty good job by international standards. I can only say what my experience is there. If anyone said—and I do not suppose there is anyone sitting around this table who would say it—'The next thing is to abolish Medicare,' I would have quite an interesting conversation with them. I think it provides for a lot of people in all sorts of ways. You have only to contrast it with what we have in dentistry where we do not have 'denticare'—it is a mess.

It is not that the government is not putting money into it. My goodness! There is $120 million a year of federal money now going into dentistry, but the government does it for those of us who use dentists and claim something back on our private health insurance, not for those people who really need it.

CHAIR—Can I move to public hospitals and ask you a hypothetical question? If you woke up tomorrow morning and found that you were the Commonwealth minister for health, what would you do—

Prof. Leeder—Do you know what I would do? I would go back to sleep until the feeling passed. I would lie down until the feeling passed.

CHAIR—I will still ask it. What would you do to stop the public hospital stories that appear on the front pages of the newspapers every day?

Prof. Leeder—It is a bit like when Malcolm Fraser came to power and said that he was going to get politics off the front page and wanted to see sport there. I do not know how long that lasted. I do not think it was all that long. It is a good question. The indicators are that we need a better mechanism of funding for these instruments of health policy than we have at present. There is this political tension between the states and the Commonwealth which is often very unproductive. People have talked about—through COAG or some other means—bringing together not just ministers for health but also finance and treasury to talk about how we can ensure that they are funded adequately to satisfy both sides of politics and both sides of the Commonwealth and state divide. I think there has to be more talking at that level and not just amongst ministers for health because that is not where the big decisions are made. These are mainly financial and political decisions. As I have alluded to in my submission, we could get better agreements on levels of funding and we could also discuss how we might achieve greater levels of efficiency. There is probably quite a lot of waste, apart from cost shifting, which could be remedied with professional goodwill because it is in the patients' interests.

Safety is a classic case in point. We keep saying, 'It's not the doctor's fault; it's the system's fault.' That may be true, but in that case let us talk about how we fix the system. It costs the US $9 billion a year in errors. If we scale that down by a factor of 10 or more for Australia, it is still a lot of money. Those are the things that I think should be on the national agenda. They are not specific to any one state or any one place. In that discussion there would be a lot of political and financial matters, but there would be some health care matters too. They would include how best to provide care for people who have a serious and continuing illness and for whom hospital care is only one part but a very important part. What part should the hospital play? Alan was asking before about letters to GPs. That is like a little flag. That is just one part of the whole business of getting a solid working team going around someone with diabetes, heart disease, kidney disease or whatever it is, so that they do not need to go into hospital as frequently as they did. It is not difficult.

I do a tiny bit of clinical work with some colleagues who look after people with really severe respiratory disease. We have been able to show, by following them, without placing an additional burden on carers, that you can cut hospital admissions by 50 per cent by talking to them. We talk to them about their anxiety over breathlessness, tell them not to feel guilt stricken that they have this problem because they smoked—that is just too bad. It is a big problem, actually. By giving them some exercise training and a bit of confidence, you can do it. These things would fit into the efficiency quest that would be part of the national mission.

I do not know whether it would get these matters off the front page, but it would be rather nice if, after a period of discussion, the various ministers could come together and say, 'We have consulted widely'—that would be part of the deal—'and we've got a really good public hospital system in this country and this is our vision for where we want it to go over the next five to 10 years. This is what everybody tells us, this is what we think it will cost and this is how we are going to work together to achieve it.' That sounds a little bit aspirational, but I have seen terrific things happen in health with strong and enlightened leadership from both sides of politics. I have seen it happen and it can be really good. I think that would begin to pacify people but, ultimately, health is a wonderful media topic. When there is a story about the latest molecule that

has the potential to extend the life of a mouse by 14 days, everyone thinks, 'Multiply that by 50 and it will give me another year of life.' I do not think you can get it off the front page, because it is like sport—

CHAIR—I will not ask you what you do on day 2!

Prof. Leeder—I do not know whether that answers your question but I think there does need to be new state-Commonwealth unity around a clearly articulated vision of what we are aiming to do with public hospitals so that people do not have bizarre expectations. We were talking earlier about how we might get public debate. It may be that someone comes out and says: 'You cannot expect something beyond blah blah blah. It is just not workable. If we are going to do these other things, that is something we cannot do.'

Ms HALL—One of the issues you raised in your submission is the Pharmaceutical Benefits Scheme. You have talked about co-payments. We have talked about dentistry and the fact that there is really no public provision of dental care. Added to that, there have been some changes in Medicare. Fewer doctors are bulk-billing, be they specialists or GPs. Do you think there is a move to cost shifting, not between Commonwealth and state but to the individual?

Prof. Leeder—I think so. It may be for good and proper reasons. I think also there has been a more general push towards favouring private rather than public, which I guess is part of the same sort of ideology—often, I might say, introduced with statements of reasons that do not quite match the reality. But that is not peculiar to Australia; that is world wide. If you go to Britain you will see what Tony Blair has done. In Canada recently, legislation was interpreted in such a way that private health insurance is no longer illegal in that country. In Singapore they have personal health savings accounts. New Zealand are now looking at personal health savings accounts. So I think there is a global political shift away from what might be called the old welfarism to a position that takes more account of the individual's autonomy. One of the big challenges for those of us who value equity greatly is finding new interpretations for what that means in this changing scene. That is not easy, but it has to be done because otherwise those of us who are Medicare advocates will find ourselves positioned in a slot of complete irrelevance. That would be disastrous because it would mean that people would identify equity with us rather than examining it as a vital and living value.

Ms HALL—Do you think it is reflecting more than just a move away from welfarism? Do you think it is more about the actual cost of delivery of health services and care? I know you have mentioned unnecessary operations and allowing people to make informed decisions, but are there any other ways you think we can control this?

Prof. Leeder—I am sure there are. It depends on the body politic as to who is going to do what to whom. I suppose in the Australian democracy you could vote in anybody you like depending on—

Ms HALL—But this is not about voting; this is about health policy.

Prof. Leeder—You do not think the two are related? I think they are alike, actually. Quite seriously, health policy is very much a reflection of where prevailing general political thinking is at. I do not know what we can do apart from explore and discuss what value we as a community

put on equity. Equity seems to be a word that has almost disappeared recently, and I think that is unfortunate. Whether you believe in it or not, it would be rather good to hear debates around that word again.

Mr TURNBULL—You have to define it first.

Prof. Leeder—That, of course, is not an easy thing to do, but let me give you my definition in health care: it is equal access to equal care for equal need. I define it as that value which is offended when we observe something that seems to us to be unfair.

Mr TURNBULL—So your proposition is that two people with the same medical condition should be able to receive exactly the same treatment. If one of those persons has more resources, should they be able to buy better quality care, or should that be prohibited?

Ms HALL—But it goes across more than just ability to pay. It is where you live and all those other aspects that you are talking about with equity.

Prof. Leeder—Access? Yes. For my money, I think that the answer is probably no because I would expect that, if equity were operating properly and fully, there would be no need to seek superior care. In other words, the care that you would be getting under Medicare would be up to scratch. I am not for dumbing down quality in favour of equity; I am for making the system as efficient as possible so that what we provide equitably is as good as it possibly can be.

Ms HALL—I have two more questions. In your submission you talk about the administrative costs of public and private hospitals.

Prof. Leeder—No, I talk about private health insurance.

Ms HALL—Yes, sorry—public and private health insurance. You say that administration costs for private health insurance reveal three- or four-fold higher costs than for Medicare. What do you attribute this to?

Prof. Leeder—Economy of scale, largely.

Ms HALL—My final question is: do you think the $2.3 billion of public money that has been subsidising private health insurance is an effective way to finance health, or do you think there is a better way of doing it?

Prof. Leeder—It depends what your goal is and if the goal is as stated—that is, to take pressure off the public system. But, if as you were describing earlier the goal is to move people in the direction of a greater private contribution to health care, yes. If it is to liberate the private sector to engage in health care, yes.

Ms HALL—What does it do for equity?

Prof. Leeder—Absolutely nothing. It reduces it, actually.

Ms HALL—It does nothing for equity.

Prof. Leeder—It does nothing by my definition. Malcolm is right. You could have Andrew Podger in here, for example, carving me up with an axe and saying: 'That's your idiosyncratic definition of equity, Leeder. Mine is: da da da dum.' He would claim that by giving money back to people who have private health insurance the system is more equitable. He and I have this fight all the time, so it is boring. But equity as I described it, as a social value, at least for me is diminished. But the other important thing which does not attract much public comment is the totally unsurprising one that, as you sacrifice the fiscal control capability of monopsony—of a single payer—and give other people the right to pay and charge what they like, total health care costs go through the roof. If you have a public stake in that, you are stuffed.

Mr VASTA—Professor, I will be very quick. We heard about the dentists who gave evidence before, but we had the pathologists as well and they were talking about a critical shortage of pathologists. I wanted to hear your comments, quickly, on that.

Prof. Leeder—There is a critical shortage of pathologists, and the number that you can attract into academia, like radiologists, is close to zero. Have a guess why: because we cannot pay them anything like what they can get. There is a catch-22 there. When you do not have people working to train the next generation, one of the consequences is that there will be a shortage.

I hold out hope with the Productivity Commission looking at these things. Along with my colleagues from the University of Western Sydney, I met with three of their representatives yesterday. I hold out some hope. Why? Because they are working to COAG rather than just to state or federal governments—it is a combined effort. I think it is coming on quite well. As to dentists, geriatricians, pathologists and developmental nurses, you could be here forever talking about that, but leave that to them and see what they say about it.

CHAIR—Thank you. We have to wind it up, but that was very entertaining.

Ms HALL—Entertaining?

CHAIR—It was entertaining!

Prof. Leeder—I hope I have brightened your afternoon!

CHAIR—If you follow the evidence of this inquiry on the net and you want to come back, you are more than welcome.

Prof. Leeder—Thank you very much.

[3.40 pm]

McDONALD, Ms Heather, Executive Manager Customer Services, Australian Council on Healthcare Standards

ROBINSON, Ms Maureen, Executive Manager Development, Australian Council on Healthcare Standards

CHAIR—Welcome. Although the committee does not require you to give evidence 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 which may be regarded as a contempt of parliament. Before going to questions, would you like to make an introductory statement?

Ms Robinson—Thank you for allowing the ACHS to provide a submission and to appear today. The submission we provided specifically addressed your third term of reference, which relates to the accountability of health services and hospitals for the quality of care that they provide to the community. We did not specifically address any of the other terms of reference because we believe that our process provides very little robust, specific evidence that would inform your deliberations in relation to these matters.

To provide a little bit of background, the Australian Council on Healthcare Standards is a non-government, not-for-profit organisation that was established 30 years ago to provide external review and evaluation of health services across Australia. Since that time we have grown somewhat. We have approximately 900 health service member organisations and we are funded by those 900 members to provide external accreditation services. Those members include public and private organisations, metropolitan and rural, very small—tiny day procedure centres—through to large level 6 teaching hospitals, acute services, community services, mental health services, divisions of general practice and various other health services. We accredit 63 per cent of public hospitals in Australia and 74 per cent of private hospitals, which makes up 67 per cent of total hospitals and equates to 87 per cent of total hospital beds. We also provide services to a number of other non-bedded health services; they do not all have beds. We review approximately 400 health services across Australia in a year.

The accreditation has five main components. They are not quite as humorous as the different components that Professor Leeder talked to you about, but we will try to make it interesting for you. The accreditation process has a governance and a stewardship role. It has a role in setting standards for health services. It has a role in providing a review process against those standards. It also provides a remediation process after that review has taken place if that is indeed required. Not all hospitals require a remediation process after the review, I can assure you. The accreditation process also has a fundamental quality improvement component to it.

The ACHS accreditation process consists of a four-year cycle of events that health services voluntarily sign up for. They are designed to try to achieve those five things that the accreditation process should achieve. In that four-year cycle of events, health services go through an organisation wide self-assessment process against our standards. They go through

two review processes by external surveyors, which we provide, and there are on-site surveys. They also develop a quality action plan from those surveys and then carry out further self-assessment on a yearly basis. The result of an on-site survey by the ACHS will be the grant of one of three different levels of accreditation: full accreditation, conditional accreditation with high priority recommendations or non-accreditation. There are very strict ways for us to determine what sort of status an organisation will be provided with. We would be very happy to answer any other questions about the process if you would like to ask some.

In relation to the value that accreditation provides in improving the accountability of health services, we believe that there are many aspects of this whole process that will achieve this increased accountability. First of all, there is the accreditation and the standards-setting process itself. The standards that we develop, the way that we develop them and the things on which we develop them provide a very high level of accountability.

We are currently going through a review of our standards and we will be introducing new standards that will even further increase the accountability of health services. They will also relate to a number of the things that Professor Leeder was talking about, with organisations having to review what they do and why they do it and provide evidence about whether they are the best things to do. The accreditation process itself places organisations in a situation where they have to be accountable, because somebody from the outside comes in, looks at their services and evaluates them against our standards.

Consumers participate both in our standards development and in our standards. We require in our standards that consumers are integrally involved in their care, in their process and in the policy development side of things in health services. That provides a level of accountability. We also want and are trying to get consumers much more involved in the surveys. Our mental health surveys all involve a mental health consumer.

The public reporting of accreditation results by a health service provides a high level of accountability, but this is not a mandatory component of our process at all. We do encourage health services to put their reports up on their web sites, because the reports they receive are extremely comprehensive. Of course, those health services that do very well are very happy to put them up and those who do not do well are not. That is at the individual organisation level.

At the national level our reporting of aggregated results of accreditation results is a very important way to provide accountability. We provided you with a copy of our report that we launched last week on the national aggregation of accreditation results, and we have others here if you require them. That has certainly thrown the cat amongst the pigeons, I have to say. It is our first report ever on the results of accreditation surveys across 674 organisations during 2003 and 2004.

Ms HALL—Do you list the organisations?

Ms Robinson—No, we do not.

Ms McDonald—But we do list the organisations on our web site. You may have seen the *Australian* newspaper report last Saturday. They got that information from our website. We put the organisations up that have the high priorities, as that is part of their contractual agreements.

Ms Robinson—The final way in which we believe this can provide accountability is the reporting of clinical indicator and other performance data in all sorts of ways. The ACHS has many member organisations that contribute to our clinical indicator program, so they report a lot of data to us and we report on that once a year in our public report. We are very happy to expand on any of these matters if you would like us to.

CHAIR—Before we proceed with questioning, do you have any role in the present royal commission into Queensland public hospitals?

Ms McDonald—Our chief executive, who is unable to be here today, is sitting on one of the review panels which are to review the quality of health care.

CHAIR—Do you have a role in accrediting Bundaberg hospital?

Ms McDonald—Yes.

CHAIR—What sort of monitoring systems are in place for anyone to pick up the fact that one doctor operated on 87 people who died?

Ms McDonald—I will respond to that without giving specifics, because the information belongs to the organisation. We did a review of Bundaberg hospital in August 2003. Some of the recommendations that were made by the survey team would have assisted if they had been implemented. Currently, our process is that we make the recommendations and we ask the organisation to give us a quality action plan. So they talk about how the recommendations made are going to be implemented—by when and by whom.

CHAIR—That is Bundaberg hospital, not Queensland Health?

Ms McDonald—That is done by Bundaberg hospital. Those are some of the gaps that we are now looking at for the next version: who has governance? Who is responsible for making those recommendations happen? We give high-priority recommendations. They are very important recommendations that have to be addressed immediately, and we want progress reports and we want action. You saw that there are still 26 hospitals with high priorities, but during last year we probably gave about 72 high priorities and the organisations who had those got rid of them. That is the process: organisations, as soon as they get one, generally panic and go, 'We'd better get it fixed straightaway'. That is what we want. We are here to improve the quality of care, not to smack people. For example, Bundaberg had some recommendations that have been ignored. What we need to think about is: how can we make that more robust? Do we have blue recommendations that go to the department of health or the boss of Ramsay Health Care so that the administrative bosses are responsible rather than the hospital managers if there is that sort of accountability structure. They have pretty much run out of accreditation. They are due for a survey now and they will not be having one, so they will not—

CHAIR—Have you appeared before the royal commission?

Ms McDonald—No.

CHAIR—Not yourself but the organisation?

Ms McDonald—No.

Ms Robinson—At the moment our relationship is with the member organisations, so we have a confidentiality arrangement with the member organisations. They voluntarily do this. We will survey them and we will give them a report and then it is up to them to act on it. There was a recommendation made to a health ministers conference last July that the results of accreditation should not just be given to the member organisation but should go a step higher than that. There has been no agreement to that process yet. If we were given the go-ahead to do that, we would change our policies so that we would provide a report not only to the hospital but also to the department of health or the area health service or the owner, like Ramsay Health Care et cetera.

Ms McDonald—Having said that, we should note that different states have a different arrangement. Victoria want all their public hospitals to be in an accreditation program. Most of them are with us. Their organisations, in their performance agreements, give the recommendations to the department of health, so their department know what is happening in their hospitals; they have that information. New South Wales do not do that currently but we are actually talking to a team at the Department of Health to see how we can improve what is happening there now. But it is for the departments of health to have it in their performance agreements with their hospitals.

CHAIR—Do you mind me asking you about Bundaberg?

Ms McDonald—No. I cannot tell you too much, but I can certainly think of the systems.

CHAIR—We can go in camera.

Ms McDonald—The reports have been subpoenaed by the commission, so the commission have got copies of the reports.

Ms Robinson—May I ask what our level of responsibility is?

CHAIR—I am trying to understand that. You do not have to answer.

Ms Robinson—Okay, thank you.

Mr TURNBULL—What the chairman is offering you is that, if we were to go in camera, it would remain confidential.

CHAIR—That is confidential to the committee. It would be a contempt of the parliament for anyone to divulge.

Ms HALL—You have got to consider confidentiality to your client as opposed to us keeping it within this room, so there are a few levels.

Ms McDonald—I am happy to talk about it because it would give you an idea of some of the recommendations that we can make.

CHAIR—Is it the wish of the committee that evidence from these witnesses be taken in camera? There being no objection, it is so ordered.

Evidence was then taken in camera but later resumed in public—

Proceedings suspended from 3.55 pm to 4.05 pm

Mr TURNBULL—I would like to ask a question about accountability. Often in other organisations, in business organisations, a board of directors or a governing body will have a series of performance benchmarks upon which they will get reports regularly: customer complaints, service defects or whatever—it obviously depends on the industry. Is it common for hospitals to have that kind of reporting so that the senior management are aware, regularly, of whether particular benchmarks are being met or not met and what types of issues are arising—complaints, deaths obviously, or complications? What sort of reporting is there typically?

Ms McDonald—Typically it has been financial. Recently, in the past five years, clinical governance has become the big word, and that is about reporting their clinical outcomes. Now they are starting to look at the clinical issues much more. Strange as it may seem, financials were far more important than clinical care reporting. Certainly most boards have now gone from most health services. It is only Victoria and South Australia rural that have boards on their health services in the public sector; everything else is run by the departments.

Mr TURNBULL—If there is no board then what price accountability anyway if that report is just going to a public servant?

Ms McDonald—You might look at Queensland for that.

Mr TURNBULL—Are you saying Queensland is an example of that kind of failure in accountability?

Ms McDonald—Yes. I would suggest you could use that, because the director-general is basically the manager and they are accountable for the entire public health service.

CHAIR—Does the Auditor-General in any of the states play a role in accreditation or the accountability side of things?

Ms Robinson—Do the state departments of health?

CHAIR—No, the Auditor-General.

Ms Robinson—No.

CHAIR—At the Commonwealth level, the Auditor-General conducts performance audits and that way it keeps ministers and public servants accountable for programs. We do not have that in Queensland.

Ms Robinson—No, I would say that this is the equivalent.

Ms McDonald—I will go back to your question, Mr Turnbull. A lot of people use our framework as a reporting framework. In fact, they will report indicators against some of the leadership and management standards. They would get that report at exec, for example. I guess in a lot of these organisations where there is no board, the executive are the ones getting the reports from the other units. But there is certainly not a governing body like a board that looks at it.

Mr TURNBULL—Should there be a national set of clinical benchmarks against which all hospitals should report? Should the results of those reports be publicly disclosed on a hospital by hospital basis?

Ms Robinson—It is very difficult to say that it should be disclosed on a hospital by hospital basis.

Mr TURNBULL—Perhaps you can answer the first part of the question. Do you agree with the first part?

Ms Robinson—The answer is yes to that. In fact, I think we have that in our submission—that there should be public reporting. At the moment, there is no requirement for our member organisations to report on clinical or other performance indicators. There have been a number of reasons for this, but we may make it a requirement of our next set of standards, which start in 2007, for all organisations to report on a certain number of indicators. Part of the reason why it has been really difficult for organisations to get a handle on clinical governance or on the clinical aspects of care and the responsibility that a board, or even the executive for that matter, of a health service has, is that it has been very difficult to measure. We all know that we have to measures things in order to be able to manage them, and there has been a lot of work put into correct measurement of health services over the last five or six years, but we still do not have it right and, until we do, it is going to be much more damaging to identify particular hospitals than it is not to.

Mr TURNBULL—That is because you are not comparing apples with apples.

Ms Robinson—That is exactly right. You get all sorts of comments like, 'You're collecting the wrong data,' 'It's not relevant to us,' 'It's poor data quality,' 'They're not defined properly,' and 'We treat much sicker patients than St Elsewhere does.' Therefore, they are not risk-adjusted appropriately and there are all of those sorts of complications, all of which are valid.

Ms McDonald—With respect to some of the public reporting, there was the New York cardiac reporting where they put up reports on different surgeons in different hospitals and their outcomes. The consumers could not have cared less. They saw it but they did not change their attendance patterns, they did not change their choices. But it made those doctors who were not performing improve their performance. In fact, it did work for the health professionals, but the consumers did not change. Some of that may be because demographically they cannot. Some people have to go because they have not got transport. The people who need the care the most are generally the ones who are unable to have a choice.

Mr GEORGANAS—In your opening remarks you mentioned—I think I have got the figure correct—that 67 per cent of hospitals are accredited by yourself. Is that correct?

Ms Robinson—Yes.

Mr GEORGANAS—Who accredits the remainder of the hospitals?

Ms Robinson—There are some that are not accredited and others—

Mr GEORGANAS—I am not saying accredited by you, but are there other bodies that accredit them?

Ms Robinson—Yes, there are.

Ms McDonald—The ISO group have a couple of accrediting agencies that use the ISO standards. They are our biggest competitor in day surgeries. We would have 50 per cent of day surgeries and they would have the other 50 per cent.

Mr GEORGANAS—How do they set their benchmarks? I know it goes on from the question previously—

Ms McDonald—No, they have got quite a different process to us. We have got a quality improvement philosophy, so we have got an organisation wide process. They have got more—it is the same ISO stuff, which is document control and processes. We look at health outcomes; they do not do that.

Mr GEORGANAS—If we look at the accreditation of aged care facilities, which are across the board—

Ms Robinson—That is done by the Commonwealth.

Mr GEORGANAS—Would a system like that be something that would be more—obviously there is an obligation upon the accredited aged care facility.

Ms McDonald—Sometimes there is a problem when it does not appear voluntary—it is legislated for aged care—and people will do the minimum standard. We have seen a great improvement in organisations striving to get to the next level. What would happen if you had that culture, if you legislated for it? I do not know really; I am not sure how to answer that.

Ms Robinson—I do not know that I could add to that.

Ms McDonald—With respect to the organisations that do not use us, this year we have got a lot more members in the rural sector because of the amalgamation of a lot of health services. That figure is probably higher now. There is another organisation called the Quality Improvement Council, and it accredits a lot of NGOs and the community health sector. It used to be CHASP—you might have heard of it as that—and it covers some of the community sector.

Ms HALL—When we were in camera we were speaking about the process and the fact that once you identify some actions that need to be taken, there is limited follow-up on that process and limited responsibility taken for those. Would you like to detail that a little bit more on the record?

Ms McDonald—That is what has happened in the report that you have got. You will see recommendations that we would not have gone back to visit for two years and we would get a progress report, a quality action plan, after the survey. We have a survey and the team makes recommendations. We then ask the organisation to give us a quality action plan. The staff in our office give feedback to the organisation to say whether they think it is appropriate or whether they think they can meet those recommendations. For example, if there was something about the credentialling, our staff would say: 'How are you going to do this? What're you going to do?' Then they expect the toing-and-froing until they have got a plan that our staff thinks is appropriate to meet the recommendations. That is the follow-up for the quality action plan. Whether they do it or not, we do not actually know until a year later when they send in their self-assessment. We then link the quality action plan to the self-assessment to see if they have done it, but bear in mind that is a year later. I guess you could have had some mishaps in that time if the recommendations had not been followed. We do not go back; even if we see a newspaper report, we do not immediately go in and say, 'We're going to take accreditation off you.' We have no provision to do that currently.

CHAIR—Your reports are confidential, aren't they?

Ms McDonald—They are only confidential if the organisation wants them to be confidential. Some organisations have got them on the web. The ear and eye hospital in Melbourne, which was named as one of the 26 worst, has its report on its web site for people to look at.

Ms HALL—Once the action plan is given to the organisation, if it is a hospital does it stay with the hospital? Is there any reporting to the area health service or to the government?

Ms McDonald—We can expect internal reporting from that. What generally happens is—and in my experience this would involve at least 90 per cent of organisations—they would be reporting on progress towards the quality action plan to their quality committees. And most organisations now have quality committees which are made up of medical staff, nursing staff and managers.

Ms HALL—Is that within the institution?

Ms McDonald—Yes.

Ms HALL—What role do you think the Commonwealth has in this process at the moment? Or what role should the Commonwealth have?

Ms Robinson—There has been a lot of discussion about the many accreditation providers, but more importantly, the many standard setters in the health arena, and that many organisations go through several accreditation processes. For instance, if you have pathology laboratories then you will have NATA come in and accredit the laboratories. Once the blood has left the laboratories then we look at it beyond that. If you have some aged care beds that are being funded by the Commonwealth then the aged care assessors come in et cetera. If you have postgraduate medical programs as well, they have to be accredited.

Many and most of the standards are very similar. Although ours have much more of a clinical focus than those of ISO and some of the other accreditation or standard setters, there are a lot of

standards that cross over. There has been a suggestion that there should be some correlation, some rationalisation, of health standards at a national level. That was a recommendation put to health ministers as well by the Australian Council for Safety and Quality in Health Care. I am not sure if a decision has been made about that, but it seems to me it would be a sensible process to pool all the standards and maybe have a box of standards from which you could take standards to assess organisations against.

Ms McDonald—Some organisations will say they have had five or six accreditation agencies in within three or four months, which is just an extraordinary amount of work and resources on top of delivering patient care, which is what they are there for.

CHAIR—Have you ever had any of your documents subpoenaed under a document search in a court case?

Ms McDonald—No.

CHAIR—What if someone was going to sue a hospital?

Ms McDonald—They would subpoena them via the hospital. In fact, I provided some information just recently to an organisation because they had lost their reports from 1976 or thereabouts. They asked me to give them their old reports which were being subpoenaed.

Mr GEORGANAS—So they would then subpoena the hospital for those reports which they would have a copy of after you have done that?

Ms Robinson—Yes, and it is the same with FOI. We are not subject to FOI either, and in fact it is attractive to some health services that we collect, for instance, infection control data for the New South Wales health system. We provide the New South Wales health department with an aggregated report and we are the ones who hold the data about the organisations.

Mr TURNBULL—Going back to public accountability and publishing benchmark information, the comparison of apples with apples point has been made: if one hospital's patients were significantly older and frailer than another's then that one's morbidity would be much higher. But there would be some benchmarks that would not be affected by relative demographic characteristics. One would be changes. Each hospital could publish the changes in particular, unless the demographic composition of an individual hospital's patients is going to change. I suppose that could happen over time, but normally that would be a long period.

Could you comment on whether hospitals could publish the changes in particular benchmarks—complications, morbidity and so forth. Also, I would find it interesting to know what sort of benchmarks, apart from changes, would be readily comparable, such as ones where the different demographic characteristics were not relevant—for example, infections. One would assume that the incidence of golden staph is an absolute issue; it is not going to be affected so much by the nature of the patient's illness—though I do not know; I am not a doctor. Also, there would be critical demographic characteristics where the differences between patients would be objective, like age. Obviously there are others, but it would be possible to compare, for example, complications in an obstetric situation. It would not be fair to compare mothers who are 20 with

mothers who are 38. Equally, hospitals could compare the results for mothers of comparable ages.

Ms McDonald—They do publish caesarean section rates now. They look at the demographics of hospitals and compare them with their own demographic organisations. But every time that data comes out, the obstetricians say, 'Ah, but they didn't take this into account.' You are dealing with people who do not do that. The blood guidelines introduce evidence based, best practice guidelines. Nobody will do it unless they have tested it in their hospitals, because they think their organisations are unique. They all need to do the testing first. The standards that we are putting in say that the best evidence should be used when doing anything.

Mr TURNBULL—Can you give some thought as to what benchmarks could be used that would be fairly comparable and could increase accountability?

Ms Robinson—We have put a fair bit of work into that over the last six or seven years, and we have a group of hospital-wide indicators. They include such things as return to the operating theatre, return to intensive care unit. Most of these are not great issues, as in they do not argue too much with these numbers.

Ms McDonald—Readmission rates.

Ms Robinson—Yes, readmission rates within 28 days of being discharged from hospital are included. Other things that you have suggested include clean wound infection rates. If you start with skin and you cut it and you get an infection in it, then that is a big problem. Also, central lines and peripheral lines that go in should not become infected, and there are good ways of making sure that that does not happen. Then there are other things such as death rates of patients with asthma. People should not die of asthma these days. Another one is admission rates for patients with chronic disease. If you have heart failure or diabetes, it should be very uncommon to be admitted to hospital. They are indications of the effectiveness of care. Blood transfusion rates, as Heather said, are another very good one.

I honestly think that we should be reporting these things. There are two distinct philosophies around the reporting of these data: you either have to keep on working on them until you get the indicators right, the numerator and the denominator—and we argue about definitions—and we keep on going until we get it right and then we publish; or you collect the numbers and you put them out there and then the people who are held accountable for them clean them up. It is my philosophy that we should be doing much more of that—putting them out there—and then we know that they will clean them up because they will be responsible for them and then that data that we get back—

Mr TURNBULL—What do you mean by 'clean them up'?

Ms Robinson—It goes to the sorts of comments that Heather made where you publish the data and then the clinicians say, 'Oh, but you didn't take this into account and we didn't know that it was going to be published, so we didn't collect it properly' et cetera. Then, when they know that it is going to be published, they make sure that the data that we receive the next time is robust.

Mr TURNBULL—They clean up the data.

Ms Robinson—Exactly.

Ms McDonald—We do actually publish that information to organisations de-identified. The organisation knows which is theirs and they compare themselves to the rest of the country—

Ms Robinson—To the national aggregate.

Ms McDonald—Yes, to the national average. So we already have that process and have had that in place for five or six years.

Ms Robinson—But we do not publish it at the hospital level.

Mr TURNBULL—The national average is probably less meaningful than comparisons with similarly situated institutions.

Ms Robinson—That is true. The data that they get back about their organisation also compares them with peer institutions.

Ms McDonald—But we do not make that public and it is not named.

CHAIR—Are there any standout differences in standards between regional hospitals and metropolitan hospitals?

Ms McDonald—In some situations there are, but they would be structural situations—some of the buildings are quite old and things like that—but they do have an impact on how care is delivered. They are struggling financially to get new buildings and all the capital infrastructure. We have other things in place, including requiring them to have a certain number of staff who are fire trained if it is a fire risk—all those sorts of things. We get it round it that way. Then there is the issue of distance and the transfer, so the discharge planning is a bit different because, unlike in the cities, it is often the GPs who are the VMOs in a regional situation. You have those differences. As to the quality of care, if people are really sick they are usually transferred anyway, because they cannot cope with those—

Ms Robinson—But if you ask rural health services whether they should not be expected to provide the same level of care or the same quality of care as metropolitan health services, they say ‘absolutely definitely not’. They provide the highest quality care.

Ms McDonald—You have in fact got multiskilled staff. They are not specialists but they are specialists across a much larger area than the metro type people.

CHAIR—I thank you sincerely for the evidence you have given us and for your submission. If you think there is other information we could use, any recommendation we should make or people we should see or talk to, please communicate with the secretariat, because I think your work is extremely valuable in what we are trying to achieve.

Ms McDonald—One of the terms of reference for the Australian Council for Safety and Quality in Health Care inquiry was regarding accreditation, which has not been done yet. I suppose that needs to be considered as well. We probably should send you the clinical indicator.

Ms HALL—That would be good.

Ms Robinson—In the report I did not beef up the clinical indicator stuff, but that is a really important part of our business.

Ms McDonald—We could give you the comparative report that we do and then you could look at—

Ms HALL—Malcolm's questions?

Ms Robinson—Yes.

Ms McDonald—Yes—whether you want to think about how that could be made public and what bits the Commonwealth might want to—

Mr TURNBULL—Accountability is an informing choice—tied in together, of course. The government has made great strides in that direction with schools. You may well consider that that sort of philosophy should extend to hospitals as well.

Ms Robinson—I will add one thing in answer to your question about how we get health services off the front page. I firmly believe—and it certainly has happened in some aspects in New South Wales—that the more information you put out there and the more data you provide, the less interesting it becomes and the less it will be on the front page. I used to work in the New South Wales health system and there was such a to-do, such a fuss, about putting waiting times and waiting lists et cetera on the web and being accountable for it. Once a month we would get an FOI from Jillian Skinner for the waiting list data, so we eventually put it on the web and nobody takes any notice of it any more. It is about being accountable. There is still a lot of activity going on to reduce waiting lists and waiting times but it is not sensationalised any more.

Ms HALL—That is very useful data, because it shows the waiting time for various doctors and it gives people who are looking for some sort of elective surgery a bit more control over their situation.

Ms Robinson—I can assure you that within a month of that first lot of data going on the web, it was cleaned up. The first lot was not terribly robust but it is very accurate now.

CHAIR—Thank you for your attendance here today, and thank you to Hansard.

Resolved (on motion by **Mr Vasta**):

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 4.29 pm