COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

MONDAY, 28 NOVEMBER 2005

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Monday, 28 November 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 Cadman, Ms Hall, Ms King, 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.

WITNESSES

Committee met at 9.42 am

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into health funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. Although Australia has one of the best health systems in the world, members of parliament are only too aware of the need for improvements. We all receive a steady stream of complaints from our constituents concerning the health system—often about private health insurance premiums, gap payments, public hospital waiting lists and many other things.

As you are no doubt aware, senior officials are due to report to COAG late this year on ways to improve Australia's health care system. We await their findings with interest. However, this committee's inquiry is wider ranging and more open than the COAG process. Unlike the COAG review, our committee gives organisations and individuals outside the government an opportunity in a public process to express their views about Australia's health care system. At today's public hearing, the committee will hear from the Department of Health and Ageing and the Australian Medical Association. The committee has currently been focusing on the private health sector, although this public hearing will also canvass issues relating to health funding more broadly. This hearing is open to the public and a transcript of what is said will be made available via the committee's web site. If you would like further details about the inquiry—or transcripts—please ask any of the committee staff here at the hearing. I now call the Commonwealth Department of Health and Ageing to give evidence.

[9.44 am]

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

BLAZOW, Ms Judith Alison, Advisor, Medical and Pharmaceutical Services Division, Department of Health and Ageing

COSTMEYER, Ms Yvette Maree, Acting Assistant Director, Policy Analysis Section, Policy and International Branch, Department of Health and Ageing

DANIEL, Ms Judith Anne, Assistant Secretary, Primary Care Policy Branch, Department of Health and Ageing

DAVIES, Mr Philip Keech, Deputy Secretary, Department of Health and Ageing

MASKELL-KNIGHT, Mr Charles Andrew, First Assistant Secretary, Acute Care Division, Department of Health and Ageing

SCHREIBER, Mr Rodney James, Director, Policy Analysis Section, Policy and International Branch, Department of Health and Ageing

SMYTH, Mr Nathan Andrew, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing

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

YAPP, Ms Gail, Assistant Secretary, Acute Care Strategies Branch, Acute Care Division, Department of Health and Ageing

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

Mr Davies—Yes, thank you. Just very briefly, I would like to thank the committee for inviting us to come back for a second time. I think last time we spoke to you was your first day of hearings, so obviously you have had an opportunity to traverse a lot of ground since then—I think it was the end of May when we came to see you. I gather submissions have continued to come in. By our reckoning, you have had another 60 since then.

There were a couple of requests put to us in the interim, specifically for further information regarding informed financial consent in the private health insurance context and an update on the state of public hospitals. What I would like to do, before we start off maybe, is table two copies of the report of a recent informed financial consent survey. We have already sent the electronic

link to the secretariat, but we thought we should give you hard copies. I have also brought a couple of copies of the annual *Report on the state of our public hospitals*. It is the latest one, which was published in June this year. Again, we have provided an electronic link to that, but I have hard copies, which I will table for the committee this morning.

We are also aware that there were a number of questions on notice raised at the end of May, last time we appeared. They are still working their way through the system, but we are following up on those assiduously. Other than that, I think we put ourselves at your disposal to attempt to answer any further questions.

CHAIR—As you know, we have had quite a few bumped hearings. We have had hearings in Sydney, Melbourne and Adelaide—and here in Canberra. We have not had submissions sufficiently yet from the state governments, who are all saying they are waiting for the outcome of the COAG process before they address the terms of reference in our inquiry. That has made it difficult for us to come to any conclusions about public hospitals. We have arranged with your department to give us a briefing on the Australian health care agreements and how they work and whether the model the health care agreements use is the best one for Australia and whether there are alternate models we should look at. As well as that, we talked last time about some of the problems that were happening in Queensland in the public health system. We have had extensive hearings with the private health sector and have received some very useful evidence. It seems to be very hard to link public and private hospitals—the problems and the relationship between the two—when the states are not cooperating with the inquiry so far. Can we ask you initially to update us on the COAG process? I think that is important, because we see ourselves as being a forum for organisations to have an input into the COAG process that normally would not. We are not aware how COAG is conducting its meetings—how the committee of officials is working and whether or not evidence taken by this committee and in other forums, such as the Productivity Commission, is being put into that committee. Could you give us an update on that?

Mr Davies—Sure. The June COAG meeting agreed that Commonwealth officials and state and territory officials would actually work together to look at ways of improving the system in nine specific areas listed in the communique and, as I mentioned earlier, report back in December this year on a plan of action to progress reform. That working group of Commonwealth and state officials has been working very intensively since June/July. Obviously, this department is represented on that joint Commonwealth-state working group, but the details of the discussions of that working group, obviously, given the COAG context, are being held in confidence. It is actually the Department of Prime Minister and Cabinet from the Commonwealth side that is responsible for managing that work—the COAG secretariat in PM&C. But I think I can say that the working group is taking account of all sources of information and opinion in this area. I obviously cannot speak for the group, but I would be surprised if the submissions made to this committee have not been something that they have looked at in their deliberations. I understand that they are also contemplating discussion with interested groups, but again I am not party to the details of when, how and with whom that might be happening—it may indeed already have happened.

CHAIR—Is your department represented on that committee?

Mr Davies—We are, yes.

Ms HALL—Do you know if the report is going to be delivered on time?

Mr Davies—I am not aware of any delays. I think COAG is scheduled to meet again in February next year. I think that is their next scheduled meeting.

Ms HALL—So, if the report is going to be delivered in December, it should be in the process of being written and printed now. We are only a couple of days away from December, aren't we?

Mr Davies—December has 31 days in it.

CHAIR—Not after Christmas, it doesn't.

Mr Davies—I am sure my colleagues in PM&C may argue otherwise. But, as I say, I am not aware that there is any conflict with that commitment to deliver during December.

CHAIR—Will that report be made public?

Mr Davies—I do not know.

CHAIR—Will it be made public officially?

Mr Davies—It is a report to COAG. What happens to it beyond that, I could not say.

Mr VASTA—You think the discussions have been going rather well? There has not been any hindrance?

Mr Davies—Without being present in the room, it is hard to say. I know there is a lot of work going on.

Mr VASTA—Is there anybody here who has been present?

Mr Davies—I do not think anyone here has been directly involved in that, no.

Ms HALL—So the federal department has been involved. I presume the state departments have been involved?

Mr Davies—Yes.

Ms HALL—Who else is—

Mr Davies—PM&C is the chair.

Ms HALL—Yes, so it is under the auspice of PM&C. Who else has—

Mr Davies—I think, by an argument of symmetry, I am right in saying that state premiers' departments would be involved as well.

Ms HALL—That would be a fair enough assumption, given that it is a COAG process. So who else has been involved?

Mr Davies—I think that is it, at the working group level: premiers and health departments.

CHAIR—The Productivity Commission has done some work through—

Mr Davies—Sorry, that was the other point you raised, Chair. As you may be aware, at the end of last month they produced a discussion document of some description. I cannot remember the technical title.

CHAIR—Yes. They briefed us a fortnight ago.

Mr Davies—I think they are also working to finalise their work by the end of the calendar year, and they then obviously will put together their final report as well, building on their interim report and submissions they have received in response to that.

CHAIR—Not pre-empting the COAG report, is their a view in the department regarding alternate models that might be considered for the health system in Australia? You know the debate that is going on about division of responsibility between the Commonwealth and the states. If we can talk hypothetically and not from a policy context, I understand the department is committed to the policy of the government of the day, and we do not expect you to do otherwise, but many people argue that there are alternative models available for the health system. We are being led to believe more and more as we receive evidence that there is far more to be achieved with the dollars put into the system than we are achieving at present.

Mr Davies—As you correctly point out, there is no government policy at the moment that contemplates or anticipates wholesale reform, reorganisation or restructuring of the Australian health system. I am not aware of any work that is going on in the department to develop, explore or evaluate alternative models. Having said that, obviously people generally in the department who work in the health sphere have, if you like, a sort of professional obligation to remain aware of what is going on elsewhere, but it is not something we would consciously allocate time to or even explore in an active way.

CHAIR—We are very keen to see the COAG report.

Ms HALL—It is going to have enormous implications for our hearing and our inquiry.

CHAIR—We have our hands tied until that process has run its course. Perhaps we might move to the health care agreements. Could you give us a briefing on the history of them and how they operate.

Mr Davies—Sure. Could I just clarify something: did you mention earlier that you had arranged a specific briefing?

CHAIR—We have not had it.

Mr Davies—Okay. So now you are just looking for a sort of overview?

CHAIR—The process has been this: the Auditor-General, in working out his audit program for the next year, has flagged that the health care agreements are one area that he wants another performance audit on. The Auditor-General was coming to brief us as a committee, but the committee felt that we should do it after this hearing, rather than before. We would like to hear from you about the agreements. Perhaps you could run us through what the Auditor-General found last time, why he would be doing a performance audit and how difficult it is to do a proper performance audit, given the responsibility of the Commonwealth Auditor-General with regard to the states—which is zero.

Mr Davies—I think my colleague Charles Maskell-Knight is the repository of institutional knowledge on this issue, so he might be the best person to speak on this.

Mr Maskell-Knight—I am a historian, so I tend to take a long view of these sorts of issues. The health care agreements we have now are effectively the descendants of the 1988 Medicare agreements. They were the first agreements that were put in place under Medicare. Prior to Medicare, under the Fraser government, between 1976 and 1983, a range of hospital funding arrangements were put in place between the Commonwealth and the states. As a result, by 1983, we were in a position where the states received a sort of identified share of general revenue grants as a contribution to public hospitals.

When Medicare came in and there was a commitment to free public hospital service, the states quite rightly looked to the Commonwealth and said, 'This is going to cost us more money than we are getting at the moment,' so what were called Medicare compensation grants were put in. They ran between 1984 and 1988 essentially. In 1988 both the identified health grants and the Medicare compensation grants were wrapped up. They were put together in something called Medicare grants, I think. Those agreements have essentially been the antecedent of what we have currently. They have been renewed three times—in 1993, 1998 and 2003. I guess the central characteristic of the agreements is that they are not purchasing arrangements; they are effectively funding arrangements. The Commonwealth makes available an amount of money which is about half the cost to the states of running public hospitals, and the states get that amount of money without regard to the volume of services they actually carry out. Is that enough to start with?

CHAIR—Sure. I am sorry for referring to Queensland all the time, but it is a system I know, because that is where I come from. Jill will do the same with New South Wales.

Ms HALL—Probably not. I am going to concentrate more on the technical aspects of it.

Mr Davies—I will make just one point, to be clear: the agreements do actually cover more than hospital services. They cover a variety of community and other non-hospital services.

CHAIR—Yes. But there are certain conditions that are applied to the grants—the agreements. Free treatment in public hospitals is an example. What would happen if a state brought in a system where they charged people in public hospitals.

Mr Maskell-Knight—I think that is a hypothetical question, but I imagine the Commonwealth government would be rather exercised about that. The agreements—

CHAIR—It is one of the options being considered in Queensland at the moment. It was in the funding announcement made by the Premier some weeks ago.

Mr Maskell-Knight—As I said, it is a hypothetical question, and a fundamental principle of the agreements is that the state commits to providing for access to public hospital services. Were they to cease doing that, I imagine the Commonwealth would take some appropriate action.

CHAIR—Like what? It is not illegal, as such, is it?

Mr Maskell-Knight—The agreements do not have any legal standing, no. No intergovernmental agreement has.

Ms HALL—It is an agreement, not a contract.

Mr Maskell-Knight—That is right.

CHAIR—The health care agreements work pretty well in general, don't they? The states always say we want more money.

Mr Maskell-Knight—They would say that.

CHAIR—Yes. But only since 1901. Ross, do you want to say anything?

Mr VASTA—If it is too hypothetical to talk about the Queensland model, I think you have explained it rather well—appropriate action.

Mr Davies—If it is a measure of how well they work, the current agreements do contain various sanction provisions for various technical breaches. In the two and a bit years that they have been in force, those sanctions have never been applied. That, if you like, is an objective indicator that the agreements are working in the way they were expected to work.

Mr VASTA—Chair, they have not been raised again by the Premier recently. Have you noticed that he has gone a bit quiet on that front as well?

CHAIR—Yes. But the report on Queensland public hospitals is due out on Wednesday. So we will know more by then.

Ms HALL—The part I am interested in in relation to the Australian health care agreements is the fact that now written into it is that if the department assess a state government or a territory as being non-compliant they can withhold four per cent of that state or territory's funding. Has that happened?

Mr Davies—No. That is one of the sanctions I was just referring to.

Ms HALL—That has not been—

Mr Davies—It has not been necessary to apply them

Ms HALL—Have you had cause to draw a particular state's attention to an area and then they have made adjustments?

Mr Maskell-Knight—We regularly engage in discussion and correspondence with the states where matters are drawn to our attention which imply possible breaches of the conditions.

Ms HALL—Which areas are those breaches in would you say?

Mr Maskell-Knight—Patient election in particular. We write to the states and they assure us that the evidence we have has been taken out of context, or they put out clarifying memoranda explaining what they really meant.

Ms HALL—Have they always been satisfactory?

Mr Davies—We have always obtained a satisfactory explanation that has obviated the need to apply the sanction.

Ms HALL—That is very good, because I have had some state colleagues who have been very concerned about the threat of that four per cent of funds being withheld and the health implications that has.

Mr Davies—Obviously we and, I am sure, our state colleagues, would do everything we could pre-emptively to prevent that happening. That is the sort of dialogue Charles has just been describing.

Ms HALL—That is right.

Mr Davies—I think it is fair to say that we would not just stand back, sit on our hands and wait for a state to be sanctioned. We regard working with them as the responsible thing to do, to avoid the need to apply that sanction—recognising that it is a significant sanction.

Ms HALL—Because you are effectively penalising the people of that state and the people of Australia by withholding four per cent funding—which means fewer services in all the areas covered by those agreements.

Mr Davies—The people of the state would obviously suffer if four per cent was withheld. As to who is imposing that sanction or who is creating the need for that sanction to be applied, that is probably something you could debate.

Ms HALL—I think that discussion obviously is a much better path to go down than withholding funding.

CHAIR—As we said, our hands are tied by the fact that we do not have contact with the state governments.

Ms HALL—I would like to talk to you about the 'Accountability and quality' section of your report. You mention:

There are also a range of strategies in place to ensure quality outcomes in the provision of primary—

health, and you list them underneath. It has been put to me that some of strategies that you have listed there are actually very time consuming, are quite a piecemeal approach to delivery of the health services and sometimes actually engage the health professional in preparing plans and meeting these requirements rather than delivering the services. Would you like to comment on that?

Mr Davies—Obviously we are always cognisant of the administrative burden that these measures might impose. Indeed I think it was last year that we actually ran a red tape task force that was specifically focused on reducing the so-called red tape burden in primary care. That did come up with a number of proposals, some of which have now been implemented. I think one is always treading a fine line here between necessary or appropriate accountability mechanisms and, as you say, impacting on the provider's ability to deliver services. I think it is probably unreasonable to argue that any administrative burden is necessarily, almost by definition, bad, because we are concerned here both with the financial integrity of Medicare and with the quality of the services that are delivered by our health providers working in the private sector. There would always be a question of balance. I think our view would be that the balance as it is is about appropriate.

Ms HALL—I understand that there is funding linked to the preparation of a number of these plans. I have GPs within my area, where there is a shortage of GPs, who just refuse to do it because they cannot do it because of the time factor.

Mr Davies—I guess that is a decision for the individual provider to make to what is the best allocation of their time but, as I say, from our point of view, I think we would be just as likely to face criticism if we did not have appropriate monitoring accountability mechanisms in place.

Ms HALL—I have to say I have other health professionals who think they are very good, just to give a bit of balance to the argument.

Mr Davies—Again, certainly without wishing to blow our own or the government's trumpet, where providers have availed themselves of many of these programs, we get very positive feedback.

CHAIR—I will go back to the question I asked a while ago about the audit process. The Auditor-General did a performance audit on the agreements. As a committee we have not looked at that but, in view of the fact that the Auditor-General has contacted us about briefing us on the upcoming audit, what was in the previous audit? What were his recommendations? Why should he be doing another one now?

Mr Davies—I do not have the recommendations to hand or even the rationale, but Charles might.

Mr Maskell-Knight—You are taking me back a few years. My general recollection is that we had an interesting debate with the auditor about the distinction between a funding agreement and a purchasing one. Auditors like to look at things in terms of direct linkages and they found it difficult to come to terms with the fact that these were independent governments who we were

giving the money to and that it was not a contract. We had some interesting debates with them about the scope of the Commonwealth's power to influence the provision of public hospital services.

My recollection is that there were recommendations about improving the performance information in the next iteration of the health care agreements. I think we have certainly reflected those recommendations in the agreements that we have now. There are many more requirements for performance information and there are much more stringent compliance arrangements around that. One of the conditions which can bring about imposition of the four per cent penalty is a failure to meet performance information reporting. That is in general terms what I remember, but we would have to go away and look at that.

Ms HALL—Can I clarify that? If they do not meet a paperwork deadline, they can actually lose four per cent of funding?

Mr Davies—If they do not meet an accountability reporting deadline.

Ms HALL—It is still a paperwork deadline.

Mr Davies—It is the submission of information; that is correct. That is one of the things that can lead to the imposition of a sanction.

Ms HALL—That is concerning.

Mr Davies—Again, it has never happened.

Mr Maskell-Knight—Let me point to the 1993-98 agreements when there were bonuses for providing the information. On the third last day of the agreements we got four years worth of backdated information from one jurisdiction, with a request to put the cheque in the mail. Let me say that the threat of taking money away seems to work a damn site better than offering money once you do it, because we have not missed a single deadline since then. I think when we are talking about expenditure of this sort it is not unreasonable to expect timely performance information.

CHAIR—Has the department been notified by the auditor that he is about to do another performance audit of the grants?

Mr Maskell-Knight—We have not heard. That does not mean that the department has not heard.

CHAIR—So you do not know what would trigger his interest?

Mr Davies—We would need to look at the reference in their work program. It may just be that, given the size of the program, it is something they revisit. As Charles explained, the agreements are relatively new, so maybe this is just a cyclical event. I dare say when you meet the auditor they will explain the motivation.

CHAIR—As I said, they were going to brief us but we thought we would get briefed by you first.

Mr Davies—I should just say that the report on the state of our public hospitals, which I mentioned earlier we would be tabling, is one of the things we are able to put together in a much more timely and more comprehensive manner because of the improved reporting that we have secured under the current agreements.

CHAIR—Having read that report, I find it very informative but very bland. Perhaps one needs more than one report to see where the system is going. Can you tell us how your department uses that report?

Mr Davies—For the reasons that we have already outlined, our role really is limited to promulgation of that information. It is clearly a report that we would like to think is of interest to our state and territory health department colleagues, to state and territory ministers and parliamentarians generally, and indeed to the citizens of states and territories who are interested in knowing how their health system is performing, and maybe particularly how it is performing relative to the system in other jurisdictions.

Ms HALL—That is really your accountability measure, isn't it? You are putting it all together and telling us what is happening.

Mr Davies—Yes, that is correct.

Ms HALL—Are you using the raw information in the workings of your department as opposed to using that report? Is the report just the provision of information?

Mr Davies—Yes. Putting that report out is, if you like, about informing the population.

Ms HALL—Are you monitoring and comparing the actual data in that report from year to year? I am not quite sure. Is that right?

Mr Davies—Yes. I think they report quarterly. Do they, Charles?

Mr Maskell-Knight—I might ask Gail to explain.

Ms Yapp—Some data does come in quarterly. The bulk of the information comes in at the end of the calendar year for the previous financial year, so by the end of December we will receive significant information that then goes into the report that is released in June the following year.

CHAIR—Do you have examples of how state governments might benchmark themselves against that report, and perhaps see that they are performing better than other states—or not as well—and how they react as a consequence?

Mr Davies—In terms of how they build that into their routine monitoring, reporting and evaluation processes, obviously we would not be party to that. But certainly I have been struck, looking at the two years worth of reports that have come out, by a lot of the data that are presented in tabular form lined up across the jurisdictions. You could argue they actually pose

more questions than they answer, but that process of posing questions is potentially quite powerful for jurisdictions.

CHAIR—Who should ask the questions? The Commonwealth gets the data and produces a report but there are no recommendations. There does not seem to be any urgency in the report to achieve an outcome.

Mr Davies—From recollection, there is commentary on the tables that draws attention to trends and also variations amongst the jurisdictions. But, for the reasons that Charles outlined, we put the information out there; it is for others to pick up and react to.

CHAIR—But half the money the states are spending is from the Commonwealth. We do not have, apart from the agreement, any capacity to demand performance or to measure performance of the states; that is within their jurisdiction. Should the Commonwealth not be a little stronger if there are apparent weaknesses when comparing one state with another? Shouldn't it be up to the Commonwealth to point out very strongly that they expect better performance from a particular state in a particular category?

Mr Maskell-Knight—We are on thin ground in that we have no levers. If we found, for example, that Queensland emergency department waiting times were twice as long as New South Wales ones—I do not know whether that is true; that is hypothetical—it is not clear that the Commonwealth minister saying, 'Isn't this terrible?' is going to do very much. Conceptually, you might imagine a world where there are levers where you pay for getting things done, and if things are not done then you do not pay. That gets you back to the point that Ms Hall raised earlier, that you would essentially be penalising the people at the bottom of the hospital system trying to use the services. It is a very difficult and vexed question in running health services.

I think the states struggle with this question much more than we do, because they are the people who are accountable directly. If you have a health service which is not performing well, what is the right answer? They find it very difficult to manage that. They are in a position to replace managers and change budgets and all that. But, if you have a service which is not doing very well, they can argue: 'It's very difficult. We've got run-down equipment. All our staff are leaving because the oxygen tanks won't work.' Cutting their allocation is not going to help them. What you need to do is give them more money. You then get into the perverse situation where people who do badly get more money than people who manage well. It is very difficult terrain.

CHAIR—The funding model used in Queensland is that, if hospitals do not reach their elective surgery targets, they get a cut in funding. That is the model being used at the state level.

Mr Maskell-Knight—I am sure you could have an interesting debate with managers in Queensland about what incentive structure that creates.

CHAIR—Do you mean including you?

Mr Maskell-Knight—I mean parliamentarians—

CHAIR—I think it is fair question. If these performance indicators are such that badly needed services get cuts in funding, does the Commonwealth have a role in that? We are getting the

blame for this. If you do not happen to know it, we know it. The Commonwealth are getting the blame for the performance of public hospitals in Australia.

Mr Davies—To generalise from Queensland, the reality is that how states and territories choose to allocate the resources within their health budgets—albeit that around 50 per cent of that health budget comes from Commonwealth funding—is, quite rightly, a decision of those governments. They are sovereign governments, and it is not for us to interfere in that process. That is a decision those governments make and live with every day.

CHAIR—But people are arguing, including our own health minister, that that is not the case and that perhaps we ought to look at other models.

Mr Davies—I am sure that debate will go on. As I said earlier, it is an issue where, to my knowledge, the government has any intention to change policy.

CHAIR—A committee such as ours is trying to get the maximum bang for the buck out of health funding. We see one state performing better than another state but we are helpless because, even though the money comes from the Commonwealth, we do not have a say in how that money is spent. That is not a very successful model, is it?

Ms HALL—In effect, we do have a say through the health care agreements. Am I correct?

Mr Davies—Clearly, within the constitutional framework—

Ms HALL—The Commonwealth cannot allocate the budgets of different states. It cannot allocate how the budgets of the area health services will be spent, but it can put in place a broad framework. To my way of thinking, that is what the Commonwealth does: it puts in place a broad framework. Then it has the accountability mechanisms that we spoke about earlier. If states do not meet those accountability mechanisms, it has got that four per cent up its sleeve.

CHAIR—How is the $42 billion in the current five-year program divided up between the states?

Mr Davies—It is formula based.

Mr Maskell-Knight—Effectively, it is divided up twice. The allocation of the health care grants is essentially a carryover from the way it was done last time, which ultimately—if you go back into the dim, distant past—reflects some notion about population. However, because the Commonwealth Grants Commission treats it as general revenue assistance, it means that the application of the Commonwealth Grants Commission general assistance relativities effectively redistributes it. What the health portfolio does matters in those states where the health care grant gets passed on directly to the health department; in other states where the health care grant just goes into general revenue, it is not particularly germane to what happens in terms of the health department.

Mr VASTA—How would your department feel if Peter Beattie said: ‘It’s not working up in Queensland. We want the Commonwealth to run the public hospitals’?

Mr Maskell-Knight—I do not think we would 'feel' about it. It would be a matter for the government to make a decision.

Mr VASTA—Is the department equipped to handle one state saying, 'Look, you look after Queensland,' while the other states wait and see if that is successful? And if it is, then they might start, state by state, giving back public hospitals to the Commonwealth.

Mr Davies—I do not think it is a model that we have actively explored, even in the hypothetical sense. Obviously, if we were asked to do it by the government of the day then we would get on and do it. The practical approach would depend very much on—I mean, running the hospitals can cover a variety of different arrangements.

Mr VASTA—Do you see it as a disaster or a nightmare? Have you got an opinion on it?

Mr Davies—I do not.

Mr Maskell-Knight—It is government policy.

CHAIR—I see you are a fan of Mr Hacker's!

Mr Maskell-Knight—There is a precedent in that in the 1970s the Commonwealth stood ready to take over the railway networks if anybody wanted to give them over to us. We finished up running the South Australian and Tasmanian ones. We must not have done a very good job, because no-one else has fallen over themselves to give us theirs. I do know what that means, whether railways are in any way related to health or not.

Mr Davies—Another example we have just worked out is that before self-government we would have run the hospitals in the ACT—arguably with a degree of self-interest.

CHAIR—It is hard to tease out this information. We have not mentioned the word 'cost shifting', because we covered that at our last hearing when your department was not very keen to talk about it. We have had evidence given to the committee that cost shifting is rampant in the system; we all knew that before we started. In the event of shifting costs in the public system onto the Commonwealth, are there sanctions in the health care agreements that would be a disincentive for states to practise cost shifting?

Mr Davies—Indirectly we have already touched on it in the sense that, as Mr Maskell-Knight explained, the issues that probably generate a sizeable number of interventions in terms of the health care agreements are patient election and compliance with the requirement that everyone should have access to public hospital services free of charge. So, to the extent that the election process is under suspicion, then that would be an example of where, if we felt that patients were not being given the right to choose that is enshrined in health care agreements, we would certainly enter into dialogue with the responsible jurisdiction.

CHAIR—One area I want to ask questions about is manpower. The big problem that everybody has is the skills shortage, particularly in health. Does anybody want to comment on the extent of the problem in Australia? Can you cover such areas as the use of foreign or overseas trained doctors and the involvement of the Commonwealth?

Mr Davies—I am happy to take questions. As you have already noted, the Productivity Commission is in the midst of a very significant piece of work in this area. The government has also in the last couple of years invested quite significant amounts of money in strategies to improve the medical work force, partly under the Strengthening Medicare package but also through a variety of other programs that predate that. It is an area where there is active involvement and concern on the part of the Australian government. The number of Australian students completing medical school studies is about 1,300 this year and, as a result of initiatives already locked in, that will increase to about 2,100 by 2011. It is about a 60 per cent increase, so it is very significant growth. But, as we saw recently from the Australian Medical Work Force Advisory Committee report, there are currently some areas of shortage.

Ms HALL—Let us walk through this and look at it from a historical point of view. A chronic shortage has developed in recent times. What does the department attribute that to? What decisions have been made from the department's point of view? What sort of research have you done into projection of work force needs? We are talking doctors with the training. What about issues surrounding provider numbers? Let us generalise a little and look at nursing, because there is a shortage in the area of nursing. Let us generalise a bit further to OTs, physios and social workers and look at why we have got this chronic health worker shortage and look at the decisions that have been made and the decisions that can be made. I am not saying to give us what you think but give us a few strategies that you think could be introduced. I think the role of the department is to put forward positions and position papers on those types of issues.

Mr Davies—I think the Productivity Commission paper—

Ms HALL—Yes, I have read that.

Mr Davies—covers a lot of those issues and, obviously, we made a submission to that review.

Ms HALL—We need to get it on record here in this committee, so that is what I would like you to do.

Mr Davies—I draw your attention to the submission we made.

Ms HALL—I have got it.

Mr Davies—The other point is that we need to be a little careful in our assumption, particularly if we are focusing on the medical work force, of shortage because the mismatch between supply and demand is not universal.

Ms HALL—I understand that.

Mr Davies—Sometimes, others describe it as a maldistribution rather than a shortage. How has it come about? It is hard to attribute it to a single cause, but we know that the number of—how can I put this?—hours of doctoring that we get from a GP has reduced. Probably, again, there are various causes for that such as individuals deciding that they want to work fewer hours. It is probably an inevitable consequence of the fact that we now—what most people consider a good thing—have more female doctors in the work force. The reality is that over the course of a professional lifetime women doctors tend to work fewer hours in total or days or whatever than

their male counterparts. So those sorts of social changes in recent years have impacted on, if you like, the ability to turn medical school places at the beginning of a pipe into doctor hours at the other end.

CHAIR—That is happening world wide?

Mr Davies—The end result is being experienced world wide. Most countries at Australia's level of development are grappling with very similar problems of health work force supply.

Ms KING—Philip, what is your observation in relation to proposals I think by Melbourne University to change to undergraduate-postgraduate medical training? Has the health department had any consideration of that?

Mr Davies—I am not aware that we have been involved in detailed consideration or discussion on that.

Ms KING—It has only been media reports that they have done it, but do you have a view?

Mr Davies—To abstract from that and put a little bit more flesh on the bones of what I was saying about the impact of these social factors, there is a very long lead time in turning a school leaver into a doctor. We are now increasing the numbers of medical school places, but we will not really feel the benefit of that until 2011. Yet the changes in demand due to population migration to the coastal areas of Queensland or whatever and people making choices about their lifestyles as professionals—people making choices about where they want to live and practise—take place in a very volatile time frame. I have sometimes likened health work force planning to trying to drive a car along a very windy road where the steering wheel is not that well connected to the driving wheels. We can make changes with a very slow 12-year cycle in terms of numbers coming through medical school, but what is going on on the ground can change in a much shorter cycle. It is always going to be very difficult to hit the target precisely when you are looking six, seven or more years out into the future. The fact, as I have just explained, that most developed countries seem to be facing these problems is testament to the difficulties of doing accurate work force planning.

Ms HALL—You did not touch in your previous answer on provider number issues—the allocation of provider numbers and the fact that there are people who could, if allocated a provider number, to some extent address that work force shortage.

Mr Davies—Sorry, can you explain what you mean by 'allocated a provider number'?

Ms HALL—If GPs were allocated provider numbers they could practise and address the shortage in some areas, but there are restrictions on the allocation of provider numbers.

Mr Davies—I would need to come back to you on that on the detail. My understanding is that any Australian graduate can get an unrestricted provider number.

Ms HALL—Any Australian graduate, yes, but there are other doctors who cannot.

Mr Davies—Overseas-trained doctors can only get a provider number if they undertake to work in an area of work force shortage.

Ms HALL—Yes, which brings me to my next question, which is on the RRMA classifications, which are not areas of identified shortage; they are basically rural areas.

Mr Davies—There are two different mechanisms here. One is RRMA, which is a classification of the geographic characteristics of a neighbourhood. The other is areas of work force shortage, which is based simply on a doctor to population ratio. Both of those are used alongside each other for different programs.

Ms HALL—Yes. I put it to you that that it is not always effective. If you look at a region, you can say that that region has an appropriate doctor to patient ratio, but if you look at certain sections within that region, that may not be the case.

Mr Davies—I guess it depends how granular you go with your unit of geography. Then you get into questions of how homogeneous a neighbourhood is or the locality used in those sorts of classification systems.

Ms HALL—I would like you to look at the issue around the RRMA and the provider numbers and the areas of work force shortage.

Mr Davies—The government, as I am sure others will point out to you, has been consulting on the RRMA classification.

Ms HALL—Is it in the pipeline that there may be some changes to that?

Mr Davies—We are not clear yet what will come of that consultation.

Ms HALL—When is that likely to eventuate?

Mr Davies—I do not know.

CHAIR—You might take that on notice.

Mr Davies—Yes.

CHAIR—I think everybody in the House of Representatives would have made a representation at some time or other to the minister about it.

Mr Davies—There is the fact, and I am sure this will resonate with you as politicians, that with any change to a scheme like RRMA it is a zero sum gain, so anything that says this area is now an area of shortage and will be entitled to these additional provisions or benefits has to be offset by removing those from another area.

Ms HALL—I must say it certainly disadvantages the area that I represent in this parliament. In one area there are zero doctors to over 6,000 people, so that classification does not work.

Ms KING—In terms of the training of GPs, how has the change from college of GPs training to sending training out to more contestable training areas gone? Has that had any impact in terms of doctor numbers or in terms of one's happiness with the quality of the training?

Mr Davies—I do not have information on that to hand. I can certainly come back with that on notice.

Ms KING—Yes, please.

Mr Davies—Just on doctor numbers—and I am actually now going back to a previous question, but I think it is important to note this—we have in the last three or four years seen a marked improvement in doctor numbers in those more remote areas. So, although there will always be exceptions—and I accept, Ms Hall, that you have probably alluded to one particular one—if you look across the country as a whole—and again we can provide on notice a histogram that shows the balance—there has been over the past four or five years a marked shift from the urban areas to the rural and remote areas in terms of doctor numbers. I am not saying the problem is solved, but certainly as a result of a significant effort in investment on the part of the government the problem has been alleviated to some degree. We are heading in the right direction.

Ms HALL—To clarify it, that area is not remote; that is a RRMA 1 classification.

Mr Davies—RRMA 1 is inner urban.

Ms HALL—That is right. RRMA 1 is the classification for that area.

Ms KING—But you were saying before that doctor numbers are actually no longer—if I am reading you correctly—a really good indication of people's access to GP services because, as you were saying, those same doctors are not necessarily practising the same hours. What is a better measure?

Mr Davies—I am sorry; when I talk about doctor numbers in this context, those are adjusted for their working hours. We have a measure of full-time-equivalent doctors.

Ms KING—So what do you call that measure?

Ms Daniel—The measure that we use mostly is the full-time workload equivalent doctor, which adjusts to take account of what the actual workload of the practitioner is to get to a full-time measure.

Ms KING—Philip, what you were saying was that that has improved, so people's access to GP services has improved?

Mr Davies—Yes, in the RRMA 5, 6 and 7 areas.

Ms KING—Where are your gaps?

Mr Davies—Again, it is the problem of an average. That will always conceal a particular community where—

Ms KING—Can you give me some examples? Obviously, Jill has just mentioned one in her electorate. Where are some of the pockets that you are really concerned about?

Mr Davies—I cannot list those offhand. Again, it is quite volatile, because it will be that if a two-doctor practice loses one doctor, through a doctor's retirement or deciding to move, then that clearly has an impact. Equally, I am sure there are many stories of doctors choosing to move into an area and set up a practice or to join an existing practice. It does vary over time in a quite volatile and essentially unpredictable manner because it depends on the choices of individual practitioners as to where they practise.

Ms HALL—How effective do you think the divisions of GPs have been in working with communities to deliver services and to try to get a better distribution?

Mr Davies—There are certainly some success stories on the part of divisions, in terms of work force initiatives. Again, I cannot name individuals and it would probably be invidious of me to do so, but certainly that is one of the areas where a great many divisions are working very hard to attract doctors. In fact, it is quite interesting that if you look in the doctors' magazines—*Australian Doctor* or the *Medical Observer*—you will now quite often see that the ads at the back are not placed by a practice that is looking for a doctor. They are actually placed by a division that is seeking to attract doctors to work in a broader area on behalf, one assumes, of the local practices.

Ms HALL—If divisions raised concerns about their ability to attract doctors, about doctor shortages and about RRMA classifications for that area, would that be fairly influential on the department?

Mr Davies—I do not have the figures, but I am sure a lot of divisions will have made submissions expressing their views about the effectiveness of the current RRMA classification. I know from experience that in any forum between the department and divisions that will be one of the topics that is quite likely to come up.

Ms HALL—How effective do you think the outer metropolitan work force strategy has been? How many doctors have actually moved to outer metropolitan areas since that program was introduced?

Mr Davies—As of 30 September this year, 236 doctors have agreed to relocate to, or significantly increase their hours of work in, outer metropolitan areas where there are doctor shortages.

Ms HALL—They have agreed to. How many have actually done so?

Mr Davies—I do not have that figure with me, but they do not get the payment until they do.

Ms HALL—It would be good to know. You should have that in your records.

CHAIR—If they agreed, I assume they—

Mr Davies—I think Ms Hall's point is that sometimes it can take some time, particularly if they are setting up a new practice. They have got to find premises, equipment—

Ms HALL—I would like to see the actual figures, if I could.

Mr Davies—We also had 201 GP registrars undertake placements in designated outer metropolitan areas. Again, that is quite a significant addition to the capacity in those areas. But I will get you the figure on what proportion of those 236 are actually in place and practising.

Ms HALL—Thank you; I appreciate it.

CHAIR—Can I come back to the overseas doctors question: what role does the Commonwealth play in recruiting overseas-trained doctors? Do we have a specific role? I know that in my own electorate there are quite a few bulk-billing clinics opening up now using foreign-trained doctors and they are working quite well.

Mr Davies—Yes. There are various things we are doing to attract overseas-trained doctors and help them assimilate once they arrive. Again, I am struggling for the exact details but as part of the Strengthening Medicare package we have entered into contracts with a number of agencies—I think maybe three or four, I am not sure—who are commissioned to actively go out and seek to attract overseas-trained doctors to relocate to Australia. I think in general they are paid on a performance basis, so if they do not attract the doctors they do not get paid.

CHAIR—These are doctors across the whole spectrum? For example, surgeons, GPs—

Mr Davies—I would not like to answer that because I do not know, but I can find out the scope for you.

CHAIR—What role does the—

Mr Davies—There is an important qualifier to that which is that as part of that arrangement they are precluded from actively recruiting in the developing world. We are not asking them to go out—in fact we are telling them not to go out—and seek to attract doctors from countries that can ill afford to lose them.

Ms HALL—These are ethical issues.

CHAIR—I asked the question before about whether overseas countries are having the same problem as we are. What can we do to attract doctors here who have the same problems in their country? I know the state governments are having major recruitment drives in overseas countries for surgeons et cetera. Do they also apply the criteria to not recruit from Third World countries?

Mr Davies—I do not know.

CHAIR—What is the involvement of the Commonwealth in the recruitment of overseas trained doctors? That includes the public sector.

Mr Davies—I would need to come back to you on whether, if one of these agencies brings in a doctor who is then employed by the public sector, that is within scope. I do not know. We will get you a full brief on the program.

CHAIR—Are we in competition with the states?

Mr Davies—I would be surprised if we were, but how we make sure that does not happen I do not know. I will happily get you details of that scheme and how it operates. And I am sure your next question will be how many doctors it has brought in, so I will get you that as well.

Mr VASTA—Mr Chair, remember the Queensland Premier was over in England actively recruiting.

Mr Davies—You would have to say there are a lot of doctors in European countries in particular who are attracted to come to work in Australia, either for a few years or for the rest of their professional career. We are probably, in the scheme of things, quite an attractive area in which to practise.

CHAIR—We seem to have a lot of applicants for migration from doctors from Zimbabwe, South Africa and similar countries. Are they classified as countries the Commonwealth would encourage the agencies to leave alone?

Mr Davies—I do not know what the list would be. I would certainly imagine that Zimbabwe would be on that list of places in which to not actively recruit. Having said that, if a doctor or any other health professional from a developing country, of their own initiative, seeks to move to Australia then we would not stand in their way, subject to the normal professional registration and immigration requirements. In a sense it would be just as unethical for us to prevent them bettering themselves by coming here to practise. It is the active recruitment that we do not allow.

Ms KING—I am sorry because my plane was a bit delayed, but what have you covered so far?

CHAIR—We have covered the health care agreements.

Ms KING—Have you got into that COAG stuff yet?

CHAIR—Yes. This inquiry is stymied until such a stage as the COAG report comes down.

Ms KING—When we had the inquiry into private health insurance in Sydney, we held it at North Shore Private Hospital and the interactions between the public and the private hospital were something that we discussed at length. I want to ask a bit more about the notion of shared services between public and private hospitals, particularly when they are co-located. Has the department done any work on that? Have you done any work on how that might be financed, and is that part of any of the discussions in COAG?

Mr Davies—I can answer the last question—we are not party to the confidential discussions of the COAG working party. We can wind back from there. Linda, are you in a position to comment?

Ms Addison—I have certainly been out to that facility as well and have done a tour with the operators of North Shore Private. My understanding is it is basically a unique facility in the sense of its arrangements, but particularly the co-location of the cardiac arrangements, which is interesting because they share the infrastructure in terms of the person who runs it et cetera. But I am not aware of any other initiatives around that. There was one, I understand, at Macquarie, up on the coast in New South Wales—

Ms HALL—Port Macquarie has a public-private partnership.

Ms Addison—but I do not have any details about that. But it is not, as Mr Davies was alluding to, something we are actively examining, particularly because on the private side they are private operators and they seek to take private commercial interests.

Ms HALL—Just for the record, Port Macquarie Private Hospital was nothing like what is happening at Royal North Shore, and they should not be confused.

Ms KING—In Ballarat there is a public and a private hospital located together, and they have done some work together in relation to cancer services. But I am looking at the future health care reform. One of the areas we are possibly going to get pushed into—this is certainly happening within eduction in the UK—is this notion that there really is not much of a split between public and private; it is about what services are provided to people. I am wondering what developmental work you have done on that, what have you looked at, what models have you developed, is there a discussion around financing and how that might work?

Mr Maskell-Knight—I do not want the committee to be left with the impression that there is North Shore and there is nowhere else. If you are looking at private, there is a lot.

Ms KING—Yes, there is stuff happening all over the place.

Mr Maskell-Knight—Yes. There is Calvary Hospital here: if you go out of the operating suite one way, you go to the public hospital, and if you turn left you go to the other one. So there are numerous examples.

Mr Davies—The key thing here is to be clear about what models we are actually exploring. There is the issue of who owns the facility. Is it owned by the state government? Is it owned by a private entity or a charity or an NGO?

Ms KING—How much of that is an issue in terms of health financing overall, and will it be in the future? That is what we are trying to explore.

Mr Davies—The fundamental principle underlying all of this is patient election—that is, every Australian, should they choose to do so, can access free public hospital services.

Ms KING—Yes, that is the fundamental principle.

Mr Davies—Provided that is not corrupted, clouded or distorted, then the issue is whether there are benefits to be captured by sharing expensive capital equipment. The other one to look

at around the country is radiotherapy. It is very expensive equipment. Typically, it is used by public and private patients.

Ms KING—I will get you to talk about infrastructure, but what about the classes of patients? For example, I do not know if this is true, but we had a major problem within our public hospital for cataract surgery. The state government came in and purchased services from the private hospital for that class of patients, because the waiting lists were two or three years for cataract surgery. Is there anything in relation to that? Obviously in terms of people over 75, we had a policy which blurred the lines between public and private. It looked at where you purchase those services from, and you may end up purchasing them from the private sector.

Mr Davies—Charles will correct me if I am wrong, but I do not believe there is anything in the health care agreement that says public patients must be given services in a public hospital.

Ms HALL—I think you are missing the point.

Ms KING—No, he is right. You are saying it is possible.

Mr Davies—It is actually that they must be given services at the public's expense. You could posit an extreme view, where a state says, 'We're not going to run any hospitals, and we will basically outsource all of our public hospital services to the private sector.' It would be hard to imagine that ever happening, but I do not believe that, as long as there is no cost to the people who opted to go for that service, it would not be at odds with the health care agreement. The health care agreements are about the patients' experience; the ownership management of the hospital facility is an issue for the state or territory government on which the agreements are agnostic.

Ms KING—You may not be able to do this, but I would be interested in some examples of where that is happening. Obviously, cataract surgery was something that happened in my area, but are there other examples around the country of those sorts of purchases for public patients from private hospitals and particular classes of patients? Again, at the hearings in Sydney, there was a real concern expressed about what was happening for mental health patients and their capacity to access services. That was certainly one of the classes of patients. They were saying there was some work being done on how you might do that differently.

Mr Davies—We can certainly ask the question but, again, our concern, as I say, is that the patients get the service. The ownership of the infrastructure of that service and the employment of the staff who deliver that service are not things we have a particular concern about.

Ms KING—Having worked in the department myself and knowing Charles's intellect and his interest in these things—sorry to say that to you, Charles—I am trying to find out what work you are doing on it. What research work are you doing within the department at the moment? Who is writing research papers about this stuff and having a bit of a look and a bit of a think about it? Are you doing any of that?

Mr Maskell-Knight—Can I just go back a step? I was slightly distracted before. I understood you were asking whether we could provide details of classes.

Ms KING—I would just like some examples of classes of patients it is happening with: how you are doing that—any really good examples we might want to have a look at or to think about.

Mr Maskell-Knight—Right. I am not sure. We would have to go and ask the states for that information, I would imagine. That is one thing. I do not know whether we have that information. If you are ever going to talk to the states, you might find it quicker to ask them than us.

Ms KING—Sure. I just assumed, with the intellectual capital that exists within the department, that some of you would know.

Mr Maskell-Knight—We would only know anecdotally and in a random way. The next point is that we can tell you that in 2003-04 across Australia about 2.6 per cent of public patients were treated in private facilities. That ranged from none in Tasmania, the Northern Territory and the ACT; 14.5 per cent in Western Australia, which would be the Joondalup campus; tiny bits in South Australia and Victoria; and a couple of per cent in New South Wales and Queensland.

Ms KING—Has that increased over time or decreased?

Mr Maskell-Knight—Without actually having the numbers in front of me, I would say that it would have increased. In terms of what research we are doing about it, I think the answer is none. We observe, but it is not our role to promote. If states and the private sector believe there are benefits to be derived then it is up to them.

CHAIR—Would it be possible to include that type of data in this annual report that you do on the health care agreements?

Mr Maskell-Knight—I do not have my copy with me, but I think it might be there somewhere.

CHAIR—I do not recall seeing it in there.

Mr Maskell-Knight—It is not the same information.

Ms Yapp—It does not have information on what public patients are being treated in private hospitals, but it does have information in terms of private elections within public hospitals.

CHAIR—Yes, but it does not identify whether a particular category of patient tends to be treated privately rather than in public facilities.

Ms Yapp—That is right, because—

CHAIR—But I wonder if that information could be included.

Ms Yapp—Yes.

Mr Davies—I think probably part of Ms King's question referred to the kinds of conditions. I think it would be fair to say that these arrangements—the 2.4 per cent across the whole of

Australia or whatever it was—would tend to be elective or planned surgical procedures. Quite often, I think, it is exactly the situation you described in Ballarat, where you have a perceived backlog and a state may then go and spot purchase procedures in the private sector. But it is difficult to generalise.

CHAIR—I think we are out of time.

Ms HALL—Could I just ask about one thing that you may wish to give us information on in writing. You have your little graph in there about the percentage of money going to the private sector and the percentage that goes to public hospitals. I am just wondering if you have a table that shows the change in that over, say, a 10-year period? I am particularly interested to see what impact the 30 per cent private health insurance rebate has made on the mix of funding—how funding is between private and public, and how the money that is allocated to the private sector has changed.

Mr Maskell-Knight—Get the secretariat to have a look at the Institute of Health and Welfare publication, *Health expenditure Australia 2003-04*.

Ms HALL—It is all in there?

Mr Maskell-Knight—It is all in there in more detail than you would ever want.

Mr Davies—There are two facets to that question that are important to tease apart. In accountant-speak it is the source and application of funds—what proportion of health spending comes from public sources and private sources and then what proportion of services are delivered by public and private providers.

Mr Maskell-Knight—And they organise it state by state.

Ms HALL—Excellent. That is great. Thank you.

CHAIR—One observation that I have made in the last few weeks in south-east Queensland, given that the states complain about aged care patients blocking beds, is that there are many vacant beds in nursing homes in south-east Queensland at the moment. They are actively ringing up public hospitals saying, "Can we have some patients?' and the public hospitals are saying, 'No, we don't have any.' Have you had that reported back to you? Is that the trend across the country?

Ms HALL—Certainly not. Maybe some of my people might like to travel to Queensland. I have a whole floor of a hospital waiting for allocation of places.

Mr Davies—Everyone else is moving from New South Wales to Queensland, so why shouldn't the elderly do so as well? I do not have information on that.

CHAIR—Thank you. Thank you for appearing before us today. I am sure we will see you again, particularly after the COAG meeting.

Mr Davies—We are happy to come back for a third round, if you want us to.

Proceedings suspended from 11.08 am to 11.14 am

HAIKERWAL, Dr Mukesh, President, Australian Medical Association

NESBITT, Ms Julia Margaret, Director, General Practice and E-Health, Australian Medical Association

YONG, Dr Choong-Siew, Vice-President, Australian Medical Association

CHAIR—Welcome. The AMA provided us with a submission and addressed the terms of reference of the inquiry one by one, which we appreciate. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal part of the proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement.

Dr Haikerwal—The AMA is the peak medical organisation in Australia, representing 29,000 medical practitioners from doctors in training, general practitioners and other specialists. All of our members elect to be members through paying fees, and this reflects the value and confidence they place in the AMA for providing them with representation. AMA positions and policies are based on consultation with our medical practitioner members, and we are independent of influences from other sources.

At the outset I would like to emphasise that, as a whole, our health system is one to be proud of. It offers every Australian access to high-quality health services in an ethical framework and in a timely manner. Our balance of private health care, which is affordable due to community rating, together with a general practice-led health care system, which provides comprehensive, cost-effective care locally and is patient-centric, is one of the best and fairest systems in the world. Indeed, the OECD report for November 2005 gave backing to those statements.

There are, however, key parts of the sector that are struggling. One part is obviously the public hospital sector, which I am sure you have heard different comments about. The particular comment I would like to leave you with today is one of the hospital service working at very high capacity—95 to 98 per cent. I call that redlining. If we redlined a car at this level, that would not be conducive to long-term sustainability. Mental health is a significant problem in our community and there are rebound effects, through the poor provision of mental health services, throughout our community through the rest of the hospital system through knock-on effects. I note that my colleague Dr Choong-Siew Yong is a psychiatrist.

The health of Aboriginal and Islander people is of course still a significant concern. This is being addressed by the AMA and other organisations in conjunction with the Aboriginal and Islander population, because it is important that this is done as a community effort on behalf of the Aboriginal and Islander population working collaboratively with mainstream services. Obviously, there are problems in state and federal relationships over the way in which money is allocated, and sometimes the gaming of the past has become a problem. There has been no real progress since the signing of the last Australian health care agreements and until the new COAG process. I see some glimmer of hope with the new COAG process where the Commonwealth

government and the state governments are working together at a heads of government level to try to address some of the situations that we currently see.

There is currently a real push towards preventive medicine, public health and health promotion. We welcome this move. We believe that significant investments that government can make in these areas will pay significant dividends further down the track. But it is not a no cost/low cost option; it has its own costs incurred with it. Public health encompasses three levels of health care prevention as well as health service design, development and skills in assessing the response to change in response to population. When government considers primary change, it encompasses the addressing of social alternative health factors like income distribution, employment and lifestyle. If we are serious about making an impact on health inequalities then we have to look at these areas of health as well.

Another issue of great importance to the AMA and something that I would like to raise specifically with the committee today is fund holding. You have previously been given the impression that the health profession is ready and willing to embrace systems such as fund holding as a feature of the health care system in Australia. I am here to emphasise to you that this is not the case. The AMA has a clear, solid position on fund holding as a feature of the Australian health care system. This is based on consultation with its members. The AMA policy stands as a reflection of the view of the overwhelming majority of practitioners in Australia that fee for service must remain the cornerstone of the health care system. That view was shared by all GP groups that attended a summit in 2003. We stated that fee for service must be retained as a cornerstone of general practice funding with appropriate indexation reflecting the true costs of running a practice because it enhances productivity and empowers the consumer. The doctor works for the consumer.

The proponents of fund holding as a feature of the Australian health care system consistently talk about improved health outcomes. There are no such health outcomes that have been proven by this system. Evaluation of the most famous primary care funded model in Australia, the coordinated care trials, found that this failed to improve health outcomes and that many of the trial's objectives could have been achieved by simply linking patients to appropriate disease management programs rather than completely changing the whole health care system. Fund-holding systems make GPs responsible for the rest of the costs of care and for reconciling the competing objectives of meeting public health needs versus the needs of and returns to the funders or shareholders. They face pressures to minimise expenditure on services, creating an ethical hazard, because the provider is obliged to extend the duty of care from the individual to the needs of a population. This ethical hazard has come into focus in New Zealand, where its system uses this sort of method. The Medical Council of New Zealand has a specific set of recommendations around rationing and the way in which doctors have to tell their patients that, while they are getting suboptimal care, that is actually all that they can afford to have.

There are many strong proponents of these sorts of changes including pharmaceutical fund holding, but Canadian and UK research have shown that, while you may get a one-off saving, it is not sustainable into the future once you have made your initial savings in this sort of arena. I can tell the government representatives today that you do not have a professional board in relation to fund holding. In fact, we are led to believe that the Minister for Health and Ageing is not convinced about this as a part of Australia's health care system, although it may be useful in some limited circumstances only. This is consistent with the AMA's policy on this issue.

Fund holding is not about patients, it is not about providing better and higher quality health care and it is not about improving patient outcomes. There are issues which must be resolved in relation to financing for health care. In 2003 a joint medical professional government committee into the medical benefits schedule supported the implementation of a seven-tiered system, which is changing the current system of tiering of health-care consultations in general practice. This would reward in many ways the quality agenda so that, when doctors are working at the rate of four to five patients an hour, patients will not be out of pocket for those sorts of consultations.

The community demands and deserves to have a Medicare that is strong, stable, sustainable and able to meet the needs of Australians into the future. The AMA maintains its strong support for the implementation of this restructure. There is much talk about the integration of general practice with other health-care professionals. The message from people, including some of those at this forum, is that integration of general practice is in dire straits. This is not the case. Integration with other health professionals is happening. Success in this area is the direct result of consultation with the profession. Some of the new NBS items we have seen, including last week, show that doctors are working, looking at chronic diseases and improving the uptake of these sorts of services so that people get more comprehensive reviews when they need it.

It must be understood that things like care plans for chronic disease are overwhelmingly targeted at patients who are still at the stage when they can self-manage their condition. Some commentators are interpreting the low uptake of team-care arrangements linked at the use of health-care workers as an indication of a lack of integration of GPs and resistance from GPs. This is not the case. There is a time lag from creating a plan to recruiting other people into the implementation side of the plan. We think that things will change in terms of uptake of the second part of those plans in the near future. As these allied health measures increase, we will see more people involved in their own self-management and there will be increasing use of other services within general practice. The AMA's model of a general practice, the nurse model—where the nurse works within the practice and is empowered to do more and more within that framework with locally set up protocols—is a key example of how we see this proceeding into the future.

Claims by some that funds should be injected into the system to reduce the mythical resistance of GPs to work with allied health are simply distractions from the problems that we have seen with the looming work force shortage in all areas. We in general practice within the AMA believe very much in the team approach—working together and pulling together in the same direction in the best interests of the patient. The general practitioner has been central in that care to make sure people do not fall between the cracks of care in the various deliveries of care that are out there.

CHAIR—For the benefit of people who read this transcript, can you tell us a little bit about how fund holding works?

Dr Haikerwal—There are several different fund holding models that have been used at various times around the world. In the UK there was one method of fund holding—in a totally different system and a totally different context, and it has to be remembered that that was the context in which it was introduced—where initially six practices and then larger numbers of practices were flagship practices. They were large and were given a fixed amount of money to pay for all the pharmaceutical services that they were asked for and to pay for their referral

services that they were asked for from various hospitals. Therefore they entered into negotiations of contracts with local hospitals. That sort of model evolved to the sixth phase of fund holding and by that stage a large proportion of patients were covered by the system. The initial gains of having a few practices that were fund holding getting a jumpstart on the others—

CHAIR—I have not heard this being proposed in Australia. Has anybody else?

Ms KING—It is floated every now and again. The coordinated care trials were an attempt, in terms of pooling of Medicare funding, but they had a slightly different purpose.

Dr Haikerwal—The other model is a New Zealand model and they both depend on a level of capitation, where certain groups get together and provide funds in a pooled manner from various parts of the population. In many ways it constrained the level of care that was given. It allows for health to be compartmentalised but anything outside that area is then seen to be the responsibility of those people receiving the funds. However, the reason a certain service is not provided may be that government cannot afford it. For instance, government may not be able to afford to allow a certain drug to be prescribed for breast cancer. It would seem that it is not a decision by government that has made that not happen; it would seem to be ineptitude on the part of the people who hold the funds. So there are various other downsides to that.

Ms HALL—The Australian example you gave is the co-ordinated care trials. Could you detail that a little bit for *Hansard*?

Dr Haikerwal—The co-ordinated care trials provided an opportunity to determine certain populations and give certain funding to try and get outcomes in a supposedly more coordinated manner. The outcomes were not particularly rewarding in terms of better health or anything else.

Ms KING—What about the Indigenous trials? They showed something slightly different in relation to population groups.

Dr Haikerwal—There were some successful trials in Aboriginal and Islander communities—

Ms KING—Yes, the Tiwi Islands.

Ms HALL—Yes, they were very successful.

Dr Haikerwal—and some that were not. It is certainly still within our policy framework. For certain populations, especially remote areas and especially in Aboriginal and Islander populations there is some benefit in getting the funds that way because they were already under a huge red-tape burden in terms of each of the different buckets of money they were taking grants out of. The acquittal process is very convoluted for them and much time and effort is taken in acquitting grants and not actually doing service provision. So if you have one level of service provision and funding, that has an enormous benefit for such organisations.

CHAIR—You mentioned the COAG process. We are running this inquiry in parallel with the COAG process and we hope to give a much broader range of people the opportunity to have input into the COAG process through the evidence given to this committee. Are you involved in the COAG process? Is the AMA able to have an input?

Dr Haikerwal—We have had consultation with one of the COAG streams. We attended and found that the process was very genuine. The attempt to get the governments together is very commendable. The manner in which it is being approached, in terms of small amounts of work that are achievable, is a very commendable way of doing it, because obviously with the numbers of jurisdictions around Australia trying to combine activities it is hard to do. But the one light that I can see in the tunnel at the moment is that this is a very good process and one that we will try and support with information and other evidence to try and make it succeed.

Ms HALL—What does this good process involve?

Dr Haikerwal—It involves the Commonwealth government working with the other governments at a senior level, where they can actually get changes across the line and do not stumble at ministerial level in terms of the state process. If there is a commitment from heads of government then this will happen.

Ms HALL—But we are talking about your input. Who were you talking to? Give us a little bit more detail.

Dr Haikerwal—I am not sure how much detail I am allowed to give because it was obviously a consultation process. They were looking at issues around primary care and improving things like preventive care including health care in rural populations—and some ideas around that the details of which I do not want to go into right now.

CHAIR—We are aware of what the COAG process is. Our concern is that it is being conducted by senior bureaucrats at the respective jurisdictional levels. We do not know who is having an input into that bureaucratic process.

Dr Haikerwal—At the outset we had no input into it whatsoever in terms of trying to give information about what is a good way to go. We were presented with a set of proposals and I am giving you the good side of what we saw. When the whole thing was announced I was despondent and the AMA was despondent because we do not need yet another review—another look at the situation. We already know what the problems are and we have many solutions that we can actually roll out. So when I went along—and I went with Mr O'Dea—we were quite cynical. I was quite buoyed by what they came up with.

CHAIR—Did you appear before the actual COAG committee?

Dr Haikerwal—We were at a consultation where they told us the sorts of things they were talking about and thinking about. I felt that their direction was good. I wish we had had the chance to have some input at the top side of it because some of the streams that they were talking about were not workable. They will have to go back to the drawing board now, which is fine, but if we had had the discussion and the consultation at the outset it could have been an improved process.

CHAIR—That was our concern.

Ms KING—Can I ask a question in relation to that? Prior to 1996 there was a pretty detailed COAG process and AHMAC was very seriously involved in health-care reform. It is my view

that that stalled after 1996. Is what we are seeing now bringing that back to life or has it left a lot of those areas off? I particularly want to look at subacute care.

Dr Haikerwal—I do not think it dropped off in 1996; I think it dropped off, more, later than that. It probably dropped off at the time the last health-care agreements were signed, because those groups were actually working in seven different streams to look at various parts of health-care delivery. But it was around the argy-bargy of signing off the last AHCAs that it kind of fell in a heap. One of the things we have been saying is that there is some good learning there: let us use that as the basis of where we are going. That was our plea to this process.

Subacute care is a very important area that allows people to be maintained where they want to be—near home, hopefully in their own homes—for longer periods of time. If they fall ill or become disabled for a certain length of time, they can be looked after in an environment that is not an acute hospital but it is not pushing them home—

Ms KING—It is not a nursing home.

Dr Haikerwal—or a nursing home, so they can be properly worked up and rehabilitated so they can go back home well, to live independently. So that is part of the way in which we have set up aged care services. In that interaction between discharging from the community to hospital or to nursing homes, if there is this middle way, it means that people can pop through that middle way and therefore not need to go all the way to a very expensive and usually inappropriate acute setting.

CHAIR—As there is nothing else on COAG, I will get onto the questions associated with your submission. Does the AMA believe that enough is being done in the area of health promotion? If not, what more can be done?

Dr Haikerwal—Health promotion is, I suppose, a kind of generic term, and there is some more detail around that whole activity around health promotion. Health promotion is simply a method for getting messages across. It is really under the bigger umbrella of public health, which is the larger detail of all the different measures that a community, on a population basis, can address to try and reduce some of the health prevention which happens at a more personal level. So health promotion is something that should happen, must happen and, in many ways, is happening. Some of the things are around environment and reducing emissions. Some of the things are around small things like alcohol and petrol, as one small way of going along that line. It is around people having access to jobs and good water, sanitation and environment. So there is work to be done—of course there is—but in some communities it needs to done with a lot more focus.

Regarding primary health, I think that we need to understand that we can have a significant impact on health when we impact on those health inequalities. If people have better access to good food and veg, for instance, they can have better health outcomes. Often people do not get access to those things.

So public health is looking at the big picture, and health promotion is promoting some of the issues around primary prevention, secondary prevention and tertiary prevention. I do not really want to get into the science of these, but there are different levels, and there are different things

that we can do at each level. I have heard much more from commentators, as well as from government, that we need to be doing more prevention in health. That includes things like nutrition, good food and good eating, but it also includes some pharmaceutical interventions—keeping blood pressure controlled, making sure that diabetes is well controlled and monitored, making sure that people's cholesterol levels are kept well under control. But unfortunately that is not a no-cost option. When we have good evidence that, if you reduce somebody's cholesterol level, you reduce their risks of ongoing heart attack, stroke and early death, that intervention is required in terms of nutrition and exercise but also medication. That medication has a cost attached to it. Currently, I think Nos 1, 2 and 4 on the bestsellers list, in terms of the cost of drugs to the PBS, are drugs for reducing cholesterol. And there is a good reason for that. It actually does have an impact, but the impact is not going to be felt for some years.

Are we doing enough? We could do more. Are we doing it in a coordinated manner? I think we could do it in a better-coordinated manner. But I am actually hearing now some drive towards this, and I think that way is important. We need to continue that. The AMA today launched the Position Statement on Nutrition, which is one step in the whole process of making people much more aware that what we do in our normal lives has an impact on our health in the future.

CHAIR—In your submission you state that public hospitals have been run down to a perilous level. At the same time, you say that we have one of the best health systems in the world. Could you outline what you see as the key issues facing the public hospital system. Are these issues primarily related to funding, or would the AMA advocate broader structural reform? You may not have been here when we were speaking with the department of health, but this inquiry has not had a very good response from the state governments in terms of our being able to speak with them. We will not get evidence from them until after the COAG process. So any evidence we have so far is anecdotal.

Dr Haikerwal—Choong may be able to help me with specific figures, if we need them. We do have an excellent health care system and the hospitals are the flagships of that system. They are world-class hospitals, but they are working at absolutely maximum capacity. There is no room for a bird flu epidemic or room for large numbers of casualty-type situations in the community because hospitals are running—I call it 'red-lining'—on the red line.

Ms HALL—What is the solution to that?

Dr Haikerwal—We need more capacity within the hospital system.

Ms HALL—More public hospitals?

Dr Haikerwal—We need more beds in the hospital sector. We need to make sure that there is access at all times to people who are acutely unwell by increasing the capacity in the hospital system.

Ms HALL—So that is an increase in funding to public hospitals?

Dr Haikerwal—It certainly needs to be increased in public hospitals. There are two parts to it. One is that the recurrent growth that is indexed in the current agreement does not allow for the growth that is happening right now. So we are not even keeping in touch with where we are at.

The other is that the infrastructure is being whittled away, worn away, and that is not being addressed. The actual load is so high because the efficiencies are so high that we are running on empty in many ways.

One way that hospitals save—Dr Yong works in New South Wales and can give us some good examples of this—is by working maybe 25 per cent of the year with things like operating rooms shut. They are saving money, despite the fact that they have the staff and the facilities there; they are just not putting throughput there.

That then leads to the other problem: retaining people in the public hospital system. People are saying: 'I want to work in the public hospital system. I want to do my teaching, my training and my research. I want to be part of this. It is the flagship of our industry. But when I take a day off to operate and consult here, my lists are cancelled. So, apart from the fact that I am not continuing my income in my other practice, I am not able to see the people that I want to see.' This business of cancellation of lists and so on is a significant factor affecting morale in the system. And it goes throughout the whole system; it is not just the surgical or medical specialties. The psychiatric specialty have significant problems of their own, which I might ask Dr Yong to address separately.

People feel that they are being driven to answer to bureaucracy and not to do clinical work. Many of the cushions that used to make people think 'I would still like to do my work here' are being taken away. They are losing their ability to teach. Clinicians are just doing service delivery; they are not teaching. They are not having the time to do additional training. Ongoing innovative care and research, which is why we have got to where we are, is all but excluded from the sector now because of lack of funding and lack of time. We need to address those things.

CHAIR—Is it happening in the private sector?

Dr Haikerwal—There is some in the private sector but it is not sufficient. One of the big moves that we plan to make in the new year is to emphasise the need for recruitment in the private sector—which people are keen to be recruited in, by the way—for teaching, training and more research. We will not be able to cope in the public sector with the number of medical students who are going to come through the system.

Dr Yong—I just want to add that the model of efficiency around hospitals has to be different from other industries. I think that is one of the problems we have now. Other industries might say that a 90 per cent or 100 per cent occupancy rate is highly efficient. From the point of view of saving money, it probably is. But that is not what a hospital is. It actually fulfils several different functions, as Dr Haikerwal was saying.

In addition to providing care for the sick, it has to be a place where research is done. It has to be a place where it trains the next generation of health professionals—nurses, allied health professionals and doctors. It has to have the capacity to do all of those things and the people working there have to have that capacity, but we are losing the ability to do so. It will have disastrous consequences for our professionals down the track if they do not get the right balance of training and work that they were getting previously. To do that, we have to ramp down the

occupancy levels in hospitals. We have to build more capacity in so that we do not have every single bed filled all the time.

The other issue we have concerns about is what would happen in the case of disaster and how would we cope with that. We do not have enough slack in the system at the moment. We do not have enough time for our professionals to teach the next generation safely. We have additional requirements in terms of increasing quality of the care we provide. Again, that requires resources such as time to check what we do, to make sure we are doing it to the highest standard possible, that shortcuts are not being taken. We really need to look at how we are funding our hospitals and looking for a different model of efficiency.

Dr Haikerwal—Do you want to talk about mental health issues?

Dr Yong—Mental health care is one of the areas where we see a lot of factors being involved around the funding. It is one of the areas where the social determinants around health are really quite important. The problems that our mentally ill are facing at the moment—that is, not having enough care inside or outside hospitals—go hand in hand with such issues as housing, social support for families, employment opportunities. All of those things are crucial to people recovering from mental illness. It would be simplistic just to look at the health funding alone when you are looking at what will help our mentally ill to get better.

Ms HALL—A more holistic approach is needed.

Dr Yong—Yes. Really, it is all of those issues. When we are talking about chronically mentally ill patients, we are talking about a group that is very poor. Essentially, one of the problems they face is extreme poverty and homelessness. We have always been pushing for a comprehensive solution to mental health, including other things like housing and social support and so on, as well as helping families to care for their mentally ill relatives.

We have a particularly acute problem with our hospital beds because of our inability to stop the revolving door syndrome—that is, stopping patients relapsing and coming back to hospital after we have sent them out. Our occupancy rates in psychiatric hospitals are even higher than our other acute hospitals. I can certainly tell you from personal experience that in my local hospital, we are often overflowing; we actually have more than 100 per cent occupancy a lot of the time.

Ms HALL—Which is your hospital?

Dr Yong—I work in Western Sydney, so there are several hospitals. There is Blacktown and there is also a psychiatric hospital at Parramatta called Cumberland Hospital. I have worked at both. A considerable amount of the junior doctors' time is spent looking for beds for patients who are brought into the hospital—by police, by their relatives or by ambulance—seeking inpatient care. It is a very acute problem now.

CHAIR—Do you think the Commonwealth should have a larger role in mental health?

Dr Yong—Yes, I think so. Certainly we need to see a greater coordination between the states and the Commonwealth looking at things like family support, employment services—

Mr TURNBULL—What do you mean by 'looking at things like family support'?

Dr Yong—Looking at ways in which we can improve services that help families with—

Mr TURNBULL—Do you have concrete recommendations as to how services can be improved?

Dr Yong—There needs to be more funding towards after-care services, things like community mental health services, so that there is not only care for patients in hospital but adequate follow-up for those patients once they leave hospital. Many of our community mental health teams are working in the crisis model only, which means that it is not until the patients get sick again that we can actually care for them. There are not enough teams in most places to continue that follow up, ensure that people stay on their medication and ensure that people are attending rehabilitation services. Our rehabilitation services are limited. We do not have enough supported housing, so homeless patients end up on the streets or being cared for by emergency services rather than having places to stay that have access to the mental health teams and to psychiatrists.

Mr CADMAN—They were all closed down. There was a definite policy to get rid of that process.

Dr Yong—That is the hospitals. The policy of deinstitutionalisation, which was closing down the large psychiatric hospitals, was not followed by funding of things like community supported housing, hospital care and so on. That also included support to carers. If patients are going home with their families, one of the things that happen is that it is not until the patients get very unwell that the mental health team comes up and helps those families care for them. There is not respite care. Carers payments may not be sufficient. There are those sorts of issues.

Ms HALL—The AMA submitted a paper to the Senate inquiry into mental health. Maybe you would like to submit that paper to our committee. That would outline a number of the issues and some of the solutions that the AMA has for those problems.

Dr Yong—We have also suggested the place of private practitioners. I think we suggested looking at the Medicare rebate to help them access services more easily.

Ms KING—I want to go briefly back to the issue relating to fund holding. For example, with that class of patients—people with mental health problems—would you look at something like fund holding for them?

Dr Haikerwal—We have many delivery models already. We do not need to go down that route because it is actually quite well thought out. But it is not properly followed through in terms of provision. So you do not have enough people. You have general practitioners doing a lot more of the work looking at mental health in the community, but there is nowhere to bail out to when there is a problem. You end up with the community health team not being accessible to cries from general practice or even professors of psychiatry because you do not meet the criteria. We also have that being magnified manyfold with drugs and alcohol misuse. Of course, that problem is much worse in Aboriginal and other rural and remote communities, where it is a much wider problem. So, depending on where the situation, the way in which services are funded may well vary.

I went to a place in south-west Cairns, when there was a very good drug rehabilitation centre where the different parts of the building were funded by different sorts of people. If you did not have enough people in one part, you would lose that funding and could not do the rest of it. It makes some sense to say, 'This is funding from government for this particular function.' If you want to call it credit funding or whatever, it is not necessarily holding complete funds.

Ms Nesbitt—There is no evidence that fund holding improves health outcomes. In the UK, New Zealand and Canada, where they have done that, the evidence does not exist. That is even for basic chronic diseases like diabetes. So there has to be an awful lot of work to demonstrate any positive outcomes from that sort of system in mental health. The other issue is that there is already a measure that is under way in Australia called Better Outcomes in Mental Health. We have been long awaiting the evaluation of that measure. While there has been decent uptake of the training for general practitioners under that measure, there has been poor uptake of the items for a number of reasons. The evaluation is nowhere to be seen. I think we need to understand how that is working before we start taking that any further.

Ms KING—I have to disclose that I was part of the KPMG team that did the evaluation of both the coordinated care trials and the Aboriginal and Torres Strait Islander trials before I was a member of parliament. There was some evidence in relation to population health groups as to what you could do with fund pooling. Obviously there is a lot of dispute around how much money goes into that and how you calculate that, but it would seem to me that, in relation to mental health patients, a regional psychiatric service would love to get hold of money to be able to access accommodation services, drug detox services and a range of other services and have some flexibility about how that is spent as opposed to having to constantly scrape the bottom of the barrel to try to find any amount of money to get a basic service. I am just exploring that.

Dr Haikerwal—Depending on the model of care and where the funds are held and what the funds are held for, what you have to do is drive bureaucracy. You actually have to detract from providing health services, which is what it is all about. The current convoluted process to accessing funds and to acquitting them is a significant program. What you are saying, however, is to have a coordinated plan—working with the different levels of health care services delivery and the different funders in the health care system. Then you can make it work better. The relationship between state and federal governments needs to be strengthened. It is very important.

Ms HALL—I have to say that the Hunter urban division of GPs also argue for that pooling and the casing out of Medicare benefits to be used in that area. That is one group where members of the AMA are actively arguing, and have argued for both government and opposition, about the pooling of funds.

Dr Haikerwal—With regard to the 111 divisions, hypothetically if they went down the road of that, there would be very small areas to do this sort of work on. The level of bureaucracy and so on would be a significant problem. As organisations, they are not geared up to do that sort of work, and I do not believe they could do it, to be honest. The other thing is that they do not have universal support from 111 divisions.

Ms HALL—I know that is one division that does. Others do not.

Dr Haikerwal—A few key divisions around the country may have said they would like to do it. Certainly the overarching body would like to do that more in terms of having access to funds and being able to provide more services and better services or get better health care outcomes, which should not be the result of that process.

Ms HALL—I am sorry; I interrupted you before, Dr Yong.

Dr Yong—I was just thinking about the fund holding idea for mental health. It is an intriguing sort of question. I guess one of my concerns is that, potentially, to achieve the sorts of efficiencies in funding there would be very strict criteria about who would actually be looked after in that plan. One of the problems we have now is that we effectively ration better health care as it is now, which means that a lot of patients are not sick enough or suicidal enough or unwell enough. I get this all the time from patients and GPs, who say, 'I can't get my patients seen by the local mental health service because they're not suicidal enough.' I had this the other day from one of the GPs.

CHAIR—Who makes that assessment that they are not suicidal enough?

Dr Yong—It depends. There is usually a triage sort of service within the local mental health service that makes that sort of decision. We have to do it with local criteria.

CHAIR—So the GP said he cannot get his patient into the mental health service but the mental service is saying—

Dr Yong—One of the problems was that that patient had a very good GP so that the mental services sort of said: 'You can manage it.' The GP said, 'I need help here.' I think that was the problem there. There can be difficulties around excluding people. The other problem is that we still have to manage that conflict. In many ways we like to be very assertive in mental health and take over care. Often parents and families say, 'Please do something for our relative.' But there are also the rights of those people who are mentally ill to refuse care if they wish. In most states we have very strictly defined laws, but when we can we step in and say, 'This is involuntary treatment.' I think that we have to be very careful because I suspect that the consumer groups in mental health would be very concerned in some ways about being labelled and about this being put into a separate bucket of money. Some consumer groups would prefer mental health to be very mainstream, to be added to the rest of health care and to say, 'This has to be funded the same way as everything else.' So I think there are potentially a lot of thorny issues to iron out before such a plan could be put in place.

CHAIR—Can I change the subject to health funding in the macro sense. In your submission you state that 'There is quite a lot of cost-shifting activity going on.' You give examples of outpatient services. For the benefit of the committee, can you expand on these areas of health where cost shifting is happening? Is it more prevalent in some states than in others? You are a national organisation. Do you see it happening more in some states than in other states?

Dr Haikerwal—Cost shifting happens in every state. Some have a different modus operandi.

CHAIR—The Department of Health and Ageing told us they have no evidence of cost shifting.

Dr Haikerwal—That is a very intriguing view. I suppose it depends on where they draw the line. If the health department has an issue then if it is determined before a certain date that is all right and after certain date it is not. Nonetheless, it leads us as a professional organisation into difficulties, because if there is a cost-shift that is not deemed to be approved by the minister under a certain section of the Health Insurance Act it is not the health service that has a problem, it is not the hospital that has a problem and it is not the state government that has a problem; the one with the problem is the individual doctor whose name goes on the bottom of that item that they have to sign before they provide that service in the system. So we have a significant concern, and certainly my colleagues in Victoria have been working to try and remedy the guidelines around this.

The cost shifting can be straightforward, if you like, by having an outpatient clinic which is no longer funded by the state health department. They set up a privatised outpatient clinic, the patients go and see the specialist in that clinic and that is charged to Medicare. Whereas previously it would have been purely a public hospital function, it is not anymore. Some hospitals will try and move some of their work to the private sector. That may be okay if the arrangements are right and it is being paid for from the hospital's state budget to supplement the work that is being done in a public hospital in that private hospital sector. But sometimes it is not done in that way. Again, if the charge is straight on Medicare, that could raise some questions.

I will ask Choong to talk about mental health in a second. That is really his area of expertise. In terms of aged care, people who are looked after in the state hospital system are obviously paid for from the state sector. If they are discharged into the community—sicker, quicker or whatever—that responsibility is then with the general practitioners who have to recruit services for those patients.

Ms HALL—Can I stop you at aged care. I have your submission open at the page where you talk about bed blockers and the solution, and I know there is a letter of yours addressing the issue of the main bed blockers. My state colleagues identify the fact that there is a number of elderly people taking up acute care beds in hospital. That is a very big issue, and they see it the other way: as the Commonwealth shifting the costs to them. I love your solution because it reflects to some extent the solution that they use in the UK and Sweden, where they charge the provider that cannot supply the service. That is a way of dealing with it and of probably putting a little bit more money back into the acute system, because if somebody is taking up an acute care bed—instead of most likely an aged care bed—then the Commonwealth should pay for the aged care bed. As I mentioned, Sweden and the UK have a very similar system.

Dr Haikerwal—The money should certainly follow the patient to whichever part of the continuum they are in. The continuum needs to be responsive to their care needs at the time, so there may well be somebody who has been in an aged care home who needs acute care, and that is actually okay. In fact, they are not bed blockers in terms of their actually having a bed open for them to go back to.

Ms HALL—Exactly.

Dr Haikerwal—In fact, a very small proportion of emergency department presentations will be from that group. There are some people that you cannot get placements for. That is a

significant problem. I think that is one way in which subacute care could help and that is another way that it could be addressed, through funding.

Ms HALL—I think it is a quite innovative solution.

CHAIR—The committee met in Sydney at North Shore Private Hospital and saw the collocation of facilities with Royal North Shore Hospital, the public hospital. Do you have a comment on the collocation of private and public facilities and the interaction between the two which should utilise more efficiently the funds that are being paid into the health system?

Dr Haikerwal—I cannot talk specifically about New South Wales. In general terms, there is some synergy. We see this very well at certain sites. In Melbourne, in my state, St Vincent's public hospital, for example, is collocated with St Vincent's private hospital. There is some synergy in terms of personnel, in terms of time and management, and in terms of equipment. But the systems that are within the public hospitals are geared up to a certain level of acuity and a certain level of intervention, which perhaps the private hospitals cannot run to. But the private hospitals have some ability to take on some of the excess work if there is a lack of supply of services within the public sector. Unfortunately—or fortunately; it is however you want to look at it—there is quite a high demand for private sector beds at the moment and the private sector is looking at quite high figures itself so there is not an awful lot of capacity within it. But certainly in terms of teaching, in terms of training and in terms of research, I see a great deal of synergy being available there.

Dr Yong—I would agree. I think they are fair comments. It does depend a lot on the ability of the two collocated hospitals to work well together. That differs from site to site, so a lot of it is about the cooperation. Where there is a lot of commonality, where doctors—specialists—are working across both hospitals, I that is more enhancing than with other sites where there is a lot of separation between the two so you essentially have different specialists working in the two hospitals.

CHAIR—Why does that happen?

Dr Yong—It is often due to the management practice in the private hospital as to whether the doctors at that location want to work in both locations or not.

CHAIR—What do you think of the idea of GP clinics in hospital emergency waiting rooms?

Dr Haikerwal—The idea of this is from the notion that a large number of presentations to emergency departments in categories 4 and 5 were consultations that could otherwise have been in general practice. Even general practitioner referred heart attacks to an AE department are actually in category 4 or category 5, depending on which way you look at it. So a lot of people are actually appropriately in an emergency department, and whether they should have been seen by a GP or not is a different kettle of fish. In fact, the number of presentations in categories 4 and 5 has actually dropped, whereas the number for category 2, which is the really acute stuff such as heart attacks at home, has actually increased.

So there is still this lack of supply of hospital and ED beds causing the problem. It is not simply because of a lack of supply of GPs. There is a shortage of general practitioner services—

granted. The co-location is not going to be a solution to ED problems. In fact, in a poorly thought-out environment, it is actually a distraction and a detraction from GP services any given area. We saw the situation in WA where they set up a string of after-hours clinics in emergency departments and general practitioners stopped consulting on weekends or they stopped providing services altogether, because they said, 'This has removed the viability of my service.' Where they have been successful is where there has consultation between the local GPs, the service providers, the state government and the Commonwealth government and that has allowed collocation to happen and Medicare benefits to be paid.

CHAIR—Would the AMA encourage that?

Dr Haikerwal—In limited circumstances, where there is agreement and where there is a need, but there has to be consultation with the local doctors. What we had around the time of the last election was talk of bringing people into areas where there were already some doctors and to supplement that without any discussion. The doctors who were there were already struggling in a hard job. Rather than helping them improve their services and recruit people into that practice, there was to be a secondary practice to the side of it, which would completely decimate the private practice that was there already. That was the wrong move.

The other move was where there was a collaborative way of dealing with this and collocation was done in a cooperative manner. It was not necessarily that you could only do it on a bulk-bill agreement; you could actually privately bill to keep the service sustainable. It was actually a much more achievable, acceptable solution.

Ms HALL—The Hunter trial has been a very good example. It is bulk-bill, but it has been very successful. I do not think it has led to practices no longer operating on weekends. I think everyone has been consulted. It supports what you say: it has involved all parties.

Dr Haikerwal—It is a good model in the Hunter, but the pump priming required from the federal and state governments for it to be successful and to keep it afloat was quite considerable. I do not think it was a bad investment—it was a good way of doing it, but it was a costly way of doing it. I am not saying it was wrong. In fact, it has been very successful.

Dr Yong—If I can just add a couple of things. Firstly, our emergency medicine directors are very clear in telling us that having co-located practices is not a solution to the crowding and the demand on emergency departments, because in fact those patients addressed by GPs are not the ones that take up the work in the departments. If you were to look at having co-located practices it would be in terms of improving care overall rather than saying, 'This is going to make our emergency departments less busy.'

Secondly, one of the reasons that the Hunter one worked well was because, when you looked at the return to the GPs of the cost of what they were doing, you see that it much more reflected their costs of practice rather than just straight bulk-billing. That was one of the things that made sure it succeeded and was much more acceptable to GPs. So in one sense if we were to improve the remuneration to patients to be able to pay for the services they get through GPs, then you would see an improvement in services in a lot of other places. Part of it was also working closely in a well-defined area with a particular hospital and a particular emergency department. That will not necessarily translate across the country in quite the same way.

Ms HALL—You mention portability as a very important issue in your submission. I would like you to expand on that a little bit more for the committee?

Dr Yong—One of the things that is clearly becoming more of an issue is the ability of doctors to move across state jurisdictions. We are seeing a pattern where our trainee doctors are having to go across different states. This is a good thing. This will solve some of the acute shortages we have in different places. It is a good thing that we have our ophthalmology trainees doing some of their training and the Northern Territory, for instance. But they do so as a great cost personally to themselves at the moment because of all the different registration systems in each state.

We have been very encouraging of a system bringing about a nationalised approach. Currently that is in train. It is being held up by legislation being written that will fit across states and the usual problems getting the jurisdictions to work together. I do not have to tell you about the train gauges and things like that. We are encouraging a system that is simple for most doctors. If they are fully registered in one state, they should be able to move across to another state, with minimal cost, and provide services there. With technology the way it is, many doctors are now virtually working across states, using video links, teleconferencing and so on. And that will only increase, so it makes sense.

Dr Haikerwal—The current situation is that, after you get your registration, a Medicare provider number is issued as well. A doctor can literally have hundreds of provider numbers. They have to apply for one each time they change location or relieve someone as a locum. We have suggested that people should have one provider number as a stem, with an ending which depends on the postcode where they work. That would simplify the whole process, which is currently quite cumbersome.

Ms HALL—You have mentioned that practice nurses have been of great benefit in providing health services. What about nurse practitioners?

Dr Haikerwal—It depends very much on the way the system is set up. We currently have nurses who extend their nursing role to various specialties and have a certain degree of expertise—whether it be in mental health, dermatology or breast clinics. In those areas they work under the guidance of a medical practitioner in a team environment where protocols are set up and people are doing things within certain parameters. We have no problem with that because that is how things will and should develop. The concern is where you have independence. There were 199 submissions to the Productivity Commission and many of them were looking for independence in doing everything. There is a reason for doing a medical degree before you go off and do things independently. There is a reason for doing nursing, because it is a different specialty. Nursing is a specialty in its own right and does its own sorts of work. Just because you have done a nursing degree it does not mean you can go off and be a doctor. Just because you have done medicine it does not mean you can go off and be a physiotherapist. They are individual disciplines. There is some coming together of some of the disciplines, but they are not substitutable or replaceable. We have no problems with teamwork and, along the way, pulling various people into those teams, but we do have significant concerns where people feel they can do the same work without the same levels of training and accountability to their own profession and to the system.

Ms HALL—Would you embrace the UK situation here?

Dr Haikerwal—The situation in the UK is very different. It is a totally different system in terms of the sorts of people who are there.

Ms HALL—I understand that.

Dr Haikerwal—The reason that has evolved is that it was a different system. In the UK system, nurse practitioners in general practice are very much working in a team environment with the general practitioners. They make sure those nurses are under the guidance of the people who run the general practices.

CHAIR—Thank you for appearing before the committee today. Is it the wish of the committee that the documents tabled by the Department of Health and Ageing, 'The state of our public hospitals' and 'The consumer survey on informed financial consent', be accepted as exhibits? There being no objection, it is so ordered. I declare the meeting closed.

Committee adjourned at 12.14 pm