COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 29 March 2006

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

Members in attendance: Mr Cadman, Mrs Elliot, Mr Entsch, Mr Georganas, Ms Hall, Ms King, Mr Somlyay 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 9.45 am

GOULSTON, Professor Kerry, Hospital Reform Group

LAMBERT, Dr John Francis, Founding member, Hospital Reform Group

LATTA, Mrs Deborah, Member, Hospital Reform Group

MACKENDER, Dr Darryl Richard, Hospital Reform Group

SKINNER, Dr Clare Alice, Hospital Reform Group

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

Prof. Goulston—Firstly, who are we? We are a group of senior clinicians—that is doctors, nurses and allied health people—working at the coalface. We include health academics, hospital managers and consumers. We are not party political. We have got no axe to grind. I guess our main weapon is that we are all passionate and committed to the public health system, particularly the public hospital system. The issues we are talking about, because we are from New South Wales, we believe occur in every other state in Australia—our colleagues tell us this—and probably overseas as well as in Western countries.

We started as a small group of about 12 of us having dinner at a Chinese restaurant in Crows Nest in Sydney every six to eight weeks and whingeing. After repeated dinners, we came to the conclusion that we should stop whingeing and come up with some positive solutions to what we saw as the issues and to stay focused on what issues we could influence. That is what we have tried to do. We are not whingeing; we are here because we believe strongly about things and that there are solutions to the problems.

We believe that the present public health system in Australia is unsustainable, particularly the public hospital system. We think it is mainly unsustainable because of the work force, and the work force is going to get worse over the next few years. We could go into why that has happened but we will briefly talk about possible solutions. We believe that we need more university training positions for doctors, nurses, allied health positions. We need them. There has been some increase but it is not enough. We believe that the roles of doctors, nurses et cetera have to be looked at and changed and that we need to break down professional traditional boundaries. We believe that is very important and we are prepared to say that to the AMA.

Ms HALL—That is quite different from some of your colleagues.

Prof. Goulston—Exactly. We are talking about people at the workplace. We believe there has got to be more flexible working conditions for people in the system. We are concerned about the increased casualisation in the system, which is true in the rest of society. but we have to become more flexible. There is very little job sharing. There is very little flexibility for young people. We believe we have to address the problem of morale of people working in the system. There is good evidence—very good research evidence—that patients' outcomes are better if the people

looking after them are happier and more content, yet our observation is people are not happy in the system. That is the first point about work force.

Two is public expectations. We think the public expectations of what we can deliver in the hospitals are both unreal and unachievable. We could go into why that has happened—again, I can tell you why—but I will go straight onto solutions. We believe the public have got to realise that every small hospital, every district hospital, cannot be all things to its community. Things have got to change. Hospital roles have got to change.

One example we give is: in Sydney there is a district hospital in Fairfield and one at Liverpool. The orthopods decided that they would do their joint replacements at Fairfield and look after major trauma at Liverpool. The same orthopods are doing that and, by so doing, over the last three or four years, Fairfield has been built up to be a first-class joint replacement centre with training, attracting young people, good retention rate for nurses et cetera. So we believe there has got to be a change in the role.

Although we are hospital-based and we are focusing on hospitals, we recognise that we need to think more about prevention of illness. We need to stop people going to hospitals by trying to keep them in good health with more self-help and less reliance on the health-care professions. We also think there has to more meaningful community involvement in decision-making. We think what has been done is tokenism, and we believe very strongly that the public have to come into the decision-making—not just doctors, nurses, managers and politicians, but the real public. They should be involved in prioritising what we do about health. As part of that real community involvement, we have been struck with the concept of what is called citizens' juries, which has happened in Western Australia to some extent and overseas. This is a chance to have meaningful public engagement and lock in amended decision-making.

We would like to see an end to the political spin of the Commonwealth slanging matches with the states, and vice versa. Everyone at the coalface has had enough of that buck-passing, because it has been very destructive to maintaining Australia's health system. It has promoted cost shifting; it has promoted duplication of services. Our colleagues from overseas visiting here look askance and say: 'Why the hell have you allowed this to happen for so long? It's ridiculous!' Something has to be done about it. What we are trying to do as a group, and we have grown to be a core group of 25 with more than 70 senior people backing us—and I am sure there are many hundreds more—is promote a dialogue between clinicians and the community, bypassing bureaucracy and politicians. We say it is time clinicians spoke to the community directly, and that is what we are trying to do.

CHAIR—Thank you for driving the introductions of our report. I do not think any of us here would dispute what you are saying. The genesis of this inquiry came about because we are all sick of blame shifting, we really are. We are the ones at the coalface; we do have contact with the community. I quote the example of Mrs Smith who comes to me because she needs a hip replacement and has to wait five years and she is 80. I write to Tony Abbott, and he writes back to me and says: 'Look, it's a state matter. I can't help her.' Then I write to the state minister, and he writes back and says, 'The Commonwealth doesn't give us enough money.' She gets two letters from the health ministers, but she does not get her hip replacement. This is ridiculous. Every one of us here—the Labor Party and the Liberal Party—shares that concern. We believe the health-care agreements are not achieving their intended purpose.

The Commonwealth health department has totally lost focus on the national agenda. I used to work in the Commonwealth health department. Catherine King, the member for Ballarat, also worked for the health department. The Commonwealth did have a national focus in health, and it used to fund health on the basis that everyone tries to achieve a national agenda, but there is no national agenda in health any more. The department of health in Canberra has turned into a postbox between the Treasury and the states. Therefore, we have all the cost shifting that you referred to. We are trying to identify those problems and make a recommendation to government, but we are having a lot of trouble getting cooperation from the state governments to even give evidence to this inquiry or make a submission. It is extremely difficult for all of us too.

Please believe me that we have the right intention with regard to this issue. For everybody we talk to and we have taken evidence from, the number one issue is the work force.

Prof. Goulston—That is correct.

CHAIR—There we are. What are you saying to us that the Commonwealth government should do? You all have community contact and that is to be encouraged. The community just wants outcomes. They do not want to get involved in the process; they just expect it to happen.

Dr Lambert—That has been said a lot. One thing that makes a lot of the members of this group unique is that we are managers as well as clinicians, so we actually understand a bit about how the system works. If you need to make a significant system change, it appears that you can have a bunch of clinicians, the administrators above them, and those all the way up to the chief executive of an area health service agreeing with the right thing to do, and then it stops because everybody is scared about what the community might think or, more importantly, what the minister or the politician in that district might think and the ruckus that they may cause, even if the decision is eminently sensible, completely justifiable and has absolutely every merit in proceeding. At that point, the community becomes disengaged.

Nobody thinks to say, 'The politicians are supposed to represent the community wishes, so if you want the politicians to assist you in doing something then you need to convince the community that this is the right thing for them.' But then there seems to be no avenue to actually communicate those perhaps smaller scale decisions back to the community. I am not necessarily talking about individual hospitals; I am talking about area health service level decisions. It seems to be discouraged at every level. The response I often get from managers in the system and, again, all the way up to the chief executives is that they feel scared about another ministerial landing on their desk. The reality does not seem to be quite as open and engaging as we might be led to believe.

Dr Mackender—As a clinician, one of the things that I find is really destroying morale is that at the moment they are the meat in the sandwich. They are being asked to help patients negotiate a system that is complicated and seems unfair. A lot of what a patient gets out of the system depends very much on who they see in what part of the system. If they see the right person, they might get their hip done in two weeks if he knows how to work the system. But equally, someone else—particularly in some parts of the country where, frankly, I think there is a scorched-earth health system—will wait for numerous months or years for the same service. It is quite inequitable and it is that inequity that we find difficult. As a clinician, you feel really torn

between being the patient advocate and, at the same time, trying to be realistic about what the system can do for people.

Dr Lambert—That is also part of the problem. You find that individual institutions have well developed services due to their good speaking ability, well connectedness or other reasons that have nothing to do with health delivery.

Ms KING—They know how to work the system?

Dr Lambert—That is right. You think, 'Hang on a tick, this is the public's health system. It shouldn't be about that; it should be about: where are the resources supposed to be that deliver the best quality care for the least amount of cost, in every sense?' Yet that does not seem to be the way it is run. It runs like this.**Dr Skinner**—You asked: what could the Commonwealth government do? One thing that could be done is some sort of national coordination, particularly in all the areas of workforce and training. I think that is where we really lack any leadership—

Mr ENTSCH—National standards.

Dr Skinner—linking training positions to workforce needs.

CHAIR—The Commonwealth should take a role in the national agenda.

Dr Skinner—And even national registration seems basic. There are some really clear things.

Dr Mackender—That is what the Productivity Commission should—

Mr ENTSCH—We have seen that in relation to the ad hoc way in which foreign doctors, for example, are engaged and the competition between states and the Commonwealth. It is absolutely ridiculous. Of course, we end up having people slipping through the net, as we have seen in Queensland.

Prof. Goulston—To answer your question about what you people could do, we are saying that the roles should change over time—we are quite open about that. We need more people in training and the Commonwealth caps the university positions. It caps the number of positions for doctors, nurses and allied health professionals. We are in a particular position in Australia because we have a strong private sector that has little part in training. So we train radiographers in the public system and press the buttons. Then they can earn twice or three times as much in private, working nine to five and not being on call after hours. We need more people. Blair increased them in England. Remarkably, Blair has done that.

Ms HALL—So your number 1 recommendation for us is to look at the workforce issues, remove the cap and then—

Prof. Goulston—Lift it.

Ms HALL—Yes, sorry—lift the cap.

Dr Skinner—There is a major issue here about thinking about what we want the health system to do and then training people to do that, rather than going along historical lines.

Dr Mackender—It may not be training a doctor; it may be training a nurse practitioner, a physician assistant or a—

Ms HALL—That is the thing I wanted to pick up on.

Dr Mackender—Even though I know there are some sacred cows we are going to sacrifice in the process of discussing it, there is no-one saying that out there. No doctors or nurses are saying that. All the usual suspects are defending their turf and their patch and their silo. We got sick of not having a voice. If you talk to the people at the coalface, there are people saying that the right nurse practitioner is a pivotal part of the emergency department—and even other roles.

Ms HALL—So you are saying very strongly to the committee—and let me get this clarified for the record—that you support nurse practitioners and that you believe that there is a role for them within the health system to improve the efficiency of the delivery of services.

Prof. Goulston—Definitely.

Dr Skinner—We also want a broader work force and a workplace redesign.

Dr Lambert—I would not restrict it to nurse practitioners. That is the only problem I have with your comment. Even clerical assistants are important. You are looking at one of the highest paid secretaries in the world. We seriously pay our registrars and residents an inordinate amount of money to do nothing more than take dictation from their bosses in a lot of cases. There is a huge amount of waste in that, and yet nobody has considered roles other than nursing roles being shared or changed.

CHAIR—Have you read the Davies report from Queensland?

Dr Lambert—I have not.

CHAIR—You should get it, because it is an examination of the public health system in Queensland. It is no different from New South Wales or any other state. We had Tony Morris give us evidence last week. He was the royal commissioner who was sacked halfway through the royal commission. Then we had the AMA come and see us last week, and Dr Cartmill from the virologists. There is a major concern about the specialist work force as well, and the fact that they are all trained in the public hospitals. The public hospitals have not got the capacity. It does not matter how many places we make available at universities, if the public hospital is not functioning as it is meant to we are not going to have specialists. Their conclusion is that specialists are getting older and are working fewer hours. However, they want to maintain their income, so they are charging higher fees. The private sector is under enormous pressure because of increasing premiums and also the increasing GAP that they are expected to pay private doctors.

We had a public hearing in North Shore Private Hospital. We had an opportunity to inspect the cooperation between the public sector and the private sector—and they have two or three cat

flaps operating out of Royal North Shore Hospital. Why shouldn't this become the working model for shared facilities, instead of them being in competition with each other? What we are trying to do as a committee is focus on the patient; our main concern is the patient.

Dr Skinner—That is the way it should be.

Ms HALL—Some of the issues that you have raised are really interesting, even exciting. I took a few notes as you were speaking. You talk about unrealistic and unachievable expectations. I wonder if you could expand on that and tell the committee of ways that could be handled and changed.

Dr Mackender—Where I come from, this has become an issue in the last few months.

Ms HALL—I understand your area well.

Dr Mackender—I bailed out of the system because the way it was dealt with was dysfunctional.

Ms HALL—Tell us how it was dysfunctional.

Dr Mackender—There are a whole bunch of incredibly expensive cancer drugs coming on to the market which give you tiny little incremental gains each time but which are designed to be given in combination. There are a whole bunch of other expensive biologic agents and expensive technologies. But we just put them into our system and pretend that they are going to be available to everybody without actually saying, 'We're going to put this through some sort of process so that we can understand how much extra gain we're going to get by spending this extra money.' As a result, when the poor manager sits at the end of the table they say, 'Look, I've just spent $500,000 on X drug and I am $2 million over budget projected in the next three months, so I'm not going to buy that drug anymore.' Suddenly, instead of having a sensible discussion about what you spend your money on and what you do not, it becomes an economic decision rather than a clinical decision.

So patients come along and I have to say to them, 'You might have to borrow some money from someone to get your ceramic kit or your special oncology drug.' They are stunned. They just expected that the system would give it to them. They heard it on *60 Minutes*. We pretend that our public hospital system is the best in the world and then, when they turn up at the front door, we say, 'Sorry, that is not on our books; we do not have access to that.'

CHAIR—We have amended that. We say we have the best clinicians in the world.

Ms HALL—We have changed things like the types of hips that are available.

Mrs Latta—This is the biggest and one of the most contentious issues, I think. It is one of the things that really has to be debated. But everybody keeps shying away from it. If we do have the debate properly, we are going to be in the position of saying, 'Sorry, we are actually not going to be doing this procedure,' or 'We are not going to be providing these drugs,' or whatever. But it would be based on good evidence. We are actually trying to do the greatest good for the greatest number of people.

Dr Skinner—I think at the moment the trouble is that that rationing happens and we pretend that it does not happen. It happens at the moment in an inequitable, unthought-out and random way and we need to have the debate.

Ms HALL—That is the core of the issue. It was the issue that I was hoping you would bring up. Are you talking about rationing here?

Dr Mackender—Yes. At the moment the clinicians are the de facto rationers and it is destroying their morale because not only are they disconnected from the system but also they are sandwiched between a patient that expects more from the system than they are going to get and their knowledge of the most they can possibly do for that person.

Dr Lambert—The problem also is that it is loudest-voice based rationing. It is not actually based on commonsense, logic, finance, research or data. It is none of those things. All of the things that you would think we would run a health system on are not involved in these decisions. If I go left instead of right on this road I will go to a hospital that does or does not deliver this service. Why isn't there a bigger picture being played here, where we look at the whole population of Australia and say, 'Okay, this is where they are, these are the services they need and this is how many.'

Dr Skinner—No matter which primary carer you front to, you will be sent to the best person.

Dr Lambert—I can see that is what you are trying to do.

CHAIR—Nobody is talking to us.

Dr Lambert—We are.

Ms HALL—They are.

Prof. Goulston—I actually read most of your submissions as well and I agreed with—

Dr Lambert—We pity you! You would have to read every page—it is just crazy; I do not know how you do it.

Dr Skinner—There are lots of bones to be chewed.

Dr Lambert—I just do not want to forget about the littler side. You talked about the 80:20 rule. In the country, 20 per cent of the activity in the country happens in 80 per cent of the hospitals, which are all tiny hospitals. Unfortunately, it is also true to say that, whilst hospital based acute care medicine has changed dramatically over the last 40 years in all of the big city hospitals, there have not been nearly as many changes in the way things are done in the smaller hospitals. For instance, there is a change to specialist medicine as opposed to generalist medicine once you are in hospital. The length of stay changes as well as the way we use multidisciplinary teams. There are also massive changes in efficiency.

We have the problem where the small rural hospitals cannot deliver the hospital care that everyone expects. Even if you live in the middle of Tibooburra, you still have access to

broadcast TV and the internet and you see the way it is done in RPA. You see that on TV. That is the expectation. We are talking about unrealistic expectations. That is what they expect. But it cannot be delivered at those sites.

There are ways to manage that. I do not believe it is rationing. I think it is better allocation of resources. If you have 300,000 people scattered over a place the size of Germany, that does not mean that you put a high level of intensive care into every town of fewer than 100 people. There are some things that we do sensibly. Nobody expects to get transplants in the middle of nowhere, yet they all expect to get hospital medicine in the middle of nowhere. Why? Who said that was a good idea? Nobody is asking these questions.

CHAIR—You would never get a heart transplant in Broken Hill and people do not expect that.

Dr Lambert—That is right. But why should they expect high level hospital care in Tibooburra?

CHAIR—Because years ago the GP used to take out the tonsils at the local hospital.

Dr Lambert—Absolutely—years ago. Nobody has educated them that that is not what happens now. That is what we mean by public engagement.

Ms HALL—This brings me to my next question. We talked about the rationing of certain services. Do you support a rationalisation of hospitals? The Fairfield model is a great example. But, when it comes to the small country towns, do you think there should be fewer hospitals in small country towns? What do you see as the roles of emergency departments as well?

Prof. Goulston—How many hospitals do you cover, John?

Dr Lambert—I cover 43 hospitals in the outer west, of which only four operate at the level that anybody working in a major teaching hospital would consider a hospital. I liked the word 'rationalisation' much better than rationing.

Dr Skinner—Using reason to plan services.

Dr Lambert—To my mind, we do not have enough resources to do everything, but let us use them better. I think a lot can be done by better using the resources we have. I like 'rationalisation'. Closing might be appropriate in some instances where there are sites within 15 minutes that have the capacity to deal with that workload—and of course the workforce that have to be displaced when you do that and a whole lot of other things. I think it is much more clever and appropriate to rationalise the services and say, 'There may still be a building there that has an emergency service, an ambulance service, a GP and outpatient community health but maybe does not have any inpatient acute beds.'

Dr Mackender—The multipurpose centre.

Dr Lambert—Yes, as has been rolled out.

Ms HALL—They are great.

Dr Lambert—They are a good model. They still have acute care beds, though. As somebody who works in the bigger rural hospital, I know that most of our problems arise from patients having stayed in those small hospitals for too long. The other thing is, it is unfair and unreasonable to expect of the GPs attendance at the hospital at the same frequency and intensity as people would get in the major teaching hospital. We have many more staff. We have 24-hour rostered cover. There are a whole host of things that you get in a decent sized hospital that you cannot possibly deliver in the smaller hospitals. When you talk to the GPs, they say, 'I don't mind being here to help out. I don't mind assisting with public hospital patients. What worries me is having to be responsible for these patients in the hospital who are too sick and who I cannot see enough.'

Dr Mackender—Our transport systems are much better. In the old days we were not able to move people from regional centre to regional centre quickly and back again. They spend a week in Orange for their acute infarct and then they rehab for four days in their district hospital.

CHAIR—What about VMOs?

Dr Mackender—What about them?

CHAIR—They are people in private practice who spend time in public hospitals. Is there any pressure on them?

Dr Mackender—The problem is that we are losing them. We are losing these teachers and mentors because they opt out. They are disconnected, disillusioned and disenchanted. They are saying, 'It's not worth the energy and what I get back out of the public hospital system to stay here and bang my head against the wall.'

Mrs Latta—Once upon a time it was really important to be part of a public hospital as a VMO. These days, in some instances the private hospitals have developed to such an extent that people can get teaching and high-level care at a private hospital.

CHAIR—Can they get their teaching at a private hospital?

Mrs Latta—In some respects—not as much as I think could actually happen.

Dr Skinner—In some circumstances.

CHAIR—Would you like to see more training in private hospitals?

Dr Mackender—Yes. I think there are some specialities that we actually risk losing from the public hospital system altogether. Urology is one. Neurosurgery is another. There will not be a proper orthopaedics unit, to a degree. You will get trauma orthopaedics; you will not get much else.

Ms HALL—You have mentioned citizen's juries and their meaningful involvement. Would you like to expand on that a little, please?

Prof. Goulston—Yes. In many instances they have a token number of one, two, three or four from the public on advisory committees. But often they are specific people who have been picked out. There is expertise in Australia on this, and I can give you the references, if you are interested.

Ms HALL—Yes, I am interested.

Prof. Goulston—The concept of citizen's juries, as we understand it, is that they take a telephone directory and randomly select, say, 150 people from the general public, of all ages and all walks of life. They then take them to a motel. They pay them for the weekend. They pay facilitators to promote discussion. They pay people like us to come and present data to them. This is what they did in Western Australia. They asked them: 'How would you rank the top priorities in health for your community?' As you can imagine, their top priorities were things like Aboriginal health, mental health et cetera. Way down the bottom were things like more cardiac surgery and more cancer drugs. This is one way of getting a fair dinkum input from the public about prioritising community needs. It has been done in British Columbia, in Canada. As I said, it has been done in Western Australia.

Dr Mackender—They recently did it in a town in China.

Prof. Goulston—There is a woman at the University of Sydney named Lyn Carson, and this is her main research interest. Gavin Mooney is Professor of Health Economics in Western Australia and he is also recognised as an expert on this. It appeals to us as a very good way of providing what we are asking for—more meaningful community involvement. We think the public should be involved. It should not just be us. It should not just be senior bureaucrats. It should not be politicians saying, 'Yes, we'll have another 10 renal dialysis machines in North Queensland,' or 'We'll start radiotherapy up in Cairns.' The community have got to be involved in making those decisions.

Dr Mackender—Gavin Mooney, who, as he describes himself, is a cold, hard-faced economist—he is not touchy-feely about this engagement—said the decisions coming out of their experience in Western Australia were not soft decisions but were based on justice and equity and were sensible economic decisions. He thought they were cost effective, that they were well-balanced economic decisions as well as human and community decisions.

Ms HALL—One last thing: if we did go to Sydney and have some public hearings there, would you be happy to appear again?

Dr Mackender—Yes, sure.

CHAIR—Even in a roundtable format?

Prof. Goulston—Sure. No problem.

Dr Lambert—We do not think we are saying anything too exceptional, so it is easy.

Ms HALL—No, but you are saying it.

Dr Lambert—It is rare to hear it said, but we do not see it as exceptional.

CHAIR—You are all tied up with the public system—

Dr Skinner—We are hard to get to.

CHAIR—and we have not been speaking to the public system—

Ms HALL—But we keep trying to.

CHAIR—because they have been very much discouraged.

Mr ENTSCH—They are not allowed to.

CHAIR—It is not a good career move to speak to us.

Dr Skinner—But doesn't that say something in itself?

Dr Lambert—Isn't that a problem? Of course it is. That is a problem. Fix that problem for us—that would be great.

Ms HALL—I do not think that is true as far as New South Wales is concerned. We have invited certain people. You are talking about Queensland. You are not talking about what has happened in any other state in Australia.

Dr Mackender—There are lots of senior managers in the New South Wales health system who say, 'We love what you're saying—it's just that we can't say it ourselves.'

Mrs Latta—I had to think twice about whether it was a good thing for me to be part of this as well, but I guess I have complained enough and it is time to start to be involved and do something.

Ms HALL—That is good.

CHAIR—You are a believer.

Mrs Latta—Yes.

Mr ENTSCH—I want to try to summarise and prioritise, because at the end of the day you can fix some of the things down the bottom of the ladder but it is not going to be worth a cracker unless you start to deal with the fundamentals. Would it be true to say that the primary thing that we have to deal with in the first instance, in your view, is some sort of a national standard in our health system so that there is something to aspire to right across the whole spectrum?

CHAIR—There is obviously a debate going on about whether the states or the Commonwealth should run private and public hospitals—who should run the system? We have that in our terms of reference. The bottom line is there are the health care agreements between

the Commonwealth and the states and, as I said before, the Commonwealth has washed its hands and lets the states do it. There are two schools of thought: either we bail out completely and include the cost of health in the general revenue grants to the states and give the responsibility to each individual state or the Commonwealth does what I believe it should do and set the national agenda and fund things according to that national agenda so that you are all working towards achieving certain goals and standards instead of everything being a panic, last-minute patch-up job.

Dr Mackender—We have been up to Queensland and we have talked to clinicians there. It is amazing that a health system for part of Australia can be perceived to be so 'scorched earth' and so neglected for so long without anybody stopping and saying, 'Aren't we getting the same rates of joint replacement—

Mr ENTSCH—No whistles, no checks and balances.

Dr Mackender—the same outcomes and the same standards of care from all our state health systems?' But basically, depending on what your illness is, there are places you can go in Australia where you will get better care than if you go to other places. Even within states there are area health services where I say, 'If you've got Crohn's disease you're better off going there, because I know that they have lots of access to this particular technology, whereas if you come to me I know it's a shut door and I can't help you.' But the public does not know that. They pay their taxes and they expect the same thing wherever they live.

Dr Skinner—It is our responsibility to direct them to services.

Mr ENTSCH—It gets back to the point that the value of an individual's health and welfare, whether they be in Kununurra, Sydney, Hobart, Darwin or Meekatharra, should be the same. It gets to this point when you talk about travel. There are some things they have to travel for, but of course there are other things. There are ridiculous situations. There is no reason why there cannot be birthing clinics, for example, in remote areas but heart replacements in capitals or in larger hospitals. At the moment they are carting everybody out because they get a sore finger when in actual fact they can set them up for a lot of the basic stuff.

Dr Mackender—And even assess them remotely. John is meeting with the CSIRO today to look at that sort of stuff.

Mr ENTSCH—So the first priority in dealing with these issues is national standards, so that we do play a greater role. We do not have to take over the system, but we certainly have to set the standards which they have to aspire to.

Let us talk about training—and I agree with you totally: on trainer training we are really lagging behind. However, training is not worth a cupful of cold water if we do not have staff retention, and when we are talking about retention we are talking about morale and conditions. So, would I be right in saying to you that if we are going to deal with this the second priority is to deal with staff retention, morale, conditions et cetera? These are things that will ensure that those professionals that we do train, whether in the public or private sector, stay in our health system and do not go overseas or somewhere else where they are of no value to us.

Prof. Goulston—It is a work based culture, if you like.

Mr ENTSCH—So that is about changing the culture and recognising the value of it.

Dr Mackender—And employee engagement as well.

Prof. Goulston—It is not just financial; it is things like creches for the children, it is good parking, it is good—

Dr Skinner—Meals.

Prof. Goulston—working conditions.

Dr Skinner—Also probably the penalties for shift work which now happen—there are lots of things.

Mr ENTSCH—I use this story as a good example. I have a very dear friend who was a child psychologist in Queensland Health and a very good one. After being totally disillusioned, she accepted a contract position with New Zealand Health. She went there for six months; she has just accepted a five-year contract. She has done it not on the basis of getting that much more money but, she said, because suddenly she feels valued, and she just absolutely loves it. She feels that she is a professional again, not just somebody who is knocked about by unqualified junior administrators who basically set her priorities. And then, of course, training would follow very closely as an equal or third priority.

Mrs Latta—The other part of that is defining the roles, because it really does have to change.

Mr ENTSCH—That is the next point that I want to make—again, from an administration point of view, it is dealing with the priorities of the clinicians versus the administrators. We had examples from Queensland—again, because that is where we were recently—where doctors had set waiting times for particular procedures, and very junior stamp-lickers came in and said, 'No, we're going to change that back,' with no medical knowledge whatsoever. People found that they had been dropped from the top of the list to the bottom of the list, not once but on three and four occasions. The prioritising according to need went out the window. So we need to look at ways in which the medical practitioners—the clinicians, if you like—can start to have a primary role in setting priorities, rather than having it done by the bean counters.

CHAIR—I am sorry, but we have to wind up.

Mr ENTSCH—Sorry, can I ask one more question. You raised the issue of allied health and, of course, it would reduce the amount of work that you guys do significantly if we could maintain a healthier population, physically as well as mentally. You would have heard recently that there was some discussion about Medicare provider numbers for psychologists. What is your view on the expansion of Medicare provider numbers to other allied professionals?

Prof. Goulston—Anyone want to comment on that?

Dr Mackender—I think it just goes with workplace innovation, if you like. You have to do it for the right reasons. I do not think you should just do it, so that you tokenistically put a nurse in every place that a doctor used to be.

Dr Skinner—It is about designing the appropriate workforce for the appropriate area.

Dr Mackender—We have not actually concentrated much on mental health, because I think it really is an enormous area, with many more difficult problems.

Mr ENTSCH—Now is the time. We have done nothing on mental health for years. It has just been a black hole. There is nothing. But there is an opportunity starting, I think in June, when the action plan is going to come out, and there is a bucket load of money that is sitting there to be spent. I hope that you guys, in time, start to form an opinion on it, because I think it is an area that has been absolutely appallingly abused. At the moment our institutions for mental health are our jails and our streets.

CHAIR—There is $1½ billion going to be announced—it will not be in the budget but it will come out of the next COAG meeting in June.

Dr Lambert—I have a bit of a distorted view because Orange happens to be the site of Bloomfield, which is one of the biggest psych institutions in New South Wales. It is about to be built into the main hospital, so we are doing all of the supposed future proofing of mental health at the moment. In 2010, we should have a combined hospital with both.

Ms HALL—That is excellent.

Mr ENTSCH—Sorry, I am rushing but citizens' juries—I think that is a brilliant concept. Do you think there is any role there for the old hospital board concept—giving community ownership back into the—

Prof. Goulston—Unfortunately, in New South Wales the hospital boards have been abolished.

Mr ENTSCH—And Queensland.

Prof. Goulston—And Queensland—have they? It is not just the people working in the small hospitals. If their souls belong and their commitment is to the hospital—not to a region or Queensland Health; it is to their hospital and some are the local community—somehow that soul has to be kept and one way is a hospital board.

Mr ENTSCH—That is a good way of having a watchdog, if you like—

Prof. Goulston—I agree.

Mr ENTSCH—to make sure that their hospital is delivering to a national—

CHAIR—I have to go because I am in the chair.

Mr ENTSCH—I would like, as Jill said, the opportunity of spending more time with you guys.

Dr Mackender—We are happy.

CHAIR—When we have a public hearing in Sydney we will talk to you again.

Ms HALL—I have been arguing very strongly that we need one in Sydney today, haven't I? I will have to talk to the health department.

CHAIR—I am very encouraged and I hope you are encouraged about our attitude to the problem.

Prof. Goulston—We appreciate it. Here are the references about citizens' juries.

Ms HALL—Thank you.

Prof. Goulston—I think our last message is, as Warren said, the work force situation. The greatest asset we have got is the people working in the system.

Ms HALL—I agree.

Prof. Goulston—That is what we care about.

Mr ENTSCH—And we are losing them to other professions because they get treated badly.

Committee adjourned at 10.27 am