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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

(Private Briefing)

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 24 May 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 9.19 am

TAYLOR, Mr Phillip John, Executive Officer, Strategic Planning Group for Private Psychiatric Services

WHITE, Dr Yvonne, Chair, Strategic Planning Group for Private Psychiatric Services

CHAIR (Mr Somlyay)—I would like to welcome you here to our normal weekly meeting of the Standing Committee on Health and Ageing. You have agreed to give us a briefing on your activities.

Dr White—I would like to thank you, Mr Somlyay, for the opportunity for the SPGPPS to appear again before this important committee. Unfortunately, I was not present for the last appearance on 21 September last year, as I was at an overseas conference at the time. On my return I was provided with a copy of the proof *Hansard* transcript of evidence taken at that hearing. It was discussed at our meeting held on 7 October in Melbourne, and there was a consensus that we may not have highlighted the positive achievements of the SPGPPS adequately in relation to how best a strong private health sector can be sustained in the future based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies, and the various levels of government. I welcome this opportunity to discuss this further.

As you are aware, the SPGPPS is a group that is convened by the Australian Medical Association. I have chaired this alliance on behalf of the Royal Australian and New Zealand College of Psychiatrists since 1999. During the past six years I have watched the SPGPPS function as a true strategic alliance of the major partners in the private psychiatric sector. The AMA, the college, the Australian government Department of Health and Ageing, the Department of Veterans' Affairs, the private health insurance funds, private hospitals, general practitioners, consumers and carers are all actively represented on the SPGPPS. The group operates on a consensus basis, and it has worked to produce some very constructive and innovative change in the private sector which, with your permission, I would like to more fully elaborate on in the time we have today.

Firstly, I would like to have it recorded that the SPGPPS is committed to ensuring that the highest quality of mental health care is available and accessible to people with a mental illness in a private sector environment that offers a full range of services in a coordinated manner that is dynamic and continually evolving to meet emerging community needs. For the past eight years or so, we have been seeking to achieve this outcome through a reform process which requires the SPGPPS to meet regularly and undertake open and frank discussions so that stakeholders can work together to formulate collaborative solutions on agreed key issues. Some of these key issues include: the quality, availability and utilisation of information regarding private sector mental health services; the provision of comprehensive mental health care in the private sector by encouraging the uptake of innovative models of service delivery that have been shown to be effective and feasible; and the participation of private sector consumer and carers in the design, delivery and evaluation of private sector mental health services.

The first issue is the need to improve the quality, availability and utilisation of information regarding private sector mental health services. In June 2001 the SPGPPS established its

centralised data management service, or CDMS, at the federal offices of the AMA here in Canberra. The CDMS was established to support the implementation of a national model for the collection and analysis of a minimum data set with outcome measures for private hospital based psychiatric services. Through their implementation of this national model, over 95 per cent of private hospitals with psychiatric beds across Australia have been able to put in place an efficient system for the routine collection of data that enables the quality and efficiency of mental health service delivery to be evaluated and reported on every quarter. These standard quarterly reports are provided to both participating private hospitals and to the health funds.

Essentially, our CDMS is helping to answer these key questions that any health system must grapple with if proper reform is to take place. Put simply, CDMS is helping private hospitals, health funds and clinicians to better understand who is receiving what services, at what cost and with what outcome. At the last public hearing the SPGPPS representatives tabled a copy of our CDMS manual, which sets out the products and services provided by our CDMS to private hospitals, health funds and the Australian governments. It was the collaborative SPGPPS process that enabled the national model to be developed and implemented.

Our second key issue addresses the need to improve the provision of comprehensive mental health care in the private sector by encouraging the uptake of innovative models of service delivery that have been shown to be effective and feasible. Our SPGPPS innovative models working group last year released an interim discussion paper on the assessment of funding service delivery for private psychiatric services. The interim discussion paper that was provided to this standing committee has now undergone substantive revision and I hope will be available for comment shortly after our 23 June SPGPPS meeting. This is yet another example of the collaborative SPGPPS process in action.

Finally, it was the SPGPPS that identified the need to improve the participation of private sector consumers and carers in the design, delivery and evaluation of private sector mental health services. The role played by the National Network of Private Psychiatric Sector Consumers and Carers is of critical importance. The national network was conceived, at the request of the sector, to give a voice and representation to those who receive psychiatric care in the private sector setting. The national network provides the private sector with the honest feedback it needs on service provision and funding. While the feedback we receive is not always what we would like to hear, without it we run the risk of our service provision and funding being out of alignment with what is actually needed. Pressing payers and service providers to look at the broader picture and viability over the longer term is a valuable service to the whole sector. The feedback I have received indicates that this committee has found the national network's previous testimony very useful.

In conclusion, the issues that led to the establishment of the SPGPPS, the CDMS and the national network have not lessened in importance. The Prime Minister and the nation as a whole have acknowledged the importance of the need to provide effective care for people with mental illness, and the private sector needs to be part of the fundamental reform process that is now being initiated.

I also need to mention something that happened recently. That is, that we have unfortunately been informed by the Australian Health Insurance Association that they intend to cease providing funding after the end of this year. We have arranged to meet them in June and are

hoping to get them to reverse this decision. We are very concerned about this and about the fact that they did not consult with us before making this decision. In fact they did not even consult with their own mental health committee. There are a number of other things I might mention later.

CHAIR—What would that mean to a person with a mental illness who has private health insurance?

Dr White—It is hard to know at the moment. It will mean that they will not have a direct say because the national network is working through the SPGPPS. The network will still lobby the AHIA I would suspect. They have written directly to the AHIA expressing their concern about this decision. They are very concerned about it because they feel that they will not be heard then. After all, it is they who are providing the funding for the health insurance by paying their premiums.

CHAIR—Do you think it would be useful for this committee to write to them as well?

Dr White—Possibly, yes.

Ms HALL—What level of funding do you receive from the Australian Health Insurance Association?

Mr Taylor—The entire operation of SPGPPS, its CDMS and the national network is around $500,000 a year, and it gets broken down across five stakeholders.

Ms HALL—So it is about $100,000?

Dr White—Yes. It is not a large amount of money in terms of their income.

Ms HALL—What would the removal of that $100,000 mean to the association?

Dr White—It would be a question of whether the other groups would take up the slack. Certainly I know of two groups that would not be in a position to do that.

Ms HALL—If they do not—

Mr Taylor—There is a chance that the whole thing could fold.

Ms KING—Are you saying there is an indication that the Australian Health Insurance Association is wanting to pull back from mental health funding as part of private health insurance? Is that a signal?

Dr White—That is how it appears to us.

Ms HALL—That is where I was going.

Ms KING—That is of grave concern to the committee.

Mr CADMAN—Wait a minute. We have private consultants here with their own group of people they work with. I notice the Commonwealth attendance is not all that good to your group, if I read your information right. In light of the comprehensive nature of the developments in mental health, I am wondering whether to have a separate consultative group for private consultants that are supported by the funds which are separate from the whole-use factor, which includes government as well as non-government providers. I would have thought something more comprehensive than a private sector outfit is needed.

Dr White—The reason for the development of this is because this is the one group that does represent the private sector. In fact, we do 60 per cent of the mental health consultations that the government funds overall nationally, and the private hospitals provide—

Mr CADMAN—But insurance does not cover just your members, it covers everybody.

Dr White—Sorry, which insurance are you talking about?

Mr CADMAN—The insurance providers are pulling out from funding you. It may well be that—and we will not know until we consult them—they have a more comprehensive view of how this should be handled. You are saying that 40 per cent of the mental health sector is not served by your members.

Dr White—No—this is government funding, not AHIA funding. We provide 60 per cent of actual consultations in mental health.

Mr CADMAN—I understand what you are saying. I am not misunderstanding that.

Dr White—And 21 per cent of the psychiatric beds are provided by the private sector.

Mr CADMAN—I understand that.

Dr White—They are the ones the AHIA fund.

Mr CADMAN—Yes, I know, but for the changes in Medicare and the provisions there for insurance, do you mean to say they do not fund patients in public beds?

Dr White—No.

Mr CADMAN—Not at all?

Dr White—No, not in mental health. In mental health, if you go into a public hospital you do not have any private health insurance cover.

Mr CADMAN—It is only in this area. So they are restricted to being insured in your area?

Dr White—Yes.

CHAIR—Do those private hospitals provide mental health services?

Mr CADMAN—I would like to see the other side of the argument before we go riding off.

Dr White—I think it is a fairly important issue for us to ride off on. I think it stands to undermine and threaten the direction that we are seeking to go in mental health.

Mr CADMAN—That is why I want to write to them—so we hear the other side of the story.

Dr White—Yes. That is why we have arranged a meeting with them, because we want to know.

CHAIR—What is in it for you out of the COAG package on mental health? A massive amount of money has been put in by the federal government, and the states are also going to put in.

Dr White—There are a number of things happening through COAG. We are making submissions to COAG for some of that money for a variety of issues. At the moment our college and the College of GPs are drafting a joint submission to COAG for distribution of some of that money in terms of increasing the access for patients to mental health services, to allied health services in the form of psychologists and, hopefully, to some community nurses or case managers who can help with patients getting access to the services they need. They do not need just straight psychiatric services; they also need help with housing, employment and physical care. There are all of those issues. One of our concerns about—

Ms HALL—To get this clear, your defunding would jeopardise all that, wouldn't it?

Dr White—Yes, that is right. One of the concerns that a lot of us in the mental health field have about COAG is that there is this committee, there was the Senate Select Committee on Mental Health, there is now COAG and there has been the Australian Health Ministers Advisory Council National Mental Health Working Group on which we are now a representative—and we are the only private sector representative on that, apart from the GPs—and we are concerned that there is no overall coordination of what is being provided within the mental health field. Everyone seems to be going off and doing their own thing, so quite often there is duplication and then there are other areas that are totally ignored.

CHAIR—We are not trying to do a comprehensive report on mental health.

Dr White—No, I know you are not.

CHAIR—Because the Senate has done it.

Mr CADMAN—It was your decision to come back here.

Dr White—Yes, because we are concerned that we are a group that has been functioning well and has been introducing—

CHAIR—We are looking very carefully at the private sector in private health and mental health services. We were going to have a look at Toowong hospital, but we did not get there.

Dr White—We wondered if you had got there.

CHAIR—We had a time restriction on us and we could not do it. Next time we go to Queensland perhaps we can.

Mr ENTSCH—Regarding the areas that you are raising in relation to where you need support—with the exception of the accommodation side, where we expect the states would keep their side of the bargain with regard to this—there would have to be significant opportunities for your areas of speciality in that $1.8 billion allocation, particularly in relation to the services that you provide. Since the last time you were here, of course, COAG has been, and we have now committed that funding to it. I assume you are putting in bids for that?

Dr White—Yes.

Mr ENTSCH—Because that is an area of additional support for mental health sufferers. This will hopefully go a long way to funding some of those areas of concern that you have.

Dr White—One of those areas is this public-private integration. Despite the fact that we have patients who would see us as private psychiatrists, a lot of them do not have private health insurance and when they get admitted to hospital they go to a public hospital. There needs to be some coordination in continuum of care there, and we see that as being particularly important. That is going to require Commonwealth-state cooperation.

Ms HALL—Do you have any ideas on how that can be achieved?

Dr White—There are various ways it could be achieved. One of them is a case manager who could be a public mental health employee or a privately employed person. That is a very large area so there is coordination between the private and the public sector. At the previous presentation I think Dr Pring pointed out that there is sometimes a problem when people go into public hospitals and are discharged, we are not informed of medication changes and other things that have been arranged, and they arrive on our doorstop wanting to continue their treatment.

Ms HALL—It can be the other way around: people can be admitted to the public sector and the public sector may not be aware of the regime that you as the treating psychiatrist have them on.

Dr White—Yes, that is correct. One of the things that we would recommend in that respect is that there be psychiatrist-to-psychiatrist communication there, because often it is done through other health professionals who may not have the knowledge that the psychiatrist might have.

Ms HALL—This all emphasises the importance of you continuing to be funded to put in place these sort of strategies, processes et cetera.

Dr White—Yes, that is right. We work as a consensus group, so we cannot do things as a group. It is up to our stakeholder groups to carry forwards with what we have agreed on. There are a number of things that we have done, which I think you had in the previous report. There are the care pathways. There are the psychiatric treatment guidelines which the college put out and which we have helped distribute—and they put out a consumer and carer version of that as well.

There are the guidelines for determining benefits for health insurance purposes for private hospital based mental health care, which previously had not been upgraded for over 10 years. Since we have been in operation they have been upgraded every year. We have recently added guidelines on mother-baby units to that, and we are currently working on guidelines for the treatment of people with comorbidity—with drug and alcohol problems as well as psychiatric problems—which is a very large area.

CHAIR—Do many people with private health insurance choose public treatment?

Dr White—No, they do not, and that is another issue. Currently, if you have private health insurance and if you have to be an involuntary patient, there are only two states in Australia where you can be that in a private hospital. One of the things which we have been lobbying for on the National Mental Health Working Group with the directors of the state mental health services is that, when they review their legislation, they change this so that people with private health insurance can go into private hospitals rather than public hospitals as involuntary patients.

Mr VASTA—Which states are they?

Dr White—Queensland and Western Australia. The other thing that it is perhaps important to emphasise is that I personally, and I know a lot of my colleagues, have patients who will pay for private health insurance, so that they can go into a private hospital, to the detriment of their own physical health. They will actually go without food so that they can make their insurance payments.

CHAIR—I want to change the emphasis a bit. The Productivity Commission in their workforce report and every group we talk to talk about a looming crisis coming up in the medical and allied health work force. That is probably going to be a big focus of our report when we bring it down. Would you like to tell us about the problems in your field?

Dr White—There are major problems. There are problems both at the medical speciality level and at the nursing level. I will deal with the medical one first. We are not graduating enough doctors, period, so there are not enough to go into all the specialties. We as a college are currently having trouble filling our training positions. That is partly due to there not being sufficient, but also due to the fact that as they are training—

CHAIR—What is not sufficient? There are not sufficient people wanting to train or there are not sufficient clinical opportunities?

Dr White—The training positions are vacant, so the opportunities are there. There are not sufficient people wanting to go into the field, and that is due to a number of factors. One is that most of their training gets done in the public system, and that is so dysfunctional at present that they just do not want to work in that area.

CHAIR—Is any state worse than the other?

Dr White—I cannot really comment on that. I am from New South Wales. Certainly, in New South Wales there are major problems. There are never enough acute beds for people to be admitted. We need to have subacute beds and chronic beds, which unfortunately were done away

with when all the major psychiatric hospitals were closed, so that is an issue. I know this had been looked at in New South Wales, because I was on the committee that was looking at this, and they did provide reports to the state government on how this could be dealt with, but those have not been actioned.

Ms HALL—Which year was that?

Dr White—That would probably have been about two or three years ago. So that is one part of it. The other part of it is that we, as private psychiatrists, are the lowest rebated group other than the GPs. The GPs now are getting special funding for doing different things, so their income has gone up from that point of view. But if someone is looking at their future from a financial point of view, then they are going to go into one of the other specialities where they can earn more money, unfortunately.

The other push that has been of concern to us is the attempt to make us only consultants, so that we only see people for an assessment and then do not follow on with their treatment. Most people that I know who go into psychiatry do it for the same reasons that I have, and that is so that I can follow people on and continue their treatment until they are as well as they can be. So if you take away that reason, then you are going to get even fewer people going in.

Mr ENTSCH—Who does the work? If you have a patient that you are asked to assess, and you find that there is work that needs to be done to bring that person to a stage where they are able to function in society, and then they say, 'You've now made the assessment; now you can take a hike,' who actually brings that person back to that level of health?

Dr White—That is what we are concerned about—who would do that.

Mr ENTSCH—Who does it now?

Dr White—At the moment, psychiatrists tend to do—

CHAIR—Are they referred by a GP?

Dr White—Yes, they are referred by a GP.

Mr ENTSCH—If I go to a podiatrist, I expect that once he has had a look at my foot, he will continue to do whatever is necessary until I am walking normally again. I would assume that if I were referred to a psychiatrist, I would expect that the treatment that I would receive would be from that psychiatrist.

Dr White—That certainly is what the patients want, and they have said that.

Mr ENTSCH—And is that not happening now at all?

Dr White—It is happening now, but there is a push for that to change, and that is what we are concerned about.

Mr ENTSCH—Where is that push coming from?

Dr White—I guess from a number of different areas. There is the belief that there are people who are not being assessed and therefore we should be seeing more people. Unfortunately, there are only so many hours in a day and you can only see so many people. Once you make that commitment to continue on with their treatment, you do that and then that takes up your timeslots.

Mr ENTSCH—Can you be more specific?

CHAIR—Who, in the end, delivers?

Ms HALL—Is it referral to other health professionals, where you do the initial assessment then maybe you link that person into a psychologist or a social worker or somebody that is—

Dr White—Sometimes you can link them into a psychologist. The problem until now has been that a number of our patients cannot afford to see a psychologist.

Ms HALL—Because they are not listed.

Dr White—Yes.

Ms HALL—Yes, that is very true.

Dr White—So that is one of the issues. One of the other moves—and it is a good move—is that they have been training GPs for better health outcomes in mental health. There they are actually training GPs to take on some of the mental health care of their patients, and that is a good move. But not all GPs want to do that.

Mr ENTSCH—We have also now included psychologists.

Mr VASTA—They can get Medicare benefits.

Mr ENTSCH—They can get them through Medicare. I would have assumed that, if I was a person who was suffering from a mental illness, there was a greater probability I would either have initially consulted a GP or had greater access to a psychologist—that may have been available as part an ancillary health service or something like that—who would have consulted with me and established that I have an issue. They are not in a position to treat, so they would then give me a referral to one of you guys as psychiatrists. I have to say that, up in my area, it is difficult to find one of you because there are not a lot of you around; you are thin on the ground. Nevertheless, they would refer me to you guys. You are saying that, once I get referred to you and you have confirmed what my GP or the psychologist has said, there is a suggestion that I then go somewhere else for my treatment. I would have thought that you were the only ones who were qualified to be able to do that treatment.

Dr White—That is our feeling also. There are a number of issues. It is all very well to go to a psychologist, but you need to go to what is called a clinical psychologist.

Mr ENTSCH—Of course.

Dr White—Unfortunately, there are a lot of people who have set up businesses and are saying that they are psychologists but who have questionable qualifications.

Ms HALL—That goes towards the registration issue too, doesn't it?

Dr White—Yes, that is right. The new money that is being made available for referral to psychologists will be for clinical psychologists.

Mr ENTSCH—Of course.

Dr White—As a psychiatrist, I would be much happier to be referring someone to a clinical psychologist for a specific form of treatment, and I think that will be able—

Mr ENTSCH—That is your choice—your professional decision.

Dr White—Yes, it is our professional choice and the patient's choice to take it up, because they still make the decision about where they want to go.

CHAIR—Can you explain to me how a person with a mental health illness is admitted to a private hospital that provides mental health services and what your role then is in that hospital?

Dr White—They either are referred to the hospital directly by their general practitioner, because some hospitals have a roster whereby they can then refer people on to a particular psychiatrist on that day, or they are referred directly to a psychiatrist who makes a decision as to whether they need admission. If I personally admit a patient to a private psychiatric hospital then I do their treatment while they are in hospital.

CHAIR—In the hospital?

Dr White—Yes, and I will go to the hospital and see them two or three times a week, depending on how severely ill they are and what other services are available at the hospital. The hospital provides individual care on a one-to-one basis with a psychiatric nurse, a psychologist, an occupational therapist or a drug and alcohol counsellor—

CHAIR—Employed by the hospital?

Dr White—Employed by the hospital. There is also group therapy in the hospital. Those groups are geared to specific areas—so it may be for people with depression, with bipolar disorder or with drug and alcohol problems. The other area which has been developing—and it is part of the innovative models working group we are looking at—is the health funds funding out-of-hospital care for their members. There were some pilot studies done in South Australia and in Victoria which showed that this was a very effective way of treating people, keeping them out of hospital—which is a much more expensive way of treating them—and getting them better quicker. They would still often have access to the hospital service on a daily basis, or once a week, to go to the programs that are provided there, and they would also have the option of nurses from the hospital or a social worker coming to their home and sorting out problems in their home.

CHAIR—Do the pressures that are on at the moment, which you feel might prevent you from carrying out treatment, affect this hospital treatment? Is that what you are talking about?

Dr White—No. Not the hospital treatment so much. It is treating people outside the hospital as part of their health fund cover which is a bit of a problem at the moment because there is specific legislation that covers that and it can be quite cumbersome at times. As a result of that, a number of the hospitals have not taken it up and the funds have not—

CHAIR—Do they only fund in-patient services?

Dr White—Yes, and that is why we are trying to get the diversity there.

Mrs ELLIOT—Can I just clarify something in terms of the admissions. If someone presents at a public hospital and is assessed there, can they then be referred to a private hospital if they have private health insurance?

Dr White—If they have private health insurance, yes. That does happen. Because of the shortage of beds in the public hospital system, you are only getting people admitted there who are acutely ill—very severely ill at that point in time. As you are all no doubt aware, because it has been reported widely in the papers, a lot of those people who are being admitted acutely into the public hospital system are under the effect of drugs, and this has produced psychiatric illness. Unfortunately, they are also quite violent, which causes problems for the staff. I mentioned the shortage of medical staff. The other area where there is a great shortage is in nursing.

Mr ENTSCH—Psychiatric nursing?

Dr White—Especially psychiatric nursing. Since the training of nurses changed to be university based, in general training they get very little exposure to psychiatric situations. I think it is a total of four to six weeks over the three-year course, which is a minimal amount. If they then want to specialise, it is another two years. A lot of them are not choosing to do that because there is such a shortage of nurses worldwide anyway.

Mr ENTSCH—Maybe we need to be looking at what we doing in the aged care sector and suggesting that we look specifically at incentives that will encourage individuals to go into the specialty. We are doing it with aged care in relation to HECS relief et cetera. Maybe this is another area that we can look at in relation to psychiatric nursing.

CHAIR—Did the college make a submission to the Productivity Commission?

Dr White—Yes. The college did, the AMA did and we did.

Mr ENTSCH—Can I just establish something here. I am a little confused. You guys are at the top of the pecking order. At the end of the day, the buck stops with you. If there has to be a decision, the ultimate decision in relation to treatment or whatever is you, because you are the most eminently qualified as clinical psychiatrists. You are saying that there is a push to basically cut you out of the treatment chain so you are only seen as a consultant. First of all, why are they doing this—is it dollars and cents?

Dr White—First of all, it is dollars and cents.

Ms HALL—Who is 'they'?

Mr ENTSCH—That was my next question. Who is 'they'? Because I would be interested in their point of view.

Ms HALL—Obviously you are not funded by the states.

Dr White—No, we are funded directly through the MBS, so it is the federal government and the HIC. At the moment there is talk of front-end loading, which certainly the college is very much against, because doing the initial assessment sometimes is not the most difficult part; it is the ongoing treatment that is the more difficult. That has certainly been an issue for our college.

Mr ENTSCH—We need to get advice from 'they' to find out what their motivation is.

Mr Taylor—It is the notion across the board in health generally that qualified doctors and nurses are quite expensive and that less qualified people can perform some of the functions that they perform. It is not just in mental health.

Ms HALL—There is also the shortage factor, isn't there—scarce resources; not enough psychiatrists?

Dr White—There is a shortage. That is what I am saying. We cannot fill the training positions. We have got to improve the conditions so that people will go into doing the work.

Mr ENTSCH—With the amount of money that has been allocated now and an expectation that it is going to be matched by the states and territories, I would suggest that there should be enough money somewhere in that package to quarantine a little bit aside. Mental health issues in this country are at crisis level—go onto the streets and into the jails. We need to start assessing some of these people to get them on some sort of treatment, while the states start building reasonable accommodation for them. But we need enough professionals to be able to deal with it in a timely manner; we cannot wait for the next two or three generations. So maybe there is an incentive, maybe there is an opportunity there, for us to see about quarantining a little bit of this money to encourage people into psychiatric fields.

Dr White—Previously, the mental health budget was quarantined at the state level, but that was changed in the last Medicare agreement. That did not occur anymore. However, even when it was quarantined, when it got down to the regional and area directors' level it sometimes did not remain quarantined and the surgeons, who were the most demanding and wanted more money, got it rather than the mental health budget.

Mr ENTSCH—I think there is an opportunity there for us to have a look and ask a few questions in relation to that.

CHAIR—We will do that. Everything the government does is based on need and outcomes. In mental health we know there is a crisis. We know what we are trying to achieve. If we are having arguments internally in the system, they should all be focused on how to achieve that outcome.

Dr White—If you look at some of the government's own figures, you can see that the private sector sees, I think, 300,000 patients for about $78 million, whereas the public sector sees 160,000 patients for about $1,000 million. I might be a bit out on the costs, but there is a marked difference in the costs.

Mr ENTSCH—That does not surprise me.

Dr White—I guess the other thing we are concerned about in terms of the COAG money is that it does not get put into bureaucracy rather than the provision of services to patients.

Ms HALL—The public and private sectors are very different. I do not think that is like comparing apples with apples; it is more like apples and oranges. The type of treatment and the types of patients being looked after are often more acute within the public sector, so you cannot really make a comparison like that.

Dr White—This is, unfortunately, an argument that is put, but we have shown with our CDMS results that, when you look at the outcome measures that are done on admission, the patients who are treated in the private psychiatric hospitals are as sick as the ones who are treated in the public hospitals. The outcomes speak for themselves—they improve with the private treatment. The problem in the public system is that there are too many and they do not stay in long enough to get adequate treatment, so some of the numbers are actually readmissions rather than new patients.

Ms HALL—Scarce resources.

Dr White—Yes.

CHAIR—Thank you very much for coming along today. We will send you a copy of the transcript.

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

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 10.04 am