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Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 31 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: Mrs Elliot, Mr Entsch, Ms Hall and Ms King

Terms of reference for the inquiry:

The Committee shall 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:

examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

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

while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

Committee met at 9.34 am

PODGER, Mr Andrew Stuart, Private capacity

ACTING CHAIR (Ms Hall)—I declare open this public meeting 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 system. At today's hearing the committee will hear from Mr Andrew Podger, AO, a former secretary of the Commonwealth health department and Public Service Commissioner. More recently, Mr Podger headed a task force established by the Prime Minister to examine how to improve the delivery of health services in Australia. The committee appreciates the opportunity to draw on Mr Podger's experience in administering Australia's complex health system and his knowledge of the government to assist this inquiry into health funding.

This hearing is open to the public and a transcript of what is said will be made available via the committee's website. If you would like further details about the inquiry or the transcript please ask any of the committee staff here at the meeting. Although the committee does not require you to speak under oath—and I am sure you know this better than I do—you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. Do you wish to make a brief introductory statement before we proceed to questions?

Mr Podger—It might be helpful if I did make a short statement. I am speaking today as a private citizen but obviously one with substantial experience as a public servant advising governments and managing the Commonwealth's responsibilities, particularly in health and aged care. Since I retired from the Public Service 12 months ago, I have presented two substantial papers about the health system. The first I did for the Productivity Commission roundtable on federalism held last October. That was published in a book by the Productivity Commission earlier this year. The second I gave in March this year as the inaugural Menzies Centre lecture. I have provided the committee with both those papers.

The first paper provides some background on the nature of health systems, including an assessment of the Australian system, and sets out some directions for reform, both incremental and systemic. The second paper focuses more on systemic reform, describing in more detail what it might look like and how we could get there, and analysing some of the associated issues, such as balancing public and private financing. My firm view is that systemic reform is feasible, but I appreciate that it would take time and effort and would present some risks, and to deliver tangible benefits it would require complementary improvements. Accordingly, I accept that the political judgment may be that it is too hard at present.

My objective is to persuade decision makers of the merits of my suggestions, at least for the longer term, so that incremental reforms are not ad hoc but have some clear direction; they should make future systemic reform easier or, at least, not more difficult. Most of the suggestions I have made have considerable commonality with those of other reform advocates over the last 10 years—and I have in mind people like Menadue, Scotton and a range of others. The points in common are: we need a more patient oriented system, rather than one based on programs that are provider focused, such as hospitals, GPs and nursing homes; there are benefits

therefore in having a single funder or pooled funds for a single purchaser; there is a need to invest more in primary care, as the most likely coordinator of care for most patients who have chronic illnesses, and in preventive programs, particularly for those most at risk; we need an information system that helps providers deliver appropriate care efficiently and gives patients more say in their care; a purchaser-provider framework would be very much a help to the system; we need flexibility to reallocate funds across programs and amongst different professionals and care providers; and we should have a regional framework for planning and purchasing. These things are in common with most of the reform reports that you will have seen over the last decade.

The main differences between different reformers is about what is the best model for a single funder, what is the best role for private funding and private health insurance, and whether we should be pursuing incremental or systemic reform. They are the three things where I believe there is most difference amongst the various advocates. My own view on those three things is that the only feasible single-funder option for Australia in the medium term is for the Commonwealth to have full financial responsibility for public funded services. This is not to deny the theoretical attractions of some of the other models. Also, compromise on both sides of politics is needed to develop a coherent and sustainable balance between public and private financing. Getting that balance is almost certainly dependant, in the long term, on having a single government funder. Finally, systemic reform is preferable—or at least incremental reform that makes systemic reform easier.

The incremental measures I would like to see implemented are mostly being pursued, if more slowly than I would prefer. The latest measures on mental health are further building the capacity of primary care to support the chronically ill and extending funds to allied health professionals as well as GPs. These reforms build on previous advances in such areas as immunisation, chronic illness planning and GP practice grants. I understand COAG is pursuing further investment into preventive measures and looking at better management and coordination of non-acute aged care services. Jurisdictions are also investing heavily in improved information systems, with the objective of portable health records, and in a national care call system. The changes to health insurance regulation, announced with the decision to sell Medibank Private, are also important steps towards making private health insurance more efficient and effective.

The other changes I would like to see placed on the short-term agenda as important steps to facilitate systemic reform are, firstly, making the Commonwealth fully and directly responsible for non-acute aged care systems and services and, secondly, building a stronger regional framework, starting with regional health reports every year by the Australian Institute of Health and Welfare that might detail the health status, health service utilisation and health spending by all jurisdictions for each regional population. Such reports would support informed discussion and cooperation within each jurisdiction and region by professional advisers such as GP divisions and planners and providers from the jurisdictions about priorities, resource allocation and improved service delivery. The reports would also draw attention to regional differences and possible misallocation of resources between regions. Such a measure would be very simple and low cost and would, in any case, be required under any of the systemic reforms we have been talking about. It is something you could do without the systemic reforms, but you would need it if you had the systemic reforms. Such a framework could also improve cooperation between the Commonwealth and states in the short term, in the area of primary health in particular.

We should also be looking to the next health care agreements to establish a consistent purchaser-provider framework for acute care services across the states and territories, which is a prerequisite for better competition amongst public and private hospitals, both for public patient services and private patient services. I would like to see a longer term plan for very substantial increases in funds for Indigenous primary health care services to compensate them for the lack of MBS/PBS funding and to better match higher health needs and higher service delivery costs. These suggestions would improve what is generally a good health system, but they are also important to address rising costs by providing better allocational efficiency, a stronger focus on cost effectiveness and greater competition amongst the key providers.

ACTING CHAIR—In your paper you talk about the model where the Commonwealth is the overall funder and then gives responsibility for the delivery of health services to regional bodies. I think you said there were about 30 regional bodies?

Mr Podger—I would think there are in the order of 30.

ACTING CHAIR—Reading it, I was not certain whether you saw that there was any role in health for the state. If there is a role in health for the state, how would that interact with your model?

Mr Podger—The model I have put on the table is that the Commonwealth would have the financial responsibility, and at the regional level it would be the regional purchasing organisations. That would be part of a Commonwealth-only role. The states could be involved in some of the providing role. There is a bit of an argument about whether it would be wise for them to be still managing the public hospitals but purchase from the Commonwealth. I suspect it would be easier if you did not have the states managing the hospitals, but that variation—that the states would continue to be the providers of a range of the services, but with the funding coming via the Commonwealth through the purchasers at the regional level—is a possibility in my model.

ACTING CHAIR—The next question I would like to ask is this: do your papers and your presentation today reflect to a large extent the recommendations that you made when you were involved in the Prime Minister's taskforce?

Mr Podger—I have been very careful not to talk about what was in my report to the Prime Minister or how the government has addressed those things. It is not proper for me to talk about that. Clearly, I have drawn on information that I have gleaned over the years and pulled together but there is nothing confidential in what I have presented; it is all based on publicly available information. I will have drawn on things over my years of service, but I am not in a position to say whether this is specifically in the report that I gave the Prime Minister.

ACTING CHAIR—Do you envisage that report being released?

Mr Podger—That is a matter for the government to decide.

ACTING CHAIR—I note in your paper that you talk about some changes to the private health insurance initiative or the way the rebate is delivered. Would you like to expand on that for the committee, please?

Mr Podger—My view on private health insurance is that, in the long run, I would like to see an arrangement which could be seen to be somewhat akin to what has happened with private schools. That is that, if somebody chooses to be privately insured and therefore shifts some of the services that would otherwise have been at the direct cost of government, they can take with them some subsidy towards that.

The concern I have is that the model we have is increasingly at risk of not doing that—that there will be some people who will, in fact, get a higher subsidy by being privately insured than they would if they had stayed in the public system. When you add the various elements together—the private health insurance rebate, the tax arrangements and the fact that privately insured people can still go as public patients to hospitals—I am not sure that you have a coherent, equitable arrangement.

In the long run I would like to see that, if a person is privately insured, all their acute-care costs would be met by their insurer and that their insurer would be able to get some subsidy towards those costs from the taxpayer, but that that subsidy would be less than it would have been had they been totally in the public system. That way, the private insurer would accept all responsibility for the hospital-related costs of their members. I think that is less likely to have incentives for people to play games.

Whether it is a member, an insurer or, indeed, a public hospital playing games, if you had a clear idea of who was paying for all the care for a particular person, you would get far fewer opportunities for cost shifting. That is where I would like to go in the long run. It would require, I think, a single government funder to make such a system work well. In the meantime, I would like to see some constraints on some aspects of it, particularly the private health insurance rebate. Also, I am uneasy about the tax arrangements in the long run, which I think are increasingly becoming a means test on the system rather than an arrangement that genuinely makes sense for a universal health insurance system.

ACTING CHAIR—There have been some comments that you have a Medicare Gold type model included in your proposal. Would you like to expand on that for the committee, please?

Mr Podger—There are some aspects of Medicare Gold which are attractive to me—that is, a clear move to the Commonwealth becoming fully financially responsible for a group where in fact there is a lot of frail-aged chronic illness and hence the advantages of a single funder are particularly strong. My uncertainty about Medicare Gold is that it confuses a single government funder with a shift in public-private funding because it involves the government taking over the private hospital arrangements and the private insurance responsibilities for the very aged. I am not sure if that is very sensible in the longer run, unless one had a model where private health insurance was just a residual role in the system. If private health insurance is going to have a substantial role in the longer term, it should have it for the elderly as well as for the non-elderly. So, to the extent that it confuses the public-private debate, I am not a supporter of Medicare Gold, but to the extent that it is a move towards a single government funder, starting with a group where a single government funder could well be of substantial benefit, I am a supporter of it.

Ms KING—I want to take you to the interface between the public and private sectors. It seems to me that one of the things that has been happening, and it is happening in all sorts of

areas, is where the public sector is in fact purchasing services from private hospitals. In my own district, cataract surgery is being purchased with money from the state from private hospitals there in an attempt to manage waiting lists. It seems to me that there is quite a blurring happening between those public and private roles within health, in the same way that it is beginning to happen in education. One of the issues with taking a population group, such as people over 75, and looking at that from a patient perspective and having a sole funder, is that it does blur the public and private roles. You say that one of the ways to move towards your system is incrementally. Surely, taking a population group, looking at it that way, in fact does allow you to incrementally move towards a patient focused model with one funder.

Mr Podger—The distinction here is public and private funding rather than public and private providing. Indeed, I believe that the system for those who are publicly funded, as well as those who are privately funded, should open up much more competition amongst the providers. The states that have been moving towards purchasing certain services from private hospitals and on so are eminently sensible. There are a number of areas, such as cataracts, where the services can be provided very efficiently and very safely outside a big public hospital context, and it is very wise for the system to be doing that. But that is a different issue from saying that everybody should rely on the publicly funded system and be in the same queues and have the same rationing there. The issue is: do you have a philosophical view that says some people who wish to pay more may be able to get more services, some services more quickly or higher quality services? I do not mean quality in terms of health quality but amenity. Should they have the right to pay for those things and get those things? If the view is, yes, that is a reasonable part of the system, then you have to ask, 'Well, how does that best work?'

Where I was coming from was that if there are those who choose to have a substantial amount of their services funded through a private arrangement then the private insurer should take wider responsibility for those people, but they should have a subsidy. If you confuse the two, what I am not too sure about is what happens, for example, under Medicare Gold, to the 75-year-old who finds that they are subject to a queue in the system but wishes to get something more quickly. You are saying, 'No, there is only going to be one way in which to do that.' That is an understandable view. It is a philosophical view that some would hold—that that is what how it ought to be. But if the view in Australian politics and among Australians is, 'Actually we are allowed to purchase to get something different,' then you would say: 'Hang on; we have now got rid of that system for that group. Are we now going to head down the path towards an NHS model where private insurance has a much more residual role than in the Australian system?' There is no right or wrong here. It is a philosophical view of which way governments wish to take these things.

Ms KING—Is there any system that has got it right or that is closer to what you are suggesting? Is the New Zealand model closer to what you are suggesting? What is happening in the UK?

Mr Podger—I think that, if you look across the Western systems, there are strengths and weaknesses in every one. I do not think I would hold any one up as a model, saying, 'Yes, we should do it that way.' I have been to a number of conferences over the years of a group called the Four Nations Group. This is a group of academics, bureaucrats, providers and insurers primarily from Holland, Germany, America and Canada, but experts from the OECD and people from Britain, Ireland and Australia have gone to it. They have been talking about those four

countries and then looking at their own. One of the major points to come from those conferences is that it is important to 'learn about' before you can 'learn from'. When you see something that looks useful in a place, you need to understand where it is coming from; you cannot simply incorporate it. And, if you decide something is worth looking at for your own place, you then have to adapt it carefully. So there are strengths and weaknesses.

For the NHS, being a single funder is clearly a strength for them in terms of being able to coordinate care and being able to get budget holding and some of the financial controls which are benefits compared to where we are. But their queues and bureaucratic processes are things that probably most Australians would say they would not be willing to accept. However, there are some real strengths in their single funder arrangement.

Even in America, where everybody says there are terrible equity problems, which is true, if you look at the Kaiser Permanente arrangements in California, again the single funder arrangement within that process has some big advantages. They in fact have a much more responsive system in their single funder arrangement. There are a lot of attractions in that. And there has been some interesting research done comparing Kaiser Permanente with the NHS—which I refer to in the paper—suggesting that, if you do get the single purchaser arrangement going well, the chances are you will put more money into primary care, information and things of that sort than the NHS does. So, in the American system you get a more responsive arrangement, generally, for those who are covered but, because of that, you also have a more expensive system overall. There is not one system where I would say, 'Here is one model.' I would cherry-pick and then adapt.

Mrs ELLIOT—I have a quick query on the provision of dental health services. How does that fit within the frameworks you have suggested today and in some of your other papers?

Mr Podger—I have not covered that in any of my papers directly. There is no doubt that dental health is a significant part of the health system in anybody's mind. To date, Commonwealth governments have chosen not to put it directly in the Medicare system. There was for a time, as you know, a program where the Commonwealth provided some funds for the states, but it was always only a small amount. The health care agreement arrangements had always assumed that the states would handle whatever the dental health arrangements might be. The health care agreements were never purely about hospitals; they were about a range of things that were not covered by MBS and PBS. Most systems around the world have drawn some lines as to how far they go, and the line is never a logical line. If you go to Canada, they draw a line, and pharmaceuticals are not generally within their Medicare system. We would say that is crazy. Pharmaceuticals are integral to the whole system.

Personally I think dental health ought to be incorporated into the whole system. But dental health, for most people, is not in as much of an extreme risk situation as the acute care side of things like that. So, if you did incorporate it, you would probably retain very much a substantial user-pays system for a large proportion of it. You would not have government buying into it in MBS style, paying for every service. That would be my suspicion. You would probably have a stronger balance between what the patient would pay and what the insurer would pay. But in terms of logic it ought to be incorporated, in the long term, into the system.

Mr ENTSCH—I have to say I am very attracted to a national framework. It seems to me the most logical way to go, particularly if you are looking at retention issues, where one state poaches from others. If you have a national framework it does not matter where you work because you have the same level of health care and the same entitlements or work arrangements available to health care professionals. What changes do you think would need to be made to institutional arrangements to facilitate something like that in a national framework?

Mr Podger—I set out in the paper in March not only a description of the model but all the steps that might be required to get there, basically saying that a three- to five-year very dedicated project management process would be required to make it happen. That would involve steps where the state departments who handle the purchasing for hospitals would be incorporated into the Commonwealth organisation. There would be some changes in the Commonwealth organisation itself, where the department might become a bit smaller on the policy side, but you would have more of an operational unit for the service delivery and the purchasing arrangements.

As you say, there are a series of arguments in favour of increasing the national role. It is not only that many of the providers now form more of a national industry and their mobility is more national but also that things like hospital networks, aged-care home networks and health insurance are increasingly of a national nature, and I think those forces tend towards a more nationally funded system. But it is terribly important to have something at a lower level that has the flexibility to be responsive to a more local or regional population. The balance is always a concern.

I presented a model, but clearly one would debate the details around these things. The model I suggested is where the regional purchaser would actually be part of the government machinery but would have advisory arrangements which would have considerable influence at the regional level to ensure more responsiveness. There are variations on that model which no doubt other people would wish to test and pursue. Are those the sorts of institutional things that you were thinking about?

Mr ENTSCH—Yes, the old hospital board concept that they had before, which brings you back to—

Mr Podger—When you get down to the hospital itself, my own view is that some sort of board or trust arrangement at that level makes a lot of sense. I would not incorporate the hospital as part of the overall national bureaucracy. That would actually be separate from the purchasing. You could have other arrangements, some of which would be privately run, but my guess is that most of them would actually be charitably run or publicly run, with a trust arrangement. That model seems to have a lot of merit and you will see that model in a lot of countries around the world

Ms KING—In terms of the regional model, you would be talking about them also purchasing population health services as well—

Mr Podger—Yes.

Ms KING—So you would go right into the preventative stuff as well; it is not just about the acute and sub-acute services.

Mr Podger—It is terribly important both for the patient care orientation but also for controlling the funds that that purchaser has coverage of the full range of money for health services and aged-care services in that area.

Ms KING—Thank you.

ACTING CHAIR—How would you ensure that there was a similar program run across regional areas as far as population health was concerned? How would you ensure that the emphasis was appropriate for that area or at least that things that were general—say, obesity or diabetes—were the same across each of those 30-odd—

Mr Podger—In a sense, you would have arrangements not dissimilar to what we have with the Commonwealth and states in this area. The Commonwealth has some national priorities and has national campaigns of various sorts. Most recently, they have been looking at obesity, but we have had the Norm ads in years gone by and we have had the HIV ads and campaigns. So you might have some national priorities but what is essential is that, at a more regional level, there is some flexibility to add to those and vary those and adapt those around their particular requirements.

ACTING CHAIR—Would you say it needed some benchmarking?

Mr Podger—You would certainly have to have very open reporting of what you spent and what performance you were able to achieve in the various areas. Yes, I guess that is a form of benchmarking.

ACTING CHAIR—Or would you have it outcome based? How would you evaluate the quality?

Mr Podger—In part it has to be outcome based—you would have measures of the performance—but it would also be output based. You would expect the reports to be saying how many services have been provided in this area and that area for these types of people.

Mr ENTSCH—You would have national standards, anyway?

Mr Podger—You would have national frameworks for reporting from each region.

Mr ENTSCH—Irrespective of whether you are in Kununurra, Hobart, Sydney or Melbourne there is the same national standard.

Mr Podger—You have the same standard of reporting requirements, but you are trying to give some flexibility. If you do not have the flexibility to shift the money between the different stovepipes at the regional level, there is not much of an advantage coming from the model I am talking about. The model is to give a degree of flexibility to be able to shift moneys between different areas according to that particular population's requirements.

ACTING CHAIR—Different communities have different needs and different health issues that need to be addressed.

Mr ENTSCH—There is one other area that you touched on that I have a great interest in, and that is in relation to Indigenous health, particularly in remote areas. I welcomed your comments in relation to the lack of access to Medicare, if you like, in these remote communities, and the need to provide alternative services. I think Madam Chair was saying that some areas need different focuses, and I think these remote areas are a good example—and a good example with which to argue that you need a whole of care which includes dental health and, I would think, probably a lot more primary care, so you would see a lot more preventative type of investment into these areas.

Mr Podger—That is exactly what I would be advocating. It is not as if what I am advocating has not been happening, but it should go a lot further, and I think the Australian population has to accept that this will require more resources. It will not be possible to simply expect more without more money. When I look at things like the coordinated care trials in Katherine West and now wider Katherine, or in the Tiwi islands and so on, some of those trials have been quite successful. But you have to remember that they did involve extra money and, in particular, extra money to make up for the low amount of money being spent on MBS and PBS. To have that sort of money more widely available across Aboriginal communities will require increased money in total.

At the moment, even in those areas, the money that has gone in has been broadly to get up to the average MBS and PBS moneys that might be spent elsewhere, but it is not getting higher again because the needs are higher or because the costs are a lot higher for delivering those services. So, even in a place like Katherine West, the changes are that, over time, we are going to have to spend more money. If we go to other places, that is going to need more money as well. But it is not just money, because we all know that getting the infrastructure there and the community capacity to handle these things takes some time. The Australian population has to accept that a steady increase over a 10-year period, or something like that, is going to be required to build up the sorts of levels of primary health care services that really are necessary to meet the needs.

Mr ENTSCH—This is the area where I find this one-point national delivery very attractive, particularly in remote Indigenous communities. When you say we need more money, one of the problems that I see—and I will be interested in your view on this—is that every program has a different deliverer. The states are doing some, some local communities are doing some and the feds are doing the odd one.

First of all, that allows for excuses to not do anything because it is always somebody else's responsibility. Secondly, you have a whole range of different delivery services there. Each of them spends a very significant amount of their budget on their own administration—they all have their own vehicles and a whole range of other things—so there is an absolute bucket load of money going into these places and there are very few outcomes from it. Whereas, if you had a single point of delivery right across the whole spectrum, you would get a lot more outcomes, I would think, for the money that is invested.

Mr Podger—I think that is true. Interestingly, of course, the COAG trials are, at the moment, going one step further—that is, trying to see if they can link health, education and a range of other things in a coordinated way.

Mr ENTSCH—Cape York.

Mr Podger—I think that is a desirable ambition, but I am a bit uneasy about whether it could let some of the people off the hook. In the health area, I think it is really important to make sure that we are actually funding and delivering good health services. One of the things that happens when you try and have a lot of players all somehow being coordinated is that sometimes you do not get a strong enough capacity on the ground to pull it together and the continuity of people to help manage that on the ground. Looking at the coordinated care trials, the ones that worked best were the ones where we had a really competent person who was there for a reasonable amount of time, had a clear set of responsibilities and was able to work the thing through. I think that was one of the factors in making those things work.

Ms KING—I was part of the team that evaluated the coordinated care trials, in a previous life. That community resilience was absolutely evident if you compared the Tiwi island trial versus one of the other ones in the remote Aboriginal communities where the community capacity was lacking, I have to say. Obviously COAG is already doing some of this work; however, it has a huge agenda across education, reform and a whole lot of other areas as well. What do you think of the notion of a health reform commission that actually tackles these issues?

Mr Podger—I do not have a firm view on that. I guess the caution I would have is that, in trying to work the way through and get an answer, while there are a lot of experienced, able people that you might want to consult with, in the end this is a government responsibility. You will have to have some arrangement which has clear political control—for example, some process between the Commonwealth minister and some of the state ministers. Something that they feel is able to be directed is going to be important. I have heard about a health commission—not the Labor Party one specifically, because it has not been well defined—

Ms KING—We are not the only ones who have suggested it.

Mr Podger—No, but some of the others are feeling that, if we just got a bunch of experts together, somehow they would come up with an answer. I do not think that is right. My experience as a bureaucrat is that you need something which has clear political coverage and political direction to actually get there.

Ms KING—But, if you linked the AHMAC structures and the health ministers council through some sort of health reform commission, possibly?

Mr Podger—You could get something there.

Ms KING—But you would still have to go through that.

Mr Podger—But, in a sense, you have to get a threshold point where the politicians say, 'This is what we agree we are after. Now we have a framework within which a commission, or some

group, can get on with it.' But if the commission have an uncertain direction of where they are heading—

Ms KING—There is no point.

Mr Podger—I am not too sure it is going to get you very far.

Ms KING—Thank you.

ACTING CHAIR—I have a couple of questions about workforce. In your model, you talk about the urban divisions and GPs playing a major role in the delivery of the model in regional areas. Given that there is currently an enormous workforce shortage with GPs—just referring to my own electorate, people cannot see doctors—how do you think that will impact on your role? What approach do you think the government needs to take to address this workforce shortage? One suggestion is that the private sector should have a greater role in training the workforce. Maybe you would like to address that. Have you any suggestions about the training of doctors, nurses and allied health professionals—ways to improve the current system?

Mr Podger—I have not done much work directly on that in recent years. I was involved in that back in the department, but that is now nearly five years ago. I have not done a great deal of work around that. I am aware of the Productivity Commission report in that area, of course, which I think has some pretty sensible suggestions in it. Some of the things I have been putting in the model would allow more substitution and flexibility within the workforce. The idea of continuing down the path of the primary care side with GPs is that there is money for allied health. There is capacity for practice nurses and things of that sort. It opens up some areas of flexibility. If you went down the path of a more flexible arrangement for funding in regions, you could think about practitioner nurses and things of that sort.

ACTING CHAIR—How does the shortage—the fact that there are not enough doctors now—impact on that? With the expanded role, how would you be able to deliver?

Mr Podger—I am not increasing the role of an individual GP; I am increasing the capacity of the general practice and widening the types of people who would be involved in it. There have been a number of steps in that direction already. I would see that continuing. Some of the issues, like the coordination of care and things like that, you would then expect to be done primarily by the practice nurse or somebody else rather than by the GP's own time, in that the GP would have the resources and the wherewithal to make that work. In that sense, you will get some substitution of labour in the system in a sensible way. But I am not pretending that what I put on the table is the answer to the immediate problems of a shortage of total medical people, and in some other allied professionals there are shortages as well. That is an agenda I have not focused on in my paper. But issues such as the way the GP training arrangements were reformed during the late 1990s period seem to be a sensible way to go. That is, you open up a process where the training is not just done by the college but able to be done by others, with the college being responsible for standards. That sort of option may be possible in other areas of the medical profession which can open up the training, but that is not something I have been focusing on.

Mr ENTSCH—I would be interested to know why South Australia and Western Australia do not have the capacity to manage a full range of health responsibilities.

Mr Podger—In both South Australia and Western Australia there have been—I am just trying to remember some examples. In a smaller jurisdiction, the purchaser-provider thing does not work quite as easily as in a bigger jurisdiction. That was one of them. If you think of things like cord blood banks, you end up saying, 'That's a national thing; you need national centres.' There was even an argument that Queensland wanted one, but basically there was not a good case for them to have one. There are certain things where, when you get to the smaller jurisdictions, you are going to find that the economies of scale are not necessarily there. The main ones who are struggling are not Western Australia and South Australia, but I am saying that, even at that size, there are certain things which are more difficult to manage at the state level.

Mr ENTSCH—They do not have the populations.

ACTING CHAIR—Do you think there is a role for the private sector at the table for COAG deliberations?

Mr Podger—Not at COAG itself. I think there is a role in making sure that there is a consultation process with them, but I think that COAG is, by definition, the political leadership.

ACTING CHAIR—Would you like to comment on medical savings accounts and rationing, in the 30 seconds you have left?

Mr Podger—There has been some suggestion from time to time about medical savings accounts, and places like Singapore have been able to integrate that as part of their whole. I think a lot of people do not fully understand how it works in Singapore. It is not quite the way it is sometimes presented. They actually do have quite an elaborate insurance arrangement within their medical savings arrangements. Medical savings accounts are quite hard to design in a way which actually provides both incentives for health and support for those who are ill. I am a bit nervous about some of the advocates of it, finding that they do not see the trade-off at times in this arrangement. I have not been as strong a supporter of that as some of my other friends.

ACTING CHAIR—And the rationing of health services?

Mr Podger—We need to be realistic. Any system is going to have some form of rationing, and there will also be some balance between what the user pays and what the government pays. You will use various devices to help in the rationing process. We have learnt to be quite sophisticated in using things like our purchasing arrangements and our cost effectiveness studies to work out sensible ways of rationing which are going to be the most cost-efficient we can deliver.

One aspect of this model is that it is trying to superimpose on the system some form of budget holding. I am not talking about an absolute, rigid, cash-limited budget, but this model is premised on a form of budget holding, and the ability for better financial control. There will be, out of that, rationing coming through. But any health system is going to have some rationing, and I think people have got to be realistic about that. It is just trying to get a model of rationing that is most likely still to deliver the best care, and get the best results from the money available.

ACTING CHAIR—So it is working out a situation where you are balancing need and cost?

Mr Podger—Indeed. Budget holding is a significant part of this model, but it would be instead of the way we do it now, where the states run essentially cash-limited hospital budgets and then you have other forms of controls on different arrangements. Here you would bring that together with budget holding at the regional level, but that is what I call soft cap budgets—that is, it may go above your cap, but there are consequences in terms of oversight; there might be management intervention to say, 'How have we got this wrong? What are we going to do next year to sort this out?' But you would have a different sort of budget holding control on the system than the sort of controls we have now.

ACTING CHAIR—So, No. 1 would be delivery on the basis of need, and No. 2 would be on ability to pay?

Mr Podger—Part of the overall controls in your national policy framework would be: what co-payments are reasonable. It is a complex area in its own right. In the long run, for example, under MBS, there is a case for us to negotiate agreements—or you might even call them contracts—with doctors where, in exchange for the MBS payments, the doctor would agree on a particular framework of co-payments. We have gone some steps towards that in the agreements we have reached with the GPs but in the long run we could go further, to clarify for the patient what limits to co-payments there would be. Some people think there should not be co-payments, but I cannot see a financially viable system that is not going to have a significant range of co-payments. The co-payments ought to reflect whether you are a pensioner or whether you are able to pay more. But even if you are able to pay more I would like to see an agreement which puts some caps on those things, as a part of a deal for us paying MBS payments and so on. There are a lot of complicated things in that area. I touch on them in the papers, and I hope that is helpful for the committee.

ACTING CHAIR—Thank you very much. We really appreciate your time.

Mr Podger—Thank you.

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

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

Committee adjourned at 10.24 am