COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

TUESDAY, 2 MAY 2006

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 2 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 Georganas, Ms Hall and Mr Somlyay

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 9.29 am

DEAN, Dr Nicola, Department of Plastic and Reconstructive Surgery, Flinders Medical Centre

GRIFFIN, Dr Philip, Head of Unit, Department of Plastic and Reconstructive Surgery, Flinders Medical Centre

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing inquiry into health care funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. This is the first time the committee has been in South Australia for the health funding inquiry. At today's public hearing the committee will hear from a group of South Australian clinicians seeking to improve public sector patient service provision and from a local, not-for-profit private hospital. The committee will also take evidence from the South Australian government, the first state government to appear before the committee, and the committee welcomes the South Australian government's contribution to the inquiry.

Also appearing today are Kidney Health Australia and the City of West Torrens, our hosts for this hearing. We are grateful to the City of West Torrens for making this venue available. This venue is, of course, in the electorate of Steve Georganas, one of the members of the committee. I thank Steve for working on liaising with the council to conduct this meeting in Adelaide.

We have some submissions that need to be authorised for publication. Is it the wish of the committee that the submissions tabled by Dr Nicola Dean, the government of South Australia and Kidney Health Australia be accepted as evidence to the inquiry into health funding and authorised for publication? There being no objection, it is so ordered.

Ms HALL—We also need to authorise for publication the additional information to the committee from Flinders Medical Centre and the University of New South Wales.

CHAIR—There being no objection, it is so ordered. This is done in order to make sure all of the submissions have parliamentary privilege. I now call Nicola Dean and Philip Griffin to give evidence. Firstly, Dr Dean, do you have any additional information you wish to add?

Dr Dean—Yes. I am a trainee in plastic and reconstructive surgery in South Australia. I would like to thank you very much for inviting me to speak about a health system that I believe to be one of the best in the world. I must say that it is very impressive that ordinary doctors like me can speak to the elected representatives of Australia about this system. Plastic surgery in the public sector involves a wide number of fields, including burns, reconstructive surgery, motor vehicle accidents, congenital abnormalities et cetera. But I am here to speak today about those patients seeking breast reduction surgery and abdominoplasty surgery. This was brought to my attention because of the crisis in the public sector of not being able to provide this sort of surgery to patients. There is a vast demand for this surgery and we are currently unable to meet it. This has led to various ad hoc and somewhat unfair schemes to limit the number of patients receiving this surgery.

Dr Griffin, other members of our group and I have sought to find a fairer way of rationalising which people requesting this surgery can receive it on the public system. The research tool that we would like to use is a way of measuring patients' proportions and comparing those to that of the general population. With the help of Professor Maciej Henneberg, who is a professor of anthropology at Adelaide University, we have devised a body shape assessment tool so that these people could be put on a scale in relation to the normal population. We could use this to prioritise patients so that those who are way off from the normal values would be prioritised compared to those within the normal range. This would seem to me a much fairer way of assessing these patients. This research has not yet started, and we are grateful that the South Australian government has shown some interest in it and is perhaps going to help us fund it.

Once we have decided upon which patients should receive this surgery in the public sector then the next really important thing is to enable them to receive that surgery. Currently the system is that there are only three categories of patients—urgent, semi-urgent and non-urgent. All these patients are put in the non-urgent category. This committee might like to consider the concept that, as well as relieving acute symptoms—these patients often have terrible backache, shoulder ache, rashes et cetera—for those who medically need these procedures, the procedures can also help to promote a healthier outcome for their whole life. Patients with massive breasts are unable to do exercise and often end up developing heart disease and other medical problems because of their inability to exercise, whereas if we can provide this surgery for them in a timely manner then it may have a further health promotion strategy in the long term.

Currently in the public sector there is no provision for any categorisation of patients in this way, so they are competing for beds with people who are gravely ill. Not surprisingly, it is difficult to get this surgery done and to get beds for these patients when there is no separate category for that kind of surgery. That is something that this committee might feel they would like to consider.

There is something else that would be useful. As far as I am aware, there is no formal mechanism for research such as this to be presented to the federal government or to any Commonwealth body and very little funding or resources are available for this sort of research. If there were a way that the results of this kind of research could be fed back into those who formulate policy for health care, that may also be useful to the government.

CHAIR—How widely is this procedure conducted in the private sector?

Dr Dean—Dr Griffin might be best to answer that.

Dr Griffin—If we are talking about breast reduction and abdominal plastic surgery, that forms a major part of most plastic and reconstructive surgery practices in the private sector. In the public sector there is a prioritising of resources, so those people who cannot afford private care have a very restricted chance of getting this assisting surgery.

CHAIR—What is the waiting list at present?

Dr Griffin—In 2004, as head of unit at Flinders Medical Centre I actually closed down outpatients for assessment for these conditions, because we had 200 patients on our waiting list for this surgery and we were doing about four to six a year. In some respects I thought it was

dishonest to even see the patients, because obviously we could not provide the care within a sensible period of time. Subsequent to that, we have had very fortunate sponsorship from our state government in providing resources for further elective surgery, and we have been able to reduce the number of those patients waiting to about 80 or 90. But, as we stand now, we do not have enough resources to answer that demand. The patients who present to outpatients asking for this surgery have already gone through a major sieving exercise. Most GPs recognise that you cannot get it in public hospitals, and so they dissuade the patients from attending. For them to get an outpatients appointment, there is a delay of over 12 or 18 months, and different hospitals do this sieving process differently. So we really do not see the true demand from those people who would benefit from having this surgery.

Dr Dean—I did a quick survey of the outpatient departments in public hospitals in South Australia and I estimated there were 500 patients who were waiting for an appointment to be assessed—that is even before they got on the waiting list—and people were on waiting lists for up to 10 years.

Mr GEORGANAS—Could you clarify this? Earlier you mentioned that there are three categories: urgent, semi-urgent and non-urgent and all patients are put into the same category. How do you assess, firstly, the people that are after the breast reduction or the abdominoplasty for cosmetic purposes? Obviously, they would not come into the public health system. There are the urgent ones where there is a health risk involved and it is detrimental to their health. If they are all going into the same category, how do you prioritise?

Dr Dean—That is one of the things we are looking to do with our research because although those patients seeking it for cosmetic reasons should not come into the public system, at the moment, they sometimes are. The problem is that we get a referral from a GP that says, 'Please see Mrs Bloggs who wants to have an abdominoplasty or a breast reduction' and we have no way of knowing whether it is for a cosmetic or functional reason. One of the things we want to do is a body shape assessment. We would write back to the GP and say, 'This patient needs to have a body shape assessment.' If she has breasts that are massively out of proportion to her body size and she also has functional problems such as neck pain, shoulder pain, then she will be seen but if she does not then perhaps she should be lower priority.

There is no current way of sieving out which ones have a real medical problem and which are slightly on the cosmetic side. We are proposing to make a tool that can be used by GPs to sieve out those two different sorts of patients. This is an international problem: in Canada, they are still debating it; in the UK, it is a problem. It is all over the world, and nobody has used this idea. It would be a bit like the child growth charts: 'You are on the 75th percentile.' Everybody over the 75th percentile, the 56th percentile or whatever is allowed their surgery on the public system, and those who are below that level will have to go private.

It seems arbitrary to select a level, but with the research we are going to correlate the level at which you do the cut-off to the health benefit. You do questionnaires for what their general health is like pre op and post op. We know that in general there is a good health benefit overall but if we can correlate it with the level of the cut-off on the scale of things then that will help us decide what is the right cut-off level for the public system.

The semi-urgent, urgent and non-urgent thing is for all patients in the public system. All breast reductions and abdominoplasties pretty much get categorised as non-urgent. People with a life-threatening cancer get classed as urgent and people that are somewhere in between usually get classified as semi-urgent. The difficulty is that if something is non-urgent it does not mean it is non-important. That is a conceptual difference. The breast reduction does not have to be done immediately because the urgency is to do with a time factor but it is important for long-term health and for taking time off work et cetera. I think it would be nice to have a category that is important for long-term health but not urgent in that it needs to be done within the next month.

CHAIR—Can you explain who it is that carries out these procedures in the public system? Are they VMOs or are they permanent employees? If they are VMOs, are they competing with other surgeons for theatres? Why should there be such a waiting list if their full-time job is performing these procedures?

Dr Dean—It is VMOs in the main.

Dr Griffin—The limiting factor is a composite one, and I think that is probably true when you are talking about all health resource issues. There probably are not enough surgeons to answer the demand. But it is not just surgeons; it is the whole operating theatre and the whole infrastructure team that manages each patient's episode of care. The other limiting factor is the available inpatient beds. Elective surgery, traditionally, is cancelled when the emergency surgery fills the hospital, and it is these sorts of patients who get cancelled. It is to do with the balance of resources. Unfortunately, this sort of patient is the one who gets the short straw repeatedly, because everyone else has so much urgency involved.

To me, conceptually, the problem for government in providing health care funding is not so much the lifesaving health care aspects; it is that difficult area of overlap between what is functionally important and what is cosmetic, because you do not want to fund cosmetic activities from the public purse. The trouble with these two procedures is that there is an overlap that is not defined. Doctor Dean said that we do not do cosmetic surgery in the public hospitals. In fact, in training plastic and reconstructive surgeons I have to train people in cosmetic surgery. So we do have to have a little there. But the government has no commitment to the public to do cosmetic surgery, and there is a major difference. For the few people who might get cosmetic surgery, that is a privilege that has been accorded to them, from my point of view, and there should be no public duty for the government to be funding that.

The difficulty with these sorts of cases is that, once you look at your constrained pie of resources, the tendency would be for you to put a big stroke through them and say, 'No, we're not going to do these at all. Everyone thinks that breast reduction is a cosmetic operation,' and most people, on the fact of it, would say, 'Yes, that's true,' but that is not at all the case. With breast reduction and abdominoplasty, people do suffer from functional problems. This submission is really an attempt to defend these patients from being struck off the public duty.

Ms HALL—From where I am sitting, I think part of the problem is the perception that it is purely cosmetic when in actual fact it does create a real health issue. A person who needs a breast reduction and is debilitated by their condition is really no different to a person who needs a hip replacement. Each of them has similar problems. I have a constituent who fits your classification or the type of person who should move up the list. She had very large breasts,

extreme back and neck pain, rashes and she became overweight. She was on the waiting list for two or three years, and I wrote a letter to see if I could help her. She died of a heart condition. That supports what you are saying about the need to look at these people who require this type of surgery and to put in place an objective tool. I think that is what you are trying to do.

Dr Dean—Yes, exactly.

Ms HALL—But I think that, along with that, you need to establish that it is not purely cosmetic and that a person is not doing it because they are dissatisfied with their body shape but rather that it is similar to the hip replacement surgery or similar type of surgery.

CHAIR—Who makes the determination?

Ms HALL—Whilst I think your tool is a really good idea and should be supported, I think you need to do some more work on the perception that is out there.

Dr Dean—It is very true. The problem is that everybody thinks they know what plastic surgery is, because they see a lot of it on television. So we do start from the standpoint of a biased viewpoint. I think this will really help us to sieve out those with real functional problems from those who are cosmetic patients. I just hope that, once we get the research done—which we need beds for, of course—there will be somebody to listen to the results. That is something that will be really nice for me: to have some way of feeding that back to people like you.

CHAIR—Will the research be done Australia wide?

Dr Dean—Currently it is going to be just in South Australia. For part of the research we will use a special body scanner, which is quite an expensive bit of equipment. At the moment we have got no funding and we have got no beds allocated for it, so we have to start fairly small. We will be based mainly at Flinders Medical Centre. We have not been assured by the state government that we will have enough beds to get the numbers that we will need, but we are trying to work on that at the moment. Dr Griffin has said that we might be able to use some of his private patients as well to incorporate into the study to increase the numbers.

Ms HALL—What about a control group? Will you be running a control group as well?

Dr Griffin—Ideally, the study would be on every woman who undergoes the surgery. There are two aspects to it. One is a measurement aspect, for which we will use this expensive machine as well as a simple tape measure. That is because if you are going to roll this structure out into the Australian community, you actually need a tool that costs $6 rather than one that costs $175,000. We need to prove that the tape measures are as accurate in working out the disproportion.

The second tool is well-accepted, complex medical questionnaires, which patients fill out beforehand and afterwards. These measure a person's function. In this sort of study, you do not actually need a formal control group. They act as their own controls, before and after the intervention, to see whether their function has been changed. If our theory is right, the people who are very disproportionate will end up with more functional improvement, and you will then be able to map a sort of cut-off point in their level of disproportion. That is the level at which I

think there would be a public duty for supplying the surgery, whilst for those who are getting the shape improvement but not much functional change, we can say that for our purposes they are cosmetic and do not have the demand and the duty to be cared for in the public sector.

CHAIR—I would like to hear how the actual day-to-day process works. If a person has a problem, they go to a GP and the GP refers them to a public hospital. Who makes the clinical decision in the hospital? Is it made by the person who would be the VMO?

Dr Griffin—The decision is made by the qualified plastic surgeon who reviews, examines and discusses the options with the patient.

CHAIR—And that person is employed by the public system.

Dr Griffin—Yes. In this state.

CHAIR—In this state—that is what I was going to ask.

Dr Griffin—It is my understanding that in New South Wales there is not an outpatient system, and the patients are seen in the doctors' rooms. I would imagine that they discuss whether they have funding there to have the surgery in a private system, and if they do not have personal funding they will make arrangements in the public system. That may lead to uncomfortable pressures on the patient, I would imagine.

Dr Dean—In an ideal world, I imagine the specialist would say, 'I am sorry; you are not disproportionate enough to need the surgery, and you are not going to get it in the public system.' However, if you place yourself in that specialist surgeon's position, it is a very difficult one. They have got no numbers and they have got no measurement data because there is no standardised tool. They are eyeballing to say, 'No, you are not quite disproportionate enough or you have not got enough symptoms. You have not got enough pain to warrant this surgery.'

This patient may have been waiting a year to get an appointment to see you, and may have seen a GP four or five times about this before then. There is a lot of pressure on that doctor to say, 'Yes, okay. We will put you on the waiting list.' The doctor then can put them on the waiting list. He knows that they will be waiting 10 years, but at least they are on the waiting list. So it is an aid to those doctors seeing the patients and assessing them to have a scale enabling them to say, 'You are only on the 56th percentile.' I think people would understand that better than just being told no.

Mr GEORGANAS—Going back to the research you were talking about earlier, the lack of beds to get the patients through to do the research would be one of the biggest problems.

Dr Dean—It is.

Mr GEORGANAS—How would you overcome it?

Dr Griffin—It is also probably the most expensive aspect of the research. At the moment, as I have pointed out, the public hospital system is a constrained resource. They have to be able to cancel elective surgery to cope with the emergency patient load at different times. That means

that from a state point of view they will be very reluctant to give any undertaking to do the sorts of numbers we need for this research. If this theory is correct, it is going to be borne out whether a patient has private or public care. As to the predictors of whether they are going to get improvement in their function, it does not matter if they are in a private hospital or a public hospital. At Flinders Medical Centre and the Queen Elizabeth Hospital there are a number of VMOs who are keen to incorporate this research into their private practices as well. So it is important to recognise that, although we need lots of cases done, the public system cannot cope with that. I am not going to drive them to make a big commitment for it. I think the research can be done just as well in the private system, and you end up with valid results.

CHAIR—In the private system do you make a determination whether a procedure is cosmetic or clinically needed for health reasons? Are they treated differently?

Dr Griffin—No. In fact, in my personal practice if a person needs a breast reduction the Medicare item number stipulates it is available for breast reduction. There is no qualifier as to whether the main purpose is improvement of profile or if it is to do with shoulder or neck pain. Most of these people do have shoulder and neck pain. Most adult women do at the end of a day. So the actual functional implication of that surgery to them is improvement of those symptoms, but whether that is enough to justify public treatment is another matter. At the moment your item number does not qualify. It does not exclude people who are doing it simply for appearance changes.

CHAIR—How is this affected by private health insurance?

Dr Griffin—At present, private health insurance defrays expenses for the patients to a large degree. If they have private health insurance, all of their costs are covered, except for any surgical or medical charges, gaps.

Dr Dean—One of the things about the beds for the research is that last year we were given beds for this sort of surgery by the state government. We were guaranteed a few beds for this kind of surgery, and that helped immensely. So we hope to enter negotiations to at least get that basic number for the research period.

Mr GEORGANAS—What would be the best mechanism, if and when this research gets done, to feed that back into the Commonwealth government?

Dr Dean—If it were me trying to organise the health funding, I would want to have somebody who was in charge of looking at what research is going on in health service provision and efficiency in health service provision and would want somebody who could coordinate the date of its coming out of that research. It would be really nice to have a link person who is in charge of collecting data from this sort of research and communicating that to people like you.

Ms HALL—I think two separate Medicare numbers may be needed to cover it: one for where it is a problem from a functionality/disability point of view and one for where it is purely cosmetic. Would that go some way to assisting?

Dr Dean—It definitely would, but we need to develop the tool—

Ms HALL—Of course.

Dr Dean—and make sure that the tool is valid, and that is quite a lot of work in itself.

Ms HALL—Generally, do plastic surgeons have less access to beds within the public hospital system? Is there generally a longer wait and a lower priority placed on your patients?

Dr Griffin—I am not sure how paranoid we feel! Plastic and reconstructive surgery is such a broad field.

Ms HALL—It is; I understand that.

Dr Griffin—We deal with a lot of trauma cases, a lot of skin cancer work and a lot of head and neck cancer work, and we do a lot of collaborative work with other specialty groups. Most of that work has a high priority. Some of our hand trauma cases are deferred because of more important cases—bleeding ones—but that is sort of local management. It is the elective surgery ones that are vulnerable to being cancelled. They are the ones we would seek to defend really.

Dr Dean—I think there is an intrinsic bias. Everybody says, 'It's just a breast reduction.' But, in fact, probably having your gall bladder out gives you less of an improvement in health than having a breast reduction. So why people should think that they are qualified to make a judgment between those two patients, I am not sure, but there does seem to be an intrinsic bias against those sorts of things.

Dr Griffin—And they are liable to expose us to a lot of argument between colleagues.

Mr GEORGANAS—I know we have spoken about breast reduction and abdominoplasty. I suspect there are grey areas in the broad spectrum of cosmetic, reconstructive and elective surgery. Are you finding the same issues perhaps with burns victims who have had the immediate treatment and have recovered, but there are some serious health issues relating to damaged skin and the need for plastic surgery?

Dr Dean—I think that is true. It is often a fine call between what is for just appearance and what is for function. In that category of appearance, it is hard to define what is normal. It is obviously not normal to have a face that is horribly scarred and those people should get that surgery. But the interesting philosophical debate is: what does society accept as normal and acceptable? I am very interested in that interface. There should be research in this area to look into this more and that would help clarify the health funding. It would also help those individuals to know, 'I'm normal and I don't get to have that surgery in the public system, and I accept that.' I think that people would almost accept things better if they could be told upfront, 'You're not eligible to get this surgery in the public system; you have to go private,' rather than waiting 10 or 11 years. At least they would know.

It is a really interesting area, to define what is normal and acceptable to the population and what we can do in the public system. At the moment, it is an excellent public health system. It really is good. I have come from the UK, where the waiting list situation has got completely unmanageable. If we can address things in a fair and professional way like this, that would really help keep things under control.

Ms HALL—In the UK, what sort of access does this class of patient have to the hospital system?

Dr Dean—As far as I am aware, they are basically in the same sort of category in that they are in principle supposed to be allowed to get it on the public system. But in reality they are waiting 10 years or more to get it, and they often are even less likely to get it there than here.

Ms HALL—So it is an international problem.

Dr Dean—It is. In Canada they have a system where they only allow patients who are having a certain weight removed from their breast to have their surgery in the public system. But the problem is that you cannot weigh the breast before you do the surgery. It is also very arbitrary. They have not related it to health outcomes research.

Ms HALL—And body size.

Dr Dean—And to body size, so obviously if you are six foot five it is different than if you are five foot nothing. So I think this tool would be much fairer in discriminating between those patients.

CHAIR—Are there any obvious differences in Australia state to state that you can tell us about?

Dr Griffin—Yes, there are. Our state government actually did some paper research on a number of conditions similar to these that we are talking about, to try to find demand limiting policies throughout different jurisdictions. So within Australia, I think Western Australia has some statements limiting access to those people with functional gains to be made. But that is a pretty woolly sort of statement. I heard recently that in New South Wales they have just put a line through it; they will not do any in public hospitals now. That may be in the region of gossip, because I have not seen it in any way. In the UK—I worked there 20 years ago, and the NHS system has gone through a lot of changes since then—there was a phase where they made separate regions responsible for the health funding, and those regions could interpret their duties accordingly. Some of the regions just cut out breast reduction completely. Subsequently I think that has changed because of pressure from their constituents who were being gravely limited. Throughout the world, governments realise they cannot pay for everything, and they are trying to limit and focus demand and access.

CHAIR—I am going to digress for a moment. One of the biggest problems identified in Australia is workforce issues. You have probably heard of, if not read page to page, the Productivity Commission report. That is of concern to this committee. Could you give this committee an assessment of the workforce in your profession? Many surgeons are telling us that in their profession they are getting old—they have an ageing profile. All these things have to be addressed from the point of view of training. Can you tell me how you fit into this pattern?

Dr Griffin—Personally?

Ms HALL—How you are ageing!

Dr Griffin—Is my sum profession tired? The workforce issues are very difficult to address, actually. I know here in South Australia that the production of local medical students has changed. I graduated from here 20 years ago. At that time we graduated about 140 local trainees for doctors. If you just estimated, that would have replaced our workforce in about 20 years. I have had a bit of an interest in this since then. Today, with our population being 1.5 million compared to about 900,000 before, the local graduate production is less than 100. The people within our universities—there are still only about 150 or 160 places available—are made up of interstate and overseas people. Obviously we are not replacing our doctors.

Ms HALL—So more doctors need to be trained?

Dr Griffin—Yes, we need to train more doctors.

Ms HALL—More places.

Dr Griffin—That was estimated 20 years ago. We have an ageing population. We have the baby boomers all coming up, and they are going to consume a lot of health resources. Yet the numbers of doctors, nurses and other things just were not increased. That means that when you come to specialist training you are dealing with quite a different situation than when I got into training, because there are lots of vacancies available for these people and they may not choose to go into surgery, which is perceived as being a harder road—we tend to toss people out if they are not suited.

The other problem in plastic surgery itself is that over the last 20 years the field has expanded a great deal. General surgery has redefined itself. We are now doing quite a bit that general surgery used to do. Also, a lot of our trained people are going away and doing cosmetic work. It is a very difficult workforce issue. When I started sitting on our training committee I made a little estimate of what we needed. I started picking trainees in about 1995 and I thought that we should have 30 plastic surgeons in South Australia by 2005. We had only 22, which was exactly the same number that we had 10 years earlier. It is a very difficult problem to solve, with a long lead time in producing a skilled specialist.

CHAIR—Do you have a view on whether the training of the medical workforce—not so much in nursing—should be reformed? The Commonwealth pays for the places in universities, but the clinical training is undertaken in public hospitals, which is half-funded by the Commonwealth and half-funded by the state. The shortage of clinical places is often such a problem that, no matter how many graduates you have, if you cannot fit them into the clinical places you still will not get the doctors that you need. We have had it put to us that the private hospitals should take more of a role in training medical practitioners and specialists. Do you have a view on how that could be done?

Dr Griffin—I do not have a mature view on that. How do you fund the people? Currently in private practice they are all funded through Medicare item numbers and things. What work can they do? A private patient expects that their private surgeon will do the cutting. This is an apprenticeship where, unless they actually do the practical tasks themselves, the learning is constrained. In the place that I worked in the United States, that was not an issue. It was a private practice and they were quite happy for me to do the cutting. That environment seemed to be protective enough to have the good outcomes that the patients accepted. Here in Australia it is a

bit different. Our litigation system may make most people reluctant to give the private training registrar a lot of responsibility. It is a very difficult question.

Dr Dean—I just want to air my views, which might not be exactly the same as Dr Griffin's.

Dr Griffin—Nor should they be.

Dr Dean—I am a specialist trainee at the moment. What the College of Surgeons needs is an assurance that there will be an adequate number of specialists in the public hospital compared to the number of trainees, so that you have a good ratio of teachers to students, if you like. If every plastic surgeon in South Australia were working in public hospitals then the ratios would be sufficient to have a lot more trainees come through the system. The problem is that, because of the huge discrepancy between what you can earn in the private practice compared to what you can earn in the public practice, only the very kind and enthusiastic plastic surgery specialists want to work in the public system. One way of addressing the problem of not having enough training places would be to encourage more specialists to work a greater number of sessions in the public system. That, of course, comes down to adequately funding those specialists.

There are big differences between the states in this area, and that is something that I as a foreigner coming to Australia originally noticed. For example, if you look at the plastic surgery research that has gone on in Melbourne over the last 20 years, amazing clinical and research things have gone on. That is partly because they fund their plastic surgeons differently. The public system funds the plastic surgery specialists by the sessions and by their extra cases, so they get a fee-for-service type arrangement. That might not be the right arrangement for South Australia, but the difference in the quality of service and research in Melbourne and the ability to train a lot more people in Melbourne exists because the specialists are keener to stay in the public system because they get funded better for doing so. I want to stay in the public system and the university system in South Australia and not do private practice as a consultant, but if I do I will be the only one in South Australia.

CHAIR—Our current funding model is that the Commonwealth pays for all the university training through places and the Commonwealth and the states share the costs of the public hospitals about fifty-fifty through the health care agreements. But the Commonwealth, through the GST and other funding, provides about half of all expenditure by the states. So a rule of thumb is that the Commonwealth would be funding 75 per cent of all medical training and the states about 25 per cent. Is there a case for the Commonwealth to fund the lot?

Dr Griffin—Yes.

CHAIR—That is really what I am getting at. Should the Commonwealth assume responsibilities for total funding of the medical profession and the outcomes?

Dr Griffin—I think, leaving aside state-federal political issues, yes, absolutely. You would make so many savings by restricting the duplication of bureaucracies and being able to standardise the system. If you have total responsibility for it, you can also fix up the efficiencies too. It is the only sensible solution.

Dr Dean—I think that is absolutely right. It makes sense to unify it and look at it as a whole, because Australia is one country and it seems sensible to have a unified approach to this sort of thing so that the training and the funding are standardised throughout the country.

Ms HALL—This has been put to the committee on a number of occasions, and I think without a doubt the most popular approach taken by people giving evidence is for the Commonwealth to fund the system.

CHAIR—The single funding model.

Ms HALL—Yes, the single funding model, however that model works. Under this model, because the states have the expertise in delivery, the states would deliver the services. Would you like to comment on that?

CHAIR—That is a bit broader than the model in your submission.

Dr Griffin—I think that could be made to work extremely well. This is 2006. Worries about bitumen stopping over the Blue Mountains are nonsense. I am sure that there would be pressures there to ensure that there was equal access throughout Australia, and you would have a far better chance of putting that in place if you had control. At the moment there is so much energy wasted in fighting over whether the state or the Commonwealth is responsible.

CHAIR—It is a waste of resources.

Ms HALL—The buck stops with the person who is funding the service.

Dr Dean—However, I think the only other side of it that I have seen is that, for example, with our little project the state government have been able to hear us and listen to us about that. As it happens, so have the federal government, but I think that is the exception. There needs to be a mechanism where local bodies can be heard by people.

Ms HALL—Imagine that you were trying to get your model up in New South Wales.

Dr Dean—I think you would probably not have a chance. I do not know.

Dr Griffin—One of the reasons that they are interested is that the issue of how to limit demand is very tropical, and this is one of the few ideas which is putting the limitation of demand, instead of being an arbitrary decision, onto the basis of a rational, scientific and defendable approach. So government should listen to people who make that sort of suggestion, I would have thought.

CHAIR—The Commonwealth cannot wave a big stick over the states on this issue—because, constitutionally, we do not have the power to do it—but I think the community is demanding that we work in cooperation with the states and be very outcome focused. People do not care if it is a state responsibility or a Commonwealth responsibility; if there is a problem, they want it fixed.

The private sector and private hospitals are very important in our current health system—maybe more important to my side of politics than Jill's, but we have some different and some

similar views on the private system. With the respect to the ageing of our workforce, we are finding that, as they age, many of our surgeons want to work fewer hours—for example, four days a week instead of six days a week—but they want to maintain their income so they are charging more and the gap is increasing. Premiums are forever increasing. When do we reach the stage when people start dropping off private health insurance? What impact will that have on the public sector? Those issues are being looked at by this committee. I do not think crisis time is far away.

Dr Griffin—You managed to avert a crisis four or five years ago with the initiatives to try to continue private health insurance. Personally, working in both the public and private spheres, I do find that the private sphere is always more responsive to demand. It is like any factor—if you have the work, they will open it up and if it is not available they will constrain it. Public hospitals, through workplace restraints, are not as accommodating to the ebbs and flows of demand. I think it is very important to retain both systems. The gap issue is a very big issue, but I do not have a personal solution for it.

Ms HALL—You do not?

Dr Griffin—No.

Ms HALL—No suggestions at all?

Dr Griffin—In my personal practice, I try to give people informed financial consent but, if they have had an emergency injury, you cannot—and neither can they choose, really. If you put a federal government compulsion on giving informed financial consent, what happens to those cases and cases where you have to do something that is different from what you predict? It becomes difficult.

It is also difficult where people abandon the schedule fee as a reference point and even the AMA recommended fee as a reference point. Once they escape from that limit, the sky is the limit. That comes back to the marketplace issues defining the charges. But the funny thing happening in medicine is that people think that they receive the quality that they pay for. So you may be the worse surgeon in town but, if you have the highest fees, people will pay them and they think they are getting a good job. It is a weird marketplace. I cannot really give you advice on how to stop that.

CHAIR—Would you like to say anything in summary?

Dr Dean—The only thing that I would like to finish with is to say that I am very grateful to have had the opportunity to come to speak to you today. If there is any way of continuing any dialogue about the results of our research, I would be grateful for that. Thank you.

CHAIR—If there is any further information that the committee needs from you in looking at the evidence today, we will contact you in writing. Thank you very much for appearing before us today.

Proceedings suspended from 10.24 am to 11.07 am

PARKES, Ms Heather, Acting Director, Office of Health Reform, Department of Health, South Australia

WEBB, Dr Richenda, Director, Clinical Systems, Public Health and Clinical Coordination, Department of Health, South Australia

CHAIR—I welcome representatives of the South Australian Department of Health. Please make an introductory statement on behalf of the department.

Ms Parkes—The South Australian government has been embarking on a program of health reform since 2003, and one of the major issues for the government has been the growing mismatch between the demand for services and the supply of health workforce—and that is health workforce in the broad sense, not just the medical workforce but also nursing and allied health professionals. We have made several submissions to the Productivity Commission report, looking for national support for changing workforce roles and responsibilities and the machinery that manages workforce in terms of accreditation and registration. We have also been working within the state on our own opportunities to reform the role of the health workforce and to increase the supply of health workforce, as well as looking at the population health approaches, such as early intervention and prevention in health promotion strategies, that we can adopt in order to meet the changing demands on the health system due to the increased pressures from growing levels of chronic disease.

CHAIR—I feel quite nervous, actually, with the state government appearing before us. We have been approaching state governments to make submissions and appear before this inquiry, and your state is the first one to agree to it. On behalf of the committee, I thank you sincerely. As you know, the COAG process is under way, and there is a committee of senior bureaucrats from each state and the Commonwealth working on that COAG process. We have framed our terms of reference, to a certain extent, to mirror or parallel the COAG process in order to give people other than those directly involved in the COAG process a say. Those in the private sector and the various colleges et cetera have had a say in the COAG process. Are either of you on the COAG committee?

Ms Parkes—I am not on the committee, but I am supporting the South Australian role in the committee. We have representation on the health working group committee and then there are some subgroups around the Productivity Commission, and we have representation on one of those as well.

CHAIR—Are you happy with the way the COAG process is working at this stage? I am not trying to be controversial. We are genuinely trying to work in cooperation with the states to achieve the same end.

Ms Parkes—At the moment there appears to be a bit of a disconnect between that and the work that is being done in relation to the response to the Productivity Commission report, which is to some degree seen as a tidying-up process. But we see it as fundamental to the reform of the health workforce.

Ms HALL—How does this disconnect manifest itself?

Ms Parkes—Primarily in having two work agendas that are not necessarily being brought together in the way that they could be. From our perspective, the human capital working group around health is working on indicators and the work of the Productivity Commission working groups is much more about the mechanics and the way that you develop, manage, redesign and innovate. So, while there is an overlap, I do not think the overlap has been well articulated and the relationship has been worked through yet.

Ms HALL—How do you see it coming together?

Ms Parkes—I think it will come together, because I think some of the work under the human capital agenda of COAG will be an outcome, if you like, of the work that comes through if the Productivity Commission recommendations, as they are being worked on, are actually delivered. There is an opportunity for some of those indicators to be addressed and for the focus of some of those to be picked up, in the innovation work that is being proposed through the development of a new innovation and workforce monitoring body and in looking at the job role and job redesign aspects around registration and accreditation as well.

Ms HALL—Would you like to walk us through some of those things that you are working on?

CHAIR—Yes, please.

Ms Parkes—It is a very big agenda.

Ms HALL—Yes. It would be good if we could get an idea of the types of issues that are being looked at and the processes that you are considering.

CHAIR—That is bearing in mind that there are eight jurisdictions plus the Commonwealth. The problems of South Australia may be different from those of Victoria and Queensland et cetera.

Dr Webb—They are.

Ms HALL—Are you looking at it from the COAG perspective?

Ms Parkes—It is probably worth while for us just to go back a little bit to what we said to the Productivity Commission about what we saw as some of the fundamental problems and how those structural things may work to address them. The first one is that what we are trying to do in South Australia is, when we are moving into an area of shortening supply and growing demand, to look at how we provide health services that best match the needs of the population and at what would give us the best result for our money. We are a small state and we cannot afford to keep growing the investment at the rate that it needs to grow, on our projections, around demand. It will increasingly impact on the amount of GDP that it takes up. We are looking at asking: how do we apply that sort of thinking around providing better health for the population and supporting wellness rather just having a system that is primarily focused on illness?

In order to do that you have to look at what it is we are turning out through our medical schools, our nursing schools and the health sciences areas and at how that meets the changing demand. There has been a radical change to the nature of both health and illness in the last 30 to 40 years in the growing burden of chronic disease, because people are living longer. Also, we are keeping alive people who previously would have died because of illness. This is an increasing burden. We have an ageing bulge with the baby boomers—and I am one of them—which means that we have a wave of chronic disease starting to hit the system. Evidence tells us that early intervention and prevention can avert or delay the onset of some of that chronic disease. But we do not have systems set up to do that. Most of our focus is on treating illness.

So we have been trying to look at the structures that we have in place in terms of both training people and the way we engage and offer services, and rethinking the types of services that we model. In doing that, we are looking to engage the community in some of that debate in order to build a service model that may allow us to reallocate some resources to different areas. Something like 65 per cent of our state health budget goes directly to hospitals which service about 12 per cent of the community in any given year. We will always have the predominance of our budget going into the acute sector—it is not that we will not—but we have to take the burden off the acute sector because we cannot turn out doctors and nurses fast enough to keep open the hospital beds to provide the services that we need. We know that the average age of people—if you take out the women's and children's hospital—in our hospitals is 72. We know that there are a lot of issues associated with trying to keep people out of hospital and we have been trying to put in place different service models that will prevent people from going into the hospital or reduce their length of stay so that they are supported.

But that means we need different skill sets. We need to have more allied health workers and more carers who can support people in their own homes rather than getting them into hospital. We need to have a better care management regime that runs across the patient continuum and we need people who can work in that environment so that they are working on their aspect, which may be the provision of a particular clinical service, but it is done in the context of that person's whole care plan and it relates the other services that we can provide in other settings. That is throwing up lots of challenges around the way people are trained and the roles that they provide and it starts to raise questions about who is best placed to perform certain functions and the level of training they really need in order to do that.

It is a microcosm of what is happening everywhere around the world. Every health system is grappling with these same issues. So we are looking at how we redesign our workforce knowing that we have got a very aged workforce profile. I think the average age of our GPs here is 54. We know that a lot of those GPs are feeling very burnt out and that they would like to retire but feel an obligation to keep going, and there is pressure on them to keep going. We have got to bring through young people, and young people are making different life choices about how they are prepared to work. So while we have got lots of doctors relative to other states, we have also got a lot of doctors who are choosing to work shorter hours. The average number of working hours is declining because we have got a lot more people coming into the workforce who want to work shorter hours, and they are and can because the market—

CHAIR—Is that also in the public sector?

Ms Parkes—Yes, very much so.

CHAIR—So the VMOs may not put the hours in?

Ms Parkes—You need more people, more supply. For example, we have a program called Family Home Visiting where families who are at risk of not being able to fully develop their child—they might suffer from not having good attachment to their child or they may be a young mum—can get assistance. We provide 34 family home visits by a nurse to those families. We are finding that we have created a totally new role for nurses. They are actually going into people's homes and are confronted by all of the socioeconomic and behavioural issues that happen in a family environment. They are building a relationship with these families in order to help deliver better health outcomes and therefore better lifelong learning and growth opportunities for the children.

It has created a nine-to-five job for them and a lot of them want to work part time. We are bringing in nurses who are not working or who want to get out of the acute sector and into something else. But at the same time they are struggling with the role because it is challenging them. It is not a controllable environment to the same degree that was when they were working in a hospital. So it is a much more complex role in some ways and very challenging. We are trying to support that and now we are looking at expanding it further. It operates in eight locations in the state now we are looking at going towards a whole state coverage for that.

CHAIR—Are you looking at integrating that type of training in a nurse's training?

Ms Parkes—Yes. There are nurses now who do a graduate certificate in community support and families—I cannot remember its correct name; I would have to get that for you. They are registered nurses level 2 and they have a graduate certificate, so they do receive specific training. But even then we are putting them into an environment where there are lots of challenges. We are trying to support them with other workers; we are finding that we have to bring in social workers. Centrelink have out-posted a person to work with the nurses to help them help families to navigate all the services needed to support them.

To bring that back to the question about how that relates to what is happening at a national level and with COAG, that sort of redesign needs to happen all across the system. In order to do that, there are some professional barriers we have to break through. We have to be able to articulate the service models that are different, articulate the requirements of those services and make sure that we are then defining who really needs to perform those functions, rather than just breaking them up in the same way that they were broken up before: this is a nurse's job, this is a doctor's job, this is an occupational therapist's job. We have to multiskill a bit more and provide opportunities for other people to enter into the professions because health is the second-fastest growing industry within the state. I think it grows by about 8,000 a year, yet the national labour market will only grow by 12,000 a year nationally by, I think, 2020. So there is a very big mismatch looming.

CHAIR—How have you achieved that?

Ms Parkes—The only way we can do it is to look at how we deliver services—how we can do it better and more efficiently, how we can bring in different people who would not traditionally see themselves as working in health and how we can use technology to support it. It is really important that we look at the opportunity to provide technological support to replace

people, if we can, so that people are doing the work that actually requires hands-on people work. We also have to be prepared to work with the community to support them in wellness rather than illness and to challenge people to make some of those hard decisions around what we can really afford. Every health system in the world faces that problem.

CHAIR—I do not think I misunderstood you to say you are doing very well compared to the other states on workforce issues.

Ms Parkes—We have more workforce, but I am not sure that we are doing very well. We are doing our best.

Mr GEORGANAS—Going back to the nurses' visits in the new babies program, or whatever it is called, could you elaborate on that a bit more? I think it is one of the areas where South Australia is actually showing the way in that it is a form of preventing not just health issues but also a whole range of issues. What benefits come out of those 12 visits over the first 12 months—I think that is what it is.

Ms Parkes—It is 34 visits over two years.

Mr GEORGANAS—What are some of the things that they pick up and grapple with before they become problems?

Ms HALL—Is that program for every baby?

Ms Parkes—No.

Ms HALL—Is it only for those that are identified as being—

Ms Parkes—It is for babies at risk. Every baby that is born in South Australia is offered what we call a 'universal home visit'. Every baby can have one visit from a nurse in their home.

Ms HALL—But it is not compulsory.

Ms Parkes—No, it is voluntary. It varies, but it is around a 98 per cent take-up of that by all new parents. At that visit, or in hospital, there are people who are identified as being at risk in terms of their parenting skills. They have lots of issues. There are some particular target groups within that. One is young mothers under 20—and this is all evidence based; it is based on international and national evidence about the people who have issues raising their children and where your best investment is made. They are identified. There are eight locations across the metro and I think it is also located in the Riverland and Port Augusta—

Mr GEORGANAS—It is in regional areas.

Ms Parkes—Yes, there are three in regional areas. I am not sure whether it is Whyalla or Port Pirie, I cannot remember.

Mr GEORGANAS—They are split up into three.

Ms Parkes—Yes. The rest are in the metropolitan area. They are based around areas of need. The nurses identify them, and they go into the homes up to 34 times—it depends on what the family wants—over the two years. They identify where there are issues that impact on the development of that child. They may find they need financial counselling, there may be issues around substance abuse, there may be issues around their connection to the community. They work to connect them to the community.

Ms HALL—How long has this been in place?

Ms Parkes—It is two years. The first lot will be finishing in June this year. They try to connect them into other services. We have other things that are now coming on stream to help them connect. A good example is the early childhood development centres that are being set up. The family home visiting nurses can refer these young parents, or parents with young children, to other services that are going to be based in schools—primary and preschools—and they can get child care. A perfect example would be Cafe Enfield out at Enfield, where the community accesses a range of services. They can learn parenting skills, they run particular parenting groups for men only, they run classes around diet and nutrition, but they also link them into higher education. They often identify literacy issues. Parents will learn it is a good thing to read to their child, and what happens then is they say, 'I actually can't read well enough to read to my child,' so they then go on to do literacy courses. The nurses are encouraging them to do that.

The nurses talk to them about smoking. One of the anecdotal things to come out of that is there has been a reduction of smoking in households, because they have been talking to the parents about how smoking is bad for the children. They have seen dietary improvements, they pick up early issues around hearing, and they pick up early issues around speech development. They work to get them into remedial services around speech, because this is one of the main issues of early childhood development that impacts later in life. If they cannot pick them up early, then the investment you need later is much greater. We are working very much on the nought- to two-year-old group to try to give them the best possible start in life. We are now linking with the education department, through the early childhood development centres, to transition people through the process.

Mr GEORGANAS—What training do the nurses who are out there for those 34 visits over two years have? You would have to train them in a certain way to be able to identify issues that sometimes are not health related but are broader issues. Is there special training in place for that?

Ms Parkes—Yes, they do a graduate certificate. In fact, we are currently having discussions about revising the content of that, because the experience—

Mr GEORGANAS—So the nurses have done their training, and then there is specialist training on top of that.

Ms Parkes—Yes, that is right. But the other thing that is involved is they also work with Aboriginal health workers, for example. It is about building relationships with the family. They have found, particularly for Aboriginal families, an Aboriginal health worker is often the best person to come with the nurse on the first couple of visits to help build the relationship until the trust builds. They work with other health professionals; they work with social workers, Commonwealth staff—they work with a range of staff. In fact, we have had to develop the

concept of brokerage as a result of that. But it is connecting these people, who previously really did not have a good way of connecting with their young child, back into the community, and teaching them some of those of the skills.

CHAIR—Where is the line between the Commonwealth's involvement in funding and you delivering what you have been talking about for the past five minutes? The Commonwealth funds the health programs about fifty-fifty with the states, but is that outside the health care agreements? Who pays the nurses? Are they in the hospital system?

Ms Parkes—The nurses are paid for through our regional health service by the state government, so they are not in the hospital system but they are paid for by our incorporated health unit, so they are state government funded.

CHAIR—So they are not being paid under the health care agreements; therefore the Commonwealth has no involvement in this.

Ms Parkes—But there are other Commonwealth family support programs that are connected.

Ms HALL—You would be connecting with the AMSs—with the health workers coming from the Aboriginal medical services—when you are working with Indigenous people in remote areas, wouldn't you?

Ms Parkes—The Aboriginal community-controlled services?

Ms HALL—Yes.

Ms Parkes—Yes, that is correct. And there are some Commonwealth and some state ones of those.

Ms HALL—Yes. I think that the program you have talked about is a really good example of an innovative approach to delivering health services. South Australia has some specific problems—very different to the areas around where I live—with the remote areas, and you also have a significant Indigenous population that lives in those remote areas, with very special health needs. At the same time, you talked about different service models that you have introduced. Would you like to expand on that a little bit and link in to those other two issues I raised?

Ms Parkes—Certainly. We have a range of programs that support Aboriginal communities in a remote setting. In fact, they are now mostly being run out of the Department of Premier and Cabinet. But within Health we have a series of programs aimed at women and children in the main, and then there are programs around substance abuse, but the main ones are around supporting women and children. So we have a 'healthy ways' program which works with Aboriginal women. Initially it started looking at issues of diet, teaching women about diet and how to get a healthy diet for their children in remote areas, but also supporting them. We are also developing an antenatal framework around supporting Aboriginal women and families through the birth process to recognise some of the cultural differences but also some of the really significant health issues that are quite different in the Aboriginal population than they are in the rest of the population. So we are doing a lot of work there. We can always do more, but we do

work with a lot of Commonwealth programs. We also have our own Indigenous unique centre of learning for training health workers at Pika Wiya, in Port Augusta, which is very successful in training Indigenous health workers.

Ms HALL—What about flexible models of service delivery to people living in remote areas—telemedicine, maybe nurse practitioners or whatever programs you have in place? You go across a very wide area.

Ms Parkes—We still do not have a huge number of nurse practitioners in the state. I think we are up to about 20-odd now—

Dr Webb—Yes.

Ms Parkes—and most of them are still based in the metro area and in acute care. However, at Ceduna we have two nurse practitioners, I think, that have come in. They are based in a hospital but they are also doing outreach services.

Ms HALL—Exactly what can the nurse practitioners do?

Ms Parkes—It depends on their area of specialty. Nurse practitioners, like medical specialists, tend to specialise in particular areas, which can be anything. They can be palliative care. They can be early childhood. They can be cancer, cardiology—

Dr Webb—Wound management.

Ms Parkes—wound management—a range. They tend to specialise. And then they have a range of functions that they can perform under the legislation. They have a set range of prescribing rights. But they are still a model that is developing here, and we have to push that harder.

Ms HALL—Has it been very useful in addressing special needs in certain areas?

Ms Parkes—Certainly, in terms of some clinical needs, there are some very good examples in cardiology, palliative care and incontinence. For example, I know a nurse who specialised in the cardiac area; her success rate in preventing readmissions to hospital was very good. I cannot remember what the percentages were, but she significantly reduced the number of people who had cardiac events and then ended up being readmitted within 12 months, by supporting them in case managing their cardiac condition as opposed to being managed like an outpatient by a cardiologist.

Ms HALL—How is the medical profession accepting them? Are there any problems?

Dr Webb—As with anything, I think it is mixed. In the remote areas in particular, there is good acceptance because there is no alternative. You also referred to telemedicine: that is certainly a modality that has been very successful in psychiatry in South Australia. We have a centre, which is based at Glenside Hospital, from which psychiatric consultations and assessments can be undertaken for many areas of the state—because one of the things that we do

not have is a large specialist presence outside Adelaide. So that is a way of overcoming that, and that has been very successful.

Mr GEORGANAS—I might digress a bit and go back to an issue you brought up in your initial statement: the ageing population. In South Australia, we have one of the most aged populations on the mainland. In fact, the federal seat of Hindmarsh that I represent, which we are in today, has the greatest percentage of 65-year-olds and over of any other place in the country. So, obviously, a lot of these people are reaching the stage—that average age of 72 that you spoke about earlier—where health problems start to set in. In what ways is the state government grappling with these issues? Is there anything that might be of interest to us; for instance, are you dealing with this issue in a different way from other states around the country? And what else would you like to see done to ensure that we deal with this huge problem that is already facing us?

Ms Parkes—In a clinical sense, there are the plans that are being worked on in terms of chronic disease. As I mentioned before, there is a lot of work being done on trying to prevent people from entering hospital in the first place, by managing their disease and identifying it earlier, and there are a range of programs that are supporting that. We work with the Divisions of General Practice; we have a memorandum of understanding with them and we work on agreed areas with them.

We are also looking at how to take population health approaches to chronic disease, because population health approaches are often incredibly successful. For example, a population health approach was taken to smoking where it was not necessarily about the individual service provider. It was based on legislative frameworks where smoking became banned. It was based on a taxation disincentive, where higher taxes on cigarettes reduced smoking. It was based on an information and support campaign, the Quit campaign. So that is a really good example of a population health approach. What we need to do as a state is work out how to apply some of that thinking to chronic disease, which is not something that people have yet done really well. The early childhood area is probably the best example we have at the moment, because there has been a lot of evidence around what works in the early years, over a lifetime, and how early intervention gives you the best return. So we have an investment from the state government because we can show evidence that shows the difference.

With chronic disease, it is a bit harder because we are already in that sort of tidal wave of chronic disease. That is starting to happen. I think about 50 is the age it starts. But we are looking at things like promoting a whole range of population health screening processes, such as bowel screening and breast screening. All of those sorts of things are population health approaches which, with early detection, can reduce both the cost to and the impact on the individual.

We are also looking at other areas. We are looking at how we provide services for a range of chronic diseases. So we are looking at not only the prevention end but also the way in which we deliver support services to those clients and whether there is a way that we can do that better, for example, in areas such as cystic fibrosis and cancer. We now have a cancer plan, which we developed with the Cancer Council of Australia, that looks at how we use our resources in order to deliver the maximum amount of service within our budget.

Health is not simple; it is very complex. We have to constantly work out where the priorities are. Diabetes is probably the major issue, so we are looking at the precursors to diabetes and at the issues around obesity as being a major push. Again, the area where we have probably the clearest responses at the moment is early childhood, but it is moving

Dr Webb—One of the other things that, to my knowledge, is unique in South Australia is the work that the Advanced Community Care Association is doing, with support from the state government, in hospital avoidance. When elderly people, in particular, have a deterioration in their health—whether they are already in a nursing home or at home—they are supported to stay in that environment rather than be transported to an acute hospital emergency department where they might lie around for some time before they are seen and become disoriented from being in a different environment. They are supported by people who go into the nursing home or their residential care site, wherever that is, in order to get them over that acute episode without their having to go into an acute hospital. That is quite an important program that is particularly applicable to the older part of our community.

Mr GEORGANAS—The flip side of that concerns frail and aged people who go into hospitals. I came across a few of those cases only yesterday. In one case a woman had spent close to 12 weeks in a public hospital because they could not find her a place in a nursing home. How do you deal with that issue? And are there many instances of that happening in the public hospital system?

Dr Webb—Unfortunately, it is a major pressure for us and one that we are particularly worried about as this time of the year moves on because, with the peak flu season coming and the activity that that brings into acute hospitals, the fact that we have elderly people who cannot be moved on to nursing homes is a problem. It is just something that we have to deal with. In some hospitals there are almost whole wards devoted to older people who are just waiting for a nursing home placement.

CHAIR—What is the answer?

Mr GEORGANAS—Exactly!

CHAIR—If it is more Commonwealth funding, put it on the record.

Dr Webb—It might sound simplistic, but I think we need to recognise that, with the ageing of the population and the change in social relationships where people do not look after their elderly relatives to the same extent as they used to, we need more nursing home places.

Ms Parkes—And we need the workforce to support that. Part of our issue is that that is not necessarily an attractive area of work for people and we need to find a way to make that a career of choice—which it is not at the moment—because that is where there is huge growth.

CHAIR—Do you know the difference between the cost of an acute bed and a nursing home bed?

Dr Webb—No.

CHAIR—We hear evidence of 'bed blockers' and cost shifting—the Commonwealth cost-shifting to the states and the states cost-shifting to the Commonwealth. I think we should all be above that argument now and trying to get the biggest bang for the health dollar that we can. That is what this committee is all about. If the problems in public hospitals are being brought about by bed blockers, as they are very unkindly called, what is the answer? Is it more nursing home beds?

Ms Parkes—And more support in the home to prevent it happening in the first place. Richenda touched on it, but the institutionalisation of people reduces their capacity to be returned to their own environment—the longer they are there, the harder it becomes and the more support they need. So I think one of the issues is around the assessment of people's need and being able to provide support mechanisms that mean it does not get to the point where it becomes an acute incident. Common ones are around the administration of antibiotics to people in nursing homes.

CHAIR—In my own electorate, I have had a problem emerge in the last six months. My electorate is on the Sunshine Coast in Queensland, so I represent most people's parents. I might not have the oldest profile in Australia, but I have a lot people who need aged care services. The practice in nursing homes is that, if one of their patients dies or a vacancy occurs, they ring the public hospital to shift over one of the bed blockers, which they can do very quickly, and the nursing homes maintain their occupancy. But there are none to shift at the moment. I have nursing homes with lots of vacant beds. Nobody can work out why. Is it seasonal or something else? Does this happen in South Australia?

Dr Webb—Not for any period of time. There might be a few days in which there would be a few vacant beds, but it does not last long, I can assure you.

Mr GEORGANAS—I called the 1800 number yesterday to see what was available in the western and southern region for the person I mentioned before, and there was zilch.

Ms Parkes—I think that is a distributional issue, because populations do change. Part of the problem is that we have to invest in infrastructure which is fixed and which is designed for that purpose. We need to have ways of designing infrastructure that is more flexible in its purpose so that, if the population profile changes and you no longer have as great a need for that purpose, you can turn the infrastructure to some other use. That is part of the problem. That is very much a problem here in South Australia, where the hospital system was designed 30, 40 years ago for different health requirements and does not match what we need now.

Dr Webb—The infrastructure issue is why things like the EACH packages—extended acute care at home—are so useful, because you are using the person's own home as the infrastructure rather than having to build more nursing homes.

CHAIR—We also have the problem of beds being provided on the basis of people being over the age of 70, whereas most people in my nursing homes are over 80. Perhaps the formula is wrong.

Ms HALL—An issue in my electorate—which I suppose links in very nicely to the workforce issue that I also want to ask you about—concerns nursing home beds occasionally not being

filled, even though there are a number of people waiting for a bed. For instance, a couple of kilometres from my office, there is a nursing home, or high-care residential facility, which provides good quality care. They cannot put anyone into beds because no doctor is prepared to look after them whilst they are in that facility. Do you experience that problem here? This is a long-term situation. I am losing doctors in my electorate rather than gaining them.

Dr Webb—That is definitely an issue. The number of general practitioners who are able and willing to go into nursing homes and provide the sort of medical support that clients need is diminishing. That is part of the whole general practice shortage that we have quite a large problem with, mainly in the outer urban and remote areas—

Ms HALL—Mine is in an outer area.

Dr Webb—but it is throughout.

CHAIR—Again I have to talk about Queensland, because that is where I come from. There are 1,700 foreign trained doctors working in Queensland public hospitals. We have a program at the Commonwealth level to recruit foreign trained GPs. How does that compare with South Australia? Do you have a program to bring foreign trained doctors into South Australia?

Dr Webb—Yes, we do. We have about 25 per cent overseas trained doctors throughout—that is not just in general practice or in hospitals but across the board. As part of our medical workforce strategy, which started at the end of last year, we are recruiting overseas for both hospital type doctors and general practitioners.

CHAIR—Do you think the states are competing against each other for the same gene pool!

Dr Webb—Yes, they definitely are. In fact, at the two recruitment expos that I went to in London last year, almost all of the states were represented. We had a chat amongst ourselves about what we were all doing.

Ms HALL—Could I go into the workforce issue in a little bit more detail? I notice the covering letter that we have here from the minister. Before I go into that, I wonder whether you could identify the areas in which you have shortages of doctors, nurses and allied health professionals in South Australia.

Dr Webb—We have shortages of all health professionals. In medicine, the major areas of shortage are psychiatry, rehabilitation, palliative care, emergency medicine—largely the nonprocedural specialties, which are not remunerated as well as procedural specialties. I think that is quite clear. In fact, we are experiencing quite a disturbing trend in the sorts of specialties that new trainees are interested in joining, which may have something to do with the sort of financial debt that they come out of medical school with. They are looking for a way of retrieving that debt as quickly as possible, and certainly that is more likely to happen in procedural specialties than a nonprocedural specialty. We are starting to see quite difficult problems because, if we have vacancies, as we do now, in geriatrics, rehabilitation, palliative care and psychiatry—the sorts of things that elderly people are going to need more and more of—that is only going to exacerbate the whole mismatch of supply and demand.

Ms HALL—That is a particular problem in a state like South Australia where you have an elderly population.

Dr Webb—It is.

Ms Parkes—Also, when you have what are relatively small numbers, the loss of a few people can have a huge impact both in terms of our ability to train more people, because we have not got people in place to train them, and to actually then provide the service. But, in our submission to the Productivity Commission—

CHAIR—Are they lost through retirement or do they go interstate?

Ms Parkes—Retirement or they go interstate. For example, both of our paediatric chairs at the universities have recently gone interstate and the associate professor of paediatrics that we had working at children, youth and women's health service also went interstate. At a paediatric academic level, we have lost significant expertise.

CHAIR—Has anyone come home?

Ms Parkes—They have only just left, but people do come back.

CHAIR—But there is movement in the medical workforce.

Dr Webb—Yes, but overall we are training for other areas of Australia.

Ms Parkes—We have the lowest rate of South Australian—

Mr GEORGANAS—Why is that? Can you put your finger on a particular reason that that takes place? Obviously it is the competitive market in terms of who pays what. That is the immediate thought that comes to my mind, but I could be wrong.

Dr Webb—And, certainly at the early stage of their careers, medical officers are looking for something different. They have perhaps grown up in South Australia and spent most of their adult lives so far here. They just want to see something different and the eastern states sound fascinating.

Ms Parkes—Also I think the range of opportunities here is more limited, so people apply to other areas as well and they often will take whatever comes first.

Mr GEORGANAS—So is South Australia looking at putting programs in place for retaining the workforce?

Dr Webb—There has been a nursing workforce strategy for several years, which has been very successful. The medical workforce strategy is just getting to the point where we are putting the retention and recruitment incentives, if you like, into place. I do not know how successful it will be, but that is what we are putting all our focus on at the moment, and allied health professionals will be next.

Ms HALL—Could you go through that nursing workforce strategy and, in doing so, detail the situation as far as nurses in this state are concerned, with the shortfall and the packages that you have to attract them? Now would be a good time to throw in something about the training of doctors and health professionals and the numbers of places that are available. I think I read in here somewhere your thoughts on the Prime Minister's announcement of the 400 extra medical places and what you think needs to happen with nurses and allied health professionals. How is it in South Australia?

Dr Webb—I think we would probably both need to take the nursing workforce question on notice because neither of us has been directly involved in that. However, I can comment on medical workforce and medical student question.

Ms HALL—I would appreciate it if you could take the nursing workforce question on notice.

Dr Webb—Yes, we will. The current position, as we have advised the Commonwealth government in recent times, is that we have an annual shortfall of 110 places for medical students, on our modelling. As you have already alluded to, if we were lucky enough to get anything like that number we would instantly have a difficulty in finding the clinical placements that need to relate to those because of the way that medical training is conducted. However, we would obviously need to tackle that. The Prime Minister's announcement of additional places is excellent as long as South Australia gets some. Obviously, at the moment, that number has not been identified, but we are hoping that we would get a good share of those.

Ms HALL—You alluded to the facts of problems associated with the training and the clinical placements. Do you think that there is potential for that to be changed? And, if so, do you have any model that you think could be implemented to replace the current model?

CHAIR—To add to that, the issue is that the Commonwealth provides the university places. The states carry out the training under the health care agreements. Therefore, the Commonwealth is paying for half of that. The Commonwealth also funds the states through the GST, which is about 50 per cent of their funding. So, in effect, the Commonwealth is supplying the funding for about 75 per cent of the cost of training doctors. Should the Commonwealth take a different role? Should it provide you with a training budget, as distinct from the health care agreements? Should we deliberately have a policy of training medical and nursing workforce specifically funded by the Commonwealth?

Dr Webb—I am not sure if either of us is in a position to answer that.

CHAIR—If you want to give a personal view, it is a personal view. You do not have to commit the state government.

Dr Webb—We are obviously referring to the fact that this is a national situation—

Ms HALL—Could you also keep in mind the question I asked prior to that?

Dr Webb—Since this is a national situation where there is a lot of mobility of all health professionals, it may well be a very sensible idea to look at training being conducted in a

different way, with funding from different sources—but that would have to stand as a personal view and not one that I have talked about in the department.

Ms Parkes—Certainly through the COAG work this is an issue that is being looked at. There has been some work done around the costing. I think Victoria might not agree with your view about the 75 per cent. They are the only state that have done some detailed work around the costing of clinical placements, so they would probably say that the cost of clinical placement is actually more than the Commonwealth puts in. But part of the issue is that we are probably in a short window of opportunity. What we have to do is almost bulk up the workforce because we know that the supply is starting to decline.

At the moment, there is not a problem with getting enough people who are, if you like, eligible to do medicine, nursing or even health science, but they are not getting into the system because they are not gaining places. So there is an opportunity to bulk up in anticipation of, if you like, the wave of retirements and exits from the health professions that we are going to see with the bulge in the workforce. By about 2030, it is all supposed to even out a bit but, until then, we are going to have problems in terms of being able to bring through enough people to meet the growing demand. But, even if we can find a way to put a cap on demand through changing service models and early intervention and prevention services, there is still going to be some tension around that. And, I am sorry, I have forgotten your previous question. I will need you to ask it again.

Dr Webb—I think it was how we managed the clinical placement issue.

Ms HALL—It was, and whether there are any models that you can think of that could be used.

Dr Webb—One of the things that has become apparent in the medical workforce project that we are undertaking is that our senior medical officers, who in many cases are at traditional retirement age or beyond, are very willing to stay in the system, at least to a partial extent, in order to train the next generation. But, again, that is a window of opportunity that we need to take advantage of because once they move on the generation behind them is not necessarily of the same mindset—I am talking about generations X and Y and their different values. So I think it is very important that we get any bulge of student places coming through quite soon in order to take advantage of the people who are willing to do that training.

Ms Parkes—The other side is that the public sector is the training ground for the private sector. That has always been a point of tension because the demands on clinical supervision and placements are not fully funded, in a sense. There is a requirement for people to do it, but the private sector does not support it to the same extent that the public sector does. It is a bit like what happens with trainees and apprentices: once the government stopped doing it, the private sector dropped the ball because they were relying on the government, and now we have some trade shortages starting to emerge. So I think there are opportunities to explore how to build the financial model that will support private sector training but encourage an interchange between the public and private sectors rather than competition. And that is part of the issue. The health system always has the threat that the people employed in the public sector can move to the private sector.

We need to create an equitable way and to have incentives. We know from some of our focus groups and things we have run that some of the things that attracted people to the public sector have disappeared to a degree: the opportunities for doing research and teaching have been diminished because of the workloads. One of the ways around that is to create a bigger work supply to build back some of those incentives and that then reinforce the opportunities in the public sector and support a vibrant public sector. But the risk in health is always that people will say: 'I've had enough. I'll go to the private sector.' That is why we end up with so many agency nurses and having to make special deals with doctors et cetera.

CHAIR—Thank you for answering the question I was going to ask next! How do you involve the private hospitals in training? That has been put to us on many occasions. We have talked about it before—we had the plastic surgery people in before you and they have the same problem. But the surgeons are saying that it is very difficult to train a surgeon in a private hospital where a patient expects a surgeon to perform the procedure. In South Australia have we explored how to do this?

Dr Webb—Yes. We are currently looking at that as part of the work that the medical specialist training committee is doing nationally. The two things that have been put forward are more training in rural areas and some training in the private sector. As you can imagine, the rural option is not much of an option in South Australia. We do not have the large base hospitals and so on that we could use. So we have looked very closely at the private sector as an opportunity. Some of our private hospitals and their operators would be quite interested in working with us but we are still trying to work through the issues of patient acceptability, which is what you referred to, and loss of productivity from having trainees work alongside specialists. Of course the thing about private hospitals and private specialists is the turnover. And there is indemnity and insurance. We can certainly look at ways of seconding our trainee staff out from the public hospitals to do placements in private, and salaries can be taken care of, but to look at the loss of productivity, indemnity and attitudinal issues is going to take a little bit of negotiation. But we are very keen on doing it.

CHAIR—That could be addressed by the Commonwealth, if it is a specific training issue.

Dr Webb—Yes, it could be.

Ms HALL—In your submission it mentions a demand management and substitutive care program. Would you like to tell us a little bit about that? It says it has:

... provided significant funding for multiple hospital avoidance strategies over recent years. This program is operating successfully in partnership with GPs, NGOs, residential care services and health services across the continuum of care, with a focus on GP and hospital emergency ... referrals and hospital discharge ...

It goes on to talk about what you have done.

Dr Webb—I think I referred to the Advanced Community Care Association, which is one of the agencies that is working with us on that demand management strategy. I referred to it as hospital avoidance, which is one of the outcomes of doing it.

Ms HALL—As you know we are looking at private health and private health insurance. I note in your submission it says:

... building this sector and supporting private health insurance should not be at the cost of sustaining a viable and comprehensive public health care sector to meet the needs of those who depend on it.

Would you like to expand on that?

Ms Parkes—It is worthwhile saying that in our submission to the Productivity Commission we made some recommendations about the Medicare scheme and the PBS in terms of looking at some of the disincentives that exist for workforce reform because of the way it is structured. What we meant there is that health is a huge cost to government, both Commonwealth and state, and to the community as a whole. We need to really rethink our delivery models and the way we fund those, and what those funding levers do in terms of driving us down pathways that are not going to deliver the result that we need for the future, which is to manage the growing burden of chronic disease and the ageing of the population and to provide a workforce to meet that.

So, in terms of what we were talking about here, we wanted to open up the debate around how we identify some of those disincentives. The funding of the health system is very complex. If anyone has ever tried to do a diagram—which we have tried on several occasions—they will know it is very hard to explain to people exactly how it is funded and what it delivers. We talk about using evidence based approaches to the delivery of clinical services. We talk about trying to then apply that at a systemic level, and it is a much bigger challenge because we have very complex funding arrangements. We have not necessarily reviewed those funding arrangements in the context of how we need to look at improving population health.

This sounds odd, but part of the problem is that we actually have a fairly healthy population. We actually have high levels of life expectancy. So, to a degree, we have already attained a very good level of service and that has been built on a system that has evolved over a long period of time. But we now know that it is not going to stay that way and we have to find a way to match the way we fund to what needs to happen in order to deliver continuing population health gains, particularly for the groups that have not really made the same gains as the rest of population—people with mental health issues and Aboriginal people. A lot of the services that we provide for those groups are not well funded under our current mechanisms.

CHAIR—Should the Commonwealth play a greater role in establishing a national health agenda? The reason I ask that question is that the Auditor-General has told us—and it is in his reports—that the Commonwealth health department, instead of setting a national agenda, has merely become a post office between the department of finance, Commonwealth-wise, and the states. Thirty years ago, in a past life when I was an economist in the health department, the health department used to set a national agenda. Do you feel that there is a need for a national agenda? Is there a national agenda somewhere that I am missing?

Ms Parkes—We certainly made the comment in our Productivity Commission submission that there was a need for a stronger national agenda and that it needed to be based on taking a population health approach to the issues that we are now facing. That means thinking differently and making investments in terms of the information required to support that, because while we have a lot of information around health we do not actually have good ways of bringing it all

together, managing the complexity of health in that environment and then coming out with clear decisions that we know will make a difference all the way through the system. Part of the complexity of health is that it is very hard to make systemic change because of the complexity and we always tend to fall back on a program response at either a regional or a state level at the most, but even then it is still difficult to do.

CHAIR—We blame you and you blame us. It is a never-ending problem which we really should solve.

Dr Webb—Especially when you look at issues such as quality, safety and training, a national agenda would be of great benefit. The standardisation of processes and systems across Australia, because of the mobility of the workforce, would make it a lot safer because doctors or nurses or anybody else moving from state to state would be encountering the same medication chart. That happens to be a project that is going on at the moment, so I know that we are getting towards a national medication chart. If you have a different medication chart in every hospital that you walk into or in each state that you move to, then clearly mistakes are going to be made. Quality and safety would be much better served by a national agenda which is actively promoted and so would training, because the relationship with the colleges could be carried out with a single voice rather than with eight or nine voices. We are never going to win with the colleges whilst we are all at sixes and sevens.

CHAIR—What about applying that to foreign trained doctors, if we need to recruit them, instead of having the states competing against each other? We had a situation in Queensland which had a royal commission into it. So you do not have here the problem of the accreditation of overseas doctors that Queensland had?

Dr Webb—We have a process of accrediting them in order for them to work in the state. So far—touch wood—we have not had any errors in it, which I think is perhaps what happened to Queensland. But it is a problem which would be much better handled on a national basis. We thoroughly support the national accreditation and national registration aims of the Productivity Commission, because it is a good idea for us to be looking at a mobile workforce as one body rather than as people who are registered in each state and move around. It is a mess at the moment.

Mr GEORGANAS—I would like to go to a specific area, it being dental care.

Dr Webb—We would both have to claim relative ignorance on dental care but we could have a go.

Mr GEORGANAS—There seems to be a lot of buck-passing, with the Commonwealth government saying it is a state responsibility and the state governments saying it is a federal responsibility. In the meantime the list of people, especially age pensioners, waiting for dental care is getting longer and greater and therefore no preventative dental care is taking place and the problem is getting worse. It is a specific area in which a lot of buck-passing takes place. How would you see state and federal governments grappling with that to make it a better system? I know that there has been some work done on it in South Australia. The waiting list was approximately five years, going back four or five years ago, but some extra money injected into it by the state government has reduced the list waiting time to two years.

Even so, I notice from when my constituents come to see me and we refer them on to the Hindmarsh dental clinic that it actually has to be an emergency before they will even be looked at, if they are waiting for dentures and other things. We are not here to say whether it is a Commonwealth or a state problem, but there certainly is a problem out there because those lists are getting longer and longer. How do we deal with the specific areas?

Ms Parkes—I think that is a good example of where you need to look at it from the population health level and say: 'What impact does good dental health have on the health and wellbeing of the population as a whole? What does it mean in terms of lost productivity? What does it mean in terms of hospital admissions?' A significant proportion of hospital admissions relate to poor dental care. We need to start building better economic cases around where we can get the best value by looking at some population health issues. In health we tend to get headline health issues, but a lot of the issues like dental care are very significant drains on the purse—whether it be Commonwealth or state does not matter. We have a lot of people living with a much lower quality of life because they cannot afford to access private dental care and there is a lot of loss to the community that we are not counting.

I think we have to get smarter in the health sector by presenting cases that show the real impact of that and then saying, 'Okay, if this is what it costs, who is best placed to fund that?' and work it out from there. We have not put the resources into that sort of thinking yet. Moving to a population health approach means we have to start rethinking what it does mean and therefore what are the trade-offs we are going to have to make. Do we buy another MRI machine or do we put the money back into something else? And what is the impact on the community? For example: this money is going to service 100 people, of whom X number have life-threatening issues; this money is going to service X number of people, but the increased productivity gained to the community as a whole will be this, and the health and wellbeing of many more people is going to be affected. We have to start engaging in that debate both within the system and also with the community. I think sometimes the community is not engaged properly in understanding how some of those decisions are made.

We have found through processes that have been run in the past that when communities are actually informed what real decisions are on the table then they make a choice that meets the needs of both the community and the budget. We are probably not being transparent enough, partly because we cannot be because we have not invested enough in disentangling that information ourselves, but also because health tends to be a very emotional issue and that tends to grab the headlines and drive a lot of the decisions that are made in health. Sometimes they are responded to because of a perception that the community is asking for this or there is a particular issue, but we are not actually making a huge effort either to inform the community about what some of the choices are and what some of the impacts could be or to engage them in the debate on that.

A good example would be that we had an obstetrics service out at Gawler and the media debate was all about 'we need more of the same', whereas there were probably other service models. If the community had been engaged in the debate they might have said: 'Well, actually, maybe we don't want that. We might want a different model of service but with guaranteed transport connections or whatever.' But that debate was not had because it was hijacked by the media. So we need to make some of those investments in better understanding the community need and then informing the community about what the options are, based on the evidence.

CHAIR—I am very pleased to hear those words about the need for community input into the health system. We were surprised when we had this inquiry that we had very few consumer groups making submissions. As you say, health is only a problem when you have a problem. It is not a top of the mind issue that people would consider having an input into on a day-to-day basis, but I think you are right that it is very important that they do.

I think that covers all the areas we needed to canvass with you. I am truly grateful for your appearance here today. I have been in parliament for 16 years, and I must say that it is not often that we get competent people like you to appear before us, who are genuine and sincere about their topic. I will put it on the public record that I appreciate the South Australian Minister for Health allowing you appear before us. We have got a lot of information from you today which will help us come to certain recommendations. I thank you again for appearing before us today.

Proceedings suspended from 12.20 pm to 1.11 pm

MOORE, Mr Declan, Group Manager, City Services, City of West Torrens

TRAINER, Hon. John, Mayor, City of West Torrens

CHAIR—I reconvene this hearing of the House of Representatives Standing Committee on Health and Ageing. Before I commence, we need to authorise a submission received from the City of West Torrens. Is it the wish of the committee that the submission be accepted as evidence to the health funding inquiry? There being no objections, it is so ordered. I now welcome representatives of the City of West Torrens. Before we start, I would like to thank you for the use of these facilities today to hold these public hearings. We have enjoyed the splendid premises. They are very impressive. I have already thanked Steve publicly, because this is in his electorate and we are visiting.

Ms HALL—And thank you for the wonderful lunch provided by council.

Mr Moore—I am not sure that we provided it directly. It certainly would have been outsourced.

CHAIR—We are thinking of offering the person who prepared the sandwiches a job in our Parliament House! I invite you to make an opening statement to the committee.

Mayor Trainer—The current City of West Torrens was created in 1997 by the amalgamation of the former City of West Torrens, which itself was established in 1853, with the town of Thebarton. It comprises a population of 52,000, covers an area 36.5 square kilometres and has 26,000 property assessments. We like to pride ourselves in the fact that each year our residential rates are either the lowest or, at worst, second lowest on average in the metropolitan area. We manage, we think, to provide a reasonable range of services with that rates base.

One difficulty we have—and I am going to introduce something that may not at first glance seem relevant, but I think as I proceed you may possibly see the relevance—is that the Adelaide Airport constitutes a quarter of the council's area and is our greatest asset and our greatest liability. Under the contractual terms of its lease contract with the Commonwealth, Adelaide Airport is required to make a rate equivalent payment on areas of the airport which are not occupied by the Commonwealth, which are subleased to tenants, or on which financial or trading operations are undertaken. The airport, while a major economic driver for our council and indeed for South Australia, has a significant impact on the environment and lifestyle of many long-term residents of the area—I will return to that later.

Much of the council area was established in the immediate pre and post World War II period but has in the past decade undergone substantial regeneration to its built structure, transforming it from an austere industrial landscape interspersed with residential nodes of predominantly working-class accommodation to a modern, vibrant municipality which has become a destination for many families with businesses and occupations in the CBD and in the western area of Adelaide. The age profile and social fabric of the population is changing, with smaller families and a larger number of single or smaller family households.

Contemporary councils provide a wide range of services, in many cases replacing services hitherto provided by various state and Commonwealth bodies, as part of the phenomenon referred to as cost shifting. There is a tendency for both levels of government—state and federal—to refer their electors in the first instance to the local government authority to provide those services. This has resulted in local authorities such as West Torrens providing sophisticated, broad-ranging services through the local community and sporting facilities distributed throughout the city. While funding may be provided by state or federal governments for project based initiatives, it is often only seed funding whose subsequent termination places considerable pressure on our ability to provide long-term comprehensive programs.

The cultural base of West Torrens is extremely diverse, and that—by way of a footnote to Mr Chairman—is reflected in our council. Of 14 elected councillors, we have four who are of Greek background, two Italian and one Lebanese, and the other seven are second generation from a variety of European backgrounds. In our federal and state representation, we have Mr Georganas, of course, the Greek federal member of parliament for the area. We also have a member of state parliament who is of half-Bulgarian descent, another one of Romanian descent and another one who, like Mr Georganas, is Greek. So that multicultural aspect of our society is reflected in our representation at state, federal and local government levels. In excess of 23 per cent of our residents were born overseas and a similarly significant number speak English as a second language. While in the past the cultural mix was dominated by people of European backgrounds, this has changed, with significant numbers of newly arrived migrants and refugees coming from Middle Eastern and African countries.

The council is the conduit for a variety of services funded by other levels of government, including home and community care services; Elder Choices, to maintain the frail elderly in their homes longer; and residential aged care. The council is presently upgrading, at its capital cost, St Martin's Aged Care Facility to accommodate a further 40 residents and to bring existing facilities up to 2008 care standards at a cost in excess of $12 million. There are also community housing projects with both the Commonwealth and the state Community Housing Authority aimed at lower income and/or aged residents, infrastructure for preschool and kindergarten, new immigrant services and a comprehensive range of immunisation services for schools and the public.

Another thing I will mention comes predominantly from our own funds. In trying to meet the social needs of our elderly residents, it has been a policy in the past that each of the seven wards into which the council is divided would have one senior citizens club or pensioners club. As the years have gone by, some of these have been downgraded in size because of a lack of participation. Some of those have withered on the vine, but we do have some that are extremely successful. The senior citizens club of Airport ward, for example, redefined itself to become the Airport Senior Citizens Club for Over 50s. They have over 200 members and they will often have over 100 people turn up at the AGM to vote for their executive, which is rather outstanding community participation in the 21st century.

As Mr Moore may mention later, we also have this network arrangement for different organisations in the community. For example, we have one where we get the RSL clubs to work together and the sporting clubs to work together, and we have one for our senior citizens clubs, which network at regular intervals. We provide a mayoral Christmas party at the end of the year, a concert that is very popular indeed—so much so that we have to double it and have it twice. I

have gone out of my way to make sure that the invitation list now includes not just those predominantly Anglo-Saxon mainstream senior citizens groups but also the Greek pensioners, the Italian pensioners and so forth.

Returning to the theme of health activities and other services: while council does not have a direct relationship with health authorities in the provision of services, the health and welfare of residents is dependent on the quality and condition of the infrastructure of the city itself. The council has invested significantly in upgrading its infrastructure in the areas of waste, stormwater mitigation, road systems and public buildings. Being on a former swamp on the western side of the city, which is where the majority of the catchment area of the metropolitan district is, we have particular concerns all the time with the huge cost of stormwater mitigation infrastructure.

We have established and maintained infrastructure facilities in the social area. At one end of the age spectrum they are appropriate to the very young, such as child-friendly parks and playgrounds, while at the other end of that spectrum we ensure that bikeways, roads and footpaths are able to be accessed not only by active residents but by those who are frail due to age or physical disability.

Council provides high standards of health related services in the form of best practice removal and recycling of household waste. A significant level of investment is required to ensure that our unique position on the western side of metropolitan Adelaide is protected from severe rain events and stormwater run-off from upstream councils. The ageing of our population and the tendency of aged homeowners to be asset rich through home ownership but income poor in terms of pensions or retirement benefits has necessitated council having to provide, on the basis of individual hardships, systems of rate rebate or postponement of rate obligations.

The local government authority carries responsibility for much of the development and maintenance of the physical, economic and social environment of its local community. In generating revenue to make those responsibilities and in delivering services, local government is not well placed to adapt those practices to the income level of individuals—at least not to do so with any great precision. The major source of local government revenue is, theoretically, a wealth tax based on the capacity to contribute—namely, council rates. In practice, difficulties are created for those, usually the elderly residents, who are asset rich and income poor. Accommodating their individual circumstances is complicated by local government not having access to the personal financial data of residents that could form a basis for policy formulation in this area and not having alternative revenue sources to fund the rate rebates that might be required to address the inequities that would be discovered.

Some support is derived from a state subsidised rebate for senior citizens, but this is based on age rather than on income. There would be more scope for making provision for elderly ratepayers who are asset rich and income poor if the Commonwealth government, as the owner of the land underneath the privatised Adelaide airport, would fully enforce the provisions of the airport lease, which requires the leaseholder, Adelaide Airport Ltd, to make rate-equivalent payments to this council. It is a dereliction of duty for Commonwealth governments of any persuasion to allow the rapidly expanding developer of Adelaide airport to evade its full responsibilities to meet those community contributions. To underline the amount that is involved and what difference that could make to the services we could provide, each quarter AAL has a

$600,000 rates-equivalent payment due to this council, but gives itself a discount and refuses to pay more than half of that figure. Added to the $500,000 in arrears from previous years, this will extrapolate on 1 July to a shortfall of $1.7 million in community revenue, a deficit that will grow exponentially as a further $500 million in commercial development proceeds on airport land. For the provision of both rate relief and of services, one of the most helpful things the Commonwealth government could do for the elderly ratepayers of West Torrens would be to carry out its duty as landlord and make its tenant, AAL, meet the obligations of its lease. Group Manager City Services, Mr Declan Moore, will now speak in detail about specific services.

CHAIR—Did you make a submission to the inquiry on cost shifting in local government—the Hawker committee? It was a couple of years ago.

Mayor Trainer—Yes, we did. The city manager appeared. I was not personally involved in the submission.

CHAIR—I was on that committee and I recall the issue.

Mr Moore—Thank you, Chair, and members of the committee for the opportunity to speak with you today. I have circulated notes. It should more formally have been a submission had I done it in time. My apologies for that. I wanted to touch on a number of things that Mayor Trainer has spoken about. We are all quite capable of reading, so I do not intend to read the whole document. I want to start with a series of acknowledgements. You do not have those at this stage in the short paper in front of you. As someone who has worked in the area within both state and local government and in the private sector and also had a bit of involvement with the Commonwealth sector I know, and council recognises, that health and ageing is a seriously complex area. There are any number of competing demands, limited amounts of money and limited amounts of resources in other forms as well. So it is important that we do acknowledge that there is a lot of support from Commonwealth and state governments to us and to our community in terms of funding.

I will move a little bit further away from the mayor, because he might collar me on this. I am reminded of one of the scenes in Monty Python's *Life of Brian* where they are sitting around discussing, 'What have the Romans ever done for us?' No-one has an answer for a while and then they start talking about roads, education and sanitation. The mayor touched on those things—that the biggest inroads made into health for generations have been the provision of those sorts of services. Local government often does not think about itself as being a health provider, but then you start talking about waste management, drainage and building controls—making sure that when people build a house that it actually has some capacity for not using all the resources around it, that it actually has some capacity for not directly impacting on neighbours. All those sorts of simple changes within a community actually have a fairly serious impact on health and welfare.

Local government does have a very large role to play, but when we starts talking about direct service delivery, which is probably more what the committee is interested in, we rely very heavily on other levels of government to provide the funding and also to provide some of the ideas. There are many things that we would like to do. Clearly when the government has opportunities for us to pick up funding, even if it is that seed funding the mayor spoke about, there are often times that it is just the right approach that this council or another council might be

looking at to actually initiate a program. Again, we have been the recipient of those sorts of funds indirectly from Commonwealth through the HACC funding agreements, where the state government has provided us with some money for a program you would not normally associate with HACC, and that is to do a lot of research in terms of creating elderly friendly communities.

As I said, local government has a very genuine role to play in the provision of health services using the broadest definition of health. From a local government point of view, we would generally concur with everything that was in the submission you received from ALGA. I know it is a bit dated now and some things have changed. It is important also to acknowledge that local government at the national level has been focusing on aged care. Coincidentally, the mayor actually passed something on to me just before we came in. I am sure members of the committee would be interested in it and I have a copy for the secretariat. ALGA's *Ageing awareness and action survey report* for 2006 has just been released. It is on their web site. I have not had a chance to look at it. All local governments were encouraged to participate in that survey, and we certainly did, and identify the types the services they provide and the types the services they believe are still required in our areas. It may be of some value, if it is not directly submitted by ALGA to the committee, for the secretariat to look for it.

As I said, council is the beneficiary of several million dollars per annum from the Commonwealth and state governments. Without it we would not be able to provide a lot of services. Even allowing for the money we received from state and Commonwealth governments and for the money that council itself puts in, I hark back to the mayor's remarks about ratepayers and the requirement for people to pay their fair share. The mayor talks about council rates being a tax. That is certainly how we view them. We have a particular issue with the airport. That is one that has been going on for some time, but we also have similar issues with state instrumentalities as well where they have privatised some services. An example in our community is a passenger transport terminal. It has been used by private bus operators, yet it is claiming privilege and not paying rates. Again, obviously council is very concerned about taking their rates in. Our argument is that instrumentalities or agencies that are enjoying a commercial operation, under the shield of the Crown so to speak, ought to pay those rates. If they do not, we place a burden on our other ratepayers.

That is not to say—and I am not naive enough to suggest—that, if the Adelaide airport and other agencies came in tomorrow with a cheque for $2 million or $3 million, that would all be spent on health and ageing. It would be disingenuous to suggest that. But it would be realistic, given this council's approach to these areas, that a fair proportion would find its way into direct service provision.

I do not want to be badgering the cost-shifting exercise. Local government has been receiving for many years now a share of the Commonwealth take in terms of personal income tax and some flow-on from the GST. We talk about the general purpose grants that are received. In 1998-99, there was something in the order of $34,438,000 made available to the Adelaide metropolitan area councils through the grants program. Of that, the City of West Torrens received just over $1 million. So we received something of the order of 3.25 per cent of the general purpose grants for that year. Fast forward eight years and a few changes to the distribution formula that we are still trying to work out, and the amount available to the Adelaide metro councils is $34,900,000. It has gone up by only 1.4 per cent over eight years. Our share has fallen from $1.1 million to $870,000-odd.

Ms HALL—And as a percentage?

Mr Moore—Our share has gone down by 21 per cent, but as a percentage we are now at about 2.5 per cent. Previously it was 3¼ per cent and now it is 2.5 per cent of an amount of money that has only grown by one per cent over eight years. Again, those councils in our northern areas of Adelaide have been the recipients of increases. Far be it from me to comment on the needs that they have, but they are developing councils—and there is no doubt about that—so they have high infrastructure needs. One of our disadvantages is that, although we are an established area, we still have a lot of infill development going on. But more importantly, because of our location we are the net recipients of migration into the city, often of older people and more recently of people from overseas, primarily from African countries. The demands upon this council are quite different. We still have issues in maintaining our infrastructure. We do not have to build a lot of new infrastructure, but we certainly have a lot of old infrastructure that we have to maintain. Councils towards the northern parts of Adelaide receive a greater share now because of their immediate needs. Our council has to try to find that shortfall through other areas, whilst still trying to maintain its position as a low-rating council, of which it is very proud.

Notwithstanding all the above, out of council's $35 million budget this year somewhere close to $3 million has come from external sources, primarily from Commonwealth and state governments. The greatest slice of that relates to St Martins Aged Care Facility. Currently it has 71 beds, and it is halfway through a build project taking it to 111 funded beds and four that are not—and I will mention those a little later. We have community aged care packages that we call Elder Choices, and that program tries to deliver equivalent care that you might receive in a low-care facility or in a hostel to people living in their own homes, and we have a variety of HACC programs. We also get about $30,000 from the Commonwealth and the state to subsidise our immunisation program.

I think it was in Caboolture that the committee was asking about the cost to councils of the delivery of an immunisation service. We have just finished an internal report that will go to council in the next couple of months that looks at our immunisation service. It is quite small—only about 5,500 occasions of service per year—but council subsidises each one of those occasions of service by about $6.70. Of the $6 subsidy, we get about half from the state and half from the Commonwealth. That generally is a subsidy on the immunisation register but also for the vaccines. If we put all our other costs together and we do not go crazy in adding overheads and all those sorts of things—but in our direct, reportable costs—we are subsidising at about $6.70 per vaccine.

Again, local government is not required to deliver any of these services in terms of our legislation. I think I heard the chairman mention that we are a creation or a beast of the state, and it is true to that extent. The wording in our act is so broad as to suggest that local government can do pretty much anything it thinks it should be doing, provided it can fund it and its community agrees to it.

We provide a lot of services that our near neighbours may not provide. If I look at the provision of residential aged care services, there are only four councils in South Australia that provide residential aged care—us; Holdfast Bay, our neighbours on the coast who have a facility that is probably in the order of 200 beds now; the rural city of Murray Bridge; and the rural city of Port Augusta. The four of us combined would probably provide in the order of 300 to 400

beds, whereas many local governments in Victoria and New South Wales provide those services. I will touch on the impact that that has on us a bit later.

CHAIR—Does your aged care facility pay rates?

Mr Moore—No, it is a council function. We are forgiven the rates, but the division pays council something in the order of $40,000-odd per annum for internal services. Most aged care facilities, if they are not-for-profits under our legislation, are entitled to rate rebates. We have a rebate, which the mayor mentioned, for age pensioners. For example, there is a rebate if you are a not-for-profit agency that is providing child-care services or if you are a hospital. If you are a not-for-profit aged care facility, you can receive up to something like 75 per cent, basically, on application, and council can elect to extend it.

CHAIR—Are there public hospitals in your city?

Mr Moore—There are no public hospitals in our city. We have the Ashford hospital, which is part of a private health care alliance, on Anzac Highway. We have a lot of private providers in aged care but not acute hospitals. Ashford would be the only acute hospital. Queen Elizabeth and Royal Adelaide are very close.

CHAIR—What is the relative treatment with the airport compared with state government facilities in the city regarding rates?

Mr Moore—We have a number of other state agencies that are on site around council that do not contribute rates, and we understand that. They deliver government services and, if it is a school, a child-care centre, a neighbourhood centre or family and community services—

CHAIR—But the airport is commercial.

Mr Moore—The airport is essentially commercial. The mayor and a couple of our staff are resident experts there, but I know enough about the operations of the airport to know that if it is not half their income at the moment through non-aviation income I would be surprised if it would be too long before it gets to that.

Mayor Trainer—It is 47 per cent.

CHAIR—I would have thought that not paying rates as a non-profit nursing home would be a major contribution from the council towards the cost of health.

Mr Moore—I will touch on the numbers of beds; I think we have just shy of 700 beds at the moment in the city. We have quite a bit of activity of late, but it is not just us. We are a fairly small provider in the scheme of things. The head office of Southern Cross Homes is located just down the road. They have some major redevelopments. Bucklands Nursing Home, a very large nursing home, has been open for maybe 12 months.

Mayor Trainer—That is Knights of the Southern Cross, I believe.

Mr Moore—We have only one private operator, called Serene, from memory, which operates in the city. Most of the others are attached either to a not-for-profit organisation or, essentially, to a church organisation. We count ourselves as not-for-profit, except that the Australian Taxation Office does not agree—and I will talk about that later.

Ms HALL—What about community health centres?

Mr Moore—There are none that are locally resident. As the mayor said, it is about 36 or 37 square kilometres from one end of the town to the other. I am not very good at telling you distances but we are not very far away from a number of services. A lot that are based in Adelaide, Port Adelaide and Charles Sturt are adjoining councils. We do a fair amount of work with the Adelaide Community Health Service. We have a number of neighbourhood centres that we either operate or support, and we have those services come in and deliver locally. We have a community bus service and volunteers. We might take people requiring those services out of the area to receive them.

Ms HALL—So the community bus service is obviously HACC funded?

Mr Moore—No, our community bus service is funded by council. I could not tell you with any degree of accuracy how it started, but it is certainly entirely funded by council now. We have three buses and we call on the Greek pensioner group's bus if we need to. They vary in size. They are only about 25 seaters down to a 14 and a 10—that sort of thing. We do not run a timetable system; we are not a de facto public transport system. Basically, we are focused on door to door—picking up people and taking them to various activities. We provide some of them but others may include, for example, a shopping trip.

Ms HALL—Medical appointments?

Mr Moore—Not so much with the bus. We have volunteer programs that are funded through HACC where we use volunteers to provide that level of support. Depending on whether the person is already a client of ours through something like community aged care packages, we have a higher duty of care and we make sure that we look after them regardless of the funding.

Mayor Trainer—One-third of the cost of our three buses—$50,000—was donated by a local service club, the Richmond Lions. It is fairly unique for a council to receive that level of support.

Ms HALL—I think it is unique for council to have a community bus service—at least, on the New South Wales model it is, I can assure you.

Mr Moore—A number of councils here have them. A lot have been funded by HACC in the past.

Mr GEORGANAS—There was a question asked earlier about health services that are run by the council in the council area and your answer was that there are none in the council area. Would you like to explain to the committee the distance between the three hospitals in the council area and how they just border the council area?

Mr Moore—I could give you driving times. The Royal Adelaide Hospital is on North Terrace, maybe three kilometres away. The Queen Elizabeth Hospital is a bit trickier to get to from the City of West Torrens but in terms of driving time it would be no more than 15 to 20 minutes depending on where you come from. If you are towards the southern side of town—some people might go out to Flinders Medical Centre—Flinders would be a fair hike from here. We have a number of 24-hour services in terms of private practitioners. We do not have a huge offering of bulk-billed services, I have to say, and that is a function of inner suburban Adelaide. In my experience—I do not have the details in front of me—it is not a very high number. In terms of acute services we are reasonably well located in that sense. As an ambulance ride, it would certainly be no more than 15 to 20 minutes to whichever centre is required.

Ms HALL—I was just going to ask about community health services while you are talking about the acute care.

Mr Moore—Physically, several are in Adelaide. Several are in and around Woodville, and Enfield which is probably getting closer to 30 minutes away from here. There is Clovelly Park which is probably 15 to 20 minutes to our south. Our approach, and what most of the community services are doing now, is outreach services. For example, there is Thebarton Neighbourhood House, which is a council owned and operated service, and we have the Adelaide Community Health Service that conducts various programs there. Another unique thing is that we have got community lawyers based in that office as well—

Ms HALL—Employed by the council?

Mr Moore—No, they are funded by the state through the legal aid program. They have been collocated with us for probably seven or eight years maybe longer. Having them available is fantastic. Our council approach—and I touched on this in our submission under 'social development'—has two streams. We talk about community services where we deliver them or we advocate on our community's behalf—meaning annoy—someone else to provide them.

Mayor Trainer—We also have a significant number of health support groups that have chosen to base themselves in the City of West Torrens. There is the Asthma Foundation and the Kidney Foundation, and Diabetes South Australia next door to the council. The Red Cross conduct their training here and there is the Red Cross shop. A lot of these have moved from being on the eastern side of the city and find it more convenient to move into former commercial premises here in West Torrens.

Mr Moore—Where we cannot provide a service or where we do not believe it is our role to be providing certain services we are certainly not backward in coming forward and putting a case to various agencies. Council support over the years has ranged from providing financial support to agencies by way of perhaps reduced rent on facilities. For example, most of the properties that surround the park just outside the council chamber between us and the library are actually owned by the council now. There are only a couple in private hands. For many years the Child, Adolescent, Family Health Service, as it was called, provided services out of that building at peppercorn rent to council. So we have offered those kinds of supports over different years.

I was speaking to Mr Georganas earlier about child-care centres and the question was asked whether we operated them. No, council does not operate child-care services, but council does

own two that are leased at a peppercorn rent to child-care providers. We have also got a large number of people who are living in retirement villages. They are the beneficiaries of council support. Council provided the land and the South Australian Housing Trust would have built the facilities back in those days. Council also has a number of community houses—the title evades me a little bit—small independent living units that people buy. I think the current price is about $140,000, though I would have to check on that. They are sold to people who are elderly. If the building cannot be sold, the council buys it out of the property and hangs onto it and tries to sell it again. The council would have been originally involved in that partnership.

So we have a long history of various partnerships. As the mayor mentioned, there are times when we are involved in a partnership where basically someone else provides a lot of the money and we provide a lot of the services. When the money stops, the expectation is very highly upon us to maintain the services. That may well be the reason why some local governments do not get too far out of their more traditional services because they are concerned they might be left holding the bag. Also, many may not have the support or the professional staff, for want of a better term, to be able to do that kind of work because they have not traditionally hired people with backgrounds in disability or human services. They tend to be more on the planning, building and engineering sides.

Ms HALL—I think your 'Seven steps to an aged care service provision' is an excellent plan.

Mr Moore—That really tries to outline the council's approach. If you look at that at your leisure—and I am sure you do not have much of it—it gives you a clear idea of what I have been trying to say in the last few minutes. We believe the earliest that we can provide an intervention the better. Where that intervention can be provided by other people, all the better because council and its ratepayers are not providing the funding for it, but we certainly get involved in creating some of these organisations. We certainly support the vast majority of them. The mayor mentioned that we have a whole series of networks where at least every two months we have representatives, whether they be from aged care, retirement homes or RSL clubs or whether they be education providers, come to council and talk about some of the issues that are facing them.

We have a number of publications—and you will see those mentioned—that council funds. We have our own newspaper called *Talking Points*, which is probably in one of your bags. That covers off a lot of those. We have the local *Messenger* that we invest in quite heavily in advertising not just what council does but what community groups are doing. We try very much to be not necessarily the lead but a bit of a backstop for lots of groups that maybe do not have the expertise. I am not saying that we are fuelled with the expertise, but we certainly have a high degree of commitment at the elected member level and certainly at the staff level to try to address as many needs as we can. It does not mean that we meet them. It may not even mean that we personally deliver anything towards it, but we will spend a lot of our time trying to advocate on our community's behalf to obtain those services.

Ms HALL—Is the wise use of medicines program outsourced? Do you get someone to come in and run that?

Mr Moore—Yes. A number of those programs are operated through the seniors associations and the Adelaide community health services. Occasionally we have general practitioners through

the divisions who get involved in providing those sorts of services. Given that we have an aged care facility, we also have a lot of expertise there as well. We try to use the resources—

Ms HALL—What about partnerships?

Mr Moore—Partnerships are pretty much the only way that we can operate, given our funding base, to try to have an influence on what happens with our community. That is essentially what we try to deliver all the time. We have a position that is called the Partnership Cultural Development Officer. It is more than just the people that we employ; it is embedded in the council's culture, I believe. We have tried to reflect it in the council's strategic plan and in its vision, mission and value statements. The ones that I think are most important really relate to our sense of inclusiveness, our concern for the health of our community. Also, the council believes very strongly in its role as an advocate. People advocate to us on people's behalf, but we would also like to be seen as someone that you can approach if you are having a problem somewhere else.

As staff members we enjoy very good relationships—and I certainly do—with local members of parliament, neighbouring councils and a whole range of service providers. We might not be able to deliver what you need today or tomorrow but, if we can get someone else to do it for you or if we can get someone else to help us deliver it, that is certainly what we will try to do. But obviously we cannot meet all needs and so priorities become the bane of our lives.

Ms HALL—For the record, you have a reasonably large human services department. Would you like to put that on the record?

Mr Moore—There would probably be in the order of 19 full-time equivalents in what we call the social development area, and I would say about half of those would be externally funded. The biggest single group would be in the community aged care program, where we are delivering—if you like—hostel level services in people's own homes. They would mostly be casual staff, because the nature of the service is that it might involve showering someone at six o'clock in the morning and then not going back until 7 o'clock at night to help them get ready for bed. Obviously, we do not have people working the full scope. We operate the home and community care program through a variety of people on staff but also through contractors, so for a lot of the cleaning programs we might use some of the commercial cleaners. Obviously, that is at discounted rates. We cannot afford to pay the standard rate, so we negotiate with people to do that.

A lot of the home maintenance is done by our home handyman, a guy that we employ ourselves. He does not do anything that requires a trade certificate. I am more than confident that Lambros could do most of it, but legally he cannot so we do not let him do it. The other part of our service is the community development side, which is really where we try and get other agencies to provide their services within our area. We are a bit parochial in that sense. It may well be the case that a service is provided next door and it is probably not too hard for someone to get there, but if we can get that service provided on our patch then we will go after the agency to see if we can negotiate that. We have a few things at our disposal—for example, a capacity to offer introductory special prices on renting facilities or maybe the use of some of our other organisational aspects. We provide auspicing services for some agencies. We have supported a

number of agencies who have applied, for example, for Commonwealth or state moneys to do various projects and we stand as the guarantor, if you like, to make sure the guidelines are met.

Mr GEORGANAS—In the provision of aged care services that you provide, what are some of the challenges that are facing council, especially in the face of the ageing population of the western suburbs? Are there more pressures on council for aged care facilities and providing services, local buses and all the other things we have spoken about? How do you see state and Commonwealth governments assisting or helping? What role can we play, if there is a role to play? Perhaps you are doing it so well that you do not need anyone else to play a role.

Mr Moore—I think we would be more than willing to have as many people as possible who are interested in the area providing support. It is not council's main reason for existence. Council has gone into it for all the right reasons, going back many years. Once you find yourself in a position where you are delivering services, it is next to impossible to withdraw and you find yourself getting drawn into delivering more and more. Either you do it yourself with your own resources or you try and get resources from elsewhere. I would suggest that, if HACC money dried up tomorrow, this council would do its level best to provide a level of service but it would be nowhere near the extent of that provided today. We are also wary of the fact that you can only operate at a certain level. If everyone wanted to provide the council with lots of resources to provide a whole range of services, we might not be in a position to be able to manage it with our own expertise.

Our emerging issues, for me, in this area relate a lot to the programs that are already being provided, and it is not just the quantum of services that is the issue. One issue—and I touch upon it in this; it may be in the copy you have or if not in the one I have here—is that there are a number of programs operating through a number of funding sources through state or Commonwealth governments where on the surface it looks like there is a lot of support, but most of those programs have very specific guidelines for eligibility criteria, very specific outcomes they look for and absolutely onerous administrative requirements.

I understand that whenever you use public money—whether it is the council's, the state's or federal money—it actually belongs to all of us who pay taxes. Therefore, we have a very high level of responsibility to make sure we can account for every dollar we spend. But the administrative load on us in trying to do that gobbles up a huge amount of the funding that is available. The administrative nightmare is difficult. We are currently undergoing a HACC audit. They have been with us a couple of days. The auditors are fantastic, but they are assessing us according to the strict criteria of the program. There are a couple of areas where we are in the grey, for all the right reasons—that is, through trying to push services using those limited amounts of money—but technically not meeting the eligibility requirements.

For us, the issue is not so much about increasing the quantum; it is more about trying to reduce the administrative load, while still balancing our responsibility for accounting for public money. Also, some of the guidelines have changed over the years, where you can try to put together a package for people. There was a time, for example, when, if you received a community aged care package through the Commonwealth residential care kind of approach, you could not receive HACC services as well. That is not normally the case, but it gives an example of where we get a level of frustration. We come to you and we see you have this range of needs and then we have to come back to the office and say, 'We can give you an hour from

this and we can give you a couple of dollars from that.' It becomes a bit of a nightmare. If you start to provide more specific programs for places like ours, we will start to crumble under the weight. Our biggest area of concern relates to residential care. The number of operational places, as they are called now, are funded by a formula—108 per 1,000 people aged 70 and over. Technically speaking, we have in the order of 10,000 people in the City of West Torrens. You would think we would get about 1,000 beds. We are operating more under the 800 mark, including community aged care packages.

A ministerial release issued yesterday from Minister Santoro talked about new allocations and about an increase in the number of beds being available, but embedded in that press release is the true nub of the matter—that is, even though we have a formula, it is an administrative formula. It is based more on finance—what the Commonwealth can afford, and I have no problem with that, but it implies that this formula is related to need. I find it very hard to accept that only 10.8 per cent of the population aged 70 and over require residential support. I know from the people whom we are receiving into our facility, from people on our waiting lists, from people we are dealing with in our HACC programs and from our community aged care packages that we have far greater needs than the administrative prevalence. So that is an issue for us in trying to meet the needs within those constraints.

I accept that constraints have to be there; you cannot fund everything. But there are messages, in my view, that are being delivered—maybe not on purpose either by the Commonwealth or the state—that suggest aged care as having a lot of resources put towards it. That is absolutely true: there is an awful lot of resources going towards aged care or ageing services. Does it actually address significant needs? That to me is the issue. There is a gap. I think that administrative targets or formulas for provision of beds are fine. They work really well; I understand them. I have had to do similar work on other Commonwealth assignments myself. But, at the end of the day, my biggest concern is that, although at St Martins we have 69 permanent residents and we have two respite beds I know for a fact—absolutely, without any doubt whatsoever—that I could go and find another 71 people in the City of West Torrens whose needs are far greater than those who are currently accommodated, because either we do not know about them, they have not yet actually hit the system or they are on waiting lists. Speaking as a service provider, not on behalf of the council, that is always the greatest difficulty.

You are focused, on a daily basis, on the clientele you know—the ones you are trying to provide services for—but most of us will step back and say, 'This is not the part of the population with the most severe needs.' We know there are plenty of other people with far greater needs who have not come forward because they do not know about the programs. They have issues of confidentiality or funding or whatever. I think, if you start to scratch the surface, this problem of aged care provision will, all of a sudden, become far worse. Our significant issues relate to trying to deal with the number who are presenting today, with the resources that we have available, while still meeting all the administrative requirements—knowing all the time that what we are providing to an individual is not meeting all their needs, while fearing that there are far greater needs out there in the community that we do not know about.

Mr GEORGANAS—Continuing with the provisions of aged care services, particularly at St Martins Nursing Home that you spoke about earlier, how do you go with recruiting and retaining good, qualified staff? Is that an issue?

Mr Moore—It is an issue. We would be no orphan in that regard in terms of aged care. It is very difficult to recruit qualified staff in health generally. The committee has obviously had plenty of submissions in relation to medical and allied health and nursing. I not sure of the extent to which you have received much in ageing, but we are very much the poor relation, in a sense. The standards in terms of pay, responsibilities and training and development—all those opportunities—are less in aged care than they are in the acute sector because of the nature of the funding of the beast. We are going through an enterprise bargaining agreement with our staff at the moment. I think our registered nurses, for example, are already in the order of ten per cent behind the salary that is paid in the acute sector. If I advertise a position for a registered nurse, straightaway I am ten per cent down because it is in the public sector.

Ms HALL—What is their hourly rate? And what is it for ENs?

Mr Moore—For RNs, in terms of our costs annually, if you include a full shift, it is about $66,000. We pay all our RNs at level 2. We do not pay any at level 1. That is how we try to get over the recruitment issue. So, even if you have only qualified by doing the graduate nursing program, we will pay you as a level 2. A level 2 for us is paid something like $5,000 or $6,000 a year less than a level 2 in an acute hospital.

We have the same issue in terms of our enrolled nurses and our personal carers. We have tried to put a lot of our current staff through ongoing training and development. Of the 40, give or take, direct care staff that we have, 15 are currently undergoing training. They are either enrolled nurses that we are putting through to train as registered nurses, personal carers that we are training as ENs or kitchen or domestic workers that want to train in aged care at certificate IV level. Most of that is being done because our manager there has an extraordinary background in aged care and has been able to work with, again, the partnership approach. Council does not directly fund much of that at all. It does contribute to it, but a lot of it is done by going outside and working with other agencies.

We know full well that, if all those 15 people were qualified tomorrow, the chances of us retaining them for a longer time are fairly narrow. That is realistic, from our point of view. We are trying to set St Martins up not only as a facility that people see as being very keen on providing high standards of care—which I believe we do—or a place that is going to have a fantastic new facility when it is redeveloped by the end of this year but also as a facility that actually looks after its staff and promotes lifelong learning. That is a bit of a sparky comment lately, but we really are serious about contributing to providing additional staff. We might have to keep doing this training and development, but it will be an element for us.

I would say our single biggest issue—and I kind of touched on this a while ago—relates to how we are treated by the tax office. If an aged care facility's service is being provided by local government, there is no way the Australian Taxation Office will regard it as having public benevolent institution status. The reality of that PBI status for one of my $66,000 RNs is that the acute sector facilities, even though state government and Commonwealth funded, by a quirk of how they have been set up retain public benevolent institution status and can offer tax free somewhere in the order of $30,000 grossed-up. I cannot compete with that.

Mr GEORGANAS—That would make it harder for you to recruit and retain staff.

Mr Moore—One of the first questions that we are asked when people ring up—we have a good name in the industry—is: are you PBI? We have to say no. Since I have been on the council I have appealed administratively to try to get it, but we have just been refused it. Holdfast Bay operates Alwyndor, which was given to council by deed under a trust arrangement. The Taxation Office removed its PBI status. They were able to get it reinstated. It cost them a fair few dollars and a few QCs, I believe, but they were able to demonstrate that that is how they started. We, Murray Bridge and Port Augusta are competing with that kind of problem.

As I said before, there is about a 10 per cent difference anyway between us and the acute sector—and that is the public acute sector. If you add the PBI benefits, it is very hard to convince an RN that it is worthwhile coming to work for us because we are a good employer and have a fantastic facility and fantastic residents and staff when we are basically asking them to give up probably in the order of $15,000 by way of income. It is pretty tough to compete.

I know the same issue is there for other agencies interstate, and particularly where those agencies and local government are providing a lot of these services interstate. Our reality here is we are not required to do it. We have been involved in it since 1982. We are spending in the order of $12 million on redevelopment. About half of that will be funded by resident bonds and whatever, but the rest of it has to be guaranteed by the council. We will have 115 beds at the end of the day. We received 40 bed licenses two or three years ago—probably getting closer to four, we have been a bit slow implementing them. We applied for another four last year, because we could build a 115-bed facility, but we were not able to get those. We will apply again, but the western suburbs of Adelaide are not a high priority, so we will have four unfunded beds. All of those things tied together place us at a disadvantage compared to our not-for-profit supporters.

But the not-for-profits also have to deal with the other issues we have—that is, the funding we receive is based on an assessment of individual client need. It is no longer based on determining what level of service a person requires. There are currently eight categories; we receive a certain amount of money per category per person. Category 8 no longer receives a daily bed subsidy from the Commonwealth. There is a new resident classification instrument being developed, it is on trial at the moment. We are a participant in that trial, and we are pretty confident that what is currently category 7 will disappear and we will end up with another group of people in our facility, who are currently supported by way of a bed subsidy, who will not be supported when the new system is in place. We will have to get the income from somewhere else. It is a tricky situation. We are no different to lots of other agencies in healthcare, but the one feature that really drives a wedge between us and our competitors is the PBI status. If the committee has any influence in that regard, we would be very appreciative—

Ms HALL—Why don't you put a submission to the committee on that one issue?

Mr Moore—I could certainly do that. Thank you for the opportunity.

Mayor Trainer—We could make a recommendation.

Ms HALL—It sounds like you are very passionate about it, and that is something that could be—

Mr Moore—I get a bit passionate about number of them, I am afraid. It is the Irish in me.

CHAIR—Can you send some of this to Queensland?

Mr Moore—We are hoping it is local rain, Chair. If it is happening elsewhere in the city, in a couple of hours we will have to get out the boats.

Mayor Trainer—We have two creeks on the other side of the city that have been converted to giant concrete drains. They can be that far from overflowing when there is blue sky. If we have this as well, we may be looking for Noah's Ark.

Ms HALL—We are going to have to leave in an aquaplane, are we?

Mayor Trainer—You may.

Mr Moore—The airport is not too bad.

Ms HALL—Have you noticed in the provision of these services that this council provides to the community any conflicts between the levels of government? Is there a duplication, because of the way the services are currently run and funded, with the competitive tendering—so competition and duplication. I mean conflict and duplication.

Mr Moore—You said 'competition'. Competitive tendering is a wonderful thing if you want to deliver the service at the lowest cost per unit, but the competitive tendering that operates with nursing home beds is another imposition on top of an already skewed system of delivering beds. A good example in South Australia was probably three or four months ago. I think it was in Whyalla. There was an elderly couple, and the wife required residential placement. There were no beds in Whyalla. That lady had to be accommodated 200 kilometres away. I do not know whether it was Port Broughton, but it was certainly on the Cape York Peninsula or somewhere around there. If you are talking about someone—

Mr GEORGANAS—It was Port Augusta, from memory.

Mr Moore—It was a fair distance from where they lived, and they had to travel. I experienced that when I worked in the south-east. One of my lovely jobs was placing people out of the hospital—out of acute sector beds—and into residential care facilities in Victoria, as far up as Hamilton, which was 100 kilometres away.

The issue of competitive tendering is one that will often leave, in my view, a gap. There may well be a higher need in a particular part of the country, but there is no agency currently providing services there. Unless you have an agency that is looking at expanding, you will never know. This is opposed to, for example, the Commonwealth or state or local government putting a case to the system that says, 'We have this acute need in our area for this number of people, and we don't have an existing provider, so we are going to need a range of supports.' I think there needs to be both. It is my view that currently both are not in existence.

I would say that many years ago there was a very high level of duplication of services. That was mostly to do with the fact that the guidelines I was complaining about earlier were not quite so strict. Most agencies now are very wary of the fact they have got finite resources and increasing demand, and so they try to make their dollars go as far as they can. You tend to put in

place a number of additional eligibility criteria so that some services, for example, will not provide a service if they know that the individual is receiving that service elsewhere. That is a very tough call to make. I acknowledge, and most of us do, that an individual might require 10 different services a day. If we are the only ones who are providing a particular service, it is not good for that individual if we do not play, because someone else is involved, so case management, for want of a better term, becomes very important.

Each agency tries to protect its patch—not so much that it is trying to protect its clientele, but it is trying to protect its resources so it can deliver better services. It does not really want to see more than a fair share, if there is such a thing, go to one client over another. The only conflict we ever experience—it is a small 'c' conflict—is when we have a particular client, or they have a particular client, who is unhappy with the level of service or the type of service or the person delivering the service. All agencies try to make that match as best they can, and if someone does not like the service you provide for whatever reason, then in my view they are absolutely entitled to go elsewhere.

The problem then becomes the 'elsewhere' is already delivering its services. We very rarely have any kind of vacancy, as I mentioned before. Turnover in these programs is very low. We might have a client who desperately wants to have nothing to do with us for whatever reason and we are desperately trying to help them move, but we cannot get them a place anywhere else because, in order to do that, someone from the other program has to drop off. Turnover of clientele is the greatest difficulty. Once the person is within a system, there is a tendency to try to meet as many of their needs as you can because you know about them, as opposed to the group I spoke about earlier that none of us knows anything about, but statistically they have a lot of needs.

CHAIR—We are a few minutes over time now. Thank you very much for appearing before us today and giving the evidence that you have, and your submissions. Jill invited you to make a submission about that taxation issue—

Mr Moore—I will do that.

CHAIR—We can have a look at that. Again, I thank you for the use of these facilities and for your hospitality.

Mayor Trainer—I hope you enjoy the remainder of your stay.

[2.17 pm]

MATHEW, Dr Timothy Hamish, Medical Director, Kidney Health Australia

WILSON, Ms Anne Christine, CEO, Kidney Health Australia

CHAIR—We have a number of documents that need to be approved for publication. They are two exhibits from Kidney Health Australia. Could I have a motion that they be accepted as exhibits and received as evidence to the inquiry into health funding? There being no objection, it is so ordered.

I welcome representatives of Kidney Health Australia to give evidence. We have had a private briefing from you and that was very enlightening. The committee is looking forward to hearing your evidence and to the inspection which will take place after this public hearing. I invite you to make an opening statement.

Ms Wilson—I would like to thank the committee for giving us this opportunity to present today. I am going to talk to a brief statement, and then I will hand over to my colleague, Dr Tim Mathew, who will talk to one of the exhibits that we have distributed today.

Chronic kidney disease is now recognised as a significant and rapidly growing global health burden. Chronic kidney disease ranges from mild kidney damage, which may be detected by urinal blood tests in the absence of symptoms, through to end-stage kidney disease, where death will occur unless essential kidney function is replaced by dialysis or kidney transplantation.

One in seven Australian adults have evidence of some chronic kidney damage, and one in three of the people in this room today are at risk of developing kidney disease. An epidemic of diabetes, combined with an ageing population, is creating a greater number of patients with kidney failure, placing a significant strain on the Australian health system. Kidney Health Australia believes that this financial and human burden is absolutely unsustainable in the long term.

Prior to the availability of dialysis and kidney transplantation, end-stage kidney disease quickly led to death. The provision of dialysis services for people with kidney failure is resource intensive, technologically advanced, as you will see when you visit the rental units later today, and extremely costly, as you will hear from Professor Mathew, as evidenced in part 1 of our study of the economic impact and burden of kidney disease in Australia. Despite advances in treatment, people with end-stage kidney disease continue to have significantly reduced life expectancies when compared to the general population. On average, people with end-stage kidney disease will have a life expectancy of less than 10 years, which is comparable to other diseases such as colon and lung cancer.

The first Australian Institute of Health and Welfare report on chronic kidney disease published in Australia in November 2005 reported that care involving dialysis accounted for 11 per cent of hospital admissions in 2003 and 2004. Research by the George Institute for International Health, commissioned by Kidney Health Australia, has identified 754,000 hospital admissions for

dialysis across Australia in 2004. As you are aware from the correspondence that we have provided to the committee, the cost of patients moving on to dialysis to stay alive is conservatively costed at up to $72,000 per annum, with home dialysis costs rising to $42,000 per annum. We note that these costs are conservative because they do not take indirect costs into consideration.

In 2004, 1,836 new patients aged 25 and over commenced renal replacement therapy in Australia. It is predicted that in 2010 the number of Australians over the age of 25 commencing dialysis will be 2,185 to 2,698. Based on this estimate of new cases, we forecast an increase of new cases above the current incidence of new dialysis patients to be between 19 and 47 per cent. Forecasted annual health costs for end-stage kidney disease services see these increasing by tens of millions of dollars every year, with the report forecasting an increase of almost $1 million a week, from $640 million last year in 2005 to $688 million in 2006.

We need to ask: firstly, what can we do to improve the quality and cost effectiveness of renal service provision in Australia; and, secondly, what can we do to stem the incidence of new patients coming on to dialysis programs in future? If we move towards greater provision of home and community based dialysis services across Australia to the levels of the renal units that have most successfully established and maintained such services, we can make significant savings. However, across Australia the delivery of those services is inequitable and some patients in some states have greater access to greater flexibility of modalities of dialysis than patients in other states.

Increasing the number of kidney transplants through improving the organ donor rate is another cost effective and life saving option. We may now see progress after the federal government's recent announcement of $26 million to the coordination of transplant services across the country, which Kidney Health Australia applauds, but what this is looking at it is the coordination of services across the country, which in the area of kidney disease is lacking. Australia needs: firstly, appropriately funded and specifically designed programs for the early detection and prevention of kidney disease; secondly, an appropriately funded national chronic kidney disease strategy to deliver service improvements across the continuum of CKD as it affects patients and families; and, thirdly, specifically funded programs to remove existing barriers currently preventing home dialysis being readily available to those who choose and prefer this form of treatment. Kidney disease in Australia continues to be the silent killer. It can no longer be overlooked by the federal government and it requires specific attention as a most debilitating and costly chronic illness that will not go away. The time to act is now.

You also have before you a communique that was signed by over 100 of Australia's leading nephrologists two years ago that went to the Prime Minister and the then Leader of the Opposition. This was a call for action that Kidney Health Australia continues to make in 2006. To date, this call for action has fallen on deaf ears. It is with great hope that we present to you today—and Associate Professor Mathew will present findings on the economic impact of kidney disease in Australia—that, through your inquiry and through the interest that you have shown in the area of kidney disease, we may be able to make a difference. We may ultimately be able to reduce not only the burden of this disease in terms of the financial and economic impact that it is going to have on Australia's health budget in the long term but also, obviously, the human burden of this disease which will not go away. Thank you.

Dr Mathew—I too welcome the opportunity to talk with you once more. I will primarily be addressing the newly released document *The economic impact of end-stage kidney disease in Australia*, which I believe the committee has had access to. I would like to commence by going back to basics and saying that the vast majority of kidney disease in Australia is caused by four things: glomerulonephritis; diabetes; renovascular disease, which hooks into the same issues as cardiac disease—that is, hypertension, cholesterol and those things; and polycystic kidney disease, which is a congenital or inherited condition. I have been a nephrologist for 40 years—it seems a long time—and it is really disappointing that in that period of time we have not progressed a jot in our ability to cure any of those diseases.

Nephritis has been, historically, the most common cause, but we are still using the same rather ineffective drugs that we were 30 years ago—strange but true. We are losing control of diabetes. Fifteen years ago, five per cent of people coming onto dialysis programs had diabetes. In 2004, which was the last year we have figures for, it was 42 per cent: 42 per cent of all people coming onto dialysis programs in Australia had diabetes. Thirty per cent had diabetes as the cause of their problem, and the remaining 12 per cent have it as coincident thing, where their primary disease is something else but they are also diabetic. Diabetes is now the most common single cause of kidney disease in Australia. Diabetes as a cause for new people coming onto dialysis rose by 25 per cent in the last 12 months. So diabetes is out of control.

Renovascular disease is likewise increasing, despite all the advances and our ability to control the risk factors, driven in part by the ageing population. I think I showed you in August last year a slide showing that the mean age of entry to dialysis programs in Australia has gone up by one year per year for the last 25 years. It is now up around the 60 mark and it is still going up. That is, I think, a sign of not necessarily a change in the incidence of the disease but rather a change in the gateposts. As a society we have changed who can get into cardiac surgery, admitted to intensive care or get onto dialysis. And the numbers are still going up. Having said that, we are still treating only about a fifth of the number of people over the age of 80, on a per capita rate, that the US is treating, so there is still severe gating going on.

The final thing I want to say as a prelude is that we have just done a survey of all the renal units in Australia, writing to each head of unit and asking four simple questions about their resources, leading to their capacity to treat the burden of people with end-stage kidney disease coming their way. Fifty per cent of those replied saying, 'We do not have adequate resources to let medically appropriate people start at the clinically appropriate time.'

You must appreciate that there is an issue of clinical judgment in here, because I do not think many in the nephrology world necessarily want to treat 95-year-olds who may have a year or two to live, such as happens in the US, but we are certainly into trying to make appropriate pathways go forward for younger people and for the majority of people. That is not happening in 50 per cent of renal units in Australia.

We are documenting this further and fleshing it out with more information, and this will be the subject of a particular study, but that is an opening of a window on the dialysis scene. You will see this afternoon at TQEH the cutting edge of that. Professor Russ will tell you that a month ago he told me that they were planning to reduce the number of dialyses offered to each patient in that unit from three a week to two a week. That is unthinkable in best practice terms. The direction is actually going the other way. There are now pilot projects in progress in Australia

where six-day-a-week or seven-day-a-week dialysis is being shown to be associated with much better outcomes—not yet better survival, but that takes a bit of time to develop, but better quality of life, better acceptance, better everything. So the direction is to do more frequent dialysis. And here is a unit, the biggest unit in South Australia and one of the biggest in the country, seriously contemplating cutting the frequency of dialysis back to twice a week. Professor Russ can elaborate.

The economic impact of CKD in Australia is a wonderful study. I have taken snapshots of four or five pages out of it for your benefit. I will talk to those now. It is wonderful in the sense that it is the first study looking at the economic impact of kidney disease in Australia. Part 2 is coming out, we think, in about three months. This is the costing and the impact around the so-called 'end of the kidney road', which is dialysis and transplantation. It is accurate, taking the best published evidence to underpin the costings report. It has been done conservatively, as Anne has said, in that it has looked only at the measurable direct costs. Everything in it has been done by a group of the highest stature. We chose this group because they are semi-academic or academic in nature, as opposed to a more commercial group. The document is a really good read. I would hope that you may find time to read the executive summary and beyond. I understand totally that reading documents like this is rather turgid for the outsider, but there is lots of good, solid information. We are very proud of this document.

CHAIR—Just before you go on—

Dr Mathew—I am very happy to be interrupted.

CHAIR—Just for the record, because obviously we will talk about this afterwards, what is the role of private health versus that of public health in the work of Kidney Health Australia?

Dr Mathew—In providing dialysis services, there is a substantial percentage now of what we call privately based delivery. That would be done in a non-publicly owned institution by a company which charges the patient, and in the Australian scene you can only cope with that by being insured. I cannot give you an accurate percentage, but it would be something like 20 per cent. Roughly 20 per cent of all dialysis in Australia is now being done in the private sector.

Ms HALL—How much is being done in the home?

Dr Mathew—That varies from state to state. In New South Wales, which has a proud record in this regard, 30 per cent of all haemodialysis is done in the home. Peritoneal dialysis, which accounts for about 22 per cent of all dialysis, is always done in the home, so you take that off to the side. When we talk about home dialysis, we do not count that, although it truly is. In this state, it is six per cent. We were the first state to do home dialysis, but our percentage as a percentage of haemodialysis has withered away.

Ms HALL—What is the barrier? You have talked about barriers.

Dr Mathew—We have got some money from the Victorian government to ask all dialysis patients what those barriers are. That is a very good question, and I do not sit in front of you with the answers.

Ms HALL—So it is more the patients?

Ms Wilson—I think it may also be at the health funding end, with the hospitals. There is also a resource issue. Hospitals then need to provide the training to be able to send people home to have home haemo. Then you also have the barriers, certainly at the patient end, where a lot of patients, particularly your elderly patients, are just very uncomfortable about doing it themselves. Having to put the needle in the arm and having to be there and deal with whatever emergencies arise makes people feel very uncomfortable. But over time, if we have the right kind of supports and services available, it is envisaged that home dialysis could certainly be a way of the future that would ultimately, from a funding perspective, significantly reduce the in-unit and satellite costs. But it is about having freedom of choice.

Dr Mathew—What Anne says is correct, but another spin on that would be that it is fundamentally a matter of attitude. I was in New Zealand on the weekend. On the south island of New Zealand you do not get on dialysis unless you are able to go home in one form or another. Their percentage of treating is the same as ours. So they are accomplishing a very high success rate with home dialysis. When I say 'attitude', it is the attitude of the system, it is the attitude of the doctors and the nurses, and that transmits to the patients. The patients are very vulnerable, very captive initially. I am not sitting in front of you suggesting that home dialysis is the best therapy for everybody; but I am suggesting to you that we have lost the plot in Australia. We have lapsed into a situation where it is not given appropriate status.

Every way you look at the success rate—that is, the survival rate, or the quality of life rate or the rehabilitation life rate—it is better on home dialysis. Above all, it gives you flexibility of timing. The so-called 'nocturnal dialysis', which is doing dialysis every night or doing a slow flow for many hours of most nights, can only be done in a home because it ties up a machine for all that time. There is a particular push to do more home dialysis coming out of some of the eastern states that relates to this flexibility. So it is a complicated area. But in essence, home dialysis is seen by Kidney Health Australia—and by the broader kidney community, I think—as something we ought to be doing more of.

Ms Wilson—If we were able to have greater coordination in this area we would be able to provide a better quality of service and greater equity across the country, which is clearly not happening right now. One of the areas that I read the committee is interested in is looking at how there could be greater coordination from the Commonwealth end of these services. That would not only be efficient, but extremely cost-effective and has the potential to provide improved outcomes and flexibility for patients.

CHAIR—How much difference is there between states and how dialysis is handled?

Dr Mathew—There is a central difference in the percentage of patients going in one pathway or another, but in terms of an acceptance rate on a population adjusted basis, there are minor differences, not major differences. We find that states like Queensland and, to a lesser extent, Victoria, switch and change their pathways. If the hospital budget is short, then they will go to the peritoneal dialysis, the funding for which comes out of the separate pathway. So there has been this patching and putting together of various options.

Ms Wilson—It has to do with health funding.

Dr Mathew—It changes from time to time. A state will go through a patch where there is reasonably easy access to money and then it tightens up.

CHAIR—What does that mean for the patient?

Dr Mathew—We have done, as I think you are aware, a CKD strategy, which is really an amalgamation of all people's wishes and identifying opportunities for improvement. In that, one of the key planks we have recommended is choice of pathway. What we are committed to is that the new person coming onto a dialysis program should be given the facts in a balanced way and be able to make a choice that suits them best. That will be peritoneal analysis for some and haemo for another and home haemo for others, and on it goes. If a patient is not given that free choice, they are pushed into a pathway which is not their preference and to which they have some objection.

We had a case reported to our help line in the last seven days, from a state I will not name, that indicates that the shortfall in resources is such that a person who had been on dialysis for only a few weeks was being offered dialysis close to home on one day, 30 kilometres away the next day and then across the other side of town, 50 kilometres away from home, the next day as the only available option. This is an open window through which you can get a glimpse of what is going on out there. We are amazed at the impositions that are being put on some patients to just survive. I am not suggesting that is the rule, but that is happening at the edge of things.

There is another thing that we want to raise. Firstly, I will wind back to the 1970s. The Commonwealth government, in its wisdom—and I think with bipartisan support at that time—introduced a Commonwealth funded program to provide home dialysis machines for all people wanting them. That program lasted about eight years and was seen at the time as being very successful. It allowed programs with which I was associated to get off the ground, to get started, because suddenly we had access to a supply of high-cost machinery that would not fit into the hospital budget. That was the genesis of the new approach, which is to consider that there would be advantage in the Commonwealth again picking up all costs of home dialysis, be that peritoneal or home haemo dialysis, as a separately funded program. Firstly, in one stroke that would even out the capacity from state to state. Secondly, it would promote home dialysis, something in which we have absolute belief as the preferred opinion. Thirdly, it would be cost saving because it would avoid the administrative duplications which currently go on in transmitting the money from the federal budget to the state, to the hospitals, to the regions and to the dialysis programs. If you were interested in that, we would be keen to put a submission together specifically addressing that purpose.

Ms HALL—I would be interested in seeing that so if you would do that that would be great.

Dr Mathew—Okay. I do not want to take up too much time by going through this study, *The economic impact of end-stage kidney disease in Australia*, because it is fairly self-explanatory. I think the first page rather beautifully depicts the growth in kidney services being delivered when compared to population growth. That rate continues at that current level.

I want to speak briefly about the modelling. The words on the next page really underline the fact that this group had access to the ANZDATA registry, which is the database which has documented the key demographics around all Australian and New Zealand dialysis transplant

patients since 1971-72. It is a remarkable database because it is complete and it has got that length of exposure. Therefore it has built up ability for a group like this to go back to it and say, 'As we want to model the future, what are the probabilities that a patient who starts on peritoneal dialysis will do something else in the next six months or two years?' They have taken a cohort and put the transition probabilities, based on real data from ANZDATA, against that cohort and modelled it forward for five years on the assumption that the transition probabilities of having a transplant or dying or having this or that are going to stay fairly similar. It is almost unique in chronic disease modelling to have the hard facts to let you make those assumptions. This has been highly acclaimed by those who have read the report. The people doing it have used discounted dollars in their projections—and I am sure you all appreciate the justification for that; I must say I took some time to come to that appreciation—and that does of course severely reduce the forward projected expenditures. But we are told—and we accept this—that is the way it is done in health economic projections.

Thirdly, the costings are only of adults over the age of 25. There is about four per cent younger than that that you can add to everything. As Anne said, there are no indirect costs in here of any sort or shape, and the impact on the individual patients and their families—the loss of income and the additional costs involved in doing that—are not costed here at all.

Ms Wilson—The quality of life.

Dr Mathew—It is a minimalist costing. If you turn over to the next page you will see the projections of numbers needing treatment done on two levels. One is a fairly flat, so-called linear model based on the fact that there may be some flattening off of new patients coming on in recent years, and the second is taking a 20-year average, going on that six per cent rate. The document is populated by information going down those two projections.

On the next page we see the cumulative spend. I am not very fond of this because this is a cumulative spend so of course it goes up. But it does show that society is going to spend over the next five years or so something like $4.8 billion on this service alone. The next page, which is my favourite page, is undiscounted dollars, so it has that question mark over it from the health economists. It is real dollars in 2004 projected with real numbers—and this is the genesis of the million dollars a week promotion we have been doing. If it continues to grow at a steady state it is almost a million a week and if it is a sharper state than that then it is well over a million dollars a week. It depends on your view of things but that to me is a remarkable figure for an Australian health area to be spending. And that is just coping with the current situation; that is not changing anything—that is our current rates of growth and our current expenditures.

We have modelled in this document two alternative approaches. One is increasing home dialysis and one is increasing transplantation. Because they are discounted dollars the total amounts are reduced. If it is five per cent compounding, which it is, it really knocks your projected five-year savings. With home dialysis, modelled on the next page as New South Wales are delivering it, the total saving against our current approach would be $88 million over that 10-year period. On the next page peritoneal dialysis is modelled the same way. The percentage chosen here are achievable; they are being actually achieved in some states like Queensland and other states, and the rates of decay are carefully modelled in. This is not quick and dirty guesswork; this is careful academic modelling. It shows that there is a substantial saving over a

10-year period of $135 million—again in discounted dollars, which really knocks it down considerably in dollar terms.

Ms Wilson—To clarify, is everyone suitable to go onto peritoneal dialysis?

Dr Mathew—In a hard world, all but about five per cent—those with battle scars and abdomen problems and grossly obese people—have trouble with it. It is suitable for the majority. Certainly, 50 per cent could go on it. Then we have modelled over a 10 per cent increase and a 50 per cent increase. I seize the moment to briefly state that we are excited by the current approach which is being taken by the federal government in funding the Breakthrough Collaborative program which has been done in the state and has been shown to have a 20 per cent increase in donation rate on top of a high figure. The Australians Donate organisation have sought and obtained funds to do that and there have been workshops in the last week to start off the process in Australia of looking at why some hospitals are performing well, what are the factors in those hospitals making that happen and trying to take those and apply them to the poorly performing hospitals.

The point about the savings is that this is real saving; this is not cost-effectiveness. This is actually spending less money. In addition, the quality of life issue is substantial with the transplant.

CHAIR—Did you say the full report is available?

Ms HALL—We have it.

Dr Mathew—This final slide, which I showed you last time, is just the compounding projection. If we can make a difference, which we believe we can, of a modest amount, we can make a huge difference to the total on dialysis in 10 years time.

Ms HALL—I noticed in something I read that there is a reasonable drop-out rate of people undertaking dialysis.

Dr Mathew—The fail rate, the death rate, on dialysis—

Ms HALL—Not the death rate, although I suppose it does end up as a death rate, but people—

Dr Mathew—The death rate on dialysis is very age dependent and will vary from 10 per cent per year under the age of 55 through to 50 per cent per year over the age of 80. The causes of those failures are simple: they are either vascular problems or infections; or they are opting out for what we code ‘social reasons’, which basically means that someone decides not to go on with dialysis.

Ms HALL—That is the area I want to explore—the social reasons. Also, in what I was reading, there was a linkage to specialist trained social workers.

Ms Wilson—There is a huge shortage in that whole area. The social and emotional support for, No. 1, the patients, and then for their carers and their loved ones is at the lowest end. If you

look at a lot of the major hospitals you will be very lucky to find dedicated renal social workers. Some of the big hospitals will have one or two. In conjunction with Launceston hospital we have partly funded a renal social worker to work down there because there was no support for the renal patients there at all. We know of stories because families ring us. Unfortunately for us it has been young people who may have had one or two failed transplants and, when faced with the option of going back onto dialysis, have taken themselves off to die. We have many of those stories.

We also have stories of carers who ring us from remote areas and who say they have had enough and want to commit suicide because they cannot cope with their loved one on dialysis and with the strains that that is imposing. Those are strains not just from physical and emotional perspectives but from the loss of income and the change in financial status. We know we have a large percentage of people from Aboriginal and Torres Strait Islander backgrounds who have kidney disease, but also there are people in the lower socioeconomic groups who are struggling anyway, so when they are hit with this double-whammy their coping mechanisms are very limited. There are limited support services. We have a 1800 number and our health service managers are busy all the time, not talking for five minutes about something that someone has rung up about but talking for lengthy periods of time about deep personal issues that are related to their or their loved one's condition. So we know that that support is minimal.

Ms HALL—I also want to ask you about stem cell research in relation to treating kidney disease.

Dr Mathew—We chose the renal regeneration project, which is a stem cell approach to healing scars in kidneys and regenerating kidney tissue, as our No. 1 choice for our major bequest. We gave $1 million to the Monash unit three years ago to do just that. There is an enormous amount going on in stem cell work. We were keen that the kidney was right up with that and chose that as our preferred project. There is a long way to go in terms of the outcome, and none of us are holding our breath for a quick fix. But you keep getting glimpses of progress, and one would not be surprised if at some foreseeable time it became a deliverable.

CHAIR—For people who have transplants is it expensive to maintain the drug regime?

Dr Mathew—No. We in Australia are blessed with the PBS. All the drugs that are necessary to maintain a transplant are PBS subsidised, so the average transplant patient is on four or five drugs and they spend an amount in the pharmacy and the only additional costs that they have are visiting the doctor every two or three months once things are settled. It is not a high-cost area.

CHAIR—It is over $100 a month.

Dr Mathew—But there is the safety net, which you hit at $700 or thereabouts. I am not suggesting it is minor.

Ms Wilson—You have to compare it with what they have had before.

Dr Mathew—For those on a pension it is $4 a drug per month. In the United States it is different and there are people there who have had to stop treatment and have lost their kidney as a consequence.

Ms Wilson—By comparison, we have costed the cost of a transplant at roughly $15,000.

Dr Mathew—The ongoing costs after the second year are about $10,000 a year. The cost in the first two years is about $65,000, which is much the same as staying on dialysis. That is for the surgery and the hospital costs and things.

Mr GEORGANAS—You mentioned earlier figures showing that 42 per cent of people going on dialysis are diabetics. Is diabetes the cause of the kidney failure?

Dr Mathew—It is 30 per cent of the total and of that it is 42 per cent. You cut the 42 up. Thirty per cent are on dialysis and diabetes was the cause. An additional 12 per cent have diabetes as a coincidental phenomenon, an important phenomenon but not the cause.

Mr GEORGANAS—You mentioned earlier that we are losing the battle of controlling diabetes, and obviously you work closely with the diabetes units in each state. I suppose there is a concern that perhaps we are—not doubling up, as those are not the correct words for it because they are two separate areas—not integrated. When you look at kidney failure from diabetes you see the Aboriginal community has one of the highest percentages of diabetes. Obviously there must be some sort of coordination between the two areas.

Ms Wilson—There is, and I will let Tim answer as to the medical side of things. As far as our organisation is concerned, we absolutely coordinate. We coordinate with the Australian Chronic Disease Prevention Alliance, which also includes the National Heart Foundation of Australia and the National Stroke Foundation as well. I am sure that Tim will comment on the data that we have about kidney disease and heart disease, which is a little bit different from what we have been saying in years gone by.

However, what is important about kidney disease right now is that, whereas there are things that we collaborate and work together on, it is absolutely crucial that kidney disease gets some specific attention of its own. I come to one of the risks that we continually run, and this is in fact the way that it has happened. Kidney disease slunk along for years and years and no-one really focused on it at all. Then all of a sudden you have got an organisation like ours, which is the peak body, saying, as it has been over the last three years, 'We've got a problem here in Australia. We need to focus on it.' So what we are actually saying is we need what we would call an absolutely modest allocation of resources to this area, one that we believe—and we believe part 2 of our burden of disease study is going to demonstrate this—will actually deliver a very significant improvement in long-term outcomes. This is along with the collaborative work that we are doing with the diabetes organisations, the heart foundations and those organisations in the vascular area in working together on modifiable risk factors that are part of lifestyle, which are clearly very important. But we do not want to mix that up with what is absolutely needed to be focused on, because this, regardless of diabetes, is one of the greatest costs to the health system.

CHAIR—Anne, next week is budget week. If we were to take a message back to the Treasurer on your behalf, a wish list, what would it be?

Ms Wilson—The wish list is simple: early detection and prevention. It is in the budget submission that we have put in that has gone to the Treasurer and the health minister. It would be the endorsement and funding of the national chronic kidney disease strategy. It would be to

undertake some work on behalf of the consumer to identify where the consumer's priorities are and it would be looking at health promotion and prevention through things like a water strategy that actually tackles all the chronic disease areas to improve the consumption of water by children from the very youngest stages, particularly at the primary school end, so that we are promoting good healthy drinking habits rather than what is actually happening across Australia right now—and we have been in the media on that in the last week. They are the four things, the four planks, of our budget submission.

CHAIR—Have you had any feedback?

Ms Wilson—No, we have total secrecy right now.

Dr Mathew—We have had some feedback from the minister for health, to the extent that he has made verbally encouraging noises and he has written to you, Anne.

Ms Wilson—Yes, but that was a while ago now.

Dr Mathew—The phone has been silent in the last 10 days.

Ms Wilson—Yes. So we are really none the wiser. That is why, in my opening remarks, I said the time to act is now. Every year that we delay doing something—and what we have asked for, which we believe is very realistic, is a very modest amount—

CHAIR—How much money is involved?

Ms Wilson—of $13.3 million over three years. So it is extremely modest, but it is beginning these projects that is really important.

Dr Mathew—It is so important, not only in the practical terms that we have described but also in symbolic terms. Kidney disease has not been a priority in health, and because of that it has been pushed under the carpet all along the way, and it continues to be. We would see some modest funding in the current budget as being a symbolic message to the bureaucrats in Canberra, 'Hey, take this seriously,' and do something about the ideas we have taken to them, and listen to us and engage us. Because we have got answers, we believe, that are not going to be terribly expensive but that will make a difference to the long-term burden of disease. But we do not have the entry—the diabetes people and the cardiovascular people all have their own strategies and entry points. We do not have those entry points. So I think that symbolically this modest allocation would be a start, a starting point. We are very keen to get this up and I am cautiously optimistic.

Ms Wilson—Yes. We realise time is running out.

CHAIR—Is there something wrong with a system where you are perhaps in competition with all these other people?

Ms Wilson—I think you know far better than us. We have a siloed approach to health funding which to this point has favoured the national health priority areas. We have been told for years now, 'You should work with diabetes.' But the diabetes sector is not going to devote specific

money to kidney disease and neither is the Heart Foundation, the cardiovascular people. So, as long as you have siloed funding, disease groups are going to slip through the cracks. That is No. 1. No. 2 is that we now do have, through the COAG allocation, $1.1 billion. But, with regard to the department that is responsible for the COAG funding, we have met with the assistant secretary, who has gone on leave; we cannot get any sense out of the bureaucrats; and at this point in time, to be quite honest, we are not able to get anything out of the health minister, who has been very receptive towards us, nor his advisers. So as an organisation we are caught between the devil and the deep blue sea in advocating on behalf of kidney disease.

So, in answer to your question, I simply believe that the siloed effect of health funding means that we slip through the cracks. We are living because we are a confederation—our organisation used to be one and we know what it is like and how inefficient that was for us, which is why we changed to a different structure—but the realities of being a confederation and having Commonwealth-state agreements is that you do not have equity across the board. You have different priorities. Queensland has kidney disease up there as part of their chronic disease strategy; other states do not necessarily have that. So, with changing governments and changing departmental bureaucrats right across the country at both state and federal levels, organisations like ours that have not had the grunt in the past get missed out. That is why kidney disease has continued to be unnoticed: there are other voices that are louder, they have been there longer than us and, really, to be quite honest, it has only been the last three years that we have been absolutely out there advocating on behalf of our stakeholders.

Ms HALL—So the strong message to us would be that we really need to look at the way that health is funded overall.

Ms Wilson—Absolutely.

Dr Mathew—The clinical edge of what Anne is talking about is, however, totally committed to working collaboratively with the other entities. A doctor cannot isolate diabetes, heart disease or kidneys. We have to, in all our programs that we are seeking funding for, acknowledge that and build on what has been done already. So at the clinical level it is very much about working together to make it simple for the general practitioner to, in a short space of time, efficiently address the multiple morbidities. It is not that we are trying to create kidney funding silos in competition with the others. We are trying to get funding for kidney issues in the context of a health system delivering combined care.

Ms HALL—Because kidney research fits into the areas of diabetes and cardiovascular disease—isn't that called the sexy end of their research?

Ms Wilson—That is right. It is not as sexy as heart disease and kids with cancer. Yet look at the amounts of money we are talking about. Part 2 of our burden of disease study we believe is going to demonstrate that a strategy that focuses on early detection and prevention at the GP end—and this is GP education—will in fact deliver significant improvements. That is not only from the burden of disease end; that is in terms of cost savings at the other end. Tim, I was wondering whether you could comment on the cardiovascular stuff and the cause and effect data.

Dr Mathew—I think we mentioned at the last hearing in Canberra that new evidence has highlighted the fact that, if you track early kidney disease patients for 20 years, they disappear

not into dialysis programs but into cardiovascular death and morbidity. There is something like a 10 times increase in the risk for cardiovascular disease. So this is an evolving story. When you talk about traditional risk factors for heart attacks, you talk about smoking, being overweight, cholesterol and hypertension. We are not about to add chronic kidney disease as a risk equivalent of those other things.

Ms Wilson—Rather than the other way around—if you have kidney disease you will get heart disease. It used to be that if you have heart disease you were at high risk of getting kidney disease. Now we can say it is the other way around. That then points to increased cardiovascular disease as a result of undiagnosed kidney disease.

Dr Mathew—Kidney disease is asymptomatic—stuff you do not know. One in seven actually has something, but they do not know about it. You only find out if you have a kidney health check.

Ms Wilson—Added to that—and this was part of the AIHW report—are the coding issues around deaths and the fact that kidney disease is often very miscoded. So the death will have been due to kidney disease but the patient died of a heart attack.

CHAIR—What a good note to end on!

Ms Wilson—We just want to thank you for the opportunity and reinforce that if this committee is able to give any message to the health minister and the Treasurer it is that the time to act really is now. We are not being dramatic for the media. We are saying we have the evidence to underpin what we are talking about and we are really concerned that if this keeps being delayed from one year to another we are not going to be able to continue getting people onto dialysis. We have already got evidence right now that there is a need, and there are just not enough beds—that is No. 1. No. 2 is that the burden for Australians is going to increase, and the cost to government is going to be totally unbearable in the long term.

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

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 3.09 pm