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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

FRIDAY, 26 MAY 2006

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Friday, 26 May 2006

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

Members in attendance: Mr Cadman, Ms Hall, Mr Somlyay and Mr Vasta

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

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

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

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

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

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

WITNESSES

Committee met at 9.09 am

FISHER, Professor Malcolm, Hospital Reform Group

GOULSTON, Professor Kerry, Hospital Reform Group

LATTA, Mrs Deborah Jeanene, Hospital Reform Group

MACKENDER, Dr Darryl Richard, Hospital Reform Group

NEEDHAM, Mrs Kate, Hospital Reform Group

SKINNER, Dr Clare Alice, Hospital Reform Group

STEVENSON, Ms Kerry, Hospital Reform Group

CHAIR (Mr Somlyay)—I now declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into health funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. At today's public hearing the committee will hear from a group of New South Wales doctors seeking to improve public sector patient service provision. Also appearing are several health organisations and health economists who have a broader view of how Australian health funding arrangements can be structured. The committee will also hear from the peak body representing the providers with diagnostic imaging services in Australia. The committee appreciates that a number of today's witnesses have travelled a considerable distance to attend the proceedings; on behalf of the committee I would like to thank them for their contribution to the inquiry. This hearing is open to the public and a transcript of what is said will be made available via the committee's website.

The health funding inquiry has been running in parallel with the COAG process that is under way at the moment, where the Commonwealth and the states are examining areas of health reform. We have given many groups an opportunity to have a say publicly and on the public record, under parliamentary privilege, who otherwise might not have had a chance to have any input into the COAG process. I would like to welcome you all here today and, if you did give us a private briefing previously in Canberra, which we found very valuable as individual members of the committee, you have agreed that we can publish those. Can someone move that?

Ms HALL—I move that they be published on the website.

CHAIR—So ordered. Would you like to introduce yourselves and make some introductory comments?

Prof. Goulston—I am Kerry Goulston. I am a gastroenterologist, University of Sydney. I will introduce the people along the table. Kerry Stevenson is an allied health professional from Gosford, Central Coast. Malcolm Fisher is the area director of intensive care for the Northern Sydney and Central Coast Area Health service. Darryl Mackender is a physician from Gosford, Central Coast. Deb Latta is a health care manager. Clare Skinner is a trainee emergency specialist. Kate Needham is a nurse intensivist. But we are here as individuals, not representing

anyone except ourselves, and we are doing so because we care deeply about the public health system, specifically the hospital system.

We are not party political, but we feel it is time for a dialogue between clinicians and the general public. We are concerned that the present system is not sustainable in its present form, and we have striven to come up with positive suggestions rather than just whinge. We think it is not sustainable mainly because of the workforce issues. We think there should be more community involvement in policy decision making. We think decision making ought to be more decentralised to people at the coalface, rather than centralised as it is at present throughout Australia, and we believe in transparency.

What we will do, because what we said in Canberra is on your record, is that I will ask a couple of our members who did not come to Canberra to say a few words about their particular field. I will start with Malcolm Fisher, who is never at a loss for words.

Prof. Fisher—As Kerry said earlier, I am an intensive care specialist, but the views I express here today are not those of New South Wales Health—they are my own—but I believe they are widely shared by other members of the intensive care community. In terms of the future and health funding, the ageing population is having an enormous impact on intensive care in this country. Every year, we spend 14 per cent more intensive care hours caring for people over the age of 80. People over the age 80 take much longer to fix, and they are more likely to die both in the intensive care unit or the wards and within a year of discharge. Many of these patients will be discharged to go home after serious illnesses and have great difficulty coping.

In the United States, where one in five people die in an intensive care unit, they believe that they will need to double the number of intensive care units by 2020 as the population ages. We are very fortunate in this country that dying in an intensive care unit does not lead to financial ruin the way it frequently does in the United States. In Australia one in 11 people die in an intensive care unit; in New Zealand it is one in 22. There has been a change in culture where people believe that it is important they should be admitted to an intensive care unit at the end of life, and often this treatment is appropriate. More importantly, there is evidence that it is against the wishes of many of our ageing population.

One of the problems that we face is that the population is ageing much better physiologically but as deaths due to cancer, heart disease and respiratory disease fall there is an increased incidence of dementia and it is often impossible for us to determine what people's wishes are prior to their being admitted to intensive care. It is also very unusual that their family are indeed aware of their wishes because often they are from nursing homes and their children have not seen them for a considerable amount of time.

Are there solutions to this? There may be a couple. There has been an initiative in south-western Sydney where nursing homes have been visited and it has been pointed out to people what the prognosis is with patients with dementia and it has been suggested that conservative treatment in the nursing home may be better than going to a teaching hospital, triggering a protocol and spending two days on a trolley and maybe getting stented or getting cardiac surgery.

The second initiative started in the Austin Hospital in Melbourne and is called 'respect for choice'. This involves training people to interview people who are on chronic health lists as attending outpatients, particularly those with neurological disease, renal failure, respiratory failure or cardiac failure, discussing their options with them and allowing their options to be recorded, if they wish, in a manner which treating doctors will have access to. At the Austin Hospital this has led to an increase in people who are not receiving inappropriate treatment in hospital but dying peacefully at home. This has been rolled out as a federal government initiative to five other health care districts where it is being evaluated once again. It seems to us very appropriate that people should be given respect for their choices, and people at the coalface can only do this if their choices are known. New South Wales Health and other areas are trying to encourage people to have not only a will and an enduring power of attorney but also some sort of advance directive stating their choices. This has the advantage of removing very difficult decisions from families who really know nothing of the patients' wishes.

There is the matter of the number of people dying in intensive care and the number of hours we spend treating people over 80, often inappropriately. Intensive care is not of its own an inappropriate treatment of ageing people, who may often be put into a coma by a number of different drugs from different specialties. I believe that, as part of your deliberations, both as a funding issue and as a workforce issue—intensive care units are becoming much harder places to attract people to work as people at the bedside question the appropriateness of what they are doing—some efforts should be made to try to change the culture of Australians to enable them to value and document their choices. That would be a very valuable initiative in health care in this country.

Dr Stevenson—The statement for allied health—which has been stated in a few public places by now—is that allied health is not a profession in its own right; it is a conglomerate of professions. So, unlike medicine and nursing, I sit here trying to represent anything between six to eight professions in some organisations and a couple of dozen across New South Wales Health, depending on which professions choose to opt in or opt out. For the purpose of our group, allied health has been put together under anything that is not included in medicine or nursing. The issues for allied health are as broad as there are number of professions available. Our workforce issues are varied. Some of the allied health professions are plentiful; others are very scarce on the ground.

The pay structures and working conditions for allied health are extremely varied. The opportunity for advancement within the professions and across the health sector for allied health is, again, extremely varied but generally fairly poor. There is very limited opportunity for anyone in allied health to move up and through and take their clinical knowledge up to a senior level of management without abandoning their profession. On a personal level, I have moved out of a clinical role; I am in a non-designated allied health position at the moment as a manager. In order to move up and through it is very difficult to represent the professions and what the professions clinically can bring to a coordinated health system under those circumstances.

Mrs Needham—I am here representing nursing from my own personal perspective. I have been an intensive care nurse for nearly 30 years. Just to reiterate what Malcolm Fisher said: patients are ageing and it is becoming more and more difficult to develop the workforce to continue to keep those patients in hospitals. The nursing workforce is depleting—I am sure you all know that. The comment I made earlier was that, whilst they are announcing new numbers

and new universities, it is a 'smoke and mirrors situation' whereby numbers are pulled out of one university and put into a new university. The main message I would like to get across is that we need real new numbers, not numbers that have been taken from a university. This is particularly the case with nursing because nursing does not attract high HECS fees and it is probably not one of the professions that the old sandstones or the more structured universities want to keep in their faculties because it is not financially viable. That may be right or it may be wrong; however, it is important that we do not just move nursing places out of one university to put them into another and cut places as you go.

We need to look at the flexibility of nursing and how nursing has traditionally grown up. The change in putting nursing into universities certainly remains pertinent and important. We need to look at how nurses can do their jobs better. We need to look at being more fluid with what they do and introduce other types of workforce to help them out. Nurses should not be doing clerical work. They should not be doing, in some cases, a lot of cleaning work. After hours in an intensive care unit nurses are spending more time answering telephones than they are at the patient's bedside. Having an additional workforce to actually put nurses back where they belong—at the bedside—is really important.

When you look back—and the past obviously was not perfect—we did not have the distractions that we have now in our everyday job. The one plea that I would like to put forward today is that we really do support the nursing workforce, that we look at it holus-bolus—not in a very linear way—and we become more flexible with its management and support it with other levels of the workforce.

The other thing that I would like to say is that we still need to have clinical involvement in managing and developing clinical services plans. Managers are very important. I have been a manager for 30 years. However, it is very important to ensure that clinicians, doctors, nurses and allied health are involved. Kerry talks about up to two dozen specialties of allied health professionals—anything from physiotherapists to podiatrists. They are very much on the outer and are not involved in any of that clinical services planning. There needs to be more of a marrying back to the middle the managers and clinicians planning services into the future.

Mr CADMAN—Could you clarify those last statements? I do not understand the implications of what you are saying.

Mrs Needham—When you are planning a clinical service it is really important that it is not just managers and bureaucrats from the centre telling you how to plan a particular clinical service such as intensive care, for example. What would someone know who is far removed from that particular specialty? They bring with them a lot of good management skills but you still need to have the clinicians, the doctors, nurses and the allied health service involved in the planning.

Dr Mackender—I do not want to put words into Kate's mouth, but I think that often the traditional silos are the only ones that get a seat at that table and allied health is usually left out of that traditional planning group.

CHAIR—While we are on nursing: you say there is smoke and mirrors with universities, that the actual number of places is not growing quickly enough. Is the number of places being

produced matching the attrition rate? There is a high attrition rate in nursing. I know from my own family's experience that, after 10 or 12 years of doing those late/early shifts, people just burn out. What is the solution to that?

Mrs Needham—It is interesting. It is a difficult situation because it is multifactorial. When I became a nurse back in 1975 there were not as many choices. There are a lot more choices now, from IT, through travel to careers that we would never have thought of back then. The average age of a nurse is around 47 or 48—

CHAIR—Now?

Mrs Needham—Yes.

Dr Mackender—In fact, Judy Lumby from the College of Nursing says it is much like GPs: 40 per cent of them will leave in the next 10 years; they will be over the age of 55. And of course they are being asked to nurse heavier patients.

CHAIR—Of those in the top end age group, how many have been nurses, have got out and have got back in?

Mrs Needham—A small proportion. There have been many programs put forward by government to bring nurses who have left the system back in. However, with night duty, as with your own personal experience, I would say that for anyone around the table, doing a late then an early is awful; but doing night duty for five and six days, as you age, is not a particularly pleasant thing to do—and there is evidence to say that your health suffers.

Dr Mackender—Judy Lumby would have those exact figures.

Prof. Fisher—We are also told that universities in New South Wales are turning away people who wish to train in nursing, because of the number of places. There was one initiative that we had that I think is worth considering, and that is that, for any nurse who works in our intensive care unit who wishes to do a postgraduate diploma or degree, we fund that using a supporting charity. That has made an enormous impact on our turnover and our skill mix. When they get to that state to five years when they are looking for something else to do, if they can be given an opportunity to expand and develop, and they can afford it—which is very difficult for a nurse living on the North Shore of Sydney—then funding that and making it free has had a major impact on retention.

Ms HALL—Mrs Needham, I would like to take up where Alex left off on the smoke and mirrors—moving from one university to another, I think you said. Can you give us an example of where places from, say, Newcastle have moved to Western Sydney or from Western Sydney to James Cook?

Mrs Needham—I would have to check for particular figures, but Sydney University have cut their undergraduate school and have moved the numbers out.

Ms HALL—To Western Sydney?

Mrs Needham—I think they have been spread amongst three or four universities. But, again, it is not going to make money for the universities.

Ms HALL—So, overall, whilst new places are being announced at different universities, they are being cut back at other universities, you are saying.

Mrs Needham—That is something that was well publicised about two years ago, in Sydney particularly. I could not comment on Newcastle.

Ms HALL—I just threw that in because that was the university that came to mind.

Mrs Needham—Sure. Judy Lumby, who is not here today, is very well equipped with the academic side of it; we could certainly give you some validation of that.

Ms HALL—We had a meeting with the nurses down in Canberra. They told us what the shortfall is, and it is enormous.

Mrs Needham—And it will become worse in the next five to 10 years because, as we say, the average age of a nurse is 47.

Ms HALL—It is an ageing workforce, and it is particularly older, if I am correct, within the aged care sector. Is that right?

Dr Mackender—And the patients are heavier. It was interesting: I was at a meeting yesterday and one of the managers of the meeting had just come out of hospital. She had been in the public system for some of her stay and in the private system for the other part of her stay. She talked about the extra workforce that was in the private system hospital, which happened to be a Catholic hospital, as 'God's recruits'. They ran around supporting the nurses to do a whole bunch of cleaning, clerical and other relief work to allow the nurses to do a lot more of their technical and more pastoral and supportive nursing. We have not been creative enough in the public system to support that yet. That is not universal.

Ms HALL—I was reading an article in one of the papers last week that referred to Dr Kerridge. It was about nurse led teams within the hospitals. Would you like to comment on that? Are you familiar with the concept?

Mrs Needham—Yes, I am familiar with that. It is almost a bit old fashioned. However, it is very relevant that the nursing workforce has become so fractured with the many different jobs that they are doing that they do not know what their core business is. Their core business is looking at the patients, giving good nursing care and giving good clinical care. This is not to put nursing care down, but giving high-tech intensive care is exceptionally fulfilling and important, but the more fulfilling and important part of my experience in intensive care giving good clinical nursing care is caring for the patient and caring for their family.

That particular article with Ross Kerridge featured was probably about refocusing the nursing workforce back to what its core business is, and having a nurse that leads the wards, that does a round in the wards and that is there instead of running off to meetings. To ensure that there is good clinical care given to those patients is exceptionally important. The way we have gone

away from that has probably allowed nursing care to diminish and, in some cases, deteriorate. That is a generalisation; there are many wards and many hospitals that give excellent care. But, with having to do more of the general duties, they are getting away from their core business.

CHAIR—Is that meant to be a funding saving?

Mrs Needham—No, I do not think so; it is just the way that it has developed. Nurses are now doing everything. I would see it as saving money by having other, less technical, people on the ground that can do other jobs.

Ms HALL—Dr Mackender, would you like to comment on that? I saw that you reacted.

Dr Mackender—Yes. I think the problem in health care is that we have not brought our silos together around the patient. I thought Ross Kerridge's article was brilliant because he finally isolated, from his point of view, somebody to become his advocate in that ward. I do not know that it has to be a nurse, but it has to be somebody who coordinates the complex system for the patient.

Ms HALL—Would you like to talk the committee through his idea or model?

Dr Mackender—Basically, he was talking about trying to get back to the old days of a charge sister that ran the ship. And if you wanted things to be done in the ward, from a patient's, a doctor's and an allied health point of view, there was a point of contact to start with. Too often, I think, we have split our health systems into silos. We each manage different parts of the journey in different parts of the system for a patient. As a clinician, you spend more and more of your time trying to help the patients navigate the complex system and not fall through the cracks.

Ms HALL—Dr Stevenson, moving to the traditional silos mentality, I would think that affects allied health workers to a large extent. Have you any ideas on how that can be broken down? I might add that we have the Australian Healthcare Association coming to speak to us later this morning. They identified the professional silos as well as the silos in funding between federal and state and how that all relates to, I suppose, a more efficient system that leads to improving the cost of providing health care.

Dr Stevenson—I am always nervous using the word 'silo' to start with. As soon as you break anything up into a manageable unit, it runs the risk of becoming a silo. You can go down the clinical line and say it has been siloed. You can go across sites and say they have siloed. You can go across professions and say they have siloed. Unless you can come up with a matrix which says 'by clinical requirement, the professions, sites and bureaucrats come together with a way of managing clients', the silos will exist no matter what. From an allied health perspective, most allied health people that I speak to do not have a particular concern about the leadership of medicine or nursing per se on a ward. It is more about the ability to ensure that in clinical planning—and that goes to high-level clinical planning, not just the individual patient in front of you, but how care will be delivered—the professions and what they have to offer are listened to and spoken to.

I guess that they are highly intelligent people by and large. These are people who could make great careers, as Kate has said, in some other professions that would probably pay them five

times what they will ever earn in a public health system. From a professional development end for allied health, very few of them have the ability to recognise specialisation in a clinical field. You do that just by working in a unit and, if you have an interest in it, you might be able to go up a minor grade or two if your area health is willing to allow you to be personally regraded. But it certainly does not have built into it the ability to develop great clinical excellence and be recognised for it. So when you find a physiotherapist, a social worker, an OT or whoever else who has exceptional clinical knowledge in a particular area, you will find that they will be, at best, a grade 2, a grade 3 or something like that. They probably are not earning more than $60,000 a year, and yet they will have dedicated an enormous amount of their own personal time and effort into becoming expert clinicians in that field.

On the professional side of things, I think a lot has been said about the fact that we are basically trying to build empires, such as a physio empire. That is very untrue. I think what allied health is saying is that each of the professions within allied health has a specific set of skills and a specific knowledge base that it comes from which comes to the table, and that needs to be recognised. We all know a large amount of generic work occurs in the care of a patient or client. We all did the sociology, psychology and basic anatomy before we got here, so we know that there is that movement around. There is certainly a recognition that, for all of the professions—nursing and allied health particularly—there is now a base level of work that is done by highly skilled clinicians which I believe could probably be allowed down to another group of people—perhaps people who have not spent four years at universities and who are salary capped at a fairly low range.

Mrs Latta—I think it is really getting back to what Kate said originally about bringing everybody to the table to look at how the services are designed, but it is also getting back to what work actually needs to be done, who is best suited to do it and who should be leading the team—a registered nurse, a physiotherapist or whoever. But a number of different people sit as part of that team, and that could even include volunteers, which some organisations have actually put in place in looking after dementia patients, for example. So I think we really have to get back to basics about what work needs to be done, who is best suited to do that and how we bring those teams together.

The other thing I would put forward is that I think we have to get the mentality of all of the groups together from an early stage, because it is very difficult once they are in the system because they become part of the system as it has evolved over a period of time. Professor Michael Field, working through the University of Sydney and the Royal North Shore Hospital, has a program going where he brings the allied health students and the medical students together while they are students to work as teams. They have actually developed that further, and it is working extremely well. I think those sorts of initiatives could actually help that sort of approach for the future.

Dr Mackender—The only other thing that crosses my mind which I think is relevant, and it comes back to the funding, is that there is no doubt in primary care that the whole care planning initiatives have made a difference in primary care and they are now being extended into aged care, but we seem to be not extending them into hospital care. There is no doubt that these elderly patients with two or three consultations while they are in hospital—often they will end up in Malcolm's ward—are just as complex and just as worthy of, if you like, a funded, almost institutionalised, dialogue around their care planning. Unfortunately, there are so many

incentives and disincentives in the health system that it almost comes to that—if that dialogue between nursing, allied health and the medical clinicians is not built into the system, it is hard to organise.

Ms HALL—So what you are advocating is a hospital care plan that links into the patient care plan and—

Dr Mackender—I do not know that I am advocating it, but I just think it is—

Ms HALL—operates within a hospital and then links into discharge et cetera?

Dr Mackender—I know of some hospitals in Australia where they mandate a family conference once you have had more than two consultations or been in more than two wards or whatever, when you know the system is starting to get complicated. Whether that is funded or not, I do not know, but there is no doubt you can pull the levers of a complex system with funding triggers, as we showed with primary care and probably with aged care and mental health care.

Ms HALL—And it leads to cost reductions in the long term. I think that is the important message.

Mr CADMAN—I just do not understand why you think we can do anything about what you are describing. You are at the workplace; why don't you do it?

Dr Mackender—That is why we are here.

CHAIR—That is the next thing we are going to get to.

Dr Mackender—Because it has been frustrating to—

Mr CADMAN—I understand that, but—

CHAIR—Because there is no leadership.

Dr Mackender—I completely agree. If you went to Toyota and said—

Mr CADMAN—But how do we impose leadership when we know nothing about your skills, nothing about your jobs and nothing about the management of patients? We know people are sick, we know that you can fix them up to a fair degree and we want you to do that without inhibition.

Dr Mackender—I agree, and I think the problem is that, whenever there is a problem, there is an incredible amount of blame shifting at all levels, between the clinical silos and the federal and state silos.

Mr CADMAN—And you want us to sort that out?

Dr Mackender—No, not at all.

CHAIR—We are at that point now. The reason why this inquiry is here and why you are here—

Ms HALL—Is to sort it out.

CHAIR—is that we are renegotiating shortly the Australian health care agreements. Half the cost of public hospitals is paid for by the Commonwealth and half by the states, but the Commonwealth provides half of the states' funding anyway, through the GST. The Commonwealth is therefore responsible for 75 per cent of the cost of public hospitals and has zero say in how they are run. What I have been advocating throughout this inquiry—I think we all have—is that the Commonwealth should set a national agenda in health and fund the states towards achieving that national agenda. At the moment, the criticism that the Auditor-General makes of the health department is that they are merely a post-office box between Treasury and the states. Now, either we have a say in something that we fund to the tune of 75 per cent of the total cost or we get out of it and give the funds to the states and step back.

Mr CADMAN—I understand that aspect of it, but it seems to me that what you are describing is merely functional organisation.

Mrs Latta—I think the main issue is that everybody is so busy and to some degree just chasing their tails. Because some of these things that we talked about have not been worked out, they cannot step back to look at it and say, 'Okay, these are the things that we need to put in place.' Managers, for example—and I have certainly been in this position—are spending most of their time resolving issues to the minister or the department of health. As a general manager of a hospital, I spent most of my time sending briefings up about why this, that or whatever was not happening rather than getting on with the work of the organisation.

Mr CADMAN—Do you mean that hospital boards are not in charge any longer?

Mrs Latta—We do not have hospital boards. We do not even have area boards.

Mrs Needham—We do not have boards.

Mr CADMAN—That is what you were saying earlier about localising it to some degree.

Mrs Latta—That is right.

Mr CADMAN—Doesn't that create the innovation and variety of service that then benefits across the board eventually as people try—and sometimes fail, but mostly succeed—to advance the care of patients?

Mrs Latta—There needs to be a mix of the variety and innovation. Also, some things could be standardised; but you have to decide which things need to be, I guess.

Prof. Goulston—It is not just in New South Wales but also in Queensland. The clinicians—doctors, nurses, allied health and the hospital managers—feel disempowered. They do not feel they have a say in decision making.

Mr CADMAN—That would be hugely frustrating if you were a highly trained professional.

Prof. Goulston—Exactly. That is why a lot of them are losing their commitment to the public hospital system. That is what concerns us. In Australia, we have a vibrant private system that is much easier to work in and is more financially rewarding, whether you are a doctor or a physio.

Mr CADMAN—In schooling we have allowed local communities to become more and more involved in the education system.

Prof. Goulston—Not in health.

CHAIR—But you are strongly advocating that.

Prof. Goulston—We are strongly advocating not only that the clinicians at the coalface and local managers have more say but also that accountability is built in.

Mr CADMAN—Of course.

Prof. Goulston—Also that the community have more say.

CHAIR—What is your view of the concept, which I have talked about, that the Commonwealth ought to put strings on some of its funding to be able to achieve what you say you want to achieve? There is the carrot and the stick—should the Commonwealth use its funding power under the national health agenda to get public hospitals working as they should be? We all, the Commonwealth and every individual, have a commitment to public hospitals.

Prof. Fisher—I think we are terrified by more layers of bureaucracy. We spend so much time getting run around by the layers that we have now. The other thing that we have talked about in public is rationalising things a little. Mona Vale in Sydney is an example. If you try to touch someone's hospital, you get all sorts of things that often eventually come down to voting and to people who are not going to act. Many places in New South Wales are not Mayo clinics. They are dodgy. It has also been put before them that you can get anything you want. There are many services we need to rationalise so that there is a critical mass and there are people who are expert in doing things rather than people doing something once or twice a year. Good health care saves money, basically; bad health care is very expensive.

Ms HALL—The Fairfield Hospital example you gave when you were in Canberra was a very good example.

Prof. Goulston—Yes. It is a good example of rationalising hospitals. In other words, Fairfield is a small district hospital out in Western Sydney but the orthopods, as I said before, tried to make it a major joint replacement centre. And so it has built up an expertise in that.

Mr CADMAN—It is local decision making by professionals, isn't it?

Prof. Goulston—In that case, yes.

Dr Mackender—I think it is ironic that, in a national health system, we do not know that we do the same number of hip replacements or colonoscopies or elective varicose vein repairs per head of population, despite the fact we all pay the same Medicare levy. In my mind, unlike other parts of the world where there is a more—

CHAIR—Centralised?

Dr Mackender—Well, there is at least a handle on what is being delivered. Canada is the example that comes to mind. We enable places to occur that, if you like, come from left field—like the whole Queensland Health experience. And that is because we do not all measure the same thing. In some subspecialties—and I think intensive care is probably a good example—there is a lot of good national standardisation. But in a lot of other things you fight for what funding you can get in the complex health system, and whoever screams loudest usually gets the most.

CHAIR—There are problems in the system now. We have had evidence from the specialists that we will not have specialists to train people. I would like to move on to workforce issues.

Dr Skinner—That is probably my topic. I am here as a trainee. I am representing myself, but I think there are generational issues that are spoken of a lot around trainees no longer wanting to work the hours that were expected in the past. I really think that your role and the Commonwealth government's role in this is actually to defragment the current training system. As an undergraduate you belong to the universities, which are Commonwealth funded. You train in the hospitals, which are state funded places. You are taught by clinicians, who are paid for by the state or are privately funded, on their own time. You then become an intern, where you are part of a state system. But you are subject to credentialing by the Australian Medical Council, which is a federal system. You are registered by the state. You work in a state-paid position.

You then become a registrar in the college, which is a national or often international organisation. For example, my college, which is the College for Emergency Medicine, covers New Zealand and Singapore as well. You pay for all of the training courses that you have to undertake as part of that college training yourself. They are quite often delivered by unpaid people. Then you are expected to work numerous hours in the state system, which is part of your training, delivering essential services for which you have to undertake training courses that you pay for yourself.

I really think that, if we want to keep trainees in the system, it becomes very attractive to work as a locum where you are being paid four to five times the amount of money or to work in the private system with limited hours. The alternative is this fragmented system where no-one is keeping control of anything, there is no coordination of which skills are essential, you are subject to a number of highly academic exams that may or may not be relevant to your current clinical practice and you are subject to a lot of state systems which move you around according to workforce needs.

There needs to be some sort of coordination of the training and workforce needs. That needs to be national because the young medical workforce—I am 32 and I am at the average age of

registrars in Australia—are not so young. We generally have good alternative careers that we can go to and there is a real issue at the moment about attracting people of my generation to stay in public hospital medicine, making it easy and skilling us appropriately. I hope you guys agree!

Mr CADMAN—We might fund the universities, but we have little say in how they are run.

Dr Skinner—But it is a completely fragmented system at the moment. We need to start thinking sensibly about workforce needs, particularly around clinical skills.

Mr CADMAN—You want a national perspective on some of those main studies.

CHAIR—If you really think about it carefully, about half of the training is in the university, which is fully funded by the Commonwealth. The other half is in the public hospital system, which I have said already is 75 per cent funded by the Commonwealth.

Dr Skinner—So you own us mostly.

CHAIR—The Commonwealth, again, is paying for the training of doctors, or pretty well—almost 100 per cent—with zero say. In making our recommendations, we want the medical workforce to increase, not decrease. For the life of me I cannot see why we have a medical workforce shortage in Australia. We should be exporting doctors, not importing doctors.

Dr Skinner—That is another issue. But I think the major issue here is that we need to make it easier rather than harder for someone to get through specialist training. We need to coordinate it, financially support it and make the jobs attractive. Malcolm made a point earlier about the ageing population. That is a major pressure on the training workforce at the moment. A significant portion of your time is spent in outer metropolitan hospitals looking after geriatric staff—I am sorry; geriatric patients—without good consultant support. That is not fair.

Mrs Latta—And geriatric staff too!

Dr Skinner—Yes, looking after geriatric staff occasionally as well!

CHAIR—The definition of a geriatric is someone older than you are.

Dr Skinner—I have actually dealt with real geriatrics. I went out at one stage yesterday in my department and there was no-one waiting in the box who was under 90 years old. That was in the acute emergency department major trauma centre. That is not appropriate.

Ms HALL—For the record, do you all believe that there should be more training places made available for doctors in university, not just shifting numbers, as well as more places for nurses and allied health?

Dr Skinner—I think that is true, but I think also we need to make sure that the training is efficient, appropriate and directed to future workforce needs. I think that at the moment a lot of the training is historical. We train people and we do not know what we are sending them out to do.

Mrs Latta—I think we talked about this last time—there is no point in giving the extra training places if we then do not have a good training program that sits behind that.

Prof. Goulston—I would like to add an unequivocal yes. Addressing your point earlier about the Commonwealth's responsibility, the Commonwealth does fund the training in universities. Most people come out into the hospitals for skills training. We teach them—whether they are doctors, nurses or allied health professionals. With the majority of that teaching, I do not think the public are aware that it is done on an honorary basis. There is no funding. So if the Commonwealth actually puts more places into universities, which it recently did, and some of them are fee paying, my colleagues are teaching them. These are colleagues who are working their guts out and who are getting more cynical and dissatisfied with the system. They are asked to teach not only medical students but—

CHAIR—They are private specialists, VMOs?

Prof. Goulston—Yes, VMOS particularly in the smaller hospitals. They are in private practice; they come and teach for nothing in our hospitals. The staff specialists like Malcolm do a lot of teaching. They are on a salary, admittedly, but the Commonwealth does not recognise the problem, and this applies to allied health as well, of their ongoing education after graduation in the hospitals. No-one talks about it.

CHAIR—We are.

Prof. Goulston—It is a major issue and a major problem. We are having more and more trouble getting people to teach, because it is one thing about which they can say, 'I'm sorry, we believe in the Hippocratic oath, we love to teach, but we're flat out with private patients in the private system; we're flat out in the public system looking after patients.' So the thing that goes is the teaching.

CHAIR—When wards are closing in public hospitals, the clinical places are not there, are they? That brings me to another point that has been raised with us on several occasions: how do we get some training done in private hospitals? How do we make the private sector—

Dr Skinner—It is a very difficult issue. The No. 1 thing that people say to me is, 'Can I go private so I don't have to deal with a registrar?'

Ms HALL—Do any of you work in the private sector as well?

Prof. Fisher—Yes.

Prof. Goulston—Yes. Most do. Even if they are on a salary in the public system, most of them have some right of private practice outside. Malcolm does North Shore Private as well as North Shore public.

Mr CADMAN—That is an interesting arrangement there.

Prof. Goulston—Yes, it is good.

Dr Mackender—You have probably had presentations from surgeons and specialists, but I suspect that, in some of the subspecialties, particularly in surgery, they must be running out of stuff to teach on in public hospitals, because so much of their day-to-day work is now being done in private hospitals. I think it is difficult but it is possible. It probably needs to start with community engagement and explaining to people that, with a private hospital, there is some give and take about teaching there and that we won't have anyone to staff those private hospitals if we don't start teaching people wherever the patients are.

Mrs Latta—There is a Commonwealth group looking into medical training in private hospitals, community settings and so forth.

Mr CADMAN—With respect to education, are we absolutely locked in to a university based nursing process?

Mrs Needham—No, that is changing. Certainly, there are different categories of nurses. There are enrolled nurses, who are going through a TAFE course. With the registered nurse training or education, they are looking at different models for that.

Mr CADMAN—What does 'looking at' mean—in five years time we decide to take a tentative step?

CHAIR—Do you mean back to hospital based—

Mrs Needham—No. I don't actually think we should go fully back. There is a mixture. It is being discussed. They are looking at different models.

Mr CADMAN—Five years time?

Mrs Needham—Nothing happens quickly.

Dr Mackender—There must be some potential in private hospitals for nursing education to come in.

Mrs Needham—To be fair, there are nursing undergraduate places in private hospitals. I think that has actually been more developed than medical education.

Mr CADMAN—Are you talking about the San? I don't know what—

Mrs Needham—Yes, private hospitals—North Shore Private, the Mater, Strathfield Private, St Vincent's. They have come to the party quicker with nursing education undergraduates in their hospitals, because of workforce issues. It is a way of attracting those nurses when they graduate back into their hospitals.

Mr CADMAN—Have they been successful in attracting people?

Mrs Needham—They are placed there. They have a workforce problem as well, but at least they are engaged in the undergraduate training. Those undergraduates are exposed to the private sector, so they may in turn go back there.

Prof. Fisher—If I may, I will return to the other workforce issue in New South Wales that we are trying to deal with, which relates to Clare and other people who when they train do not want to work in the way that we worked. This was really brought home to me when I was investigating a death in a hospital out west. I spoke to a young man who was an overseas graduate and an emergency medicine doctor who had absolutely no intention of training because he could not afford the drop in income. He worked four 12-hour shifts a week as a CMO. He said that if he went off to train he would work longer hours and earn half as much and that if he became a specialist he would earn $30,000 a year less than he made as a CMO. We really need to be creative about harnessing this part of the workforce and turning it into an asset rather than the liability that it may sometimes be because of the lack of training and supervision.

Mr CADMAN—What are CMOs?

Dr Skinner—Career medical officers are people who do not choose to get specialist qualifications. Instead, they work clinically in hospital and their industrial grading is based on their time served and their clinical experience rather than on any academic qualifications.

Mr CADMAN—So they become generalists?

Prof. Fisher—Yes.

Mrs Latta—There is another aspect to that though. They do not necessarily get any further training, which is part of the issue. They need to be encompassed into general training.

Mr CADMAN—You're in a parking station?

Mrs Latta—Yes.

Ms HALL—You have identified a fairly important issue: the need for training for career medical officers, being ongoing training linking with the training structure.

Prof. Fisher—They are the only group that has really no maintenance of professional standards.

CHAIR—How many of them are there? What types of hospitals are they in?

Prof. Goulston—They are often in the smaller hospitals—the outlying hospitals in Sydney and rural based hospitals. New South Wales is doing something about it. The Institute of Medical Training and Education is designing a career education structure for those people, and I think that will happen more and more.

Dr Skinner—However, there are industrial issues as the career medical officers sit in parallel with specialist trainees and the specialist trainees have different pressures put on them and are quite often paid less than the career medical officers. So there can be a financial disincentive to joining a specialist program, which I think is a concern.

Ms HALL—But over the long term you would be a lot better off as a specialist than as a career medical officer?

Prof. Fisher—Not in emergency medicine.

CHAIR—So, Dr Skinner, you are saying that in your discipline there are financial incentives for you to become a CMO?

Dr Skinner—There are financial incentives for me to work as a locum.

CHAIR—What do you mean by 'as a locum'? In the system?

Dr Skinner—I will give you an example. **Prof. Goulston**—Perhaps define a 'locum'.

Dr Skinner—A locum is someone who does ad hoc shifts working for an agency in emergency medicine. A survey done by New South Wales Health in February 2004 showed that there are currently vacancies of the order of 400 to 500 places for emergency registrars in New South Wales hospitals, which means there is a considerable black market for people who are emergency registrars. To give you an example, I earn $32 an hour in my current job. I work all around the clock, including shifts that are not great for my life. I could pull in of the order of $150 to $160 an hour for those equivalent shifts if I were working in a private capacity on a contract.

CHAIR—So it is the same as agency nursing?

Dr Skinner—Yes. That is a massive incentive for a lot of people to pull out of emergency training in particular. It is not quite there in other specialties to the same extent.

CHAIR—Is that happening?

Dr Skinner—Yes, it is. There is 10 to 15 per cent attrition. When you are not feeling particularly loyal to your system and you are not feeling valued by your system, there is a viable alternative. That is dangerous, because those people are not known to the system and they have no training incentives whatsoever.

Dr Mackender—Our workforce is increasingly female with the people being in their mid-30s by the time they finish, because they were mature-age students.

CHAIR—We know the problem, so what is the answer?

Dr Skinner—The answer is to make public hospital work in those critical care disciplines, which are currently so short staffed, better remunerated and, in particular, better valued. A lot of people say, 'If I felt that I was valued by the system and I had good child care and I could park the car there and I could eat a meal there and I was given some training, I would be loyal to the system.' The moment that loyalty evaporates is when people start saying, 'I'll join the private sector.' The other issues are around hours. We know that the safe-hours stuff came through from the AMA in 1996 but it exists mostly in word only because staff shortages mean it cannot be implemented. That means there is considerable workload pressure on specialist trainees, which means that working as a locum becomes attractive, because you can determine your own hours instead of being subject to short-notice shift changes, which is currently the situation for most specialist trainees.

CHAIR—We had the South Australian government appear before us, and they were very good witnesses. They were very competent and very proud of their system. I was hoping they would provide an example to the other states here before us.

Dr Skinner—This is a major issue for all states at the moment. With Virgin Blue offering flights that cost $60 from just about anywhere in Australia to Sydney, we are getting workforce from New Zealand, Melbourne and Adelaide. We are actually pulling workforce from elsewhere to perform these shifts at high rates.

CHAIR—We have the states competing with each other to bring doctors into Australia. The Premier of Queensland was in London for a week.

Dr Skinner—Most hospitals that I have worked at actively recruit overseas each year.

CHAIR—Yes, the hospitals do.

Dr Mackender—The state health departments are just starting to wise-up to it. Gosford, for years, has relied on the UK holiday crowd to staff 50 per cent of its junior medical officer shifts. Last time we went to the careers fair, the state government was there.

Dr Skinner—To give you an example: I work at Royal North Shore Hospital, which is a very popular teaching hospital. It is one of the better places to train in emergency medicine in Australia. It is a major trauma centre, major burns centre and major spinal centre, so good clinical experience can be gained there. I am one of three Australian trainees on the registrar roster out of 12 to 15 at Royal North Shore Hospital, which is an attractive place to work.

CHAIR—Where are the others from?

Dr Skinner—The others are from the UK, New Zealand or South Africa.

CHAIR—Are they going to stay here?

Dr Skinner—It is a mixed picture, but probably not. They are here for two or three years. To give us our dues, the emergency training program in the UK is recognised as weak, so a lot of those trainees choose to come here and do their qualification here instead.

Prof. Fisher—We have four senior registrars. They come from Norway and Germany, and we have two Australians this year. We had one Australian last year. One thing is that we are able to attract people who want to come here to train, whereas once upon a time everyone went to England and was used as slave labour. We are not allowed to use them as slave labour, unfortunately, but we are propped up by being able to train as well as to recruit for financial reasons.

CHAIR—But, again, that is a big workforce issue.

Dr Skinner—Absolutely.

Prof. Fisher—Yes, very much.

CHAIR—You will not solve this problem in public hospitals until you solve this workforce issue.

Prof. Fisher—Absolutely.

CHAIR—So where do we go? Help us. Now that the Commonwealth has a Minister for Vocational and Technical Education, I really think it ought to be looking at the medical professions as part of vocational education and training.

Dr Skinner—I speak about medicine, because that is what I know, but these issues are common to all of the health professions. For example, the nursing workforce in my department is primarily from the UK.

Prof. Fisher—It would be very interesting to create an oversupply of doctors and see what happens. No-one has ever really done that.

Ms HALL—That would be interesting.

CHAIR—Is it possible?

Prof. Goulston—Just increase the number of places at university. The catch, as I said before, is that once they get out of university you have to have people like Malcolm and others to train them.

Dr Mackender—Certainly in New South Wales we have a big blip of interns coming through in the next few years, from some increases in numbers and a new medical school that commenced about five years ago. We are actually going to experience that in the next two or three years, because we are going to have a whole bunch of extra first- and second-year-out doctors to train in our public hospitals.

Mrs Needham—But we also need to keep nurses in the workforce to help those interns assimilate into the wards. The one thing about interns and young residents coming out is that they need that back-up, that support and that understanding of how the system works. There will be an influx of interns but there will be a downturn of good, experienced registered nurses.

CHAIR—Do we need some more medical schools? In my area, which is a fast-growing area, and places like the Gold Coast are now talking about co-locating universities and hospitals, and training the workforce so that they are linked together and there is recognition of the clinical training involved in medical training. Do you have a view on co-location? Would it make it easier?

Prof. Goulston—I do not think it would make any difference. In New South Wales, for example, you have created more medical schools—at the University of Western Sydney, the University of Wollongong and Notre Dame. The problem is that they are now squabbling amongst themselves to get clinical placements in the hospitals. That is where the block will now occur—and also with the workforce to teach them once they get into the hospitals.

CHAIR—Does the Commonwealth have to take a role in that?

Prof. Goulston—Yes, definitely.

CHAIR—Instead of just concentrating on the university places they must play a role?

Prof. Goulston—You said yourself that you had a lot to do with providing the finance so surely you have a responsibility also to make sure that education continues.

Ms HALL—What role do you think the Commonwealth should play in that and how do you think they should play it?

Prof. Goulston—You can provide extra funding and extra sticks, if you like—

Ms HALL—So it is a funding role?

CHAIR—For clinical places.

Prof. Goulston—For clinical placements—not just for doctors but also for allied health—and some reimbursement for potential time for the people who are teaching.

Dr Skinner—I think there is a need for some nationally coordinated teaching strategies for those new graduate doctors and specialist trainees. Quite often there is a problem. We rely very heavily on local staff to provide programs when a lot of it is common training and there could be the development of some national teaching strategies around those things and some delivery which allows economies of scale. Train one place to do something, get one place running a program well, and then deliver it nationally, roll it out nationally. That helps with national accreditation standards but also helps with delivery without relying too heavily on local staff doing something that is going on elsewhere over and over again.

Ms HALL—Is there a problem with national accreditation standards?

Prof. Goulston—No. I come back to something Mr Cadman raised which is linked to this, and that is teaching in the private sector. We have now a large number of private hospital beds but private hospitals do very little teaching, whether it is of doctors, medical students, radiographers or physiotherapists. The teaching is primarily done in the public sector. I think the Commonwealth could use some stick nationwide to encourage the inevitable, which is that teaching has to occur in the private hospital sector. It will happen. We will deal with the culture change amongst our colleagues; it would help if you did something on a national scale to encourage hospitals in the private sector to teach. Ramsay have done this successfully at Greenslopes in Brisbane. But not much is happening elsewhere.

Ms HALL—If training extends to the private sector would it have any negative impact on the public sector? I have been told that a lot of the attraction of working in the public sector is the teaching and training role.

Prof. Goulston—That is true.

Ms HALL—Would that impact on public hospitals if teaching extended to the private sector?

Prof. Goulston—I do not believe so. It is the same people.

Dr Mackender—If there was a fixed number of people to train then maybe that is a realistic problem. In reality, we are talking about needing to train more people in nursing, allied health and medicine. We are saying: let us not overload the already disenfranchised and disillusioned public sector.

CHAIR—You have the obvious problem with training in the private sector in that the patient does not want to be treated by a trainee when they are paying for it.

Dr Skinner—The private sector and the public sector offer very different training opportunities as well. The public sector offers good, general bedside medicine. The private sector offers people with one problem, people with surgical procedures and people in outpatient settings. I think there are different training opportunities. Current trainees miss out on some of those opportunities available in the private sector, and we need to get more of them as well.

Dr Mackender—The old model we had was that if the registrar did the procedure then he was pretty much doing it on his own. If you actually talk to the people in those procedural specialties now, the stuff they are doing is so complicated that they are not unsupervised. If the registrar is doing it, almost always there is someone standing beside him and he is really not doing the procedure, he is assisting the procedure and it is a degree of assistance. It is a public perception thing; all my patients ask me whether I am going to do the procedure. I say yes, but I also tell them that my registrar will be there.

Prof. Fisher—In the private intensive care unit at North Shore we have approved training positions which we use. It has just come to me that I do not think that there have ever been people there who were not Australian graduates in those positions rather than the unit across the road. It is approved for one year of training and they often allow us to have a look at people who will move into the other one or they may go in the other direction.

Ms HALL—How popular are they? Do you fill the places every year?

Prof. Fisher—It is sometimes difficult. We have regulars who fill in. We have one lady who likes intensive care but she is a doctor for *Survivor* three months a year so she cannot really train. For some of the time when she is in Australia she will work with us. The thing is that if someone is sick or anything then Ramsay has to buy somebody, which is $1,000 a day. It is expensive because it is a much smaller workforce, basically. We have always managed to fill those positions, I think.

CHAIR—Professor Goulston, would you like to sum up?

Prof. Goulston—We are here as individuals; we are not representing anyone else except ourselves and our own views. We are not the usual organisations that appear before you; we are people from the coalface. We are very happy to answer any further follow-up questions. We are committed to and worried about the sustainability of the public hospitals in particular. What we have discussed today is more community involvement in decision making in that system and we would like to see that much improved.

Mr CADMAN—Could you write to us about that? Would that be possible? We touched on it enough to know your intention but not possible remedies.

Prof. Goulston—Okay.

Ms HALL—The citizens' juries.

Mr CADMAN—Exactly.

Dr Mackender—Lyn Carson could not make it today; she is in Italy. I know she is keen to talk more with the group.

Prof. Goulston—Lyn Carson would be the best person.

CHAIR—We might invite her to Canberra. Thank you.

[10.24 am]

GROSS, Mr Paul Francis, Director, Health Group Strategies Pty Ltd

CHAIR—Welcome. Would you like to make an opening statement?

Mr Gross—With pleasure. It is good to see some old faces I have known for a long while here. This is my 44th year in the health business. It is a very timely inquiry. In a nation where often more is said than is done I hope this inquiry will do more than talk. My background is in health services research, directing it at the state level, and intergovernmental relations at the state level here in New South Wales. I was a commissioner of the Whitlam and Fraser hospital and health services commission at the national level. I was adviser to many governments at the federal level internationally and at state government level in New South Wales. My most recent inquiry as a member was as a member of the state health advisory council here in New South Wales. I am also an honorary professor at the University of Hong Kong and see a lot of Asian health systems.

With that background you certainly do not expect me to duplicate what you have just heard from a bunch of committed individuals who are fearful about the future of the public hospital system. Whatever else I say to you this morning, I would like to share their fears. But I want to talk about the broader health system in which we all exist, only because I think there is a danger of it being ignored in this inquiry. The interfaces between the two are critical to the future funding of health care. It is an $86 billion health care system that we have today—that is, $4,300 per head. So look at those alongside you in this committee hearing and ask: where did you spend my $4,300 last year? You will not know the answer because it is a system that is absolutely hidden from the view of mere mortals. It is a system that is split in its funding about two-thirds to the public system and one-third to the private system. But the private system is growing, as are the out-of-pocket costs of this health system to the ultimate payers for all health care, you and I. We, in the end, pay for it through whatever route we choose.

In my submission to you I have tried to identify problems that need fixing with ease and problems that do not require wholesale disruption of the system and the addition of a third level of government. I speak with conviction on that particular score because I was once a commissioner of a national hospital and health services commission that had many of the roles that are proposed for a third level of government. I have to say to you that we were eminently successful at the time by staying small and then getting out of business because we had finished our work. The notion of a permanent commission above two levels of government is to me a fatuous waste of time.

Ms HALL—Could you put a time frame on it for me, please?

Mr Gross—It was 1974 through to 1978—years ago. In my submission I have tried to talk about a system that has its problems. I describe it somewhere in the submission as an inelegant funding system. It is not yet a system in crisis, but it is a system that is heading towards a bigger and bigger mess. That mess can be arrested by the activities of this committee. I have tried to identify for you particularly the problems of the sickest. I draw to your attention a survey

released in April, less than a month ago, by the New York based Commonwealth Fund, the third of a number of international surveys it does of different nations. It tells us once again that in our care of the sickest it is uncoordinated and unsatisfactory.

In its most recent survey the Commonwealth Fund tells us that out-of-pocket costs are rising, despite the safety nets, despite health insurance and despite everything we are trying to do from government to help the average citizen. I draw your attention to a chart in that report which shows that even amongst high-income people interviewed in that survey about a third of them did not take up a drug they should have, did not go to a medical or did not attend a hospital. So we have a system here where how we pay for care is starting to affect the access of the sickest. If anything else in this inquiry needs a priority it is this challenge because, if we cannot look after our sickest, it seems to me we cannot claim to be a caring society.

I have also drawn to the inquiry's attention some gaps that I see. I will reiterate them here but I will summarise them in a different form. I was in Victoria yesterday looking particularly at wound care. In another study I am doing at the moment for other clients, I am looking at cancer care. In my daily work in two states right at this moment I am seeing the sickest and those who have wounds that are creating angst and low quality of life. But if I had to say to you the thing that worries me the most about this inquiry it would be that I think the system is underfunded at the moment—and in my paper I have suggested to you the sum involved—to the tune of $5 billion to $6 billion out of the $86 billion that we are now spending. The most conspicuous gap is in the information technology that we need to help doctors and nurses make decisions that are safe and effective. We need to fund the care of the cancer patient. By my estimates, we are about $1.5 billion short in cancer care already. Aboriginal health screams out. We have plastered up the mental health crack with a $1.8 billion investment, not yet matched by all the states, and that investment was way overdue. In home health care we are pathetically, lamentably deficient in all regards. Hopefully, by the end of this inquiry, you might be able to ask, 'Why is it that the lowest cost care is not funded and used and that we are one of the highest users of hospitals in the Western world?'

I said to you, in the latter part of my submission, that Medibank in its original derivatives and Medicare derivatives have created a society that has the entitlement mindset. As a result of that entitlement mindset, as consumers we are not really turned on to the notion of self-help and personal responsibility in looking after our health status. Yet 15 diseases that afflict this nation are responsible for between 55 and 60 per cent of the rise in health expenditure in the last 15 years. Most of those 15 conditions are chronic conditions that are not being attacked at source. If they were, 62 per cent of our population would not be obese or overweight today and we would not be screaming for action from the federal government to protect our kids. Given that obesity is implicated in six of those chronic conditions, it will come as no surprise to you that I have recommended somewhere in my report that we use Medicare with private health insurance—uniting the two—as a new strike force to attack obesity at source with a new national program.

I conclude by saying that you are seeking solutions. I heard that lament in your request to the previous group. Reforms are needed now to develop out-of-hospital care and to pay for it. The HACC program is chronically underfunded. It is a federal-state program. You cannot sit here as a federal committee and ignore federal-state programs. I said to you in my submission that we are paying for good and poor quality care equally and, by my count, three per cent of the health expenditure we are now spending is waste due to medical errors, some of which can be removed,

but not with the absence of the information technology that we need in Australia. We cannot blame doctors for every error. In the end it will come down to recognising, as other entities in this world do, that heavy investment in IT is needed. By my count, another $2 billion to $4 billion a year is needed now in the hospital system to link it to community services.

But you are also seeking a solution at the federal end—what to do about this unholy cacophony that arises between federal and state governments every time there is a problem. My suggestion to you on page 31 of the submission is that, in lieu of a large reform commission that sits on top of federal and state governments and virtually acts as a third political arm—something that is destined to fail, in my view, from the beginning—Australia, through this particular committee, could create a short-term solution and a longer term solution. The short-term solution, on page 31, is the equivalent of a commission on a high-performance health system. Let us aim for the best. Let us aim for a high-performance health system in which people can actually see what they are paying for. That model is a model that I have drawn from the United States, again from the Commonwealth Fund, an independent entity with public and private sector expertise on it.

The major lament I have about all the other proposals that are before you at the moment is that they seem to ignore the fact that the private sector is there and growing. You cannot let it sit there untouched. I am suggesting a longer term reform at the national level in lieu of the current COAG process, which is entirely government oriented, secretive and formulated to reach its conclusions by ticking a box at every meeting. We look towards a model similar to the German system, which in the old days was called concerted action—the German concerted action program. It was, again, a blend of the public and private systems, and within the government system, the federal government and the state or lander governments, as they are called in Germany, to reach broad conclusions on what should be funded and the priorities that ought to go into funding for a three-year period. Of all the talkfests that we lack at the moment in Australia, it is this talkfest that would aid your inquiry into health funding mightily. It is a talkfest where you know anything about what the private sector is planning for the next three years. You have heard this morning from a very eloquent witness about the options that exist for not going back into the public system, and a private system that is growing because the patient can recognise quality.

I conclude by saying that I seek from this committee, above all else, a review of health funding in Australia that links the public and the private sector in a short-term inquiry that has three small goals. Firstly, identify the shortfalls. You will not be able to do that in this inquiry. That can be done in two to three months. We have talked about it enough. Secondly, find some mechanisms for attacking the high-priority issues, of which chronic illness and obesity is a lay-down misere starter, because you have heard again today about silo care. Silo care is what we do have in Australia: funding for primary care separate from PBS; MBS separate from what is paid for in hospital outpatient clinics; public hospital data on patients in outpatient clinics but we do not know where they go to—they are not counted in the stats so we really do not know how much ambulatory care we have got in Australia or its quality. So the second aim of that commission is to find a vehicle for attacking the high-priority cases.

Thirdly, above all else, something that you can point the way to, is enabling the federal government to figure out for the next 10 years, with budget surpluses we may or may not have, with economic situations that may or may not be better than today's international economy, how

much we can afford to pay and then telling you and me, the citizens, how much more we are going to have to pay for health care to achieve these particular goals—instead of leaving me absolutely beguiled and befuddled by regularly rising health insurance premiums where I cannot see what I am getting, a debate between federal and state governments on the front pages of newspapers, queues in public hospitals, no home health care, inadequate funding for cancer care and, in surveys like the Commonwealth Fund, people screaming their disappointment with the existing system. No matter how good it is, the public is telling us something different and it is time that we listened. Thank you.

CHAIR—Thank you. Were you here from the beginning of the hearing today?

Mr Gross—I was.

CHAIR—You would have heard me talk about the need to have a national agenda, which we just do not have. We had it under your commission, the Sax commission, I think it was called.

Mr Gross—It was.

CHAIR—That was an attempt to set a national agenda and fund it through the states.

Mr Gross—It was.

CHAIR—The Auditor-General has observed very strongly that the system now is that the Commonwealth health department or the Commonwealth at least has become a postbox between Treasury and the states. There is very little input by the Commonwealth into what public hospitals do and what they should do. You are talking about a national agenda now and I have been talking about a national agenda. If you were renegotiating the health care agreements—they are coming up for renegotiation in about two years—what would you want to see in those agreements that would achieve a national agenda?

Mr Gross—It is quite simple. I would be signalling now that the next set of agreements will be different from the current set. I would be signalling that they will be different in the following respects. There is another level of government involved here, by the way, already. You have heard their submissions, and they are quite eloquent. There is a local government providing care as well—in fact, much of it in the home and in the community. I would be signalling that in the future all of the agreements that involve public sector allocations from fed to state to local will be performance payment driven, that all payments to public hospitals from the state will be in the form of a pay for performance allocation rather than a case mix hospital payment, which is what we have tended to rely upon.

The model is the model that, to give you an example of an entity at the Commonwealth level that is thinking way ahead, the department of vets affairs is now considering in its contracts with private hospitals. The hospitals will be paid more for the quality that they are able to be measured on, not for their claims that they have a great system. We are measuring it.

Four of the five criteria have to do with efficiency of use of resources; patient safety, which I mentioned in my testimony; patient satisfaction, the extent to which the patient is totally satisfied with the hospital visit; and the extent to which the hospital creates a linkage with care

outside the hospital walls by informing the patient before they leave the bed about what they will need to with their congestive heart failure. That is a condition that is going to kill a lot of us if we are overweight, if we have a chronic heart condition to begin with, if we are eating wrongly and not exercising and, for many of us, if we are not on our ACE inhibitor. Six or seven days after I get out of hospital my GP and I would like to hear from the hospital that I actually am on an ACE inhibitor that I was put on in that hospital. My GP should be looking at me to see whether or not I am exercising and losing weight. My family should know I should not be eating salt and other fatty substances.

That is not what happens in Australian health care. It is what is described in the document I am holding up now. I will leave it with the committee and table it with your approval. It is entitled 'Kaiser Permanente: population management for chronic conditions'. It was a speech given in September last year by Warren Taylor. Kaiser Permanente is a not-for-profit health maintenance organisation treating about nine million people in the United States, six million of whom are in California. It is the benchmark, and it has always been the benchmark in my 44 years of health care. I first went there in 1965.

The patient I am talking about who is coming out of the hospital with congestive heart failure will not have any of the care that the Kaiser patient gets automatically. They will not have somebody automatically following them up from the hospital into primary care. I am hoping that by the time you have come to the end of your conclusions you will have said that the next agreement will therefore be performance based and that amongst those indicators will be the extent to which the hospital integrates with community care. There are ways of doing that. We talk about doing it here but the funding is not in place to do it. So we have to think about how to do that and you will have to read this document to see the way in which information technology makes that possible.

The third thing I would say to you is that I think in the next agreements there will have to be an explicit recognition of holes that need filling outside the hospital walls. To the extent that states do control and have access to care outside the hospital walls and ought to be developing it more intensely, the states and the feds will need to agree on budgets that are required for that next set of agreements.

There is another thing that I would drag into the requirements for the next agreements—that the federal government will agree to gradually move back into a position where it becomes the centre of the criteria for the grants and getting the needed dollars out of Treasury and the taxpayer to fund whatever is needed. Let the states become the doers under responsibility of performance based agreements, none of the current rubbish that we have, and negotiate regularly.

Another requirement would be that the private sector is involved in the next stage of those agreements because of the overlap between public and private that you are hearing about this morning. You cannot go on leaving the private sector investing in hospitals and health services oblivious to what is going on in the public system, except that the private sector knows one thing: doctors are moving out of that public system into that private system and as a result there will be capital investment in the private sector. But it does nothing for the interface between public and private that you heard so eloquently described today as a morass, particularly in the area that affects health manpower planning.

So those three things in the next agreement, I am sending a signal to the federal government that they will be different, they will be performance based. They will involve setting priorities for care outside the hospital walls and they will involve the private sector in the planning process and the deliberative process, using something akin to the German concerted action program. Why is it not possible for a government giving leadership at the federal level to say, 'We've got to change this current mess. COAG is not working; the private sector is not in the tent; the consumer is not informed. It is time to change.'

CHAIR—You will not get an argument out of me.

Ms HALL—Thank you. It is a very interesting concept; quite practical in what you are saying. I want to clarify a couple of things. It is my understanding with the interface at the moment between when a person leaves a public hospital and goes home is that they are issued with a care plan, it is followed through and there is exchange of technology between the person's GP and the hospital, but that it is not quite the same when it is in relation to specialists. In my area I understand that that does happen. I presume, though, that it is not a thing that is universal. Is that what you are saying?

Mr Gross—If it were universal then the Commonwealth Fund report of less than a month ago would not have been written. What that report is telling you is that there is confusion on the part of the sickest patients about the therapies they are being given, there is no consistency in the drug prescribing that is going on. They see multiple specialists and they are repeating the same information to different specialists on the same condition.

Ms HALL—That is what I was getting at. It is more at the specialist level, isn't it, than at the actual GP level. That is what I am hearing. I am hearing complaints about the fact that the communication, whilst there is a process—whether or not it is followed—with the patient's GP, that does not extend to the specialists. That same area of communication is not available.

Mr Gross—I am not a clinician. I am basically a humble health economist—there are very few of us around—therefore, I cannot speak about that. What I can speak about is what I see in national and international surveys that involve Australian citizens. And I can talk about those things that I am doing in Australia where I get closer to patients. I cannot speak about relativities of information exchange between GPs and specialists—

Ms HALL—That is fine.

Mr Gross—But I think some of the testimony before you, along with the Commonwealth Fund data, would enable you to reach the conclusion that things are not what they need to be. The Kaiser Permanente communications process is what they ought to be. This is world's best practice. What we have is talk.

Ms HALL—We have Medicare in Australia. Do you believe that Medicare should be abolished and a different system put in place? Do you support the retention of Medicare in its current form or with changes? What kinds of changes would you like to see in that area?

Mr Gross—On page 45 of my submission I have stated unequivocally my belief that Medicare should continue.

Ms HALL—In its current form, as a universal—

Mr Gross—As a universal scheme, absolutely. The time we start walking away from universal care is the time we start walking away from any claim that we are a caring society. I stop short elsewhere in my submission, as you know, from saying that we go totally towards a federally funded, tax financed health system. I have evidence in that particular submission that that is the absolute road to dumbness. Even Canada, the last of the dumb nations—in which I lived—is walking away from that at 300 miles an hour, because you cannot finance access to a universal system from a tax base unless you are prepared to finance access to widening queues. As the Chaoulli case before the Supreme Court of Canada showed—and I documented it fairly intensely—providing access to a widening queue is an infringement of human rights. We are danger of doing that here.

So I want Medicare to stay as it is, but I want Medicare restructured—see my submission from page 45 onwards—to begin to focus on things that really matter in people's lives, and amongst those is the care of the chronically ill. I have laid out for you a vehicle that involves both public patients under Medicare and privately insured patients who would have access to Medicare benefits. But the benefit structure is changing and the incentives are changing, particularly the incentives for consumers, and that means a different Medicare. Isn't it time, after 34 years, that we embraced a system that was more appropriate, that has moved on, in a world that has moved on? We now know we have chronic illness; we cannot let Medicare be just a benign bill payer. That is all it is: a benign bill payer.

Ms HALL—You also mention—and I think it is one of your core arguments—the responsibility of the individual. Would you like to expand on that, please.

Mr Gross—In simple form, my view is this: we have gone far enough with saying, 'Any time I talk personal responsibility, I am talking about blaming victims.' So if I say, 'Let's have more personal responsibility for the rising tide of obesity in Australia,' does that mean I am automatically blaming fat people for being fat, blaming a chronic illness on the victim? No, it does not. I am saying that, for a large part of our lives, we have some control. About 15 per cent of people in Australia have no control over their weight, exercise or anything else; they are beyond that because of their condition. But, for the other 85 per cent, it seems to me that it is incumbent upon us to state the following case: without some personal responsibility on our part, health expenditure per capita—that is, your taxes—will continue to go skywards. There are now case studies, some of which I have documented in the submission, of entities now providing incentives.

Ms HALL—For the record, could you go through the proposal you set out in your submission, towards the end, where you use obesity as your case study, looking at a regional approach. I would like you to do that if you could.

Mr Gross—There is a separate paper where I have costed obesity in Australia, and it looks like obesity, with the physical inactivity costs added to it, is costing us about six per cent of health expenditure, or $86 billion today. That is big enough to make it the sixth largest expenditure item in Australian health care. So it is big enough.

In that detailed paper, I have laid out a system of looking at incentives. Why have I done that? Because everywhere I look in the world at the moment, there are national governments as well as regional or state governments, and private health insurance funds as well as private employers offering economic incentives to their workers or members to lose weight—I take weight loss just as an example. And they are doing that in a number of ways. Funds are basically saying: 'All right. You lose weight over two years and your health insurance premiums will drop in the next year.' Or employees are being told: 'If your weight drops over the next two years, we will make an added contribution to a medical savings account that we are paying into; we will up the interest rate for the next year for you.'

These are financial incentives that people find tangible, but they are not the only incentives that we face as humans. There are behavioural factors that affect the way we look at how fat we are and what we do about it. But these economic incentives are burgeoning at the moment, and the evidence is quite clear that they can be embedded in health insurance schemes fairly easily and in workers compensation schemes—not Australia's, because it is basically just an income maintenance scheme for those who have accidents. And it is a multistate mess, but elsewhere in the submission I have talked about solving that problem.

But under Medicare it seems to me it would be possible to do two things. In the first instance, it would be possible to empower GPs to spend more time with obese and overweight individuals and get them on regimens of care and weight loss that make a difference. But under the current MBS arrangements very few GPs are going to do that, because they are not paid to do that. The economies of general practice at the moment is in doing 10-minute visits. You cannot do what Kaiser is doing with obese persons and particularly with obese children in a 10-minute visit. It is a lot more than that. It is before the visit and it is after the visit; it is the follow-up as well as the visit itself.

It is quite incumbent—it would be possible—on Medicare to pay incentives to me to go to a Jenny Craig or a Weight Watchers 12-week program. That is 150 bucks; it will pay me 85 per cent of it and encourage me to go and try that on. Of course, there will be recidivism with those sorts of programs. I will lapse back into my old behaviours. In fact, I lost 10 kilos over Christmas but I have now put two kilos back on. The question is: what is he going to do about that? I will start at the gym this afternoon, when I get out of here.

There is another form of subsidy that can be offered. There are subsidies that can be offered through PBS for drugs that do work, and the government has recently made a decision to move one set of drugs outside PBS and into a situation where consumers can buy them. Those drugs have safety profiles and efficacy profiles, and they work for a limited group of people before recidivism sets in and 12 or 24 months later something happens. So there are a number of ways in which subsidies being applied elsewhere in the world can work here. It is just that, under Medicare—and I am talking about MBS and PBS Medicare—we do not choose to do that. Under health insurance we are stopped from doing it because of the provisions of community rating, which stops a health fund from offering you a different benefit from your chairman, because you are lightweight. And, with due respect, he is not.

Ms HALL—If only!

Mr Gross—I cannot do that under community rating. But there are things we can do—

Ms HALL—So that is a carrot approach; is there a carrot and stick approach in your model?

Mr Gross—You want me to now start whipping into people who do not—

Ms HALL—No, I am just asking.

Mr CADMAN—They will just die, won't they?

Ms HALL—Well, that is a big stick. But seriously?

Mr Gross—There is.

Ms HALL—Please expand.

Mr Gross—I cannot do it under Medicare, because that is where I will be accused of belting the daylights out of people who cannot help themselves. So it is not a smart move to do it that way. Life insurance funds can do it, because they can get your weight and height, figure out that your BMI—your weight divided by your height squared—is over 30 and therefore you are at risk for something. They can do that. Under traditional health insurance it cannot be done, and under Medicare it should not be done. But there are a number of ways we can do it.

I prefer to go with the carrot approach, for example in the debate you are having in parliament at the moment, and that the minister is having with himself, about whether or not we should regulate advertising of food products to children. I happen to believe—this is from a separate part of a book coming out later this year—that regulation is not going to work. Regulations just do not work, so for most of my effort I am talking about incentives before we go to the ultimate step. If all else fails, then by all means regulate a whole lot of things. Regulate school canteens, regulate how much exercise kids have got to have in schools and regulate food packaging. But for the moment it is not as easy as doing some of these other things, except for one small problem. What I am talking about requires somebody to say, 'A subsidy is required; a rebate is required; an incentive through the tax system is required.' It is hard to deal with.

Ms HALL—In New South Wales this week they outlawed the sale of soft drinks in school canteens. You do not think that is such a good idea?

Mr Gross—I do not mind people, armed with evidence, regulating whatever they want to. Soft drinks are implicated, there is no doubt, in obesity—but not in all obesity. Is it excess consumption of soft drinks that is implicated in obesity or a single drink? I do not know; I have looked at the evidence, and the evidence is not conclusive to me. It was not even conclusive to the Institute of Medicine, in its report on obesity and children in December last year. I would encourage any of you who want to regulate our way out of obesity to read the report by the Institute of Medicine of December 2005 on childhood obesity. It will dissuade you from doing things fast. It will encourage you to bring the private sector to the table and talk about it: 'Hey, listen; can't we reduce the size of Big Mac meals? Can't we put details on packaging that make consumers think about what they do?' I think some form of inducement might be required; regulation is not going to work.

Ms HALL—My final question is: do you believe that the private sector should be brought to the table in COAG negotiations?

Mr Gross—From your question I am not sure whether you believe that COAG has a sacrosanct position in the Australian health sector.

Ms HALL—No, I asked you.

Mr Gross—I think COAG is a talkfest, and we have many of them. The question is: does COAG do the job of bringing rapid response to situations involving the health sector? Just take the example we are discussing here today. I do not care if COAG thinks it is acting with alacrity or not; the track record shows that over the past two or three years it has been remarkably slow to act. If you look at the recommendations of the 9 February meeting, you see that when it does its recommendations are all in generalities. They are about the need for us to have lifestyle changes, chronic illness coordination—

Ms HALL—So, basically, abolish COAG?

Mr Gross—No. Expand COAG till we add the private sector to it. We are not beyond doing things like that. We are very smart. We are not beyond adding to the pile of talkers. What we have to do is change the agenda and move more towards the German system.

Ms HALL—So your answer to my question is yes?

Mr Gross—My answer is: change COAG.

Mr VASTA—Mr Gross, you were talking about obesity; what about, say, smoking and alcoholism? They obviously affect the health of the nation. You were talking about incentives and things with private health insurance and, let's say, a smartcard link or something like that. Is there some merit—

Mr Gross—I am not an expert on either of those, and I would prefer not to give obiter dicta on those sorts of things, because there are people in New South Wales who really are expert, like Professor Simon Chapman. But I do believe it is possible to create incentives for everything. Alcoholism is a special case. Smoking is a particular case where the level of recidivism is, I think, far less than it used to be. We are working well at the moment by raising the prices of cigarettes and exhorting people through messages on television that are quite stark to not go that way with their lungs. It is a bit harder with obesity, although the same model might apply. There is a school of thought, by the way, that says if we went the same way with obesity as we went with tobacco, we would get obesity down quickly—that is the regulatory road. I think that is a completely spurious comparison, and I would be quite prepared to provide you with insights on that from another place.

Mr VASTA—Thank you.

Mr CADMAN—Paul, I am interested that you are on the board of a hospital or an organisation in Singapore.

Mr Gross—No, I am not on any board.

Mr CADMAN—There was some Asian country you mentioned earlier.

Mr Gross—I am an honorary professor at the University of Hong Kong.

Mr CADMAN—Does that give you an insight into Asian health systems?

Mr Gross—Yes.

Mr CADMAN—I am curious as to how Singapore, which is highly regulated and well managed, handle their MSAs. Is it by regulation, incentives—what is their approach?

Mr Gross—Singapore has a completely different democracy to the Australian system.

Mr CADMAN—It is a bit guided.

Mr Gross—It is what we would call a very strong version of democracy. Some would call it benevolent despotism—I do not; I just happen to think it is a very different population that is much younger than Australia and much more used to discipline and self-discipline than Australia.

In 1984, the government said: 'We cannot go on funding health care the way we are. We will create medical savings accounts into which all workers will have to put a proportion of their income through a provident fund.' They subsequently set it at a particular level of income. The money goes into the medical savings account, and from that only particular types of health care can be paid for initially. So it is a forced savings account for the most common users of health care, not the most expensive.

In subsequent years, in the mid-1990s, Singapore added to that Medisave scheme. There were then two other 'medis' added, one of which was Medifund to look after the poor. So, belatedly, Singapore recognised that the poor also had to be looked after in the system because they would be left behind; if we were to go the same route as Singapore, I would like to think about how to do that slightly differently. And, in the middle, Singapore created a special fund for paying for catastrophic diseases—the sorts of diseases that we see in Australia with some regularity, particularly cancer. So Singapore's system, since 1984—in the last 22 years—has developed into a scheme that has forced savings, and where I can use my medical savings account not only for health care but also for investing in housing or higher education if I want to. I can take it out of my account for that as well; that is part of the employee provident fund.

We do not have the equivalent here. We have gone the other way, with superannuation. We have done nothing to provide forced savings for our retirement. In my submission I argue that maybe it is time to look at the need to fund at least retirement from medical savings accounts. The work I was doing in Hong Kong for the chief executive was basically about how Hong Kong can fund care and retirement from medical savings accounts. South Africa has them, the People's Republic of China has them—more than 200 million workers in China are now covered by medical savings accounts—and, under legislation from 1998 onwards, America has what it calls health savings accounts. So you can take the view that you can provide incentives for

individuals to save and, from those accounts, you can pay for care or choose to pay out of pocket.

In some of the newer versions of the medical savings accounts in the United States is a device that I am enthused about for Australia. These accounts earns interest at a certain rate and it is rolled over to the next year if you do not use it—so it is forced saving. If I choose to get my weight down and look after my weight, I get a higher interest rate on my next year's savings. So I have an inclination that whatever I am doing leads to some form of addition to my account which is needed to pay for my care in the future. There is a linkage between what I do now and what happens in the future. That is something we do not have in Australia under any form of insurance or Medicare. It is worth while looking at that. I am not sure if it will work for everyone.

Mr CADMAN—It is worth while looking at it.

CHAIR—The health of the nation is a dynamic thing, not a static thing. It concerns me that in recent weeks and months we have been hearing about diseases such as diabetes and coronary artery disease in kids. What does it do to health funding models if the young population is coming out with these chronic diseases?

Mr Gross—It does two things—or, for you, one thing in particular. It says you must signal to the nation in your report that, if we let this go on, our health care is going to be unaffordable if we have to start paying for kids who are getting sicker and sicker earlier and earlier—and that is what is happening. We already have warnings in the statistics from ABS that came out just before the COAG meeting on 5 February on the burden of chronic disease and obesity. We know that some of those chronic disorders are increasing. I went to the New South Wales diabetes summit about three Mondays ago and heard that report on growing obesity in New South Wales school kids. This is not an iceberg any more. Unlike conventional icebergs, much of the iceberg is now starting to appear above the water. We are starting to see warnings in diabetes. We are seeing children with diseases that are associated with being obese—gallbladder disease, sleep apnoea and depression being three of them. Where do we stop? In America, hospital care for children under the age of 17 increased threefold from 1985 to 1997.

CHAIR—What about here?

Mr Gross—We do not have the data.

Mr VASTA—What about illicit drugs like marijuana and amphetamines?

Mr Gross—I know nothing about them. It is not my field.

CHAIR—Do you think that, as part of the carrot, we should be introducing nutrition courses into schools at a very young age?

Mr Gross—It was my impression that many schools are doing that now. I just do not know how consistent that is and how much depth there is. It seems to me that if there is one thing we know about obesity, certainly from the new research on the linkages between childhood obesity and adult obesity, it is that it is not enough for just the kids to know what is going on; their

parents have to hear the message as well. It is not as though kids are going to their parents and demanding to go to McDonald's. I use that as an example. There is a lot of literature that shows it is not the kids who are making the sole decisions in that regard. It has a lot to do with a lot more complex things that we will not go into here.

CHAIR—How do we educate the public into thinking about preventive measures? When annual increases in health insurance funds occur, members of parliament receive letters from constituents complaining that the fees are going up because such and such a fund is giving away free gym boots. Encouraging people to buy gym boots would be a preventive measure that you are talking about. So how do we educate the public?

Mr Gross—Two years ago we had the horror shock of expensive gym boots being bought as part of a fund benefit under ancillary benefits. I remember thinking at the time that it would rebound on us because the only problem with that particular policy was that it encouraged you to buy a thing without doing something with that thing to reduce your weight. I am arguing here this morning, and anywhere I get a chance to speak, that that is not enough. The funds are not doing the smart thing. If they give me the boots, they ought to then give the incentive to use the boots and they then ought to reward me when the boots lead to some change in my behaviour.

If you want an example of how smart people think about it, Virgin, owned by an entrepreneur, has opened a new account called 'health miles'. I think I may have mentioned it in my submission but if I have not I will send you a paper on it. They can see what is coming. They have done a joint venture with a bunch of fitness clubs. If I go to their fitness clubs and get my fitness levels up so that they are documented, I will get health miles with Virgin. I respond to that given the way in which the airlines that I travel on regularly are devaluing my frequent flyer miles. I would like to see something that actually makes a bit of a difference.

CHAIR—Maybe they want to be able to have smaller seats.

Mr Gross—No. We are going the other way.

Mr CADMAN—MSA is an insurance. Do they work side by side?

Mr Gross—They do. The medical savings account can be used to buy an insurance policy of my choice. There are a couple of ways of doing it. I can choose to buy my current comprehensive policy with my 30 per cent rebate where I end up paying more for health insurance than I would want to if I was a 21-year-old. I do not need comprehensive cover when I am 21—at least, I do not think I do. If I am a risk taker, I would like something a bit lower. That is what my kids tell me. I would like minimum coverage so that if I have an accident I get this—

Mr CADMAN—Catastrophic cover.

Mr Gross—Yes. I can then buy at the other end of the spectrum catastrophic cover for a higher deductible paid by me upfront. I get a cheaper premium. In the end, I have to figure out as a consumer what mix of deductible and health insurance premium I will then pay for. If that catastrophic cover covers a whole lot of diseases that are not there at the moment, including chronic diseases, I might get interested in that. However, I would like something in between whereby that same medical savings account can encourage me to do things with my risk factors

that neither of those can do for me alone. That is what I talked about in my paper on what health insurers are now doing to provide additional benefits and rewards if I get my fitness levels up or if I get my weight down. That is how I then use the medical savings account component.

By the way, I forgot to mention that in July last year one insurer in New Zealand—the biggest insurer—took the risk in an unregulated market and said, 'We are going to create medical savings accounts.' I would encourage you to look at the Activa website on Southern Cross Healthcare where you will see the notion of medical savings accounts for New Zealand. My argument is that we are overregulated here. New Zealand is not regulated. Somewhere in between we might be able to find some similar options. I am not arguing for medical savings accounts for everybody—I am not sure they would work for everybody—but they ought to be an option. Under current health insurance they are not possible.

CHAIR—One of our biggest problems, of course, is medical workforce issues about which we have heard evidence this morning. In the private sector, particularly with surgeons, the problem is that they are getting older. They want to work four days a week, not six. They want to maintain their income. Consequently, we have a situation where we have insurance premiums going up and gaps rising. How can that be addressed? I am concerned that the private sector, which is growing, is heading for disaster if the gaps keep increasing.

Mr Gross—I learnt a long time ago that the major problem for Australian doctors is the culpable inadequacies in the Medicare Benefits Schedule—the way it is designed, the relativities that are embedded within it and the way in which doctors who treat with technology are paid at a different rate that is often higher than those doctors who have to think and cajole and persuade me to lose weight. We had a chance to fix it five years ago and we botched it entirely because the government advised us to redesign the Medicare Benefits Schedule as a relative value scale.

Putting that all to one side—and acknowledging that this will not fix things overnight—the Prime Minister and the health minister are now attempting to address the problem of medical gaps by saying to the AMA, 'You must declare your medical gaps in advance and we would prefer them to be zero.' The health funds, on the other hand, are trying to do their part by saying, 'We will have schemes where we promise you no medical gaps or no known medical gaps—we are trying to inform you.' What is missing in that at the moment is something that I did not talk about in my paper, and it may be the subject of an additional paper. Elsewhere in the world, faced with that particular reality that the subsidies mask who is paid by whom for what, with no data on the quality of care being consumed, people and governments are coming to a belated recognition that the only way to fix that is to put the gap payments by doctor and specialty up on websites where people can look at them and do their comparative shopping, not just with the prices embedded but with some measures of the quality of the care offered by the doctor as well. This is the medical form of pay per performance. I would encourage you to look at a number of American websites where this is already occurring. They are basically saying that patients will remain uninformed about price and quantity—

CHAIR—How do you measure the quality of medical service you are going to receive?

Mr CADMAN—How many patients die?

Mr Gross—Patients dying is a rather extreme measure, I am afraid. There are measures that are now accepted by the medical profession, which I have embedded in a footnote on page 29 of my paper. I have given some references to the way in which even American doctors, so mortally wounded by the problem of managed care, have come to the conclusion that they will do better if they actually declare the quality of the care they are offering. In those footnotes I have given a number of references that I would encourage you to read. If you need any more, look at the sites of the American academies of medicine—the equivalents of general practice here—and see how they are embracing it. There are now American doctors receiving $300 to $400 million more per year in incentive payments that actually measure the quality, and those documents will tell you about the measures being used. They relate to the chronic diseases you have just alluded to. They relate to defined measures of how we treat the diabetic—how we measure them at every visit and what we measure at every visit. This paper from Kaiser that I am leaving with you has one memorable page, for anyone who has diabetes, on the minimum treatment and questions that should be asked of the diabetic. I invite you to look at that and ask yourselves if, at the average general practice visit here in Australia, you get the same questions asked.

Ms HALL—I move that that be accepted as an exhibit.

CHAIR—It is so ordered. I thank the witness for a very comprehensive presentation.

Mr Gross—Thank you for the invitation to appear.

CHAIR—I am sure you will keep your eye on the evidence and submissions we receive from here on. If you wish to give us any further information, please do.

[11.21 am]

DEEBLE, Professor John Stewart, AO, Consultant, Australian Healthcare Association

GREEN, Associate Professor Deborah, Past President, Australian Healthcare Association

O'CONNOR, Mr Daniel James, General Manager, Australian Healthcare Association

POWER, Ms Prudence Howard, Executive Director and Company Secretary, Australian Healthcare Association

CHAIR—Welcome. Is there anything you would like to add regarding the capacity in which you appear?

Mr O'Connor—I am also appearing as a member of the Australian Healthcare Association.

CHAIR—Would you like to make an opening statement to the committee, please?

Ms Power—Yes, thank you very much. For the record, the Australian Healthcare Association is the national industry body for the public health care sector. It represents hospitals, health care organisations, aged care facilities and primary and community health facilities. The AHA used to be called the Australian Hospitals Association. It is quite an old organisation. It has been established for over 50 years now, providing mostly policy development, advocacy, representation to the sector and membership services. The Healthcare Association puts out a peer review journal quarterly and provides other services such as that, at a very high level. Unless there are any questions about the AHA, we will continue, but I thought that would give you a background of who we are.

CHAIR—Thank you.

Ms Power—One correction to our submission, which I might talk about straightaway, is this. In the last paragraph of page 4, we stated:

> ... a longer life often brings with it a heavier disease burden. The growing experience of many Australians is that some two-thirds of their additional years will entail living with a severe handicap.

More recent research is published in a 2006 report by David Johnson and Jongsay Yong of the University of Melbourne. There are other reports saying this, but this is more recent. They say it is proximity to death that drives health costs and that, once proximity to death is accounted or, the population ageing has either a negligible impact or even a negative effect on health care demand. That is because, as somebody truly ages and they are near death, it is less likely that great amounts of health care costs will be expended. Mostly the person does not want that to happen anyway. That is a correction.

Ms HALL—There are different views on that. There is the view that you are putting and—

CHAIR—The group that we had here before us this morning were saying the opposite.

Ms HALL—Well, they were not saying the opposite. They said an ageing population was impacting on the health system. They were not opposing what you are saying.

Prof. Deeble—I can leave a copy of the paper for the committee, if they wish.

Ms HALL—That would be very good.

CHAIR—Thank you.

Prof. Deeble—That conclusion has also been reached in America by some eminent health economics, and I agree with it. As one person says rather wryly in the paper, you can go through all sorts of illnesses but you die only once. Most of the high expenditure is to prevent you from dying, and Ms Power mentioned treatment by doctors. Some aggressive treatment is often initiated to keep the young ageing—that, is the 65- to 70-year-olds—alive because it is not seen that they have had a fair run for their money, but an 80-year-old will not be treated that way. Can you see what I am projecting? More heroic efforts will be made with a child. In fact the simple notion, which is just associating cost with age, is not the only thing; it is cost and death. I work with Aboriginal people, and they die much younger. It is the same thing, but they die in their 50s, not in their 80s. It means that ageing, as such, does not predict high costs, but eventually we all have to die.

Ms HALL—There are a number of studies. I think the first group who were before to us were talking about people who were 90-plus going into public hospitals—

CHAIR—But they were in critical care.

Ms HALL—and that once they would have been going to that box and pulling out people who were probably 60- or 70-plus. What you are saying is that it has moved up the spectrum and it is just that last period. Those people probably fit into that last period and there are probably more of them. I know there is some debate on this issue.

Prof. Deeble—But the costs of dying are constant for all of us.

Ms Power—Just by way of introduction, I will pick out three points that we made in our submission. Firstly, we are saying that optimal health will only be achieved if we better integrate both the traditional approach to curing disease and the population health approach. The AHA changed its name from the Australian Hospitals Association to the Australian Healthcare Association because the association recognised that the optimal approach is to care for people across the sectors, not to concentrate simply on curing illness in major hospitals. Secondly, although we represent the public sector, we believe that health policy must involve both the public and the private sectors. We think there should be a more healthy approach to integrating those two sectors. We are not one-eyed about that and never have been. Thirdly, all Australians should benefit from a needs based and equitable distribution of high-quality services. Whether we provide that in the public sector or in the private sector, we believe that it is important.

I will move on to the terms of reference that we addressed. The first one was examining the roles and responsibilities of the different levels of government, including local government, for health and related services. We argued in our submission that Australia's current system of funding and delivering health services is far from optimum and that there were specific problems that reduced the efficiency and the effectiveness of the system, including cost shifting and funding duplication between federal and state governments, the lack of accountability for health funding due in large part to the federal-state division of responsibilities, and gaps in service provision due to cost shifting and deficiencies in integration across state jurisdictions. In our submission we outlined eight principles for a new system.

In the submission we also said that we preferred a model which would have the federal government as a single funding body for core health services and that the funding would be provided directly to service providers. There are a number of ways that could happen. In principle, this is the policy of the organisation. The Commonwealth as a single funder would be technically efficient. We believe it would support increased accountability, although I must say that there might be limitations on responsiveness. The responsiveness might be better if the funder were closer to the source of service. We think that it would enhance integration and coordination of services, particularly where an acute care hospital interfaces with aged care and primary care. We think it would enhance the implementation of a national health information and communications network—an electronic network. We recommended that this should be seriously considered in the lead-up to the 2008-13 Australian health care agreements.

On the other hand, though, if we were looking at practicalities rather than an ideal world, we would not be sure that this change could be made in the short term, and I am not sure that the change could be made even in the medium term. That is why, also in the submission, we looked at some alternative models. I will list those models. We talked about a national partnership, which you could say is what should happen now underneath the Australian health care agreements, and that could happen if the governments could cooperate more efficiently and more effectively under those agreements. We looked at the Commonwealth government maybe funding a population group, a geographical area, a stream of care or a health program. We talked about those in the submission and we are prepared to discuss those if you would like us to. Term of reference b.—'simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals'—was actually picked up in that conversation. We are happy to talk about some of those options, including how the Australian health care agreements could be more effective.

CHAIR—How we recommend that the government will handle the renegotiation of the health care agreements is really basic to our inquiry.

Ms HALL—That would probably be a good starting point. Ms Power, could you expand on that?

CHAIR—Just to clarify from our point of view, the health care agreements basically provide 50 per cent Commonwealth funding and 50 per cent state funding. The states get 50 per cent of their revenues from the Commonwealth, so basically the Commonwealth is paying for three-quarters of the public hospital system.

Ms HALL—There is some disagreement on how Alex calculates those figures.

CHAIR—I do not want to have a debate during the hearing. We have the criticism by our Auditor-General, who says that the Commonwealth health department has become merely a postbox between the Commonwealth Treasury and the states; that we no longer have a national health agenda and the health care agreements no longer fund a national health agenda, because it is not tied to funding but comes under general purpose grants; and that the Commonwealth should have more of a say on how the public hospitals are run, or at least on what they are trying to achieve through the public hospital system through having a national agenda. Having said that, I ask you: what would you do in the renegotiation of the health care agreements?

Ms Power—We might start with the funding issue because we have handed up an extra bit of paper this morning which you have in front of you.

Prof. Deeble—I will discuss that if you wish.

Ms HALL—That would be really good.

Prof. Deeble—It is a little piece just correcting the record. It is a little bit of academic interest but it is an important issue. My concern with the interpretation you put, Chair, is that it is not so much a matter of funding, it is a matter of practical administration. The Commonwealth has no past experience and no specific expertise in health care delivery. The arrangements with the states are not so much the funding arrangements but that the states have, for over 100 years, run hospitals and know what they are doing. I have worked as a senior officer in the health department and I can tell you that the Commonwealth does not have the faintest idea, but it can use its financial clout to influence the way that the states go. In the health care agreements it is the amount of money that the Commonwealth gives and for what purposes that does drive the agreements. The states are more or less bound to match that but find difficulty in going beyond it. Whether that is just because that has been the convention or whether that really is it, nevertheless it is the Commonwealth rate of growth that determines the rate of growth of the whole system, and to that extent the Commonwealth plays a big role.

CHAIR—We are sick of the blame game.

Prof. Deeble—Being honest with you, I am not so convinced as many other people would be about the enormous actual inefficiencies in the system. And I am not convinced that they are as large as many people say. But they are significant for the players. They are significant for the Commonwealth and state ministers and for the Commonwealth and state bureaucrats. Whether they impinge so much on the individual patient I am not at all certain because systems have a way of going around these things. So the blame game suits both parties: if you took that away then I do not know what they would blame.

Ms HALL—How do you see that we can get around that? What is your solution to getting rid of that blame game?

Prof. Deeble—This is my personal opinion; this is not the AHA's. My personal opinion is that the separation is not entirely bad. That is, I would be very cautious about giving one level of government control over all of it because if it was the Commonwealth I think it may be too far away from the delivery interface to respond to what the real pressures are and it will be run too much by Treasury bureaucrats. At the state level it is run more at the state level, and indeed those

who are state members are much more active with their minister on behalf of their constituencies than perhaps at the Commonwealth level. I do not think that is unreasonable to say.

CHAIR—I would argue with that.

Ms HALL—There is a state member in the room at the moment.

Prof. Deeble—But there is a responsiveness at the state level which is different to the responsiveness at the federal, and I think it is a good thing that there is some competition between the two levels of government in terms of advocacy for health. The Commonwealth will wish to push the states in a certain direction and the states will wish to do something else. I would be uncomfortable with a completely monolithic system.

Mr VASTA—Accountability?

Prof. Deeble—Accountability is one thing, responsiveness is another. But I think accountability can be overemphasised. I will give an example. The Commonwealth laid down a set of hospital agreement conditions in the last agreements which had no discussion, no contribution from the states at all and that was it. Why would it not act similarly if it ran the whole system? So I am not one who actually believes that a single funder is always better. A single funder is more powerful and can control costs, but it might just cut expenditures. Well, you asked for an answer!

Ms HALL—Yes, that is good. I can see the rationale behind what you are saying and I am not averse to it, but what I think happens a lot within the system is that, when the Commonwealth or the state underperforms, the Commonwealth tend to say, 'It's not our problem; it's because of the state,' or the state says, 'It's not our problem; it's because of the Commonwealth.' How do you get around that?

Prof. Deeble—The only way to get around it is with some objective measurement of performance or underperformance. The blame game works when nobody can prove anything, so it just shifts across to the other.

CHAIR—The most basic example of the blame game is when Mrs Smith from Noosa writes to me and says: 'I've got to wait four years for a hip replacement. I'm 80 years of age; I can't wait.' So I write a letter to Tony Abbott. He writes back to me and says it is a state matter, so I write to the state health minister and the minister writes back to me and says, 'The Commonwealth doesn't give us enough money.' Mrs Smith gets two letters, one from the Commonwealth and one from the state, blaming each other, but she does not get her hip replacement.

Prof. Deeble—That is true, but they are conventional almost programmed responses.

Ms HALL—They are.

Prof. Deeble—And the programmed response is important to the political game, but the fact is that—

CHAIR—I want her to get a hip replacement.

Prof. Deeble—she does not get her hip replacement.

Ms HALL—My approach would be different. I would contact my state member, Matthew Morris, who is the state member for Charlestown, and I would like to acknowledge his presence here today. We would talk about it and we would try and resolve the issue and get that person's hip replacement done for them fairly quickly.

Prof. Green—Both of those stories are very good as examples of influence and advocacy for an individual but, in truth—

Ms HALL—It should not be like that.

CHAIR—It is at someone else's expense.

Prof. Green—Yes. I was going to use the expression 'queuing', which is the issue that we have to face in public hospitals. People are queuing in the emergency department to be seen, they are queuing to get a bed if they need admission and they are queuing to get a new hip. Going back to John's point, we have talked in our submission about national standards and I think we also need national results. The variation that you are talking about at Noosa—four years—goes to some extent to the issue that we have about medical and nursing workforce shortages. It is one of the reasons people are queuing. Whilst you can have letters coming from this one, that one and the other one, in reality, for the population that needs the care, that is the bottom line. People do not want to have to queue and they also do not want to get jerked around, and they are the two things that, whatever we need to do, we need to improve for people, because we have a position on universal access. If you need a hip replacement and you are uninsured, you will wait.

Mr O'Connor—The scenario that you describe is quite descriptive of many dysfunctional families where you have perhaps two key members of the family who have worked out a series of rules of blaming each other for the dysfunctionality or the behavioural performance of the family. In lots of families, that ends up being functional—that is, it keeps that family together. It may not be healthy; it may not be happy, but it is functional and it works. In fact, it misses the point about good parenting, good modelling and determining what the key results for all members of the family should be.

I actually think the blame game works, because it distracts the key participants from the key issues. Deb has just mentioned what some of those key issues are—what is reasonable and unreasonable about queuing for this, that and the other. Going back to the beginning of our conversation: what is reasonable or unreasonable about the decisions that are made about the quantum of resource that is expended towards the end of life; and what can we do to separate ourselves from this reasonably entrenched conflict behaviour and agree upon a series of deliverables or results that we think in the one sense should be universally applied across all particular types of health care settings and then on the other hand a set of results for deliverables that ought to be determined at a local level as they reflect local circumstances? I think the blame game debate and a lot of the talk around the blame game actually continues to deflect us from the key issues.

CHAIR—I am stunned.

Mr O'Connor—Sorry.

Ms Power—Under our alternative models, specifically '1. A National Partnership', the dot points we have there say that there should be planning on a nationwide basis by all governments working together to prevent duplication and service gaps and overcome competitiveness; and there should be an agreement for sufficient resourcing through proper cost share agreements that are going to work rather than competition between who spends more and who does not and so on and so forth. Deb has mentioned national standards. It is so important, because that will govern the delivery of services. Essentially it takes competition out of it. If you have agreed national standards and agreed performance measures for those national standards and then you can meet them through a cost-sharing agreement, essentially that should be able to work with two parties funding. It should take any subjectivity out of it, so that we are objective about meeting those standards.

CHAIR—Let me ask: do you agree with John Howard that we have a world-class health system? I know we have world-class clinicians. Do we have a world-class health system or could it be better?

Ms Power—It could be better. Australia has a good system. We are always careful in all our presentations to say that. However, for certain conditions—for example, prostate cancer and bowel cancer—we are towards the bottom third of OECD nations in delivering outcomes. In suicide we are not looking too good. Of course, the health of our Aboriginal population is very poor. It is actually a national disgrace. I am not sure either that we do the population health aspects terribly well—the prevention. We have seen growing numbers of obesity and diabetes. In smoking we are tolerably good, but we could be better at anti-smoking. So it could be better, yes, and we could point to areas where we could be a lot better.

Ms HALL—I liked the fact that you mentioned population health as part of your first point, where you are looking at the optimal approach. Can you expand on that a bit more. You also have some interesting models—the proposed model that is, I think, on page 8 of your submission—that I would like to see expanded on a little more for the committee. The other thing that I am interested in—it is something that was brought up by the first group when they spoke to us down in Canberra—and I picked up on a couple of occasions in my reading, is the use citizens juries as a way of getting more input from the community into the health system. The other one is the Romanow commission in Canada.

Ms Power—If you were to vary the model of Australian health care agreements somewhat but still have two levels of government funding health then there might be other ways that you could do it that would perhaps make it more logical or neater. Maybe I could just take a step back. We could say the Commonwealth government could fund all ambulatory care. Already the federal government pretty much funds out-of-hospital services, through the MBS—not entirely, of course, because state governments do fund various community services. You could make the cut whereby the federal government funds all ambulatory care and state governments fund all institutional care. Then you would change the border. A&E, casualty, would probably be institutional, but outpatients would be ambulatory. Then of course you raise other questions, such as where aged care sits: does that mean aged care is split so that institutional aged care goes

to the state and ambulatory aged care stays with the Commonwealth? Wherever you look, there are going to be border issues. It may be that you do not consider aged care entirely health related and therefore it could stay with the Commonwealth. You can create an argument if you wish. The truth is, though, that most aged people in institutional care do require a reasonable amount of health or at least nursing care.

We have said also that perhaps you could create a situation where the Commonwealth could be more responsible for a whole health program, and we have given the example of the pharmaceutical program. Currently the Commonwealth is not responsible for pharmaceuticals in hospitals in the main, but it is responsible for pharmaceuticals out of hospitals. Or maybe the Commonwealth should be responsible for the whole pharmaceutical area and that might be another way of cutting it. However, if you think about it, the very first point we made, about a national partnership, seems to make the most sense. If you have a partnership and you are running that against objective criteria—against outcomes—as the first thing you look at, then presumably both levels of government in partnership can discuss where the boundaries are and how they might work better.

Ms HALL—So the key factors are those objective criteria and then evaluating your outcomes against those objective criteria?

Ms Power—Yes, for outcomes. That is exactly right—and for funding levels.

Ms HALL—And the funding is connected to how those objective criteria measure up against the outcomes?

Ms Power—Yes. Within the health care agreement you would need a proper understanding of the growth factors, and there is a problem around that at the moment. You need to build into the agreement growth factors that are agreed by both parties, not just laid down, I have to say, by the Commonwealth—and insufficient, actually, to deal with growth over five years.

Ms HALL—So do you support outcome based funding?

Ms Power—My colleagues might like to answer that. They work right there in the system.

Prof. Green—I would not go that far. I would prefer to describe it as results based.

Ms HALL—Results based?

Prof. Green—Yes, I think we are a long way off having data that would support our health outcomes.

Mr O'Connor—Yes, I agree.

Prof. Green—We two agree with that, anyway. But I think you need some results that are clearly linked to the funding.

CHAIR—Okay. What if we add another variable to that equation and ask where private hospitals fit in?

Prof. Deeble—Private hospitals are demand driven.

CHAIR—But it was suggested to us by Paul Gross, the previous witness, that they should be an integral part of the health care agreements.

Prof. Deeble—I agree. In fact I think one of the big mistakes, which I have regretted for many years, is that Medicare is viewed as the public hospitals and the medical benefits system, or the medical benefits schedule. But Medicare is a system—it is not just that bit—and it includes the private hospitals and private insurance. It should be regarded as part of the system. It should be made to integrate with the system and be designed to integrate with the system. I think the belief people have had has been fostered to some degree on the private insurance and private hospital side because it is actually to their advantage to be outside public health. But I think it is to our advantage for them to be in it. The private health insurance rebate should have been used to promote more integration between the two sectors rather than to be a purely demand-driven system outside of the mainstream, because the mainstream is still the state system. The next agenda item is how to make it more effective, and there are some things that I think should be done there.

Ms Power—That is in reference to term of reference (d). We have term of reference (c), which Danny was going to address.

Prof. Green—I would like to just make a point about the private sector as well.

Ms Power—Shall we do that now and go back to (c)?

Ms HALL—Yes, deal with that now, seeing we are on it.

Prof. Green—Prior to the change in policy about private health insurance, my recollection is that between 20 and 25 per cent of people who went to private hospitals were uninsured. I can recall being one of them, to avoid queue jumping and to get a procedure done. So, there is a history, as you say, John. The other point I would make—and I am taking off my AHA hat and putting on my Sisters of Charity hat—is that we have co-located public-private hospitals in both Sydney and Melbourne at St Vincent's. One of the great outcomes of that is in terms of doctor retention because they do not have to move around. To be able to work in both public and private is one of the positive things about many of our specialists. For us they are great retention and attraction strategies. If you can identify that rooms can be made available then their whole practice and professional life can be spent there. We are talking about the medical workforce being critical, and to me that is a critical element of that. Like John, I believe the future is in finding a way to look at the whole health system rather than to just segment it off. Hopefully, that will inform the next health care agreement.

CHAIR—You are talking about co-located hospitals.

Prof. Green—I am.

CHAIR—Can you have the same degree of integration if they are not co-located?

Prof. Green—You can. But what I am saying is that in my experience of where they are—in my previous life in public health care there were a number of them as well—it is very effective. If they are too far apart it will not work. A few kilometres will not matter. If they make that sort of commitment to stay there, teach there and do their research there then you have a total package effectively in one place. For a very busy doctor, that is not unattractive.

Prof. Deeble—So we are missing that other term of reference and going on to this?

Ms HALL—We will go back to (c).

Prof. Deeble—For a number of years I have been trying to tell anybody who would listen that the way that private insurance should have been linked was that full subsidies should have been linked to a formal association between the public and the private hospital. That does not mean they have to be adjacent because they cannot always be. For instance, one of the problems with a private hospital is that they do not have resident medical officers. One of the reasons they find it difficult to do some procedures, certainly emergency procedures, is that they do not have resident staff and, where they do, they are generally general practitioners who are brought in. The registrars that the specialists are training are not present. One of the things that has happened in the big expansion of the private hospital system through private health insurance is that the two systems have diverged even more than before.

Since the rebate came in, the cost per case in public hospitals, in constant prices, has gone up. But it has gone down markedly in the private hospitals because the big expansion has been in the low-intensity care and the two sectors have sorted themselves out. But they are getting further apart, not getting closer together, if you understand what I mean. I have no objection to a subsidy, but not a 100 per cent subsidy, to people where it is purely demand driven. They will use more services and they will not necessarily be funded fully for them from the Commonwealth. That is as against a system where you may have some degree of waiting or rationing but it does not cost you anything. The difficulty in administering that is that if one section diverts completely away from the other and specialises in one thing rather than the other, you will never get the two together. I do not know whether you feel the same about the way that the private and public hospitals have separated. When I was a hospital manager, many years ago, we had private wings in the public hospitals but we do not have them now. The doctor did his work for private patients within the public hospitals, but there is very little of that now.

Ms HALL—I want to pick up on something that you mentioned a couple of minutes ago and just again now. As a group, what is your attitude to rationing and waiting?

Mr O'Connor—It is inevitable. It is a normal part of the industry that we work in. In some ways, I suppose, it is related to term of reference (c). In social policy, of which health care is an aspect, as we invest and reach a certain benchmark performance, there is a natural inclination for us as human beings to expect the bar to rise, because we can further improve the condition or the conditions under which we live. Therefore, assuming that there is a particular quantum of investment at any point in time, there is always going to be a rationing, according to the way in which that investment is disbursed.

With regard to term of reference (c), we have emphasised two issues. One is the issue of consumer or community involvement in health care decision making, and the other concerns

national standards for safety and quality. Picking up on the first issue, there are three key points that should be emphasised around community and consumer involvement in health care decision making.

The first is a point that we touched on in the discussion a few minutes ago—that is, the issue of accountability for performance and the accountability arrangements that we have in place for health care providers to demonstrate their performance. We have a clear obligation of having those mechanisms in place for the people who come to receive health care and, of course, for the people who provide the resources for that health care to be provided.

Chair, you asked whether we have a world-class health care system and whether it could be improved. The answer to both questions is: yes, we do have a world-class health care system. There is ample evidence for that. Could it be improved? Absolutely; and there are many ways in which it could be improved. One of those ways is to have a much clearer, agreed upon and broadly rolled out system for results reporting—a system showing the performance of the health care providers, how they are reported and how they stack up against one another.

The second point in relation to the first issue is the issue of the actual involvement of the community or community representatives in decision making around health care. It is tough, vexed and complicated. There are many ways in which one attempts to involve members of the community, community representatives or voices from the community in health care decision making. That should continue to be supported, and we should continue to be innovative around that.

The third point that needs to be emphasised in relation to that is community debate—about the question that you put of rationing, about where health care resources are expended, about what are the priority issues that health care ought to be attending to and about the tough issues of what point in time or in what circumstances one ceases or does not spend the limited health dollar. There is a great reluctance or an absence of leadership from many quarters for many of these issues to be debated openly, thoroughly and, ultimately, successfully in the public arena. I mentioned this before and I will mention it again just as an example: end of life issues certainly fall into that category.

The second major point that we have emphasised is national standards for safety and quality in health care. This is a very good illustration of a point that I have mentioned twice previously, perhaps even more than that, and that is that if we have an agreed upon set of standards according to which we are governing and delivering health care services and against which we can monitor and assess performance, we then have a framework within which we can make assessments about achievement, absence of achievement and the potential for improved achievement. It is also a way of closing the holes in the net around risk in the delivery of health care to patients and the way in which that health care is understood by those who receive the care. So we would emphasise very strongly the need for national standards for safety and quality, standing alongside national standards for registration and credentialing.

Ms HALL—Is any community consultation part of this submission? You mention citizens juries and those other innovative approaches. What sort of feedback have you had on them?

Ms Power—The examples that are at the top of my mind are citizens juries that were held in Western Australia where the citizens came back with quite innovative ways to spend the budget if they had a limited budget. They were around spending more on Aboriginal health, for instance, and more on primary health care and preventative care rather than necessarily the top end or high end of the curative sector. So it is more likely that if citizens are given the chance to have a view they will look at the end of life issues, as Daniel has talked about, and consider whether the resources that are put in there sometimes could be better spent elsewhere, even though that is a painful discussion.

Ms HALL—The national standards you mention could be very much linked to—you did not say outcomes, you said?

Prof. Green—Results.

Ms HALL—Results. Yes?

Mr O'Connor—Absolutely.

CHAIR—What is the difference?

Prof. Green—In health terms I think outcomes are very specific and measurable differences. I just do not think we have the data and the information and the ability to compare in order to do that meaningfully. I was interested to hear Paul Gross talking earlier about Kaiser Permanente. They have been working on this for years now. They actually produce a very good status report which compares populations in different parts of where Kaiser operate hospitals. I will use mental health as an example. Some of the indicators are more about process, about how far someone is seen, but not about whether in fact we got the right outcome in terms of the disease of the person. I think Kaiser have been working on that for a few years now. Some are about results: how many you have seen, how fast you have seen them. But does that necessarily mean that you get a better outcome for the person? To me, those things are different.

Mr O'Connor—We are getting better though. We are getting much more sophisticated.

CHAIR—One thing we hear constantly is that there are too many clinical decisions being made by bureaucrats in the system. That does not happen in the private hospitals. Doctors operating in private hospitals do not complain about being bogged down by bureaucracy but everyone in the public sector does, particularly in the commission of inquiry in Queensland.

Prof. Green—I suppose we cannot really speak on behalf of AHA in relation to this, but I can speak about it more in terms of my immediate past experience, as can Danny. I think it goes to the heart of the issue we discussed earlier. The closer the political arm is to the decision making, the more it will want to influence it. That is almost inevitable. So we do see whilst we have broad policy directions within that framework, I think you will see influences being brought where you have a minister and a department that are concerned about the way a hospital is operating or the way priorities are set.

Mr CADMAN—If that political influence is at a more local level—it may not be party political in the general sense—can that be less obstructive?

CHAIR—Or positive?

Mr CADMAN—What is your assessment on that?

Prof. Green—Perhaps it goes to some extent to what Prue talked about a minute ago. It needs to be balanced by what the community wants. Getting that balance right has probably been done well in some places at different times. I would have to say that, over the last decade, we have seen increasing influence. To move away from that would be quite challenging.

Mr CADMAN—To move away from what?

Prof. Green—Having a lot of political influence in health. It would be quite challenging to do that.

Prof. Deeble—Chair, you asked before about good systems. I think Australia has one of the best systems in the world. But one of the problems is how do you measure it. We have just about the highest hospitalisation rate in the world. Is that a good thing or a bad thing?

CHAIR—It depends on whether you are the patient or the—

Prof. Deeble—Is more better than less? We see doctors, GPs, at about the same rate as every other country in the world, but we have more pathology and radiology than most other countries in the world. Is that a good thing or a bad thing? Our hospitalisation rate is I think only possibly equalled by one or two European countries with a much older age structure than we have. But the whole thrust of public debate is that we do not have enough—we need more. Are we succeeding by doing a lot? The usual thing is that economists count everything up and the more you produce, the better it must be. Actually, it might be better to do less. But that would be perceived by the community as a failure because it would not meet their demand and expectations. So it is just a question I would put to you. You would have to do a great deal to convince the community that not being able to get to a service on demand that might conceivably be valuable to you because really in the national interest you should not have it. That would not win over many people.

Prof. Green—I suppose the other point that I was thinking about when we were talking about what is world class was that for many of us, when we are overseas and get sick, where do we want to be? Almost without exception people want to come to Australia. All of us who have travelled to other countries would almost always say that you want to go home. So whilst I think we are actually very harsh on our own health service—I think we are very critical; I am not sure why, but we are—in fact, it stacks up against just about any health service in the world.

CHAIR—The reason we are critical about it is that we read about it in the papers day after day.

Prof. Green—That is right.

Prof. Deeble—If there is something we did not do, therefore we should do more.

Ms HALL—I suppose that along with this comes the issue that we have not thrown at you, which is the cost-shifting within the system. Would you like to comment on that?

Mr O'Connor—It is a market. There is a market there and a particular organisation would be foolish if it did not take advantage of the market conditions, so cost shifting occurs for very sensible and rational purposes. Without being cynical, and as I said many minutes ago, that is the structure that is in place and therefore they are the conditions according to which the respective organisations will design themselves. The real question of importance here is I think not so much whether cost shifting is ethically unsound or structurally unsound. The question is whether it creates perversions in the design and delivery of care and therefore in the results or outcomes that we can achieve. That is the key question.

Ms HALL—What is your answer to that?

Mr O'Connor—There is no doubt in my mind that clinicians as well as bureaucrats are very influenced by the ability to meet costs, cut costs and grow services according to the financial conditions that they are in. Although in most of the examples that I could think of it would be difficult to point to a deficiency in the quality of care provided, the next question behind that becomes: would one have thought about designing that service and growing that service differently if the structural features had been different?

CHAIR—Taking the point of view of the patient, the patient does not care if it is paid for by the Commonwealth or the states.

Ms HALL—That is right.

CHAIR—I do not care either. The emphasis of this committee is on making sure that as much as possible of the health dollar is spent on the patient. With cost shifting, there is a cost involved in it. There is an administrative cost involved in cost shifting.

Ms HALL—It would be a waste of health dollars.

Prof. Green—The groups that are impacted by that are the ones that have ongoing connections with the health system, people with chronic illness and a number of older people.

Ms HALL—Yes, aged care.

Prof. Green—Aged care, yes. That is where you can see impacts on the quality of care.

Mr CADMAN—In your introductory comments in respect of term of reference (a), you mention lifestyle problems but you do not deal with them. I would encourage you to have a go at that. You seem to present solutions which are generally structured around traditional problems such as chronic disease. I refer to pages 8 and 9. In your proposed model you deal with primary health care, aged care and the resolution of some of those problems but there is sparse information about how a health system might deal with lifestyle health problems, which are two of the main points in your introductory comments.

Ms Power—That comes back to the conversation we were having around how health would be funded and back to conceiving a better partnership, a more effective partnership, between the funding bodies, particularly the Commonwealth and the states although we would not rule out the private sector also having a role to play. While the Commonwealth is funding mostly the MBS and the PBS and then the hospitals—through the states with the states picking up the hospital funding and giving some to community care—we are going to have a situation where prevention is not being dealt with adequately.

Obviously there have been some reasonably successful preventative programs in Australia. We must always remember that our response to the HIV-AIDS epidemic was world-class and that our response to smoking is up there—it is not the best in the world, but it is certainly amongst the best in the world—and there are probably other examples. However, I do not believe that there is enough accountability. At the moment the funding arrangement allows both levels of government to get off the hook a little in regard to their accountability for public health programs, which is what we are talking about in lifestyle—prevention and so on.

If we come back to the idea that we are going to have two levels of government funding health conceivably in the short and medium terms—I do not know about long term—then we need to have a national partnership to govern that funding arrangement where it is agreed what needs to be dealt with under that funding agreement. Then the governments could agree that prevention is a really important part and that they will fund it either jointly or separately, but it is acknowledged that it is part of the agreement; it is part of the expenditure. If it were separately funded by the states, the Commonwealth would have to agree that that was part of their contribution, and then I think we would be able to deal with it. It is partly because the different levels of government cannot feel totally accountable that things can fall away and through the gaps.

Mr CADMAN—National programs for preventative areas tend to be a Commonwealth thing—for instance, the smoking program. The ones you have mentioned have tended to be national in character, haven't they?

Ms Power—That is right.

Prof. Deeble—The only problem with prevention is that we need to be realistic. I would say to myself :'Be realistic. What do we prevent?' The things that I know of that have a very specific and defined relationship are diabetes and obesity. Tell me what else. We are all being—

Mr CADMAN—You might say that 'heart condition' is also linked.

Prof. Deeble—Heart condition would be. Maybe it has the same sorts of dietary measures. We want people to change their lifestyle.

Ms Power—Breast cancer—

Prof. Deeble—The changes in lifestyle—Prudence, you might be able to comment more on this—associated with the smoking campaign came about because of a change in social attitudes to smoking. They did not come about because cigarettes cost more or because people thought that smoking was going to do them harm; they changed because smoking was no longer

approved of. I am not sure—and this is the difficulty with promoting it in a democratic society—what you would show to the individual person as a result of a preventative campaign that simply involved asking them to give up all those things that they like doing.

Mr CADMAN—HIV-AIDS might be one!

CHAIR—There is a causal relationship there.

Ms Power—The HIV-AIDS campaign was a joint campaign. There was a great deal of cross-party collaboration at the federal government level, which I worked in at the time, and there was also a lot of collaboration between federal and state governments.

CHAIR—AIDS was new.

Ms HALL—It is a good example of what can happen when everybody works together, isn't it?

Ms Power—There are lots of other points to be made; that is absolutely right.

Prof. Deeble—It was very frightening.

Ms HALL—Yes.

Ms Power—But it is a good example of what can happen when you work together.

CHAIR—We are getting close to time.

Prof. Deeble—Chair, there is just one little thing I want to mention and then I will leave you to it. I gave you a little bit of paper—'Funding of public hospitals, 1997-98 to 2003-04'.

Ms Power—There are two things.

Prof. Deeble—The last item on the agenda on the Medicare items: some things should have been added to it. I think the Medicare Benefits Schedule has been fairly stagnant. They have added some new things recently in preventative medicine and so on, but among the things which are covered under private insurance and which are two of the biggest growing items in the private hospital use area are chemotherapy and dialysis. Both of these are related to life-threatening conditions. They do not have to involve the admission to a hospital, because most of the public dialysis centres are actually stand-up.

CHAIR—We were down in Adelaide a fortnight or so ago and we saw some dialysis in public hospitals.

Prof. Deeble—In short, there are plenty of things on the Medicare Benefits Schedule that are not provided directly by doctors. Most pathology is not and a great deal of radiology is not. I can see no reason why dialysis and chemotherapy should not be Medicare funded, with the development of stand-alone centres—which will not grow up while it is part of the hospital insurance system. There is no reason to attach it to the hospitals. I am not saying that some of

what is covered by private insurance should realistically be taken over by Medicare. But I think there is no justification for why Medicare should not fund an item like that, which is not discretionary and for which there is no choice of treatment site. I would certainly recommend it for those two, anyway. Some of the arthroscopies and so on may well be considered to be sufficiently established as procedures so that included in the medical benefit can be the non-medical part of that as well. The doctor is paid for but the rest of it is not.

Ms Power—That is an additional item that was not included in our submission.

CHAIR—In the couple of minutes that we have left, how are we going to solve our workforce problems? All medical training is done in the public sector. We have heard views that the private sector, because their share of the procedures is increasing all the time, should take a role in training.

Ms Power—And do some training?

CHAIR—Yes.

Prof. Green—There has been quite a lot of discussion around that over the last 12 months. I am aware of that.

Ms Power—I think we need to use all possible sites for training.

Mr O'Connor—The thing that matters is what comes out the other end—that is, that we have a set of standards or competencies according to which we assess the graduate, the doctor. As long as they have those it does not matter a great deal where they have derived them from. However, it is important to recognise that there are still and there will continue to be—mainly because of cost structure—significant differences in the type of work and the type of exposure that occurs in many large hospitals compared to many small hospitals. It is a matter of fact that most, not all, of the large hospitals are in the public sector. There are some differences in the types of experiences and exposures that trainees will get in some of those settings. One would need to control for that as one trains the doctors in those settings.

Ms Power—Obviously, there are a whole lot of other issues around how health professionals work with each other or not. We could talk for a long time about how there needs to be a breaking down of the silo mentality within the health workforce.

Ms HALL—I think you mention that in your submission.

CHAIR—Have you had a look at the Productivity Commission report?

Ms Power—Yes. The AHA supports most of the recommendations in that report.

Prof. Deeble—I gave you a couple of pieces of paper, which are about the funding of public hospitals. This was a particular thing of my own, not necessarily from the AHA. There is always debate about who pays more money than everybody else. Prior to the last election—well, prior to the state agreements—the government certainly made the point that the states were not living up to their responsibilities, that the Commonwealth was paying more money and that it was

growing faster. It was as clear as that; it said so in the ads. Actually, that was not true. I am not suggesting that there was any intention on behalf of the Commonwealth or the people who said this to be wrong. It is simply that they were using figures that they did not understand. To my horror, actually—because I knew at the time that it was wrong—the states did not know it either so they did not object to that interpretation.

That bit of paper just leads you through the reasoning. It is fairly densely written but it says that, instead of the Commonwealth paying more, in fact they have been paying less. That is because they have added into their sums as part of their contribution two items that are outside the agreement altogether: vets, which is a 100 per cent Commonwealth responsibility, and a notional allowance which the Australian Institute of Health and Welfare makes for its own economic purposes. It is a notional allocation of the 30 per cent private insurance rebate which does not go to the hospitals—they just get the fees—but it goes to the patients via the health funds. If you take those out then the sharing is the wrong way around. The states have always provided more except for one year. If you have a look at that paper you will see that the margin is widening. It was about $430 million each in 2004—that is, the Commonwealth should be paying $430 million more and the states should be paying $430 million less. In the year after it was about $500 million and I would think that this year it will be even larger because the escalation factor means that the states have to pick up more of the growth.

I just mention it because, while I am not suggesting that anybody was deliberately wrong, they did not understand the figures they used. The states are facing a growing shortfall in overall funding and, in the next two or three years, the agreements will get to be a very considerable sum. Over the period of the agreement, it will probably be a couple of billion dollars. I only put this to you because I thought it was useful to have this brought to your attention.

Ms HALL—I move that this be made an exhibit. Also, you have another paper there that you said we could have; I move that that be made an exhibit as well.

CHAIR—There being no objection, it is so ordered. Thank you very much for appearing before us today. What you have told us is very valuable to us. During the course of this inquiry, evidence goes on the website. If you see anything that is of interest to you that you want to comment on, please follow it up. We would be very interested to hear it.

Ms Power—Thank you for the opportunity.

Proceedings suspended from 12.32 pm to 1.02 pm

BARNIER, Mr Gary Paul, Executive Member, Australian Diagnostic Imaging Association

MEIKLE, Dr Ronald Gordon, President, Australian Diagnostic Imaging Association

PRYCE, Mr Edward James, Treasurer, Australian Diagnostic Imaging Association

SHNIER, Dr Ronald Cecil, Vice-President, Australian Diagnostic Imaging Association

CHAIR—Welcome. We know you have come from a long way away to give evidence to our inquiry, and for that we thank you. Would you like to make an opening statement?

Dr Meikle—In coming today to address the committee, the ADIA has brought representatives with great expertise in the business of providing radiological services: Mr Barnier, who is the chief executive officer of I-MED; Dr Shnier, who is a well-recognised technical expert in MR and other high-tech radiological and imaging matters; and Mr Pryce, who represents the provision of country services in the ADIA.

The ADIA represents about 70 per cent of private radiology, which is about 10 per cent of all Medicare outlays, and about $1.3 million is spent on radiology under the radiology MOU. We are part of an industry which has annual expenditure of about $2 billion.

There has been an explosion in radiological demand, and for people who live in a capped funding environment under an MOU this creates great difficulties. MOUs have served governments well. The previous MOU provided $400 million worth of savings, which were achieved through high-tech and efficiency, but there are no more of those savings to be made. We are now in an entirely different environment, with new technological requirements, new IT requirements and enormous cost pressures. Those cost pressures include massive increases in wages for paramedical people. We are looking at the moment at the desperate situation of a very significant overspend in radiology which is estimated to be about $100 million in a fiscal year, and we are facing cuts to the rebate to keep the MOU on budget. Such an action will have catastrophic effects on our ability to deliver service, both in the country, to meet the demands of high-tech and to maintain our workforce, which has become globalised.

The principal messages we would like to give today are these. When there are policy changes under an MOU they have very significant impacts on outlays for the provision of these very important diagnostic services. Most technological medicine is underpinned by high-quality imaging services. There has been very significant cost shifting, as you would be well aware from the submission that we have made, which is eroding the amount of money under the MOU, and this is increasing almost weekly. The size of this cost shifting is very difficult to determine. We are extremely concerned about it. We are extremely concerned about the unlevel playing field of public hospitals competing for private arms-length referrals in the marketplace as a strategy for raising income to support the public hospital system. To give a snapshot of the implications of some of these changes, I would like to invite my colleagues here, first of all Mr Pryce, to comment on the impact of some of these changes on rural services.

Mr Pryce—I provide a rural and regional service in the Northern Rivers area of New South Wales—the Clarence and Richmond valleys. We have outlying branches, if you like, where we provide services to those regions. They are supported by our larger facilities, basically because they just do not make any money. If we do not have a decent business case with a decent income flow to make it worth while to continue to do these, they become a real struggle for us. So the situation is now that we are actually asking the community to subsidise that service. The community has to make a contribution in order for us to meet their expectation to provide the service.

CHAIR—Is that based on volume?

Mr Pryce—Based on volume and margins, yes. If you take a location like Tenterfield, for example, which is two hours from everywhere, and you run vehicle up there, you have someone on the road for four hours—two hours up and two hours back. And to provide an ultrasound service you have a $250,000 machine sitting up there. You are providing a service to that community. If you do not do that, the community has to travel. But it is not a money-making exercise; it is a community-making exercise.

CHAIR—How often would you do that?

Mr Pryce—Twice a week.

CHAIR—Would you have a full book of patients?

Mr Pryce—Yes. We get 10 or 12 a day. It is appreciated by the community, as you can imagine, but we are doing it out of the goodness of our hearts. That is just one example.

Dr Meikle—This cost pressure is being felt in metropolitan areas. Perhaps it would be appropriate to invite Mr Barnier to make some comments because he is the chief executive officer of what is probably the largest radiology company in the world.

Mr Barnier—The cost shifting that we believe is occurring is impacting us in several ways. We also think it is impacting the delivery of health, and that concerns us. The first issue that concerns us is that hospital administrators seem to be encouraging clinicians to work on private work while public work is not being done. We are aware and concerned that there are 8,000 unread films in the state of Queensland right now in the public system; there are hundreds of films at Westmead Hospital not being read. Last weekend a chap was discharged from Sutherland Hospital—it was reported in the ABC—with a fracture because nobody read his film. Meanwhile we are competing vigorously against the public hospital system for Medicare work, while those things are not occurring. We do not mind competition; we are not frightened of competition. But it concerns us that we are competing against public hospitals who have already had their equipment paid for and who have already had their staff paid for through other grants, yet they are working on Medicare work in the private sector.

CHAIR—Are you saying an X-ray was taken and not read?

Mr Barnier—A specialist did not read it, yes, and that is a common occurrence.

CHAIR—So there is no radiologist's report on that patient—

Mr Barnier—Correct.

CHAIR—which you must have in private practice?

Mr Barnier—That is our whole private practice. In many instances, the private practices are asked through contract with the public hospital system to do that reading. We are happy to do that, but it concerns us that we have to do it where it is difficult for the public hospitals to provide their own staff, yet where they are able to get staff they compete with us on this basis.

CHAIR—Let me go back a bit. Why is it not being read in the public sector? Is it because they do not have the expertise or staff?

Mr Barnier—They just simply do not have the staff concentrating on reading accident and emergency films. They try to get more and more staff, and to entice them they encourage them to do the public work that they are looking for them to do but they also give them private rights of practice, which move more and more into these private areas. The public hospitals have budgetary constraints; they are short of cash. The hospital administrators say, 'Here's an opportunity; let's do even more private work on public infrastructure,' and they encourage the scarce resource to do even more private work. In our view, this is at the expense of the public work they are mandated to do.

CHAIR—And that they are being paid for under Medicare?

Mr Barnier—Correct.

Dr Meikle—One of our principal complaints is that in many cases the eligibility for Medicare is contrived in the public system by spurious reclassification of patients, by privatising outpatients and by transferring the people making elections out into the corridor and back into the X-ray department—in the interim, one apparently became Medicare eligible. There are many examples of that that we could probably give you in camera. This is a very serious, ongoing problem whereby the public system is using Medicare moneys to fund itself and to make extraordinarily attractive packages for radiologists—a commodity in internationally short supply—such that we are now seeing packages offered in the public sector which are augmented by Medicare funding and which we simply cannot compete with. So the sustainability of the workforce and our goal of accessible and affordable services is being severely thwarted.

Ms HALL—Are there any private radiological services that are high cost or cutting edge that are referred to the public sector? That is cost shifting back the other way.

Dr Meikle—The only example of that that I can think of is for PET scanning. Perhaps I could pass that to Ron Shnier to comment on.

CHAIR—Just remember that we are all laypeople, and that sometimes we do not know what you are talking about.

Ms HALL—I know what you are talking about.

Dr Shnier—I actually think there are two answers to your question. I work for Symbion Health, I am their national director, and we have community and hospital based practices. There is no question that there are some community based service diagnoses which are referred on to the public system because they require a much greater level of complexity than you can supply in a community practice. I am not aware, and we run several private clinics all along the eastern seaboard, of anything that can be done in the public sector not done in our rooms that we refer on to them. I can imagine that there are certain levels of sickness of patients where it is not appropriate to do it in private practice. There is no question then that that could be seen as a cost shift back, for example to get your abscess drained. Certain procedures are much safer when done in a public hospital. I do not think it is a significant issue but it would happen to some extent.

Mr Pryce—That becomes an appropriate way to care for someone. Generally speaking, they would be admitted to a private or public hospital and once that admission takes place then that is the correct place for it to happen.

Dr Meikle—One issue which I think we need to emphasise to your committee is that we actually sit on the Radiology Management Committee with the Department of Health and Ageing and the College of Radiologists and manage the $1.3 billion or $1.4 billion a year in outlays. We are very close to the action about making these decisions and monitor the outlays on a regular basis. Our biggest problem is that we are monitoring and managing a fiscal envelope not a health care delivery envelope. This is a very important distinction. Modern technology is changing the role of the gatekeeper. There is another issue that we could get Dr Shnier to comment on. For instance, it is now possible with new modern CT to make pictures of the coronary arteries in just a fraction of a second. These are in three dimensions and are of amazing quality. Who is going to be the gatekeeper of this? Who is going to fund this? How is the benefit of this new technology going to flow back into the MOU so that it is appropriately funded? Perhaps I could pass this to Ron Shnier so that he could comment on the impact of some of these new technologies. They are not just more of the same; they are entirely different approaches.

Ms HALL—So the MOU is still a big issue?

Dr Meikle—It is if the answer is that we have to accommodate all these new techniques and we have to accommodate this massive growth in services as a result of government policies to encourage further GP activity. They have had a flow-on effect and this is very substantial. We are currently in deep and meaningful discussions with the department about making further contribution to the cap to compensate for the larger amount of this overspend on which we have done considerable amount of work with Access Economics and the like to demonstrate that there is a link between the two. But to come back to this point about fiscal policy and actually a health care delivery paradigm policy structure, I think is important.

Dr Shnier—I might start with a very brief overview. I will use CT as an example, but you could apply this, for example, to MRI. If you take a five-year snapshot retrospectively, every new CT scanner, the day it is released to the market in Australia, sits between $1.2 million to $1.5 million. Every year a significant change in that operating platform has occurred. If you are the owner of such a machine, you devalue them as if they were sophisticated PCs. You might say, 'Well, you actually don't need that new technology.' I would agree with you until about one to two years ago where multi-slice technology came of age. There is not a government in the

world, including this government, that will not accept that preventative medicine and early diagnosis is a far more effective health care delivery system than diagnosing middle and advanced stage disease. What CT, for example, has done is to provide some tools that have changed that paradigm. You can do earlier diagnosis quickly and more safely. More importantly, it is now being used not only as a diagnostic tool but as a triage tool. The only lever that we have used with, for and against us at the moment is a fiscal lever. I actually think that, because of what technology has done, we need some direction and some debate with the department of health to say there is possibly a new paradigm of health care. Who is going to be the gatekeeper of this technology? Remember that theoretically all tests are arms-length referred.

CHAIR—Are you having this debate with the Department of Health and Ageing?

Dr Shnier—We have it to some extent at the level of the RMC, but it is my feeling—and this is my independent view; you would need to see what my colleagues think—that it is more a fiscal debate than a health care delivery debate. We are not sure how to engage the department to come up with a solution to it. I was in Seattle two weeks ago at a big MR conference, and the gentleman who is the head of NIH—this man looks forward to see where their multibillion-dollar research project will go—is going to put the majority of his budget into early diagnosis and preventative medicine, of which radiology will be a substantial part. Yet we are still stuck on the paradigm of diagnostic imaging per se rather than early diagnosis and intervention.

Dr Meikle—This is one of the constraints, of course, of the current MBS system. It is an insurance rebate system based on illness, not on wellness maintenance. In fact, it is an offence to make a claim for a screening procedure under the MBS.

Ms HALL—Do you think that should be changed?

Dr Meikle—Clearly. I think there are very clear indications for the early detection of a large number of illnesses—colon cancer, breast cancer and the like.

Dr Shnier—I think it is an antiquated paradigm.

Mr Pryce—The issue is that for every person we keep out of a hospital bed someone else hops in, so quantifying it is the thing. But Ron is totally correct. The diagnostic ability that we have and the things that we are asked to do are fantastic, and the money does not represent it.

CHAIR—I cannot understand the logic of the health department not giving this recognition. Do you want this recognised in the MOU?

Mr Pryce—Yes, absolutely.

CHAIR—So, change the current one that is in force until 2008?

Dr Meikle—The current MOU is, at the moment, under extreme pressure. We have a claim before the government for $186 million, which represents only a small part of the impact of policy change. We are not particularly—

CHAIR—Which policy is that?

Dr Meikle—These are the policies that related to increasing GP consultations through extended Medicare type arrangements. We have quantified the cascade effect of those—more people going to the GP and therefore more imaging; more people going there then having specialist consultations and more imaging from that. We have quantified those and come to a view, with external statistical assistance, that that is the quantum of money that would need to be put back into the cap. And that, of course, takes no account whatever of the extended Medicare safety net and the disinhibition that it has produced amongst presumably doctors and patients, to say: 'You can have these tests.' People have a great appetite for testing and certainty. But if you know you are going to get 80 per cent of the cost of these tests refunded, of course there is an even bigger appetite to have these done. We believe that there is a very large component of disinhibition from the extended Medicare safety net which is also driving some of the overspend in radiology. There are three components: the GP incentives, the extended Medicare safety net and the cost shifting. We believe they are the three dominant issues which are causing enormous pressure.

CHAIR—This may seem simplistic to you, but can you explain to me what happens with the funding when my GP sends me off for a CAT scan? It does not cost me anything.

Dr Meikle—If you are bulk-billed?

CHAIR—If I am bulk-billed by your practice, say. How are you paid? It is not a fee for service, is it?

Dr Meikle—Yes, it is a fee for service. If the patient is bulk-billed, whatever the MBS schedule fee is for that particular item—and there are numerous CT items in place, to add to the complexity—you will get that amount of money as a refund or an assignment from Medicare.

Dr Shnier—To put that in context, Ron said initially that we saved $400 million in efficiency under the last MOU. We basically cannot find any more efficiencies. In other words, our systems are as efficient as they can be; our staff are working as hard as they can. I think in 10 years there has not been a fee increase—

CHAIR—Is that reflected in the price that you get paid under—

Dr Shnier—That is what I am coming to. Particularly now, with the threat of cuts, the only way for us to sustain our imaging businesses and refresh our technologies is to increase the out of pockets to patients. Jim, for example, supplies a service in a more rural location. He—correct me if I am wrong, Jim—has been in one location for close to 30 years. He has not had to put up his fees, except until recent times, as successive wage increases have come. But it is not going to be sustainable for him. Either patients are going to have to say, 'It's going to cost me more,' or you are going to have to reduce those types of services which has a flow-on effect to central practices. You do get a benefit but it does not compensate you.

Ms HALL—It has happened to a large extent in a number of areas where there has been an increase in the out of pockets for patients. I know in my area there has been a significant impact.

Dr Shnier—It is a real issue.

Dr Meikle—I would like to ask Gary Barnier to comment a bit on this. Let me preface what I hope he is going to say by commenting that the total profitability of private radiology is now dependent on gaps. Those gaps are only paid by about 40 per cent of the patients, because the other people simply cannot afford them. What we are seeing more and more is that we are going to have to charge more and more of these people at least something towards the cost of their procedure if we are going to maintain our position in the current high-tech revolution, weather the storm of huge cost increases and maintain our workforce in an internationally competitive environment. I will ask Gary to comment on that.

Mr Barnier—Maybe I will just take it a step or two back. The memorandum of understanding is, I think, three years through the five years. It is a fiscal tool. It basically says: 'Here are the total outlays. This is where they are tracking against the target. Therefore, either the volume comes down or up or the price goes down or up.' And, because the volumes are tracking so highly at the moment, the idea is that the price might come down. The problem with a fiscal tool like that for us is that it really does not recognise the value proposition of radiology, particularly to the extent that we provide the first line of defence in a patient's management. The second thing is that it does not take note of changes in the delivery system in rural Australia or even in metropolitan Australia. I will come back to that in a minute.

I will give you an example of what we are finding. Last year a very high-profile celebrity was unfortunately diagnosed with breast cancer. She is a young woman in her mid-thirties. It is hard to diagnose. We were inundated with young women who have the desire to know whether they have similar problem. They have breasts which are difficult to diagnose because they are young women. We have invested a lot of technology in assisting them with that screening, and we have also done the work. The MOU does not recognise that; it actually inhibits that by suggesting that one should get a price reduction.

The question that is not clear to me is whether that is a good outcome or not. It seems to me that screening for that is a good public outcome and that person's very unfortunate event raised an issue that we are able to assist with. But, with the way the MOU works, we could well take on a reduction over that. The question then becomes, in the private sector and in my business: do we invest in new technologies to assist the public in looking at some of these outcomes? That is true in oncology; it is true in colon cancer, for instance. We can invest in CT that can do virtual colonoscopies that can assist people in early diagnosis. The question for us is: should we do that? While that is a good health outcome for the general public, with the way the MOU is currently structured we would get a reduction.

CHAIR—Are the public hospitals investing in that technology?

Mr Barnier—They are. This goes to my second point, which is that the way the MOU is structured it is not really discerning in terms of who is doing the work or the policy implications of that; it really just talks about Medicare as one bucket. So we get ourselves into a situation where the public hospitals actually are investing significantly in high-end cardiac CT and other high-end work, and that is very appropriate because they are at the acute end of care, but they are using some of that machinery to compete again in the private sector to get more money coming in.

Ms HALL—How can they compete in the private sector if you do not have the ability to offer that service?

Mr Barnier—We do.

Ms HALL—It just does not have an item number?

Mr Barnier—No, I am talking about two things. The first thing is the public policy and good implications of doing new work—and I will put that one side. The second thing—and this is a completely different point—is that the MOU does not discern who gets the Medicare rebate. So we find ourselves in a situation where the public hospital system buys this new kit to do the acute work it should do for public patients who are admitted—and that is exactly what it ought to be doing—and also to compete in the private sector because they get access to Medicare from private patients. The problem with that is that we find ourselves—

CHAIR—If those patients are referred by a GP to the hospital? Is that what you are saying?

Dr Meikle—Absolutely.

Mr Barnier—Yes, that is part of it.

Dr Shnier—There are two categories. Can I clarify that?

CHAIR—Yes, please.

Dr Shnier—If a general practitioner decides that a patient should go along to the radiology department at the hospital and have an examination, that is a choice made by the doctor and the patient. Our beef about the cost shifting by the public hospitals is that if you close the public hospital outpatients department those patients still need to be seen. I do not know if you are aware that the Monash Medical Centre was proposing to close its paediatric outpatients department in Victoria and 3,500 people on their books were going to be told to make private arrangements. That is a direct cost shift to the Medicare system and it has a cascade effect as well.

One of our great complaints is not only that they are competing there but also that they have 'good kit'—as Gary describes it—and they are campaigning in the community to use that to provide arms-length public services. Our complaint is that it is not a level playing field. When we provide the same services we have to buy the machine, employ the staff, rent the space and pay all the outgoings. In most cases, the public system has a lump sum payment made to it for those costs. We believe it would be quite appropriate to have some very clear definitions of what represents an episode of care, to stop this cost-shifting process, and even to consider having a differential schedule so that the reward is appropriate to the investment and the risk.

Mr Barnier—I have an addition concern—and I am sorry it is such a complex matter.

CHAIR—It is—and we are trying to get around it.

Mr Barnier—This is an economic issue and I want to take it slowly. My other concern is that the public hospitals should be buying the best equipment because they have the acute people; as those people are admitted and cared for acutely, it is absolutely appropriate. It worries me when they invest in even more equipment and start sucking in more resources to go the private route because there is the ability to get extra Medicare funds to top up their budgets. What happens when you are in the private sector—and this is me—is that the Bathurst Hospital up the road puts it in the newspaper that it has a 64-slice CT and is offering bulk-billing services against you. So you do not have the four-slice CT anymore; you go out and buy a 64-slice CT to compete directly against the public hospital system. We need to have a public policy and strategy conversation about how the private sector and the public sector can work together to provide the best level of service, not waste resources and, even worse, not drive up people's salaries—because we are competing for them.

CHAIR—Can a patient go to a hospital and ask for a CT or do they have to be referred?

Dr Shnier—Let me make this really simple: I will be the patient in three scenarios. In scenario 1, I come to you, Mr Somlyay, as you are my GP, and you say: 'I like the public hospital scanner. Here is a referral. Go up the road. I think it is your right and the hospital's right to do that procedure and bill Medicare for it.' The type 2 scenario is where I am an inpatient and I want an MR. We have a legal definition of an episode of care so, if I come in as a public patient, theoretically all my care is covered by my admission, not under Medicare separately. As I arrive in the radiology department, I would be classified as an outpatient, billed at the same rate as a private practice on that MR machine and become an inpatient as I leave that department. That is one type of cost shift. Not only do I get billed the same rate, but I do not have to pay the $1.8 million to put in that machine, I do not have to pay the $100,000 a year for the technologist to run it or another several hundred thousand dollars a year for the extra radiology costs to service it.

The other cost-shift scenario is what is called co-located practice. So I am a radiologist and head of the department in a hospital, and I decide to put in a comprehensive private practice on my campus. I then take a percentage cut out of my staff specialist salary—so my salary is still being underwritten to a large degree by the hospital—and this private practice competes against private practices off campus. There are issues of rent, and there are extremely grey issues of who is staffing it and who is paying the costs to do it. I can tell you that I have witnessed sonographers running into co-located practices, doing the tests and then going back into the hospital. That is a hidden cost. It encourages dishonest use of the service.

So the two cost-shift scenarios that we are most worried about are the patient's right and the doctor's right to refer an outpatient to a hospital and that it is appropriately billed under Medicare. It is the artificial reclassification of patients to outpatients—in other words, breaching what I understand is what is called an episode of care. It is co-located practices that force the lowering of the lines of who pays for what in terms of the infrastructure.

CHAIR—Does this happen in every state?

Dr Shnier—It happens in every state. It is most mature in Victoria and New South Wales. It is exponentially increasing in Queensland and Western Australia.

Mr Barnier—Yes, and recently an organised Western Australian effort was taken to go down this route.

Dr Meikle—It is alleged, according to the *Age*, that $200 million a year is cost shifted in Victoria. That claim was made a couple of years ago.

Dr Shnier—Again, if you take the cost-shift issue that I talked about, technology and the ability to actually change the health care paradigm, we do not have avenues to address this under the current format of the MOU. The current MOU is not necessarily bad. It has levers in it which should be compensated for under certain policies, and that is the subject of a claim that you are aware of. Surely the current module of fiscal levers being used to drive health care policy is antiquated, and it does not work. The system is heading towards a disaster.

Ms HALL—What is your solution?

Mr Barnier—As the major private provider in this country, I think the first thing we have to do is to take the current regime seriously. There are regulations around cost shifting, There is legislation in place. We should audit it and commit to it. I would like Medicare Australia to be given the right level of resource and to be advised that they should properly undertake an audit. I think that is the first thing that should happen. Again, as the major private provider, I think we should have a strategy conversation as soon as we can about how the private and the public systems can better work together to deliver the health outcomes. It seems anomalous to me that, right now, when the public hospital system cannot deliver health outcomes, I am asked to do it—for example, in the major regional centres. I am the only guy in Wagga and the only one in Albury, yet when the public hospital system sees an opportunity they compete against me. The problem I have with it is that I am competing for salaries and salaries are getting driven up. That seems crazy. There must be a better way we can work together. That is the second thing. The third thing is that we ought to start talking now about how we structure the MOU going forward, or the next MOU at the very least, on a values basis—on an outcomes basis, not just on a straight fiscal volume for price. It has to be much more about the outcomes that we can provide to the Australian public.

CHAIR—The Commonwealth Auditor-General is currently conducting a performance audit of the health care agreements. Would you be comfortable if the Auditor-General looked at the problems you have raised here?

Mr Barnier—I would be delighted. I think that is a great idea.

CHAIR—Would you request me to bring it to the attention of the Auditor-General?

Mr Barnier—I would request you to do that and I would be more than pleased to provide whatever assistance we could to that review.

Dr Meikle—Chair, you may not be aware but it has been HIC policy not to conduct audits of public hospitals even though these matters have been brought to their attention.

CHAIR—The Commonwealth has not got the power to audit the states but they have got power to audit the compliance with the health care agreements. Part of the health care

agreements are about not cost shifting. I can write to the Auditor-General and bring it to his attention to include in his current audit of the health care agreements. He is looking at another issue that was brought before the committee by another doctor and it is not beyond him to examine this. Would anyone disagree with that?

Mr VASTA—It is a good plan of action.

Dr Shnier—It is all very well to embark on a mission statement that says that we are going to audit public hospitals—

Ms HALL—We cannot do that.

Dr Shnier—but the truth is: can you really do that? Do you have the resources to do that and is the system viable enough for you to do that? I suspect that the answer is going to be no. I think that you will only ever find the tip of the iceberg. A smarter way to do it would be to come up with a true cost model that says that, if you are in a hospital practice or a co-located practice, you get MBSA, and if you are a true private practice then you get MBS2A, for example. This is no criticism of the processes of government but, as an example, often you should enter some that you think you can succeed with and put the right resources into it, trying to be smart and saying you can really get to the bottom of the problem and change it. There may be simpler ways to do that, and that should be a debate that we should have as to whether it is a fair system.

Dr Meikle—It is possible with respect to claims under the MBS to conduct audits because those claims are made by doctors even if they are made on behalf of the institution in which they are working. So it is possible to conduct a very significant audit of the appropriateness of claims with respect to the eligibility of those patients to make such claims.

CHAIR—So I could also raise it with Medicare as I have with—

Dr Meikle—With the HIC, yes: that there is a serious matter of audit in the public hospitals and that the LSPN data, which is location specific data that tells you exactly where that institution is or the site where that claim is being generated—not just the doctor's name; the doctor might be peripatetic, but the actual spot where that data was raised—needs to be looked at and its integrity confirmed. There is some data at the moment but we have serious doubts about its rigour.

CHAIR—If the committee agrees, I will be very happy to write, firstly, to the Auditor-General to have a look at it from the point of view of the health care agreements and, secondly, take it up with Medicare, the HIC, and they can be in contact with you and you will have to give them specific examples. I am more than happy to facilitate that. You are in negotiations with Commonwealth at the moment, aren't you?

Dr Meikle—We are. That is correct.

CHAIR—Do you want to tell the committee how that is going?

Ms HALL—Maybe that should be taken into account too when all these things are being looked at.

Dr Meikle—In recognising the stress and the overspend in the radiology milieu and faced with the prospect of significant rebate reductions, the College of Radiologists together with the Diagnostic Imaging Association obtained the services of Access Economics to do a very broadly based statistical analysis of the impact of various government policies over the last two years. That resulted in a very substantial report which we have lodged with the department with commentary. At the moment that report is being assessed by the department. I must say that the process is slow—it has taken more than five months—but we are expecting soon to hear what the independent advice on our statistical analysis is.

As I mentioned before, the scope of this is a catch-up payment for the last two years since the MOU in the form of an ongoing contribution to the MOU for the remaining years, the total being $186 million. This, however, falls a long way short of the projected overspend at current levels of demand. We think that, with the current levels of demand, the overspend over the remainder of the MOU and with the current already accrued overspend will be somewhere close to $300 million. That is a very large sum of money and we are very mindful of our responsibilities with regard to this. But, in the context in which we are operating at the moment, we are feeling both very anxious and very concerned about the viability of the MOU, the sustainability of the industry and our ability to provide high-quality, accessible and affordable services.

Dr Shnier—To clarify one point there: we have put in a claim for those things we feel we have identified, but there are substantial things yet to be identified and there is an element X quantity, however big it is, of something no-one can quantify and that we do not understand—nor does the department of health, and they are embarking on their own drivers-of-growth study to understand it. So the claim is quite conservative. We have only claimed for something we think we can relatively accurately quantify. There may be subsequent claims arising from that, but there is an element that neither party understands, and the department of health is making an independent inquiry into that.

CHAIR—Is your Access Economics report public?

Dr Shnier—It has certainly been tabled to—

Dr Meikle—The department.

Dr Shnier—the department, so I would imagine it is.

CHAIR—Could you give this committee a copy if you have one?

Dr Meikle—I do not think we have a problem with that.

Dr Shnier—No, none at all.

CHAIR—Okay. We have told you what we will do. I believe the department and the minister are very close to making an assessment. So I will write those letters next week and we will get the process under way.

Dr Meikle—Thank you very much, Chair.

CHAIR—Do you wish to add anything else?

Dr Meikle—I will say one thing. This is obviously a very complex issue. The provision of these services underpins a great deal of medicine, and I really do not feel we have been able to give it the justice it probably deserves in the broader scheme of things in the time available. So I would just like to express our willingness to come back and address the committee again or take further questions from you and give considered responses to them.

CHAIR—Okay. That may be necessary after we contact the Auditor-General and the HIC, and after I speak also with the minister regarding the status of the report. Thank you very much.

Dr Meikle—Thank you very much.

CHAIR—Could someone move that we accept that Access Economics report?

Ms HALL—So moved.

CHAIR—As there are no objections, it is so ordered.

Proceedings suspended from 1.48 pm to 2.03 pm

CHAIR—I declare this meeting closed. Thank you for your attendance.

Resolved (on motion by **Ms Hall**):

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 2.03 pm