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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

THURSDAY, 20 JULY 2006

NEWCASTLE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Thursday, 20 July 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 Entsch, Ms Hall and Mr Somlyay

Terms of reference for the inquiry:

To inquire into and report on:

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

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

The Committee shall give particular consideration to:

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

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

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

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

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

WITNESSES

Committee met at 9.07 am

CHAIR (Mr Somlyay)—I now declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing in 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. The committee is pleased to be visiting a major regional centre as part of the health funding inquiry. At today's public hearing the committee will hear from a number of local health service providers including representatives from the Hunter New England Area Health Service. Also appearing are the Hunter Urban Division of General Practice and the Belmont Birthing Centre, organisations that are recognised as delivering innovative health services to meet the needs of local communities. The committee will also hear from the local branch of the Australian Psychological Society and NIB Health Funds, a major private health insurance provider in Australia. This hearing is open to the public and a transcript of what is said will be placed on the committee's website.

I will give a brief background to the inquiry. The Council of Australian Governments, COAG, is dealing at the state-Commonwealth level with future health policy. COAG established a senior committee of bureaucrats to carry out this exercise. What we have been doing in this inquiry is running our terms of reference virtually in parallel with the COAG process but giving people, such as the witnesses we will hear from today, a chance to have an input into that process—an input which they would not otherwise have in the COAG process. We have gathered some very important evidence over the past 12 months. A lot of the information that we have been given in evidence has filtered through to the COAG process and the government has responded quite positively to some of the problems we have identified.

[9.10 am]

CLOUT, Mr Terrance James, Chief Executive, Hunter New England Area Health Service

CHAIR—Welcome. Although the committee does not require you to give evidence under oath you should understand that these hearings are formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be considered a contempt of parliament. Would you like to make an opening statement?

Mr Clout—Thank you for the opportunity to make some comments which I hope will be of some assistance in the committee's considerations. I have prepared for today a short background paper that I do not intend to go through in detail but will provide to the committee. There is some information I will take you to quickly, and I will leave the rest for your consideration. If it is acceptable to the committee, I would then like to make some comments on the paper. Some of it I will talk to; some of it I will read. Then I will be available to answer any questions.

The background paper gives you a sense of the Hunter New England Area Health Service. Hunter New England Health has been in existence as a separate corporate entity since 1 January 2005. It has the responsibility to provide public health care services to a population of about 840,000 people. It covers a reasonably large geographical area. There is a map on the third-last page of that paper. It covers the major city and regional centre, which we refer to as greater Newcastle, and extends into rural areas of part of the Hunter Valley. It extends on to the other side of the Great Dividing Range and up through Tamworth and Armidale, and follows the western side of the Great Dividing Range all the way to the Queensland border and across the Queensland border west to Boggabilla, Toomelah, Mungindi, Moree and down through Narrabri. It is an area geographically the size of England.

Within the health service we employ about 14½ thousand staff. We engage about 1,500 visiting medical officers who are contracted senior medical consultants and we have the support of about 1,600 to 2,000 volunteers at any point in time. We provide services to about 12 per cent of the state's population. This area health service has within its boundaries the largest number of Aboriginal people of any of the eight area health services in New South Wales but, as you will appreciate, not the greatest proportion. The Western Area Health Service of New South Wales, while having lower numbers, has a greater proportion of its population with Aboriginal or Torres Strait Islander background. We have an expenditure budget for 2006-07 of about $1.3 to $1.4 billion, and a net cost of service budget of about $1.1 million.

We have, therefore, within our area health service a major city, rural areas and remote and rural communities. We have about 50 physical facilities called hospitals across the area and we provide services off about 120 sites across the area. Our hospitals range in size and service from the John Hunter Hospital, which is at this time the largest hospital in New South Wales. It has the busiest emergency department in New South Wales. It incorporates one of the three paediatric hospitals in New South Wales, the other two being in metropolitan Sydney. It is a centre for one of the three major retrieval services in New South Wales, and a centre for one of the three networks of children's retrievable services in New South Wales. It is a very major service provider, teaching hospital and research base hospital.

It also incorporates and works with the Hunter Medical Research Institute which is a collaboration between the University of Newcastle and the area health service. That is a centre for one of the hubs for medical research in New South Wales, so it is a major facility. It is probably the head of what we call our acute network of hospitals. There are seven other hospitals within that acute network. They are basically also teaching hospitals and referral hospitals within our network.

If you have a look at the map those other major teaching and referral hospitals, other than John Hunter Hospital, are the Mater hospital—the Mater hospital works within the network of our hospitals but it is what used to be called a third schedule hospital. It is owned and run by a religious order and has its own board. It is totally funded by the state government through a service agreement with the area health service. We work very closely with it and it with us in terms of providing services within the network, so it is another of our acute network hospitals. There is also Belmont hospital—within which is the birthing service that you will hear about later on—Maitland Hospital, Tamworth Hospital—in the New England and northern part of our area health service—and Armidale Hospital. Then in the coastal regional area is Manning Base Hospital at Taree. They make up our acute network of hospitals.

We then have a further 41 hospitals that are within our primary and community network of health services. I am making the distinction between a health service and a hospital because once we get outside of our acute network of hospitals we have another 41 sites where we are attempting to improve the integration and, if you like, continuity of care between our community based services and our hospital services. Those hospitals range from quite significant hospitals through to very small hospitals. They are also supported by multipurpose centres or services, which I will refer to a little bit later because of the importance they represent in terms of an innovative model of care that takes into account the integration between the Commonwealth, the state, local government and the others. They are something that I am very supportive of and I will talk about it a little bit later. We also have an area-wide mental health service, and you will hear from myself and two of my colleagues in the mental health services in the next session, so I will not dwell on that.

Obviously, we are required to be self-sufficient as far as is possible. There are very few services that we do not provide within this area health service. Probably the two that we do not—and we are in partnership with the Royal North Shore Hospital—are major burns and major spinal injuries. Those are ones where there is a delineated role for the John Hunter Hospital. Then above that it operates in conjunction with that hospital which provides a state-wide service across New South Wales.

That is the background. I want to briefly draw your attention to the diagram, which I am not going to go into, but simply to say to you that the change that occurred in January 2005 meant that area health services no longer have area health service boards, notwithstanding that they are corporate entities. The relationship is one where the Minister for Health has the Director-General of Health responsible to him. The chief executive of the area health service is directly responsible to the Director-General of Health. That is represented two pages further on—in terms of a governance diagram. That is a significant issue in terms of how to govern as a chief executive as well as being the managing director of the senior management team of an area health service. I will leave the diagram with you to show how we attempt to do that.

I have included, on the next page, a diagram of the clinical and community engagement framework and process that we operate within the area health service. Suffice to say that as an organisation that is 18 months old, over an area the size of England and with more than 100 communities within that area, the concept of engagement with the community is a very difficult one, but we believe a significantly important one in terms of how we get to a level of comfort that there is confidence in the health services that are provided.

It is also absolutely essential for the things that you are looking into in terms of how we ensure that there is integration between the levels of health services that are provided that are funded through our service—in other words, those that are funded through the state and the Medicare agreement through the state—on the one hand and the general practitioners who are providing services on the other hand, as well as the other health care providers who work under the other systems. The integration between those services is absolutely essential. The further you get from a major metropolitan area, the more critical those relationships become. I would argue—and I suspect Arn Sprogis from the division of general practice this afternoon will argue—that while they are essential in the more remote and rural areas they are also critically important for the provision of services into the future in metropolitan areas. I am sure he will give you a full explanation of his views in relation to that.

The next page simply sets out the structure of the management of the area health service, and I will not dwell on that. The next part is simply, for your information, a statement of Hunter New England Health's vision. That document represents our strategy map, how we are trying to work towards our vision, and sets out the values of the organisation. I will not dwell on that. The next pages I will leave for your information. They are a description of the various combinations of services that are provided across the area health service and some definitions in relation to those so that we can get some synergy of understanding of what services are available through and at each of the clusters and the sites. That is some background information.

Very clearly, the Hunter New England Area Health Service covers one of the most diverse areas of New South Wales. That is both its challenge and what makes it exciting to work within such a service. We are unlike the other area health services in New South Wales, which are predominantly metropolitan—in the Sydney basin basically—or clearly rural, and there are three of those. We are probably the only one where there is a significant mix of the two. We are challenged by the fact that we have a mix of population which varies from the quite affluent to the poorest of the poor.

We have socioeconomic disadvantage in our area health service. It is patchy. It would be nice to think it was all in one area so that you could make decisions and have those decisions have an effect on the health outcomes and the health status of the communities in a nice set of boxes, but it does not appear like that. The socioeconomic disadvantage shows in the health status of the community. Our Aboriginal population in this area health service, whether it be in metropolitan Newcastle or Toomelah or Boggabilla or Moree or Tenterfield, exhibit all the same health status differentials that we see across Australia. For example, the life expectancy, whether it be male or female, is some 20 years less than for the general population of this area health service, this state and this country. That is a significant difficulty for us.

One of the other differences within our area is that it goes from metropolitan areas where we have a reasonable availability of workforce—general practitioners, other specialist medical staff,

specialist nursing staff, allied health staff—through to rural and remote areas, where the availability of general practitioners, senior medical consultants and allied health staff in particular, is a major challenge for us.

It could be argued that—and I would argue this—if you look at our system of health service delivery in this country, it is split between state and federal. It has different funding systems which have different incentives and perversions in all of them. We have an uncapped system at one end through the MBS and the PBS and we have a capped system through the Medicare agreement and funding that comes from the Commonwealth to the state and then the added state funding which is capped. Often the question arises: should we be putting more into health funding? I am not going to make any comments about where that funding should come from and what the proportion should be. That is not my job; that is a job for governments and politicians, quite frankly. Our job is to provide the best services with the best coverage that we can to the communities with the budgets that we have provided to us.

However, there are some controls that are put in place by the system in the uncapped end of that system which act as caps on service availability and on access to services. One of those is workforce. For example, when we make decisions about how many places we will have in universities for doctors, nurses, allied health staff and all manner of health professionals, if that is too limited—and obviously in the current workforce arrangement I think everyone accepts that it has for the last while historically been so—you finish up with a workforce shortage. We have that in medicine, nursing and allied health. Where does that impact most? The evidence is clear on this in my view. If you are in metropolitan Sydney, or if you are in New South Wales, the further you are from the Harbour Bridge, the greater the impact of the shortage of trained doctors, nurses and allied health staff brought about by the restriction on places in universities and other colleges. The more it impacts on the workforce, this acts as a cap on the availability to provide services.

Ms HALL—Can I just interrupt. Would you say that in our region though, the further you are from the heart of Newcastle a similar effect takes place?

Mr Clout—My view about that is quite simple. In metropolitan Newcastle, what we call greater Newcastle, we have a greater difficulty attracting and retaining than if we were in inner metropolitan Sydney. I say 'inner metropolitan Sydney' because I would say we have the same difficulty as the outer western hub of metropolitan Sydney. It does not matter what word you use, we say we are a regional centre. The outer western part, and probably the rim around northern Sydney and the Central Coast which borders our area, would have the same difficulty. They have greater difficulty attracting and retaining a workforce than inner metropolitan Sydney. But there is no question that we are able to attract and retain a workforce in a much better way in greater Newcastle than we do in Maitland, and Maitland is probably better than Muswellbrook and Muswellbrook is probably better than Armidale and Armidale is probably better than Moree and Moree is probably better than Tenterfield. That acts as a cap. My view about that is that as a country we need to train more doctors. I think there has been a recognition of that right across politics, right across the states and the Commonwealth and that is being addressed. We will have a significant problem for the next 10 years at least until such time as we can continue with the increase in those training places. Obviously, I would like to see it happen more quickly.

Mr ENTSCH—Do you have the capacity here within your own training facilities to be able to take more on?

Mr Clout—We need to do that too. I think the answer to that is unequivocally yes. We were very pleased with the commitment at the COAG meeting last week and to see that there are additional places available for medical students in what is, I think, an incredibly innovative model developed across two universities—the University of Newcastle and the University of New England in Armidale—in partnership with the area health service to provide that. Obviously, in putting that proposal together to get state and Commonwealth support, we needed to ensure that we had the capacity to provide the training places, which is our responsibility.

Mr ENTSCH—Are you finding that the more that you can attract locals into your local training facilities, the more chance you have of retaining them in the region?

Mr Clout—There is no question about that; there is absolutely—

Mr ENTSCH—It seems to be a common trend.

Mr Clout—It is. We often hear people talk about the need for us to recruit clinical professionals. When I say 'clinical', I am talking about medical, nursing and allied health. That is the major issue. I think that the issue of retention is as critical.

Mr ENTSCH—How does that pan out when you have a look at the very proactive campaign that Queensland is going through at the moment to try to bring in more professionals by offering very significant increases in pay? Are you finding that that is having any impact?

Mr Clout—Not at this stage, but obviously it is a challenge to us. From my perspective, that is a risk to be managed. Obviously, if we have any part of the system across Australia making a major push, as Queensland clearly is at the moment, to attract more health professionals, as the pool is limited and the shortage exists nationally and internationally, if you have 10 per cent going to Queensland, that is going to put greater stress on everyone else.

Mr ENTSCH—So that would be a concern. What are the salary and conditions like here, compared to what they are offering under the new arrangements in Queensland? Is there much difference?

CHAIR—Queensland argues that—

Ms HALL—I suspect that you are not so concerned about Queensland but are more focused on our area. Is that correct?

Mr Clout—It is a bit like a balloon. If you poke out one area, you cause a problem in the other area when you are in a workforce shortage. My view about the salaries is that salaries are only one component of things that allow you to attract and retain. For senior clinicians—be they doctors, nurses or allied health staff—sustainability of their capacity to teach, having a range of services that they can provide so that their professional skills are retained and having confidence in the quality of the services that will be provided, being able to be involved in research and

having a range of services in which they can ply their trade are also significant parts of the package.

Another package in rural and remote areas is: what is available for the partner? What is their profession? What is available for them in employment? Another issue is: what is available for education of children? How can I do that? What is the package available in relation to that? What are the issues around accommodation? Is it possible to find someone to act in a locum capacity when I want to go on leave? There is absolutely no point in just looking at salaries and wages; you have to look at the whole package. For some people, the driver is salary until you get to a certain level, and then those other things kick in.

Mr ENTSCH—Then there is lifestyle and quality of life. What about VMOs? What is the level of support from the public sector for VMOs? You need them in the public sector to be part of the training process, if you like.

Mr Clout—There are two issues here. Again, it is a package issue. There is no simple answer to it. For VMOs the issue is: how can they be satisfied that there is a quality of care and safe practice? That is No. 1. No. 2 is the money. No. 3 is: what is the availability of junior medical staff to support them? That is a key driver for visiting medical officers—and not just visiting medical officers but senior medical staff in general. For staff specialists that is also a driver.

Ms HALL—Terry, you have not finished your presentation yet, have you?

Mr Clout—That is true.

Ms HALL—So we should probably let you finish.

Mr Clout—It will not take long. We have had some great success in developing local partnerships to overcome some of these challenges, and I think some of these would be useful for your consideration. Our Aboriginal health coordinated care trial, which is the mid-North Coast Aboriginal health coordinated care trial, has now passed the trial stage. It is at a stage where we are providing services to our Aboriginal communities at Coffs Harbour, Port Macquarie and Taree—and the Taree part of it is in my area. It has involved the New South Wales government; it has involved the federal government in terms of funding input and coordination; it has involved four or five Aboriginal medical services; and it has involved other local health providers—the divisions of general practice—within the community. It is a really successful model in providing services to Aboriginal communities in circumstances where we know, when we look at the MBS and PBS, that those Aboriginal communities are accessing those services one-third less than the rest of the population. We also know, given their health status and standing, that that does not make sense, and it is clearly an access issue. This trial, which has been a collaborative trial across all government levels, has significantly increased access to those services by those Aboriginal communities.

As I said before, we have also had great success with multipurpose services. I think you would all know that, if you look at how we provide services to small and remote communities, it is not economically viable to be providing every service to every town or every place. It is just not doable. No government can afford to do that; it is not a matter of whether it is Commonwealth or

state or a combination of the two. We need to make sure that those communities have access to quality services when they need them.

The integration of the nursing home type service, the emergency department service, the low-level acute service and the hostel service in one setting, run as one service with the collaboration of all levels of government and funding coming in from all the appropriate levels of government is, in my view, an absolutely brilliantly successful model and a credit to all levels of government and all service providers who have put that together. It in fact overcomes the difficulties associated with having a split in the funding mechanisms within the system that we have in the country.

I would like to encourage the committee to further consider that model and how it could be applied in a wider framework than it traditionally has been and have it rolled out to those communities as quickly as possible. It works, and that should, in a sense, be the only measure. It works for those communities. It provides access to those communities of a very high quality. Across our area we have a significant number of multipurpose services, a number more coming on and another stage coming behind that, so it is of great application to us.

The health service, along with the Australian government, is also working with the Hunter Urban Division of General Practice to provide a comprehensive system of after-hours primary medical care. This service provides after-hours telephone triage and advice. There are five GP clinics co-located with the Maitland, Belmont, John Hunter, Toronto and Newcastle services, so some of those are at hospitals and some of those are co-located with our community health services. There is a funded transport system for patients who need to see the doctor but have no transport to attend the clinic or the emergency department, a home-visiting service and telephone triage and advice, as I said.

It is a great model. It works for this community, so basically you will see it is running in an urban metropolitan area. I am not suggesting for a moment that it is the model that will work everywhere. It works for this urban metropolitan area. We have other models which, again, are run cooperatively and funded from all sources—from Commonwealth, state and local governments and area health services. At Cessnock we have a clinic run in partnership with the University of Newcastle. It is a different model that works for that community.

We need a number of different models that have the same idea, which is all the parties working together, the funding being dealt with cooperatively across the Commonwealth and the states, and there being a service delivery that incorporates the general practice service, the community based health services traditionally provided or still provided by the area service, the local council and the hospital. Those models need to be context based, but the thinking behind them has to be the same, in my view, and they are very successful.

One of the issues, though, that I deal with on a daily basis—as do my senior staff across the area—is that the funding for service delivery responsibility, and the split across the different levels of government, actually means that it is the rural and remote parts of the area health service, and the rural and remote parts of New South Wales and Australia, I am sure, that are missing out on the services. For the reasons that I have indicated to you, the funding that is available is very much dependent for its delivery on the workforce availability. If you don't have workforce you can't provide the service. It is great that we have got an MBS and a PBS but if

you don't have doctors in your town—if you don't have general practitioners in your town—you don't have any drawing on that funding for that community.

The end result of that is that we know that our workforce difficulties are exacerbated. As I said, the further you get from the Sydney Harbour Bridge in New South Wales—or, from a Newcastle perspective, the further you get from Newcastle, where we are sitting today—the thinner on the ground and the lower is the proportion of doctors, nurses and allied health staff per head of population. At the same time we know that it is those remote communities, in the main—it is not absolutely true, because you can find pockets in the metropolitan areas—that have a lower health standing status, on any of the major health measures. Yet there is an incapacity for them to access the MBS and the PBS because the workforce is not there.

It is also true that if we do not have the workforce in our area health service for the services we provide, people cannot access them. I think that is a problem. I think it is rural and remote communities that are missing out. It is not the sole challenge, but one of the significant challenges for us as a society and for governments in general is how to overcome and change the system of funding we have got at the moment, which causes that perversion, because it is based, at the Commonwealth funding end, on an uncapped model that is dependent upon the workforce. If you have got a bigger workforce, sure as eggs you are going to have people coming to that workforce. They are going to access the MBS and PBS. Of course they are; why shouldn't they? That is what it is there for. However, on the other hand, if you have got a shortage of workforce and therefore no workforce, you don't do it.

What are the outcomes of this? The outcomes are that the health standing and status of those communities is lower for some. Others have to travel significant distances, and they bear the cost. They bear the social cost of having to travel for those services. The group I worry most about though—and I think our total system produces this—is the many who don't bother accessing the service until they have no option. And often then it is too late. And, therefore, in my view, the quality of care that they get throughout the system is significantly lower. When I go through all parts of my area health service I see evidence of that all the time.

Another issue is GP bulk-billing. There are issues around that, again. We know for a fact that in rural communities in my area only 61 per cent of GPs bulk-bill. You would know, as I know, that if we look at New South Wales generally, or Australia generally, it is much higher than that. This just backs up my point that if you take the workforce availability, if you take the proportion of bulk-billing, then the rural communities are bearing the higher cost if they access the service, or they are not accessing the service because there is no workforce and therefore they are significantly underspending what I would argue is their fair share of the MBS and the PBS. This is not the fault of the GPs—let me be very clear. This is not the fault of those communities. It is probably no-one's fault. It is, though, a very significant outcome, in my view, of our system of funding health services across this country. It is a result of the system that we have in place. I think we have to look very much at how we can take those unintended perversions out of that funding model.

If I were sitting where you are sitting I would say, 'How are you going to do that? Give us the answer.' I am not sure that I have a neat answer. What I do know is that at the moment we have an out-of-pocket system in those places where we have the least workforce availability and that workforce availability is, whether intended or not, one of the mechanisms which caps the

expenditure of the MBS and the PBS. That is what it does. If you not have the workforce there it caps it. That is felt most in rural and regional areas.

We have out-of-pockets brought about by much lower levels of bulk-billing in rural and remote communities, which forces people to pay more than they should and more than they do relative to their colleagues like us in metropolitan areas. At the same time, it therefore forces those people who are also in the greatest socioeconomically disadvantaged groups into a situation where they cannot afford to pay or, if they do, they pay a much higher proportion out of their available income or, conversely, they do not access the service. As I said, my greatest worry is where that system is leading many of the people in rural and remote areas. Because, as you know, 94 per cent of this state is in drought, many of those people do not have the money to feed their cattle and do all those other things. They do not have the money for the out-of-pockets to go to the doctor. I think that is a major problem.

On the co-payment issue, I got some of my staff to pull out some stats. These are just a couple. Let us look at how that out-of-pocket is going and where it is going. As I said, it is a greater burden on rural and remote communities. It is a greater burden where you have lower rates of bulk-billing. But between December 2005 and March 2006, the advice that I have from my staff is that the average patient co-payment for all health services increased about 23 per cent to about $27.10. At the same time, what was expenditure doing? It certainly did not go up by 23 per cent from any source and certainly not from the Commonwealth government. If we just look at the GP component, co-payments for GPs have similarly increased by 18 per cent to about $17. I make the point again that when that goes up people stop going to the doctor, particularly if you are in a remote rural community or if you are in a socioeconomically disadvantaged group.

One of the challenges for us as a system of health service providers and as governments is that we have to have direction on how we are going to reduce health disadvantage in the next five, 10 or 20 years. The things I have talked about point to an increase in health disadvantage between those who have access to the health workforce and who can afford to pay and those who do not have access to the workforce and do not have the capacity to pay.

The question I think we as a society have to answer is: if, at the end of 20 years, we have improved the general health of the community from what it is today—and I have no doubt that we will have done so—and at the same time we have increased and improved the health service to the socioeconomically disadvantaged groups or the health disadvantaged—and that can include rurality, as I have said—but the gap between the two is the same, have we been a success? I would argue that we have not. We have to do something about reducing that health disadvantage that comes across from all of the reasons that I have talked about. One of those is the system we have for funding our health services and health system across Australia.

What impact does this have on the health services that Hunter New England Health provides? Clearly—and we have very clear evidence that this is happening—if people do not have access to bulk-billing, if they are in the group that cannot afford to pay increasing co-payments, and they need a service, where are they going to go to? If the workforce is not available in a rural community or even in a metropolitan area, where do you go to? There is no point in going to a private hospital, because they do not have emergency departments—none at all. There is no point in going down to a clinic that does not have after-hours access, because there is no-one there. The only place you have left is the public hospital emergency department. The evidence of

that is clear. We have significant increases in attendances at our emergency departments. You would expect there to be increases. Populations are increasing. Expectations as to when you should go to the doctor are increasing. It could even be argued that we have been very successful with our health promotion and awareness programs in which we have said to people, 'Go early.' All of that is true, but it does not explain the 15 per cent increase in attendances at emergency departments in the last five years. It does not explain that.

One of the things that we do when we are looking at statistics is to say, 'Okay, you would expect an increase to be about in line with the number who attend who actually do need to be admitted.' That is a reasonable proxy. So if they attend and they need to be admitted then, very clearly, they needed to be there. For us, the increase in the number of people who have been admitted over the same period is about eight per cent. But the increase in attendance is about 15 per cent. I would argue that that is a result of the reducing availability of bulk-billing in all of our areas; the increasing out-of-pockets that people are having; the reducing availability of after-hours services—in the metropolitan area here we have the GP clinics and that has helped us with that, but in the rural and remotes it is not there—and the significant workforce shortages we have that are brought about by a number of reasons, one of which is an inadequate number of places at universities over the last X period to train the health professionals that we need.

What is the solution? The problem is that I have between 9,000 and 15,000 extra people attending my emergency departments, and I have an increase in funding coming from Commonwealth and state that is not keeping up with those costs. If we accept the proposition as it is, if we accept that what is happening in terms of where people are attending is changing—and I think the evidence for that is overwhelmingly clear—then, among all the other strategies, it is to try to reverse that in the longer term with increased training of health professionals, more places at universities and increased initiatives and incentives. I acknowledge that there have been increased incentives at both the Commonwealth and the state levels in terms of looking at rural and remote, but at the moment they are not cutting it. They are not leading to what we need and I would argue that, in a sense, those other incentives cannot work and cannot really make much difference until such time as the workforce is adequate.

We must embrace some of the really challenging and confronting issues, like geographically distributed provider numbers and provider numbers for some of the other health professionals. The issue of provider numbers to psychologists is good, but what is the impact going to be? Are all the clinical psychologists going to say, 'Good, now I can do this'? Where are they going to go? Are they going to go to Tamworth, Armidale or Moree or put their shingles up in Newcastle or Sydney? That is a real worry to me. The intention is good; I am worried about the implication that it may actually drain staff that I have working for me into the metropolitan areas of Newcastle and Sydney—again, out of the rural and remote areas. I am also worried that it will drain the people I have in Newcastle to Sydney and we will have to try to find a way of providing those services again.

On flow-through impact, the community expects governments, area health services and health service providers to meet their expectations, and those expectations are increasing at an increasing rate. If we wanted to meet those, we would probably have to use all of the budgets that are available through the government purses and we probably still would not meet the cost. And we cannot do that, because if you did how would you fund education, defence and all the other areas? You have to fund those others, so there has to be a sensible decision-making

process—and I do not envy governments that have to make those decisions at the federal or state level. But the fact of it is, if we have more people attending emergency departments and requiring medical treatment in public hospitals, we will have less funding available for elective surgery and mental health. I welcome the contributions to mental health at the Commonwealth and state levels, but there is still going to be a drain on those other services. It is going to be a drain on health promotion and community based services. The main effect it will have, though, is that we will not be able to fund as much elective surgery. That will be the big thing that will go, and that is a major problem for us.

I say to people all the time, and my managers in particular, 'We have the budget we have.' If there is a part we cannot control and we must service—such as emergency departments and critical care areas—then we have to do less of the things that are not as clinically urgent or important for health outcomes. There is no simple equation for that; there is no magic bullet. That has to be the outcome, and that is a concern.

I want to briefly talk about the Medicare safety net because I am worried about some of the perversions that it causes. I have talked about the out-of-pocket costs of Medicare in services like GP, pathology and specialist care. We have an out-of-pocket component of that and we have a safety net. As you know, the safety net has recently increased from $300 to $500 for pensioners and those eligible for family tax benefits and to $700 for everyone else. In my view, this is going to impact in the very areas to which I referred before, namely the least well serviced areas and those people who, for the reasons I have referred to, are not accessing services. Those people simply cannot afford to carry the burden up to the $300 or the $500. Therefore, they either come to an emergency department at a public hospital or they do not access the service at all. I am worried about both of those things.

I suppose I would argue that the people who benefit most from the safety net are those who have the greatest access to the services—again, those people in metropolitan areas. There is some evidence to support that. Of the money that is paid through the safety net, about 0.75 per cent of safety net payments are made in the electorate of New England. If you go to Sydney's North Shore, it is over six per cent. I do not think I need another stat to support my case. It is very clear that, whatever the intentions were, they are not having the impact that, in my view, was needed.

When I saw the Strengthening Medicare package of $918 million, I thought it was great. When I then heard that a third of that is going to come out of state funding, I thought it was bit thimble and pea and I was very disappointed by that. Having said that, I think it would be better for me to stop there and answer any questions for you that I can.

CHAIR—Thank you for that presentation. There were some areas that you covered where we have been desperately searching for evidence. We have not had the opportunity to get much evidence at the state level officially, from state governments, as you know. So that was very good, from our point of view. I would like to throw another thing into the equation, and that is private health—private hospitals and what role they play in complementing your area health service. Of course, it is the same story: metropolitan areas get much more access to private health than rural areas do, and membership of private health funds is higher in metropolitan areas. According to every witness we have had at this inquiry, the main problem is workforce issues. It has been suggested that private hospitals should have a role in the training process. It is

no use providing training places at universities if you cannot match the clinical training. This committee would not argue with you over workforce issues. We should be exporting doctors, not importing them. A country of the stature of Australia should be able to produce its own doctors and possibly even use our aid budget to train doctors for other countries. Could you just comment on the private sector?

Mr Clout—My first comment would be that, for us to be able to provide services to the community at least to the level that is possible and to meet community expectations, we require a robust and well-funded public health system, a robust private hospital system and the continuation and support of health insurance. I am not going to make comment about the funding of private health insurance—that was not your question—but in my view the system to operate and provide the services that are needed to the community needs all those. That would be my starting point.

We obviously do have private hospitals in the Hunter New England Area Health Service. We have not-for-profits as well. We can take non-public as being private hospitals, the not-for-profit sector and the nursing home sector. You are right when you say that they have the same difficulties as many of the other services, in that the major private hospital services are in metropolitan areas or major regional centres and therefore they are not of great assistance in rural and remote areas. There are some exceptions to that. There are good private hospitals in Tamworth, Armidale and Taree. We work very collaboratively with them. I do not see them as competitors at all. We as a public health system could not deal with the demand for the services if there were not a robust private hospital sector. Mind you, if we were all funded more, we could all do more. There is no question about that. I do not see them as competitors, however.

In terms of issues about workforce and training, I think we have to look at all the options that are available for providing more places at universities. By the way—and I am really going to be a pedant on this—it is not just doctors. We need to train more doctors, more nurses and more allied health staff. If we look at rural New South Wales, the major workforce shortages are doctors and allied health staff. If we look at metropolitan Sydney, the major workforce areas in shortage are doctors and nurses. So we need to train more of all of them.

But you are right: we also need to have a capacity to provide the training places within the health system, and I do not see any reason why that cannot be public or private. In fact, given the way the funding is at the moment, I think there has to be an absolute encouragement for the private hospital sector to have emergency departments. In my view—and I feel very strongly about this—they should be part of that emergency department care and I think the Commonwealth government needs to facilitate a change in the current arrangements to enable that to occur. The only impediment to that is a structural one. It is not a reality one. They will not do it unless they can cover their costs, but there is no theoretical or clinical reason why they should not, and I think they should. I think there should be an acceptance by them of their capacity to train, to do research.

CHAIR—We had a public hearing in North Shore Private Hospital and we were pleasantly surprised to find that North Shore private actually had their cath labs in the public hospital. That was cooperation and perhaps a model that could be followed even more.

Mr Clout—I think all of those models need to be looked at. When we do those things—and I have been in this game for a long time now—there is an understanding that there needs to be a collaborative manner in doing it. There is a will to do that. The difficulties that everyone finds frustrating are the barriers that you come up against that exist because of the structure of the funding system. There has to be an agreement that there should be no difference in the infrastructure costs associated with doing that. There should not be a barrier if it is public or private or if it is a collaborative model. There should be a commitment by all levels of government to say, 'If we want to do this—and we should—then we have to make sure that we're not spending all of our time and lots of money arguing about who should be paying for which components of the infrastructure funding.'

One of the sayings that I use with my staff is that people do best who do the best with the way things are. What we have to do at the moment is to make the best out of the way things are. My plea would be that we change the way things are so that we do not have to make the second best out of those. If we had agreed funding models for infrastructure funding that meant we did not have to have arguments every time about whether it is Commonwealth or state, in my view, some of the models of care that already exist there could be put into place much more easily. But many times the clinicians and bureaucrats like me say: 'Look, I know that sounds good, but here are all the impediments we've got to jump through because of the Commonwealth-state divide in relation to the funding for infrastructure, for the recurrent. I'm not sure I want to go there.'

Another concern I have is that, when we try models of care—and the Commonwealth has put a lot of money into models of care, as have the states, over the years—we have to look at the evidence, get the clinical advice and we should then run with them. There is a continual piloting of models that then get withdrawn at a particular time or when some other new idea comes up. People stop being innovative about their models if there is no certainty about funding. Talk to Arn Sprogis when he talks to you this afternoon about how that impacts on the development of further models of care. I will not take up any more of your time on that.

My view on the private sector is that we need a robust private sector. We need health insurance; we need a very robust and well-funded public sector. As I said before, we are all providing services to the community. If you think of it as a balloon, if you stick your finger in one end and cause a problem, the rest of it has to fill up, so you need the hole. You need to fund it well. I will pre-empt the question: 'Could we spend more; is there enough money going in?' I am not going to answer the question: 'Is there enough money going in?' I have been around too long to fall for that one. But could we spend more effectively? Absolutely. We know the areas in which we need to spend the most—that is, in the areas that are getting the least access and are the lowest, if you like, socioeconomic and therefore health disadvantaged. In my view, there has to be a predominant think about the funding models so that additional funding that needs to be poured in goes into those rural and remote areas.

That is not to say it should not go into the metropolitan areas—it should. Caps are being put on. If you have an uncapped funding system under the MBS and the PBS, I understand that there are other indirect controls that are put on—one of those is workforce—but when you do that, it is the rural and remote areas that miss out.

Ms HALL—I notice that to date you have not mentioned anything about aged care and the crossover between aged care and the acute care sector. Belmont Hospital has a transition care

unit being built. To what extent does the crisis in aged care and the shortage of aged care beds in this area impact on the operation of the public sector?

Mr Clout—I will answer in two parts. Firstly, I think I have referred to the collaborative models in relation to the MPSs. However, there is unquestionably an issue around the manner in which we allocate and commission nursing home places. I have very strong views on this issue. There has unquestionably been an increase in the allocation of nursing home places, and that has led to an increase in the number of commissioned nursing home beds. But there is also a very big gap between the number of places that have been allocated and those that have been commissioned. The metropolitan area health service but also the Forster-Tuncurry area, Raymond Terrace and Port Stephens are major growth areas for increases in population over the age of 65. There is not a match between the commissioned places—and I am being very precise—and the need.

The effect of that is fairly obvious. If demand for those services is not able to be met in the nursing home sector, which is a Commonwealth government responsibility, then people are in our emergency departments and, through our emergency departments, in our acute wards. If they are in our acute wards they take up the spaces we have and the dollars that we have. Again, that impacts on increased costs in the medical side of our services. If we are spending money on that, we are not spending it on our elective surgery.

Mr ENTSCH—Can you quantify the numbers of beds that have been taken up in the acute wards unnecessarily?

Mr Clout—I can give you an example. It is a little dated now, but it is the one that I have available today. It is for what was the old mid-north coast—so that was the Coffs Harbour, Port Macquarie, Taree area. Taree covers Foster-Tuncurry and Foster-Tuncurry is a significant growth area in that area. On any day we had 131 beds occupied by people who were awaiting nursing home placement. To his credit, Bob Baldwin has been pushing very hard for an increase in those numbers for his part of that area, which covers Foster-Tuncurry and also the Raymond Terrace area. But for my money I have not seen the impact of those coming on board, although clearly there have been numbers coming on board. I have not seen a reduction in the number of people we have in our beds waiting nursing home placement. Obviously, that hits most in winter. So we are in the middle of it now.

CHAIR—In Queensland it is only in the last 12 months that I have had nursing homes ringing me. The practice is that if a bed becomes available in a nursing home and they want it filled, they ring a hospital and say, 'We have a bed available.' The nursing homes are telling me that when they ring the hospitals there are no patients to take the beds at the moment. No-one can give me a reason for that, but in the last 12 months there have not been the bed blockers there.

Mr Clout—I envy their position.

Ms HALL—That shows a significant difference, Alex, between your electorate and my electorate. I have constituents ringing my office because they cannot get their relatives and loved ones into beds in nursing homes. I get on the phone and ring around to all the nursing homes and I get the big 'No' every time.

CHAIR—A year ago I had the same situation.

Ms HALL—It has not been a year; I have been experiencing this problem for eight years. If we talk about Belmont Hospital, we are looking at people waiting for beds. You just have to go to the second floor of Belmont Hospital and you will see a large number of people who are sitting there waiting for a nursing home bed to become available.

Mr Clout—I can give you an example. We have had to develop a particular part of our service that is only providing for people waiting nursing home placement. I am funding that. It makes clinical and commercial sense for me to have a separate unit that does that because then they are getting a bit closer to the care that they need. But it is not just that they are not getting into the nursing home. It is a question of whether they are getting the right care. If you are in an acute hospital and you are awaiting a nursing home placement, you are not getting the care you need. The care you need is going to be provided in a nursing home setting. It is very different care. I am concerned about that very much too. But we certainly have the stress and strain. Not solely—this is one where it is a bit different—but particularly in our metropolitan areas and in our significant growth areas it is a major problem for us. I cannot quantify it any more than that, I am afraid.

Ms HALL—I have two questions. I am going to ask a local member's question here—I cannot resist it, having you sitting in front of me. I notice the increased use of emergency wards in this area. As you would be aware, recently all the doctors in Swansea and Belmont have closed their books. Doctors have moved away from the area. A significant proportion of the people living in Swansea and Belmont cannot access a doctor locally. My question is; has that been reflected in the use of the emergency ward at Belmont Hospital and, I suppose to some extent, in GP after-hours access? But maybe you cannot answer that part of the question.

Mr Clout—My comment on that is this: have we had an increase in attendances at our emergency departments, including Belmont? Yes. Has it been significant and has it been causing pressure? Yes, and yes. Are we aware of the significant difficulty involving lack of bulk-billing and closing of books in the Swansea-Belmont area? Yes. Are we working with the general practitioners and everyone else to try to overcome that? Yes. But here is the other thing I would say: just because two things happen at the same time does not mean that one causes the other. I think the increase in our emergency department attendances is brought about by a significant number of things, of which that is one.

Mr ENTSCH—You made a comment about the initiative to give psychologists access to provider numbers. You made reference to a greater need for allied health workers—and there is a critical shortage right across the spectrum. What is your view on expanding the provider numbers to include the likes of allied health workers and counsellors?

Mr Clout—I think that has to be worked through, but I am generally in favour of that. I would add nurse practitioners and other nurses as well.

Mr ENTSCH—I am talking about allied health workers.

Mr Clout—I think we should. However, as I said before, if we are going to do that, I would say that you have to look at the dollars being, in a sense, available equitably to communities. I

know there will be some rolling of eyes or concern regarding talking about geographic provider numbers. Let's not worry about how you do that, but if you are going to do that, you have to make sure that it does not cause the perversion that I referred to earlier. No. 1 is that, in having greater availability of providers who can access and charge from HIC, they should not all be in the metropolitan areas. Also, we should not cause a greater transference of practitioners from places of more significant workforce shortage to areas of less workforce shortage. I think we should do it, absolutely, and we need to develop models of care that are not so rigidly structured as they have been historically. A lot of work would need to be done in order to do it, but I think we should move that way.

We need to make sure that the dollars are available equitably to communities. In one sense, if you think about it, this is taxpayers' money. In almost every other area involving taxpayers' money, we say, 'Here's where we want to provide the service. If you want a job there, you go there, and you can access taxpayers' money.' In my view, that is what policy makers and government should do. They should determine what the needs are, where that need is, put the taxpayers' dollars there, and then say to the providers of that service, 'We're not constraining you in any way, but if you want to access taxpayers' dollars, go where we've put the taxpayers' dollars.' How you do that is a very much more complex question and there is not enough time to comment on that today.

Ms HALL—To what extent do you think the silo mentality between the state and the Commonwealth impacts on the effective delivery of health services to people in this area—and, I suppose, throughout the nation? What do you think are the first things that need to be addressed?

CHAIR—Can I add to that?

Ms HALL—Go for it.

CHAIR—Do we have a national health agenda? If we don't, should we? Should the states be funded to achieve that national health agenda?

Mr Clout—You can answer that at about four different levels. I am trying to work out which is the most appropriate one to start with. If you had a clean sheet of paper and you were designing a health care system, you probably wouldn't start where we are now. You would say, 'Okay, it doesn't make sense to spend a lot of money with the negotiations between the different levels of government and the different levels of providers.' If you were designing it again, you wouldn't start there.

But we have what we have: a federalist system where there are responsibilities at a state and a federal level. My view is that, given the structure that we have, and will have for the foreseeable future, we need to significantly improve and increase—and, dare I say it, take the politics out of—the collaborations that need to be put together so that we minimise to as close to zero as possible the dollars that we are spending on negotiating, governing, policing and monitoring the interface between what the Commonwealth does and what the states do.

To give an example, it is crazy to me that we have a program that would be funded by the Commonwealth that is for $50,000 a year and we will spend $9,000, just in our health service, providing the monitoring arrangements to get that amount of money—let alone comment about

how much it is costing the Commonwealth and the state to be party to that. I do not think that makes sense. So my answer is: given the current structure of government and of health funding that we have, COAG provides an opportunity for us to work truly collaboratively to minimise the number of dollars spent on that interface.

For example, if there is a national agenda that says mental health needs to have a significant boost of funding—as it does—then we have to make absolutely bloody sure that there is one plan that everyone is signed up to and no-one is playing around working out how we can do a Commonwealth part, a state part and another state part. If we are going to have an electronic medical record, we need one agenda, one group doing it one way and not playing parts between the two. That will need infrastructure funding; that will need recurrent funding. But if everyone says that we have to do it, let us get on and do it. If we are going to have an oral health plan, do the same thing. That would be my answer.

CHAIR—You are suggesting that health dollars should be spent on the patient.

Mr Clout—I think that would be a very good idea.

Ms HALL—I think we would all agree with that!

CHAIR—We are out of time. We really appreciate you appearing before us. We find your evidence very valuable, I can assure you.

Ms HALL—Terry, do you chair the CEOs of all the area health services?

Mr Clout—Of the rural ones.

[10.35 am]

CLOUT, Mr Terrance James, Chief Executive, Hunter New England Area Health Service

CROMPTON, Associate Professor David Robert OAM, Area Director, Hunter New England Area Health Service

KENNEDY, Ms Judith Louise, Deputy Director, Mental Health Service, Hunter New England Area Health Service

CHAIR—Thank you for appearing today. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. Having said that, do you wish to make an opening statement to the committee?

Mr Clout—I want to introduce the other two witnesses. You already know their positions. In relation to our previous conversation, we have recently recruited Associate Professor Crompton from Queensland. I thought you might like to know that. He has been with us now for seven or eight months. Judy Kennedy has been deputy director of our service for a—

Ms Kennedy—Very long time.

Mr Clout—I was going to suggest that, if it is appropriate for the committee, I would ask Judy Kennedy to run you through some very brief highlights on a document we have already given you on the service. There was an addition to the document we provided to the committee yesterday, which was a background document. I apologise. In putting it together, I did not check it thoroughly enough and there is a page that flicked off the end of it and I have been appropriately scolded by my colleagues for it. That is in addition to the background document. We have also provided the committee with a submission which has as the first part of it that background document again just for completeness and has three other parts. One is on the delivery of mental health services in the Australian community, which David will talk to, one is on the recruitment of medical staff, which we are all happy to talk to, and the other one is on pharmaceutical benefits, which David will talk to. If that is appropriate, we will get Judy to give you some highlights of the services we provide.

CHAIR—We are in your hands.

Ms Kennedy—Thank you. Hunter New England Mental Health merged, as you would know, in January 2005. We have a population of roughly 840,000 people. We have 12 per cent of the state's population and we have roughly 20 per cent of the state's Aboriginal population. Our area comprises rural and remote and metropolitan components, and it is made up of seven clusters. If we look at the rural northern section first we will see we have three clusters. There is Peel around the Tamworth area, Tablelands around the Armidale catchment and Mehi Macintyre, which is around the Moree Plains area. They are serviced primarily by an in-patient unit at Banksia that is based at Tamworth. There is a small eight-bed voluntary unit at Armidale.

Manning also became part of Hunter New England in January 2005 and has a 20-bed mental health unit and comprises mainly the services at Taree and Foster.

In terms of the former Hunter, there are also three clusters. For us, there is Newcastle, Lake Macquarie and the Hunter Valley. The Hunter Valley incorporates the Port Stephens catchment. Those services are primarily focusing on adult psychiatry. They are supported by specialist services such as dual diagnosis, child and adolescent rehabilitation and services for older people with mental illness. The major emergency service is based at the James Fletcher Hospital. It operates seven days a week, 24 hours a day. It is supported by the other units at Maitland, Taree and Tamworth—those three particularly—and those services operate specifically through the general hospital emergency departments. We also have specialist services in consultation liaison psychiatry, neuropsychiatry, and we have a service called the Centre for Psychotherapy, which is a day focused program in terms of psychotherapeutic interventions. Its major role is around education and training of clinical staff in broader mental health interventions.

We also have a partnership with the university and have created the Centre for Mental Health Studies. That is based in Newcastle but has a focus on research and the marriage between the service delivery and the academic components. It has a strong influence in terms of the evidence based practice for mental health services in Hunter New England. We also have a Hunter Institute for Mental Health which is focused around prevention and promotion of mental health issues to the community. It provides quite a large degree of education to community groups and individuals as well as just staff within the health system. It does expand its influence through to New England and Manning. It is a very small service but it operates largely on grants and successful tenders for education programs. There is obviously a focus on consumer care. We have consumer representatives in our service who provide support and understanding on issues from a consumer and carer perspective. I think that they are the major areas that I would like to cover.

There have been initiatives recently around clinical improvement and clinical redesign. We have done a fairly extensive program around acute in-patient services. It was based around James Fletcher, Manning, the Taree hospital, the Hunter Valley service at Maitland, and the Tamworth Inpatient Unit. The intention there was to focus on the patient's journey through the mental health system and to develop a structure that was common and effective across all systems, not splintered and difficult to follow. There are obviously the links with our clinical governance through the Area Health Service.

Prof. Crompton—The first document I will speak to relates to the report from the Senate on the delivery of mental health care across the nation, and I think that there are a number of important issues that we can look at. Clearly, there is going to be a recommended increase in funding and there should also be the establishment of community mental health centres across the nation, particularly in areas that are in need of them and reflect the community needs. The other important things of note from the report that was issued through the Senate were the development of direct Medicare recurrent funds for the employment of mental health staff and the inclusion of psychiatrists, psychologists, general practitioners and mental health nurses and social workers in these areas. I note too the expectation from this process that it would also cover times of high need such as weekends and after hours, which is obviously a major problem for our services. The principles are that it should be able to meet the needs of people, be responsive to the needs of the community, provide ready access for people who are in need of mental health

care, and there should be equitable funding. As part of this process it recommended benchmarks. It also involved a recommendation to use the Better Outcomes initiatives to provide Medicare funding through general practitioners and involve them specifically in this process. Importantly, it should be done in a collaborative manner. These were the suggestions that were put through with the Senate report.

Certainly, the Australian health ministers have identified a number of issues: the national strategy, measurable targets that are monitored on a regular basis and the need for various plans to be integrated rather than each one sitting in isolation. Public mental health should be of high quality and this high quality of service will help in the recruitment and retention of staff. There should be incentives for the provision of care to general practitioners and mental health professionals in rural and remote areas, and the Commonwealth announced the funding. A couple of key messages came out of this. It was of no surprise that mental health issues have a significant negative social impact on the community and this is measured both at the broad community level and at the level of the individuals and their families.

The recommendation for increased funding or investment in mental health services is noted and also that there needs to be a focus on promotion, early intervention and, importantly, community care and that public and private services should act in a collaborative, integrated manner for the delivery of care. The statement is about equity of access—that is paramount—and that care should be evidence based and of a high quality. Importantly, we need to be focusing on a number of specific issues, and these go across the age range from children and adolescents through to older people. There needs to be a specific emphasis on dual diagnosis. In this case we are talking about people with mental illness and substance abuse or dependence as a comorbid condition. We have the important culturally and linguistically diverse groups, which are increasing in our population, and Aboriginal and Torres Strait Islander groups across the nation, which notoriously have a fairly poor outcome for and poor attendance and involvement in mental health care. The recommendation by the Commonwealth that the funding boost should be through investment in the Better Outcomes initiative is noted. Backing this up there have been the recent announcements by the New South Wales government, again with a focus on promotion, prevention, early intervention, across the lifespan, the importance of improving integrated care, participation in community employment, accommodation and improving the level of participation in the workforce.

The next part of my submission reflects some of the issues already outlined, but again it is important to mention that our service covers a very geographically and democratically diverse area. We have the metropolitan area and then we go up to rural and remote communities where there is a very limited access to resources for a variety of reasons. That is particularly about workforce and that imposes issues around recruitment and retention. Then we have the problem of the ageing workforce. Certainly, the Better Outcomes initiatives that need to be achieved have been well documented; however, there are difficulties achieving this task in rural and remote areas. Access to resources through using Better Outcomes runs the risk of the denuding the public sector of some of our professionals. In many of the outlying areas the only mental health professionals available are in the public sector.

The key message from that part of my document is that there are certain significant challenges confronting the Hunter New England Area Health Service in the delivery of mental health across our area. Rural, remote and non-capital city populations are disproportionately affected by

current inequalities of access to mental health care, professionals, primary health care providers and funding. The new Commonwealth funding initiatives may, due to the unequal distribution of psychologists, psychiatrists, social workers, mental health nurses and primary care providers, actually accentuate the current inequalities of service delivery. There is a risk that the disparity of access, funding and distribution of health care professionals for rural, remote and non-capital city populations may impact upon the capacity of the health service to deliver care in an integrated, collaborative manner with these factors accentuated by the ageing of our workforce, inadequate infrastructure to support the delivery of services and difficulties that we have with recruitment and retention of health professionals.

In relation to the latter, there is a small document that reflects upon the problems that we have in recruitment and retention. The recruitment of medical staff, especially those with speciality skills, is a challenge that confronts our mental health services. I might add that this is not just about the medical staff, even though the document often refers to that. We have the same problem with our nurses, allied health professionals and other groups who have an active involvement in caring for those who are mentally ill. As I indicated, this is particularly problematic for rural and remote areas.

There are very clear guidelines as to the requirements for the recruitment, employment and supervision of staff. However, an issue that is repeatedly confronting our service is the difficulty that we are faced with in progressing this process. An example of that is that the person may be quite suitable for a service and be registered in another state, and they decide to move to New South Wales, Queensland or South Australia but, because of the varying rules, that person may take several months to move from one point to the other. It takes just as long for that person to move from, say, Victoria to New South Wales as it would if they were working in Europe at that time. So there are problems, and that slows down the ability of our services to provide access to mental health care in the communities where we need them most.

We must face the problem that this is a competitive environment that we work in. It is competitive both within Australia and internationally, in that many other countries try to attract the same group of people that we are trying to attract, and often they are funded at a higher level. There is obviously a desire in terms of their salary to go to a place where they earn the most money, and that is the competition that we have to face.

Certainly, while it is recognised that there are important parameters around the employment of people from overseas in terms of supervision and support, it is evident that these parameters are often unfunded and remove the person from face-to-face clinical care on a regular basis. An example of that is somebody who requires appropriate supervision because they are from overseas. If they are employed as a full-time consultant, they may in fact only be working four days a week because they require supervision, so they are actually removed from their face-to-face work. In relation to these issues, it is recognised that it is important for appropriate supervision and support to be provided, but the cost of such a process should be taken into account. It is also recommended that the various jurisdictions, professional bodies and the Australian Medical Council endeavour to develop uniform assessment and supervision policies, guidelines and procedures that reflect the needs of our communities but also take into account the issues of the individual who is applying for a position. The last document that I will refer to is related to pharmaceutical benefit prescriptions.

Ms HALL—Will you be tabling those documents for the benefit of the committee?

Mr Clout—You have them.

Ms HALL—Thank you. I did not know that.

Prof. Crompton—The background to the pharmaceutical issue relates to the AHC Agreements 2003-08, where pharmaceutical dispensing should not be delivered to admitted patients, and that should be undertaken free of charge as part of the process. At the time of discharge, a patient may be provided with a small amount, but once it goes above that, there is a copayment fee for a public patient. However, it is important to understand the PBS prescription cannot be issued to these people at discharge. Eligible community patients presenting to our services must be treated free of charge as public patients unless there is a third-party process such as WorkCover or an insurance claim. However, if there is a referral to a named specialist who has indicated that they wish to undertake private practice, the patient may be charged and therefore be eligible for a PBS prescription—but it is up to the patient to indicate whether they choose to be treated as a private patient. If they indicate that they do not wish to be, even though it is a named referral, a PBS prescription cannot be issued.

The important issue for us in the Hunter New England is that there is a considerable burden on the provision of care for patients in our area because of this process. This area is significantly underresourced in terms of private psychiatrists both in the metropolitan area and particularly in rural and remote areas. Outside Newcastle, the majority of mental health care is delivered through the Hunter New England mental health service by either staff psychiatrists or visiting medical officers of the mental health service. In addition, the number of general practitioners available in the area is not sufficient to meet the demand, and most general practitioners do not undertake bulk-billing, which places a further burden on our system.

In general, the treatment of a mental health patient occurs within the community, either in a community setting or in their home. The centres often are at some distance from the local hospital and therefore the hospital based pharmaceutical services. Prescriptions issued to a public patient by treating practitioners are required to be dispensed at the local hospital, adding a further cost burden to patients who are already significantly disadvantaged. It has already been identified that since the introduction of this process—and this admittedly has been going on for a long time—there have been significant problems in terms of medication adherence. There has been an increased rate of relapse due to nonadherence and therefore the potential for an increased rate of readmission, which longitudinally has an impact on the individual's recovery and rehabilitation.

While our service puts considerable effort into obtaining referrals for our patients, this is often difficult due to the mobility of mental health patients, difficulties of engagement with general practitioners and the lack of community support to enable patients to attend the local hospital for the dispensing of medication. The processes have increased the amount of administrative time required to provide care and to ensure up-to-date referrals and the patient's understanding of the process.

Our service is therefore confronted with a conundrum as it seeks to deliver optimum, evidence based community care to those who present to our service. The national mental health policy and

strategy that has evolved over 10 to 15 years and which has now been reinforced by the Senate report has a desired outcome of the provision of care in the community so as to meet the needs of the patients and their families and carers. To provide this community based care distances the patient from the resources of the local hospital and makes it more difficult for the person or their family or carer to obtain prescribed medications from that hospital. However, should the community mental health service return to the proximity of the local hospital, it deviates from the national mental health policy, strategies and standards that encourage the provision of quality care in a manner that promotes responsiveness to the needs of the individual and the community and the imperative that services should be community oriented and integrated with primary and general health care.

The recent Senate report certainly amplifies the importance of this issue. The report highlights the current crisis in the delivery of mental health care. It reinforces the need for a multidisciplinary approach to care, and at various jurisdictions it should significantly increase the use of assertive community treatment programs. These treatment programs, it advises, are to be associated with active case management that aims to support the person with severe illness and associated problems to live in the community. The Senate report noted the need for the expansion of mental health programs and case management, with community based services for people with mental illness.

In order for the Hunter New England mental health service to deliver mental health services in the manner recommended by the Senate report and the national health strategy, there will of necessity often be a significant geographical distance between our community mental health clinics and the hospital based services. This is particularly an issue for our rural and remote patients, who are potentially further disadvantaged due to limitations such as distance and access to all services.

As previously indicated, the current AHCA imposes on the non-referred mental health patient, their family and carers and the service the need to dispense medications through the hospital pharmacy. This incurs considerable cost for the patient and the service as it seeks to locate general practitioners willing or able to provide care for mental health patients. This cost is further expanded due to the increase of nonadherence due to the failure to obtain medication. Considerable anger then ensues because families do not understand the process, and there is also difficulty linking to the general practitioner. With these increased rates of relapse, there is an increased rate of rehospitalisation.

The solution to this problem is not easy. The provision of medication for mental health patients attending mental health clinics can be addressed by not just one solution. There is evidence that mental health services need to engage general practitioners as collaborators in the delivery of best practice care. However, for many reasons—itinerant lifestyle, patient resistance, lack of access to primary care services and remoteness—this is not always possible. Alternative strategies may include co-location with primary care clinics or services, enabling general practitioners to refer to the mental health service. This would require a change in AHCA which precludes the referring of public patients to a specialist. An alternative is the funding of pharmacies in community mental health clinics. This would potentially represent a duplication of private health care providers which are often sited near major community centres of activity. In addition, as with many areas of health care, there are difficulties in recruitment of

pharmacists. Therefore the creation of community mental health clinic pharmacies may result in an exacerbation of an already current skills shortage.

From a pharmacotherapy perspective, a successful outcome to the challenge of delivering optimum care may mean the adoption of a number of solutions that meet the needs of the patient, family and carer. Any solution that seeks to provide the best chance of recovery must reflect upon the notion, 'Is this the treatment I want for my son or my mother?'

In conclusion, it is evident that a collaborative solution to this issue must be found as many patients have become confused over what is occurring. There have been problems with adherence, distress to families and evidence of symptom relapse due to compliance issues. These factors place an increased burden on families, the patient and the mental health system where community resources and in-patient beds are at a premium. Increased numbers of admissions for any individual patient increases the likelihood of an impaired level of recovery and rehabilitation which ultimately has a cost to the Australian community through the broader social security system.

Ms HALL—I acknowledge the issue you have raised about the PBS. That is a strong message and we will be very mindful of it when we are putting together our report. With the money that has recently been invested in mental health at both the federal and state levels, what are the challenges to ensuring that that money is directed towards the patient and getting the maximum bounce for the dollar? What sorts of partnerships and strategies do you think need to be put in place to ensure the optimal outcome?

Prof. Crompton—I think the first part of this is that it is going to require considerable investment on our part in developing a collaborative approach to the management of people in our community. At the moment we have the Commonwealth funds and we have the state funds and we need to work together. I certainly believe that the best way we can deliver care is by utilising as often as possible the primary care providers, the general practitioners, those who are working with a general practitioner. There are many patients who may not readily engage in that process, but we have to get together and work as a team. Those are some of the issues that we are already working on. Our staff, Judy and I regularly go up into rural areas and meet with the Divisions of General Practice. Through the Area Health Service, we are arranging to meet with the divisions so that we can all get together and begin to work on these issues. That is what we have to do. Otherwise, we would be dividing our resources and I think we have to work in a collaborative manner.

Ms Kennedy—I fully support that. I think the risks if we do not do that are that we split our workforce. We were discussing this on the way out, actually. Many of the mental health workers, particularly in the rural areas, are in our service. If we become competitive it is going to be pulling those resources out of our system, which would be a major difficulty. I think the other issue is in that collaboration we have to look at the client group which we are trying to serve and ensure that we do the best to cover the spectrum of mental illnesses through both services—that we do not become split into 'this is your group and that is our group'. We have to make sure that we complement the skill base across the system. That is going to be the biggest issue, I think—attracting appropriately qualified staff and interested GPs to the rural and remote areas to help us work in collaboration in those areas.

Mr Clout—My comment would be to answer the opposite question, and that is: what do we not need? To make this happen we have to ensure there are not, at any level, bureaucratic requirements that fetter the development of those collaborations, and the determination of how the services can be delivered through those collaborations. Because of issues in relation to 'this group has to get this part of the funding and that group has to get that part' we need to get the providers to work together as to the services within the state and Commonwealth agreed framework of the objectives and the priority areas, work out how that is best able to be delivered and not fetter that by any other things that we are putting in the way of being able to deliver it in the way that it has developed. Clearly, KPIs are needed for everybody. Let's not have five different sets of KPIs; let's have one. We have to work within the framework, we have to meet the KPIs, but then do not fetter how that can be put together. Allow the clinicians, the GPs and the mental health professionals to put that together.

Ms HALL—We are getting a pretty strong message here that we need to cut and remove a lot of that red tape and allow the people that have the expertise and the specialty to deliver the services to the people who need them.

Mr Clout—In one way I am saying that. But, on the other hand, when you invest on behalf of the taxpayers of this country a huge amount of money, you must have accountability. I am not saying there should not be accountability. There needs to be an appropriate level of red tape to ensure accountability. However, this is one where you plan an account at the state level and you allow the delivery to be at the local level. The Commonwealth does not want to be a health care provider. That is all right. It needs to allow that collaborative stuff to happen. But there still has to be sufficient red tape to get that accountability back to where the funds are coming from. I would not fund extra money unless I knew that the outcomes that everyone agreed to were being delivered and there was a line of accountability.

Ms HALL—Maybe it is just putting the person first and ensuring that they get the services.

Mr Clout—You have to do that.

Ms HALL—Yes. Taking the public-private services a little bit further, in the Hunter what is the interface between public and private psychiatric and mental health services? Moving away from the GPs—you have already dealt to some extent with the GPs—to private providers of mental health services in the Hunter New England area, what is the interface between the public and the private like? You might like to touch a little bit more on equity of access and how that comes into both public and private areas.

Prof. Crompton—I can answer some of those questions, but Judy has been here a long time—and I mean that in the kindest possible way. I think there is a significant degree of cooperation that occurs, in my experience since I have been here, between the public and the private sector. Many of the private psychiatrists who are out there actually work within our system as visiting medical officers.

There is also an arrangement we have with one of the private hospitals, the Lingard Private Hospital. We actually have some of our registrars in training at the Lingard Private Hospital. That is a highly sought-after position for our registrars. They go and spend a term there, which is about six months. They do that as part of their training and then they return to the public sector. I

think that is a very good arrangement. It is a model that has been adopted for training in many parts of Australia now and is encouraged by the college and the recent AMC review that was undertaken.

I think the other process of collaboration that occurs between the public and the private sector in terms of the psychiatrists is that there is a sharing of patients. There are patients that go out and go to that part of the service and then for their in-patient care may come to us.

Ms HALL—What I am really interested in is the sharing of information on that patient and the continuity of their treatment between public and private.

Prof. Crompton—Judy, you might like to comment on that, because you have had a longer exposure to that process.

Ms Kennedy—The area I was thinking of was more with ECT and the treatment for outpatient ECT which we provide. Often the private sector—again Lingard, certainly—make many referrals. The information—what people need to know about the treatment issues—would be shared. Obviously that would include the reasons for referral; there is not a difficulty with that. We would do that, certainly maintaining the confidentiality of the person. In fact the consultant who works with us and is our expert on ECT is a Lingard employee too. There is a very strong collaborative approach. That links also with the anaesthetists, who work within our health system and within the private sector. It is the work around not only the giving of the ECT but also the anaesthetics associated with the ECT where that link is.

Mr Clout—I will add a couple of other comments. One is that there is an inverse correlation between the availability of private psychiatrists and the distance that you move away from the foreshore of Newcastle out to Moree. The further you get away—there is an inverse relationship. That is No. 1. No. 2 is that among psychiatrists—and I think this is true of doctors generally—there are those who choose to operate exclusively in the private sector, and they have got a right to do that. There are those who choose to operate solely in the public sector and there are some who choose to operate in both. We can think what we like about that, but that is a choice they have. In psychiatry, the proportion of private-public is about 70-30 in favour of private. That is a significant challenge for us.

The other view about that is that, if you are servicing a community, you should share a responsibility to provide services in the public sector if you are providing services and having funds from the taxpayers' Commonwealth funding body, whether it be through an appointment at a hospital or through the HIC. There should be some component of requirement to provide services in the public setting. That is not somewhere that we as a nation have gone, but it is my view. I am taking my CE hat off and putting my personal view. We can take it out of psychiatry and put it into general practice. If there are places where we have 24 general practitioners in a town and only four of them are prepared to help us provide services in our public hospital, at a personal level I have a problem with that. But I emphasise it is a personal level problem I have.

Ms Kennedy—For us, with the merge of services and the relationship between the private and public sector, in the past we certainly have relied on VMOs from Sydney and Canberra for Taree and the northern region. We have had a very strong push for recruitment of staff specialists into our system and we have been successful in getting four staff specialists into the northern sector

around Tamworth and that group. We have not been quite so fortunate at this stage with Manning.

That has an impact—having a high reliance on VMOs within the service. There needs to be a proportional mix between staff specialists and VMOs. With respect to the Hunter, we have a greater proportion of staff specialists, but we still employ a small proportion of VMOs—both GP VMOs and psychiatry VMOs—to complement the mix of service. As I said, in the northern and Manning sectors, our reliance on VMOs has been significant. Whilst they contribute well, the lack of continuity of care across that service provision and in direct patient care has been an issue that has been of concern, and it is one of the reasons why we continue to try and recruit staff specialists into the more rural settings.

Prof. Crompton—I spent many years as a private psychiatrist. I had a very good relationship with the local community mental health service. They would actually bring patients to my surgery who were not able to travel for a variety of reasons, and they would sit outside and wait for the treatment to be delivered and then they would take the patient back to their home. They would then gradually remove themselves as the person gradually improved. So I think that sort of relationship is one that we have to work on. It goes a long way towards helping our own service meet the needs of our community. With respect to that sort of model, I certainly envisage, under the report and the agreements that are coming through, that that is what we need to be working towards. There needs to be a shared relationship so that somebody is not my patient or your patient; it is the individual that we have to look after. I go back to my comment: what would I want for my mother or my son in being cared for? I think that is what we are working towards. Certainly, that is the vision that we have—that sort of collaborative approach.

Mr Clout—Legislatively, the area health service has a requirement and responsibility to facilitate the building of those relationships with all other health providers in our area.

Mr ENTSCH—One of the areas that I have been particularly interested in, and in which there has been a chronic shortage—we haven't mentioned it yet—is supported accommodation. How are you placed in that regard? As I see it, in this country our supported accommodation is either our prisons or our streets. Part of this sudden focus on the whole mental health investment is in order to address such issues. My understanding of the commitment from the state and federal governments is that the states are to provide funding for supported accommodation. Firstly, in your area, how is that service being delivered? In relation to supported accommodation for individuals, is the service sufficient at the moment or is the need being addressed? Secondly, with respect to families or single elderly women who are caring for profoundly disabled senior aged children, what sort of initiatives are there to address that issue?

Ms Kennedy—On the first question, the HASI program is a collaboration between housing, the non-government sector and health. We will always need more supported accommodation. It is the cornerstone of any person with a mental illness becoming more independent and improving in health. A range of accommodation options are being looked at. Low, medium, high and very high support levels are being proposed. We are currently into the fourth, which is really the fifth, stage of HASI. Certainly, on each occasion, we have obtained beds. We are not just looking at the Hunter but at the Taree, northern Armidale and Tamworth areas. We have had a collaboration with a range of non-government organisations—PRA, Neami and Richmond Fellowship are the three major groups that we have been involved with in that area.

As to the second part of your question, it is a dilemma, I think, for families when they have an adult mentally ill person and they have concerns about their retirement. When they die, what is going to happen to this person? Our psychiatric rehabilitation service has been working strongly for some time in the area of accommodation and it is the component that is actively involved in the HASI area. Prior to that, we had some independent accommodation homes and group homes in the old systems. They have all been aimed at addressing the issue of trying to improve the level of independence of adult children so that they can live independently from their families. One of our primary focuses in rehabilitation is the issue of enabling young people and not-so-young adults to move from that dependent relationship and get jobs. We have a very active vocational program that aims to get people back to the workforce.

Mr ENTSCH—The area I am looking at in particular when I mention adult parents—and it is usually women—is the large number of elderly women in their eighties who have disabled children in their sixties and mid-sixties. For the young ones it is fine—there are programs there. I know that in my own area there are elderly women who are actually contemplating joint suicide because they are afraid of leaving this very elderly child behind. I am just wondering whether you had done anything in that area to address that.

Mr Clout—I think that at a societal level this is one of the conundrum areas.

Mr ENTSCH—It is.

Mr Clout—I think the honest answer to your question is yes, there is work done and yes, there are services provided. When that occurs, normally aged care facilities are seen as the answer. I do not think that is the answer. But I do not think anyone has an answer to your question at this stage. It is a significant problem. I do not think that we are doing any better or any worse than anyone else, but a major hole in the national program is how we provide services for those people. I honestly do not think we have an answer to that.

Mr ENTSCH—I have just one other question, again on accommodation. I personally see supported accommodation as a key to resolving a lot of these issues. Any amount of clinical support you can give these individuals, if they do not have a safe place to go to at night-time where they are supported, is going to be worth very little.

Mr Clout—I think we agree with you.

Mr ENTSCH—Is there any private investment in supported accommodation? I know that in Western Australia, for example, they do have a supported accommodation house. There might be four or five units in it. They are sold to families so that they actually own their room or unit. There might be four or five in one of those.

Ms Kennedy—Yes.

Mr ENTSCH—It is strata title, if you like.

Ms Kennedy—Private accommodation now is through the boarding house. DADHC is the group that now has to license those facilities. There are strict criteria. We used to have several hundred boarding houses in the Hunter and 600 or 700 beds. That has reduced to 200 now. They

have to be licensed and they have to be clear about the population group that they are dealing with.

Mr Clout—That is actually looked after by DADHC.

Ms HALL—That is probably outside the area of this group.

CHAIR—We will have to wind it up. The time spent talking to you has been very valuable. As I said, the committee wishes it had a lot more evidence from the other states. Thank you for participating.

[11.25 am]

CLOUT, Mr Terrance James, Chief Executive, Hunter New England Area Health Service

HASTIE, Ms Carolyn Ruth, Midwifery Manager, Belmont Birthing Service, Hunter New England Area Health Service

CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the parliament. Giving false or misleading evidence is a serious matter that may be regarded as a contempt of parliament. Having said that, I will hand over to you, Ms Hastie, and ask you to make a brief introductory statement before we proceed.

Mr Clout—Just very briefly, the Belmont birthing unit is a very innovative and exciting service from our perspective. Obviously, the Belmont birthing unit is part of Belmont Hospital, which is part of Hunter New England Health, and Carolyn has been involved in it from the time it was planned right through until now. She will talk to you about the service and then we will answer any questions we can.

CHAIR—We are looking forward to this presentation. Jill has told us about this many times.

Ms Hastie—Lovely.

CHAIR—Please proceed.

Ms Hastie—Thank you. As you know, the Belmont Birthing Service came about because of consumer pressure. The old service at Belmont Hospital, which was an obstetric and gynaecology service, was no longer sustainable because the paediatricians and anaesthetists no longer wanted to be on call and come in at night time. So the plan for the area health service was to close maternity services at Belmont. A very strong push was mounted by people in the local region to maintain a service in the Belmont region for the women who wanted to birth in that way. So the department of O and G—obstetrics and gynaecology—at John Hunter Hospital, with the stakeholders from everywhere, including ambulance officers, GPs, obstetricians, the people in Belmont, the women of the area plus the area executive—

Mr Clout—And the midwives.

Ms Hastie—And the midwives.

Mr Clout—You forgot the midwives!

Ms Hastie—I did not; that was a given! The women and the midwives always work together. They approached Anne Saxton who is the service and midwife manager of the whole O and G department at John Hunter and a midwife. They all worked together with the risk management governance area to look at how a service could be managed at Belmont. They came up with a model of one-to-one midwifery care, which means that every woman who books with a service

has their own midwife who follows them through the pregnancy, birth and three weeks postnatally—but often it ends up being longer than that. The whole idea was to screen the women who came to birth on site at Belmont, because there was no medical coverage or backup on site, so that the women who birth at Belmont are what is designated as low risk. They have no medical or obstetric features which would mean that they may have a complication arise in pregnancy or birth. But, as we know, risk status is a poor predictor of outcome, so we have all sorts of strategies and transfer processes in place if there is a problem for anyone.

I am very happy to say that, despite the rhetoric from some of our obstetric colleagues at the beginning, it has been a very safe service. People have been transferred in adequate time for any intervention that needed to be done. It has been very much: 'Well, it's not working here. Let's go.' If you need an epidural or you need some intervention, it is available. Our outcomes at the end of one year are excellent. Our caesar rate is 2.5 per cent, which is startling when you consider that overall—right across the board—it is about 30 per cent in most places. The intervention rate is very low. We have only ever had one woman actually induced for pre-eclampsia, which runs at about 20 per cent in the normal population.

You might ask yourself what is going on, and I think that would be a really good question. The human genome project has illustrated to us very clearly that the social conditions you find yourself in lead to particular genes expressing. If we are looking at a primary health care strategy for reducing the enormous social ills that we have which are escalating in our society—and I have a whole list if you want me to read them out—including mental health problems, we do know that the origin of all mental and physical health is in the womb. It is epigenetic. Depending on the circumstances people find themselves in, certain genes are more likely to express if they are already there or to be created if they have not yet been, because genes are dynamic and ongoing developmental things. We actually know that, even at the gamete stage, when the ovum and sperm are creating, depending on the milieu around both the woman and the man which genes will be expressed in the egg and which genes will be expressed in the sperm are contingent upon the environment. We now know it is a social plus genetic storage box, if you like. There is a whole bunch of information that the environment brings out.

The relationship between the woman, her family and her care provider is very important for helping the physiology work well. I would say to the committee that this model is actually what all women and their families want. There is a great demand for the one-to-one care. The midwives are the experts in normal physiology and normal birth, so they are the most appropriate people to have the primary lead with normal, healthy women. Also, women who have complications require that relationship, trust, empathy and emotional care for their pregnancy, birthing and postnatal period. We also know that postnatal depression and third-day blues are greatly reduced with one-to-one care for birthing women.

My vision is to see a Belmont type birthing service in every community and in every suburb so that women can go to their local areas feeling safe and relaxed, can have their babies with someone they know and trust and can smooth out all those wrinkles in problematical birth. It would be fabulous to see it Australia wide. As a committee, it would be terrific if you would look at that. The other aspects of it are that we need Medicare provider numbers for midwives working one to one, whether they be in independent practice or within the case load models of area health services or government run organisations. We also need more direct entry or bachelor of midwifery positions at universities to meet the demand. This is actually sustainable and

economically viable but also about health and wellness. The origins of violence and peace are in the womb and at birth. We know more and more that how babies are born has huge implications for how they go on from there. The other thing is that listening to the women and to what they want is really important, because they are the ones who know what suits them.

I want to congratulate the federal government on the first round in the early nineties that started off the whole process, with what was called the alternative birthing services funding. That started a lot of change right across Australia and started getting health services thinking about it. The Fremantle Community Midwifery Program is one such example of what came out of that, and that is still going. The other thing I would like to do is congratulate our health service on having the foresight and the strength to actually withstand a lot of the negativity and the virulence of the opposition from our medical colleagues, which was really quite nasty in lots of ways. I think it took from the state government—from Morris Iemma at the time—and our health service enormous strength, commitment and belief in what women wanted and in what women were able to do if they were given the kind of care that would enable their physiology to work well. I think it has been a terrific federal, state and area health service initiative.

I also draw your attention to the last Ryde evaluation—Ryde has a similar model to ours—which showed that there was a $900 saving per woman for this kind of care. Some people might call it boutique, but I think that is what women deserve anyway. They deserve something that is absolutely special and important. There is nothing more special in our society than having a baby, is there? It is the future of the society, and our health and wellness as a society depends upon healthy, well-nurtured, nourished babies, so they deserve that. It is also economically sound. I could keep on going, but I will not.

Mr Clout—Carolyn referred to the issues that needed to be confronted—and it is clear that there were some. Whenever you run the model and look at other places where the context is appropriate for it to be provided, you will have those things to confront. You need to have the courage to be prepared to do that. You need to have the clinical support behind you to do it, and we have had that clinical support. This is a very good example, though, for the committee to look at in terms of the balance between expectations. You have the expectation of absolute safety of care. In addition to that, you have the expectation from most women that they will have a full range of choices around the modality in which they will have care throughout their pregnancy to its conclusion and to an appropriate outcome with a healthy mum and a healthy bub. There is no question that those things need to be balanced.

I think the trick to that—apart from teamwork and support; Commonwealth, state and area health services; and midwives and clinicians who have been supportive and strong—is that there have been clear guidelines, protocols and procedures that have been worked through collaboratively so that there can be total clarity about what the service is doing and how it interrelates when it needs to. It is very clear from a funding point of view that there are clear advantages to this, but the biggest advantages are in relation to a shift in the balance between those. We were using a model in which the choices were becoming more and more limited and there was not a preparedness to move to a better balance and to give wider choices.

I think the reality of it is—and Carolyn and I do not necessarily agree on this—that you need to have all of those things lined up and able to be worked through before you can have the service. A service that is constantly under threat because those things have not been worked

through in the way that the Belmont one or the Ryde one have been, one that is constantly under threat from more than an isolated part of a profession, will always be spending lots of its time defending itself, whereas if it has been worked through collaboratively in the way this one has been and has the support and the protocols, clinically, no-one can argue with it. No-one can argue with it from a clinical outcomes, a clinical governance or a patient safety point of view, and the economics of it are clear. The issues around provider numbers and around more training are ones which I think Carolyn has articulated well and I support her.

CHAIR—Do you cater for private patients as well?

Ms Hastie—Yes. Anybody can come to us. It is a public facility, so insurance status does not mean anything.

Mr Clout—It is a public health service. Therefore, anyone can choose to register with that service. If they have private health insurance, within the framework and rules that are allowable under the health care agreement, we seek and encourage people to utilise their health insurance.

Ms Hastie—I will tell you about one of the things that I think is just so beautiful. We get a lot of socioeconomically disadvantaged people, because of where we are. I asked one of the women, who was at the end of her time with us: 'What was it like for you? How did you find our service?' She said: 'You know, I felt like a real person.' I thought: isn't that just beautiful? That is the thing that is really important. Our joy is seeing women and their babies and families leave our care and pass on to early childhood feeling really good about themselves, feeling really competent, positive, empowered and loved through that. We really focus on encouraging attachment to the baby, because we know that if you help that mother and baby become well attached in pregnancy then their postnatal period from then on is just so much better.

CHAIR—Isn't that happening in the conventional system?

Ms Hastie—Well, um—

Mr Clout—I think the answer to that is that, obviously, all efforts are made by the people involved in the care in the other components and the other modalities for that to occur. There is a question about whether or not one is better than the other. I do not think that is the issue.

Ms Hastie—That is probably where we disagree!

Mr Clout—I think the issue is: providing choices that enable people to exercise those choices, ensuring you have the appropriate mechanisms and safeguards in place so that they can have a level of confidence if they do choose that.

Mr ENTSCH—I think it is fair to say too that what you are wanting to do has been assisted by the chronic shortage of doctors, who would have normally had a lot more objections to the establishment or the provision of this service exclusively by midwives.

Mr Clout—We would both agree to disagree with you!

Ms Hastie—We have had a lot of opposition—a huge amount, a lot of very dreadful opposition.

Mr ENTSCH—It is interesting; this gets back to the argument of expanding the provider numbers, from psychologists to allied services like that. I am a very strong advocate of birthing centres and the type of service that you provide. If you want a further example of the success of them, you do not have to go further than a small, remote Aboriginal community called Kowanyama in western Cape York, which had an incredibly high level of infant morbidity due to foetal alcohol syndrome, where the brain did not develop because of the alcohol problems and substance abuse problems of the mother. When the old hospital shut down in the community, the local community council took the hospital over and set it up as a birthing centre and mothers centre. They got support from a whole range of people, like Johnson and Johnson and those types of people. When a woman became pregnant, she basically was then supported through this centre, with nutrition, education, the whole thing, up to the time of the birth. They even provided accommodation at the centre for mother and child, to ensure the feeding and everything else. This was done with the remote nurses and midwives. Over a period of about four or five years, they have reduced the foetal alcohol syndrome to zero.

Ms Hastie—That is wonderful, isn't it?

Mr ENTSCH—I notice there is a 20 per cent Indigenous population serviced within this area, and that is another area where it has been outstandingly successful. I think it is culturally acceptable, in not only the Indigenous population but the broader population as well. I think it is something we should look at.

Mr Clout—The general issue, though, is that we are past the day where we say that every health service that is provided has to be, of necessity and of rule, led by a doctor. That is not sustainable and nor does it make sense. The fact that there needs to be a team approach to it is accepted.

Mr ENTSCH—We have survived hundreds of thousands of years without—

Mr Clout—Bear with me—the fact that there needs to be a flick in and flick out in appropriate circumstances of all of the appropriate clinicians in the team is accepted. But, if there is a service led by the midwife that can appropriately be provided, then it should be. If there is a time when the doctor needs to be part of that, then the doctor needs to be part of it—likewise in other areas outside of midwifery. You need to have choices, and you need to have appropriate safety and guidelines, but it is not necessary to have every service led by a doctor. I think we in this country have to accept that and work with it, and I think we do.

Mr ENTSCH—That is what happened for thousands of years. It is a—

Mr Clout—Return to the past.

CHAIR—With this model, what are the implications for indemnity insurance, which we went through a number of years ago?

Ms Hastie—In terms of us being a public health service facility, the indemnity is covered by the public health service. However, the privately practicing midwives certainly need to have indemnity insurance, and it would be a fabulous thing to have that.

Mr ENTSCH—And doctors are of course available if there are complications.

Ms Hastie—Yes. One of the things that our state government has just done is issue guidelines on home birth processes, really pushing—and that has been true for some time now—that interweaving and interlacing of services so that, wherever a woman chooses to give birth, if everything goes well that is great but, if there is any need to move, then they are able to move seamlessly and are appropriately and properly taken care of, wherever they need to go to. That is the thing—it is about providing the services where the right place is for that woman at that time. However, all women have midwifery care because they need it whether they are high risk or low risk, but all women do not necessarily need medical care, because having a doctor around for a childbirth is like having a cardiologist around for doing exercise—you only need them if you have a heart attack.

Mr ENTSCH—It is a pretty natural event, isn't it?

Ms Hastie—It is a natural, normal process, and the more relaxed women are the better it goes. That is the thing that we really need to understand.

Mr Clout—I think we have to take Carolyn's point generally, not just in midwifery, and that is that the appropriate professionals need to be involved in the appropriate care at the appropriate time in the appropriate place—and you need to provide as much choice as you can within that.

CHAIR—We look forward to going out there this afternoon. We can continue the conversation and the briefing for the committee at a later time. Is there anything else you want to tell us on the record?

Ms HALL—I think the important points you have made are the cost effectiveness and safety of the service and the fact that you are providing that very special personalised care—

Mr Clout—And the choice.

Ms HALL—And the choice.

Ms Hastie—And that the women want that.

CHAIR—Thank you again for the evidence you have given us.

[11.51 am]

BROWN, Mr Duncan Alexander, Private capacity

CHAIR—Welcome. We have not had many submissions from individuals or consumers. On that basis, what you are going to tell us will be very useful to our committee. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. You may wish to make an introductory statement.

Mr Brown—As I have indicated in my submission, I would like to thank the chairperson and committee members for the opportunity of giving evidence here. In my submission, everything I have said is factual and comes from experiences which I have had in the last nine months. I can only say that I am not coming here as an advocate for the medical profession. I am not a member of a political party and never have been. I come just to give you an opinion of where I see deficiencies in the current system. I think a lot of people out there are hurting because of the way the medical system now is. I look forward to seeing it improve. If the committee wish to ask me any questions, they can.

CHAIR—I thought you might run us through the problem you had.

Ms HALL—Give us a brief overview of your submission.

CHAIR—People who read the transcript may want to know what your case history is.

Mr Brown—In 1982 I had cardiac surgery, a triple bypass. I went along fine for a while. At that time I worked for the New South Wales public works department. The government medical officer decided I would be too great a risk in my job and they subsequently retired me out. In 1998 I was diagnosed as having further cardiac problems and the doctors indicated to me that my medical condition would not allow me to have another bypass operation. I found out on the internet that there was an operation being done in America called transmyocardial laser revascularisation, which means holes are burnt in the heart muscle to form new vessels.

In my case, I was told in Newcastle, 'We can't do anything for you here; you're inoperable.' So I took the bit in my teeth, and I sent emails around the world asking for anybody that had any human Drano to clean the arteries out. I got emails from all around the world. One email from London suggested I contact the medical people at St Vincent's Hospital, which I did. They said at the time that they had just started laser surgery. I inquired about having it done in America, and they said the cost would be $50,000, which I did not have.

While I was talking to St Vincent's, they said, 'We're after candidates for the operation.' I asked at the time, 'How many patients have you done?' and they said, 'Five.' I asked, 'How many have you lost?' and they said, 'Three.' So the odds were not particularly good. Anyway, I went down there and they said, 'Yes, we think we can do something for you, because you're at a

fairly young age'—I was 57 at the time. They subsequently burnt 31 holes in my heart muscle, and I had eight years with no problems at all.

I started to get some form of angina about 12 months ago, and I had a heart attack on 27 September last year. I was admitted to Belmont Hospital. At no time did anybody say to me, 'You have a choice of cardiologist,' yet I pay into a private health fund. I saw the resident—

CHAIR—Did they offer for you to be treated as a private patient?

Mr Brown—They asked me if I wanted to be a private patient or a public patient. I said, 'What's the difference?' They said, 'Well, if you come in as a private patient, you'll get a free newspaper and free TV,' but they did not say I would have a choice of doctor. They did indicate that if I came in as a private patient the hospital would get additional financial benefit from the private health fund which they could distribute for the welfare of all other patients. So I then said, 'Right,' because I had been told, at some other time prior to that, that I would have a choice of doctor because I was a private health contributor. I said I would come in as a private patient, which I did.

At the time, one of the consultant cardiologists said, 'We'll give you an angiogram.' I said, 'Whoa, hang on a minute. I think you'd best talk to St Vincent's Hospital, because I go down to St Vincent's and I'm under the transplant unit there. I go down there twice a year.' It is not that they have ever thought that I would need a transplant, but they are the best. They are rated as the third best in the world, so I just go down there. I went down there and they asked me to have certain tests: a cardiac echo and also maybe an angiogram. I had the cardiac echo, and I—

CHAIR—That was at St Vincent's?

Mr Brown—I had the cardiac echo up here. At that time, the gap fee was $52. I have to have another cardiac echo tomorrow.

CHAIR—Was that as a private in-patient in the hospital?

Mr Brown—No, not in the hospital; in their rooms, in the cardiac centre. It was suggested to me a few months ago that I have another cardiac echo before I go back to St Vincent's in October for just a general check-up. I rang, and they suggested that I have it done at the same centre where I had it done before. I rang up yesterday to make an appointment for the cardiac echo which I have to have tomorrow, and the gap fee has now gone from $52 to $80. I have no problem with the doctors charging the gap fees, because all the time the doctors have said to me that they only charge what the AMA recommends. But there seems to be quite a gap between the Medicare schedule rate and the AMA rate.

Getting back to my history: after having some tests in Newcastle I also had a sestamibi scan and I went back to St Vincent's and they said that I needed an angiogram down here. I went down and had the angiogram and I was told that I had five blockages, so I needed bypass surgery. I said that I was told before that I was inoperable. They said, 'Yes, but our medical techniques have improved quite substantially since the last time you had cardiac surgery.' I then had the cardiac surgery. I had it done by the top man at St Vincent's. I had a lot of hurdles to overcome and I had a lot of pain. But the treatment I had was first class. As I have said in my

submission, the only doctors that said there would be a gap were the surgeon and the anaesthetist. No other doctor suggested that I had to pay a gap free.

CHAIR—Did you meet the other doctors before you had the operation?

Mr Brown—No. If you have a look at the attached schedule you will see that the surgeon's charge was $7,043 and the cost to me was $3,823. What I cannot get around is that if you pay into a private health fund and you also get the Medicare rebate then I believe those two should add up to somewhere around the AMA schedule. Why is there such a gap? I do not mind paying 10 per cent. I would not mind if the doctor charged $50 and I paid $5—or 10 per cent of the charge whatever it might be. I am not a wealthy person. I have not worked full time in 24 years, so I did not have the benefit of being able to stay at work until I got to 60 and build up a nest egg for when I retired. This has created some difficulty for my wife and me but you live by the cards you are dealt. I am grateful because I am still alive and I am grateful that I can come here and say what I think.

CHAIR—The point you are making is that the out-of-pocket expenses are quite significant. Under top level medical cover you are informed of some gaps; there is no requirement on the doctor to stick to those gaps. You then get accounts from people like profusionists, everybody else involved and people whom you did not meet. We have heard evidence before this committee that surgeons, particularly, are getting older as a group and they can no longer work six or seven days a week—they like to work four days a week—but they like to maintain their incomes at the previous level, so they pass on the costs of the surgery to the patients. There is nothing within the power of the government to do anything about that because we do not have constitutional power over prices. They can charge what they like.

What we do have the right to do is make sure that before doctors qualify for benefits there should be informed financial consent so that you should have the full team costs for the surgery put to you before you make a choice. You should then have a choice of your surgeon and other members of the team. In the condition which a person usually is when they have cardiac surgery they are not really in a position to bargain and say they want a certain person because they are cheaper. That does not happen.

Mr Brown—That is right. You are trying to cling onto life and you are not very lucid—

CHAIR—You do tell them, 'If this doesn't work, you're not getting paid'!

Ms HALL—Your total out-of-pocket expenses were really quite exorbitant. They were $8,264.35, weren't they?

Mr Brown—That is correct.

Ms HALL—You might wonder why Alex seems to be very much in tune with what you are saying—

CHAIR—I have had two lots of it myself.

Ms HALL—I do not know what his experience has been with out-of-pocket expenses, but when I saw your costs and read of your experience I felt that it was something that you needed to share with our committee.

CHAIR—The anaesthetist told me what my gap would be, but when he found out I was a MP it doubled!

Mr Brown—I did not tell them that I only had a Centrelink pension—maybe he might have halved mine!

CHAIR—You should have!

Mr Brown—On the schedule of the coronary surgery costs, at the clinical part there are a couple of items, one of which is $1,297. I was out of pocket $651.85. Another one is $1,537, and I was out of pocket $789. I did not meet those doctors. That would have been while I was in intensive care and unconscious, and my wife certainly did not see anybody.

CHAIR—And what does not appear on that cost schedule is the cost of the hospital.

Mr Brown—Yes. That is right. I had to go to Medibank Private the other day and the lady said that our costs from the hospital were in the vicinity of $17,000—

CHAIR—That is what your private health insurance cover is for and that is done by contract between a hospital and the health fund. Whether your operation takes three hours or eight hours, they get paid the same amount for the operation. Apart from having a personal interest, my concern is that there is more pressure coming on the private health system with premiums increasing and gaps increasing. How long can that continue before the system collapses or approaches collapse? Given that the Commonwealth government puts in 30 per cent of the cost of private health insurance, and more for older people, we have an interest, as far as the government goes, in making sure that the private system is sustained. Without the constitutional power to require doctors to charge certain fees, there is very little the Commonwealth can do except ensure informed financial consent and make it compulsory for doctors to tell people exactly how much they are going to charge. There will be variations of course. If there is a complication during surgery and they are in there for three or four hours extra time, it is different from the quote you get, and you accept that. But asking somebody who is on a Centrelink pension to have to fork out three grand a year in premiums and then pay $8,000 or $9,000 on top of that for a procedure is not really acceptable.

Mr Brown—That is the beef that I had. I have no problem with doctors if they charge the AMA schedule, but it was difficult for my wife and me when the surgeon said that there would be a gap fee. I did not think it was going to be $5,000 but I ended up, as you can see, out of pocket. But there were complications in the surgery that I had. I cannot complain about the service that I got while I was a patient. They were absolutely marvellous. But it is a problem. I do not know what the answer is; I am not smart enough.

CHAIR—What would the outcome have been if you had gone there as a public patient?

Mr Brown—The words that the surgeon used in the initial consultation were: 'You know you'll have to come into the private hospital because the public one is not up and running yet.' I know that St Vincent's general hospital has just gone through a massive rebuilding program. As a person who has been in the building industry, I took what he said to mean that the theatres were not yet up to speed to perform operations. Yet some of the post-operative things I had—they had to put me back into surgery to zap my heart to get it back into kilter—I had in the general hospital.

Ms HALL—In the public hospital?

Mr Brown—Yes.

Ms HALL—They took you from the private to the public to do that?

Mr Brown—Yes. But some of the other tests that they did, such as a cardiac echo and several CT scans, were done in the private hospital. X-rays were done in the private hospital.

CHAIR—But not as part of your hospital costs?

Mr Brown—No.

CHAIR—They were done in the private hospital.

Mr Brown—Yes, and I was billed for them.

Ms HALL—There was no gap either.

Mr Brown—I think that if the government pursues private health insurance, which is what its policy is, the gap fees have to be addressed. I am getting to the stage now, because of the income that I get from my allocated pension plus my Centrelink pension, where I do not know whether I am going to be able to afford to be in a private health fund for much longer. The only reason I am staying in it for as long as I can is in case I get sick again. If have to have further major medical attention I am going to try to go to the people who I have dealt with and who have treated me.

CHAIR—So you are saying you are locked in.

Mr Brown—I am locked in. The thing was that I had to go to John Hunter Hospital. I am not complaining about John Hunter Hospital, but I had to go in there for a period of about four days with unstable angina, in the mid-1990s. People were saying to me: 'You've got a bad heart condition.' After I had laser surgery, some of them did not even know what transmyocardial revascularisation was. That is pretty scary. I thought: 'I will stick with the people who understand and who have worked on me.' My wife and I go down to Sydney twice a year, or maybe more if they need me to go down there, and I get treated by them. But it still locks me in. I have said to the family that I will be in the old men's home before I die because I will not be able to afford to stay where I am. I just make a joke of that. Hopefully, it will not happen.

Ms HALL—You are making the point that cost is a very important factor.

Mr Brown—It is.

Ms HALL—It is increasing and it is making it harder and harder for you to maintain your private health insurance. That, coupled with gaps, is really making you question, even with your serious medical condition, how long you can maintain it.

Mr Brown—As I have stated in my evidence, the anaesthetist was a very nice fellow. He explained that there would be a gap. The surgeon initially said, 'There will be an estimated gap fee of about $5,000, and that will cover the anaesthetist and me.' When I got the account from the anaesthetist—and I think it was $6,000 all up; I have the document there—

Mr ENTSCH—$6,200.

Mr Brown—Yes. It said that, if I paid within 30 days, I would get a 33 per cent discount. I initially went to the Medicare office and said, 'Can you issue the cheque within 30 days?' and they said, 'No, we can't guarantee it.' So my wife and I withdrew the $6,400 or whatever it was from our allocated pension fund, and I received a $2,200 discount. If I had not had that money—if a person was on a Centrelink pension and did not have any backup funds, how would they get on?

CHAIR—They would probably say, 'Sue me'!

Mr Brown—They say, 'Well, you can give us payments. Can you pay it off?' I do not like to get locked into anything like that. If somebody is willing to do a service for me, I have never been the kind of person that would not pay anybody for whatever service they gave me. I pay straightaway. That is just me.

CHAIR—We have heard your evidence. It is not unknown to the chairman!

Mr Brown—I thank the committee very much for listening.

Ms HALL—You made some very valid points.

CHAIR—We thank you for coming along. We need to be told this by people in the community, not just by peak bodies, organisations, clinicians and other people. It is very important to hear from the patients, and I really thank you for making your submission to the committee and appearing before us today, Mr Brown.

Mr Brown—Thank you for listening.

[12.20 pm]

THOMPSON, Mr Cecil Russell, Member of Branch Committee, Newcastle Branch, Australian Psychological Society

CHAIR—I now call the representative of the Australian Psychological Society, Newcastle Branch, to give evidence. Do you have any comment to make on the capacity in which you appear?

Mr Thompson—I have been a member of the Newcastle branch of the Australian Psychological Society for the past 20 years. I am filling in for the current chairman, Mr Don Munro, who is unavailable at this time.

CHAIR—Thank you. Although the committee does not require you to give evidence under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament, and the giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an introductory statement to the committee before we go on to questions.

Mr Thompson—First of all, I am aware that our national office has made a written presentation on this matter. I am happy with their presentation on that score. I do not wish to say too much more about that. At this time, as a practising psychologist for some years now and, as I said, a member of the committee for the past 20 years, several things have come to mind about the situation of funding for psychologists. They are matters that we have come across in this period.

The issue of access to psychologists has always been difficult, and the summary position on funding for psychological services is summed up, from our position, as inadequate. When you seek psychological services, as you would be aware, you can receive them from public service psychology. The state governments provide psychological assistance, usually through the crisis mental health service or through community health services.

The crisis service is just that, and I think the recent parliamentary findings on that are that it is quite inadequate and has been for a long time. There is also a problem when you are treated in crisis about how much service you get when you get back into the community, which seems to produce a revolving door sort of thing for too many people. I have to be restricted to qualitative information on this. I do not have numbers, but certainly the impression that we get is that only having that crisis service exacerbates the situation because so many people are in and out and in and out.

If you need some psychological services and you do not go through that method, you can get service through private practitioners such as myself. In respect of the access you get there, often you are referred by your general practitioner. However, those referrals have in the past been limited very much by how you may pay for the service privately. If you happen to be on workers compensation, it will be covered by workers compensation insurance. For motor vehicle injury patients it is the same; the liability is taken up there.

The other form that a number of us engage in is providing employee assistance programs for both private and public organisations. Those are somewhat limited. Some of them provide two hours of free service and some provide six hours. Some provide more, but they are very few. That allows you to at least get some service and perhaps some direction as to where you are going and where you might get sufficient service from.

There is one further one. If you happen to be a victim of crime, you can get psychological services. Every victim of personal crime in this state can have two hours of service and may get more depending on the injuries they have suffered.

The other referral from general practitioners would be if you have sufficient private insurance, but that is at a very high level. You have to have what we refer to as ancillary benefits and they are fairly limited in most funds. GPs will also refer you if you have sufficient private funds and the cost of going to a psychologist will not be onerous.

As well as that, in recent times there have been a couple of federal government initiatives. One is the Better Outcomes in Mental Health Care service, which has been taken up in this region in the last 12 months. There have been a large number—by our standards—of people involved in that and it has had some impact on providing psychological services. The comment we would make on that is that at this time my understanding, from speaking with Arn Sprogis—who I believe will appear before you later today—is that only a minority of the GPs in the urban division have taken up training to be involved in the better outcomes program. At this stage in the Newcastle branch of the APS we do not know how quickly they will proceed beyond that. We just do not know whether or not it will be quicker in the future. That obviously limits the number of people.

The other thing we find limiting is that a lot of GPs—I understand this indirectly—find that that particular process is a lot of paperwork, which they do not wish to engage in. By comparison, if someone is referred to us because of workers compensation or something like that, it is a simple matter of, 'Would you please see Mr Smith today and let me know how he is going and what you recommend?' It takes no time at all in that sense. By comparison, there is a lot more paperwork involved, which limits the general practitioner's interest in pursuing it because they always feel, for their own reasons, which they can explain, under a lot of pressure and that is paperwork they will not wish to do.

The other one that was legislated for is MedicarePlus, which is a very limited scheme because it talks about five half-hours of access to allied health. Most GPs are not prepared to fill out the paperwork because for a chronic case he is going to get only five half-hour sessions. No-one in my area is having any work from that scheme because it does not seem to be getting anywhere with the GPs. Again there are two things. One is that it is very paperwork heavy for a very small amount of service which they then perhaps have to spread among physiotherapists, occupational therapists and psychologists. Most psychologists would baulk at any session less than 50 minutes as being particularly valuable. You may be able to demonstrate to us that it is. I know in some areas there is a half-hour service going ahead in health psychology. They are for particular matters and they seem to be working, but that is right outside the norm for most of the conditions that I see.

CHAIR—What are you recommending?

Mr Thompson—With any recommendation that I make I would have to say, as I mentioned to Ms Hall before the session started, I cannot speak on behalf of anyone much more than myself at this stage because we have not had sufficient involvement from our branch to say much more. So I am reluctant to go further than to point out what I know has happened in the branch.

Ms HALL—So share with us from a personal perspective.

Mr Thompson—One of the funding issues we have is that, even in the proposal for 1 November, when the Medicare benefits scheme will begin, the situation is that we depend upon referrals from GPs and psychiatrists to us. We would suspect that, if it becomes, as they see it, a lot of paperwork for them to do, people will be excluded from our service. Therefore, all the things that are being said about how wonderful we are in our national paper will not be available again. That is the point I am making. I am saying to the committee that, if you have a system that works, it will have to be one that makes it easy for a flow of people to come to us.

When we are talking about who we see, they are not your usual health patients. These are people who are more reluctant, who find having any sort of paperwork or having too many people to talk to barriers to looking after their case. They go away rather than be involved in what they see as a complex matter of extra difficulty at a time when they are having difficulty. They say that, from their perspective, if it requires them to jump through hoops, they are less likely to come.

CHAIR—What does this mean for the patient?

Mr Thompson—Our view has always been that at the moment the patients do not get to see us as often as we believe is in their interests. That has been very much our point of view for a very long time now. It has been much harder to see us than the local chiropodist. Many more services are being covered by a government subsidy or health fund subsidy than have been covered in psychology for a very long period now. That has been one of the issues, and the other issue has been that lots of the initiatives that have come forward have had inherent, if you will forgive the term, bureaucratic barriers in them. I think that makes sense.

Ms HALL—Access and equity of access is a really big issue in your area, isn't it?

Mr Thompson—Very much so.

CHAIR—Are we now talking just about the Hunter, or do you think this has a wider application?

Mr Thompson—I am sure it has a wider application.

CHAIR—So it is not just happening here.

Mr Thompson—No. Again, we too suffer, as Arn Sprogis will probably tell you this afternoon. You have to be careful: if you just give access to the providers, you will concentrate the services where the providers live rather than according to the need in the community. I think that is a very good point that he made—I cannot claim any authorship of that. In our discussions with him on the Better Outcomes in Mental Health Care Program, he said he has attempted to

spread it through the community by their operation by saying, 'We would prefer to have access according to the need rather than according to where the therapists or the treating professionals are.' Otherwise, you get figures like those that have been in the press all the time, where, if you live in the eastern suburbs of Sydney, there is a doctor for every 500 people and if you live in Cessnock there is one for every 3,000. That is an inherent problem and is one that we have too. Sorry—it just adds to your problems, I know, but it is no different for us at the moment.

The other matter that I was asked about was training. Training is very difficult in our area. Firstly, it is inherent in our training that we tend to be very academic at university. You come out with a four-year degree and then you have to do two years to be registered. Access to the two years for registration has been greatly limited because the easiest way for many psychologists has been to train with their employer, and the best employer is sometimes a large employer and that turns out to be the public employer. Traditionally, or when I was a new psychologist, that was the easiest way and perhaps the only way into the business. You took a position in the public service, you got your necessary training and you could then move on with your career.

Nowadays registration is a barrier because you have to find your own payments for registration. If you are going to be supervised by a psychologist, you have to pay for that. Most of us prefer to be remunerated for providing that supervision. So, in effect, it makes it a six-year trained profession, which has other consequences, too. So the training is a real issue for us. It means that you are going to get certain people who are perhaps more committed and more prepared to go that way, rather than everyone you might wish to have in the profession.

CHAIR—I am not hearing this in my electorate. Psychologists in my electorate are not coming to me, as a local member, and saying that these problems exist.

Mr Thompson—That would be wrong. We are not very well organised.

CHAIR—Are you hearing it, Warren?

Mr ENTSCH—No, not really.

Ms HALL—I have heard it for a very long period of time, not only in this area but in areas that I have been in. It probably has a lot to do with my work history and the fact that I know that this has been a big problem, along with issues surrounding the registration of psychologists, the ability of people to portray themselves as having certain skills that psychologists have and not having any sort of mandatory requirements associated with that.

Mr Thompson—I am not quite with you on that comment, sorry.

Ms HALL—Where people can set themselves up as counsellors and provide services similar to the services that you provide—

Mr Thompson—Apparently similar; that is right.

Ms HALL—Yes—without having the proper requirements and registration that psychologists and your members have.

Mr Thompson—That is right.

Mr ENTSCH—What is your view on extending the access to Medicare, as we have recently expanded it to psychologists—expanding it further into allied health services and trained counsellors?

Mr Thompson—Again, before I make a comment I would have to refer to: whom do you wish to service with those people? There would be some where that may be very useful, but there would be some others that we would—

Mr ENTSCH—They do not have to be through an accredited—

Mr Thompson—Yes, but my question is: would they be servicing people who have a major psychotic illness, people who have major depression or just people who have minor anxiety conditions?

Mr ENTSCH—Probably the latter, but using them as a first port of call for referral on to either psychologists or psychiatrists, depending on what the level of need was. However, I would assume there are a range of services that could be provided by qualified counsellors in some areas. While there is an acute shortage of psychiatrists, particularly in regional areas, there is a lesser shortage, but still a shortage, of psychologists in some of the—

Mr Thompson—Very much so in the regions.

Mr ENTSCH—In the regions—and, as a first port of call, there could be this opportunity to access counsellors.

Ms HALL—Mr Thompson, I suspect you would have some concerns about people going along to receive services from, say, somebody who has done a six-month correspondence course on counselling that has some accreditation. Rather, I suspect—and correct me if I am wrong—you would feel very strongly that people need to have the sort of qualifications, training and experience that psychologists like yourself have to provide the quality psychological services that people need.

Mr Thompson—In general, yes.

Mr ENTSCH—There are qualified training—

Mr Thompson—But again, with respect to Mr Entsch's question, you may be able to use people who do not have the same level of qualification if they are working in the same organisation—such as in the next office to a psychologist—so they could have reference. Because of the particular nature of the—

CHAIR—Does that happen in the one practice?

Mr Thompson—Not very often. It can happen to some degree where people engage mental health nurses but, at the moment, they tend to be more in the psychiatric field rather than in psychology per se. I do not see any particular link in the information so far from the COAG

meeting that announced there would be extensions that would look to go ahead with that model. Certainly I can understand Mr Entsch's comment that there is no point in having the best services for some and missing out the people who need it most just because of their location. That does not seem to be a great success. It is better than none but it is not great.

Mr ENTSCH—We have denied people for a long time because there were no psychiatrists in a lot of those areas, and that was the push to get provider numbers for psychologists. There is certainly a view that there should be a range of allied health professionals who should be considered for provider numbers. I am not talking about mail order counsellors either. There are university qualified and trained individuals who are counsellors, who are on the ground and can identify problems that can be referred on for appropriate levels of treatment, either through psychologists or psychiatrists. It is the on-the-ground availability, which I guess is dependent on the regions.

Mr Thompson—I think what you are referring to is the proposal for nurse practitioners or someone of that ilk.

Mr ENTSCH—I am just interested in your view.

Mr Thompson—There is always this tension between, 'Let's get them the service that is required,' and, 'Let's not put anyone into a service where they are going to be asked to provide a service beyond their capacity.' Therefore, from my previous comment, it is the required backup for those people that is instantaneous and readily available. As with any medical condition, the worst part is wrong diagnosis. If we diagnose you with a cold and you have really got meningitis, we are in trouble. The same happens in psychology. If we say, 'You've got a minor anxiety,' but in fact you are suicidal, it can have disastrous consequences.

Mr ENTSCH—That can be terminal.

Mr Thompson—Very much so. Again, I am taking the conservative view. With my experience, I would say that there has to be backup for those people so that they feel quite comfortable to say that they want to check that their diagnosis of a cold is a cold, that their diagnosis of a minor anxiety is a minor anxiety.

Mr ENTSCH—It is a bit like going to a chemist and saying, 'What do you think I've got?' and they say, 'You'd better go and see your GP.' It is the same sort of thing.

Mr Thompson—That is right.

Mr ENTSCH—Yet, they are qualified as chemists.

Ms HALL—We already have an uneven distribution of psychologists, and I think you emphasised that the higher the population concentration the more psychologists there are.

Mr Thompson—You have only to look at the *Yellow Pages* and you will see how it is. I am in there in the central business district.

Ms HALL—I will remember that if this gets too much for me!

CHAIR—Do you provide services in the rural areas?

Mr Thompson—No.

Ms HALL—If provider numbers are issued to psychologists, do you think that would be a greater incentive for them to localise themselves in those high-population areas and to move away from areas that are already starved of psychological services? Would it encourage people to leave the public health system and move to private practice in a metropolitan area?

Mr Thompson—Or a non-metropolitan area?

Ms HALL—Would it encourage people to move from a non-metropolitan area to a metropolitan area, thus further exacerbating the shortage.

Mr Thompson—If we gave out provider numbers and more moved out of the public service, there is certainly a risk of that. If that was just the procedure then, yes, that is probably what happens with general practitioners to some degree, even though I have noticed that not all the general practitioner training places have been taken up, according to the press reports I read recently. But there would be that risk, again, that there would be people who would prefer to move out of the public service. I thought your first question was, as far as provider numbers were concerned, whether we would get them to move outwards—and the answer is no.

Ms HALL—The opposite.

Mr Thompson—I think that is more likely.

Ms HALL—The other questions I would like to ask are in relation to state-Commonwealth issues that impinge on psychologists. Do you think there is any conflict between the two and what role or extended role do you see for the Commonwealth in relation to psychological services?

Mr Thompson—At the moment we just get inadequate help from both. That is our position. It is the Commonwealth that has Medicare and the Commonwealth that funds it that way, and that is the biggest gap—certainly from where I sit as a private psychologist. It does not extend to us in any sensible way as yet. The Better Outcomes in Mental Health Care program is a step in the right direction but how far that will go and how well that will be refined, I really do not know.

CHAIR—We have not concentrated so much on mental health in this inquiry because, obviously, the Senate committee is handling it in depth. We have been talking about the funding of the overall system and the relationship between different levels of government and how we can get more efficiencies out of the same amount of dollars. All the evidence we have been receiving is telling us there are wastages in the current system regarding the way that it is run and how it can be improved. From your point of view in your profession, is there any way that you can see wastage in government expenditure that could be better directed towards patients?

Mr Thompson—It is a bit hard to see wastage when there is not much expenditure.

CHAIR—That is a fair answer.

Ms HALL—That is a very good answer.

CHAIR—There being no further questions, thanks for appearing before us today. If we need more information from you, the secretariat will be in touch.

Mr Thompson—Thank you for the opportunity to speak to you.

Proceedings suspended from 12.48 pm to 1.29 pm

SPROGIS, Dr Arn, Chief Executive Officer, Hunter Urban Division of General Practice

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal part of the proceedings of parliament. Giving false or misleading evidence is a matter that may be regarded as contempt of parliament. Do you wish to make an opening statement to the committee?

Dr Sprogis—I do, and I will keep it brief and to the point, I hope. This committee is one of the most important committees as it is related to Australia's biggest problem in social policy, and one of the greatest challenges in Australia's social policy is our health care funding system. I will present the problems as I see them as briefly as I can, and then I would like to put forward a solution as we see it in our region. Australia has a mainly bipartisan health policy, and both sides of politics agree at least on three things: that access is an essential part of Australia's health care system, funding should be based on need, and equal quality should apply for health care services across the nation. It is fair to say that that has failed in rural and regional areas. It has not just failed in a minor way; it has now failed in a catastrophic way.

Regional and rural areas are socially disadvantaged. Something like 35 out of 36 of the poorest electorates in Australia are rural or regional. They are socially disadvantaged in health because of the Commonwealth funding system, not despite it. All Commonwealth funding arms—there are three major funding elements: Medicare, PBS and the private health insurance rebate—have led to this failure of access and quality in rural and regional areas. This is certainly well known to the department of health, although it seems to be a well-kept secret outside the department, but there is little or no policy to equalise this failure. Those three funding systems all reward and reinforce the status quo, which is capital city provision of health funding and health resources. They reward service providers but they do not reward communities. It is pretty simple stuff really. Because of that, there is a major split. The three members of this committee here today know, and I know because I have had a look, that there is a major split in access to health services in rural and regional regions compared to capital cities. This has been accelerating for five years, and is rapidly getting worse.

Compared to capital cities, rural and regional areas have a lot fewer GPs. Where we sit is the sixth biggest city in the country and only 160-odd kilometres from the biggest city in the country, and yet we have a GP workforce shortage in the few kilometres surrounding me. If I remember rightly, there is no doctor at all in Boolaroo, and there has not been for ages. In a relatively underprivileged area, it is a disaster. The ratio in this region is roughly 1:2,000—one GP per 2,000 people in the population—it should be about 1:1,000. There is a critical shortage of medical specialists. You reckon the GP thing is bad in rural areas—again I am preaching to the converted—the specialist situation is worse. There is little or no access to private hospital care, which I will get onto in a second, and many rural areas have none of the above: no specialists, no private hospital, no private hospital services, no GPs and no allied health, thank you very much, and we wonder why that has happened.

As we all know, this increases figures in relation to the capital cities. Relative death rates are higher in rural areas and relative disability rates are higher in rural areas. Again, I am happily sheeting that home to the major cause being our funding system. I am going to talk a bit about

GP services, but GPs are a bit like the canary down the coalmine. If it is bad in general practice, you can put your money on the fact it is even worse in the other services that follow on from that. I am talking about general practice and although I will mention it briefly, I would like you to extrapolate that to the other services—that is, specialist services, allied health services and hospital services.

I would argue that Medicare—Medibank and then Medicare, a 30-year-old system—has been one of the major contributors to disadvantage in rural communities. If you look at our region alone—and this is not a rural community, this is a regional capital centre—in comparison to the best funded capital cities, relatively speaking, we miss out on $30 million a year for GP services alone—not counting the PBS, not counting specialist services, and not counting private health insurance rebates.

I am going to give some of you at least a bit of an indicator of what GP services are in your region. You can multiply the number by your population and you will work out what you are missing out on if you live in a rural or regional area, as some people definitely do. It is a disaster. There should not be inequality of Commonwealth funding to communities. It just should not occur. That directly leads to lack of access. It sends a clear market signal to the workforce to stay in capital cities. Why would you stay in a capital city? Because you are going to be well paid for it. More money goes into capital cities, away from rural and regional areas, because that is the way the system is structured. I thought I would give you a couple of examples. I have run the entire committee through GP services, just out of idle curiosity.

Ms HALL—You might like to table that for the committee so that we can share that with our colleagues at a later date.

Dr Sprogis—You can. It is rough, but it is not bad. I have looked at what the division of general practice—because they are the statistics I could get hold of—is in your area. The winner, interestingly, is Alan Cadman. He is not present today. His region, per head of population, gets $243 per person per year for GP services. The loser is present: the Hon. Warren Entsch. His region gets $66 per head of population per year for GP services. It is a quarter.

CHAIR—Does that reflect the performance of the member?

Dr Sprogis—If it did then consider that the Hon. Kim Beazley, who is the Leader of the Opposition, for a part of his electorate, sadly, gets only $120 per head of population per year. In fact, there is no advantage in being the Minister for Health and Ageing, because Tony Abbott's electorate gets fractionally less than us or approximately the same. The Prime Minister's electorate of course gets more, as behoves a Prime Minister's electorate. It gets $168 per person per year. The point is that you cannot have a system of health care funding from the Commonwealth which gives four times more money per head of population for one area just because it is convenient for the providers than to another area because it is inconvenient for the providers. You cannot do that and expect those areas then to have access to services. The market signals that are being sent are really clear. They are saying, 'Stay away from rural and regional areas. Go to live in the middle of a city.'

If you want to know the most spectacular ones, the Melbourne Division of General Practice, the Eastern Sydney Division of General Practice and the Central Sydney Division of General

Practice all receive a bit over $200 per head. The worst are Cairns—well done, Cairns—and the Kimberley, at about $60 per head. That is not an acceptable disparity.

This is about to be repeated with a greater issue. Both the Commonwealth and the states have agreed to participate in improved mental health service provision. Money has been allocated. It is an absolutely wonderful thing. We are going to fund clinical psychologists under Medicare. That is a very good thing, but I will tell you now that, if you think rural regions miss out on GP services, boy are they going to miss out on psychology services. There are towns that might have a GP, but the one thing they do not have is a clinical psychologist. Yet again, we are going to watch the eastern suburbs of Sydney, Toorak and a few other places, where every second house has a clinical psychologist in it and every other house goes to visit them, all benefit from this under Medicare. This is not a useful way of allocating Commonwealth resources to hard-pressed areas.

I cannot help but mention the private health insurance rebate. The first thing you notice about private health insurance in regional areas is that you cannot get any data—at least I could not. You probably can, but I bet even you have trouble getting regional data for private health insurance rebates. The *Medical Journal of Australia* in 2005 published an article that says that rural areas are $100 million a year short by comparison to their city counterparts. Every year $100 million of private health insurance rebates does not go to rural areas that does go to their city equivalents. That is not acceptable. That is the problem. Now let us look at the solution. There is no point in talking about problems if you are not going to talk about solutions. I will give you a couple of examples just to show that it actually can be done. They are not pie in the sky solutions.

The first thing that has to happen is that there has to be a Commonwealth top up for regions that are obviously underfunded under Medicare, PBS or private health insurance rebate. These are all good systems. Medicare is a good system. Private health insurance rebate is a good system. The PBS is a good system. What is required is that regions should be given a top up saying, 'For reasons that you do not have the providers, here is your money top up to make you equivalent to what your city counterparts are getting. Now what are you going to do with it? You have to provide health services with it. You actually have to do something that is a regional solution.'

Regions are good as local members would know. Each region is different. Each region requires a different solution. This region has one solution. Our division of general practice is one. I have recently been talking to my counterpart up in the north-west alliance of divisions—a wonderful group and the only division of general practice that I think is better than ours. They have provided other solutions for their region which are spectacular in what they have managed to accomplish with additional funding. But the solutions are quite different because it is a different patch. So there should be a regional top up by the Commonwealth.

Regions should be funded equally on a per head of population basis. New South Wales Health does it. This is not rocket science. This is not some miracle cure that nobody has invented yet. All state health services attempt to equalise funding across their entire state. Recognising the differences, there is no reason the Commonwealth should not be doing the same. And there should be a benchmark. You could set a benchmark for funding and you could top it up.

We already have a structure in place. In fact, for 15 years the Commonwealth has had a structure in place. The Commonwealth has divisions of general practice—122 of them and all providing services and programs at a regional level using regional funds. They are waiting for a job to do and some of them—and I would like to include ours—actually do the job. So there is a structure in place, and that is the first thing.

The Commonwealth has already funded small-scale initiatives. Again, if you are a rural person, you would know about them—even here, in this region, we know about them—and the classic ones are the Better Outcomes in Mental Health Care program and the More Allied Health Services Program. They are wonderful programs where the Commonwealth has recognised the deficit in these services, particularly in rural areas but including in ours. We are spending half a million dollars a year on psychology services in this region, and most rural divisions are doing the same thing, from this year's top-up funding to provide services that would not have existed before. It is a wonderful thing. This ought to be expanded and it is the sort of thing I would say should be expanded in those areas that will not be able to access Medicare rebates or clinical psychologists because they are not there in the first place. Again, the north-west alliance is the first group in history to have actually produced additional psychologists for that region where mental health problems are huge and in need of addressing through top-up funding.

The other example, and the last one I am going to use, is our after-hours service. It is world's best practice for an after-hours service. Why? Because we got a grant to do it in one hit. We got $6½ million—most from the Commonwealth and a proportion from the state—in order to provide a region-wide service in an area that has a doctor shortage. When there is a doctor shortage, after hours is the first thing to go. We got a grant for that and we provided a regional solution. We have 254 GPs working in five clinics every night. We guarantee that 90 per cent of patients will be seen within 30 minutes of their appointed time—faster than category 3 ED patients in our hospital emergency departments. It is 20 per cent cheaper than Sydney, as it turns out, on a per head of population basis—much to the minister's horror, so he had to refund us for another year.

We have reduced the ambulatory emergency department workload by 30 per cent. Ten thousand patients a year are no longer seeing emergency departments in our region. Does this affect hospital care? Yes, it does. Our nurse call centre has reduced GP services at night by 20,000 year. Again, that is because we have a workforce shortage. We are trying to reduce the workload of our GPs—and we have managed to accomplish that. We have preserved the workforce and improved service to the community at the same time—we are nearly there. And we reckon we could do the same for the PBS with drug utilisation for private specialist care and for allied health. We reckon we could improve those three things and I believe that rural divisions could do the same thing and do it better than current health services.

In summary: the time has arrived to do what is fair for rural and regional communities and to give them the same amount of funding that their city counterparts have taken for granted. I think that fair access to Commonwealth funding will lead to fairer access to health services—or will at least take us a long way there, where we are not at the moment. We need regional top up funding leading to regional solutions. I am sorry to have taken so much time.

CHAIR—Not at all.

Ms HALL—I think that the proposal you put forward does emphasise the lack of equity that exists within the current system and how regional areas like ours miss out. As you know, in the Shortland electorate I represent, the doctors in Swansea and Belmont have closed their books—simply because of the fact that we have got this shortage, this maldistribution. Anything that we can do to change that distribution will certainly have an impact in the communities, where at the moment there are a lot of people who are not accessing medical treatment at all.

I was interested to hear you say that your after-hours access services had led to a decrease of 10,000 people attending the emergency departments. This morning—and this was not taking that into account—Terry Clout told us that there had been a 15 per cent increase in people presenting at emergency departments. From my perspective I would say that, without your contributions, after-hours access would be in a crisis situation. Could you detail a little more how you would manage the PBS side of the funds if they were allocated and run through the division.

Dr Sprogis—There is already a proposal being put forward by the Australian Divisions of General Practice with eight large divisions, of which we are one, proposing that we tackle the PBS at a regional level. The fundamental principle should be that people should get access to evidence based care related to pharmaceuticals. In other words, we should be providing the best pharmaceuticals for the right condition at the right time. There has been some modelling done which shows—surprise, surprise—a bit like our after-hours services, that there would actually be cost savings if we did that.

In some pharmaceutical areas, costs might in fact go up. But our belief is that, from a government perspective, the only thing government worry about in cost terms is when they are spending money on pharmaceuticals that are not required or that are being misapplied. I have got to say to that I have never had any experience of any parliamentarian or minister saying that they did not want people to access the right medications at the right time. Pharmaceuticals are the technology that general practitioners use the most, and the proposal has been put forward that divisions take on managing evidenced based quality provision of pharmaceuticals and work to, in a sense, a budget in managing those. If there are savings, they get turned back into health care provision in that region. If there are not savings, they have to account for those to the government at the time. So it is managed regionally, not just nationally.

Ms HALL—When you were talking about private health and the way private health runs, and then public health and the provision of services by GPs and allied health services, how would your proposal work to bring all those services together and ensure equity within the region?

Dr Sprogis—I think the Commonwealth has actually gone a long way in at least setting the framework for being able to do this. I use as an example the Better Outcomes in Mental Health Care program. Rural regions do it even better than we do, because they have had fewer services to start with. You decide on what pool of resources you have to work with in the first place. The underpinning of that is the Medicare arrangements, because individual service is provided under Medicare.

If they are being provided, no-one has a problem. If there is an amount missing then that region gets asked, 'What would you supply in health care services for the extra money?' The division of North Queensland are a terrific example of that. I am full of admiration for them, because they work in a much harder environment than I do. They have bought in not doctors so

much—who are hard to buy in—but additional nurses, additional allied health professionals, additional other workforce, capital infrastructure, communication infrastructure and IT. You buy other things. You might even buy transport. Transport might be a health care service. As Jill knows, in our after-hours service we provide free transport to people because it turns out that that is the most cost-effective way of managing people when there is a doctor shortage. You bring people to the doctor; you do not necessarily bring the doctor to the people. It is cheaper. So transport is actually a health service provision.

The point I am trying to make is that each region, once it knows how much money it has to work with and how much top up money it has, provides regional solutions, which might not be—and it is strange to hear this from a doctor—just doctors. It might be all sorts of people. In this region, we have had an enormous drive to produce more nurses or provide more nurses inside doctors' surgeries because we have a workforce shortage. We have gone from 45 four years ago to nearly 190 in our practices now. I think there ought to be double that. I think it should be one to one. I think we are still short. It is that sort of thing. Our patch would provide its own solutions. We have a few more doctors than perhaps Cairns and the Far North Queensland areas do. They might have a completely different approach to taking this on. The aim is to provide health care. It does not matter how you get there.

Mr ENTSCH—What is the bulk-billing percentage in your after-hours facility? How does that compare percentage wise?

Dr Sprogis—The after-hours service is free. It was always designed to be free. Up until this month, as we have changed contracts, it was free and there was no bulk-billing. There was no billing of any kind, shape or form. It was a total Commonwealth grant. This year—and I have to say it was against our protests—we have been forced to bulk-bill and use Medicare and that has cost more money. It is less efficient. But we are doing it. One hundred per cent is the answer.

Ms HALL—Of course, that is going to show up in the figures for bulk-billing in my electorate—and it really has not changed anything at all.

Dr Sprogis—That is right.

Ms HALL—It is just a paper fiddle, and it will look like I have had an increase in bulk-billing.

Dr Sprogis—I thought I was cynical about these things! I actually had not thought of that. Thank you very much.

Ms HALL—That is okay, Arn; anytime.

CHAIR—I will look forward to the next set of figures.

Ms HALL—I will make sure the people of Australia understand what those figures mean.

Dr Sprogis—So it is free. We treat that as a public service. Emergency services are a public service that should be provided to the public for free, just like emergency department services. What happens during the day is a different story.

CHAIR—One problem with general practice in my area—and this is not with respect to you, of course—is the ageing nature of the population of practising doctors. In fact, a lot of them are getting out and being re-employed as salaried doctors in the rooms that they used to operate from but in a practice owned by somebody else. General practice is not a very good business to be in, from the point of view of returns, compared with other aspects of medical practice. How can that be improved?

Dr Sprogis—You are talking to the right person. I am actually in that age group. My wife, dare I say, is less so, but she is the full-time GP in our family and is also heading towards that age group. It is a really important issue. The first thing is that we have to devise methods for making sure that general practitioners at one end of their career remain in the workforce. There has been a lot of emphasis on maintaining professionals in the workforce overall at the end of their careers. We have been successful at it. We have produced 254 GPs to work at a time of night that they do not actually want to work. None of them wants to work after 6 o'clock at night or on weekends. Yet we roll them out. In fact the age group of that group is slightly higher than the average age of our GPs overall, because they tend to be people who are a bit more responsible. Yet we have made them work after hours.

How have we done that? We have done it by providing working conditions which are spectacularly good. In fact the ratio of nurses to GPs in that group is two to one—one on the phone in our call centre and one on-site. We have two ancillary staff for each one of them so they stick to doing doctor work not any other work. We pay them well. We are not embarrassed about paying them very well for working after hours. How can we afford to pay them well? We manage the number of services we do. They are not overworked so we are not paying by trying to grind through more services. They know that when they turn up to work they will be seeing people who need to be seen. It is professionally very satisfying. They like it.

Facilities are great. Security is provided and it is well-lit, well organised and well structured. Staff in fact work in a corporate practice, except that the corporate practice is owned by the community through the division of general practice, not some faceless corporate entity with a bunch of shareholders on their back all the time. For that we have retained a bunch of retired GPs. One immediately comes to mind. He actually does a lot of our after-hours work in the service because it is a good way for him to finish his career.

The other thing that these people should be doing is teaching. With this doubling of new graduates who are now going to come through the system—again, a great initiative—their job should be teaching. Someone has got to teach the new people and it should be the most experienced group, not the ones that have got to put in the hard yards seeing patients. That is a young person's thing. As you get to the end of your career you should be using your knowledge base and experience more effectively and more efficiently and passing that on to others. If we did that we would be maintaining a whole bunch of them in our system. I do not see that as a problem.

One thing that they cannot do is stay in solo practice. That is not an option for them. That is death country. No wonder they go. They need to be in an environment where they feel supported, structured and well organised. If you do that they will work on until a decent age, like some well-known leaders of this country perhaps.

CHAIR—How about the problem with gender and the women in the workforce? Obviously they want to leave the workforce to have children. How hard it is it to bring them back?

Dr Sprogis—It is very hard. It is not just gender. When we raise gender I always talk about our division of general practice which employs five general practitioners. All of us are in our prime working lives. Four of us are men and all four of us went from being 60-hours a week GPs to about eight hours a week GPs. So the part-time nature of general practice does not just affect women. It is a source of embarrassment to me; I feel that I have to work harder to justify my existence because I have taken myself out of the workforce in an under-doctored area—my wife's practice is in an underprivileged area. So I feel I have to work harder to try to get others to work harder.

With women, it is true that they work part time much more—and we have looked at our numbers—than men do. It is the same story, and you will hear me chanting this like a mantra: we have got to create environments where work for one part of our general practice population is structured and organised around their family lives. We just have to do that. We have got to provide things like, for example, child care. We should be doing that. That should be just a normal sort of thing that a practice would do.

One of our best practices has 20 GPs in it. About 16 of them are part time and something like a dozen of them are women. They have highly flexible hours which are highly structured around their personal lives, and they are providing an excellent service to the community. Our gender balance for our after-hours service—and you would imagine that after hours would be the worst thing and that women would never want to do after-hours work—is exactly the same as it is in hours. We have had a very close look at it. Why has this happened? It is structured. Usually in fact it is better for them. A few of them have said very openly that it is the one time that they can tell their husbands that they have to mind the kids. They are off to work, thank you very much, and because the partner has managed to come home from work at five o'clock he can cook tea and put the kids to bed. The women tell them that they will wander off and do a bit of work, thank you very much. If you think about the population of the workforce and you deal with them at a regional level—not just a practice-by-practice level—you can structure a system that works. I do not think that it is all that hard, to be quite honest. It is just that we do not deal with general practice at a regional level.

CHAIR—Workforce is the single largest issue that comes up all the time.

Dr Sprogis—Yes, absolutely.

CHAIR—What is the answer to the workforce issue, not only in medicine but in nursing and allied health?

Dr Sprogis—In the short term or long term?

CHAIR—It has to be long term. We all know the problem. The Commonwealth government are responsible for university training and university places, and through the health care agreements they pay for half of the clinical places because they pay for half and the states pays for half. Should the Commonwealth be totally responsible for training? Should they fund the states separately for training?

Dr Sprogis—Who does the funding is not necessarily the critical issue. The first thing is, unless you know something that I do not, Australia does not actually have a health workforce policy. It does not have one. I cannot find one. Unless you can find one, it does not exist.

CHAIR—We cannot find a national health policy.

Dr Sprogis—That is absolutely right as well. But there is certainly no workforce policy. Thirty years ago, when I worked in the UK, they used to have a book and every person doing specialty training, including general practice, would know how old the workforce was, where it was, where the next available positions were going to be and how many positions were going to be made available in any particular region. You could plan your life pretty well around that. They knew what was going on.

We have nothing like that. We are absolutely missing anything that resembles a policy that says: where do we want people and roughly how many? These are long-term plans and you are always out by some kind of factor. So, what is it that we want and where do we want them? That is the first thing. Then you have to create an environment that encourages people to go there. That, again, is not all that difficult. We work in a system where market forces actually do work. If the Saudi Arabians can get doctors to work in Saudi Arabia then Australia can get doctors to work certainly in Cairns, thank you very much and, in fact, anywhere in Far North Queensland—it would be just fine. But we do not have a system for doing that.

I think what we need is, first, a workforce policy clearly identifying where the workforce is needed. Then, put the market structures—the Commonwealth basically is the market—in place that encourage people to go there and you will need a certain amount of coercion as well. This is where I get shot, certainly by the AMA. A certain amount of coercion is needed—that is, carrot but no stick or a different kind of carrot where people should be told clearly and up-front where the spaces are available for them and where they are not. And there needs to be some degree of restriction on provider numbers, for example.

Ms HALL—Regional provider numbers?

Dr Sprogis—We would argue for regional provider numbers. And interestingly, even the most right wing of the doctors in my region would agree with regional provider numbers because they see that that is the only way you can spread the workforce evenly across the nation. Then let the market do what the market does—let there be a trade in provider numbers. If someone wants to move to the city, let them settle up for moving to the city.

Let's have something that distributes our workforce evenly across the nation, and let's tell people right up-front—before they even apply for nursing, medicine, allied health or psychology—where it is their opportunities are going to be. And if they do not want to do that, do not apply. There is a queue a mile long—something like 1,000 or 2,000 intelligent, bright, motivated young people are going to apply for something like 80 places at Newcastle University for medicine. There is no shortage of people wanting to do the job. Let's ask them if they are prepared to do the job in the appropriate place. It is pretty straightforward, and you can set it up without even being too—

Mr ENTSCH—But is that not already happening now? Is there not some sort of funding arrangement provided they stay?

Dr Sprogis—Yes, there is.

Mr ENTSCH—That is already happening.

Dr Sprogis—It is bitterly resisted because, again, there is a lack of equity in it. It is not applied across the board.

Mr ENTSCH—Bonded places?

Dr Sprogis—Yes, bonded places. But there is a lack of equity. You cannot go around expecting people to jump up and down with joy when only some people have to go to the one place. It is a bit like conscription; there is not a lot of joy in conscription. It is not there for everyone and the market forces—the funding—that are required to make that attractive are not there either.

I actually sent something off to Tony Abbott's office when he first became health minister to show how you could do it even without provider number restrictions. You could actually do it by just funding encouragement, getting people to work in certain places at certain times. We certainly could do it. If we held all the incentive funds that go to general practice, other than Medicare, I could guarantee that I could staff Jill's electorate with doctors tomorrow—no problem.

Ms HALL—You have got this in a document form, haven't you?

Dr Sprogis—I have.

Ms HALL—Why don't you submit that to this committee? I am sure they would love to see it.

Dr Sprogis—I will find it and submit it. It is now a three-year old document.

Mr ENTSCH—We would be interested to have a look at it.

CHAIR—How much is the workforce shortage the fault of the Commonwealth and how much is it the fault of the colleges?

Dr Sprogis—I think it is all the fault of the Commonwealth. That is the honest answer. When we say 'the Commonwealth', this now transcends even the life of this government. A huge mistake, a huge error of judgment, was made some significant time ago now, about both workforce needs and clearly thinking through the incentives required for workforce to move into rural and regional areas. I think two huge mistakes were made and there was no anticipation of the effect of the new type of graduate, who has a different set of demands on where they choose to work. Those three things, I think, are all in the Commonwealth's purview, sadly. In reverse, I think the Commonwealth can fix all three things, both short-term and long-term. We can look

around all we like, but I think this one is a Commonwealth issue. It funds health services basically, other than public hospitals, and it is its job to sort it out.

Ms HALL—What are the short-term solutions?

Dr Sprogis—Again, we have introduced some of them. The after-hours service is a good example. That was a workforce solution for us. It was not just a community solution; it was actually a solution looking after our workforce. The first thing is that you look after the workforce you have got. You manage what you have already got hold of and you try and extend its life and its efficiency. We are very highly focused on removing all the tasks we can from our general practitioners that they do not have to do, so they can focus on their professional jobs and are not driven nuts by everything else other than doing their medical work. The nursing thing was the best example. We would like to double the number of nurses. Again, it is not all negative stuff. The Commonwealth provided a terrific subsidy for nurse services in underdoctored areas—a fabulous thing. If that were extended, we could probably double the nursing workforce. We could double the nurse workforce as well if we had the space to put them in. It is interesting: practices pretty well everywhere were designed for doctors and they were not designed for doctors, psychologists and other people—or training.

Mr ENTSCH—But we are seeing them coming through now.

Dr Sprogis—Slowly.

Mr ENTSCH—The ex-head of the division up in Cairns has just opened a new practice and they have got their own surgery. They have got clinical nurses there and a whole range of facilities that I have never seen at a doctor's before.

Dr Sprogis—That is the modern GP surgery.

Mr ENTSCH—There are about four doctors there now. They have all got their practice nurses and he has got an assistant and a theatre nurse. They do a broad range. On certain days they operate on a whole range of things. A second one opened up only a matter of a few weeks ago in the southern part of the city. It is the same sort of thing. She is a sole practitioner at the moment, but she has three or four doctors' rooms there and she has got an application in for doctors at the moment for the same sort of thing. It is good.

Dr Sprogis—That is the sort of thing we should be doing. And the last thing is information technology—we should be using all the available information technology resources that we have to improve the efficiency of general practice work. So it is: other workforce, prolong the workforce you have, alternative workforce—that is, other workforce added in—space and technology.

Mr ENTSCH—I am surprised you cite that lower figure in Cairns: $66 per person.

Dr Sprogis—I had a look at the rest of the electorate; Cairns is only one part, isn't it?

Mr ENTSCH—We have the third-largest Indigenous population in the country, which includes the Torres Strait, and they are factored, as you know, very differently. They do represent

a very significant portion of the population. If you were to take them out of the equation, I think you would find that the Cairns figure would be significantly higher.

Dr Sprogis—Very likely. To some degree, I cheated a bit, didn't I? But I had to make a point, and the point is still quite clear. There are parts of Kim Beazley's electorate at $120 per head of population, with the maximum being about $240 in Melbourne and Western Sydney; so it is still double. And what you would say with the Indigenous population is that there is already a top-up going in, so you count that in. You factor that amount for health services, if there is a top-up. We are talking about, in your area or at least in that division, a population of about 260,000.

Mr ENTSCH—That is correct.

Dr Sprogis—And so the missing number is something like $40 million. Is $40 million disappearing into Indigenous services good?

Mr ENTSCH—Most of the services up there are funded in a totally different way. Quite often they—

Dr Sprogis—You still add them up and put them in. It will not be $40 million; I would almost bet my bottom dollar on it, especially if you count specialist services. If you count PBS specialist services and private hospital services then you multiply that by about 2½.

Ms HALL—Figures that I have seen show that Indigenous Australians spend less on health.

Mr ENTSCH—They have no private health. They usually rely on the community nurses.

Ms HALL—When we were doing the inquiry into Indigenous health, it showed that they receive fewer health dollars than other Australians, even though they were sicker and needed more.

CHAIR—Your division covers the urban areas of the local health area—who covers all the other parts?

Dr Sprogis—In the Hunter, Hunter Rural. It stops just past Maitland, probably at about Singleton, and then heads further up the valley. So they have a population of just under 200,000.

CHAIR—How are their problems different from yours?

Dr Sprogis—Theirs are slight exaggerations of ours. They are, again, under resourced and under doctored; there is no question about that. The doctor shortage gets worse the further you go up the valley and, of course, their access to allied health is worse. They do get this thing called MAHS, which is the More Allied Health Service program. So there are some balancing factors. They are like us, but worse. Access is worse and specialist services are worse. There are no private hospitals up there, and allied health is a real problem as you start to move into small regional towns.

CHAIR—If you had to write a recommendation for this committee in regard to primary health care, what would it be?

Dr Sprogis—It would be that primary health care ought to be funded on the basis of a fixed amount per head of population, at least as a benchmark, and that where regions are not receiving that amount of money through Medicare, the PBS or the private health insurance rebate, that region ought to be given top-up funding so it can provide additional health services for the region. That would really be an extension of the beginnings of existing policy through divisions—extending that and having a per capita minimum that each region should be getting from the Commonwealth. If some regions exceeded that then the Commonwealth could deal with it in whatever way it chose. But there should be a minimum benchmark that says a region is entitled to a certain amount of health funding. If it is not getting it the conventional way, it should get additional resources, and then the region could decide how to use it through some system. It could be through divisions—or you might choose some other system—but there should be some regional system where the community itself says, 'If we had the money, this is what we would do with it to improve our health care.'

CHAIR—How do you improve community input into the health care system so that the community has an ownership of the hospitals et cetera?

Dr Sprogis—There are two choices. New Zealanders have gone down one path. I cannot remember what they are called but they have something like community health organisations, an actual elected community body, which is the board or the body that distributes these resources. Some people might say that the council input is not an inappropriate way to tackle community health care resources. That is something Australia has never done. These are elected representatives, for better or for worse, and that is their job. You could argue that you could work with councils. If I had a vested interest I would say that you already have a system—you have divisions and the only thing missing is formal structured community board input, for example, and we could elect or appoint people onto those boards.

Ms HALL—Have you heard of community juries? What is your view of them?

Dr Sprogis—Yes, I have heard of them. That is another way of doing it. It is a very innovative and clever way of making sure the community has input. In the end, this is community money; it is not doctor money. Certainly, in our division we are very clear about this; we know whose money it is, we know who we are supposed to be serving. It is very straightforward. I have a view that doctors do all right no matter what happens. We are not last cab off the rank. Our job is to make sure that the community gets a fair deal out of whatever is on offer. Some kind of formal community input is essential—there is no question about that—so that it is a fair deal and is seen to be a fair deal. It could be existing structures—councils, as I said, are a good example—or you could establish a much more active way of communities getting input into how additional resources are being spent and what they see as a priority when government manages them.

CHAIR—Thank you. I think we are running out of time.

Dr Sprogis—I usually have this effect on people.

Ms HALL—I can think of a lot of controversial things to ask you, but I am not going to.

CHAIR—Is there anything you want to say about the Hunter specifically that might apply to the rest of Australia and that we should take into account?

Dr Sprogis—Only what I have said before. The Hunter is a microcosm of a whole stack of regional areas and regional towns, all of which are suffering the same problem—they are all under doctored; they are all under resourced. If they were to receive the equivalent resources that some of their city cousins receive they would do a better job of it.

CHAIR—Do you have the problem that I have in my area where the hinterland doctors are delivering a different type of medicine from the bulk-billing clinics down the coast?

Dr Sprogis—Yes.

CHAIR—How do you deal with that issue?

Dr Sprogis—That is what you have regional solutions for. That is why you have a division of general practice. It is not our brief to look after daytime practice but certainly with night time practice, where we do have experience, we manage our 254 doctors as a group and we have quality indicators that they are supposed to meet. For example, the use of narcotics at night has just about disappeared in our region. Why? Because we have an active management program for narcotics use. So you can manage a region if you are given the responsibility to do that. Why would we be given the responsibility? Because our doctors own the organisation. They are all members. Why have they handed over a bit of control and power to their organisation? Because it is good for everyone if they do. So, it can be done but you have to give some of the responsibility for doing it. You can manage quality.

CHAIR—GPs in rural areas do different procedures from GPs in urban areas.

Dr Sprogis—Yes, they do.

CHAIR—There are no specialists. How does that affect a rural practice compared with a bulk-billing clinic?

Dr Sprogis—I missed one of the points you were making. One of my proposals was that we ought to be thinking about where there is deskilling of, for example, urban GPs. Why has this happened? And, equally, why don't urban GPs go to rural areas first? My wife and I trained to go to a rural area, and we finished up in Nelson Bay, which is a bit of a paradox. But both of us trained to do that, in obstetrics, anaesthetics and a few other things.

What we should be doing is encouraging a system that encourages people to train with a broad range of skills, including procedural skills, and to go to the country first—or, in your case, as was one of my proposals, we ought to be sending out GPs. They start at the edge and use all their skills. As they get older, their kids gets older or their kids get to high school age and they really want to move a little bit closer to a centre, you offer them the opportunity to do that if they have done their time. It is a bit like the old education department did.

In this case, it is a skill thing. If they have those skills, they can be brought in closer to an urban centre, and they bring their skills with them and they keep doing procedures, they keep doing extra work and they keep doing that high-skilled stuff that we are missing out on because GPs have never gone out to a rural area to do it. I would encourage a bit of a cycle that says, 'You've got to be skilled at pretty well the maximum level to do most things and, as time goes

on, you bring those skills back to an urban area where perhaps demand is not as great but, gee, you have done your time somewhere else.' You are coming back, lifting the game and taking the pressure off specialty services as well.

Ms HALL—I would be interested to know: do you think the GP training is effective? Are you happy with the way that is going? Do you think that there need to be any changes in that?

Dr Sprogis—I think it is reasonably effective. We have run out of time. The only comment I will make about training is that I do think—and a few people have said this nationally—there has been a dumbing down. I do think we have compromised standards because we have not had the resources with which to train effectively, and I think that is a pity. Again, I think one of the reasons that people stay in cities is that they do not have the skills to go to a rural area. They have not been trained well enough. Even at undergraduate level the expectations and the demands have not been high enough. I am not the only one who has said that; there is a common theme emerging across the country.

I think we have underinvested in training people, but we have also 'underdemanded'. I will not take any more of your time, but it is the same old story: if you have thousands—and I know a whole bunch personally—of intelligent young people dying to do the job, out of those there is a whole bunch that would be happy to really put in the hard yards and be well-trained, highly qualified, hardworking, mostly full-time doctors. I think we have done something. A lot of universities have done something very unpleasant to a cohort of undergraduates for about 10 or 15 years. I think that their expectations have been lowered by the university experience, not heightened. Now that is in *Hansard*, I will be killed when people start reading it.

CHAIR—Thank you very much. I have to think back to the days when I had my appendix out and it was done by a GP. A GP took my brother's tonsils out and thought that he had better do mine at the same time.

Dr Sprogis—And that was in an environment where it was not as safe as it is now. Some of this surgical stuff is not rocket science. Fred Hollows reckoned that you could get Eritreans and train them within a week to take cataracts out. I think we sometimes overplay how hard it is to do some of it. Thank you very much for your time.

CHAIR—Thank you very much indeed.

[2.27 pm]

FITZGIBBON, Mr Mark Anthony, Chief Executive Officer, NIB Health Funds

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. Do you wish to make an opening statement before we proceed to questions and discussions?

Mr Fitzgibbon—When I read the committee's terms of reference I was not quite sure what you were looking for today in terms of my contribution, so I thought I would be as broadly encompassing and as liberal as I could possibly be. I am sure some of the views I am about to express will not necessary find fertile ground with some of you, but nevertheless they are my views and I am entitled to them. I will leave it to the questions for you to explore any specific direction you want.

I have been in the business now for nigh on four years. It is the fourth industry I have participated in so, while I am wet behind the ears in some respects, I like to think that at least I bring a new perspective, particularly given my own academic interest in economics and marketplaces. I have looked at the situation in 2050 in these terms: if you were arriving here and colonising the planet from Mars, what would you be looking to establish? What are the pitfalls? What are the failings in the current system? I have separated things into the nature of the market—I am talking about the market for total health care now, not just private health insurance—the structure of that marketplace and the various funding mechanisms which would apply.

My first view regarding 2050 is that there will be no direct government involvement in the provision of health care—I mean the actual provision, the owning of hospitals et cetera. Health care is fundamentally a private good, like any other good in the marketplace. It can be bought and sold. There is no exclusion principle. You get what you pay for. The only broader reason you would want direct government involvement in this particular marketplace is for public health—issues like immunisation, which is not a private good; it has broader public interest quite different from the private interest of replacing a hip or taking one's tonsils out, recalling your experience. So government would not be involved directly in service provision in the marketplace.

Why does government own hospitals? Nobody can explain that to me. There are historic reasons to do with the socialisation and clinical popularisation of health care post World War II. I think inevitably, by 2050, government ought to recognise that it cannot fund our health care expenditure. It is about $80 billion a year. Government funds about 70 per cent of that. It is growing. It will be 15 per cent of GDP before we know it. It is in the States now. It is currently nine per cent here. Government cannot possibly fund that level of increased expenditure, particularly with the shifts in demography that we are seeing in Australian society—and in international society.

That said, though, the equity objectives and the universal community service obligations of government will become even more profound, particularly with the ageing population, except government will not try to satisfy those objectives through providing free hospital care and everything for free. I will come back to that point in a moment. It will do so through the welfare system—free health care for the unemployed, for people on incomes beneath certain levels—and through a system of community managed care. Arn was actually just hinting at this, and I will come back to that point in a moment. The role of government is to ensure equity access to those people who genuinely need assistance. When I go to the GP, it costs 50 bucks and I get 27 bucks back from Medicare. That is ridiculous—I do not need that subsidy. That subsidy should be going to somebody who does need it.

I think that is the nature of the market, broadly summarised in terms of no government intervention in direct service provision, but certainly government sitting behind the private market in achieving its equity objectives and satisfying its community service obligations. The private sector just does it all. Everyone is charged to go to hospital. But if you are in need or if you have any disabling health characteristics, government supports you, based upon your inherent unfavourable health status.

As to the structure of the market, health care will be delivered by the private sector, and a price mechanism will start to play a role. I have been studying this industry for four years now, and the most fundamental thing missing from the health care market is the great Adam Smith's invisible hand—the price mechanism. The consequences for this market are terrible overconsumption and moral hazard. By 'moral hazard', I mean people going in for their full dig, because they are not paying for it. They seek to take out more than they contribute. There is no consumer sovereignty and little choice. I will go to Dr X rather than Dr Y, because I am not paying. There is no need for me to exercise a choice. There is no price tension, no real quality tension, everything is commoditised. There is little accountability: 'Don't worry about what it is costing, NIB is paying' or, 'the government is paying—who cares!'

There are resource shortages. Contrary to popular belief, technology is actually impeded. One thing price does is send a signal to the marketplace that, because of high demand for health care—or any market good—we want more resources, and we can justify it because people are prepared to pay for it. When everything is free, where there is no price signal, you do not get the level of investment and you do not get the level of innovation that you will see in another marketplace. We do not stress out about the additional money people are spending on plasma TVs and the technology associated with that, because they are paying for it. It is a choice that they make.

Technology has been an unfortunate whipping post in this debate about rising health care expenditure, including in my own industry: 'The spiralling costs are to do with technology.' Hello! Unless you are a Luddite, technology will actually improve health outcomes and improve the overall welfare of society. The problem is that if a $60,000 defibrillator is for free—'I want it.' It does not necessarily mean I absolutely need it. There is emerging evidence in the States that people are insisting on defibrillators for preventative reasons, not just because they have had an incident but because they have a family history. Where do we draw the line in terms of what is discretionary and what is nondiscretionary?

So it will be a structured market where the price mechanism will have its place and, getting back to Arn's point, where health care organisation will compete for members and for government funding to satisfy community obligations. You will still have a company like NIB there to help you finance your health care—and most people will be insured—and also to manage money which the government has assigned to it based upon its universal community service obligations. That money will be a major factor in that type of assessment. It will be a needs assessment like Arn was talking about—understanding inequality between a rural and a metropolitan community and the epidemiological study of communities, because some will have higher needs than others, and so forth. This is the type of proposal that was proposed by Scotton back in the 1970s with his managed care. He was right.

Ms HALL—So you are fairly supportive of managed care?

Mr Fitzgibbon—I think the best person to manage their care is the individual, but I am supportive of resources and systems that help the individual make informed choices about their health care. One of the things most lacking in the form of choice—and an earlier point of mine—is the absence of a price signal.

The funding mechanisms will be interesting. At the moment, in the private system we have funding by indemnity insurance. Insurance works well for funding expenses we do not want to incur, such as replacing our stolen car or rebuilding our house if it has just burnt down. It does not work well as a saving mechanism for expenses we actually want to incur, such as deciding to get a replacement hip at 45 because our golf swing is acting up, getting a defibrillator because we might just need it one day or having a caesarean section when perhaps it is not necessary. In this country we have caesarean sections at a rate of 25 per cent when in the OECD the average is 15 per cent. Why? Because people do not pay for it and it suits the doctors—again, another perverse consequence of no price mechanism, no accountability.

What I am imagining is that we will continue to insure only those catastrophic things, those things that people only incur through some misadventure. Increasingly, as medical intervention becomes more discretionary, such as replacement hips and body parts et cetera, we will need to fund those through savings plans in the same way as we do superannuation. So people will not be forced to save but will be encouraged to start to save towards meeting their health care needs, which double between the age of 55 and 65.

Again, this is not a novel idea. You will see medical savings accounts in places like Singapore. I have to be very cautious here: I am not for a moment here to talk down the rebate, because it is a crucial means of promoting the private sector and delivering the types of outcomes I am talking about, but we do need to see a system that also starts to reward people for saving towards their future health care expenditure. In the States, for example, you are starting to see these hybrid models whereby you are insured for a catastrophe but your savings are meant to cover your more discretionary expenses.

Ms HALL—Mark, how would you reward people?

Mr Fitzgibbon—Mainly through not taxing the income they make on their savings accounts. At the moment, if I wanted to save towards a hip replacement in 30 years time, my savings would be taxed. I do not have to do that, even if I am planning to do it, because I have health

insurance. Government will still play a big funding role in funding the community service obligations and the low-income people I mentioned. But that is all a bit out there and a bit too dramatic. In terms of the here and now and a current pathway to that type of environment, if it were attractive to anybody, the first thing that needs to be done is to continue to support the private health sector. The reality of it is that, if the 30 per cent rebate were removed tomorrow, coverage would probably plummet to 30 per cent just like it was before the rebate was introduced.

It is an economic incentive which is creating good policy outcomes. Fifty-six per cent of elective surgery is now done in the private sector. Remove that private coverage and the pressure will fall straight back on the public system. On a broader role for private health care in the total continuum of care: the government's current proposals to broaden our ability to cover people outside of the immediate hospital environment are good ones. We are only able to pay for any procedures or services people have within a hospital setting, and it is the institutionalisation of people that biases sending people to hospital. So we need to be able to cover people beyond that hospital setting or outside the hospital gate, as it is colloquially known.

We need to start examining tax incentives for saving plans, as health care expenditure for us as a society becomes more discretionary. I have mentioned that. We need the government to divest its interests in hospitals—sell them to the private sector, for goodness sake, and fund them to the levels necessary to meet equity objectives and CSOs. We need to make private health insurance more attractive to younger people. I am not quite sure how familiar you are with the community rating as it relates to a reinsurance pool and equalisation scheme for health insurance. It means a fund which has a lot of young members, as we have, who pay a large loading to fund the older population within other funds. That is fair and reasonable. But it gets to the point where I will collect $600 off a young person for their private health insurance. They will claim, on average, maybe $150 so that leaves $450. Of that, about $430 will be dumped in this reinsurance pool. So the young are subsidising the old, which is fair enough, but it has gone a little bit too far and it needs to be capped. It is now proving to be a disincentive for young people to join, because we cannot keep their premiums low enough. Young people want low premiums. They are prepared to pay a little bit more, recognising community rating, but the subsidy is becoming too much.

I would like to see reinsurance capped at, say, $300 per person. We could do that. I could offer that same coverage for $500 a year. Inside the category, it is very price inelastic, but outside the category it is very elastic. If you drop the price a little bit for young people, they will come in droves. We are proving that at NIB. We have grown our membership 30 per cent in the last few years by focusing upon this segment.

Community rating means everyone pays the same premium, irrespective of their age, location or health status. That is fine. People should not be penalised by being risk rated and having to pay higher or lower premiums depending upon where they live, their age or their inherent health status. But there is no reason a community rating should not be modified to reward or encourage changed behaviour. It is palpably absurd that we cannot offer a discount to people, for example, for not smoking. It is absurd that we cannot offer a discount to people if they engage in a certain health program that we may have on offer. The idea that everyone pays the same is a sound policy, but it is too blunt at the moment. We should be able to use it to reward or penalise behavioural factors.

CHAIR—Can we jump back to 2006. Our immediate problems in the private health sector are: premiums and gaps keep going up and that is putting enormous pressure on the private health system. I am a passionate advocate of the private hospital system, but something has to give. The government has a vested interest in providing 30 per cent of the income for the funds and more for older people. What can we do to make this attractive not only to young people but to people who are now getting to the stage of life where they are using the system and expecting to have full coverage for a procedure and finding that, because doctors are getting older and only working four days a week, they cop a gap and then their premiums are increasing each year? What is the answer to that from your fund's point of view?

Mr Fitzgibbon—I am pleased to say that I think you will see it settle down a bit. We have been a bit misled in believing that we have that out-of-control growth in health care expenditure and thereby premiums. All premiums do is to fund what is being spent. My analysis suggests that, at least for private health insurance in the immediate aftermath of the important policy changes of the 30 per cent rebate and the lifetime loading, we saw a huge explosion of private health insurance membership of 50 per cent. The industry went from 30 per cent in cover to 45 per cent in cover almost overnight. They served their 12-month waiting period and then it went up. All of a sudden you had a brand new funding mechanism. People talk about technology ageing, but it is the doctors who drive utilisation in prices; they are the steam engine. There is a big train behind them in terms of hospitals, beds and pathology et cetera but it is the doctors who drive utilisation. We saw a huge uplift in utilisation as doctors very quickly—as men and women, the economic beasts, do—took advantage of the situation and seriously increased their incomes. They did more work and put people in private hospitals; they reduced their VMO hours in public hospitals.

Of course, so much health care is supply induced, but we seem to have got to a point now where the doctors have met all their economic needs. There is very little capacity left in the system by way of specialists, even by way of hospital beds and theatre time, and we are starting to see, not only in NIB but in the industry generally, a great slowdown in utilisation. So the days of extraordinary utilisation growth in the private system are behind us; I am quite certain of that. We are seeing utilisation in NIB as more like two per cent a year, which leads back to the cost side—what you actually pay doctors, the hospitals and pathology. That has slowed down considerably as well. For a number of reasons, hospitals do not have the bargaining power they used to have. Firstly, Medibank Private has been very aggressive on that front. A lot of the health funds have banded together to form purchasing groups, as we have. Funds are taking a stronger view in terms of gap payments to specialists as well. I think we see a future, at least in health care expenditure, where rates of inflation will be more like five or six per cent per year. You might say that that is still greater than inflation, but that is simply because consumers are exercising their sovereignty and, having satisfied many of their material needs—for a car, a house and a boat or whatever—they are turning to health care. They want to live longer and to have a better quality of life in their older age.

CHAIR—In talking to the private hospitals and talking to the health funds, I have found that the inevitable conflict comes up: the private hospitals are saying that they receive inadequate funding under the contract system and that there will be no money for reinvestment and for expansion and that the private sector is expanding. It is a long time since I can remember a new private hospital being built.

Mr Fitzgibbon—It is mainly because we have seen consolidation. You could debate this for hours and hours.

CHAIR—We have.

Mr Fitzgibbon—I just refer you to the Ramsay share price in recent years and, even though it has come off a bit, the Healthscope share price. These private hospitals have done very well since 2000—and good luck to them; they are in business like anyone else. But things are hardly tough in the private hospital sector. We had too many hospitals. There was this great rush of supply. Everyone thought they were going to make a killing in the aftermath of lifetime cover. Some did. Now we are seeing rationalisation. There is enough capacity in the system to meet current needs. That is why you are not seeing any great expansion in capacity. There is sufficient capacity there and utilised. They built capacity to meet double-digit utilisation growth that we saw in 2000 through to 2003. Now utilisation has come off and there is sufficient capacity in the system. But they are still doing very well. Ramsay just negotiated a 4½ per cent increase with us—5.9 per cent in Queensland because of the nurse situation there. That is more than reasonable.

Mr ENTSCH—How do you respond to—and this is from Ramsay too—concerns that the health funds are basically dictating the level of service that can be provided for particular procedures—

CHAIR—Making clinical decisions.

Mr ENTSCH—making clinical decisions in relation to how much can be invested on a particular procedure?

Ms HALL—That goes down to managed care. That is what people worry about with managed care.

Mr ENTSCH—This is one of the issues that is raised.

Mr Fitzgibbon—That is a nonsense. People who manage the care of patients are their GPs and their specialists. We do not involve ourselves at all in managed care. Most of the health funds are now shifting towards a casemix payment system—DRG, as it is known. Something which we all know from now being able to make comparisons in things like a non-complicated hip replacement in one hospital versus another, including the hospitals, is that there is great disparity. All the health funds are trying to do is say: 'Look, we want to pay what is a standard normal cost. We do not want to pay for any inefficiency in your hospital.' George Savvides at Medibank Private will show you data—he may already have done so—which shows you can pay $12,000 for a non-complicated hip replacement in Melbourne but you can jump on a plane and go to Adelaide and pay $6,000, and there is no evidence of any clinical differences. All the health funds are trying to do is understand what is a reasonable price for certain procedures, like in any market, and pay a fair price—not just pay the asking price or the cost-plus asking price of the hospitals.

CHAIR—What will be the impact of the sale of Medibank Private?

Mr Fitzgibbon—At the very least we will see the emergence of a more aggressive competitor. We are not worried about that—bring it on. It will be a competitor which is probably focused more on our space. We focus as a business on the young uninsured. Seventy per cent of our new membership is new to the category and 80 per cent of those are under 40. So as a company we expect them to want to go after more of that market. There are 4½ million Australians under 35 and only 1½ million of them have PHI, so it is a big pond yet to be fished.

On a broader basis, whenever government leaves a market, inevitably the changes to that marketplace are generally much more profound than the initial transaction. Look at banking, look at airlines, look at general insurance when all the state governments sold out their ownership in general insurers, and look at electricity distribution. The sale of Medibank Private, being such a large part of the market, almost a third, will certainly have far-reaching consequences beyond that initial transaction. I think you will see a consolidation in the industry. It will only take one or two of the large mutuals to demutualise and it will probably start a stampede. I think somebody is just looking for a trailblazer, so to speak. The sale of Medibank Private will certainly smarten up competition in the industry. I think it will reduce premiums as a result of that increased competition, but more broadly I am sure it will lead to a different industry structure and a less mutual structure in our industry.

CHAIR—What will it mean for regional areas? We have heard a lot about the Hunter region today and the lack of private hospitals out in the bush. My own experience in my electorate is that Medibank Private tends to be very tough on small hospitals that do not have negotiating power. They can receive payments for services in their hospital which are 20 per cent or 30 per cent lower than at another hospital 15 minutes down the road. They have no bargaining power. With Medibank Private being in government ownership, there is some possibility of using some influence, some friendly persuasion, to give regional hospitals a fair go. If government ownership goes, do you think that these impacts on rural hospitals will just happen or will they disappear?

Mr Fitzgibbon—I think there are a couple of issues around rural private hospitals. One of the reasons that you do not have more investment in private hospitals in rural areas is that the investment is crowded out by the presence of a public hospital.

Ms HALL—Not always, Mark. There are many rural areas that have no public hospital, no private hospital and maybe even no doctor. I do not think that it is because of public hospitals that you do not find private hospitals in those areas.

Mr Fitzgibbon—I did not mean to make a sweeping generalisation. Rural Australia is many different things, and those types of situations where there is simply insufficient critical mass to justify the creation of a hospital asset, whether it be government or privately owned, are exactly the types of situations to be dealt with under my 20-50 model where regional funding bodies—much like Arn was talking about—would fill this gap in service provision. How they fill it, I am not quite sure. It may be cheaper to fly people to the nearest hospital 300 miles away rather than spend $50 million on a hospital.

Ms HALL—Or an extension of the MPS models.

Mr Fitzgibbon—Potentially, yes. But, to the other point, that is why I think the sale of Medibank Private is so important. They will not like me saying this, but the sale of Medibank Private must not go to MBF or BUPA, which are the second and third largest players. If that happens, instead of having three large players, you will only have two. What mitigates against some of the risks you mentioned, Chair, of that power or symmetry is having good, solid competition. If there is a hospital in a regional or country area and Medibank Private does not want to deal with them, somebody else will for the right price. We will just say to people in that town, 'Move from Medibank Private'. You cannot tell them that, but the market will sort it out. Those people will go to the funder that allows them to access the facilities they need to access. It is no different to any other market.

CHAIR—It is the same as banking.

Mr Fitzgibbon—Yes. We could talk about many marketplaces where there is the risk of a single supplier or purchaser dominating. That is why we have competition laws.

CHAIR—The difference here is that the Commonwealth government is providing a third of its income.

Mr Fitzgibbon—Certainly. That is why a government has to have a vested interest in an efficient marketplace.

CHAIR—Tony Abbott's response to that is that the government can always regulate.

Mr Fitzgibbon—Yes.

CHAIR—I am interested to hear what you as a fund think about the privatisation of Medibank.

Mr Fitzgibbon—We are supportive of it.

Ms HALL—There is another argument that the privatisation of Medibank Private, rather than putting downward pressure on premiums, will put upward pressure on premiums, and there will be less competition as opposed to more competition. Would you like to comment on that and give me your reasons?

Mr Fitzgibbon—The reason there will be downward pressure on premiums is because more competition has that effect. If government saw a role for itself in keeping prices down by direct involvement, why isn't government involved in every market? We have tried that. It used to be an excuse they used for government owning a bank, that they would keep the other banks honest. It really is an argument we no longer accept as credible. The view that we need government in the health insurance market to keep the competition honest just does not wash. If you really believed that you would have a government organisation in every market, keeping the competition honest.

CHAIR—Some people think we should have.

Mr Fitzgibbon—What you want is workable competition. Generally workable competition in our context is an oligopoly. The sale of Medibank Private, provided it does not go to MBF or BUPA, will maintain oligopolistic characteristics. Just for the record, can I say that I believe in so much of this market based reform and competition because the savings that can be achieved can then be deployed to meet genuine equity objectives and community service obligations. I really believe that with all of my heart.

CHAIR—Thank you for giving evidence today.

Mr Fitzgibbon—Good luck with your inquiry.

CHAIR—Thank you.

[3.02 pm]

MAWDSLEY, Ms Betty Elaine, Secretary, Union of Australian Women, Newcastle

CHAIR—Before we start, I would like to ask for a motion moved that the document I have be accepted as a submission.

Ms HALL—So moved.

CHAIR—It is so ordered. I welcome Ms Betty Mawdsley, who is appearing before the committee. Ms Mawdsley is from the Union of Australian Women. I am sure that Jill has had a bit to do with making sure that Betty is here. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Do you wish to make a brief introductory statement before we go on to questions?

Ms Mawdsley—Apart from what I have presented in the submission?

CHAIR—Would you like to run us through that?

Ms Mawdsley—That might be better. Would you like me to read it or will you read it yourselves?

CHAIR—You can read it or speak to it generally—whichever you prefer.

Ms Mawdsley—Maybe I will speak to it. But I have something in addition to that—that is the problem.

CHAIR—We are in your hands.

Ms HALL—Why don't you highlight your points in the paragraphs and then make your points in addition to that? Don't read it; just highlight each paragraph.

Ms Mawdsley—I am from the Union of Australian Women. As a women's organisation we are very concerned about women and their families. In particular, health does worry us. We have noticed for some time a decline in the health system. Unfortunately, we have seen a change in attitude of health professionals towards elderly women and elderly people. Ours is an organisation that does mainly consist of elderly women. In one case here, I state that one doctor was heard to say that elderly patients have complex problems and they are 20 times more of a burden.

We would like to remind the doctors and others that it is those who are elderly now who, years ago, fought for the introduction of Medicare for the benefit of people today. The doctors get the credit for making us live longer. But when it comes to making our lives more bearable, because we are living longer, they seem to want to abandon us. As people get older, and are often too ill,

they need a doctor to come into their home. But these days very few doctors are prepared to make home visits. We realise that there is a shortage of doctors and that their time is precious. But the UAW has noted that, with the shortage of doctors, the waiting time for appointments is anything from two to four weeks. When one is feeling ill and in need of seeing a doctor, this length of time is unacceptable.

For instance, in Swansea, where I live, two years ago we had a choice of three doctors' surgeries. Now the doctors at the only surgery left in Swansea have all closed their books. Elderly patients—and there are many who have retired to Swansea to live out their lives—are now forced to travel to Belmont to see a doctor. They can either have an appointment in the afternoon, and wait at least two weeks to get it, or go to—

Ms HALL—Can I draw that out. That is the same doctor that they saw in Swansea before they moved to Belmont, not a new doctor.

Ms Mawdsley—Yes, the same doctor. They have to wait at least two weeks to get an appointment.

CHAIR—How far is it?

Ms Mawdsley—If you drive, it is not too bad. I don't know—Jill would have more of an idea.

Ms HALL—It is about six or eight kilometres.

CHAIR—We are not from this area, so we don't know the geography.

Ms HALL—How long does it take on the bus?

Ms Mawdsley—On the bus it takes at least 20 to 25 minutes. But when I have gone to the surgery there have been very elderly patients who still do not even drive, and most probably would have a problem getting onto a bus.

Ms HALL—You don't drive, do you?

Ms Mawdsley—I don't drive. When I complained to my doctor about his moving down to Belmont, and told him he was deserting us, he said, 'Oh, but it's not a bad drive down to Belmont.' I assured him that I did not drive. It is very difficult for a lot of people in Swansea. My understanding is that the doctor who is now in Belmont is receiving a terrific amount of complaints about people who are having to drive down there.

CHAIR—Are there other doctors in Belmont?

Ms Mawdsley—Yes, there are other doctors, but I would imagine that a number of them have also closed their books.

Ms HALL—All of them, actually—there is not one doctor in Belmont who is accepting new patients.

Ms Mawdsley—It is very difficult to get a doctor here; it really is. You most probably do not know but, in a very short time, we are going to have an influx of hundreds, even thousands, more people. There is development going on south of Swansea. The nearest suburb is Swansea, so there is going to be no service available for those thousands of people who are going to be building south of Swansea in the near future.

We ourselves, over the years, have seen a decline in the number of doctors. It is our understanding that the present federal government has for many years limited the number of students who can study medicine at university and that there is a limit on the number of provider numbers given to the doctors. Also—and I do not know whether this is true or not—I have heard that once a doctor retires he does not always hand over his provider number. I do not know whether this is true or not, but certainly I think we would have to see that this does happen, because we need as many new doctors as possible.

Recently I wrote to the Minister for Health and Ageing on behalf of the Union of Australian Women, and we told him of our concern. He wrote back, and he certainly set out a number of different initiatives that are being taken now. But we feel that these initiatives could have been taken a long time ago, so that there would not be the situation that there is now with the shortage of doctors.

As members of the UAW, obviously we do not have the answers to this very serious problem, but when we look, for instance, at the fees that specialists are able to charge, with no restrictions, in comparison to GPs' fees, there does seem to be an anomaly there. Should the government increase their Medicare payment to GPs, or should there be a restriction on the amount of payment specialists are able to demand? I think something certainly needs to be done.

We do sympathise with the doctors, with the stress that they are suffering as a result of the shortages, but we would like to ask them to remember that their patients are not responsible for this situation. It seems ironic in this week, Family Doctor Week, when doctors on the one hand are urging all in the family to have regular, annual check-ups, that some doctors are saying that the elderly are more of a burden and that they now have to accept that times have changed and the past level of service is no longer available. The doctors on one hand are taking credit for extending people's lives, but they do not seem to want to take responsibility to help them make their lives liveable. I understand that there are even vacant beds in some aged care facilities, not because we do not have people wanting to come into the homes but because they cannot be accepted unless they have one of their own doctors to go into the aged care facility. This is why so many elderly are occupying beds in public hospitals. I think this certainly needs remedying too.

CHAIR—My only comment on what you have said—and I do not disagree with you—is that the reason the Commonwealth government, no matter who is in power, cannot control doctors' fees is that we do not have the constitutional power to control prices. There have been a couple of referendums held, trying to get the government the power on prices, but we do not have it. That is why we have a big problem, even in the private sector, with private hospitals and the gaps that people have to pay, which is also a burden on people who have private health insurance—and there are many elderly people on pensions with private health insurance because they want it.

Ms Mawdsley—I do not know how they do it, frankly.

CHAIR—Well, they do it. And when the time comes to use those services, they find they cannot afford it because of the gaps that are being charged. And the gaps are there because we do not have power over price control.

Mr ENTSCH—On your comment there about the present government limiting provider numbers: that was done specifically to encourage doctors to move out of metropolitan areas. The problem you are talking about has been faced for a long time, where doctors have graduated and gone straight into a specialty, often, and stayed in the cities. It was the present government that introduced a scheme whereby doctors could get a provider number if they moved out into the rural and provincial areas like Swansea. They could get a provider number to provide a service in areas of need. How many medical schools have we opened up in recent times? There have been a number.

CHAIR—There have been quite a few.

Ms Mawdsley—The department of health did set out quite a few, but that is now—

Mr ENTSCH—No, I am sorry, but the first medical doctors from—

CHAIR—James Cook.

Mr ENTSCH—James Cook, for example—we have focused on opening medical schools in regional and rural areas—graduated last year, which means that that school opened, I think, in about 1999 or 2000.

CHAIR—I announced it in 1998.

Mr ENTSCH—They were initiatives that we took almost immediately, but there is unfortunately a time lag of seven to 10 years—

CHAIR—It is 10 years.

Mr ENTSCH—from when these initiatives are taken to when you are actually seeing them on the ground. Our first cohort of medical students, I think about 50-odd, graduated from James Cook University last year. The other problem we have with doctors with after-hours care is that a lot of them are tending to go towards lifestyle and they do not want to have the responsibility. This is why the present government funded—we were talking about it just prior to you coming here—

Ms HALL—Betty is aware of the after-hours access.

Mr ENTSCH—the after-hours centres. That is what we are trying to do to take the pressure off individual doctors so that they do less time but are in a position to be able to provide that service. What you are talking about with regard to access has been a challenge that we have been trying to deal with right across the whole spectrum. There is no quick fix, unfortunately, for it.

Ms HALL—The James Cook and the extra medical faculties have been good—

CHAIR—And Newcastle.

Ms HALL—No, Newcastle is not new. In Newcastle up until the last announcement we had been having our numbers of students restricted and cut.

Mr ENTSCH—That is not the case everywhere else.

Ms HALL—Now you have opened other ones. The Newcastle University medical faculty—

Ms Mawdsley—Is restricted.

Ms HALL—has been a cutting edge faculty with a very unique approach to medicine and training doctors. I think it is great that the government has agreed to allocate more places in the Newcastle and New England area, but in this area we have been fighting for places at that university for years and we are pleased that the minister has finally listened. With the home visits, maybe the thing that is missing is that we can get elderly people to the after-hours GPs but a lot of older people in this area are restricted to their homes. One particular doctor closed his practice. He used to go around and see all the oldies, and he was 74 himself when he finally closed his practice. Now there is—and you can tell me about this too—a number of people living in that community whose only way to get to the doctors is going to be after hours where they are picked up and taken.

Ms Mawdsley—The doctor that I used to use, and I suppose I am still going to, used to do home visits when he was in Swansea. But, now that he has closed that surgery and he is only down in Belmont, my understanding is that he does not cross the bridge across to Swansea any more to do home visits.

Mr ENTSCH—That is a choice, unfortunately. You cannot force them to do it.

Ms Mawdsley—I realise that.

Mr ENTSCH—It is the older doctors that are doing it. There are a few younger ones that I am aware of that are home visiting.

CHAIR—What is relevant to us is the fact that, if these people cannot get to doctor to—

Mr ENTSCH—They have no access.

Ms HALL—They have no access.

Ms Mawdsley—They have nothing.

CHAIR—Is that putting pressure on the hospitals' emergency departments?

Ms Mawdsley—For sure. If they cannot get down to the doctor—and that is within certain hours too—they finish up at the hospitals.

CHAIR—In my area, on the Sunshine Coast in Queensland, people—

Ms Mawdsley—Yes, I know about that. I was in hospital there for two weeks, when I went on holidays.

CHAIR—You understand what I mean. We have people moving out there who don't have family there, and they don't have family support. Do elderly people here in Swansea generally have their families nearby to help them out if they need to?

Ms Mawdsley—My family certainly isn't. I have a daughter in Sydney and I have a daughter in Queensland. That is it. There are some who do have family support, but there would be a number who do not, because a lot of people come from Sydney up to Swansea to retire.

CHAIR—The same thing happens in my area.

Mr ENTSCH—I thought we had provided cash incentives or some incentives for doctors to make after-hours calls, particularly in relation to aged care. I thought there was a recent initiative where we did that. Correct me if I am wrong. I will have to have a look at that, but I am pretty sure there was something in one of the recent initiatives.

Ms HALL—All I can say, Warren, is that in this area doctors are not going to see people in their homes. In this area in my office I have had to arrange a situation where an ambulance will pick up a woman and take her to a hospital just to get her blood pressure medication prescribed for her because that is the only way she could do it. In this area, where we have an enormous waiting list for nursing home beds, where we have people sitting in the hospital waiting for beds, we cannot get them into the nursing homes because there is no GP who can take them over. So it is a big issue in this area. I appreciate that it changes from area to area, but that is what is happening. I think that is what you have tried to tell us.

Ms Mawdsley—Yes.

CHAIR—Why did your doctor move from Swansea?

Ms Mawdsley—He had a surgery in Swansea and one in Belmont. He closed his Swansea surgery and sacked the two girls there and he has gone to Belmont.

CHAIR—Has your union written to the developer who is developing 4,000 or 5,000 new homes to tell him to make sure that the shopping centre they put in there has a surgery?

Ms Mawdsley—No, we haven't.

Ms HALL—You can't get a doctor to go there.

CHAIR—You have to build a surgery before you can get a doctor.

Ms HALL—But we can't get doctors in empty surgeries in Swansea.

Ms Mawdsley—They have closed that, and that is empty. The doctor did say to me, when he was closing, 'This is just a trial', but there is no way he is going to come back to Swansea. That is the second doctor who has done that—who has had the two surgeries and closed one and just moved down to Belmont alone. At the doctor's surgery that is left there the doctor has closed his books. I have spoken to the people who are there—a number of pensioners recently—and they are very dissatisfied with that surgery. There are a number of doctors in that surgery. People are waiting at least two weeks to get in to see that doctor. If you are ill, you need to see a doctor before two weeks elapse.

CHAIR—In some areas you go to you see bulk-billing clinics on every street corner.

Ms HALL—Yes, and that goes back to regional provider numbers. As a committee I think that is worth our looking at.

CHAIR—We haven't got any magic pudding to offer you, I am sorry.

Ms Mawdsley—No, I realise that.

CHAIR—But I appreciate you coming here to tell us about it.

Ms Mawdsley—The doctors have upset us a little, I must say, because some of them seem to blame us for the problem.

CHAIR—I don't think doctors are doing that.

Ms Mawdsley—Well, their attitude makes you feel that. 'Because you are elderly, we haven't got time to waste with you. We have to deal with people whom we can really help.' Many people have been made to feel this by doctors. I know a lot of it is because the doctors are under stress because they are so busy, but I don't think we should be blamed for it.

CHAIR—I do not think you would be blamed for it, surely, Jill. Every doctor would have many elderly patients on their books at any one time.

Ms HALL—I have not had doctors say to me that the problem is the elderly patients. I have had doctors say to me that they cannot cope. I have had the odd doctor ringing me after somebody has turned up there and said, 'Jill Hall said you've got to take me,' and then I have had to spend 10 minutes placating the doctor and saying, 'No, I don't send constituents up and say that you've got to see them.'

CHAIR—He could have seen three people in that 10 minutes!

Ms Mawdsley—This is apparently what another doctor has said—that he can see so many more people in the surgery than if he has to take time to go to see somebody in their home. I guess that is true, but—

CHAIR—This morning the division of general practice were telling us that they are providing transport to take people to the after-hours surgery. It is more economical for a doctor to have someone pick a patient up in a car and take them to the surgery than it is to do a home visit. In the time taken to do the home visit, travelling there and travelling back, they could see three more people.

Ms Mawdsley—I realise that, but if you are old and you are very ill you are used to seeing a doctor in your home.

Mr ENTSCH—If you are young and you are very ill, you appreciate a home visit too.

Ms Mawdsley—For sure. If you are old, it just makes it harder.

Mr ENTSCH—You are never old; you are just mature!

Ms HALL—You can come back with me, Betty, and I will drop you at my office and someone will fix it up from there.

Ms Mawdsley—Okay.

CHAIR—Thank you for appearing before us today. We appreciate the input. We have not had enough people who are consumers giving us evidence. We have had evidence from all the organisations—the AMA, the hospitals—

Ms Mawdsley—But it is the people who are suffering.

CHAIR—It is the patient that we are interested in. So thank you.

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

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

Committee adjourned at 3.27 pm