COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

FRIDAY, 21 JULY 2006

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Friday, 21 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

ARMSTRONG, Ms Fiona, Member of Executive, Australian Health Care Reform Alliance; and Federal Professional Officer, Australian Nursing Federation 40

BAUM, Mr Noel Henry, Strategy Manager, Local Government and Shires Associations of New South Wales 1

CLIFT, Mr Bryan John, Consumer Consultant, Australian Lung Foundation........ 13

DARBISHIRE, Mr William Anthony Peat, Chief Executive Officer, Australian Lung Foundation 13

FRITH, Professor Peter Anthony, Chair, Chronic Obstructive Pulmonary Disease National Program Committee, Australian Lung Foundation........ 13

JENKINS, Professor Christine Russell, Member, Chronic Obstructive Pulmonary Disease Coordinating Committee, Australian Lung Foundation 13

KIDD, Professor Michael Richard, Member of Executive, Australian Health Care Reform Alliance........ 40

KORCZAK, Ms Viola, Member of Executive, Australian Health Care Reform Alliance 40

MENADUE, Mr John Laurence, Private capacity 26

MILLER, Councillor Bruce Edward, Vice President, Shires Association of New South Wales Executive Council, Local Government and Shires Associations of New South Wales........ 1

SCOTTON, Dr Richard, AO, Private capacity........ 50

STAUGAS, Dr Rima, President, Thoracic Society of Australia and New Zealand 13

WHITTINGTON, Ms Vanessa, Policy Officer, Public Health, Local Government and Shires Associations of New South Wales 1

Committee met at 9.06 am

BAUM, Mr Noel Henry, Strategy Manager, Local Government and Shires Associations of New South Wales

MILLER, Councillor Bruce Edward, Vice President, Shires Association of New South Wales Executive Council, Local Government and Shires Associations of New South Wales

WHITTINGTON, Ms Vanessa, Policy Officer, Public Health, Local Government and Shires Associations of New South Wales

CHAIR (Mr Somlyay)—I now declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for our inquiry into health funding. Before I go on, is it the wish of the committee that submissions Nos 134, 136 and 137 to the inquiry be received as evidence and authorised for publication. There being no objection, it is so ordered.

We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. At today's public hearing, the committee will hear from several leading health experts giving a national viewpoint as well as from two organisations with a regional approach. Firstly, the committee will hear from the Local Government Association of New South Wales and the Shires Association of New South Wales. Also appearing today are the Australian Lung Foundation and the Australian Health Care Reform Alliance, groups that are committed to delivering sustained and innovative health services to the community. The committee will also hear from Dr Richard Scotton AO, a prominent health economist, about his model and from Mr John Menadue AO, a highly experienced health bureaucrat who has been called upon to provide big-picture workforce reform models to several state governments. This hearing is open to the public, and a transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry or the transcripts, please ask any of the committee staff here at the hearing.

I welcome and thank the witnesses for appearing. I believe you have all travelled a long way today. Coming from Cowra to Sydney to arrive here by 10 past seven is a fair effort in anybody's language. Although the committee does not require you to speak under oath, I have to remind you that these hearings are a formal proceeding of the federal parliament and that giving false or misleading evidence is a serious matter that may be regarded as a contempt of parliament. That is a statement I have to make; it is not directed at you as individuals! I invite you now to make an opening statement to the committee.

Councillor Miller—Thank you very much. Firstly, might I apologise for my colleague from the Local Government Association Helen Westwood, who was unable to be here. I speak on behalf of both associations. I also apologise on behalf of both of our presidents, Col Sullivan and Genia McCaffrey.

We certainly welcome this inquiry. I want to make it very clear from the outset that, while local government has an involvement in health issues right across the spectrum, we neither have nor seek legislative responsibility for them. It is a community role that we play and, depending on the situation, whether it is in rural and regional Australia or in the metro areas, it is a very

diverse role that we play in health issues. Our submission perhaps gives an indication of the crisis situation that there is as far as health is concerned, particularly in rural and regional areas, when you look at the amount of money that local government has been required to spend to supplement what is coming from state and federal parliaments. It is a funding role that we are reluctant to play. We see it as a responsibility of other tiers of government to be involved in for the benefit of our communities.

We are obviously involved right through the spectrum, including health councils in hospitals, and we have some very strong opinions on their ability to influence tiers of government and other health boards as to how the health funds are distributed and utilised. We are also involved in community activities which perhaps border more on healthy communities. We are involved in some funding at the moment where we have distributed health funding which has come from the state government to more practical areas such as looking after some cancer issues in that area. We are involved in many of our communities with such things as healthy living promotions.

All of those are worthy parts of our responsibilities, but they do impact on our ability to carry out our other roles and responsibilities as far as local government is concerned. I can give you a couple of examples of that. According to the Allan report, which has been released, local government in New South Wales is certainly under stress as far as our infrastructure is concerned. There is a shortfall there at the moment of about $900 million per annum to bring that up to scratch, and once it is brought up to a level which is acceptable there will be a funding shortfall of about $600 million per annum. I have just attended the roads and transport congress in Alice Springs with people from right across Australia, and the federal government itself has indicated that just with local roads there is a shortfall in funding of about $404 million per annum.

So when you look at those issues and at our submission, which talks about health, welfare and child care, which is costing us about 50 per cent of our available funds—that certainly has an impact—it is little wonder that our other infrastructure is being run down. As I said, we do not require and do not want legislative responsibility for health, but we do want some support in some of these areas in the future. Part of that, as we have indicated through ALGA, our national body, is the need for a guaranteed stream of income to meet all of these needs.

CHAIR—I was part of the Hawker inquiry into cost shifting onto local government and I am well aware of the problems of local government being asked to administer schemes on behalf of the Commonwealth and the states without the appropriate funding. It should not be a burden on the ratepayer; it should be funded by both Commonwealth and state government. Sorry—I interrupted you.

Councillor Miller—That is fine. Certainly, from my perspective, we would prefer to answer questions and obviously there are going to be a number of questions. My two colleagues here, who are in policy positions with the Local Government and Shires Association and who are much better briefed than I in many aspects of this, will answer at the appropriate time.

CHAIR—I know it is a sore point with local government that they do not have constitutional recognition, yet the Commonwealth does use local government to deliver programs. Some are popular and some are not. I know the Roads to Recovery is very popular with local government. But this is a health and ageing inquiry, so we will stick to those issues. Can you give me

examples of programs that the Commonwealth are asking local government to deliver, without the appropriate funding to cover the administration of such initiatives?

Mr Baum—I do not think we have direct examples that fit exactly what you have asked. The Commonwealth seldom asks local government to deliver programs, especially health programs, without there being some sort of funding. The issue is that councils are very often picking up what are probably market gaps where, until recently, they had not come under any sphere of government responsibility. In our submission the points we are making are the issues around 30 councils supporting 45 centres for 59 doctors. So it is that sort of stuff. It is more that there is a market failure.

The Commonwealth government very welcomely introduced the rural medical infrastructure fund. I can never get the acronym right so I will not try to say it. That has been very welcome but it is our experience across New South Wales that it is probably very modest compared to the demand on councils. Councillor Miller had an example that he was telling me about over breakfast, of a mid-western town where a surgery has simply burnt down so half of the doctors now have nowhere to practise and they are coming to council saying, ‘We need you to supply that resource.’ I do not know whether you want to expand on that.

Councillor Miller—It is a good example, I suppose. Certainly, whilst this submission has identified some areas and it is about—

CHAIR—This is a private practice?

Councillor Miller—This is a private practice but it has become the norm in much of rural and regional New South Wales that the infrastructure is expected to be supplied by either council or a third party. The example that Noel has spoken about just now is in Forbes, which is only four or 4½ hours’ drive from Sydney. It is not in a very remote part of the state but it is a practice that housed about half of the doctors of Forbes and they are now saying, ‘If the council does not supply a medical centre which is fully equipped we will ply our trade elsewhere.’ They are being held to ransom. That demonstrates two things: firstly, that there is an absolute shortage of medical professionals in rural and regional New South Wales; and, secondly, because of that, there is an expectation from the professionals that are prepared to work in those sorts of areas that the facilities will be supplied by a third party—and in most cases that is the council.

CHAIR—And that is happening in remote areas and rural areas?

Councillor Miller—That is happening, yes. We have mentioned it in the submission. As I said, when this submission was written we were in the process of trying to identify all of the funding that is going from local government into health issues, which traditionally have been another sphere of government responsibility. That figure at that time was about $3½ million from councils that, as I have indicated, are very stretched for funding anyway. I suggest that if we did the same exercise today, it would be a much higher figure than that.

CHAIR—You said $3½ million?

Councillor Miller—Yes. The Allan report, which I referred to earlier, has indicated that of the 152 councils across New South Wales at the moment there are about 30 that are unviable. There

are another 30 or so that are borderline at the moment as far as being able to fund their traditional roles and responsibilities in local government, let alone meet the rising need for involvement in other areas, such as health issues.

CHAIR—As you know, local government is a creature of the states and it has different functions in every state. It is very difficult to talk about local government as a broad-brush statement without knowing the different nuances and what their functions are in different states. I am sure that Western Australia is different from Queensland. I used to use the example of the electorate of Curtin, which is a very small electorate in Western Australia in the middle of Perth. It has 14 local authorities in one federal electorate. We have one council in Queensland just south of Warren's electorate that has 140 ratepayers and it is slightly bigger than Belgium. They are the two extremes.

Services, particularly in health, are delivered differently from state to state. That does not help us as a committee and it does not help you as a local government in clearly identifying this problem of cost shifting. In our terms of reference we are concerned about cost shifting by the states to the Commonwealth. The states are concerned that we are cost shifting to the states. In the meantime, there is a lot of money spent cost shifting whereas the money should be spent on the patient. That is what we are trying to identify. We have had evidence from many organisations which are encouraging communities to take ownership of their health system. How does a community in a small town do this? Forbes is not a small town, but how does Forbes take ownership of its health facilities if not through the council?

Councillor Miller—I think that is a good question. Certainly as far as local government in New South Wales is concerned, I do not believe that we want to take overall responsibility for our delivery of health services. Certainly we see ourselves as best placed to deliver some of those services subject to a guaranteed stream of income.

Ms HALL—What services do you see yourself as best placed to deliver?

Councillor Miller—Vanessa might like to comment in a moment on this, but from my perspective I see us being best placed to deliver preventative services such as healthy communities and promoting better health. So it is the promotion areas and also facilitating a lot of those activities.

Ms HALL—Do you have any examples?

Ms Whittington—Yes. We do have a statutory role in health protection and a traditional role in the area of food safety. That would be environmental health officers in councils performing roles under the Public Health Act and the Food Act 2003. There are a range of roles—for example, legionella control. They do arbovirus monitoring and the monitoring of skin penetration premises. That is a health protection role. We also have a health promotion role, which is being recognised in the sense that we provide sport and recreation facilities. We have the opportunity to contribute to the health of communities. We do land use planning. We plan for open spaces and footpaths. All of those things contribute to the capacity of communities to be active and healthy. Currently, other levels of government are looking at how local government can do that better to create healthier communities.

Ms HALL—But they are basically part of the infrastructure role of local government as opposed to any—

Ms Whittington—We also have service provision roles, which deal with target groups in the community like the aged, young people or Aboriginal people.

Ms HALL—Give us an example.

Ms Whittington—Some councils will be running Meals on Wheels services for the aged. That is through HACC. Councils are funded by the Home and Community Care program to run those services, which obviously have a health impact for older people. There is a whole range of services like that. They might run recreation classes for young people.

The program that Bruce is referring to is the Healthy Local Government Grants Program, which the state government has just funded the associations to deliver. We have been looking at programs in four areas—sun protection, physical activity and nutrition, safety and injury prevention, and equity and special populations. We have funded 29 projects across New South Wales for councils to deliver in those areas. For example, some councils have been funded to put up shade structures at swimming pools to prevent skin cancer, because councils have not had the capacity to actually deliver all of the infrastructure that they have needed to deliver to promote health and prevent disease.

Ms HALL—In New South Wales, councils are no longer involved in immunisation.

Ms Whittington—I think only a few are, but we still provide the baby health centres.

Ms HALL—I know that in my local government area the council has removed itself from any contact or involvement with baby health centres.

Ms Whittington—It varies. Noel would be better informed about this than I would. I understand that a few councils still deliver immunisation and they do provide the facilities.

Mr Baum—You are very accurate. Over the last 10 years in New South Wales there has been a dramatic decline in local government involvement in immunisation. The situation with early childhood health centres is harder to plot. Some individual councils have divorced themselves from the role. But councils under a program that developed in the 1940s—and it was a genuine partnership program with the state department at that stage—have been supplying the premises, whereas the area health services, as they are now, supply the personnel.

Ms HALL—That is how it previously operated in my area.

Mr Baum—Yes, and some councils have got out of that. Although, given it is hard infrastructure and given that there is not much changeover in some of that infrastructure over many decades, many councils are still in that, although at the moment some are actively in the process of negotiating what a modern early childhood health centre offering might be and trying to re-engineer it so that the early childhood health nurses are in multipurpose centres next to child-care centres and those sorts of things. But, on the whole, councils are still supplying most of the buildings.

Mr ENTSCH—On another area, I noticed in your submission that local government does not support the transfer of management of health from state and territories to the federal government. But you raise the issue here of split systems leading to duplication of services, poor coordination between the services and cost shifting. So, while a single deliverer of health services across the country is being mooted, you are saying, ‘No, we do not want that.’ However, you have identified all of the problems associated with not having it. I will be interested in how you see a way of streamlining it and removing these issues without having to go to a single deliverer or provider.

CHAIR—To add to that, you are spot on: that is what this inquiry is all about. At the moment there is a process of consideration by COAG. Hopefully that will lead to a disappearance of the of blame-shifting game. The Commonwealth and the states are finally talking to each other. But the COAG processes are being driven by a committee of senior bureaucrats from each of the states and the Commonwealth. Our concern when we drafted our terms of reference was that we try to parallel the COAG process so that organisations other than the bureaucracy—state and federal—have an input into the health policy that is being developed by COAG. Is local government part of that COAG process?

Councillor Miller—Yes, we are. We actually do have a seat at that table. Our president, Paul Bell, is involved with COAG itself. I can only make an assumption that, certainly at a bureaucratic level, we would have some involvement in formulating that policy as well.

Mr ENTSCH—You have identified the very problem that is causing much of the crisis within our system. Quite often it is not just a matter of additional resources; it is a matter of how they are focused, how they are managed and how they are delivered into the community. You say, ‘No, we do not think there should be a single deliverer.’ Do you have a position on how you think they should be delivered?

Councillor Miller—I certainly have a personal position.

Mr ENTSCH—Let us hear it.

Councillor Miller—I will start with that. In actual fact I think the best solution overall would be to have one system for health delivery in Australia, but I think it goes further than just health. My view is that there needs to be a very mature dialogue between all spheres of government but, as the chairman alluded to earlier, local government does not have constitutional recognition. There needs to be a very mature discussion about the roles and responsibilities of the three levels of government, obviously in this case as far as health delivery is concerned but also right across the spectrum, whether it be law and order, education or whatever. We believe that would be the best approach—or, certainly, that is my position on that. But as far as the associations are concerned, I think it is really about identifying the specific roles of each level of government and then having the income streams to be able to best deliver those services to our communities. I agree with the comment you have just made, Warren. I believe there is enough money there. It just needs to be better spent; it needs to be better directed than it is at the moment.

Ms Whittington—It is more about the impact of change on the health system. We have just been undergoing an amalgamation of area health services in New South Wales, reducing them from about 15 down to eight. That has been going on over a two-year period but it is still not

finalised, and it does cause a lot of disruption to staff and perhaps to the capacity to deliver services. If we are going to be making decisions about change, they have to be seriously considered because changing the structure or the system does have a disruptive impact. That is the only comment I would make. I believe we do not have a formal policy on the best model of service delivery, re state and federal, at the associations at the present time.

Councillor Miller—Further to that: while that really is a state issue, there certainly is a concern within our communities, particularly in rural and regional areas, about being disenfranchised from the whole decision-making process. That is why I say there needs to be a really mature discussion about the roles and responsibilities and the involvement of local communities in that decision-making process.

Mr ENTSCH—Just staying on the same theme and in relation to your response there: what is your view on the old hospital board concept that was driven from within the community?

Councillor Miller—That was the reason for the comment I just made. Communities certainly feel disenfranchised now even though, as part of the current structure, there are health councils which are supposed to be representative of the local communities. But, because of the rules that have been put in place, you do not necessarily have the right mix of people on those health councils—firstly, because of having to have a representative from all the different groups in the community, to some degree; and, secondly, because there is no requirement for the health boards to either listen to or implement any of the suggestions made by the health councils. So there really is a feeling of disenfranchisement within communities about health delivery.

Mr ENTSCH—So that local board arrangement would help. One of the issues you raise here is about defining roles and responsibilities within a local area, and it would help to better define those roles and responsibilities and to identify specific issues.

Councillor Miller—Absolutely.

Ms HALL—I noticed in your submission that one of the issues you highlighted was the workforce shortage that exists in a number of your areas. Would you like to expand upon this and give us your thoughts on how this should be addressed?

Councillor Miller—I will start and perhaps pass over to Noel. Obviously this is an inquiry into health delivery.

Ms HALL—That is part of it. We are looking at workforce issues.

Councillor Miller—That is right. This is certainly right across the spectrum, particularly as far as professionals are concerned. In rural and regional New South Wales there is great difficulty in attracting the best qualified people. As is indicated in our submission, to try and keep a level of service out in those areas there is a need to subsidise, whether it be through facilities or even to some degree housing, transport or whatever. We think that perhaps some of that can be addressed by the provider numbers as far as Medicare numbers are concerned. It might sound simplistic, but at least allocating those numbers to specific areas may help address that. I think there were other issues. We are involved in bursaries and all sorts of things, including, obviously, refunds on HECS. There is a whole raft of different ways that perhaps that

could be addressed. You might like to expand a bit further on it, Noel. I have perhaps done a Rolf Harris on that, with the big brush.

Mr Baum—I think it is one of the most vexed issues that our members raise with us. I am not going to pretend that we are workforce planning experts, because we are simply not. But everyone raises every conceivable health and health related profession as suffering shortages. It is apparent everywhere west of the divide but it is also apparent, apparently, in some of the outer suburbs of Sydney. It seems to us that some of it lies in the quantum of training places you have and some of it lies in what strategies you have in place to retain people once you have trained them. When we say 'retain', we do not mean just retain them in Cowra or Broken Hill; we mean retain them in Australia.

Ms Whittington—And also retaining in the public system, say, dentists. There is not a great incentive for them to stay in the public system.

Mr Baum—We are not well placed to know the answers, but it is about supply and retention strategies, and that is the best we can answer at this point. As Bruce mentioned, local government will keep stepping into the breach in its local area with things like bursaries, rural exposure schemes and that sort of thing in the hope of getting one in 10 or 20 people that might come there to stay there. I think it is about training places and about retention, but the detail is not really our area.

Ms HALL—I suppose with dentists it is even worse than with doctors.

Ms Whittington—I think it is, yes. On that issue I want to make a brief comment. There is, I think, what has been called a crisis in dental health in New South Wales at present with people not being able to access the public dental system to obtain adequate care and with long waiting lists. That has been related to some extent to the removal of Commonwealth funding to New South Wales for that provision of service. At the same time we find local government providing water fluoridation services through their role as water supply authorities in local areas and paying for the ongoing provision. The capital costs are paid by the state government but the operational costs are paid by local government. We find that local government is intervening in this area, where the Commonwealth has seemed to have removed itself from a recognition of responsibility. We have not raised that in our submission, but it is an issue we have been working on of late and we would like to bring that to your attention.

CHAIR—Yesterday we took evidence in Newcastle, in Jill's electorate. It was very enlightening. One comment that struck a chord with me was that in New South Wales per capita health funding diminishes in proportion to the distance from the Sydney Harbour Bridge.

Ms Whittington—That sounds right.

CHAIR—That really had an impact on me. Then they talked about the need, at a federal level, to recognise this fact. If you do it by federal electorate—that is how the statistics are collected—somehow you make sure that expenditure in a federal electorate west of the divide is at least as much as in a federal electorate covering a metropolitan seat. How would you deliver that sort of expenditure to people in these rural, remote or regional areas? I could not see it being delivered without an involvement by local government.

Mr Baum—Can I ask a question before we try to answer that? Does that include all medical expenditure? Is it Medicare as well?

CHAIR—Basically it is Commonwealth expenditure.

Mr Baum—So it is Medicare.

CHAIR—Yes, it includes Medicare and health insurance.

Ms HALL—In New South Wales a few years back they moved to equalise the spending across different areas in the state. This particular witness to the committee was saying that in the Hunter we receive much less money. He was looking at the Hunter as a whole, not at electorates. He pulled out figures for some of our electorates compared to, say, the Prime Minister's electorate or an electorate in eastern Sydney or Toorak or somewhere like that.

Mr ENTSCH—Or Cairns.

Ms HALL—No, Cairns was very bad. He said that there should be some formula in place that ensured that areas such as Cairns are treated in a similar fashion to areas like the eastern suburbs of Sydney.

Councillor Miller—That is too simplistic, though. The more remote the area, the more there would need to be some compensation for that. Simply having the same amount of dollars per head would not work. While I do not know Warren's electorate, I know basically where it is; and I would think there are many other electorates like that that have a whole range of different sized communities that have different needs to those of a very closely populated part of Sydney. So there would need to be an acknowledgment of that.

Mr ENTSCH—You are right on the money there. The other thing that I raised yesterday is that Cairns was seen as the lowest but we also have the highest Indigenous population in the state. It is something like 18 or 20 per cent of the population in remote communities, and they do not access Medicare. So you cannot factor that in, because that money is totally separate. The figures are quite startling. You have got to compare oranges with oranges; otherwise you run into trouble with that. You raised an issue about the ageing population in regional areas having a significant impact on the public health roles of the New South Wales government. You suggested that strategies are required. From a rural perspective, I am interested, first of all, in what the health impact from an ageing population in your areas is going to be. Do you have any ideas about what needs to be done in that area?

Councillor Miller—Vanessa touched on some of them. You are right; the ageing population is much greater in rural and remote areas than it is in the metro areas, per electorate. We are involved in a number of areas at the moment. Some of the issues concern infrastructure, such as ease of getting around. Public transport is virtually non-existent in rural and remote areas, so that needs to be addressed as far as ageing populations are concerned. That is part of some ongoing discussion.

Regarding activities that promote better health—making sure that we have the right type of housing for an ageing population—my personal view is that that should not mean a whole host

of retirement villages but, certainly, making sure that we can keep people healthier and in their own homes longer; and therefore there may need to be some retrofits. Some of the health budget may have to go into looking after the aged in their own homes. As I say, there needs to be a better direction of funding, in that sense. That is where we see our role in promoting better health and those types of activities.

Mr ENTSCH—In relation to regional areas, do you see a greater demand for provision of services for nursing home type facilities? Or do you see a greater demand for continuing to maintain or upgrade residences to accommodate the additional needs of ageing residents?

Councillor Miller—I think there is a mix. I would think, certainly, that the evidence is showing that, whilst we are living longer, we are staying healthier longer as well. Therefore, given a choice, most people would prefer to stay in their own homes. But there would need to be the opportunity there to, as I say, retrofit many of those homes to make sure that they are able to cope with frailty better than they are at the moment. There is certainly a recognition from private enterprise that there is quite a lucrative market developing as far as retirement or aged care facilities are concerned. I do not necessarily advocate that as something that is going to solve all of the aged care issues and the problems associated with it. I think that a mix of both, perhaps, is what we should be aiming for the health budget to be spent on.

CHAIR—Your association also represents those areas that are now called ‘sea change areas’. Whereas places like Cowra and Forbes, which we spoke about earlier, have particular problems, the sea change areas have specific health problems, which are emerging more and more each day. In my own area, on the Sunshine Coast in Queensland, I have 1,400 people a month being added to my electoral rolls.

Councillor Miller—All Victorians!

CHAIR—Most of them are; they always have meetings when the State of Origin is on! But they do not have family nearby, so it falls upon the community to pick up for those services. Normally, older people would be helped out by their families, who would be nearby. In the sea change areas families are not nearby and, because the community has to pick up for them, local government has to provide a lot of those services. From your association’s point of view, is this causing a problem in the out years?

Mr Baum—The simple answer is ‘yes’. The sea change areas especially have qualitatively different problems to deal with. Places like Coffs Harbour have invested through the council large amounts of energy—less so money—into thinking about how to deal with this because, with a large influx of older people and not a corresponding influx of younger people, they have had simple problems with, again, how many nurses and home-care aides and those sorts of people they have. They have had to develop strategies to deal with that workforce issue. So it is an issue that the association are very much aware of. We have been encouraging our members to do some serious work on it. The uptake of that is slow; we only started on that sort of project about 2½ or three years ago. We have made some inroads, but the lessons we learn from places like Coffs are quite interesting and, I think, should be shared more widely.

Ms HALL—There has been some quite innovative work done in the Coffs area. The council has been quite proactive.

Mr ENTSCH—We have talked about doctors and doctor shortages in regional areas and you raised the issue of dental services. What about other allied health services like psychology, physiotherapy and a whole range of other services? How are you positioned with regard to those services?

Councillor Miller—In rural and regional areas they are virtually nonexistent as the population is ageing and as many of those professionals are retiring and are not being replaced. There is a reasonable level of those support services in the regional centres. Traditionally, many of these services have been in townships such as Cowra, Forbes, Parkes and ones further west, but those services are no longer there and people there rely on perhaps attracting a visiting specialist once a week or once a month or whatever. It is not because the demand is not there; it is simply because the personnel are not there.

Ms HALL—So you would be relying on them being in the public sector as opposed to the private sector. Any that are available will be through the public sector?

Ms Whittington—I am sorry, I am really not able to comment on that.

Mr Baum—I think the trend is that they are hoping they will be available through the public sector. We have seen little bits of evidence where occasionally councils support physiotherapists or other allied health professionals—

Mr ENTSCH—Speech therapists—

Mr Baum—Yes. We do not have strong evidence but we have the background, as Bruce has said. It is an issue across the board and when that is an issue, yes, you do look to the public sector to provide.

Mr ENTSCH—I raise it deliberately because one of the other areas you touched on here, which of course is a serious concern, is the high level of suicide within the rural community. You raised the view that there needs to be an increase in funding to prevent suicide, which is much higher than in other areas. That is of course directly associated with the lack of counselling facilities and a range of other allied health facilities that are needed on the ground and I would suggest that the two are tied.

Mr Baum—I think that you are absolutely correct. For example, in some of these areas you have one counsellor to look after an area perhaps stretching from Lithgow through to Broken Hill so, putting aside the issues that are perhaps causing some of these suicides and some of the mental health issues, there are the sheer distances involved as well. Distance is just a problem but there are just not enough people there to supply a level of service.

Mr ENTSCH—Another issue you raised was in relation to requiring the New South Wales government to reduce the eligibility criteria for regional patients accessing financial assistance for receiving medical treatment. It is a pretty sad state of affairs, I would suggest, when people needing critical medical attention have to rely on a charity like Angel Flight to be able to get them to treatment. I would be interested in any comments you have with regard to that.

Councillor Miller—I think that has improved a little bit. I do not have the ability to be specific about that. My understanding is that since this submission has been written that situation has improved slightly, but it is certainly not ideal. Because the cost of delivery of health services is perhaps being consolidated in some regional areas, there is always going to be a need for someone to at least subsidise access to—

Mr ENTSCH—There is of course a subsidy through the federal government's Isolated Patients Travel and Accommodation Assistance Scheme, but I understand that there is some sort of blockage with regard to criteria requirements for the state government.

Ms Whittington—I think there is some kind of limitation in terms of kilometres travelled and the ability to access it. I think you have to travel over X number of kilometres.

Ms HALL—It has recently changed.

Councillor Miller—It has improved. I think it is down to about 80 kilometres now, whereas it was much greater than that before.

Ms Whittington—I cannot be more specific.

CHAIR—I want to thank you for your comprehensive submission. It is very comprehensive. I want to draw everyone's attention to the opening sentence in your conclusion, which says:

From the NSW Local Government perspective the entire health system may not be in crisis but it is certainly under stress.

I think that is a very accurate, non-emotive statement. We often talk about our health system being in crisis. The fact is that we probably do have one of the best health systems in the world. We certainly have world-class clinicians in Australia—as good as anywhere. One witness about a month ago, sitting exactly where you are, said to our committee, 'If you were overseas and you got sick, where would you want to go for treatment?' The answer was, of course, 'Back in Australia.' We have to keep that in mind when we talk about improving the system, not denigrating it or belittling those people who work in it. So thank you for your attendance today. If we need to get some more information from you, the secretary will be in touch. Thanks for coming all the way from Cowra this morning.

Councillor Miller—The pleasure was all mine. Thank you for the opportunity for us to speak to our submission. We certainly agree with the comments you have just made. We do believe that our health system is second to none, but that does not mean that there does not need to be some improvement in it. Certainly, we agree with the comments you made about the better cooperation now with COAG and all of the states and local government working together. I cannot emphasise more strongly the need for the roles and responsibilities of each level of government to be properly delineated and then the correct streams of money going to all three levels.

[9.58 am]

CLIFT, Mr Bryan John, Consumer Consultant, Australian Lung Foundation

DARBISHIRE, Mr William Anthony Peat, Chief Executive Officer, Australian Lung Foundation

FRITH, Professor Peter Anthony, Chair, Chronic Obstructive Pulmonary Disease National Program Committee, Australian Lung Foundation

JENKINS, Professor Christine Russell, Member, Chronic Obstructive Pulmonary Disease Coordinating Committee, Australian Lung Foundation

STAUGAS, Dr Rima, President, Thoracic Society of Australia and New Zealand

CHAIR—Welcome. I know a lot of you have come from far and wide—from Queensland, South Australia and New South Wales. I see that you have a number of supporters in the public gallery supporting the evidence that you are going to give us today, so I welcome them as well. Do you have any comments to make on the capacity in which you appear?

Prof. Jenkins—I am a thoracic physician.

Prof. Frith—I am a thoracic physician from Adelaide.

Dr Staugas—The Thoracic Society of Australia and New Zealand is a partner in the Australian Lung Foundation.

CHAIR—The committee does not require you to speak 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 which may be regarded as a contempt of parliament. I invite you to make an opening statement.

Mr Darbishire—Thank you, Mr Chairman, for your invitation to appear before this inquiry into health funding. You kindly extended this invitation to the Australian Lung Foundation when we met you in parliament last year. I appear today as the Chief Executive Officer of the Australian Lung Foundation, or the ALF as we are known. We are a not-for-profit, public benevolent institution with medical and support group representation in every state and territory in Australia. Our vision is to be a key agent of change in Australia, bringing about improved understanding, management and relief of lung disease. In all, we represent approximately 15,000 members of support groups right around Australia and the millions of Australians living with lung disease.

The focus of our evidence today is chronic obstructive pulmonary disease, or COPD. Members of the committee may be more familiar with the terms ‘chronic bronchitis’ or ‘emphysema’. In our calculations, there are approximately one million Australians suffering from this disease today. Chronic obstructive pulmonary disease is a fatal disease characterised by

progressive and irreversible airflow limitation. Every hour, COPD is estimated to kill 350 people worldwide. The annual death rate from the disease is greater than that for lung cancer and breast cancer combined, and yet the majority of people have never even heard of COPD. At least 6,500 people in Australia die every year from COPD. In Australia, as I said, we estimate that over one million people have COPD but, even more alarmingly, our research shows us that approximately three-quarters of those with COPD do not know they have it and therefore are not taking the critical steps to manage their condition.

People with COPD suffer a range of impacts, from shortness of breath through to chest infections and pneumonia, that will often require admission to hospital for intensive treatment of their disease. Our research is in line with that of the AIHW, the Australian Institute of Health and Welfare, and shows that COPD is the third leading cause of burden of disease and the fourth biggest killer in Australia. There are approximately 49,000 admissions every year into hospital with an average length of stay of approximately eight days. Each one of those admissions costs at least $4,000. Given that this inquiry is looking into roles and responsibilities of our national health system, you will no doubt appreciate the cost of COPD as a major factor for you to be aware of, particularly given that this cost, in the main, can be avoided through disease prevention. The case we put to you today is that improved and earlier diagnosis along with greater access to treatment will reduce the burden on the Australian health system and improve the quality of life for COPD patients.

Australia is by no means alone in coming to grips with COPD. As recently as the week before last, on 28 June, in the United Kingdom the Hon. Patricia Hewitt, the Secretary of State for Health, announced a new national service framework to improve standards of care and increase choice for patients with COPD today. This framework will reduce inequalities in treatment which can vary across the UK and will seek to improve standards of care for patients. In Australia's case, the announcement of the $500 million five-year Australian Better Health Initiative might provide an opportunity for Australia to keep up with the pace being set by the UK in directing a portion of these funds earmarked for chronic disease prevention to COPD.

With me today is Professor Peter Frith, the head of respiratory services at the Flinders Medical Centre and Repatriation General Hospital in Adelaide. He is also Professor of Respiratory Medicine at Flinders University. Professor Frith has chaired the COPD coordinating program for the Australian Lung Foundation since 1998 and is a member of the International COPD Coalition. We are also joined today by Professor Christine Jenkins, who probably needs no introduction from me. Christine is the clinical professor at the Faculty of Medicine in the University of Sydney. Professor Jenkins is head of the asthma group at the Woolcock Institute of Medical Research at the Royal Prince Alfred Hospital, which is also here in Sydney. She is also the previous chairman of the National Asthma Campaign and former chairman of the National Asthma Reference Group of the Department of Health and Ageing. Christine is also President-elect of the Thoracic Society of Australia and New Zealand.

We are also joined at this table by Mr Bryan Clift, who is a resident of the electorate of Hindmarsh in South Australia. Bryan was first diagnosed with asthma, believe it or not, in 1994 and subsequently diagnosed with emphysema. He is here today as somebody living with COPD to give you an opportunity to better understand the nature of a condition unknown to many Australians. Finally, we are joined by others living with COPD who you have already noticed behind me. They have come today against impossible odds. You have no idea how difficult it is

for them to come in this weather, and this is a relatively early hour for what we call ‘our lungies’. I am very grateful that they have come to support me and my team today. Also here is Dr Rima Staugas, who is the President of the Thoracic Society of Australia and New Zealand and who we characterise as our scientific arm. Beatie Pearlman, the executive officer of the Thoracic Society, is also here today to support us.

The first of your terms of reference is ‘to examine the roles and responsibilities of the different levels of government for health and related services’. Our submission to you is that COPD is not yet adequately recognised by any of the different levels of government across Australia. The impact of poor provision for COPD is a burden on Medicare through the cost impact of inefficient and delayed diagnosis, which in turn is shifted as a burden to state and territory hospitals that provide for longer bed stays when patients require hospitalisation—hospitalisation which could have been prevented if simple rehabilitation treatments were more widely available. Put simply, we argue today that the Commonwealth, with the states and territories, should be focusing on early diagnoses and prevention strategies to prevent further cost impacts on Australia’s taxpayer funded health system. I might ask Professor Peter Frith to outline a few of these issues.

Prof. Frith—I have had quite a degree of experience in the care of patients with COPD over my professional experience. I do a little bit of pro bono rehabilitation work in the rural areas as well, so I have a little understanding of the situation there. I face the problems of the patients and the problems of the health professionals who deal with the patients concerning their health. Many of these patients have come to us extremely late in their disease, and that has a huge impact on their personal lives and the lives of their families and care givers.

In your role in considering how best to provide for financial viability within the complicated federal system, I urge you to adopt a new focus on hospitalisation prevention. I work in a public hospital and I see patients in private and public clinics. I see every day, particularly at this time of year, the impact of hospitalisation on the patients, their carers and on the health care system. We believe—and when I say ‘we’, I mean the professional groups around the world—that early diagnosis will allow early intervention and will in effect prevent hospitalisation. We can achieve earlier diagnosis through better awareness among general practice and in the community of the symptoms of COPD and spirometry testing—a very simple lung function testing, which is uncommonly used at the moment in Australia and around the world.

We would also find that hospitalisation reduction could be achieved through greater awareness and uptake of pulmonary rehabilitation, which is a program of exercise training and increased understanding by patients who are already suffering from COPD to deal more effectively with their own illness, notice problems occurring and for action to take place before they end up in hospital. At the moment, only about one per cent of people with COPD have access to pulmonary rehabilitation. It is even less in rural and regional Australia. Our target would be to increase access to that effective treatment. Up to 50 per cent of COPD patients should be participating in pulmonary rehabilitation within two years; that would be our aim. This would require improving awareness amongst health care professionals, but also redistribution of funding and improvement in infrastructure to allow it to happen, to allow there to be greater access to pulmonary rehabilitation throughout Australia.

Additionally, you may be aware, through your constituencies, of the complicated and usually inconsistent access arrangements to oxygen therapy. Oxygen therapy is of greatest benefit to those at the end of their illness. That end of the illness might actually take 10 years, so oxygen therapy becomes a life-enabling tool for people with COPD in their later years. In many states and territories, access is inequitable and oxygen is certainly difficult to obtain. We believe that by establishing a national register of access to home oxygen it would account for current resources, it would allow for a better accountability than currently exists, it would ensure that resources are properly distributed to those in need and it would identify any gaps in the provision of this therapy amongst the states and territories. Again with your permission, Professor Christine Jenkins might be able to expand on this.

Prof. Jenkins—I will start by elaborating for you the nature of shortness of breath and why it is such a substantial burden to people with chronic lung disease, especially people with COPD, and why it is so crucial in terms of identifying the disease and contributes in some respects to the disease tending to be identified late in the health care environment, and, therefore, minimise the chances of doing anything really substantial for the disease until the end, when it is, at that time, usually a very major imposition on the quality of life of the people who have it and on their carers.

Shortness of breath is not a normal part of ageing, contrary to popular belief. It is an indication that the process of getting air into the lungs is impaired in some way, and that then necessarily results in poor delivery of oxygen to the tissues. But the breathlessness that people with COPD experience is because their air passages are narrowed by the damage to the lungs. In our community, this is usually done by smoking, although in other parts of the world, it is very substantially done by occupational and domestic exposures to biomass fuels. In other parts of the world, equal numbers of women to men are affected in communities where women are very, very significantly exposed to those sorts of domestic irritants and noxious gases.

But in Australia, shortness of breath is an issue because people do not recognise it as being as serious as it is, and put it down to ageing, to gaining weight, to a sedentary lifestyle and to lack of fitness. In addition, patients who smoke blame themselves if they actually do perceive that it is perhaps related to the fact that they have smoked; therefore they tend to present very late to their practitioners, because of all of these issues that they attribute to normal phenomena rather than serious illness.

As a result, we need to increase the COPD awareness amongst health professionals. One might think this was a basic understanding, but in fact lung function is infrequently performed in clinical practice. Many GPs do not own spirometers. This is a spirometer I have here. It is a very simple little handheld device that enables you to measure lung function in a very simple test. At the present time, however, that test is not adequately reimbursed through the Medicare benefits schedule and, in particular, it is not reimbursed for monitoring lung function. As a result, GPs do not have an added incentive that would help them to do it because it is not actually easy to incorporate into a clinical consultation, especially when there are very substantial pressures of time and when these people are presenting in winter when general practice is especially burdened with a demanding patient throughput.

So it is crucial that we identify this disease earlier. If we do we can intervene in two very major and crucial ways. The first is, as Peter has already outlined, to be able to offer patients

pulmonary rehabilitation at an earlier stage. The evidence is that pulmonary rehabilitation is effective for patients at all stages of their disease, not just when they have severe disease. As a result of that, if we were able to intervene earlier with self-management interventions that help patients to look after themselves more effectively and maximise their treatment early on, they would manage to remain active contributors to and participants in their normal everyday lives for very, very much longer. Secondly, the evidence is accumulating that pulmonary rehabilitation very substantially reduces hospital admissions from this disease, which is a major cost to the community.

The second intervention—and primarily the reason why we need to identify the disease earlier—is to encourage patients to recognise the relationship between smoking and their lung disease and to help them give up. We need additional resources to provide smoking cessation interventions to patients who have chronic lung disease. We know that counselling combined with nicotine replacement therapy has a substantial benefit in terms of smoking cessation. It more than doubles the rate of successful quitting and sustaining of successful quitting on top of either nicotine replacement therapy alone or on top of smoking cessation advice. We need recognition of nicotine replacement therapy as a funded item on the PBS combined with the additional counselling interventions that can make a difference to helping people give up. That is the way we are going to prevent the further development of the disease in the community.

Another point I would like to raise, and this is a point perhaps one step away from clinical practice yet crucially related to it, is that clinical practice is based on evidence and that evidence comes from clinical research. You have already emphasised the fact that we have very high-quality health care professionals in our community in Australia—second to none. One of the reasons for that is that we have a very healthy research community. We are very encouraged by the increase in the NHMRC funding which has come in the most recent round but we really need additional funding to help us translate research into practice and to incorporate what we know about clinical research into clinical practice guidelines to help practitioners know where the evidence is for the early identification of disease and its appropriate management.

So, through the Australian Lung Foundation's appearance here today, we want to emphasise the fact that we believe there is still a very major gap in the translation of research into clinical practice. We need to do that through the sorts of initiatives that William mentioned—service improvement frameworks which enhance optimal practice and care for patients with chronic lung disease. A good example of the way that has been done would be through the CRC for asthma and the national health priority of asthma where we have seen dramatic falls in asthma deaths as a result of more active translation of research into clinical care, and similar national programs to optimise outcomes for patients with COPD would be one way we could achieve that. To speak about the patient's perspective nobody could be better placed than Bryan so I will hand over to him.

Mr Clift—I have COPD and it is best described as emphysema with some asthma content. Yes, I smoked, and used all forms of tobacco products. I was first diagnosed in 1994 with asthma. Pulmonary rehabilitation programs are the pathways to conveying information, which is the key to ongoing wellness and quality of life as well as to limiting hospitalisations. Because I have participated in rehabilitation I bring some first-hand knowledge and some benefits of my experience over the past 15 years without, I am happy to say, readmission to hospital.

I have participated in two forms of rehabilitation. The first was in 1991, following my heart surgery, and again in 1998, following my emphysema diagnosis, COPD. Like many people I wrestled with my respiratory condition for a couple of years until a conversation with a friend who was a member of Air Club, a lung net support group member, who extended an invitation to join and attend a one-day rehabilitation refresher to be held at the Repatriation General Hospital. I eagerly accepted both. The presentations were so informative and professional, I decided to join the full program. The procedure to enrol was a well-established one of tests, interviews, a physical examination, including spirometry, and an introduction to the program. The next eight weeks were full of information, increased understanding of the condition, medication, handling of anxiety and depression et cetera.

The most important element of this program was a well-supervised exercise program. The importance of this I cannot understate. Maintaining physical exercise has become a ritual with me, both walking and in a group situation at a nearby gym to work at under supervision of qualified instructors. By joining a group it encourages ongoing incentive and a certain amount of social contact as well. Exercising has enabled me to remain active in the community, helping other people physically, as well as serving on committees to establish pathways for consumers to return to fitness in the best possible way. Finally, I would like to say I enjoy the challenge of working with and following the paths of progress of projects which will assist people on the road to wellness and improved lifestyle. I hope my presence here today will encourage you to consider the needs of COPD as you continue your deliberations.

Mr Darbishire—We have today with us Dr Rima Staugas from the Thoracic Society. I have asked her to join us in case we have any curly questions in relation to Indigenous people. Rima is also an expert on paediatric health. There is quite a big issue with premature lung disease. In conclusion, from the Australian Lung Foundation’s perspective, addressing your first term of reference, examining the responsibilities of the different levels of government for health services, and the third term of reference on accountability, we argue universal health system savings can be made, cost shifting between jurisdictions be reduced and health forum shopping be removed.

To achieve this we believe that improved diagnosis of COPD achieved through community awareness and enhanced spirometry access will be one element. We talked about the redirecting of the funding to lift the pulmonary rehabilitation from its current one per cent to a magic 50 per cent, in our view, as a means of extending life quality and reducing patient hospital stays, a big fiscal impact.

We would also, as mentioned before, like to see reform of responsibility across the states and territories in the arrangements for access to home oxygen. I must say the Commonwealth’s DVA program is leading in this regard, but the other programs have been variously described as a dog’s breakfast so there is a lot of work to do there. We would also like to see greater funding and strengthening of research, as Christine mentioned, as well as links between the Commonwealth research priorities and their translation to state and territory clinical practice. It is very important from the Lung Foundation’s perspective and that of my friends behind me that there be greater resources for the self-help patient support groups, by way of a clear determination of which arm of government within our federal system will accept responsibility for empowering self-help and support.

We are really grateful, again, to have had the invitation to appear before this important inquiry. We hope you will consider the needs of COPD an important component of the inquiry. We would welcome your questions to clarify any matters we have raised here today. I know that the three of you are from sea change and tree change areas, and we see a lot of activity in those. In Fairfax and Shortland we have a lot of interest from members, but we need to get there in Leichhardt still. We are getting there, but further progress is needed. Over to you, Chairman.

CHAIR—Thank you. What is the cost of the spirometer?

Prof. Jenkins—Although this looks like an exceedingly simple piece of equipment, in fact this one was $900.

Mr ENTSCH—It is still relatively inexpensive.

Prof. Jenkins—In fact, for reimbursement through the PBS at the present time, GPs have to perform spirometry before and after a bronchodilator—that is, a medication that opens up the airways—to see whether the problem is likely to be airway obstruction due to asthma or COPD. They have to wait 15 minutes between those tests, which is one of the impositions and one of the difficulties. They also have to produce a tracing, which the patient can then be shown to help them understand the test. The devices that have a built-in printer cost in the vicinity of $3,000.

CHAIR—I find it remarkable that a GP would not have a spirometer. The Heart Foundation and Diabetes Australia are high-profile organisations. I cannot imagine a doctor who does not have a machine to do an ECG or a blood glucose test. Why wouldn't they be armed with a spirometer? I guess what I am saying is this. If you surveyed the community, everybody would have heard of the Heart Foundation. I do not think too many people have heard of the Lung Foundation. I had heard of it but before I met with you in Canberra it was not a top-of-the-mind organisation for this inquiry. Why is it that the public is so unaware of the importance of treatment?

Prof. Jenkins—I think there is a multiplicity of answers to that. The first thing to say is that the Heart Foundation has been around for a long time. One reason why ECGs are part of medical practice as an absolutely core piece of equipment is that people die if you do not get it right. If the patient presents with chest pain and you do not identify that they are having a myocardial infarction, they may walk out your door and drop dead. That is not going to happen, unfortunately for the patients who have COPD, if they do not get their spirometry done on that day or if it is not identified until they have lost 30 or 40 per cent of their lung function. The long-term consequences will be, well, tough. Maybe it will now not be identified until they have irreversibly lost 60 or 70 per cent of their lung function. Unfortunately, the same applies to glucometers in clinical practice. If you have a patient in front of you who is about to have a hypoglycaemic fit then that is a big incentive to make sure that you can measure their blood sugar and correct the problem pretty promptly.

The other issue is this. There is a global issue around lung disease not having been recognised because it develops so insidiously. People lose lung function over 20, 30, 40 or 50 years of their lives, from the time they are smokers at the age of 18, and they often do not present with breathlessness until they are in their 50s or 60s—by which time they have usually lost over 50 per cent of their lung function and are into the category of being disabled. Around the world,

lung disease has probably been grossly underrecognised as a serious contributor to chronic ill health. Indeed, there are global initiatives that now recognise that fact.

So we are a latecomer to the scene, in part, because people now do survive their heart attacks and their hypoglycaemic fits and pneumonia, which people used to die from at age 40—they no longer take people's lives. We now have people living into their 60s and 70s and their lung disease is now an absolutely crucial imposition on them. I think that is, at least, part of the reason.

Mr ENTSCH—Could it be also that issues such as tuberculosis have been pretty much eradicated? As a youngster I can remember my mum spent a year in a thoracic block with tuberculosis and it does not now occur in our population generally. When you talk about coronary issues, you could compare diabetes closer to issues of lung disease. I have to declare a pecuniary interest here. I was doing a calculation. My grandfather died of emphysema. I have six uncles on my mum's side. Two of them have died of emphysema, two of them currently have chronic emphysema, the third one has severe emphysema, and only the youngest one at this point has not been diagnosed with emphysema. They are all from Leichhardt, so I have an interest.

Mr Darbishire—The good news is, Mr Entsch, we could give you a quick spirometry test at morning tea.

Mr ENTSCH—The point is that Diabetes Australia has made progress in relation to diabetes awareness. For example, the federal government now has what is called a diabetes doctor—we are interested in the Indigenous side of things as well—in the Torres Strait. We have funded a doctor who is there purely for preventative practices. He travels around the various remote communities educating people on diabetes and whatever. The number of people now who have not lost arms and legs because of the education directly attributed to this particular 'Dr Diabetes', as we call him, has been quite profound.. The other organisation, which you are so closely associated with, is the Asthma Foundation. It is interesting that, in recognising the Asthma Foundation, which, again, is quite a high-profile organisation, there does not seem to be the same level of linkage as the Lung Foundation.

Mr Darbishire—Through you, Mr Chairman, I make no apologies for being 10 years old, which is what the Lung Foundation is. You are right in terms of TB. There are 1,000 new cases a year in Australia, mostly imported. We are now working with the Australian Respiratory Council quite closely, as we are indeed with the Asthma Foundation, because there is a huge overlap, as you are probably aware, between COPD and asthma. But we are definitely making progress. I do not suppose anybody had heard of COPD and they would not know that it was the fourth biggest killer in Australia.

Mr ENTSCH—I didn't, although almost everyone is dying from it. It is not a criticism. There are things that are happening in the parliament that I think would be very useful.

CHAIR—There is the parliamentary diabetes organisation.

Mr ENTSCH—There isn’t an asthma organisation as well. Maybe our next step in raising the profile is to establish an organisation that helps the COPD organisation or the lung and asthma organisations so that people can connect the two.

Mr Darbishire—We are working very closely together. I will ask Christine to respond to that point.

Prof. Jenkins—I think the issues you have mentioned are examples to us about what can happen when the Commonwealth government puts together a process of funding that facilitates better Commonwealth-state interaction on a major chronic disease like this. We have, unquestionably, seen it in asthma. We are now seeing probably a 25 per cent mortality rate from asthma, compared to only 15 years ago. Substantial outcomes have occurred regarding asthma. Again, when people die, especially children, things become very high profile. There is an urgency and people respond to that. I think that is why COPD has not had that attention and things like asthma and diabetes and heart disease have.

Our time has come. We recognise the capacity of state governments to interact with the Commonwealth in a way that is productive. A funding arrangement that can work both ways to facilitate better care can have dramatic impacts. We have a good model of that in asthma. On the National Asthma Reference Group there is a unanimous view that what has been achieved in asthma needs to be achieved in COPD. There is very substantial open-mindedness to expanding the initiatives that have occurred in asthma, although the funding is currently strictly for asthma, to COPD. We know that it really would make a very substantial difference. The sorts of relationships we have had with the state health departments through that initiative have actually facilitated interventions coming down to state level.

At present with COPD the opportunities to access things like pulmonary rehab and smoking cessation are not there. Smoking cessation advice has only just come to us in New South Wales hospitals—and this is metropolitan major teaching hospitals; it would not be true in any respect of anywhere outside of that—through the Chronic Care Collaborative that has occurred through New South Wales Health in the last couple of years. We have not had a funded smoking cessation counsellor up until now, despite the fact that tobacco is the primary cause of admissions to hospital in our state. We know that a lot can be done, and this is a great opportunity to do it.

Ms HALL—Have you joined together with the asthma foundations and looked at running joint awareness campaigns?

Mr Darbishire—I can answer that very briefly. Yes, we have. We are working very closely with not only Asthma Australia and the asthma foundations but also the National Asthma Council and, as I mentioned before, the Australian Respiratory Council. There are probably half a million Australians walking around today who do not even know that they have COPD. There are a thousand people in hospital beds right now because of a flare-up or exacerbation in their COPD. So we can see that there are potentially huge savings to be made.

You heard Bryan talking earlier. He did touch wood when he said he had not been into hospital since the pulmonary rehab, but it has worked wonders for him—much more so than the seafood he had last night! I might ask Rima to respond in relation to the Aboriginal and Torres

Strait Islander issue and, very importantly, children. Often children hardly come into the equation with COPD, but I would like to have the opportunity for Rima to give us a couple of minutes on that perspective.

Ms HALL—If you could, please, I would also like you to deal with the relationship between the state and federal governments in dealing with your disease and any crossovers or problems that arise out of the dual systems that we have.

Dr Staugas—Could I comment on that as well, because I come from the state jurisdiction?

Ms HALL—Yes. That is great. I thought I would throw it in at the same time.

CHAIR—Could you throw in also the availability of oxygen bottles in different states. They are provided by the state government in some jurisdictions but not in others. My father-in-law was a veteran, TPI. All of his oxygen needs were provided for by DVA, but the person next door, who was a pensioner, had to pay for their oxygen privately when they wanted mobile oxygen to carry with them.

Ms HALL—Let us look at the big picture first and then go to the oxygen bottles.

Dr Staugas—I come from a state jurisdiction. In my other life I am a general manager of a health service. It is primarily women and children focused, but on a day-to-day basis I look at this issue with another lens, which is the overwhelming burden of disease that is coming through our doors in older people, of which this is one very important component. I strongly support the idea that we need to have a framework. We need to have money invested in a framework which picks up all these elements, as it did for asthma, and which can be driven by the Commonwealth in partnership with the jurisdictions. It probably needs to be done more strongly than it was with asthma, with a set of outcome measures which are to do with things such as the uptake of rehab and a well-structured oxygen delivery program. South Australia has a pretty good one, but many states do not. It needs to consider all the things that you can pick up that make a difference, such as pulmonary rehab, early diagnosis and educating GPs about the use of spirometry and its application.

As a health system we need to get on to that front-end demand and prevention of hospitalisation issue pretty soon. I represent the professional end of the spectrum. In our profession, part of the problem is the burgeoning level of disease and the inability to have enough doctors, nurses and allied health professionals to service it. The only way you are going to do this is if you put some things at the front end which prevent hospital admissions, which keep people well and which keep them out of hospital.

Ms HALL—Can I clarify that the workforce shortage is impacting on your area?

Dr Staugas—They are impacting in every area and every jurisdiction in every part of the world. I have recently been away. These issues are issues for every part of the world. In the end, we are going to be poaching from each other and it is going to go round in a circle. Ageing lung disease and ageing heart disease are issues for the whole of the world. The demand is where people are focusing, setting up frameworks and guidelines, and implementing best practice, as Christine said. If you introduced a spirometry program, there are ways you can tie outcomes and

measures and reviews into those sorts of programs. We need to get a lot better at that to get the professions to respond so as to benefit the patient at the other end.

In terms of Indigenous people, the impact of this is relatively poorly researched. TB could still become quite a significant issue in the northern areas of Australia and impact on this area as well. It is poorly researched and poorly understood. Again, there is a whole other issue of how you would implement such a national framework into the work of Aboriginal health workers. I am aware that the Commonwealth is about the roll-out of a new set of competencies for Aboriginal health workers. Dealing with lung disease in Aboriginal communities and even in metropolitan Aboriginal communities would have to be an important component of that to have some impact.

Mr ENTSCH—There is still a very high level of smoking, for example, in Indigenous communities, compared to mainstream Australia. While in mainstream Australia there are a lot more people starting to stop smoking through the restrictions, you do not have those restrictions in Indigenous communities. Unfortunately their levels of smoking are still at Third World country highs.

Dr Staugas—So the issue is those sorts of programs and how they fit into the new Aboriginal education and training programs. People are hoping to bring a more sustained form of health service into Aboriginal communities. It is important. Lastly, on children—because I am a paediatrician by background and I do not want them forgotten—it is not a large group, but there is a small group of children who are the survivors of infant lung disease, who have been ventilated and who do develop chronic obstructive lung disease. There are even some indicators that they could get worse later in life. People are assuming that that is due to smoking, but there are some indicators that they could again get worse later in life. So there are even conditions that occur early in life.

On the question you asked of William and Christine, about why lung disease is not so evident, I think it is partly because it is very much at that preventative end. There are things you can do but prevention is never sexy. It quite often takes 10 to 20 years to see a good outcome of a preventive program. While you might see some short-term gains, when people do not look at the longer term they tend not to invest in those sorts of programs. So I think there is a range of reasons.

Mr Darbishire—Mr Chair, you asked a thorny question about oxygen and the state-Commonwealth linkup—and you have some personal experience there. I think the perfect person to answer that question would be Peter, who is one of the authors of our guidelines for COPD management. So I will ask him to address that question.

Prof. Frith—With your permission, I was also going to mention that the Lung Foundation and the Thoracic Society have partnered to create evidence based guidelines of practice for medical practitioners, nurses and so on that will help improve the delivery of care at that end, providing the resources can be found. In addition, we have developed pulmonary rehabilitation guidelines and toolkits that will enable allied health practitioners in particular to set up and provide those services if they are funded. But in terms of the oxygen therapy, yes, there are vast differences between states. The DVA, as you mentioned, is probably the shining light in that regard.

It is crazy for a person to be provided with home oxygen, to be linked to a machine that provides them with oxygen 24 hours a day, and not be able to get out of the home because they don't have a cylinder on wheels. That is an absolutely crazy situation, but that is what happens in several states of Australia. It is far better that those people are up and about. They can be made to be relatively fit and active contributors to society instead of being stuck on that oxygen machine in their home 24 hours a day. COPD is not just a condition of the elderly. It is not just people over the age of 75 or 80 who have COPD. People in their forties and fifties are developing it. They may not realise they are developing it. It is incumbent upon us to provide these sorts of diagnostic tools so that we can prevent the need for oxygen therapy further down the track, and hospitalisation.

As a final point, this divide between primary, tertiary, and in the middle, secondary care—that is, state funded versus Commonwealth funded programs—is counter to what we can provide in chronic care programs. I am associated with the development, as is Bryan, of community care programs for chronic disease in general. COPD is not different in this regard. Greater ability for state and Commonwealth funding to be put together to provide chronic care programs, including COPD—and from our point of view especially COPD—is necessary.

CHAIR—Are you happy with the access you are getting to federal and state government?

Mr Darbishire—This goes back to one of your earlier points, when you said that nobody had heard of the Australian Lung Foundation. We have spent approximately $5 million to get to where we are today. When we started looking at this we thought, 'This is great; we will have a community and a clinician education phase'. Then we thought about it and Peter and his executive got together and said, 'Look, we cannot possibly go to the community until the clinicians are ready.' This is why we have had to spend the last five years and $5 million. We have had to borrow, beg, steal and fund raise—we have had chook raffles and all the rest of it. We have got to a fantastic position as far as the clinicians are concerned. We still need some help with GPs. There would not be a GP in the land who would not be exposed to COPD. They may not pick it. According to Professor Frith's research, four out of every five we found with COPD had not been diagnosed.

Ms HALL—Have you done work with the urban divisions of GPs?

Prof. Frith—Urban and rural. It is scattered across different states. It is very much a state driven system, but certainly with the urban divisions and some of the rural as well.

Mr ENTSCH—I strongly urge you to look at us as a means of developing an awareness group in the national parliament, as we did with diabetes and as we have done with other conditions. It would be a very useful tool. If we are going to look at some of these initiatives, which I think are very good, we need to raise awareness within the parliament itself. We need some sort of an awareness group, whether it be a 'friends of' type of group, or something like that, which seem to very successful. They have everything—not only with health, but there are 'friends of mining', 'friends of tourism' and friends of a range of groups. It gives an opportunity for you to come down and address parliamentarians—rather than just this health committee; I think you need to go past that—and put together a list of things that we need to do.

If we start it at that level, then you can bring on board a lot of members that are probably not as focused on or aware of some of these issues. I think that would be a very significant start. Then we could focus on the areas that we need the Australian government to get involved in. That is how we got the diabetes initiatives up and that is how I believe we can get issues in relation to this up. I would encourage you to do that after this hearing process.

CHAIR—If you bring your spirometer with you, our hearts and minds might follow!

Mr ENTSCH—We can organise maybe some sort of a luncheon or something like that in the parliament and invite all members along. Bring along your spirometer, line them up and start to raise that awareness, and give them a list of what you need.

Mr Darbishire—It has been done before, in Poland, where they found that 20 per cent of the members of parliament had COPD. It was a bit of a shock.

Mr ENTSCH—It is a great way to raise awareness and it is a great way to get a focus in starting to address some of these issues. I would urge you to do that.

CHAIR—I thank the witnesses very much. If we need to contact you for more information, we will do so.

[10.58 am]

MENADUE, Mr John Laurence, Private capacity

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mr Menadue—I am the chair of Newmatilda.com.

CHAIR—Thank you. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament and that the giving of false or misleading evidence is a serious matter that may be regarded as a contempt of parliament. I would like to thank you for giving evidence to this committee. You have had a long and distinguished career, including the office of the highest public servant in the land, so your experience is very valuable to this committee and I sincerely welcome you. I ask that you make an opening statement. I understand you have tabled a six-page paper, and I will ask Mr Entsch to move that we accept it as a submission.

Mr ENTSCH—It is so moved.

CHAIR—There being no objection, it is so ordered. I now invite you, Mr Menadue, to speak to that paper.

Mr Menadue—Thank you, Chair and members of the committee. My interest in health is a fairly recent one, although on a personal basis I can claim that I introduced Gough Whitlam to John Deeble and Dick Scotton, which was the beginning, back in 1967, of Medibank-Medicare. More recently, I have chaired two state inquiries in the health system. I have distributed this paper to you, but I will speak—hopefully very briefly—to it and leave time for some discussion.

I believe that there are opportunities for greater efficiency and effectiveness in health in Australia, quite significant opportunities to get better value for money. The cost of health care in Australia over the last 10 years has been rising significantly, and we are now running at an increasing rate ahead of the OECD in general. That was not the case 10 years ago. Costs have been driven by many factors, two of them of course being the ageing population and new technology. My own view is that Australia does not need to spend more money on health. We should be spending it much more effectively and efficiently than we do. I often say that treasurers and treasury departments should be the allies in forcing reform. Reform is needed. We do need to get better value for money.

There is quite a lengthy list of areas that I suggest in this paper should be considered to get better value. The first is that we cannot have all we want in health. Choices have to be made, but they need to be rational and informed choices. Secondly, hospitals in Australia are the core and centre of health care. It is an expensive way of ordering one's priorities in health. It should be in primary care as the focus of care. Thirdly, we have significant problems in quality and safety which add to costs as well as being considerable problems for individuals. We have the Commonwealth-state fragmentation and the cost involved in that. We have probably one of the

most extraordinarily inefficient workforce structures within Australia. It has been practically unchanged for 100 years, and there are very substantial national gains to be achieved by addressing serious restructuring of the health workforce.

In Australia, we have a sickness model of health rather than a wellness model. The earlier group was speaking about preventive medicine, preventive care and action. I believe we do need to orient our system much more to wellness rather than to sickness and get that balance right. We need an improved electronic health record in Australia which will enable improved, better quality and lower cost health care. Finally, there is the question of personal responsibility. I will be suggesting ways in which personal responsibility can be entrenched much more thoroughly in Australia—that is, basically, through increased co-payments on a rational, considered basis and by funding direct to private hospitals and not via private health insurance.

I will deal very briefly with the first point: making choices in health. If we had a market mechanism, demand and supply would be managed through pricing, but we have decided—for, I think, good social reasons—that we do not want to price people out of the health market. But we do have an enormous demand for health services. Demand is pushed by community expectations, providers, equipment manufacturers and the pharmaceutical companies. All provide very good services to the community, and we want them, but the fact is that we cannot have it all.

My experience is that when the community is well informed about priorities in health—and I emphasise ‘well informed’—it comes to a quite different view to what we read in the newspapers, which is invariably about more hospitals and more hospital beds. In my experience, when the community is informed, it has always highlighted mental health and Aboriginal health as the two priority issues in this country, but that is not reflected in the way choices and priorities are set in health in Australia. So engaging the community in that important issue I believe is a central matter that we need to address. We cannot afford everything. I think that is an important issue which we all avoid. I have yet to meet a minister, state or federal, in Australia who has levelled with Australians and said, ‘We can’t have everything we want. We have to make some hard choices.’ And I think the community would respond to an informed debate on that subject.

In Australia we have a very hospital-centric system. In South Australia, hospitals take 58 per cent of the state budget; in New South Wales, it is well over 50 per cent; I suspect that in other states it is much the same. Thirty per cent of total health costs in Australia are spent in hospitals. We in Australia and in the community increasingly regard hospitals as the first resort, when they should be the last resort for care. It is consistent with efficiency, cost and the autonomy of the patient for individuals to be treated in their home or as close to their home as possible.

Hospitals will always be full, as I have said in this paper. It is a bit like the family refrigerator: whatever size refrigerator it is, we will fill it. It is the same with hospitals in Australia. We will fill them, regardless of the number of beds. Within the health industry, if I can call it that, there is an accepted view that about 30 per cent of people presently in hospitals need not be there—if there were appropriate alternatives available in the community or through home visitation. Clearly, we could achieve very significant improvements in health care in Australia if we oriented our health services towards primary care. I think that the big issue for the future is for the development, growth and success of Australian health care to focus on primary care rather than hospital care. Hospitals are a key element, of course, but they are being allowed to drive the

health policies in Australia. To many people in Australia, hospitals are synonymous with health. In fact, they are not. Hospitals are part of a health system.

Another area where there could be greater effectiveness is quality and safety. The review by the Quality in Australian Health Care Study in 1995—10 years ago—estimated that, conservatively, avoidable adverse events were costing more than $4 billion per annum. I believe it is substantially greater than that figure at the present time. A recent example which I have taken an interest in, which I have mentioned, is joint replacements. There are 65,000 hip and knee replacement procedures in Australia each year. But our revision, or redo, rate for hip and knee replacements in Australia is 20 to 25 per cent. In Sweden it is seven per cent. There are various reasons for that, which clearly need to be addressed. Usually it comes down to systems and information to improve the quality and safety of the procedures. I have mentioned that there are very significant costs because of the large number of knee and hip replacement operations and the additional costs which result from redos or revisions, which are commonplace in Australia. That needs to be addressed urgently. If we were to get anywhere near the Swedish revision rate, there could be savings of up to $200 million per annum in this country.

I mention in the paper the experience of airlines and their success in developing a much more effective, transparent safety culture. We have a particular problem in health, in that hospitals—particularly in country areas and with some specialist services in big hospitals—are kept open for political reasons when in fact there is not the available staff to keep them open. There is also a major disconnect in hospitals between corporate governance and clinical governance. After chairing two inquiries—perhaps I am a slow learner—I asked myself the question: who runs hospitals? I did not get a satisfactory answer, so I became emboldened, and my proposition now is that no-one runs hospitals. It is anarchic that you have this responsibility divided between corporate governance and clinical governance, which is a significant problem in Australian hospitals. This disconnect is a problem in every large organisation, between what they want to do in terms of their vision and their strategy and how the services are delivered lower down.

I think, above all else, a major problem is that quality and safety in health in Australia is not dealt with openly and transparently. There is a fear—for professional, legal, financial and political reasons—that to expose the issue will present major problems. So, unfortunately, there is a cover-up in Australia as a result of that attitude. A veil of silence often descends, a scapegoat is found, but the system does not change very much at all.

I mentioned Commonwealth-state relations, and you would be familiar with the arguments and concerns on that point about fragmentation and blame shifting. I have seen estimates of costs of that fragmentation ranging from $1 billion to $20 billion per annum, but I think it is much nearer $1 billion than $20 billion. How do we address it? I think it is unrealistic to expect that the Commonwealth would take over all state health functions, or the reverse. What I have suggested, and what I have called a ‘coalition of the willing’, is for the Commonwealth and states to agree to establish a joint Commonwealth-state health commission in any state that agrees to it. There would need to be pooling of funds, agreed coverage of that commission and of course agreed governance. Local government could be dealt into that agreement as well, because, whilst it is important nationally that national policy and national standards be enforced, it is also important that the delivery of services is driven to the lowest point possible in the organisation, particularly in a country as large and diverse as Australia.

I mentioned the restructuring of the workforce. I think it is a major issue in this country, alongside the development of primary care. We have a workforce structure which really has not been changed for the last 100 years. We have seen the very considerable public and social benefits of workforce restructuring in the blue-collar manufacturing area, but unfortunately the professions, particularly the health professions, have not really been touched by workforce restructuring. Demarcations and restrictive work practices abound. Professional people are trained in boxes and then they work in boxes. They are kept separate.

There are a whole range of areas where I believe that there could be significant improvements. There are signs that the Productivity Commission is aware of that and has indicated the changes that are necessary. One example—probably the worst in Australia—is in obstetrics and midwifery. In Australia about 10 per cent of normal births are delivered by midwives. In the United Kingdom that figure is 50 per cent and in Sweden it is 70 per cent. That situation exists in Australia due to restrictive practices, usually in the name of quality and safety. They abound across the health system. There are big productivity dividends to be obtained by addressing this question of the health workforce. One way of doing that is, frankly, by political, administrative or executive leadership by governments in Australia, and the second is by using the MBS system to encourage and promote greater upskilling, sharing and teamwork within the health system.

I have mentioned in the tabled paper that our health system is based on a sickness model rather than a wellness model. Less than two per cent of Australia's health funding is spent on prevention in public health. The balance is very largely spent on medical services. Unfortunately, the urgent invariably gets priority over the important. There is always pressure for more of this and more of that in response to particular problems in the community: health difficulties, problems that arise, shortages of beds—so-called—and important public health prevention is neglected.

I have mentioned in this paper the importance of addressing tobacco induced disease and early childhood development. Now there is the gathering storm over obesity and of course poverty generally, which is the major cause of bad health in this country. It comes from socioeconomic factors. The most obvious example of course is in the Aboriginal community. Poverty is the biggest cause of poor health, which leads to a whole range of other things—bad lifestyle, bad diet, lack of self-esteem, lack of exercise and so on.

CHAIR—Can I interrupt you there for a second. I will ask you to continue, but Warren Entsch has to leave and he would like to ask you a couple of questions before he goes.

Mr ENTSCH—There are a couple of quick questions I would like to fire off before I go. I was interested in your comments in relation to the hip and knee replacements and having to go back and do redos. I was recently, in another role, responsible for an action agenda on medical devices in this country and I am well aware of the capacity in Australia to manufacture good quality hips and knees specifically for this. We have companies here that are doing a good job. Why do you think that there is such a high level of redos? We have a high level of skill within our surgeons, I would assume. The packs are sold as a whole, with all the instruments and everything that you need to do it. Why is there a high level of redos?

Mr Menadue—It is not about the skill of the surgeons in orthopaedics. It is very largely about the information and system problems. It is an area where technology is changing very rapidly.

New prostheses are being employed and new methods are being employed. The key is getting the feedback from that experience back into the system so that changes can be quickly made if necessary, if something is or is not working. A register has been established in Australia to draw together a lot of this information to address this sort of problem. It is a rapidly growing field. There is new technology and we are not getting quick enough feedback or changes in procedure as a result of experience. We are not closing the loop fast enough.

Mr ENTSCH—So we need to link the manufacturers into this whole circle, because they are the ones that need to make adjustments if they need to be made. So we need to bring them into this whole equation in a more timely manner. Is that what you are suggesting?

Mr Menadue—That is right. I think it is about time and just closing the circle of experience more quickly so that improvements can be made.

Mr ENTSCH—The other question is about the Commonwealth-state health commission, which I think has a lot of merit. Have you put in any submissions or had any discussions with any state or territory governments in relation to this model?

Mr Menadue—I chaired the South Australian inquiry and that was in our report. But to my knowledge it has not been seriously considered beyond the bureaucratic level. I had been hoping that perhaps two smaller states, South Australia and Tasmania, might be interested in that as a trial project. I think it would not cause the political problems perhaps of doing it in New South Wales or Victoria. It would not be so groundbreaking.

Mr ENTSCH—Mind you, with what has happened in Queensland in recent times, it would be a useful one for Queensland and the Australian government to consider.

Mr Menadue—If Queensland would like to be first out of the blocks on that one, I think it would be well worth pursuing. It is the only politically feasible way of proceeding. I do not believe it is possible to get all the states and the Commonwealth to agree, for various reasons. Western Australia would always be difficult, I think, and Queensland often would but perhaps not now. So it is more politically feasible to get an agreement state by state and then hopefully, once the record and the experience was successful, it could extend to other states and become a national arrangement.

Mr ENTSCH—It needs one to lead. It needs leadership.

Mr Menadue—Yes, leadership is essential. That is why I call it a coalition of the willing—excuse the metaphor from another area.

Mr ENTSCH—Another example is in relation to obstetrics. We heard some excellent evidence yesterday in the Hunter from the Belmont Birthing Service. We had the opportunity to go and see it yesterday. You wonder about how advanced we are in our society when what they are doing there has been done for thousands of years and is still widely practised in Third World countries and here we are—we have walked right away from it.

CHAIR—They have rediscovered it.

Mr ENTSCH—Yes. It is great to see that New South Wales Health and the Australian government are supporting that. I agree with you that it is an area that should be expanded right across the country.

CHAIR—Childbirth, surely, is not a sickness.

Mr Menadue—No, but it is treated as a sickness.

Ms HALL—It is very difficult to bring about the changes that took place at Belmont, because of all the issues you have identified in this paper.

Mr ENTSCH—Finally, your suggestion for a sickness model is so accurate. I agree with you that there needs to be a greater focus on primary health care rather than on treating symptoms. We are starting to do that for diabetes and some other areas. I gave an example to previous witnesses about a person we call 'Dr Diabetes', who goes around in the Torres Strait. I was talking to him only recently. That was an initiative put in place by former Minister Wooldridge, so he has been going around for that long. We have lost count of the numbers of arms and legs that have been saved through early intervention and education to reduce the onset of full-blown diabetes. I agree that we need to be looking at greater investment in those areas rather than at just treating the symptoms, which is of course a hell of a lot more expensive.

Mr Menadue—I would describe it as putting the ambulance at the bottom of the cliff when we should be putting handrails at the top. That is the nature of our health system. We need primary care out in the community which delivers a range of services to keep people well and to treat sickness, and it should start with multidisciplinary teams that include dieticians and all sorts of other people.

Mr ENTSCH—I commend you for what you have here. I think it is outstanding.

CHAIR—You must have had an impact in South Australia. When we met with the South Australian departmental officials, they were advocating the wellness model.

Mr Menadue—One interesting thing that SA has done recently is establish home visitation for single, disadvantaged mothers with young children. They are not really wanting medical treatment as much as nurturing support in a very difficult situation. It seems that, for a very small amount, preventive care like this in early childhood is showing very considerable benefits. I hope and expect that that type of scheme will extend across Australia and that the whole focus on early childhood, including in utero, and what can be done to improve those early stages of life will produce dramatic benefits individually and socially in the years ahead.

Mr ENTSCH—Yes. We were talking about foetal alcohol syndrome in remote Aboriginal communities. A community itself intervened and started a program that eliminated it completely from their particular community, and not one of the people who fixed it was a doctor.

Mr Menadue—I mention the importance of the electronically held record and the productivity and quality improvements that would occur. I have seen estimates of 10 per cent and up to 15 per cent for improvement in productivity, for the reasons I have outlined in that paper. I am concerned that developments in that area are occurring pretty slowly. That is an issue

that your committee might like to address, because an electronically held record is an important enabler of improved and more effective care.

The final point I would like to make is about what I call private care, private insurance and personal responsibility. I agree with one of the terms of reference of the committee: it is important to encourage more personal responsibility in health. On the whole question of moral hazard and insurance, unless people are conscious of the cost of treatment they do not make sensible decisions. That is not to say that equity should not be preserved and that people should be excluded; they should not be. But my view is that the present arrangements are not working satisfactorily.

I have two suggestions. In terms of making people more responsible for their own health care, I am perhaps a late believer but I believe now that co-payments are an important way of doing that. In 1975 Medicare was established. Since then there have been dramatic improvements in income. I have mentioned for example that, since 1985, real annual disposable income per capita has increased from $24,000 in 1985 to $36,000 in 2006—an increase of 50 per cent. Well-to-do Australians can afford to pay much more for their health without detracting from what I regard as an important principle of a universal delivery system. But people can pay differently in terms of their access to it depending upon their means.

My own view, further, is that, to support the private sector—and in this case I am referring particularly to private hospitals, which are clearly an important part of our health system—it would be much more efficient and better for the Commonwealth government to pay funds direct to private hospitals, either in a bed subsidy or a DRG, diagnostic related group, basis rather than through private health insurance. I think that private health insurance and the subsidy is one of the worst examples of public policy I have seen in this country. It is not a large amount of money, but in terms of results I think it is working extremely badly and against the public interest in terms of equity and allegedly giving relief to public hospitals. It has not done so. It has just opened up a new area of demand.

The private insurance companies also undermine the role of Medicare and its ability through its purchasing power to control and manage costs in the country. Private health insurance companies are price takers. They do not use and do not have very much power to influence outcomes in the market, whereas Medicare has. Being passive price takers, they are undermining Medicare's ability to set prices and standards in the community. My suggestion, as I said, is that, rather than putting government funding through a private financial intermediary like insurance companies, the government and the community would be better served if the money was paid by subsidy direct to private hospitals on a formula that could be agreed on.

We hear a lot about the nanny state. I think we have in the case of the private insurance companies the nanny corporations, dependent on government subsidies for their continuation. I believe that the government should address more efficient ways of making people more responsible for their own care. I do not think that paying subsidies to private financial intermediaries is a sensible way to go, particularly as all of the evidence is that the growth of a private insurance industry pushes up costs.

The successful countries in the world in terms of controlling costs are those which have a universal system whereby the government, usually the 100 per cent provider, has bargaining

power in the market on prices. Private health insurance undermines that bargaining power in the market. That is why we have this extraordinary situation in the United States, which is just on its own in terms of costs. It is because private insurance companies just keep pushing up costs year after year. My suggestion is that, in fact, to make people more responsible it would be appropriate to consider the expansion of co-payments and not to put government funding through intermediary private insurance companies but to pay direct to private hospitals.

CHAIR—Thank you very much for that presentation. That is the first time we have had that view put.

Mr Menadue—That is the first time I have put it, actually. Moral hazard has been worrying me. How can people be made responsible in an equitable and fair way for their decisions?

CHAIR—I would like to go back to a point that Warren Entsch made before he had to leave about the re-dos of hip and knee replacements. They are exempts of elective surgery, and the majority are done now in private hospitals—in the private system. Is there any evidence that the re-dos are more significant in either the private or public systems?

Mr Menadue—My initial advice was that there was—that the private rate was higher. I checked again yesterday, and the advice I received was that there was no significant difference between the two. It may be worth some additional inquiry, but that is the advice I received yesterday. I am satisfied that it is reasonably correct.

CHAIR—So it would be a matter of time lag in the waiting list?

Mr Menadue—Yes, that is right. But the growth is certainly occurring in elective surgery, particularly joint replacements, in the private sector. There are about 65,000 of them a year now and it is growing quite rapidly, so it is a major area that needs addressing. It is pretty clear that it is also providing very substantial benefits to the community; people who were previously immobilised and in pain are now recovering well.

CHAIR—It is also evident, I think, that a prosthesis provided in the public sector is not as technologically advanced as a prosthesis provided in the private sector. And, in cardiac surgery or in cardiac angioplasty, the stents used in the private sector are treated stents, which last longer than those used in the public sector, which would require re-dos much more quickly.

Mr Menadue—That is right. I have no doubt that in elective surgery the private sector—private hospitals—have a great contribution to make. I think the public sector is much better at the other end in terms of emergency and critical illness.

CHAIR—We are aware that there is debate in the community, and that there are about four different models being proposed, yours being one of them. We have had Mr Podger appear before the committee to give his view. Do you have a view on the Podger model?

Mr Menadue—I would certainly favour the Commonwealth taking over state health functions, provided that local government and local institutions were properly included within that system. Of course, local governments are creatures of the state government, so the states have the ability to do that as long as it does not result in increasing centralisation of the system.

The national government should set national policies and national standards, but I do not see why the Commonwealth government should be running hospitals in the backblocks of Australia. Clearly, that must be delivered at the state or, even better, at a local area level. And it is possible, I think, to do that in the formula. I would favour that model, but I am being a political realist in knowing that it is not likely to happen and that it would be more profitable and successful to go state by state to achieve a result. It may, in the end, produce an outcome such as Andrew Podger has mentioned, but I think that will take some time to achieve.

I notice that Mr Abbott has been talking about takeover of state hospitals. This would be a problem. In the public mind—and perhaps in the minister's mind—hospitals equal health; they do not. For the Commonwealth to take over hospitals and not touch all the other areas of health would compound a lot of the lack of integration we already have in the health system in Australia. We do need to integrate it. Hospitals and health must be brought together and not treated as separate projects.

CHAIR—I think Tony Abbott is talking about the next round of negotiations for the health care agreements and that there is pressure on MPs—there is pressure on me and on other members of the committee and other members of the parliament—to do something about the parlous state of public hospitals. I think you heard me before when I said that we still have one of the best systems in the world, we have the best clinicians in the world, and a lot of the criticism is unfair. We had Deborah Green appear before us, and she said very clearly that, while there are shortcomings in the system obviously, if you were overseas and you got sick and you were asked the question, 'Where do you want to go for treatment?' everybody would say, 'Back in Australia'. So people have faith in the system.

We are trying to get a more efficient health system. You were head of the PM&C in the era when governments actually set a national health agenda. It is my belief that we do not have a national health agenda anymore, and the health department has become a post office box for Treasury and Finance to provide funding to the states. I would like to see a national health agenda, and have the states fund it to achieve that national health agenda. Can I put that to you?

Mr Menadue—I agree, we do not have a health agenda, and the changes we see are incremental. I do not think we are addressing some of the fundamental questions that we face. If I could just mention it, in New Matilda we will be putting online shortly an alternative national health policy for Australia which I hope will influence the agenda for the key issues that we need to address. Universality will be a key, but I think universality needs to be looked at differently in light of the growing incomes and changes that have been occurring in Australia.

Medicare was very largely about the financing of health services. What we do need to look at increasingly is the delivery of the health service, because we do have a health system which is almost at the end of its design life. If you look at our workforce problems, the Commonwealth-state problems, our quality and safety issues, the delivery system is not working as well as it should, and the Commonwealth-state problem is clear. So a health policy needs to draw together not only the financing of health care but also the delivery of health care, and that has not occurred in Australia. The debate has invariably been about how we fund it. What do we do about bulk-billing or putting dental into the universal Medicare system? We have neglected the delivery side, where our major inefficiencies are at present.

CHAIR—When you say 'we' have neglected it, are you speaking collectively or saying we the federal government have neglected it? I think we the government have not neglected it, that we have left it to the states.

Mr Menadue—I meant that we collectively, as Australians, have neglected the delivery side.

Ms HALL—I think the chairman highlighted the problem with health in Australia. He said, 'I don't think we, the Commonwealth, have caused the problem, I think the states have.'

CHAIR—I did not say that.

Ms HALL—Yes, you did. That highlights the problem with the Commonwealth-state relationship: the Commonwealth blames the states; the states blame the Commonwealth.

CHAIR—I said we the Commonwealth have walked away from it.

Ms HALL—And you threw it at the states. Anyway, I want to pick up on what you were talking about with co-payments, Medicare reaching the end of its life and, at the same time, looking at how co-payments—and I agree, people do need to take more responsibility for their own health—can act as a barrier to certain individuals receiving health care. I would like you to explain to me how a model based on co-payments would ensure that there was an equitable delivery of service to all people in the community, and that we would not move towards a US style health system.

Mr Menadue—What I am suggesting would not take us down the US system, which is based on private insurance—

Ms HALL—But explain it to me, so I understand your model.

Mr Menadue—The problem with co-payments at the moment is that they are inconsistent. There is a co-payment for pharmaceuticals. It is a quite significant one, but it is adjusted for income purposes or particular types of members of the community. There is a gap or a co-payment for hospital services for most people, again depending on income. There is bulk-billing for individuals, whereby they can get free services. At New Matilda, we are still working on how that co-payment could best work, but I am confident it is possible to do that without prejudicing the position of low-income people in Australia. The case I make is that well-to-do Australians can pay more for their health care than they are at the present time. I believe the way to do that is not through private health insurance; it is through co-payments.

As I said, we are working out, and will have on our site soon, how those co-payments can be introduced to make people more responsible for their health decisions but at the same time not prejudice the position of low-income people in access to services. We will probably bulk up the co-payments so that individuals would pay the first, say, $500 of their health expenditure each year. After that, there would be a graduation. We are still working out the detail of it, but I think the co-payment is an important way to go. I have not always felt this way, but we are becoming so much wealthier in this country that most of us—not all of us, but most of us—can afford to pay more.

Ms HALL—You have the two extremes.

Mr Menadue—Yes.

Ms HALL—The other issue that really gained my attention in your submission is the one around the workforce and the need to develop a different approach. Do you think that in Australia we need an overall health workforce plan? If so, could you give me an idea of what should be included or how that plan should be developed?

Mr Menadue—I think the change will probably be incremental, rather than part of a grand scheme. I have mentioned in my paper areas in which demarcations could be broken down. I mentioned particularly midwifery and obstetrics. One example which is being piloted in the United Kingdom is the development of what is called a 'generic health practitioner', which covers in general practice and, to some degree, in hospitals, the job descriptions of senior nurses, junior doctors and registrars. So there is a broadbanding of those skills, with appropriate training, so that there is this new category of worker, not split ones as we have with different demarcations in Australia and elsewhere. That is the sort of thing which we need. We need upskilling and broadbanding of skills in our workforce. There is the possibility of strong opposition to it on the grounds of safety and quality.

Ms HALL—I am sure.

Mr Menadue—But I believe that in the health field, with primary care, it is the central issue that we need to address to improve the delivery side of our health services.

CHAIR—Is resistance to it both in the private and the public hospitals?

Mr Menadue—Yes. And, frankly, not just in the professions but in the unions as well. That is my experience.

Ms HALL—There is definitely resistance among the professions because professionals think of themselves as doctors, nurses, social workers, occupational therapists, and it often impacts on the way they work together as teams. How do you feel about increasing the role of nurses and nurse practitioners? That is getting right into that demarcation area. Doctors will accept practice nurses, but what about the idea of nurse practitioners?

Mr Menadue—It is an area which needs to be dramatically expanded, both in general practice in the community and in hospitals. There have been some improvements, but the changes that have occurred across Australia have been really quite marginal. That is a major area of potential expansion. In general practice, nurse practitioners could be in screening and in prescription, and in hospitals they could do triage and screening.

There needs to be a major expansion and recognition of the role of nurses in Australia. Nurses hold our hospitals together. There is no doubt in the world they hold hospitals together. There are all the other individuals with their specialist skills, but nurses—with binder twine and wire—hold the hospital system together. They are the core of our health system in this country, but they do not get proper recognition. Their careers are extremely limited. The best nurses invariably leave; they go into the professions; they go into teaching, into academic work or into

administration. They cannot find an adequate outlet for their career and adequate opportunities in the health system, and I think that is a major waste, individually and socially.

Ms HALL—Did you pick up on the article by Dr Ross Kerridge? I think it was in the *Sydney Morning Herald*. He is at John Hunter Hospital. He was arguing very strongly that the nurse is the key person within the team and the person who should basically head up every team in a hospital. Within the current environment where, in many areas in Australia, there is a chronic doctor shortage, that role of nurses could be expanded to go out into the community. Would you agree with that sort of a model?

Mr Menadue—I am very cautious about the suggestions that have been made that we have a shortage of doctors in Australia. We have a shortage of doctors to do the roles they are performing now. But if the role of nurses, the division of responsibilities between others were to be changed, if people could work more as teams rather than as individuals, I think there would be a very significant improvement in the quality and the amount of health care services that we had available. The last thing we want, in expanding the numbers in health care, is to do the same things in the same way we have done them for the last 50 years.

Ms HALL—I agree.

Mr Menadue—That is what worries me. In Queensland, for example, and recently with the Commonwealth government, more money has been provided for doctors places. Maybe as a short term measure it is necessary, but it is not addressing the fundamental question, which is that we need to change the whole structure of our health workforce and not have people doing the same things in the same way.

Ms HALL—And that is exactly what I was trying to get at there. Rather than having more doctors, you could get nurses out doing some of those functions, maybe like the nurses in the UK who undertake those sorts of roles.

Mr Menadue—And some of the paramedics in Australia in the ambulance systems are extraordinarily good.

Ms HALL—Definitely.

Mr Menadue—I know that if I had a heart attack I would rather go to a paramedic than to a GP. We have very capable people in these areas, and they should be used more effectively.

CHAIR—In the same circumstances, I would rather go to a public hospital than a private hospital.

Ms HALL—It is changing the concept that we have of delivery of health services. And it is thinking back to what you were saying about Medicare and changing the way that that functions, your provider numbers, the MBS numbers that you can charge under, and the whole concept. Is that what you were getting at?

Mr Menadue—I am a strong believer in a universal system. I think you have probably gathered that. But the case I am making is that the way we fund it could be changed. But I think

that the key is a universal system. I am very worried, as you would have probably gathered from what I have said, about the growth of private health insurance. It is undermining cost controls in Australia, and pushing up our costs. But my own view is that it would be possible, by focusing on primary care in the community and establishing clinics—wellness and sickness clinics—out in the community, staffed by multidisciplined people. That is the way to build teamwork and to build new functions into the health service. It would be a great pity if we developed primary care and then brought into that new architecture of primary care the old work practices. When we establish that new architecture, hopefully, the primary care clinics in the community would bring a new workforce structure.

Ms HALL—Could you expand on the wellness clinics and link that into the responsibility that people have for their own health care needs?

Mr Menadue—I do not think there is an inconsistency in having within the one clinic the preventive area—preventive screening, dieticians, checks, screening and so on—as well as the handling of sickness—wounds, flu, colds and aches and pains. I think it is possible to put them both together in the one clinic, and I think as a result you would get a much greater emphasis on prevention than we do at the moment, because it has increasingly happened that there is very little that the GP is able to do, with time and pressures, to help on the prevention public health side. It is usually left to another program, by the state government, to handle that. If it is all contained within the one clinic, I think we would get much better service provided to the patient.

Ms HALL—So that is getting around that fragmentation?

Mr Menadue—Yes, with multidisciplinary teams. I remember that friends of mine who were in health clinics in South Australia back in the late seventies left for various reasons—political reasons, philosophical reasons or they did not like it. I said to them, ‘If these clinics could be re-established on a better basis than they were previously, would you like to work there again?’ They all said yes. I asked why. They said, ‘We worked as a team.’ I think that is an important attraction for professional people—that they are not isolated in a general practice of one or two people but are part of a multidisciplinary team. That brings great professional satisfaction.

CHAIR—That was the old community health centre program that the government of the day had.

Mr Menadue—I think we have learnt some lessons about how not to do it from the past, but I think that is the way to go.

CHAIR—This committee will report by the end of the year, but later on it might be useful to have a roundtable with different people proposing the different models, through the chair. We could have that at a public forum, perhaps in Canberra, before we wind this inquiry up. Thank you for coming today. I am sure when the other members of the committee read the transcript they will value your contribution as much as I do.

Mr Menadue—Regarding the document that I tabled, to what extent could I use that for media purposes?

CHAIR—That is a public document. It is now covered by parliamentary privilege.

Mr Menadue—So I can distribute it?

CHAIR—Yes. It will be on our website.

[11.56 pm]

ARMSTRONG, Ms Fiona, Member of Executive, Australian Health Care Reform Alliance; and Federal Professional Officer, Australian Nursing Federation

KIDD, Professor Michael Richard, Member of Executive, Australian Health Care Reform Alliance

KORCZAK, Ms Viola, Member of Executive, Australian Health Care Reform Alliance

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Kidd—I am also the President of the Royal Australian College of General Practitioners.

Ms Korczak—I am also a health policy officer with the Australian Consumers Association.

CHAIR—I am required to tell you that although the committee does not require you to speak under oath you should remember that these hearings are a formal proceeding of the Commonwealth parliament. Giving false or misleading evidence to the committee is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement.

Prof. Kidd—Thank you very much for the opportunity given to the Australian Healthcare Reform Alliance to address the committee. The Australian Healthcare Reform Alliance is an independent alliance of 46 consumer, clinician and academic organisations. We are working together to help introduce urgently needed reforms to improve Australia's health system so that it better meets the needs of all people in Australia. The alliance is the largest organisation committed to health reform in Australia. I think you have tabled a list of all the organisations which are involved with the alliance. It involves many of the major consumer and clinician organisations in the country. The alliance welcomes this opportunity to contribute to this inquiry on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest quality health care to all people in Australia.

In this introductory statement, we will be responding on behalf of the members of the alliance to each of the five terms of reference in the inquiry. This response is based on the position statements developed by the members of the alliance at our national forum held last November and submitted at that time to the Council of Australian Governments. The full papers are available on our website at www.healthreform.org.au. The vision of the alliance, similar to this inquiry, is that our nation's health system assists individuals to be healthy and delivers compassionate and quality care to all. The alliance has six agreed principles. These are based on access, primary health care, community engagement, equitable outcomes, workforce and efficiency. The alliance members believe we need reform to ensure integration of health care. The alliance also has a special focus on rural, remote and Indigenous health issues.

The alliance believes the following features must underpin Australia's health system: universal access by all people in Australia in a timely fashion to an appropriate service because of health needs and not because of one's ability to pay; equity of health outcomes, irrespective of socioeconomic status, race, cultural background, disability, mental illness, age, gender or location. Health care services must be focused on the needs of patients and their carers and the needs of Australians wishing to avoid illness. Health promotion, including both preventing disease and maintaining health, must be appropriately emphasised and balanced with our duty of care to those already unwell.

Personal and corporate tax contributions should fund our health care. This is the way we wish to provide health insurance to each other. A fair balance of public and private resources and investment is needed to ensure equitable health outcomes for all Australians. The health outcomes of Aboriginal and Torres Strait Islander Australians must be improved so that they match those of other Australians. Health services must be appropriate, safe and of high quality. The community, especially consumers and carers, must play an integral part in the development, planning and implementation of our health services. This nation's health workforce must be valued and appropriately supported. Finally, our health system should be one that assists individuals to stay healthy and one that delivers compassionate and quality health care to all when and where required.

In response to the first of this inquiry's terms of reference: we believe that equity of access and equity of health outcomes is essential. The alliance firmly believes the jurisdictional inefficiencies associated with the Australian and state governments being responsible for different segments of our health care system have produced a major problem. Solutions for this problem have been sought for at least the last 20 years. The current arrangements are now widely recognised as a serious impediment to the delivery of quality, equitable and cost-effective health care. They represent a major historical mistake and, were we to design a health care system from scratch, we should not make the same mistake again.

The Australian government is a purchaser of health care for Australians but has little capacity to tie health expenditure to health outcomes. State and territory governments are providers of services that are partially supported by grants from the Australian government. The lack of integration of the programs organised by state and federal governments is resulting in an unfortunate and costly amount of duplication and inflation within the health care sector and a lack of capacity to focus on patients' needs. This is particularly problematic when there is a requirement for a horizontal integration of the services required by individuals and communities.

The inefficiencies under discussion are responsible for poorer health outcomes than would otherwise be the case. Many problems are related to the provision of health care across state boundaries and difficulty in promoting the essential partnership required in Australia between public and private sector providers of health care. The current arguments fuelled a disturbing culture of antagonism between state and federal authorities rather than the collaboration, partnership and mutual trust needed to continuously improve the health of Australians.

There is no quick fix to our current problems. However, in order to take the vital first step to health reform, the alliance recommends the establishment of a national health reform council, reporting directly to COAG, to oversee vital reforms to funding and health service delivery mechanisms. A national health reform council would be responsible for many of the reforms

necessary so that our health care resources provide more of a wellness model and the fusion of state and federal programs. The alliance believes this could be done in partnership with consumers and clinicians led by a chief executive officer and staffed by experienced bureaucrats from existing health departments and committees.

The alliance believes an urgent response from government is required to meet the immediate needs of the Australian health workforce. This requires the allocation of substantial additional funded places to the higher and vocational education sectors as well as the introduction of improved strategies for entry, retention and re-entry to the health workforce.

Additional funding to address the appalling health outcomes of Indigenous Australians is urgently required. Governments must acknowledge that improving the health of Aboriginal and Torres Strait Islander people requires national leadership, engagement with Indigenous communities, investment in infrastructure, jobs, housing, education, water and additional resources for health services. Emphasis should also be placed on increasing the number of Indigenous Australians trained to care for Aboriginal and Torres Strait Islander communities.

Health care systems must be built on a partnership between the Australian community and consumers. Health policy must be grounded in and measured against community values, and changes to the health care system must be developed in consultation with the Australian community to ensure that they are well informed and ready to embrace change.

The health needs of rural and remote Australians require support if they are to share equitable health outcomes with their urban counterparts, as their access to health services is limited by geography and the availability of health care professionals. Health infrastructure in rural and remote areas must be maintained and those populations must have access to Medicare funded services. Therefore, there is a need for additional scholarships to enable students from rural backgrounds to study medicine, nursing, pharmacy and allied health courses.

In response to the second of this inquiry’s terms of reference: one of the most urgent reforms requires reducing the current hospital-centric approach to health care. Health care in Australia is overly hospital-centric. We have more hospital beds per capita than any other country. Continuing to focus the funding of health care on hospitals is counterproductive. Integration of state and federal programs is urgently required and could be assisted with the development of agreements between Australian governments around specific programs. Examples could include the integration of primary and community care services, the integration of cross-border programs to solve current inefficiency and the fusion of numerous state and federal programs all aimed at improving the care of older Australians.

Whatever we do needs to be within the context of wider population health needs and the addressing of social determinants of health. New models need to support delivery of primary care, especially to populations that experience access difficulties, and such models need to have community ownership and control. In this context, the alliance supports the examination of new models of integrated primary care provision, with state and federal government cooperation featuring a team medicine approach. Primary care needs to be part of any reforms. Advances in primary care could provide us with the better capacity for health promotion, the prevention of avoidable decease, early intervention to minimise the onset of chronic disease and the capacity for clinicians to care for more people in a community and home setting rather than hospital.

In response to the third of this inquiry's terms of reference: the current division of state and Commonwealth funding results in dysfunctional care, a clear example of which currently occurs in aged care. Poor integration results in the inappropriate and inefficient situation where many elderly people are going into public hospital beds because of a relative lack of aged care facilities and nursing home places. The situation is exacerbated by the lack of liaison and cohesion between the public and private sectors. The alliance believes that strong primary care is the only way we will be able to contain rising health costs, meet the needs of our ageing population and take pressure off our acute care hospitals and emergency departments. Primary care is the most effective way of managing the epidemics of chronic diseases and cancers as well as addressing the rise in mental health problems. These approaches will facilitate a primary health care system where individuals can maximise their own health, reduce the epidemic of disease, minimise health-care costs and ultimately improve the health, wellbeing and productivity of the population.

Professor Gavin Mooney has said in his report to the alliance that it has been estimated that more than $1 billion per annum is wasted through the duplication of services that results from the state-Commonwealth split in health care. More savings could be made with a national electronic health record system operating across all health systems. It is estimated that allowing access to a consumer's health records and relevant information on diagnosis, treatment and medication could eliminate duplication of diagnostic tests alone, with estimated savings of around $56 million a year.

In response to the fourth of this inquiry's terms of reference: positive relationships are important, and our alliance is an example of a model of a positive partnership that works. The partnership that the alliance advocates between federal and state and territory governments must also be supported by efforts to promote and evaluate partnerships between the private and public sector deliverers of health care to ensure the delivery of equitable and high-quality care where it is needed. As I have said, the alliance has been advised that almost $3 billion of taxpayers' money spent on private health insurance has not resulted in relieving pressure on the public hospital system.

In response to the final of this inquiry's terms of reference: it is the view of the alliance that paying 30 per cent or more of the cost of an individual's private health insurance represents poor policy and bad economics. We are advised that it creates an impost on the Treasury soon to reach $3 billion a year. Australians re-embraced private health insurance only with the introduction of whole-of-life rating scales and the rebate but this has not achieved the aim of taking pressure off public hospitals. Rather, the increased activity observable in private hospitals appears to be supplier induced demand.

We thank you for the opportunity to make this statement to the inquiry. We are happy to respond to your questions but we ask you to note that we represent only three of the 46 member organisations which make up the alliance. Some of our responses will reflect our own backgrounds and the views of our organisations, and we may need to take some questions on notice if we are to reflect the view of all members of the alliance on a specific issue.

CHAIR—Thank you. It would be a very dull world if everybody agreed with each other, so it is no wonder that what you are saying will not be universally accepted within your organisation. I am sure that a lot of things I say are not universally accepted in the parliament.

Ms HALL—I think you might be right.

CHAIR—Would anyone else like to make a contribution as an opening statement? I would like to hear from the nursing profession as well.

Ms Armstrong—I am happy to take questions.

CHAIR—We are looking at how to get more value out of the health dollar. The usual request from the states is: ‘Give us more money.’ The usual request from everybody is: ‘Give us more money.’ But evidence that we have been hearing in this inquiry is that there are so many inefficiencies in the system that we are not using the money that is given to health by the Commonwealth or states in such a way as to get the maximum benefit for the patient. A figure is thrown about—and we have no verification or empirical evidence; I suppose at best it would be a guesstimate—that only about 20c in the health dollar gets through to the patient. If that is the case, we think it should be much better than that. That is what this committee is looking at. COAG, as you know, is going through a process of health reform. Have you had an input to the COAG process?

Prof. Kidd—Yes, we have.

Ms Armstrong—We have. We have made a submission to COAG, based on—

CHAIR—What was the outcome of that? Did you get a response?

Prof. Kidd—Prior to the COAG meeting in November last year, we invited all the health ministers and presented our viewpoint to those who turned up, which was almost all of them. We have not had a lot of response back since that time, although we know that many of the principles which the alliance is built on—the principles of access, primary health care, community engagement, equitable outcomes and about workforce inefficiency—are very much on the COAG agenda.

CHAIR—And a lot of other people’s agendas as well.

Prof. Kidd—Absolutely.

CHAIR—You might have heard Mr Menadue speaking about virtually the same agenda. My concern in this whole thing is that the Commonwealth over the years has adopted a position of the Commonwealth health department being a post office between Treasury and the states. The role of government in setting a national health agenda has just not been there. Tony Abbott, in considering the renegotiation of the health care agreements, is hinting at funding the states on a performance basis so that, instead of just giving a bucket of money to the states to run their public hospitals, there would be a national agenda set and the states would be funded to achieve that national agenda. Do you have a view on that?

Ms Armstrong—Certainly we would be in favour of improving the accountability of how health dollars are spent, and I think on that basis I can speak for not only my own organisation but the alliance. Many of the principles that we espouse in the alliance are focused on the efficient and transparent use of health funding to achieve sound health outcomes for Australians.

So certainly improving the transparency with regard to how health dollars from all sources are spent would be welcome.

Ms HALL—I will add to what the chair has just put to you. Yesterday we heard how, with a $50,000 grant to the health system, $10,000 of that $50,000 is spent on administration. Do you think that linking money that is given to the states and organisations could actually lead to that administrative burden and a greater amount of money being spent on accountability, meeting those outcomes and making sure that the paperwork meets the criteria, rather than ensuring that the people get the services?

CHAIR—The red-tape burden.

Ms HALL—Yes, the red-tape burden. I think it is horrific that $10,000 out of $50,000 that is given to an area health service for health is spent on—

CHAIR—Compliance costs.

Ms HALL—compliance processes.

Ms Armstrong—One of the reasons that we advocate the establishment of a national health reform council to oversee the types of reform agendas that we are proposing is to minimise the duplication that is associated with the current administration, and hopefully that would improve efficiency significantly in that regard.

Ms HALL—Can you give us some good examples of duplication?

Prof. Kidd—From general practice? As we have mentioned, whenever our patients move from general practice into hospitals, when they cross a boundary in our health care system if you like, from a community hospital, private to public, inefficiencies travel with them. Often their medical details, their personal health information, does not travel with them. Often tests that have been carried out in the community are duplicated when people arrive in hospital. Expensive investigations may be duplicated. People may be discharged back into our care without relevant important information being transferred. Therefore, we may see people who subsequently get sick again because they have not had the proper follow-up which they required after discharge, and they manage to go back into hospital again. So the inefficiencies run across the system.

Ms HALL—Why does that happen? Identify the actual problem.

Prof. Kidd—Why it happens in part, and I think John Menadue alluded to this, is the problem with health information not travelling with the patients—so the lack of easy and simple access to information about our patients in different parts of the health care setting.

Ms HALL—Solution?

Prof. Kidd—Electronic health records are obviously part of the solution, but it is the solution which we are working towards. However, just a simple change in the culture within our health care setting would do—for example, a change in the culture in our hospitals that it is important that discharge information is sent to the people who are going to be providing care for someone

once they are back in the community, and therefore that is given a priority. At the moment, it is not given a priority in our health care setting. Similarly, a change of culture on the community side as well—when somebody is admitted to hospital, it is absolutely essential that all the critical information is provided.

CHAIR—I will give an example. Are you talking about the fact that a patient has a blood test and, as the result of the blood test, the GP says, ‘You should go to hospital,’ and puts him into hospital and the person then goes straight in and has another blood test?

Prof. Kidd—Precisely. Sometimes we get fed back that the hospital casualty department does not have a high degree of confidence in the private laboratory where the original blood test has been carried out, even though the results are sitting there in front of them, or that for medico-legal purposes it is important for the hospital itself to have carried out that test before instituting treatment on a particular patient. All of our laboratories are accredited towards the same set of standards, whether they are public or private, across Australia.

CHAIR—Is that legal issue a problem? Do you think it is a top-of-the-mind issue when a patient is admitted?

Prof. Kidd—That is probably a question you would have to put to people who are working in emergency departments. I find it a source of frustration where I have carried out a test on a patient, and as a result of that have sent them in and the same tests are repeated. Personally, I cannot understand it.

Ms Armstrong—I think poor integration also occurs because of the difference in funding sources. We see that in community care, where you have state and federal funded services that are providing the same sorts of services, but at different levels or different components of a similar service—that kind of thing. It is very inefficient.

Ms Korczak—One example that was recently cited was a small hospital in Victoria that had 47 different funding streams. That illustrates the problem.

Ms HALL—That is the sort of information I was trying to get.

Prof. Kidd—The compliance problems with individual government grants for running your health service can be enormous and time consuming. They take essential attention away from working with your patients and your local community. Your staff are focusing on dotting i’s and crossing t’s in order to meet the requirements of a large number of different contracts for the different contractual requirements. It is a real headache and a real problem, and it especially affects, for example, many of the Aboriginal health services, who get multiple grants.

Ms HALL—So you are identifying fragmentation here.

Prof. Kidd—Absolutely. If we could move to a system of experimenting with some pooling of funding to some of those services, so it is a single contract—‘Here is the money’—there would be more of a focus on looking at the health outcomes. At the moment we are not judged on the health outcomes; we are judged on our efficiency in meeting what is in a contract.

CHAIR—I think I know what pooling means and Jill certainly does know what it means, but for laypeople reading this transcript could you explain how pooling would work, Commonwealth and state? At the moment hospitals are funded through the health care agreements, fifty-fifty Commonwealth/state, but then 50 per cent of state government funding comes from the GST or other federal funding, so we are looking at 75 per cent of hospitals being funded by the Commonwealth.

Ms HALL—Although some of us dispute of those figures.

CHAIR—Okay. How would pooling work?

Prof. Kidd—We are not advocating pooling for the entire health care system but we are saying, 'Let's have a look at some of these areas.'

CHAIR—I think the Labor Party were, weren't they, at the last election?

Ms HALL—Yes—a very similar model.

Prof. Kidd—We are looking particularly at those communities and those services where we have communities which are underserved and which are getting funding from multiple sources. Can we look at a simple way of pooling the funding there so it is a single arrangement to assist those people to provide the service that the community needs?

Ms Armstrong—That would be funding from both federal and state sources and administered from a single entity.

Ms Korczak—That would obviously reduce administrative costs as well.

Prof. Kidd—And the compliance burden on the people running the service.

Ms Armstrong—And the fragmentation because they would be required to deliver the entire range of health services.

CHAIR—So there would be more money going to the patient rather than being wasted in administration?

Ms Armstrong—That is what we would hope, definitely.

CHAIR—As I have said, that is what this inquiry is about. You might have heard me mention that we will probably do a roundtable of people who have different views on different models later on, before the end of the year, before we report. We could invite you to be a part of that roundtable in Canberra.

Prof. Kidd—We would welcome the opportunity.

Ms HALL—I would like a comment on workforce issues. Would you like to give us your thoughts in that area?

CHAIR—Bearing in mind what Mr Menadue said, that we might not have a workforce shortage of doctors if other reforms—

Ms HALL—We must not direct them.

CHAIR—Why not? I would like their comments on what he said.

Ms Armstrong—One of the most important principles espoused by the alliance is to address the sustainability of a safe and effective workforce in Australia. There are enormous shortages in the health workforce in medicine, nursing and allied health professions. One of the most urgent reforms required, we believe, is to dramatically increase the health workforce. One of the other problems with the health workforce is the poor geographic distribution affecting the health outcomes of people living in rural and remote areas, and also the absence of sufficient numbers of adequately trained Indigenous Australians to care for their own communities. But certainly we would like to see far greater investment into the education of health professionals to deliver the care that is required to meet the health needs of all Australians.

Ms HALL—Could you pick up on what the chair was saying about shortages and a breakdown of the demarcation that exists at the moment, looking at an expanded role for nurses and other allied health professionals and not just the doctor shortage?

Prof. Kidd—The background paper which has been provided to you provides a lot of the statements on the primary care models which the alliance would like to see explored. They are very much based on team approaches to providing health care to communities and—as was said by the previous speaker—combining the wellness model with providing care to those who are currently ill.

The alliance welcomed the Productivity Commission carrying out a review of the workforce. We believe it is important that our workforce is valued and supported, and that is not the case for many of the groups within the Australian health care workforce. We believe that there is a need for an increase in training places for our workforce. There is a need for an increase in training places specifically for those from rural backgrounds and for those of Aboriginal and Torres Strait Islander backgrounds. We need to be doing a lot of work here.

I think that all the organisations involved in the alliance can see that there are areas where we could be much more efficient in the way that we use the health care workforce that we currently have. But we do have very serious shortages, and they are going to get worse as our population grows and ages and as the need for continuing care continues.

Ms Korczak—It is also an issue of equity and access. As Fiona outlined, the real shortages are in the rural and remote areas, but they are also in the urban areas. Obviously we do need to train more doctors and nurses in allied health to ensure equitable access for all people living in Australia.

Ms Armstrong—We already have those acute shortages. These are not in the future; they exist right now and they are affecting the ability of health professionals to deliver quality care.

Ms HALL—I think that all members of this committee would acknowledge that, don't you, Mr Chair?

CHAIR—I certainly do, and we know that no matter how much money you were to put on the table today, you would not get one professional for at least five years. The problem is immediate, but the outcomes are down the track. Have you got any further questions?

Ms HALL—We probably need to move on.

CHAIR—We do have to move on. We will be in touch about the possibility of conducting a roundtable. Thank you very much for your comprehensive submission and for the evidence you have given us today.

[12.27 pm]

SCOTTON, Dr Richard, AO, Private capacity

CHAIR—Welcome, Dr Scotton. You are a well-known health economists and one of the architects of the original Medibank, of Medicare and of our current health system.

Dr Scotton—I appear as a very much retired professorial fellow in health economics at Monash University.

CHAIR—You would have heard me saying before that the committee does not require you to speak under oath. These are proceedings of the Commonwealth parliament, and the giving of false or misleading evidence is a matter which may be regarded as a contempt of parliament. I am required to say that. I invite you to speak to your paper and model. Also I would ask you: would you be available at a later time to take part in a roundtable with all the different proponents of the different models that we will be looking at?

Dr Scotton—On some other occasion, not at a later time.

CHAIR—No. Before the end of the year.

Dr Scotton—Yes, I would be. I must say that I now speak very much as an observer rather than as an active researcher, which puts me two stages removed from what is going on in the health system at this stage. I would make the general comment to start with that we have got much to be happy about in the performance of our health system in relation to the quality of care and the access of the population to it. We are very much in line with other advanced developed countries in Western Europe, and our system is very largely our version of a common, universal, publicly administered program.

One of the worries that we have had is the steadily increasing cost of health care over the years as a percentage of GDP. This seems to be quite similar to our European peers. In 40 years we have gone up from five per cent to 10 per cent of GDP, and I think there are a number of things yet to affect us. In recent years our percentage has tended to rise just a little bit faster than that of our European peers and that may be something to do with ageing. I note the long-term Treasury projections that in 40 years we are heading up to 15 or perhaps 18 per cent of GDP. That is not necessarily a disaster. We have to keep in mind that the other 85 per cent is 85 per cent of a very much larger GDP than we have now, so it does not exclude the expansion of our consumption of a whole lot of other things. It does mean that there is a policy imperative, I think, to try to improve the efficiency of the health care system in terms of the resources that we use to achieve our ends. As an economist, I think that comes immediately to mind as an objective. That is really one of the major objectives of the model that I produced some years ago. I have given you my little diagram of that, which I will talk about.

If we are trying to achieve greater efficiency, I think that it is very important to do several things. Firstly, it is important to cut administrative complexity. At the moment we have a welter of different programs to deliver different pieces of health care and we have the divided

responsibility between the Commonwealth and the states and the public and private sectors. There are constant tensions along these lines, so the first objective is to cut administrative complexity.

I think that the second objective is to increase efficiency—and I speak here as an economist—to which the classical remedy is to have some increased degree of market competition as a way of exercising constraint in the use of resources to achieve the given ends. The question is: how can we achieve these without sacrificing quality of care and access? The radical solution that I have been talking about for some years as an ideal model—and I will talk a bit further about it today—is managed competition. To some extent this may be regarded as an academic luxury but, even if it is, there is also some value in knowing where we might like to be, because then we can judge when proposals come up whether they push us towards or away from that direction.

I do not know whether you have seen a recent paper by Andrew Podger, the retired secretary of the Department of Health and Ageing, a very interesting contribution, I believe, and I imagine that certainly would have come to your notice. It is very good to see a retired administrator of such calibre coming out and putting forward a model for the future. I thought that I would just speak about the model—and I presume you have that little paper.

It is designed to produce an administrative rationalisation within the public sector and an arrangement in which competition can take place inside the system to produce improved health as well as administrative efficiency. What we see basically in the top part is that the Commonwealth has a major role in this, but its role is discharged by distributing adjusted capitation payments; that is, it is now possible through the administrative records of the experience of people in a universal program to obtain health profiles and actually do what insurance companies would normally do—classify the risks and put people in risk groups for which the average experience can be determined. These can even be done with computers now at the individual level. So each person in fact can be allocated to a risk class and the Commonwealth money can be distributed to budget holders, who are then at risk for the purchase of services. They take the full responsibility for the delivery of services for people who enrol with them either as public or private budget holders, and they then have the responsibility of contracting with providers for the provision of those services in a quasi-market situation.

That has the benefit of taking away at the budget holder level any possibility of trying to pick good risks and trying to exclude bad risks, because there is not much money attached to good risks—all the money is attached to bad risks and all the savings, one might assume, if one were to look for efficiency, would be in better servicing of the people in high-risk groups.

That allows for a public and private system, it allows for consumer choice and I think it provides for incentives through the market for those holding the budgets to get the best deals and to do things which in fact maximise the achievement of better health for their populations, and to do that in a market environment. It does it with enormous flexibility.

One of the best examples that I can think of in this program would be the combination of all the health programs into a single bundle and not having separate pharmaceutical and medical benefits, hospitals, nursing homes and so on. You would want to allow the maximum of substitutability between services to allow the budget holders to have a very great incentive to do things in the most efficient way. An example of what they might do for people who we might

classify as potential nursing home patients is that they would get the money that would correspond to the risk of say the people in that age group being 30 per cent probability of admission to nursing home. There would be a very strong incentive to do things that would cut that down to 25 per cent to keep people out of nursing homes at the margin, which would be to the benefit of themselves but also to individuals, by contracting to provide them with services in the home or elsewhere—even, if you like, extending to paying a relative to look after them. If you can do that in a poor household, instead of paying the full cost of sending them into a nursing home, it is a win-win situation all over.

The idea is that the budget holders would have total responsibility, subject, of course, to assessment of outcomes of their population, which could be fairly reasonably measured. In other words, they would be economising but they could be judged with a computerised system in terms of the health status they produce. There are a variety of innovative things that might be done at the budget holder and provider level. It would be a very flexible sort of arrangement.

A lot of the economic progress we have had in recent years in all our countries has been a greater move to market solutions for things—where people find markets. There is real room for market solutions in a publicly funded universal health program—for market incentives to work in terms of looking for lower cost ways of managing the health care of people. These can be monitored, as we do now, to ensure that these are not done to the detriment to the health of the population.

This is a system which I think leads to efficiency in every sense—efficiency in the purely market sense of getting more done for a lower cost by a better and more efficient product mix, but also incentives to improve health. It is a big step. Utopias are quite useful sorts of things to think about because they do give you some idea of where you might like to be. It is really a model. That was in a sense the apex, the unifying idea, of my academic career. I am purely and simply an academic. I am an academic economists in particular. I dabbled in health administration at both the Commonwealth and the state level. I had a bit of time involved in actual administration.

There are obviously all sorts of administrative, constitutional and other obstacles to moving along this path, but I think there is some value in knowing where you would like to be, even if that is some sort of measuring rod when things come up to determine which step is a step forward and which one is a step back. We do have potentially in the longer term a very serious problem with health costs going to 15 per cent or 18 per cent of GDP. It is a good idea to think well ahead of what you might do to put some sort of brake on that, because there may well come a time when the rising demand for resources for health care may start to impinge on other areas of great value to our society. That, of course, is the economic issue. The idea of just being able to improvise—put more money and resources in, patch up here and patch up there—may get us in the longer term into a situation that we would very much like to avoid.

CHAIR—You are really proposing what I would call a national health agenda—

Ms HALL—Based on competition.

CHAIR—Well, with a component of competition.

Dr Scotton—There is internal competition. It is based on the Commonwealth taking responsibility for the whole lot but devolving that by a formula which incorporates incentives to efficiency, both in the sense of efficient resource use in the health care sector and market efficiency—doing things in the least cost way—and devolving that responsibility. The Commonwealth takes over but it does not get into the service delivery area at all. It devolves the control over service delivery to others—to a lower level where it can be managed.

Ms HALL—The states do the same sorts of things. They put their money into—

Dr Scotton—The Commonwealth does not give the states any more money—

Ms HALL—The states then put their money into the same system.

CHAIR—How does your model differ from Andrew Podger's? Jill and I went to a Melbourne Institute lunch where they debated the four models. Yours was one of them. I think Andrew Podger's was more the big bang theory—do it overnight. People were suggesting that you were going to arrive at the same place but with a softer landing.

Dr Scotton—I think Andrew thinks that mine is a big bang.

CHAIR—I might have it the wrong way around.

Dr Scotton—I think one could devise a staged implementation, and I have done that, but it is a major restructure of everything.

Ms HALL—Yes, yours was the big bang.

Dr Scotton—I thought Andrew's paper was extremely insightful. He thinks that what he wants might well be a stage along the way to this sort of proposal. It may well be. Certainly, some sort of staging is required. Health is going to be, whatever we do, a very much larger proportion of our economy, even though that economy is larger, and I think efficiency is going to be increasingly important. This offers some sort of way of managing that and there is some value in knowing where you would like to be, even if at the moment you cannot think of any precise way of getting there.

CHAIR—Things change over time, including people's views. We gain something called wisdom over the years. If someone had said to you in 1972 that health expenditure would be 18 per cent of GDP, you would not have believed them. That was at a time when government was proposing to fund it with a 1.25 per cent levy on taxable income. When I came into parliament 16 years ago I think it was 1.5 per cent of taxable income, but the actual health expenditure was 11 per cent of the total budget. So it was not 1.5 per cent of government revenue; that was only income tax.

Dr Scotton—It also assumed basically the same contribution from Commonwealth revenue. It was explicit in part of our original proposal that the amount of the Medicare levy should be tied to the increase in the federal cost of health care. Treasury do not like that sort of thing; they like to have elbow room to make up their budget on an annual basis. They were the ones that saw to it that that was not incorporated, but we specifically had a health insurance fund to run this. The

proposal was that the Medicare levy would constitute half the funding of that, it would grow over time and its growth over time would be a signal both to government and to taxpayers that health care costs were rising and that thought might be given to doing something about that. That was in the back of our minds.

CHAIR—It was still all Commonwealth revenue but the taxable income contribution has virtually stayed the same—1.25 to 1.35 to 1.5 per cent.

Ms HALL—I would like to express my concerns about your model, and you can reassure me. I am very much of the view that health dollars should be spent on health. That is one of the big issues as far as I am concerned. In your model the taxes are collected through Treasury, then it goes to the health department, then it goes to the Health Insurance Commission and then it goes to the budget holders. I presume it would be competitive tendering?

Dr Scotton—Some would be public and some would be private—they would be quite large organisations.

Ms HALL—I understand that. I do not doubt that they would be responsible organisations. You have got state taxes to state governments and—

Dr Scotton—Yes.

Ms HALL—My little concern is that it is passing through all these different bodies along the way and everywhere it stops off you lose money, and there is more money spent on administration—

CHAIR—And overhead costs.

Ms HALL—Yes. My first concern when I look at the model is that there is going to be a lot of wastage along the way. You are going to lose dollars until it gets to the budget holders, who then give it to the providers, who then utilise it for the benefit of the consumers. Can you assure me that that is not going to be the case?

Dr Scotton—I see no reason why this would have a larger administrative component than what we have now.

Ms HALL—Every time it passes through someone's hands you lose some of the dollars, don't you?

Dr Scotton—This would all be done basically in a big computerised exercise. You could see the budget holders and the federal administration of this as just being something like Medicare as it is now. It would be performing something of the same function, but the budget holders would have total responsibility for meeting the health costs of a specific population, and meeting global health costs. The efficiencies would be that they do not get something for hospital and something for medical and something for pharmaceutical; they get a sum which they have to use in the most efficient manner, in whatever mix—

CHAIR—What role has the health department, at the top of the chart, got in determining the outputs of the providers—where the providers spend the money? The debate at the moment that concerns a lot of us at the Commonwealth level is due to the blame game between the Commonwealth and the states. We blame the states and they blame us. The Commonwealth say that under the heath care agreements we pay half, the state pays half and that we have no say in where the money is spent. We are told: 'Go and mind your own business. Don't you worry about that! We've got the money, we'll provide the services.' We know that there are problems in the services but we get the blame with absolutely no say. In this model, how would the health department pursue this national agenda?

Dr Scotton—The budget holders have a devolved responsibility for all health services delivered to a defined population whose health care use—and health status, for that matter—can be evaluated. They are looking after defined populations and it—

Ms HALL—The Commonwealth and state would not have a role other than putting the money into the budget holders.

Dr Scotton—Yes. Here is the budget holder, here is the risk mix of your population. If you have got a lot more people in the older age brackets, you will get money that is the assessed expected expenditure that they would have; and, if you get a lot of healthy young singles, you can virtually get no money at all. And that can be done now through a thing called HCGs, health cost groups. It is possible, by analysis of utilisation data, to put people into categories and to pay the budget holders by a differential related to the risk of the population that they are looking after.

Ms HALL—'Leakages' was one of the words I was thinking of when I looked at this. Another thing that concerns me when you say that the budget holders would fund the whole of the health costs for an individual is that they would be in a position to influence the clinical care, the medical care, that an individual received, rather than the clinician or the health professional who was working with that person. The budget holder may say, 'Okay, you've got $1,000 for this', and the clinician may say, 'Actually, there may be $1,000 for this but we are looking at the individual and we see that they need $1,500 for this, as opposed to the $1,000 for that.' How would you deal with that under your model?

Dr Scotton—I think the budget holders would not be involved in clinical decisions at all—

Ms HALL—No, that is right, but funding—

Dr Scotton—any more than a private health insurer would be.

Ms HALL—This is managed competition and the managed care model would probably fit very nicely into the managed competition model—

Dr Scotton—It could amount to that.

Ms HALL—which then has those other concerns; that is when the other concerns kick in.

Dr Scotton—Somewhere down the line, some cost considerations have to kick in. But, on the other hand, when you have a defined population, it is actually possible to monitor the health outcomes. Because you would have a budget holder responsible for all the health care received by a population, the health outcomes of that population could be monitored and in the longer term that might come into the remuneration arrangements.

Our problem now is that hospital money goes here, doctors' money goes there and there are umpteen different ways in which money goes around for the treatment of an individual patient. There is no particular necessary overall responsibility, particularly for the people who have major long-term chronic health problems, yet these are the people who incur the great bulk of the costs. Having someone responsible for the whole of their health care would give them a very strong incentive to see that this was managed in an effective way.

Ms HALL—I see the plainness of your model.

Dr Scotton—It is a nice model, I think.

Ms HALL—But I see some weaknesses, too.

CHAIR—Were you here during John Menadue's evidence?

Dr Scotton—Only the last part of it, and I was sitting right up the back.

CHAIR—He did say that he felt that the way the private sector, private hospitals, work at present is putting cost pressures on the health system through private health insurance. Is that a correct interpretation, Jill?

Ms HALL—He had a problem with the way the private health insurance rebate worked and the way private health insurance—

CHAIR—was pushing up health costs.

Ms HALL—Yes; he felt that it was driving demand; that would be a way of putting it, wouldn't it? He felt that it was leading to increased expectations, which in turn led to increased demands, which in turn leads to increased costs et cetera.

Dr Scotton—The private hospitals sector is a sort of uncapped sector and, yes, that is a weakness. That we break up the money and say 'Here's hospital money for hospitals and medical money for medicals and pharmaceutical money for pharmaceuticals' is really not, system-wise, an efficient way of doing things. I think paying for the total care of a population and leaving somebody at a lower level in relation to a defined smaller population is a way that this system can be brought under a degree of control.

Ms HALL—Yes. He claims the subsidy boosts private health insurance. He says that the current system cannot be sustained, that the subsidy is geared towards the wealthy, that it has not taken the pressure off private hospitals; and that private health insurance funds undermine the role of Medicare, which seeks to contain costs through its buying power in the market. He says

that the evidence is clear that encouraging private health insurance leads to escalating costs. I did not give you his quote.

Dr Scotton—I think there is a problem with the subsidy arrangements. I do believe that you have a universal system which provides to everybody the expected cost of treatment in the public program, that benefit goes to everyone and after that, if people want optional extras of all kinds, they pay with their own money. The only control on private insurance can really be a private market. What little extra cost will people bear out of their own pockets that will sustain a private health sector? That is a market solution.

CHAIR—With a third of the income of the health funds coming from the government in the form of the rebate.

Dr Scotton—But from the government's point of view, if everybody gets their due to cover them for something at the level of the cost of treatment in public provision, what happens after that?

CHAIR—It does not matter.

Dr Scotton—Is it purely a private matter for the market to determine?

Ms HALL—Good food for thought.

CHAIR—Thanks for making the time available to come and appear before us. We are still trying to get ourselves around all the models being debated and on offer. We will think about it when we have organised that roundtable. It will be a very interesting debate with all the different proponents putting their views.

Dr Scotton—I am very pleased that Andrew has come out with a model. Having been an administrator, it is much closer to practicability than this one. But I think there is a real use in having some idea of where you would like to be, because then you at least know when things come up whether that is going in that direction or in the opposite direction. We know that in the real world things tend to be incremental. At least you can know whether your increments are pointing to where you would like them to be or away from that, and that gives you some sort of measuring rod to judge things by.

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

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

Committee adjourned at 1.03 pm