The Senate

Select Committee on Health

Second interim report

June 2015

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Terms of Reference

That a select committee, to be known as the Select Committee on Health, be established to inquire into and report on health policy, administration and expenditure, with particular reference to:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
d. the interaction between elements of the health system, including between aged care and health care;
e. improvements in the provision of health services, including Indigenous health and rural health;
f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
g. health workforce planning; and
h. any related matters.

Acronyms and abbreviations

ACEM	Australasian College of Emergency Medicine
AHCRA	Australian Healthcare Reform Alliance
AHHA	Australian Healthcare and Hospitals Association
AMA	Australian Medical Association
ANMF	Australian Nurses and Midwifery Federation
APA	Australian Paramedics Association
BEACH	Bettering the Evaluation and Care of Health
CEO	Chief Executive Officer
COAG	Council of Australian Governments
GDP	Gross Domestic Product
GPET	General Practice Training
GP	General Practice
GPs	General Practitioners
HGPA	Hunter General Practitioners Association
MBS	Medicare Benefits Scheme
MRFF	Medical Research Future Fund
NACCHO	National Aboriginal Community Controlled Health Organisation
NHRA	National Health Reform Agreement
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Records
PGPPP	Prevocational General Practice Placement Program
PHAA	Public Health Association of Australia
PIP	Practice Incentives Programme (After Hours Payment)
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
VicHealth	Victorian Health Promotion Foundation

Executive Summary

This interim report is the second of a series in which the Senate Select Committee on Health proposes to report its findings and conclusions to date. The first interim report, tabled on 2 December 2014, is available from the committee's website.[1]

Primary healthcare is the foundation of Australia's health system and general practitioners (GPs)—often referred to as the 'gatekeepers' of the system—are the principal point of contact for most Australians. GPs play a critical role in providing chronic disease management, preventative health advice, diagnosis and referral to other important areas of the health system, including allied health and mental healthcare.

Budget 2015-16: ongoing impact of the indexation freeze

Whilst the initial proposition for an upfront $7 co-payment has been abandoned, the four year freeze on indexation of Medicare fees for all services provided by GPs, medical specialists, allied health practitioners, optometrists and others remains. The indexation freeze is likely to be felt even more acutely, especially for vulnerable patients.

Department of Health figures released through a Freedom of Information request by *The Australian* show that the government's decision will have a $1.3 billion impact on Medicare rebates for GP services.[2]

As the Australian Medical Association (AMA) and others have argued there is an inevitability that these costs will be passed onto patients seeing an increase in out-of-pocket costs and a reduction in levels of bulk billing.

The AMA President, Associate Professor Brian Owler, explained that this measure is 'a freeze for the patient's rebate. It is not about the doctor's income. It is actually about the patient's rebate and their access to services.'[3]

Dr Stephen Parnis, Vice President of the AMA, told the committee that the indexation freeze was 'a co-payment by stealth':

> …irrespective of the model of business that you adopt, when the government component of contribution is fixed at zero per cent while all of the other overheads continue to rise, that means the margin there will

1 Senate Select Committee on Health, *First Interim Report*, 2 December 2014, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First_Interim_Report.

2 Freedom of Information Request, Mr Sean Parnell, Health and FOI Editor, *The Australian* to Department of Health, 27 April 2015, p. 1.

3 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

> diminish. If one is a practice that exclusively bulk bills, it will not take long before that impacts. Inevitably doctors will have to make decisions to change the way in which they bill—effectively, asking patients to make a contribution where the government is not. We believe that bulk billing rates will diminish.[4]

Research undertaken by the University of Sydney indicates that the indexation freeze would cost GPs $384.32 in 2017-18 per 100 consultations, requiring an $8.43 co-payment per non-concessional patient consultation. The research also shows that the total estimated loss in rebate income to GPs would be $603.85 in 2017-18 per 100 consultations which equates to a reduction of 11.2 per cent.[5]

Dr Parnis told the committee that the indexation freeze would raise costs for primary healthcare and push patients into under-funded public hospitals:

> Medicare rebates for most consultations and operations will not change for almost six years. Even if indexation comes back in on 1 July 2018, the effects of the freeze will be felt forevermore because of the compounding effect. This will increase out-of-pocket costs for private medical care and force more people to seek care in the public sector. But the likelihood of them receiving timely care and treatment will be diminished by the squeeze on funding flowing from the Commonwealth.[6]

Unprecedented response from GPs

As indicated in the committee's first interim report, the health sector was concerned by the lack of consultation and evidence that preceded the Abbott Government targeting GPs for budget savings in the 2014-15 Budget. GPs' and health consumers' fears were further realised at the government's December 2014 decision to penalise short medical consultation times and the introduction of a $5 co-payment.

Associate Professor Owler told the committee that the announcement of the short consultations policy came as a 'complete surprise':

> …again we found out 20 minutes before the announcement was made. In fact, I was in the United States in Chicago, in my hotel room, when the phone rang from the minister stating that these were the changes about to be made.[7]

Although the policies were announced just prior to the Christmas break, the political action of the GP networks was unprecedented.

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4 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 2.

5 Christopher Harrison, Clare Bayram, Graeme C Miller, Helena C Britt, , 'The cost of freezing general practice', *Medical Journal of Australia*, 10 March 2015, www.mja.com.au/journal/2015/202/6/cost-freezing-general-practice?0=ip_login_no_cache%3D2711da5acfee8a84b8bbb5566569664a.

6 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 1.

7 Associate Professor Brian Owler, President, Australian Medical Association, *Committee Hansard*, 5 February 2015, p. 3.

The feelings of Australians were made clear in support for the Royal Australian College of General Practitioners (RACGP) *You've Been Targeted Campaign*, part of which was an online petition which collected over 44 000 signatures in less than a week.[8]

Cost-effective healthcare

According to the RACGP, around two and a half million Australians visit their GP each week.[9] The RACGP argued that while hospital costs rise, general practice costs are stable, confirming general practice as both cost-effective and efficient:

> Primary healthcare services are the most cost-effective part of the health sector. They can reduce healthcare costs through chronic disease management and health service integration, decreasing emergency department presentations and preventable hospital admissions.[10]

The Australian Healthcare Reform Alliance (AHCRA) agreed, noting that:

> The total cost of GP services is less than 7% of the total health budget – a relatively small slice of the pie. International research shows that countries with stronger and more easily accessible primary care systems have better overall health status at lower costs.[11]

Clearly, any policy which negatively impacts upon GPs will have a magnified impact on the local community. Despite the arguments of the RACGP, AHCRA, health economists, and public health community advocates, the government continues to produce policy that is at odds with the evidence given by experts in Australia's primary healthcare system.

Ms Jenny Johnson, Chief Executive Officer of the Rural Doctors Association of Australia (RDAA), explained the significant value that GPs provide, particularly in rural communities:

> …a rural doctor who is working in his or her general practice will also most likely be providing visiting medical officer services to the local hospital. They will probably be providing mental health services and counselling, they will be teaching medical students and they will be providing after-hours and emergency services. They may be providing more advanced procedural services… [If] a rural practice is forced to close or it loses a doctor because of economic circumstances, then that will flow onto the

8 Ms Sophie Scott, 'Medicare Changes: How doctors' anger and backlash from patients forced Government to scrap rebate cuts', *ABC News Online*,15 January 2015, www.abc.net.au/news/2015-01-15/why-the-unpopular-medicare-rebate-changes-had-to-be-scrapped/6019314.

9 RACGP, 'Family Doctors acknowledged internationally as foundation of healthy communities', Media Release, 19 May 2015.

10 RACGP, *Submission 115*, p. 2.

11 AHCRA, 'Government still tunnelling away to undermine universal health care', Media Release, 14 December 2014.

> local hospital, which will have less doctors to fill its after-hours rosters and to provide emergency and secondary care. This in turn will compromise the ability of communities to access after-hours services. It will lead to a downgrading of services in the hospital and then we get into that awful downward spiral.[12]

Ms Johnson's evidence reveals the intimate systems connections between primary health and the hospital setting.

Hospital funding cuts of more than $57 billion from the 2014-15 Budget continue, with resulting cuts to state government budgets, for example:

- $17.7 billion cut from Victorian Government health budget[13]
- $11.8 billion cut from Queensland Government health budget[14]
- Over $1 billion cut from South Australian Government health budget[15]

The committee will focus on the impact of these cuts throughout the rest of the year and produce another interim report in due course.

Healthcare sector responses

Since its first interim report the Select Committee on Health has held 19 public hearings across Australia. During its extensive and transparent consultations with stakeholders, the committee has heard of the widespread concerns for Australia's healthcare system resulting from the Abbott Government's health policy omnishambles.

Fiscally driven

Peak groups have argued that the government's single-minded focus on cutting the health budget and ignoring expert advice from health economists, has created policies which will damage Australia's primary healthcare system. Associate Professor Owler told the committee:

> I think the proposals that have been made, as I have said, have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of

12 Ms Jenny Johnson, Chief Executive Officer, RDAA, *Committee Hansard*, 5 February 2015, p. 17.

13 Ms Jean Edwards, 'Budget 2015: Victoria blasts Abbott Government of health cuts', *ABC News Online*, 13 May 2015, www.abc.net.au/news/2015-05-13/victoria-blasts-abbott-government-over-budget-health-cuts/6467526.

14 Ms Melinda Howells, 'Budget 2015: Queensland Premier Annastacia Palaszczuk says no job cuts to health', *ABC News Online*, 13 May 2015, www.abc.net.au/news/2015-05-13/palaszczuk-no-job-cuts-to-health-despite-cameron-dick-comments/6466908.

15 Mr Steve Archer, Deputy Chief Executive, Finance and Corporate Services, Department for Health and Ageing South Australia, *Committee Hansard*, 11 June 2015, p. 20.

> health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system better.[16]

Witnesses told the committee that the government's policy changes were ideologically-driven fiscal measures rather than policies to improve health outcomes. The AMA argued that:

> …one of the reasons we are in this mess in the first place is that the changes that were flagged were always designed as fiscal measures, they were never viewed through the prism of health policy and I think that has been the failing of both sets of policies.[17]

> …whoever is in government or whoever is Prime Minister needs to consult with the profession and go away from being driven only by personal assertions and ideology and get back to looking at evidence and data.[18]

Other areas of concern

Ms Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association (AHHA) outlined the impact cuts to Flexible Funds will have on frontline services:

> The flexible funds are used to support a whole range of programs and organisations that deliver services to people across the Australian community, including prevention type services and also chronic disease management, drug and alcohol treatment, mental health services and the like. Because they are largely delivered into the primary care sector, one of the important contributions that they make is reducing some of what might be preventable hospitalisations. That is very important not only for the health of the community but also for the sustainability of funding in the health system overall.
>
> Ad hoc cuts in flexible funds will damage individuals, will damage organisations and potentially will increase the burden on the hospitals.[19]

Dr Morton Rawlin, Vice President of the RACGP told the committee that the scrapping of the Medicare Healthy Kids Check was another example of the Abbott Government acting without consultation:

> The scrapping of the Healthy Kids Check health assessment was surprising and unfortunate. The assessment aims to improve health outcomes for Australian children by detecting health, hearing, speech, language and behavioural issues at an early stage. Part of the value of the health assessment items, apart from providing an appropriate patient rebate for the

16 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 7.

17 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 4.

18 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 6.

19 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 22.

> work involved, was that it allowed members of the general practice team, practice nurses and Aboriginal health workers to contribute to the assessments supporting multidisciplinary practice within primary care. The general consultation items do not currently support this kind of teamwork or the non-face-to-face time often required to conduct a quality health assessment. If there are identified issues with the Healthy Kids Check, as the government stated, we would expect a discussion to find solutions rather than scrapping the items with no consultation or discussion.[20]

Committee's second interim report

Given the fluid and uncertain nature of the government's current policy priorities for primary healthcare and general practice, the committee is using its second interim report to record rather than make recommendations. It is clear from the government announcements since the 2014 Budget that the Abbott Government has no long-term strategic policy plan for positive healthcare reform in Australia. The committee, in conducting its comprehensive and public hearings, has created a transparent forum for public debate on healthcare policy which the government has failed to provide.

20 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 8.

Chapter 1

Introduction

1.1 On 25 June 2014, the Senate established the Senate Select Committee on Health.[1] The final reporting date for the committee is 20 June 2016. The committee's resolution allows the committee to make interim reports such as this one.

Public hearings

1.2 The committee has completed 34 public hearings to date (a full list of hearings is at Appendix 1).

1.3 Through its extensive program of public hearings, the committee has taken evidence from many health experts, practitioners, consumers and communities. The public hearing program has also enabled the committee to engage the wider Australian community, including those in rural and regional areas which may not normally be able to directly engage with a Senate Committee.

1.4 As part of its program of hearings, the committee conducted a week-long series of hearings and site visits in northern Australia between 27 April and 1 May 2015 visiting:

- Darwin (NT)
- Halls Creek (WA)
- Kununurra (WA)
- Katherine (NT)
- Galiwin'ku, Elcho Island (NT)
- Mount Isa (QLD)
- Cloncurry (QLD)

1.5 The hearing and visits program allowed the committee to focus on Indigenous health issues, as well as access to primary healthcare in rural and remote communities. The evidence received by the committee has contributed to this second interim report. Later in 2015 the committee will address in detail the issues raised in relation to Indigenous health in a separate, third interim report.

Submissions

1.6 The committee has received 149 submissions since the beginning of its inquiry (a full list of submissions is at Appendix 2).[2]

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1 *Journals of the Senate*, 25 June 2014, pp 996–998.

2 The submissions received by the committee can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

1.7 While the committee is still accepting general submissions, it is the committee's intention to seek submissions on specific topics as the need arises over the course of the inquiry.

1.8 Additional information, tabled documents, correspondence and answers to questions on notice received by the committee to date are listed at Appendix 3.

Health Select Committee's first interim report

1.9 The committee's first interim report was tabled on 2 December 2014.[3] That report detailed the committee's findings and conclusions to date, focussing on issues raised during the committee's hearings and through submissions. Key areas of focus for the committee in its first report were:

- the government's proposed patient co-payments, cuts to hospital funding and the abolition of Australian National Preventative Health Agency;
- the government's plan to close the 61 Medicare Locals and replace them with 30 Primary Health Networks; and
- the merger of the Organ and Tissue Authority and the National Blood Authority.

Structure of this report

1.10 This interim report is the second of a series with which the committee proposes to report on its findings and conclusions to date. The committee's terms of reference are wide-ranging and it is the committee's intention to explore various issues in depth over the course of its inquiry. This second report will outline the evidence received to date regarding the government's primary healthcare and general practice policies, and in particular the report will be a record of the government's frequent changes of policy since the 2014 Budget. Following this introductory chapter the report is divided into four subsequent chapters:

- the vital importance of general practice and primary healthcare and the threat posed by the government's numerous policy changes since the 2014 Budget (Chapter 2);
- the responses of GPs and the primary healthcare sector to the government's various primary care policies (Chapter 3);
- an examination of the 2015-16 Budget's health measures and commentary from stakeholders (Chapter 4); and
- Related issues which have been raised in the committee's public hearings (Chapter 5).

1.11 The committee notes that Government Senators will table a dissenting report at a later date.

1.12 Given the fluid and uncertain nature of the government's current policy priorities for primary healthcare and general practice, the committee has decided not make recommendations as part of this interim report. Committee observations are

3 *Journals of the Senate*, 2 December 2014, p. 1948.

provided throughout the report, however the committee reserves its recommendations at this stage.

Future inquiries

1.13 The committee's terms of reference are broad and encompass many aspects of the Australian healthcare system. While the evidence heard by the committee to date has primarily focused on the effect of the government's disorganised primary health policy development, the committee has also been able to examine other major areas in healthcare. These have included:

- issues in Indigenous healthcare and funding;
- hospital funding – in particular the effect of the decision in the 2014 Budget to cut $57 billion from hospital funding;
- the closure of Medicare Locals and the transition to Primary Health Networks; and
- mental health and frontline services.

1.14 The committee has also heard evidence about the economics of healthcare, including:

- the economic benefits of funding primary healthcare and preventative healthcare;
- Australian spending on healthcare as percentage of GDP in comparison to other countries;
- sustainability of government spending on health and Medicare; and
- alternative models for funding healthcare systems, including international comparisons with New Zealand, Canada, the United States and the United Kingdom.

1.15 The committee believes these are issues which need further scrutiny, particular as some – such as Indigenous healthcare and mental health – have been negatively impacted by the government's 2015 Budget. The committee will use its future interim reports to examine these issues in more detail.

1.16 During the second half of 2015 the committee will also conduct public hearings on a number of other relevant topics:

- Australia's response to the Ebola crisis;
- the proposed privatisation of Australian Hearing and the National Acoustics Laboratories; and
- the National Mental Health Commission's report into mental health services and the government's response.

Notes on references

1.17 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to the committee Hansards are to the proof transcripts.[4]

Acknowledgements

1.18 The committee thanks the many organisations and individuals that made written submissions, and those who gave evidence at the public hearings to date.

1.19 The committee also thanks the city councils, health services, communities and community organisations who have hosted public hearings and site visits.

4 Committee Hansards can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

Chapter 2

Importance of General Practice and Primary Healthcare

Introduction

2.1 Speaking at the AMA National Conference on 29 May 2015, Associate Professor Owler spoke of general practice as the cornerstone of primary healthcare. Associate Professor Owler told Health Minister the Hon Sussan Ley MP and the Opposition health spokesperson Ms Catherine King MP that investment in general practice was vital for healthcare in Australia:

> "We need investment in general practice. With investment, GPs will continue their work in providing world class, patient-centred care."
>
> He [A/Professor Brian Owler] appealed directly to Health Minister Sussan Ley and Labor's health spokesperson Catherine King to address the task of rebuilding general practice.
>
> "So Minister Ley and shadow minister King, I say to both of you, if you want to improve care and drive lasting change in the health of all Australians, don't waste your money on fragmenting care in other settings.
>
> Invest in general practice – general practice will deliver for you."[1]

2.2 The RACGP President, Dr Frank R Jones, made a similar statement in response to the health measures in the 2015-16 Budget:

> GPs see more than 80% of Australia's population every year and are the most cost-efficient pillar of the healthcare system so it makes sense to invest in general practice. Investment in primary healthcare will produce long term health savings and better outcomes for patients.[2]

2.3 From a rural perspective, Ms Jenny Johnson, Chief Executive Officer of the RDAA, told the committee that GPs are often at the heart of a rural community. Any policy which negatively affects GPs will have a magnified impact on the local community:

> Detrimental impacts on rural practices will also flow onto other healthcare services in rural communities. I think this is an issue that is largely ignored. Rural doctors traditionally provide a range of primary and secondary care services and some tertiary care services. For example, a rural doctor who is working in his or her general practice will also most likely be providing visiting medical officer services to the local hospital. They will probably be providing mental health services and counselling, they will be teaching

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1 Ms Julie Lambert, 'We will overturn the indexation freeze: AMA vow', *Medical Observer*, 29 May 2015, www.medicalobserver.com.au/news/we-will-overturn-indexation-freeze-ama-vow.

2 RACGP, 'Budget delivers mixed bag for general practice', Media Release, 12 May 2015.

> medical students and they will be providing after-hours and emergency services. They may be providing more advanced procedural services… if a rural practice is forced to close or it loses a doctor because of economic circumstances, then that will flow onto the local hospital, which will have less doctors to fill its after-hours rosters and to provide emergency and secondary care. This in turn will compromise the ability of communities to access after-hours services. It will lead to a downgrading of services in the hospital and then we get into that awful downward spiral.[3]

2.4 The sentiments expressed by the AMA, RACGP, and RDAA are similar to those the committee has heard throughout its inquiry. Throughout more than 30 hearings, witnesses have emphasised the central importance and effectiveness of general practice and the importance of access to primary healthcare for providing:

- better health outcomes;
- cost-effective healthcare; and
- more responsive healthcare than acute care.

2.5 The committee has heard consistent arguments for a primary healthcare model which recognises that GPs at the centre of an integrated healthcare system, working for the patient's best interests with allied health practitioners, specialists and acute care. This chapter records the evidence presented to the committee regarding the need for general practice to be at the centre of primary healthcare.

2.6 Further, as part of its report, both in this chapter and Chapter 3, the committee notes the evidence it has received regarding the risks to general practice and primary healthcare from the government's numerous policy changes (from 2014-15 Budget to the current Budget). Witnesses and submitters have told the committee clearly that without an emphasis on primary care in healthcare policy they fear for the:

- viability of general practice;
- increased inefficiencies in the health sector; and
- loss of opportunity to improve health policy outcomes.

Effectiveness of general practice in healthcare

2.7 The *Bettering the Evaluation and Care of Health* (BEACH) study is a long running study of general practice conducted by the Family Medicine Research Centre, at the University of Sydney. It is unique internationally for its examination of general practice including patient encounters and treatments. Findings from the 2013-14 BEACH study included that:

> General practice and primary care represent the interface between complex (and expensive) health care services and the wider community. Australian general practice can reasonably claim to represent world best practice in terms of both cost and patient outcomes… There is ample evidence that

3 Ms Jenny Johnson, CEO, RDAA, *Committee Hansard*, 5 February 2015, p. 17.

> preventive and primary care services that are patient-focussed rather than disease-focussed provide the most cost effective health outcomes for those individuals and communities.[4]

2.8 Although primary healthcare is the most efficient part of the healthcare system, there are already a number of reasons that Australians avoid going to see their GP. According to the *2013-14 Patient Experience Survey* conducted by the Australian Bureau of Statistics, cost is a significant barrier to accessing healthcare. At a national level, the *2013-14 Patient Experience Survey* showed that:

- One in twenty (4.9 per cent) people who needed to see a GP delayed or did not go because of the cost;
- One in twelve (7.9 per cent) who needed to see a medical specialist delayed or did not go because of the cost; and
- Of the one in seven (14.3 per cent) people who had visited an emergency department for their own health in the previous 12 months, one in five (21.6 per cent) thought the care could have been provided by a GP.[5]

2.9 The RACGP noted that hospital admissions are a major driver of Australian healthcare costs. Figure 1 below, taken from the RACGP submission, shows the comparison between rising hospital costs and the relatively stable costs for general practice. The RACGP submission argues that:

> Primary healthcare services are the most cost-effective part of the health sector. They can reduce healthcare costs through chronic disease management and health service integration, decreasing emergency department presentations and preventable hospital admissions. Better use of and access to properly resourced general practices will reduce hospital expenditure and stress on the system.[6]

2.10 The AHCRA noted that for the cost of primary healthcare, it is exceptionally efficient:

> The total cost of GP services is less than 7% of the total health budget - a relatively small slice of the pie. International research shows that countries with stronger and more easily accessible primary care systems have better overall health status at lower costs.
>
> And in terms of benefit-cost, investment in prevention and early intervention are always the wise choices.[7]

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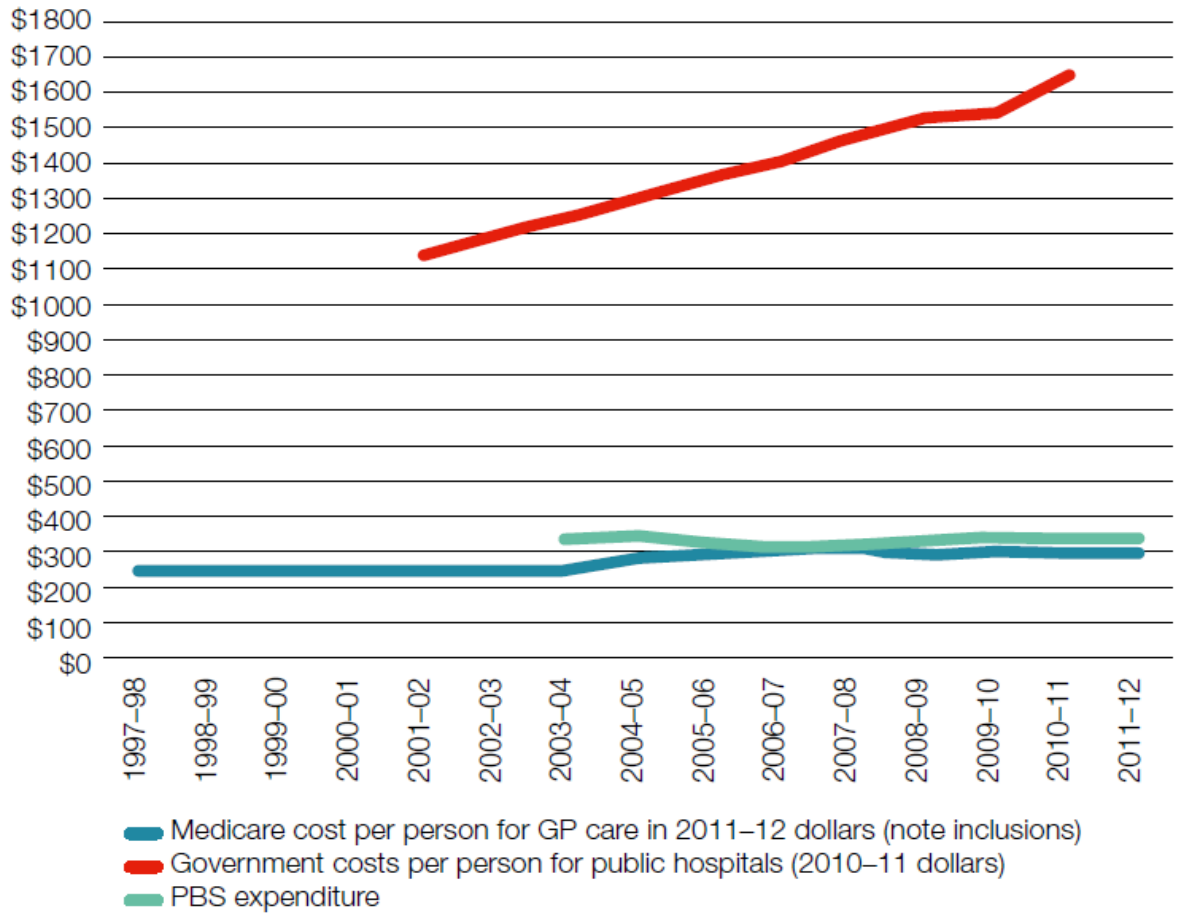
4 General Practice Series Number 36, 'General practice activity in Australia 2013-14', Bettering the Evaluation and Care of Health (BEACH) Study, Family Medicine Research Centre University of Sydney, p. iii.

5 Australian Bureau of Statistics, *4839.0 – Patient Experiences in Australia: Summary of Findings 2013-14*, 28 November 2014, www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0.

6 RACGP, *Submission 115*, p. 2.

7 AHCRA, ' Government still tunnelling away to undermine universal health care', Media Release, 14 December 2014.

Figure 1—Healthcare expenditure between 1997-98 and 2011-12[8]



2.11 Evidence received by the committee of the benefits of primary healthcare, delivered through a model in which GPs are central, is explored below in the following sections:

- better health outcomes;
- cost-effective healthcare; and
- greater responsiveness than acute care.

Better health outcomes for health consumers

2.12 In his submission, Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong detailed a recent UK study which examined the effect that general practice could have on delivering better health outcomes for a community:

> Twenty quality of care indicators were selected by the researchers, each indicator having evidence of mortality reduction. This broad range of activities included items such as influenza vaccination in patients with diabetes, coronary heart disease, stroke or emphysema; treatment of hypertension, diabetes and hypercholesterolaemia; use of beta-blockers in

8 RACGP, *Submission 115*, p. 2.

> patients with coronary disease and other evidence based use of medication in chronic illnesses; and Pap smears.[9]

2.13 The results of the study demonstrated clearly the value of general practice in delivering life-saving primary health interventions to health consumers:

> High performing practices were potentially saving over 300 lives per 100,000 of the population per year from these 20 activities alone (there are many other mortality reducing activities not included in this study). Given that the overall mortality rate for this population is approximately 900 per 100,000 per year, the impact of high functioning general practice on the health of a community is significant (Ashworth, Schofield et al. 2013).[10]

2.14 Ms Ellen Kerrins, the Manager of Advocacy and Policy at the Health Consumers Alliance of South Australia drew the committee's attention to a quote from the Director-General of the World Health Organisation which succinctly summarises the benefits of primary healthcare:

> Decades of experience tell us that primary health care produces better outcomes, at lower costs, and with higher user satisfaction.
>
> … … …
>
> It can prevent much of the disease burden, and it can also prevent people with minor complaints from flooding the emergency wards …[11]

Cost-effective healthcare

2.15 In its submission, the Hunter General Practitioners Association (HGPA) gave a series of examples which highlight the role GPs play in providing cost-effective healthcare:

> It is far more cost effective *(and better for the patient!)* for a GP to both see a patient and administer a joint injection, than for a GP to see a patient and then refer the patient to a specialist for the same joint injection. So why has the MBS item number for GP joint injections been removed?
>
> It is far more cost effective *(and better for the patient!)* for a GP to see and treat early a patient with a skin infection. The alternative is for the same service to be done at the emergency department for a much higher system cost; or for an extraordinarily higher system cost to be imposed if the patient has to be admitted due to a late presentation.
>
> It is far more cost effective *(and better for the patient!)* for a GP to optimise the care of a patient with diabetes and high blood pressure, than for the patient to have a stroke, be hospitalised, undergo months of rehabilitation, and then spend the rest of their life in an aged care facility.

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9 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

10 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

11 Ms Ellen Kerrins, Manager, Advocacy and Policy, Health Consumers Alliance of South Australia, *Committee Hansard*, 11 June 2015, p. 39.

> So why try to deter people from presenting to their GP?
>
> International research shows over and over again that primary care is, when viewed from a "whole-of-system" perspective, the most cost-effective way to deliver health care. (Starfield, 2010)[12]

2.16 The HGPA submission's examples demonstrate the main reasons why GPs are at the forefront of cost-effective primary healthcare:

- improved access to healthcare;
- reduced cost to the overall healthcare system; and
- superior preventative health outcomes.

Access to healthcare

2.17 As primary healthcare is one of the fundamental foundations of the Australian healthcare system, access to general practice for consumers is essential. A strong and properly resourced Medicare system, which provides universal primary healthcare for all Australians, is fundamental to ensuring access to general practice.

2.18 Dr Anne-marie Boxall, Senior Policy Adviser with the National Rural Health Alliance argued that universality—a key aspect of Australia's Medicare system—has been lost in the current healthcare funding debate:

> We have been talking a lot about the impact on patients of the potential changes, which is right, but the potential changes also have a big impact on our health system if they are implemented. One of those is that threat to universality. High bulk-billing rates have been pursued by both sides of government for a long time, and there is a reason for that. It is because it essentially functions as a safety net. Whilst some people may be able to afford to pay more, and they do, through the taxation system, bulk-billing is seen as a universal benefit. So if we are undermining a system and scaling back bulk-billing and making it a targeted system, we then need to be very sure that the safety nets we have in place are effective, and that is something that we are not entirely sure about at the moment, and we have evidence that people are falling through the safety nets.[13]

2.19 Bulk-billing allows equity of access to healthcare, in particular for vulnerable groups and those with chronic illness. Dr Graeme Alexander of the Claremont Village Medical Centre, Tasmania, maintained that the practice of bulk billing was a means to achieving better health outcomes:

> We use bulk billing to get better health outcomes. We might use it to pay part of the cost of an urgent visit eg. Acute Myocardial Infarction, a child with a fractured arm presenting directly from school, improve follow up,

12 Hunter General Practitioners Association, *Submission 123*, p. 2. Original emphasis in italics maintained from submission.

13 Dr Anne-marie Boxall, Senior Policy Adviser, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 44.

> treating those with ongoing chronic illness and also helping those who have troubles handling their finances e.g. mental health patients.[14]

2.20 Dr Con Costa, President of the Doctors' Reform Society, argued that adding barriers to healthcare access, in the form of any price signal, would reverse the gains made since the introduction of Medicare, particularly for lower socio-economic areas in both cities and rural areas:

> Let us be quite clear about what we will lose. We will lose all those gains that we outlined before [Medicare's expansion of GP care to outer urban areas, rural areas, for working people and lower socio-economic areas]. There were very few doctors in the western suburbs. Working people never had a family doctor, and the only women who had pap smears were the women in the inner city. This would come back. People would leave the poorer country towns, for example. There are no hospitals around the poorer country towns, and so where they will go, I do not know. There will be a cost explosion for sure. I am certain there will be a cost explosion, which will need to be covered by the private health funds. And you will lose that control of costs where Medicare bulk-billing is holding back on the whole system.[15]

2.21 Dr Stephen Duckett, Director Health Program, Grattan Institute, told the committee that the debate about Medicare had originally been one regarding the efficiency and equity of a universal scheme. He observed:

> …I am old enough to remember what life was like before Medibank [now known as Medicare] was introduced. Before Medibank was introduced a number of programs were introduced to try to target and introduce special programs for poor people. The reality was, even with special programs for poor people, there were other people who could not afford health care because they fell outside the restricted definitions and restricted mean tests. So the debate about Medibank and Medicare was: is it more efficient and more equitable to introduce a universal scheme so no-one falls through the cracks or should we have schemes where it is possible for people to fall through the cracks? The Australian people have made the decision time and time again that the right way to do it, and in my view demonstrably the efficient way to do it, is a universal scheme.[16]

Reduced cost to the healthcare system

2.22 Regarding cost to the healthcare system, many submitters argued that the better the primary healthcare system, the lower the costs for acute care and the overall health system. For example, Professor Andrew Bonney, Wollongong University, told the committee:

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14 Dr Graeme Alexander, Claremont Medical Village, Tasmania, *Submission 129*, p. 3.

15 Dr Con Costa, President, Doctors Reform Society, *Committee Hansard*, 5 February 2015, p. 75.

16 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

> The first is that internationally we know, and there is no doubt, that jurisdictions with strong primary care also have lower costs and reduced rates of health expenditure increase. At worst, in comparisons among countries in Europe, strong primary care is associated with lower levels of health expenditure increase even if the baseline healthcare costs were higher in the first place. So there is no conflict between seeking to contain costs and improve health outcome, providing that it is recognised that serious policy investment in primary care is the vehicle.[17]

2.23 When announcing the campaign against the government's attempt to introduce a health price signal by co-payment, the RACGP observed that primary healthcare delivers far more for far less than acute care:

> The RACGP believes that the Australian health system is complex and that there are many opportunities for improved efficiency without targeting general practice.
>
> According to Bettering the Evaluation and Care of Health (BEACH) data, the average cost of a patient visit to the GP is $47 as opposed to the emergency department, which can cost as much as $599.
>
> GPs in Australia see approximately 85% of the population annually with referrals to secondary and tertiary care accounting for less than 5–10% of consults. However, in terms of comparative Government spending, general practice and hospital spending represents 15.5% and 84.5% respectively.[18]

Improved health prevention and management

2.24 The Victorian Health Promotion Foundation (VicHealth) stated in its submission that Australia currently invests less in preventative health than most other OECD countries 'with just 1.7 per cent of 2010–11 health spending going towards prevention efforts, or less than 0.2 per cent of GDP.20.'[19] Yet, as VicHealth's submission argues, the economic benefits of investing in preventative health are substantial:

> Conservative estimates in 2008 found that if the prevalence of key risk factors were reduced to realistic targets, it would save $2.3 billion across the lifetime of the adult Australian population. In addition, economic evaluation of the costs and benefits of specific health interventions shows that some can be very cost-effective, and in some cases investment can have cost savings.[20]

17 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Committee Hansard*, 5 February 2015, p. 25.

18 Networking Health Victoria, 'RACGP releases information sheet on co-payment and rebate freeze', Media release, 14 January 2015.

19 VicHealth, *Submission 80*, p. 5.

20 VicHealth, *Submission 80*, p. 5.

2.25 Professor Andrew Bonney, University of Wollongong, argued that primary care provided by GPs is the most effective method for delivery of preventative healthcare:

> Primary care provides first access to medical care for the whole of the population – young, old, male and female. In the course of that care a relationship with a practice is formed and from this ongoing person-focused care opportunities arise for preventive activities such as checking blood pressure or screening for diabetes or Pap smears. This is all part of a comprehensive range of care provided at a practice. Where chronic disease has developed, continuity and co-ordination of care improves chronic disease management and secondary preventive activities. This includes reaching targets for diabetes, blood pressure and cholesterol level control; as well as appropriate immunisations. Unnecessary and avoidable hospitalisations are prevented and patient satisfaction, trust and compliance are higher. The net result over time is improved health outcomes at lower costs, demonstrated by international research (Starfield, Shi et al. 2005).[21]

2.26 Dr Stephen Duckett, the Director of the Health Program at the Grattan Institute, noted that there are national and international studies showing that better access to primary health results in improved preventative health rates and better health management. With general practice being recognised as the most efficient level of the healthcare system, internationally the trend is towards improving access and encouraging health consumers to visit general practice:

> Certainly we know that, if you have out-of-pocket costs, people defer visits to doctors. We also know that, if you have out-of-pocket costs and people defer a visit to a doctor, the patient cannot make a judgement about what is necessary care and what is unnecessary care; so they end up missing out on necessary care as well. And there have been a number of overseas studies which have shown that. There has been a major study which has assessed the impact of co-payments… Generally, the overseas policy direction is not to have financial barriers in general practice. The whole international direction of health policy is to try to strengthen general practice, to try to strengthen primary care because this is the most efficient level of the health system. I am not saying that general practice or primary care is perfectly organised in Australia at the moment and, indeed, I do not believe it is. I think there need to be changes, but the changes you need to make are not forcing the consumer to drive all the change in primary care when they are people who just do not know what is necessary care and what is not necessary care.[22]

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21 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

22 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

2.27 Similarly, Associate Professor Owler, told the committee that in primary healthcare 'the first step when someone has a problem is the key to prevention and the key to chronic disease management. That is not where we want a price signal.'[23]

2.28 The government's previous policy of $7 and $5 co-payments as a price signal on GP visits drew much criticism for the potential negative effects on preventative health and management of chronic conditions. Organisations such as the Doctors' Reform Society of Australia argued that GPs must be the ones to decide if medical care is needed. The submission advocates for minimum barriers to a person's decision to seek medical advice:

> We doctors want patients to see us with what they might think could be trivial complaints because we know it can save lives. The indigestion which is really a heart attack, the blood in the faeces which could be piles but could be completely curable bowel cancer, the small ulcer in a diabetic which if ignored leads to gangrene and amputation, the mild/moderate depression which could progress to suicide. Let doctors be the judges of how trivial the problem is. That is why we are expensively and highly trained. Patients aren't, whether rich or poor.[24]

2.29 Dr Emil Djakic, a GP from Ulverstone, Tasmania, told the committee that his experience was that Australians understood the role GPs have in preventative health. Dr Djakic felt that this attitude was reflected in part in the increase in GP visits. He observed:

> The last point I would like to make in my introduction is clearly the role of GPs over this past 30 years has moved into a space that I do not think people predicted, and that is significant involvement in prevention. Some simple statistics I can look at in my municipality: in 1991 when I first appeared as a registrar in my patch, the population of Ulverstone and Penguin, which were two separate municipalities, was about 19½ thousand. Those populations are now about 22,000. In that period of time, my practice, when I was training there, saw about 85 people or 85 contacts a day. The number of practices in the area has not changed, but the doctor numbers have. Recently, in this same population, my practices are now seeing 300 people a day.[25]

2.30 In concluding his opening remarks Dr Djakic echoed the sentiments of other witnesses at previous hearings:

> So I see us in a grave situation of disenfranchising the very sector of the healthcare system that is the highest value… if we want to aspire to the very best health for Australians, then we need to be investing in primary care, not divesting in primary care.[26]

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23 Associate Professor Brian Owler, President, AMA, *Committee Hansard,* 5 February 2015, p. 6.

24 Doctors Reform Society of Australia, *Supplementary Submission 85,* p. 2.

25 Dr Emil Djakic, Ulverstone GP, *Committee Hansard,* 17 April 2015, p. 26.

26 Dr Emil Djakic, Ulverstone GP, *Committee Hansard,* 17 April 2015, p. 26.

More responsive than acute care

2.31 The Australasian College of Emergency Medicine (ACEM) is well placed to provide comment on the differences between primary and acute care. Dr Anthony Cross, President of the ACEM, told the committee that the problem for acute care was with treating patients whose conditions were preventable:

> We work in emergency. But so much of what we see is preventable. If it were not for alcohol, tobacco, speed—as in driving fast—there would be work for three or four emergency physicians in Australia. I am exaggerating. I am sorry. But we would be very pleased to see that. The burden of preventable disease that we see is dramatic, all throughout the health system. So of course, yes, anything to improve primary and preventative care we would be supporting 100 per cent. This is where you get the bang for your buck in health care.[27]

2.32 Acute care is aimed at treating emergencies, not chronic and ongoing conditions, as Dr Simon Judkins, Victorian Councillor, ACEM, noted. Dr Judkins told the committee that patients who chose the emergency department over the GP due to increased cost would not be able to receive the ongoing care and management they required:

> …we do not need anything to encourage patients to come to us to access care because we do not provide good GP type of care for patients. We see them once and send them on their way. We are not there for continuity of care. We are not there to treat chronic conditions. We are there for accidents and emergencies.[28]

2.33 The ACEM argued that any policy which targets primary healthcare for cost savings will be ineffective, 'as research has shown that the increase in the rates of GP visits is in fact more cost-effective than if these services were provided in other areas of the health care system'.[29]

Risks to general practice and primary healthcare

2.34 The evidence of the effectiveness of primary healthcare and general practice is indisputable. However, this has not deterred the government from targeting general practice as a source of budget savings. While the proposed co-payments have now been dropped,[30] the Minister for Health, the Hon Sussan Ley MP, has stated that the indexation freeze will remain in place and that the government still believes that Medicare spending is unsustainable.[31]

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27 Dr Anthony Cross, President, ACEM, *Committee Hansard*, 8 October 2014, p. 22.

28 Dr Simon Judkins, Councillor, ACEM, *Committee Hansard*, 5 February 2015, pp 55–56.

29 Australasian College of Emergency Medicine (ACEM), *Submission 132*, p. 1.

30 The Hon Sussan Ley MP, Minister for Health 'Government continues Medicare consultation', Media release, 3 March 2015.

31 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

2.35 As a result of this government policy, the committee has heard growing concerns from submitters and witnesses for the future of general practice. In particular:

- the viability of general practice;
- increased inefficiencies in the health sector; and
- the loss of opportunity to improve health policy.

Viability of General Practice

2.36 While the Prime Minister has insisted that the co-payment would not be greater than five dollars,[32] Dr Duckett told the committee that in reality the co-payment could be as high as $40 per visit. Dr Duckett argued that the impact on general practice of the government's proposed changes to Medicare is likely to amount to a 10 per cent decrease in general practice income:

> There are two changes that are taking place. There is a rebate reduction that only applies to GPs' patients…who do not have a concession card and are over 15. That is $5. That is the first change. The second change is the freeze in rebates through to July 2018. That is a bigger change in its cumulative effect. If you assume a two per cent increase or so inflation per annum, it is a six or so per cent impact in reduction in revenues to GPs, versus a four or so percentage impact from the $5. So it is a 10 per cent impact we are talking about altogether.[33]

2.37 Dr Graeme Alexander, a GP from the Claremont Village Medical Centre near Hobart warned that the government's policies threatened the ongoing viability of general practice in Australia:

> There will be a vastly inferior health system for the poor and the disadvantaged whether they access clinics or get their health care through the pharmacy. There is an interesting thing happening at the moment: as general practice comes under attack—and I point out to you that one of the few areas of general practice that will survive is the large corporate-run clinic, and people should be asking the question why. The huge void that this will fill as general practices' doors close—and that is what we are talking about; we are talking about the viability of general practice, because general practices are going to the wall as we sit here now and they are going to go to the wall with this new health policy.[34]

2.38 Dr Richard Terry, Practice Principal of the Whitebridge Medical Centre near Newcastle, outlined the impact of the government's proposed changes to Medicare on solo practices:

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32 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3.

33 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, pp 68–69.

34 Dr Graeme Alexander, General Practitioner, Claremont Village Medical Centre, *Committee Hansard*, 5 February 2015, p. 37.

> I would just like to draw attention to the financial vulnerability of solo practice. I have been in solo practice for a long, long time, and for the last 10 to 15 years we have suffered a lack of indexation medical rebates—10c a year on some rebates. Many of us in solo practice have stayed in practice for the love of our patients, because our actual remuneration, which is the money left in the pot at the end of the day, has been going down as the cost has increased… Certainly if that Medicare level B [short consultations policy] fiasco had gone through, you would have seen practices dropping by their thousands, because you simply would have had to close the door because you could not afford to keep it open. I think that the co-payment and the lack of indexation again have the similar effect.[35]

2.39 The RACGP President, Dr Jones, talked about the difficulty of balancing quality care, and managing a general practice in the face of the government's proposed changes:

> Australian general practice patient services have been unfairly targeted by the government to find savings within the health budget. GPs and practices are now faced with an ethical dilemma of providing ongoing quality care balanced against practice business imperatives. Please remember that most general practices in Australia operate as small businesses.[36]

2.40 The RACGP felt that the result of the Medicare reforms was that 'the Government has shifted the onus of finding savings onto GPs'.[37] Feedback from the members of the RACGP indicates that, facing the decision of whether to pass on greater costs to patients or absorb the costs from their own practice, 'most GPs will not be in a position to absorb these costs'.[38] The RACGP noted that:

> While these changes [$5 co-payment and extended indexation freeze] will clearly have a negative impact on patient access and tertiary healthcare expenditure, they will also threaten the sustainability and viability of the business of general practice and the future of the profession.
>
> Operating as small businesses, general practice owners will now be forced to revaluate the viability of their business model and determine if, under the proposed arrangements, the return on investment will be sufficient to continue operating. It is likely that many practices will cut practice staff, general practice registrars, medical students, and patient services as required.[39]

2.41 According to the RACGP, the cut to funding for primary healthcare is also negatively affecting the future of general practice:

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35 Dr Richard Terry, Practice Principal, Whitebridge Medical Centre, *Committee Hansard*, 5 February 2015, p. 27.

36 Dr Frank Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 9.

37 RACGP, *Supplementary Submission 115*, p. 2.

38 RACGP, *Supplementary Submission 115*, p. 2.

39 RACGP, *Supplementary Submission 115*, p. 2.

> Feedback received indicates that many young doctors view general practice as an unattractive vocation and that the proposed government changes are forcing many GPs who are currently practising to reconsider their chosen speciality.[40]

2.42 Dr Ian Kamerman of the North-West Health practice in Tamworth provided a clear example of the concerns voiced by others that the out-of-pocket costs to patients was likely to be much higher than the $5 in the government's announcement:

> …it is a concern to me as a business owner and operator as well as a GP that there is no funding now, essentially, to support the actual practice of general practice. Certainly it is marginal at the moment, and, with the changes to indexation, the gap between expenses and income is going to increase from marginal to about $100,000 a year that I am going to need to make up in costs and income in my practice. Either I am going to have to put staff off or I am going to have to increase patient fees to do that over a period of time. Currently, my non-concessional patients pay a $35 gap. That gap is going to increase to about $60 or $65 if I am going to stay afloat as a business. It is certainly much more than what has been talked about as the cost of a latte. Either that or I am going to need to cut out bulk-billing altogether.[41]

Increased inefficiencies in the health sector

2.43 Dr Duckett noted that there are national and international studies showing that better access to primary healthcare results in improved preventative health rates and better overall health management. With general practice being recognised as the most efficient level of the healthcare system, internationally the trend is towards improving access and encouraging health consumers to visit general practice:

> Certainly we know that, if you have out-of-pocket costs, people defer visits to doctors. We also know that, if you have out-of-pocket costs and people defer a visit to a doctor, the patient cannot make a judgement about what is necessary care and what is unnecessary care; so they end up missing out on necessary care as well. And there have been a number of overseas studies which have shown that. There has been a major study which has assessed the impact of co-payments… Generally, the overseas policy direction is not to have financial barriers in general practice. The whole international direction of health policy is to try to strengthen general practice, to try to strengthen primary care because this is the most efficient level of the health system. I am not saying that general practice or primary care is perfectly organised in Australia at the moment and, indeed, I do not believe it is. I think there need to be changes, but the changes you need to make are not forcing the consumer to drive all the change in primary care when they are

40 RACGP, *Supplementary Submission 115*, p. 2.

41 Dr Ian Kamerman, North-West Health, Tamworth, *Committee Hansard*, 5 February 2015, p. 26.

> people who just do not know what is necessary care and what is not necessary care.[42]

Loss of opportunity to improve health policy outcomes

2.44 The committee heard from witnesses that the government's single-minded focus on "budget repair" has led to the government developing policies which will damage Australia's primary healthcare system. As a result, the national healthcare reform debate has been side tracked into protests against the government's poor policy formulations and the opportunity has been lost to engage meaningfully with stakeholders on positive health policy reform.

2.45 Associate Professor Owler told the committee that the government had focused on fiscal saving to the detriment of debate about beneficial health policies:

> I think the proposals that have been made…have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system better. I am pleased that the new minister appears to be embarking on that process, but I think it has been a disappointing 12 months from that perspective.[43]

2.46 Dr Linda Mann, a GP from Strathfield, Sydney revealed the loss of trust between the government and general practice:

> General practitioners, I think, are very insulted by the idea that we are the part of medicine that has to show a price signal.[44]

2.47 Dr Charlotte Hespe, a GP from Glebe in Sydney with 20 years of experience, articulated the frustration of GPs with non-evidence based, fiscally driven policy making:

> There seems to be a concern about the amount of money that the government is spending on health, with the increasing population and the increasing complexity of medicine that is before us; therefore, there is this need to take control of the amount of expenditure that goes into health. If that is truly what the government wants then this attack on primary health care—which, can I say, has come from three directions in the budget: the co-payment, the change with Medicare Locals and the change with the GP training scheme—is completely ludicrous. When you look internationally, there is astounding evidence that the way to make your health system efficient, to increase its capacity, to improve health outcomes and to achieve the triple aim of universal health—which is improving the patient journey, improving the health of your population and decreasing cost—is to build up your primary health care. The co-payment as an example of that is

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42 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

43 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 7.

44 Dr Linda Mann, GP, private capacity, *Committee Hansard*, 19 February 2015, p. 29.

> ridiculous. It is not going to do that at all. What signal it puts out is ridiculous.[45]

2.48 Dr Duckett summed up the views of many who spoke to the committee with his observations on the progress of the Minister's 'wider consultations' process:

> We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at primary care in general practice and we do need to think about whether the current arrangements are right for the future.[46]

Committee observations

2.49 The evidence heard by the committee indicates that from the 2013 election to the recent 2015-16 Budget, the government's apparently single-minded focus on making savings in healthcare has blinkered its approach to policy. The government's fiscally drive approach has resulted in unjustified cost burdens falling on the primary healthcare sector and in particular on general practice.

2.50 As this chapter has discussed, there is overwhelming evidence of the importance of general practice and access to primary healthcare. The evidence gathered by the committee has demonstrated that general practice provides:

- better health outcomes for consumers;
- cost-effective healthcare with an ability to focus on preventative health; and
- more responsive healthcare than acute care, particularly in providing continuity of care and management of chronic conditions.

2.51 Despite this evidence, witnesses continually told the committee that government policy has threatened the viability of general practice. In particular, the committee notes with disapproval the government's renewed commitment to non-indexation until an agreed "value signal" is reached with stakeholders in primary healthcare.

2.52 The committee observes with concern that instead of beginning a public discussion about positive healthcare reform, the government has eroded the trust and goodwill of the medical community. The government's targeting of primary healthcare for budget savings has led to:

- threats to the viability of general practice as GPs are forced to pass on costs to patients from the continued indexation freeze;
- poorer outcomes for patients as out-of-pocket expenses increase or the indexation freeze prevents GPs from maintaining viable practices (particularly in rural areas where attraction and retention of GPs is already problematic);

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45 Dr Charlotte Hespe, Private capacity, *Committee Hansard*, 19 February 2015, p. 29.

46 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

- increased inefficiencies in the health sector as patients who cannot pay for primary health enter the public hospital system with preventable conditions or mis-managed chronic conditions;
- loss of opportunity to introduce positive healthcare programs and policies; and
- the loss of the trust and goodwill of the primary healthcare sector.

2.53 The committee agrees with Dr Duckett's observation about a future approach to healthcare policy:

> Further, public policy should be based on both costs and benefits. Purely focussing on outlays without considering the benefits from those outlays can again focus policy attention in the wrong place.[47]

47 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Supplementary Submission 29*, p. 2.

Chapter 3

Government healthcare policy and sector responses

Introduction

3.1 Since the 2014-15 Budget, government policy regarding general practice has changed five times:

- May 2014 – the 2014-15 Budget introduced the $7 co-payment on GP visits, diagnostic imaging and pathology, as well as a pause on indexation of some MBS fees.
- December 2014 – the then Health Minister, the Hon Peter Dutton MP announced that the $7 co-payment has been dropped. In its place the government introduced a package of reforms: reduction of the MBS rebate for short consultation times; a $5 co-payment with certain carve outs; and a four year extension of the previously announced indexation freeze out across all specialist and GP services under the MBS.[1]
- January 2015 – after a concerted campaign from GPs and health consumers, the newly appointed Health Minister, the Hon Sussan Ley MP dropped the short consultations policy and the $5 co-payment policy. The indexation freeze remained in place and the Minister announced her intention to consult with GPs and other stakeholders 'in order to come up with sensible options to deliver appropriate Medicare reforms'.[2] The Minister said consultations would include the need to 'insert a price signal of a modest co-payment into the health system for those who have the capacity to pay'.[3]
- March 2015 – while the Health Minister's consultations continued with little available information, primary healthcare stakeholders voice concern over the lack of detail of government policy direction prior to the 2015 Budget. The Health Minister announced that the $5 co-payment 'has been taken off the table' as it lacks broad support. But the Minister argued that expenditure on Medicare is unsustainable and 'to ensure we protect Medicare for the long-term, the Government would be proceeding with its pause on indexation

1 Mid-Year Economic Fiscal Outlook (MYEFO) 2014-15, p. 166. See also the Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of media conference, 9 December 2014.

2 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media release, 15 January 2015.

3 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media release, 15 January 2015.

of Medicare rebates for GP and non-GP items'.[4] During her press conference to abandon the co-payment, Minister Ley indicated ongoing interest in a price signal: 'It's definitely good policy to put the right price and value signals in health to make sure that number one people value the service they get from doctors…and also that they make that modest contribution according to their capacity to pay, and those who can pay a bit more are asked to pay a bit more. It's really that simple.'[5]

- May 2015 – the 2015-16 Budget introduced a broad ranging review of MBS items, major cuts to Flexible Funding programs, maintained the MBS indexation freeze and confirmed $57 billion cuts to public hospitals in the medium term.

3.2 The changes in government policy have been uppermost in the public debate about primary healthcare in Australia. This chapter provides a record of the public debate, as facilitated by the committee's many hearings and roundtable discussions, alongside the government's policy changes.

3.3 The chapter is divided into sections which reflect the policy announcements and major developments: May 2014, December 2014, January 2015, and March 2015. Chapter 4 examines the 2015-16 Budget health measures, with particular focus on those measures which effect primary healthcare and general practice.

3.4 As noted elsewhere in this report, due to the fluid and uncertain nature of the government's policy priorities for primary healthcare and general practice, the committee has decided not to make recommendations as part of this interim report. For this same reason the following record of the government's decisions and ensuing public debate is highly necessary.

May 2014: the 2014-15 Budget

3.5 The first patient co-payment policy was introduced in the 2014-15 Budget. The patient co-payments (comprising the $7 co-payment for GP visits, out of hospital pathology and diagnostic imaging) were raised as a key issue at every one of the committee's 15 hearings in the second half of 2014. The policy drew strong and consistent criticism across the health sector. The committee's first interim report, tabled on 2 December 2014,[6] examined the co-payment policy, amongst other issues arising from the 2014-15 Budget.

3.6 In examining the criticisms of the co-payment policy the committee also undertook to continue to monitor this issue.[7]

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4 The Hon Sussan Ley MP, Minister for Health, transcript of press conference, 3 March 2015.

5 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media release, 3 March 2015.

6 *Journals of the Senate*, 2 December 2014, p. 1948.

7 Senate Select Committee on Health, *First interim report*, 2 December 2014, p. 3.

3.7 The committee noted that it was 'deeply concerned by the substantial body of evidence it has received regarding the negative effects of the government's proposed patient co-payments'. Further, 'more than 100 submitters and countless witnesses have expressed consistent and overwhelming opposition to the proposed $7 co-payments'. The committee recommended that 'the government should immediately abandon its plan to implement the $7 co-payments'.[8]

3.8 Further discussion on the $7 co-payment can be found in the committee's first interim report.

December 2014: short consultation times, $5 co-payment and indexation freeze

$7 co-payment dropped

3.9 On 9 December 2014, the Prime Minister, the Hon Tony Abbott MP, and the former Minister for Health the Hon Peter Dutton MP, announced that 'the $7 Medicare co-payment measure announced in the 2014-15 Budget will no longer proceed'.[9] Instead, the government committed to introduce a new package of changes to Medicare largely through regulation. This package included:

- a $20 reduction in the Medicare rebate for short GP consultations of less than 10 minutes;
- a $5 reduction in the Medicare rebate for non-concessional patients (the $5 co-payment); and
- a four year freeze on the indexation of Medicare fees for all services provided by GPs, medical specialists, allied health practitioners, optometrists and others until July 2018.[10]

3.10 In their joint press conference, the Prime Minister and the former Health Minister estimated that each element of the new package of changes amounted to around $1 billion. According to the Prime Minister, the overall savings projection for the new package of changes would be around $3.5 billion over the forward estimates.[11] The original $7 co-payment was expected to achieve a similar savings

8 Senate Select Committee on Health, *First interim report*, 2 December 2014, p. xix.

9 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 1.

10 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, pp 1–2.

11 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3. It should be noted that representatives from the Department of Finance indicated at a public hearing on 5 February 2015 that the overall projected savings of the 9 December package was $3.6 billion. It should also be noted that this estimation of savings is for the package announced on 9 December 2014. The changes announced on 15 January 2015, which included the removal of the proposal for a reduced rebate for shorter consultations, was estimated by Finance officials to reduce the projected saving to $2.6 billion over the forward estimates.

figure. As with the $7 co-payment, the savings from the new package of changes would go into the Medical Research Future Fund.[12]

Changes to short GP consultation times

3.11 The MBS currently defines four levels of consultation type (Levels A to D) and sets a rebate to each level. Writing in *The Conversation* shortly after the 9 December 2014 announcement, Dr Duckett noted that a majority of consultations are under 20 minutes and so fall within Level B, which attracts a $37.05 rebate.[13] The change proposed by the government would have put a minimum time limit on Level B consultations of 10 minutes.[14] As a result, any consultation under 10 minutes would then attract a Level A rebate of $16.95. Dr Duckett described the effect of the change to consultation times:

> This change will dramatically reduce the rebate for those shorter consultations, from $37.05 to…$16.95 for general patients. Again it is highly likely that GPs will pass on $20+ gap to patients. The $5 co-payment has quickly morphed into a $25 one.[15]

3.12 The former Health Minister stated that the reduced rebate for short consultations would:

> …ensure that Medicare expenditure more accurately reflects the time a GP spends with a patient. It encourages a shift away from 'six minute medicine' so that appropriate, comprehensive care is better rewarded over patient throughput.'[16]

3.13 At the press conference announcing the new package of Medicare changes, the former Health Minister elaborated on the meaning of 'six minute medicine'. The Minister argued that the rebate change for short consultations would encourage GPs not to 'churn people through':

> The only other point that I'd make is about seven out of 10 non-concessional patients at the moment, so seven out of 10 people without a pension or a concession card, are bulkbilled and this is the element around the six-minute medicine. We think the change in the way in which the [Level] A and B can be charged, so having a minimum of 10 minutes before they can charge for a level B consultation, that that will concentrate a lot of the doctor's effort on those who are most in need of help, those with

12 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

13 Dr Stephen Duckett, 'GP co-payment 2.0: a triple whammy for patients', *The Conversation*, 11 December 2014.

14 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

15 Dr Stephen Duckett, 'GP co-payment 2.0: a triple whammy for patients', *The Conversation*, 11 December 2014.

16 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

> chronic diseases. It will skew the finances, if you like, when the doctors are considering this, towards spending more quality time with patients as opposed to just churning people through, so there are a number of benefits out of what we propose.[17]

3.14 According to data collected by the University of Sydney's Family Medicine Research Centre, approximately one-quarter of all consultations billed to Medicare in 2013-14 lasted less than 10 minutes.[18]

3.15 The Prime Minister estimated that the rebate change for short consultations would create savings 'in the order of $1 billion'.[19] Regulations were formalised by the former Health Minister in mid-December 2014 which would have brought the short consultations change into effect on 19 January 2015.

$5 co-payment

3.16 The revised co-payment announced in December 2014 reversed several unpopular aspects of the original version. Unlike the $7 co-payment policy, the new $5 co-payment would not apply to diagnostic imagining and pathology services.[20] In response to criticisms about the disproportionate impact of the $7 co-payment on disadvantaged groups, the revised $5 co-payment would not apply to the following vulnerable groups:

- Pensioners
- Concession card holders
- Children under 16 years of age
- Veterans for services funded through the Department of Veterans' Affairs
- Attendances at residential aged care facilities
- GP mental health plans
- GP management plans[21]

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17 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 4.

18 Britt H, Valenti L, Miller G, Debunking the myth of general practice as '6 minute medicine' University of Sydney 2014, http://sydney.edu.au/medicine/fmrc/beach/bytes/BEACH-Byte-2014-002.pdf. According to this study about 35 million GP consultations of the total 134 million lasted less than 10 minutes.

19 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 5.

20 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

21 Government Factsheet 'A Strong and Sustainable Medicare: How is the co-payment changing?', Department of Health, December 2014, p. 1.

3.17 In announcing the new policy, the former Health Minister argued that without the $5 rebate reduction and the $5 co-payment, Medicare would become unsustainable:

> Medicare will not survive in the long term without changes to make it sustainable…
>
> In the last year alone, 275 million services were provided free to patients. That's three out of every four Medicare services being bulk billed.
>
> These changes will contribute more than $3 billion to the Medical Research Future Fund which will fund the research needed to find cures to the health problems of today.[22]

3.18 The practical effect of the policy would have been to reduce Medicare funding for GP services, unless individual GPs chose to pass on the cost to non-concessional patients, an estimated 70 per cent of whom are normally bulk billed:

> Currently, 70 per cent of non-concessional patients are bulk billed. For doctors who choose to continue to bulk bill non-concessional patients, they will receive $5 less for eligible services.[23]

3.19 In their press conference of 9 December 2014, both the former Health Minister and the Prime Minister stated that the co-payment, if passed onto patients, would be no more than five dollars. For example, the Prime Minister explained:

> …this is a question for the doctors and what we're saying to the doctors is for adults who aren't on concession cards we don't think it's unreasonable for you to charge a co-payment and what we want to do by legislation is enable them to directly claim the rebate, provided the co-payment they charge for that particular class of patients is $5 or less.[24]

3.20 The assertions by the government that GPs would have a choice as to whether to pass on the $5 co-payment, and that the co-payment would only amount to five dollars were widely criticised. The government's argument that non-concessional patients should be easily able to afford a co-payment has also drawn substantial criticism.

Government's extended indexation freeze

3.21 Mentioned almost in passing at the 9 December 2014 press conference was a further measure aimed at reducing Medicare funding. The Prime Minister briefly added at the end of his description of the consultation time changes and the

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22 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

23 Government Factsheet, 'A Strong and Sustainable Medicare: What it means for doctors', Department of Health, December 2014, p. 1.

24 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3.

$5 co-payment, that the government would extend the freeze on indexation of Medicare rebates over the forward estimates.[25]

3.22 In practical effect, this measure means the freezing of Medicare fees for services provided by all GPs, medical specialists, allied health practitioners, optometrists and others at the current level until 2018.[26] Justification for the government's extended indexation freeze can be found in a factsheet produced by the Department of Health in December 2014:

> The previous Government, in the 2013-14 Budget, announced a pausing of indexation of rebates – changing the indexation period from November to July each year. In the 2014-15 Budget, the Government paused specialist rebates for two years which commenced on 1 July 2014.
>
> Rebates for Medicare-eligible consultations and procedures performed by GPs, specialists, allied health professionals, nurse practitioners, midwives and dental surgeons will now be paused until 1 July 2018 to ensure Medicare remains sustainable.
>
> Pathology and diagnostic imaging are not currently indexed and therefore not affected by this measure.[27]

3.23 The 2013-14 Budget had introduced the MBS short-term indexation measure as a means of realignment of the indexation with the financial year:

> The Government will realign the indexation of Medicare Benefits Schedule (MBS) fees to the financial year in line with many other Government programs. MBS fees, which are currently indexed on 1 November each year, will be indexed on 1 July each year. The next indexation date will be 1 July 2014. This measure will result in savings of $664.4 million over four years.[28]

3.24 The Prime Minister stated that the three measures announced—the $20 reduced rebate for short consultation times, the $5 rebate cut/$5 co-payment, and the extended indexation freeze—amounted to a saving of around one billion dollars each over the forward estimates.[29] This was, the Prime Minister advised, a collective saving of around $3.5 billion in comparison to the $3.6 billion anticipated from the measures in the 2014-15 Budget.

3.25 Department of Health figures released through a Freedom of Information request by *The Australian* show that the extension of the indexation freeze announced

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25 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 2.

26 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, 'A Strong and Sustainable Medicare', Joint Press Release, 9 December 2014, p. 2.

27 Government Factsheet, 'A Strong and Sustainable Medicare: What it means for doctors', Department of Health, December 2014, p. 2.

28 2013-14 Budget, Budget Paper 2, p. 177.

29 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 5.

in December 2014 would have a $1.3 billion impact on Medicare rebates for GP services. This would partially account for the increase in savings from the 2014-15 Budget to MYEFO in December 2014.[30]

Stakeholder criticisms

3.26 The proposed change to short consultations were strongly criticised by peak health groups such as the AMA, RACGP, Consumers Health Forum of Australia, and other health advocates. The criticisms raised included:

- the government's lack of consultation about the proposed changes;
- the absences of evidence linking short consultation times with poor quality healthcare practices; and
- the significant negative impacts that would flow from the changes.

No consultation

3.27 The committee heard that the government developed the proposed Medicare changes without consultation with the health sector or consumer groups. For example Associate Professor Owler told the committee that the announcement of the short consultations policy came as a 'complete surprise' to the AMA:

> I think co-payment mark 1 and co-payment mark 2 were both instances where the announcements were made without any consultation with the medical profession. The announcements in the budget, I have to say, were a complete surprise…
>
> Regarding co-payment mark 2, again we found out 20 minutes before the announcement was made. In fact, I was in the United States in Chicago, in my hotel room, when the phone rang from the minister stating that these were the changes about to be made. But there was absolutely no consultation with the AMA. I understand you will hear from other groups as well. I suspect no-one else had any consultation about the impact of those changes.[31]

3.28 Similarly, Dr Jones, President of the RACGP, was not informed until just before the Government announced the proposed changes to Medicare:

> …we think that what we need to do is be able to advise government on the implications of policy changes. Their policies seemingly have been made on the run, with no consultation. Like my colleague Professor Owler, I also received a phone call about half an hour before the announcements were made. There was no consultation with our college or our members whatsoever.[32]

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30 Freedom of Information Request, Mr Sean Parnell, Health and FOI Editor, *The Australian* to Department of Health, 27 April 2015, p. 1.

31 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 3.

32 Dr Frank R Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 10.

3.29 The concerns about the lack of consultation were also expressed by members of the GP panel who appeared before the committee. Sole-practitioner Dr Richard Terry of the Whitebridge Medical Centre in Newcastle, NSW, told the committee:

> The total number of GPs in Australia, as far as I can see, is about 43,000. It is interesting that the RACGP, who presented here earlier today, say they have a membership of 28,000 GPs and, by their own admission, they are an educational body. That leaves at least 15,000 GPs in the community. Essentially, taking both of those numbers into account, there are 43,000 grassroots GPs who represent thousands of patients who have not been consulted on these healthcare changes.[33]

3.30 Officials from the Department of Health however claimed that this was the government's typical approach to Budget measures:

> Between the May announcement and the December announcement there was significant consultation—again, as has been said in these hearings—with a whole range, and we have a significant number of people we consulted with. Those consultations raised a number of issues and concerns with that proposal from the May budget and raised a number of areas that they had particular concerns with. We did not consult specifically on the actual budget measures that were then announced in December, but we were informed by those consultations.[34]

No evidence base

3.31 As outlined previously, the government's justification for proposing the short consultations policy was to avoid the problem of 'six minute medicine'. However, medical experts that appeared at the committee's public hearing argued that there is no evidence to support the government's assertions.

3.32 For instance the Australian Health Care Reform Alliance (AHCRA) criticised the unsubstantiated link the government had made been short consultations and poor practices:

> Addressing 'six-minute medicine' is not an unreasonable strategy if directed at poor quality practice only (six minutes may be totally appropriate for some brief consultations). Short consultations do not necessarily mean poor quality. However change needs a carefully planned approach, based on evidence and consultation with GPs and consumers, not used as a post-hoc rationale for previously determined budget cut.[35]

3.33 The RACGP also criticised the lack of evidence base:

> …the evidence that time based consultations improve quality is relatively poor. It is not good but there is some evidence. In our modelling for

33 Dr Richard Terry, Practice Principal, Whitebridge Medical Centre, *Committee Hansard*, 5 February 2015, p. 27.

34 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

35 Australian Health Care Reform Alliance (AHCRA), *Submission 90*, p. 2.

> government—this is one of the discussions we wish to have with them—we wish to remodel the [current consultation level] system. We have some ideas and we have done some financial modelling as well. Tagged on to that—very importantly—is improving the quality of care.
>
> We have a proposal whereby the items of service would be reframed, if you like, and it would encourage longer consultations and disincentivise superficial consultations. Tagged onto that—very importantly—are payments for practitioners to provide quality care, for practices to be able to enable practitioners to do that, and, thirdly, reflecting the complexity of the local demography. We have modelling along those lines. So I think that we do have some potential solutions (a) to improve the health of the population, which is by far the most important thing, and (b) to help this government out of the dilemma that it is in.[36]

3.34 According to several witnesses the lack of policy rationale and the rapid changes from one policy to the next demonstrated the ad hoc nature of the government's policy development process. For instance Dr Duckett told the committee:

> We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at [the effectiveness of] primary care in general practice and we do need to think about whether the current arrangements are right for the future. That is not something that can be done in a two-week period.[37]

3.35 Furthermore, the AMA explained that the policy changes appeared to be ideologically-driven fiscal measures rather than policies to improve health outcomes:

> I have also said publicly that one of the reasons we are in this mess in the first place is that the changes that were flagged were always designed as fiscal measures, they were never viewed through the prism of health policy and I think that has been the failing of both sets of policies.[38]
>
> …whoever is in government or whoever is Prime Minister needs to consult with the profession and go away from being driven only by personal assertions and ideology and get back to looking at evidence and data. As I said before, the ideology that has driven most of these proposals has ended up becoming the natural enemy of common sense, moderation and logic. We need to get back to talking about good health policy and map out a program of how we are actually going to make our healthcare system better not only for general practice but across the board and to make Australians healthier and safer as well.[39]

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36 Dr Frank R Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 12.

37 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

38 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 4.

39 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 6.

3.36 Health Department officials were not able to explain to committee the health outcomes that could be expected from the proposed changes to Medicare:

> Health outcomes are a very difficult thing, because there are so many elements that impact it.
>
> …we cannot say one thing versus another thing will affect health outcomes. There are a lot of things, including a person's individual decisions, as to what will happen with health. So it is very difficult to ever have a broad comment as to what the health outcomes are, and we do not tend to, as a result, make comment as to what we anticipate a health outcome will be. We anticipate what we are looking for, which is improved health through whatever the policy might be covering at the time.[40]

Unprecedented protests by GPs

3.37 Despite the announcements being made in the lead up to the busy Christmas period and the proposed implementation date being in the midst of most Australians annual summer holiday, health sector advocates reported an unprecedented reaction from medical professionals and patients. The RACGP launched a campaign called *You've been targeted* to publicise its concerns throughout GP practices.[41] In early January 2015, the AMA announced plans for rallies to be held in capital cities for GPs and others to protest against the proposed changes, including the short consultation time changes.[42]

3.38 Perhaps the most vocal response was generated by the RACGP's *You've been targeted* campaign:

> The government's changes in December [2014] lead to an unprecedented protest from GPs. Thousands of GPs contacted the RACGP with concerns regarding the changes and requested advice on how to implement them. Nearly 47,000 patients, GPs and other medical specialists signed our petition to the health minister. Others wrote to their MPs and displayed posters in their waiting rooms informing their patients of the impending changes. We do not often mount campaigns. We are an academic college. But this situation warranted an immediate response.[43]

3.39 The response from the AMA's membership was also resounding:

> …the amount of feedback that we [the AMA] had on that initiative in particular exceeded the feedback that we have had on just about anything else. I think a lot of people felt very insulted, particularly experienced GPs,

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40 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard,* 5 February 2015, p. 90.

41 Networking Health Victoria, 'RACGP releases information sheet on co-payment and rebate freeze', Media release, 14 January 2015.

42 Lenore Taylor, 'Doctors to demonstrate in protest at 'plan B' proposed Medicare changes', *The Guardian*, 7 January 2015.

43 Dr Frank R Jones, President, RACGP, *Committee Hansard,* 5 February 2015, p. 9.

> who were saying, 'We can provide quality care in eight or nine minutes.' The issue is not whether it is 10 minutes or above.[44]

January 2015: short consultation times dropped

Short consultations policy dropped four days before implementation

3.40 The proposed $20 reduction of the Medicare rebate for short GP consultations was to have begun by regulation on 19 January 2015. However due to the significant grassroots pressure from GPs[45] and health consumers, as well as concerted advocacy from the AMA, the RACGP and other health organisations, on 15 January 2015 the newly appointed Health Minister, the Hon Sussan Ley MP announced that the planned changes would not be implemented.[46]

3.41 Minister Ley said that 'the Government is responding to concerns that have been raised about the new Medicare measure' by not commencing the changes to short GP consultation times. Instead the Minister announced that the government would undertake:

> …wide ranging consultation on the ground with doctors and the community across the country in order to come up with sensible options to deliver appropriate Medicare reforms.[47]

3.42 At the same time the new Health Minister confirmed the government's intention to press ahead with the $5 co-payment:

> We must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay.[48]

3.43 The Minister's announcement to withdraw the proposed changes to short consultation rebate structures was welcomed by GP representative bodies such as the AMA,[49] Rural Doctors Association of Australia (RDAA)[50] and the RACGP.[51] In particular, groups welcomed the consultation with government which had been

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44 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 3.

45 The RACGP noted in their media release of 15 January 2014 that in less than seven days 'a staggering 44,000+ signatures from GPs and patients' had been added to an online petition against the consultation time changes. RACGP, 'Sanity prevails in proposed Medicare shakeup', Medial Release, 15 January 2015.

46 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

47 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

48 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015, p. 1.

49 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015.

50 RDAA, 'Rural Doctors welcome Minister's announcement on Medicare', Media Release, 15 January 2015.

51 RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

missing from the formulation of the previous policies. Associate Professor Owler, said he looked forward to the opportunity to work with the government on any future changes to Medicare:

> We are very pleased that the changes to the [short consultation] rebates have been taken off the table. This was really essential if we were going to move ahead with having a proper consultation and discussion about the sustainability of Medicare and making our health system better for patients but also more sustainable in the longer term.[52]

3.44 Of the package of reforms announced on 9 December 2014 the short consultations policy attracted the majority of criticism, due to its planned implementation in January 2015. However with the announcement on 15 January 2015 that the short consultation changes had been dropped, attention then focused specifically on the $5 co-payment and the extended indexation freeze. These measures too were roundly criticised.

$5 co-payment remains

3.45 The short consultation times policy had gone, however the healthcare community remained concerned about the government's continued imposition of a price signal. After the 15 January 2015 announcement, stakeholder attention focused on demonstrating to the government the detrimental effects of the $5 co-payment and continued indexation freeze.

3.46 While initial stakeholder comments had welcomed the dropping of the $7 co-payment, there was disappointment that the government had seemed not to have listened to the concerns raised about co-payments and the deleterious effects of a price signal on health outcomes. The RACGP, for example made this statement on 9 December 2014:

> The RACGP is pleased the Government has listened to the profession and the community and compromised on its proposed $7 co-payment model.
>
> We are disappointed the Government has proposed a $5 cut in Medicare rebates for standard GP consults.[53]

3.47 Further, peak groups argued that the government's single-minded focus on "budget repair" had created policies which will damage Australia's primary healthcare system. Associate Professor Owler told the committee:

> I think the proposals that have been made, as I have said, have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system

52 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015.

53 RACGP, 'RACGP pleased vulnerable patients protected under changes to co-payment model', Media Release, 9 December 2014.

> better. I am pleased that the new minister appears to be embarking on that process, but I think it has been a disappointing 12 months from that perspective.[54]

3.48 The AHCRA submission gave a similar summation of the government's proposed Medicare reforms:

> - Lack of policy framework: The proposal is not based on any overall articulated and coherent health policy, analysis or framework from the Government. It appears to have been developed solely to save the Government money with no clear rationale why this area of health spending was targeted and not other more wasteful ones…
> - Lack of transparency: the moves have been made with little regard for or consultation with the practitioners or consumers as to the impact on the effectiveness and delivery of care.[55]

Disadvantaging vulnerable groups

3.49 In addition to these criticisms, stakeholders felt that, despite making concessions to disadvantaged groups such as pensioners, concession card holders and children (see paragraph 3.16), the government was refusing to take into account the effect of a price signal on other vulnerable groups, which also faced difficulties accessing primary healthcare such as:

- those in rural health settings;
- people with a mental health condition;
- Indigenous Australians;
- residents of aged care facilities;
- women with specific health concerns;
- the chronically ill;
- those in the LGBTI community; and
- people with a disability.

3.50 Witnesses at the committee's public hearings argued that a price signal on healthcare access unfairly targeted vulnerable groups as these people would be least able to afford additional out-of-pocket costs. Stakeholders argued that such a policy undermined the principle on which Medicare was based: universality of access to healthcare.

3.51 Dr Anne-marie Boxall, Senior Policy Adviser with the National Rural Health Alliance argued that universality—a key aspect of Australia's Medicare system—has been lost in the current healthcare funding debate:

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54 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 7.

55 Australian Healthcare Reform Alliance (AHCRA), *Supplementary Submission 90*, p. 1.

> We have been talking a lot about the impact on patients of the potential changes, which is right, but the potential changes also have a big impact on our health system if they are implemented. One of those is that threat to universality. High bulk-billing rates have been pursued by both sides of government for a long time, and there is a reason for that. It is because it essentially functions as a safety net. Whilst some people may be able to afford to pay more, and they do, through the taxation system, bulk-billing is seen as a universal benefit. So if we are undermining a system and scaling back bulk-billing and making it a targeted system, we then need to be very sure that the safety nets we have in place are effective, and that is something that we are not entirely sure about at the moment, and we have evidence that people are falling through the safety nets.[56]

3.52 The Consumers Health Forum of Australia agreed that any further pressure on GPs would result in a drop in bulk billing and access to primary healthcare for non-concession card holders. Its CEO, Mr Adam Stankevicius argued:

> And it will be patients who will suffer, as many doctors will have no option but to demand the $5 from patients. It will be the chronically ill, families and the elderly not covered by concessions, who will be hit hardest. While pensioners and other concession patients, children and veterans may still be covered by bulk billing, the squeeze on doctors' income could well see a dramatic downturn in their ability to continue bulk billing which currently benefits more than 80 per cent of cases.[57]

3.53 Despite the concessions included in the revised co-payment policy (see paragraph 3.16), criticisms from other groups focused on concerns that the new co-payment would continue to create a barrier to access to primary healthcare. Some groups, such as National Aboriginal Community Controlled Health Organisation (NACCHO), believed that it would force community health organisations and GPs to carry the cost of the co-payment so as to ensure access to healthcare, particularly for those with chronic illnesses:

> …the majority of Aboriginal Community Controlled Health Services, whose overriding purpose was to encourage Aboriginal people through their doors, would choose to absorb the discretionary $5 co-payment.
>
> "Aboriginal Community Controlled Health Services are making the biggest gains against the closing the gap targets – helping Aboriginal people to live longer and healthier," Mr Cooke said.

56 Dr Anne-marie Boxall, Senior Policy Adviser, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 44.

57 Consumers Health Forum of Australia, '$5 cut to doctor equals co-payment by default', Media Release, 9 December 2014, p. 1.

> "Many Aboriginal people do not fit in the exemption categories but still have low disposable incomes and can ill-afford to pay extra for their often complex medical needs and repeat appointments.[58]

3.54 Professor Andrew Bonney, University of Wollongong, agreed that improving access to primary healthcare is vital:

> The premise of the price signal is that people are unnecessarily seeking health care and that it was for trivial reasons and therefore it was a waste of the taxpayer's money. We know health-policy-wise that the things that improve overall health outcomes are four components of primary care. The first is access to care, and following on from that, once they are in the primary care system, is continuity, comprehensiveness and coordination…
>
> We are in a small town, and we are under-doctored, so my waiting time is two or three weeks, or longer. And to try to improve access, because we are dealing with so much chronic disease, we have an hour walk-in clinic in the morning. So, if there is an acute problem, you can just turn up and we will see you… [W]ithin that walk-in clinic, the people turning up just for things like, 'I'm a bit worried about this, Doc' included two patients who had lost sight in an eye because of diabetic haemorrhages and a fellow who had a lump in his groin, which turned out to be lymphoma... [H]aving a walk-in clinic so that people can access care when they need to means that people with very significant, serious things can have those picked up and dealt with quickly. Now, if we had just standard appointments at standard rates, I am not quite sure when those folk would have turned up. But by improving access to care—because patients do not understand sometimes when they truly are ill—you can prevent an awful lot of grief and mortality down the track…
>
> [A]bout 10 per cent of my patients are Aboriginal. Those folk do it very tough, and a co-payment for my Aboriginal patients would significantly restrict their access to our care. And I know just from prescribing and medication that the Close the Gap incentive, such that Aboriginal patients do not have a co-payment for their medications, has made a huge difference.[59]

3.55 Ms Jennifer Johnson, Chief Executive Officer of the RDAA explained that putting a price signal on healthcare access would impact severely on rural communities. She noted that not all non-concessional patients were necessarily able to afford a co-payment:

> We have already stated that a co-payment—a price signal, for example—will probably impact more severely on rural doctors and rural communities. We know that rural patients are far more reluctant to seek medical assistance. That is for a number of reasons—one of which is access. Most

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58 National Aboriginal Community Controlled Health Organisation (NACCHO), 'NACCHO Media Release: Revised GP co-payment policy remains a hit to Aboriginal health', Media Release, 10 December 2014, p. 1.

59 Professor Andrew Bonney, Roberta Williams Chair of General Practice, Graduate School of Medicine, University of Wollongong, *Committee Hansard*, 5 February 2015, p. 29.

> times, they obviously have to travel much further to see a GP. We know that economic and social circumstances are quite often poor, and particularly economic situations. In rural communities that might not necessarily be reflected in eligibility for, for example, healthcare cards. So quite often in farming communities you will have people who are asset rich, for example, but cash poor.[60]

3.56 Despite the government's assurance that vulnerable groups would be exempt from the co-payment, peak groups like the AMA argued that all health consumers will be affected because the changes force GPs to pass on the additional costs:

> Even if the Government abandons the rebate cut for shorter consultations, the AMA President warned other changes, including a $5 cut to Medicare rebates for general patients from 1 July and a freeze on Medicare rebate indexation through to mid-2018, amounted to an attack on general practice that would inevitably lead to increased out-of-pocket expenses for patients and undermine health care.
>
> [Associate Professor Brian Owler] said the policies were likely to lead to higher health costs in the long-term, as patients deterred by increased expenses put off seeing their doctor. Eventually, as their health deteriorates, they will need more intensive and expensive treatment, possibly even hospitalisation.
>
> "Primary health care is provided primarily by practitioners who practice in a small business setting," A/Prof Owler said in his letter to Mr Abbott.
>
> "These practices will not be able to absorb the cuts your Government has made to the Medicare rebate. Costs will be passed on to patients. Some will be able to make these payments but many will not. These costs may deter many patients from seeking early treatment."[61]

March 2015: $5 co-payment dropped, non-indexation retained

3.57 On 3 March 2015, recognising that 'it is clear the proposal for an optional $5 co-payment does not have broad support' the Health Minister announced that:

> The measure, including the proposed $5 reduction to the Medicare rebate, will therefore no longer proceed and has been taken off the table...[62]

3.58 During the Minister's press conference she confirmed a 'pause on indexation of Medicare rebates for GP and non-GP items while we work with the profession to develop future policies.'[63]

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60 Ms Jennifer Johnson, Chief Executive Officer, RDAA, *Committee Hansard*, 5 February 2015, p. 19.

61 AMA, 'Time for Prime Minister to abandon rebate cut', Media Release, 15 January 2015.

62 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015, p. 2.

63 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015.

3.59 The Minister confirmed that the government is committed to introducing a price signal into the Medicare system:

> …it's definitely good policy to put the right price and value signals in health to make sure that number one, people value the service that they get from doctors…and also that they make that modest contribution according to their capacity to pay and those that can pay a bit more are asked to pay a bit more. It's really that simple.[64]

3.60 The Minister's announcement was welcomed by stakeholders. The RACGP, for example, had called for a six-month moratorium on further policy announcements and the establishment of a 'GP health reform advisory committee consisting of the Government, patients and GP representatives to guide informed consultations'.[65] The RACGP implored the government to conduct a constructive discussion with all stakeholders as the best way to:

> …inform the development of a sustainable and efficient healthcare system that meets the needs of all Australians, now and into the future.
>
> At the very least, we believe a structured review of all time-based and content-based consultation item numbers would work towards ensuring the long-term sustainability and quality of general practice patient services.[66]

3.61 Several other organisations supported the call for a six month moratorium including: the RDAA;[67] the National Rural Health Alliance;[68] the PHAA;[69] the ACEM;[70] and Dr Stephen Duckett, Director, Health Program, Grattan Institute.[71] Others, such as Dr Fiona van Leeuwen, Vice Chair of the HGPA told the committee that the government needed to work collaboratively with general practice:

> …we urge against any further erosion of what is an essential part of the Australian healthcare system—that is, general practice. We urge against proceeding with both the GP co-payment and the freeze on MBS rebates. Limit the damage with regard to both financial and human currency. Instead, use our collective knowledge and experience to help to begin to craft a health system that can improve the patient experience and improve

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64 The Hon Sussan Ley MP, Minister for Health, 'Government continues Medicare consultation', Media Release, 3 March 2015.

65 RACGP, *Supplementary Submission 115*, p. 2.

66 RACGP, *Supplementary Submission 115*, p. 2.

67 Mrs Jennifer Johnson, Chief Executive Officer, RDAA, *Committee Hansard*, 5 February 2015, p. 24.

68 Mr Gregory Gordon, Chief Executive Officer, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 42.

69 Public Health Association of Australia (PHAA), *Supplementary Submission 76*, pp 6–7.

70 Mrs Alana Killen, Chief Executive Officer, Australasian College of Emergency Medicine, *Committee Hansard*, 5 February 2015, p. 58.

71 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

> the health of all Australians. We want your help to rebuild the trust. Please let us use this opportunity to take the first step towards working in partnership with grassroots general practice for a health system that will meet both the healthcare needs and the financial challenges of Australia for generations to come.[72]

Health Minister's consultations continue

3.62 In January 2015, when the planned $20 cut to rebates for short consultations was dropped, the Minister gave an undertaking that she would conduct 'wide ranging consultation on the ground with doctors and the community across the country'.[73]

3.63 According to the Minister the consultations would be guided by four principles:

- We must protect Medicare for the long term
- We must ensure bulk billing remains for vulnerable and concessional patients
- We must maintain high quality care and treatment for all Australians
- We must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay[74]

3.64 The Minister's announcement was well received by many peak groups. The AMA and the RACGP both welcomed the removal of the short consultation policy[75] and stated their willingness to work with the government on its planned consultations.

3.65 Although no details were made available through the Department of Health's website about the consultations, peak groups such as the AMA and the RACGP had meetings with the Minister. During a round of consultations with GPs in Albury and Wodonga, Minister Ley told *The Border Mail* that the timeframe for the consultations was quite restricted:

> Ms Ley said the timetable for consultations was constrained by the May budget and changes scheduled to come into effect in July.
>
> "We're talking weeks here, not months," she said.[76]

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72 Dr Fiona van Leeuwen, Vice Chair, Hunter General Practitioners Association, *Committee Hansard*, 5 February 2015, pp 26–27.

73 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform' Media Release, 15 January 2015, p. 1.

74 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform' Media Release, 15 January 2015, p. 1.

75 Associate Professor Brian Owler, President, AMA, transcript of doorstop, Gold Coast, 15 January 2015; and RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

76 Natalie Kotsios, 'Sussan Ley delivers Medicare consultation as prescribed', *Border Mail*, 28 January 2015, www.bordermail.com.au/story/2845272/sussan-ley-delivers-medicare-consultation-as-prescribed/.

3.66 Dr Jones, President of the RACGP, told the committee that his understanding was that the consultations would be quite short:

> While I have had brief discussions with the minister since she took charge...I understand that consultation will end in a couple of weeks, and this is simply not enough time to analyse and identify the serious implications of these changes and will likely result in more budget measures that damage the most effective part of Australia's health system.[77]

Minister conducting consultations

3.67 Information regarding the consultations announced by the Health Minister has been limited and largely available only via the media.[78]

3.68 The committee sought details from the Department of Health regarding the consultation process, asking for example whether there was a plan for the consultations and a time limit. Ms Kirsty Faichney, Acting First Assistant Secretary of the Medical Benefits Division advised that the consultations were being conducted by the Minister and organised through the Minister's office:

> …the minister is undertaking consultation. I understand her office has provided advice, and we sought it as well when we heard the comment regarding the time limit. We are not aware of any time limit with regard to the consultations… At the moment the minister is meeting directly with GPs. She is meeting directly with the peak bodies, literally one-on-one or in groups. She is doing forums, she is visiting clinics and she is going to hospitals. I am trying to think of other ones that have been happening.[79]

3.69 The Department also advised that the Minister's office was setting the topics for consultation:

> [Senator O'Neill]: Could you provide us with the areas of primary health care that are being consulted on, specifically with regard to general practice and matters that relate to general practice? Could you also provide us with a schedule of consultations that are anticipated and ones that have already occurred and the groups that are to be invited or have been invited?
>
> Ms Faichney: We can ask the minister's office.
>
> Mr Stuart: We can ask the minister and the minister's office if they are willing to provide it. We will take that on notice.[80]

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77 Dr Frank Jones, President, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, 5 February 2015, p. 9.

78 See for example Natalie Kotsios, 'Sussan Ley delivers Medicare consultation as prescribed', *Border Mail*, 28 January 2015, www.bordermail.com.au/story/2845272/sussan-ley-delivers-medicare-consultation-as-prescribed/.

79 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, pp 94–95.

80 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health; and Mr Andrew Stuart, Acting Secretary, Department of Health, *Committee Hansard*, 5 February 2015, pp 94–95.

3.70 The Department of Health's response to the question on notice regarding the Minister's consultation was:

> The Minister has been travelling the country consulting with GPs, health works, medical and consumer groups and a range of medical associations. These consultations are ongoing.[81]

3.71 It appears from the evidence that the Minister's office organised the consultations with little or no support or interaction with her Department.

3.72 The Department of Health's own previous consultations have left much to be desired in terms of thoroughness. Ms Faicheny explained that:

> Between the May announcement and the December announcement there was significant consultation… Those consultations raised a number of issues and concerns with that proposal from the May budget and raised a number of areas that [stakeholders] had particular concerns with. We did not consult specifically on the actual budget measures that were then announced in December, but we were informed by those consultations...[82]

3.73 Ms Faichney then clarified that by 'consultation' the Department meant 'providing information' and 'receiving communications':

> I did not say people were consulted; I said there was a range of information provided, as you well know, including what we all get all the time, whether it is through media or correspondence to the department or direct contact to us or to the minister's office. A significant amount of the information gets provided in those ways, and that gets taken into account. You would have to ask the government how they then took that into account in making the decision on 15 January.[83]

Response to Minister's announcement of 'wider consultations'

3.74 When the consultations were first announced the RACGP President, Dr Frank R Jones was positive about the opportunity for discussions with government, saying that the RACGP looked forward to:

> …constructive discussion to inform the development of a sustainable and efficient health system that meets the needs of Australia.[84]

3.75 However, between 15 January 2015 and the committee's hearing on 5 February 2015, the RACGP had discovered that the Minister's consultations would not be as comprehensive as promised:

> The RACGP participated in discussions with the Minister for Health in late January 2015 as part of United General Practice Australia (UGPA) and

81 Answer to Question on Notice No. 12, Department of Health, 5 February 2015.

82 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

83 Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division, Department of Health, *Committee Hansard*, 5 February 2015, p. 92.

84 RACGP, 'Sanity prevails in proposed Medicare shakeup', Media Release, 15 January 2015.

> anticipates further discussion with the Minister in February. However, the Minister for Health has indicated the consultation process is likely to be completed within the next month.
>
> We consider this insufficient to adequately consider and analyse the most effective options for reforming Australia's complex healthcare system.[85]

3.76 Dr Duckett summed up the views of several witnesses with his observations on the progress of the Minister's 'wider consultations' process:

> We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at primary care in general practice and we do need to think about whether the current arrangements are right for the future. That is not something that can be done in a two-week period.[86]

Conclusion of the Minister's consultations

3.77 On 22 April 2015 the Health Minister announced the outcome of her consultations, which began in January 2015. The result of the consultations was:

> …overwhelming feedback…[that] Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions or the complex interactions between primary and acute care.[87]

3.78 In reporting the outcomes of the Minister's consultations, the media release noted that the government continues to categorise Medicare funding as unsustainable. However, the release insists that the government's process in response to the consultation will not seek savings.[88]

3.79 In comparison to the announcement of the Minister's consultation in January 2015 (see paragraph 3.63 above), the Minister's media release of 22 April 2015 stated that 'the Government's consultations did not include a co-payment policy – or proposal to examine one.'[89]

3.80 The government's response to the findings of the Minister's consultation are:

- establishment of the MBS Review Taskforce;
- establishment of the Primary Health Care Advisory Group; and

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85 RACGP, *Supplementary Submission 115*, p. 2.

86 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

87 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

88 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

89 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

- the government working with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks.[90]

3.81 Each taskforce will report back with priority areas in the later part of 2015.[91]

3.82 Chapter 4 provides a further discussion of the government response and the establishment of the MBS review as part of examination of the health measures in the 2015 Budget.

Committee observations

3.83 Associate Professor Owler wrote in March 2015 that health policy development in Australia has stagnated:

> The co-payment has sucked the life out of health policy development, discussion, and debate. This has not only been detrimental to the Government, it is also harmful for the practice of medicine and for our patients.[92]

3.84 As this chapter records, it has been difficult for everyone in the healthcare sector to understand whether or not the current government has a strategic plan for healthcare reform. Ms Alison Verhoeven, CEO AHHA, summed up a view that many witnesses had put to the committee over the course of its public hearings:

> It is not clear at all to me that there is a strategic vision or an articulated policy. What we do see is a compendium of attempts to address health budgets by measures that are aimed at cutting dollars from the health budget but then that are often reversed, such as the co-payment, obviously, and we welcome that reversal. It is indicative of the approach. A policy is put out into the public domain. It has largely got a funding cut element to it rather than a strategic objective. It is tested in the public domain and found wanting and then it is reversed or partly reversed, and then we see another measure put out into the public domain to be tested. I think that testing approach is really problematic. We need from the government a very clear strategic vision articulated so that health stakeholders can respond appropriately.[93]

3.85 Constant changes in government policy have been uppermost in the public debate about primary healthcare in Australia. The committee notes that while the major policy announcements from the government have become less frequent in recent months, the transparency around consultations and decision making has not improved. The committee observes a significant gap between the government's and the healthcare sector's perspective on public consultation and effective policy

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90 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

91 The Hon Sussan Ley MP, Minister for Health ' Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

92 AMA, 'Health Policy Stagnation', Media Release, 2 March 2015.

93 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.

development. The committee's view accords with that of the majority of witnesses being that there is a lack of evidence to indicate careful consideration or evidence-based policy making.

3.86 Although no further co-payment has been introduced, there appears to be conflicting comments from the government about its commitment to a price signal. The Minister for Health began her consultation in January 2015 with one of her four stated principles as 'we must insert a price signal of a modest co-payment into the health system for those who have the capacity to pay'.[94] She re-emphasised the importance the government places on a price signal while dropping the $5 co-payment in March 2015. But once the consultation was finished on 22 April 2015, the Minister's media release insisted that 'the Government's consultations did not include a co-payment policy – or proposal to examine one.'[95] The committee, in addition to those in the healthcare sector, and health consumers, wonder which statement in fact reflects government policy.

3.87 The other constant in government health policy, alongside the on again-off again co-payment, has been the MBS indexation freeze. This policy has, unlike the co-payment, endured throughout two budgets and numerous revised policy announcements. As discussed in Chapter 4, the indexation freeze has effectively become the price signal the government seems determined to implement. By being a significant constraint on the revenue for general practice, the indexation freeze will force general practice to pass on more costs to patients in order to remain viable. One witness observed that this shifts 'the odium [of the budget measure] from the government to the GP practice.'[96] As Chapter 2 outlined, this is the same effect as the co-payment would have had on general practice.

3.88 At the time of writing, the committee has begun hearings with stakeholders to determine the effects of the health measures in the government's 2015-16 Budget. These findings are detailed in Chapter 4 of this report. From this recent evidence, and the evidence the committee has heard so far—as detailed in this chapter—the committee is concerned that the government has failed to heed to the calls of general practice to work with it on positive reforms to primary healthcare in Australia.

94 The Hon Sussan Ley MP, Minister for Health, 'Government to consult on Medicare reform', Media Release, 15 January 2015.

95 The Hon Sussan Ley MP, Minister for Health, ' Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

96 Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation, South Australia Branch, *Committee Hansard*, 11 June 2015, p. 17.

Chapter 4
2015-16 Budget

Introduction

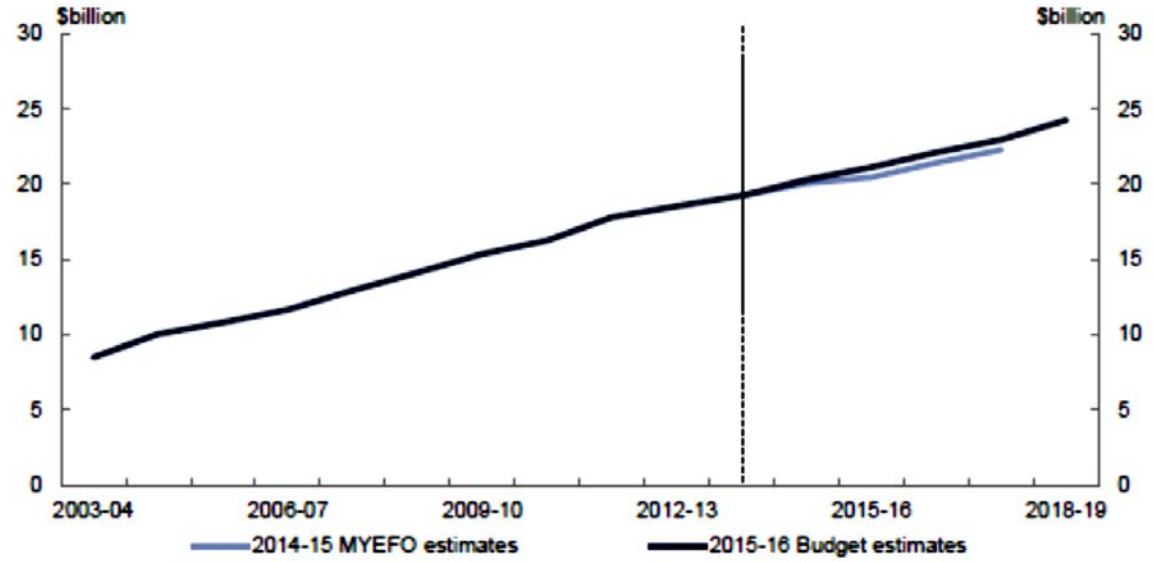
4.1 On 12 May 2015 the Government handed down its 2015-16 Budget. This chapter outlines those Budget measures which affect primary healthcare and general practice, and examines the initial commentary made by stakeholder groups.

4.2 The main 2015 Budget measures affecting primary healthcare are:

- Review of Medicare Benefits Schedule
- Rationalisation and streamlining of Flexible Funds
- E-Health: Introduction of the myHealth Record
- Re-introduction of Practice Incentives Programme (PIP) after hours care
- Removal of the Medicare Healthy Kids Check

4.3 The Medicare changes announced in the 2014 Budget and the 2014 MYEFO – consisting of the $7 co-payment and the shorter consultation times respectively – are excluded from the 2015 Budget.[1] The result is a gap in savings of around $3 billion over the forward estimates. This is represented in the 2015 Budget and 2014 MYEFO charts analysis completed by the Parliamentary Budget Office (see Figure 2).

Figure 2—Change from 2014-15 MYEFO to 2015-16 Budget[2]



1 Budget 2014-15, Budget Paper No. 2, 'Medicare Benefits Schedule – changes to GP rebates – reversal', p. 102.

2 Parliamentary Budget Office, *2015-16 Budget and forward estimates – charts*, 28 May 2015, p. 18.

4.4 The $7 co-payment and short consultation times policies and commentary around them can be found in Chapter 3.

4.5 Out of the measures introduced in the 2014 Budget, only three major health measures were continued into the 2015 Budget: the allocation of savings to the Medical Research Future Fund,[3] the continued indexation freeze, and the $5 co-payment on PBS items.[4]

Medical Research Future Fund

4.6 Despite its initial introduction in the 2014 Budget, the Medical Research Future Fund legislation was only introduced into the House of Representatives on 27 May 2015.[5] When questioned about the Medical Research Future Fund Bill 2015 during June 2015 Budget Estimates hearings, officials from the Department of Health told Senators that a number of concepts relating to the fund remain to be clarified.[6]

Indexation freeze

4.7 Another measure continued from the 2014 Budget is the indexation freeze. The Health Minister has stated that indexation freeze will remain in place even while the MBS review proceeds. In a statement on 22 April 2015, the Minister said:

> "As an article of good faith, I am open to a future review of the current indexation pause as work progresses to identify waste and inefficiencies in the system."[7]

4.8 The continuation of the indexation freeze has drawn strong criticism. The AMA have argued that the freeze will have the same effect as a co-payment as it will put a strain on general practice and force doctors to pass on additional costs to consumers:

> Even if indexation comes back in on 1 July 2018, the effects of the freeze will be felt forevermore because of the compounding effect. This will increase out-of-pocket costs for private medical care and force more people to seek care in the public sector. But the likelihood of them receiving timely care and treatment will be diminished by the squeeze on funding flowing from the Commonwealth.[8]

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3 Budget 2014-15, Budget Paper No. 2 p. 132.

4 Budget 2014-15, Budget Paper No. 2 p. 140.

5 *Votes and Proceedings No. 117*, House of Representatives, 27 May 2015, p. 1317.

6 Mr Martin Bowles PSM, Secretary, Department of Health; Mr Mark Cormack, Deputy Secretary, Department of Health; and Ms Janet Anderson, First Assistant Secretary, Acute Care Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, pp 26–27.

7 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

8 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 1.

4.9 The RACGP too have expressed significant concerns, telling the committee that ultimately additional costs for healthcare will cause most difficulties for the vulnerable:

> The RACGP has calculated that the freeze of general practice patient rebate consultation items will result in a total reduction of funding of $558.6 million up until 2019 for general practice consultation items alone. General practices cannot absorb the reduced funding and will be forced to either pass costs on to the patients, including those in society who are most vulnerable, or close down. Freezes on patient rebates are not sustainable for an already stretched sector.[9]

4.10 GPs told the committee that the indexation freeze would impact on the viability of their practices. For instance Dr Emil Djakic, a GP from Ulverstone, Tasmania, explained that the freeze would harm his business and the community in which it is based:

> The introduction of a price point and a co-payment and the change in our MBS rebate rates and a freeze over a period of time is going to significantly put pressure on that [low socio-economic] part of the community… Access, [to primary healthcare] I think, is under threat and my business views that as a concern.[10]

4.11 Dr James Wilson, another Tasmanian GP, expressed a similar view to Dr Djakic. He observed that the indexation freeze would dissuade medical students from choosing a career in general practice. Further, Dr Wilson felt that the government's indexation freeze policy would threaten GPs continuing to bulk-bill:

> As to the cuts, the freeze, and that, I am not quite sure that came from a medical think-tank, and it also basically says to someone who is young and up-and-coming: 'Either get out of or do not go into general practice, and don't bulk-bill.'… I think that the Australian system – and it is not perfect – is, in general, a wonderful thing. As to tearing away at the basis of that, like [Dr Djakic] was talking about, in general practice – which is a recognised value-for-money proposition – those changes do not sit well with me as a GP.[11]

Medicare Benefits Schedule review

4.12 As discussed in Chapter 3, after the Minister for Health announced that she would conduct wide ranging consultations with all stakeholders about possible healthcare reforms.

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9 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 8.

10 Dr Emil Djakic, Ulverstone GP, *Committee Hansard*, 17 April 2015, p. 26.

11 Dr James Wilson, Tasmanian GP, *Committee Hansard*, 17 April 2015, p. 27.

4.13 On 22 April 2015, the Minister announced that the outcome of her consultations was a review of the MBS.[12] The 2015 Budget provides $34.3 million over two years from 2015-16 for the Medical Services Advisory Committee's activities, including an expanded MBS review overseen by a clinician led Medicare Benefits Schedule Review Taskforce.[13]

4.14 Also included in the $34.3 million measure is the formalisation of government consultation with stakeholders on primary care. The consultation will be led by a Primary Health Care Advisory Group with 'will include primary health care professionals, health economists and health academics.'[14]

4.15 The Minister has identified three priority areas for the review:

> 1. The Government is establishing a Medicare Benefits Schedule (MBS) Review Taskforce led by Professor Bruce Robinson, Dean of the Sydney Medical School, University of Sydney. Currently, the MBS has more than 5,500 services listed, not all of which reflect contemporary best clinical practice. The MBS Review Taskforce will consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients.
> 2. The Government is establishing a Primary Health Care Advisory Group led by former Australian Medical Association President, Dr Steve Hambleton. The Advisory Group will investigate options to provide: better care for people with complex and chronic illness; innovative care and funding models; better recognition and treatment of mental health conditions; and greater connection between primary health care and hospital care.
> 3. The Government will also work with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks. The vast majority of medical practitioners provide quality health care, but a small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients.[15]

4.16 While the review is to be an ongoing process, each taskforce will report back with its key priority areas for action in late 2015.[16]

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12 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

13 Budget 2015-16, Budget Paper No. 2, p. 104.

14 Budget 2015-16, Budget Paper No. 2, p. 104.

15 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

16 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

4.17 During Budget Estimates, Mr Bowles, Secretary of the Department of Health, explained that the Primary Health Care Advisory Group would have a broad focus, looking at:

> …opportunities to reform primary healthcare to support better management of patients, particularly in the chronics and complex space. We are trying to make sure that Medicare and primary health care in those broader issues are sustainable into the future. We want to have a look particularly at the complex and chronic care conditions and at whether there are other ways of looking at those. Ultimately, that will look not only at models of care; it will look at the issues between the hospital sector and primary care and it will also look probably at some of the funding mechanisms that currently go to how we pay for services, particularly in that chronic disease space.
>
> You will see in the media sometimes that it is looking at blended funding models. It could be fee-for-service for certain things or it could be a payment for a certain set of activities. But if you have a look at some of the chronic disease categories like diabetes, some of the things you need there are care facilitation, allied health resources and all sorts of different things, not only doctor related issues. So this is about trying to have a bit of a fundamental rethink of how we might do that.[17]

4.18 Mr Bowles expected that the Primary Health Care Advisory Group would report back on its identified priorities by the end of 2015:

> Dr Steve Hambleton has been appointed the chair of that group and the rest of the group will be announced shortly. He has already started to talk with a range of people. The department is obviously underpinning a lot of the work in this space. We are supporting him in trying to look at how we might do things in this space. The idea would be that we come back to government later this year, probably closer to Christmas, around some options. That does not mean that we will have definitive answers to everything by Christmas, because, as you would appreciate, reforming Medicare and primary health care involves quite a complex set of issues. But, by Christmas, I think Dr Hambleton and others will have a pretty good idea of what is feasible and what may not be feasible.[18]

4.19 Asked about the relationship between the Primary Health Care Advisory Group and the Reform of Federation process currently underway, Mr Bowles acknowledged that there would be some overlap in the processes, but he could not outline the exact way in which one process might inform another:

> The green paper is likely to be out before then [Christmas time, when the Primary Health Care Advisory Group will report], but the white paper comes out at some stage early next year. Clearly, there will be overlap in

17 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

18 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

> some of these issues. It is fair to say that the reform of the Federation white paper, the health component, will have something to say about primary health care, and particularly chronic disease management…
>
> …Reforming the Federation white paper will go to the states and territories and the Commonwealth—the relationship, obviously, because that is what the Federation is. This [the Primary Health Care Advisory Group] will feed in to some of the thinking on it, but there will be a whole range of broader thinking as well.[19]

Commentary

4.20 The MBS review has been cautiously welcomed by stakeholders. For example Ms Alison Verhoeven, CEO of the AHHA told the committee that the AHHA welcomed the review:

> By taking a critical view on the validity of some of the treatments and processes currently in place, increased efficiency rather than blunt fiscal measures will drive sustainability. We hope that the government will commit to making public the findings of the review, and we recommend that mechanisms for regular ongoing reviews of the system be put into place to ensure that the MBS continues to operate in the most sustainable and cost-effective way possible.[20]

4.21 Noting the Minister's comments about her being open to remove the indexation freeze in the future as part of "good faith discussions", the RACGP told the committee that:

> The MBS review needs to examine the value and appropriateness of Medicare rebates, focusing on meeting patients' needs. While the health minister has indicated that the potential lift of the freeze may form part of the MBS review, the RACGP believes that they should be separate discussions.[21]

4.22 The AMA has welcomed the MBS review but remains sceptical of the outcomes and urged the Minister to hold to the stated object of the review and not have the review become a Budget savings exercise:

> The MBS review is one where we are encouraged by the statements that she is making—that it is to be clinician led with the prime goal of improving care and to have the MBS review reflect modern medical practice. But we are also extremely wary that this could be used as a device to simply to cut funding out of MBS wherever possible. We remain intensely alert to that possibility. We have always said that, as leaders of the profession of health care, we are open to good evidence and innovation in models of care, but

19 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

20 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, 19.

21 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 8.

> we are always looking to preserve the best of what we have built to this point and to improve the models of care. We think that Minister Ley is speaking in that regard, but again it is the outcomes that matter. We are always prepared to act in good faith. The question is: over time, will the deeds and policy positions of the government match that?[22]

Flexible Funds

4.23 The Flexible Funds were created in 2011 as a means of consolidating 159 health and ageing programs into a more efficient funding structure. Eighteen broader funds were created within the Health portfolio at this time. In 2013 following Machinery of Government changes, the following funds were transferred to the Department of Social Services:[23]

- Aged Care Workforce Fund; and
- Aged Care Service Improvement and Healthy Ageing Grants Fund.

4.24 The 16 Flexible Funds which remain under the Health portfolio are:

1. Chronic Disease Prevention and Service Improvement Fund
2. Communicable Disease Prevention and Service Improvement Grants Fund
3. Substance Misuse Prevention and Service Improvement Grants Fund
4. Substance Misuse Service Delivery Grants Fund
5. Health Social Surveys Fund
6. Single Point of Contact for Health Information, Advice and Counselling Fund
7. Regionally tailored primary care initiatives through Medicare Locals Fund
8. Practice Incentives for General Practices Fund
9. Rural Health Outreach Fund
10. Aboriginal and Torres Strait Islander Chronic Disease Fund
11. Health System Capacity Development Fund
12. Health Surveillance Fund
13. Quality Use of Diagnostics, Therapeutics and Pathology Fund
14. Health Workforce Fund
15. Indemnity Insurance Fund

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22 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 4.

23 Department of Health, department website, 'Flexible Funds – Funding the nation's health priorities', www.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfunds.htm.

16. Health Protection Fund[24]

4.25 The measure in the 2015-16 Budget states that savings of $962.8 million will be achieved over five years by 'rationalising and streamlining' funding across a number of programs, including Flexible Funds.[25]

4.26 However, Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, advised the Senate Community Affairs Legislation Committee at Budget Estimates that by a decision of government two funds had been excluded from the Budget measure:

- Aboriginal and Torres Strait Islander Chronic Disease Fund; and
- Indemnity Insurance Fund[26]

4.27 The 2015-16 Budget measure is in addition to a measure announced in the 2014-15 Budget to freeze the indexation on the Flexible Funds from 2015-16. This earlier measure resulted in "savings" of $197.1 million.[27]

4.28 At Budget Estimates, the Secretary of the Department of Health, Mr Martin Bowles, advised the Senate Community Affairs Legislation Committee that the 2015 Budget measure would take $596.2 million from the Flexible Funds, in addition to the $197.1 million from the 2014 Budget.[28]

4.29 It became clear during the Budget Estimates hearings that the government and the department have not considered the detail of how the Flexible Funds are to be "rationalised" and "streamlined". Mr Bowles told the Senate Community Affairs Legislation Committee that:

> We will do some detailed analysis over the next couple of months. There will be a range of different factors that we will take into account and we will have conversations with government about that as well.[29]

Commentary

4.30 The Department of Health's lack of detail about which Flexible Funds will be cut, to what extent and by when, have caused major confusion and concern amongst

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24 Department of Health, department website, 'Flexible Funds – Funding the nation's health priorities', www.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfunds.htm.

25 Budget 2015-16, Budget Paper No 2, p. 110.

26 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 10.

27 Budget 2014-15, Budget Paper No. 2, p. 131.

28 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 9.

29 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 11.

both stakeholders and the organisations dependent on this important source of funding.

4.31 The RACGP Vice President, Dr Morton Rawlin, told the committee that in the current circumstances it is impossible to estimate what programs might be cut. Dr Rawlins was concerned that evidence-based programs might be in danger:

> Our main concern is that we are really unclear as to what programs are being cut, what are not being cut, what the extent of visit percentage cut across the board of all programs is or whether a particular program is defunded. Without that level of evidence definition it is very hard to make an evidence based prediction. There may be, within those programs, some which—without funding evidence based programs—will disappear and that would be very negative. But there are others that may not be evidence based and it is not such an issue. We need to have more detail of where those cuts might affect, who they might affect and how they would impact on general practice and the health system, more generally. It is hard to say.[30]

4.32 Ms Helen Tyrrell, CEO of Hepatitis Australia, told the committee that her organisation's core work is funded under the Communicable Disease Prevention and Service Improvement Grants Fund. For Hepatitis Australia, the funding from the Flexible Fund is essential to its ongoing viability. Ms Tyrrell explained that she had raised the issue with the Minister:

> In this context, I asked the minister at the post-budget briefing at Parliament House what value she placed on the role of peak national organisations like Hepatitis Australia. Her response showed an understanding of our role and our commitment to the partnership approach. But, to be honest, it is of little comfort until I secure ongoing funding.[31]

4.33 Ms Tyrrell advised that without funding certainty, her organisation (and others like) it was subject to inefficiencies which undermined its core work:

> Since the Abbott government came into office, I have had two six-month extensions and now one 12-month extension to our core funding contract—and that takes us through to June next year. The inefficiencies that this has created severely undermine our ability to conduct the work that the government wishes us to conduct to address viral hepatitis in Australia.[32]

4.34 Ms Cathy Dyer, the Director of Corporate Services at the Maari Ma Health Aboriginal Corporation, provided a similar perspective on the disruptive nature of short-term government contracts. Her evidence also suggests that the duration of government contracts to non-government organisations are becoming shorter and shorter:

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30 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 12.

31 Ms Helen Tyrrell, CEO, Hepatitis Australia, *Committee Hansard*, 9 June 2015, p. 14.

32 Ms Helen Tyrrell, CEO, Hepatitis Australia, *Committee Hansard*, 9 June 2015, p. 14.

> As soon as you have attracted someone to the region, we always cross our fingers and hope that they will stay long-term…but, when that does not happen, you lose them to the region. If at the 12th hour or three months down the track or six months down the track a government department does find the funding to continue your program, you have lost that person, the relationships they have built up with their clients is gone and a new person needs to be found. That period of time of recruitment is long. They move to the region, they have to become familiar, they have to build relationships again, and you are 12 months further down the track. It is just the reiteration of the cyclical nature of funding that has plagued Aboriginal health forever. All this [uncertainty of federal funding] does is play into it again. So we do the best we can to maintain some level of stability, but government funding does not assist us. It really does not assist us in building relationships or in maintaining a good rapport with the clients that we are trying to assist. When government funding goes three years, 12 months, six months, three months, you lose people.[33]

4.35 Evidence given by Ms Amanda Mitchell, the Acting Deputy Chief Executive Officer of the Aboriginal Health Council of South Australia Inc, appeared to confirm a trend in government contracting for short-term contracts:

> We have had a very successful program with our tackling smoking and healthy lifestyle team. We found out a couple of weeks ago that it will be going to select tender later on this year, via invitation, and our program will continue for the next six months. In the last 18 months of the funding there has been a freeze on employment, so we have to have the same people in the team. For the last six months it has been extended by three months and then a further three months.[34]

4.36 Ms Alison Verhoeven, CEO AHHA, explained that the Flexible Funds support a large number of frontline healthcare and preventive health services:

> The flexible funds are used to support a whole range of programs and organisations that deliver services to people across the Australian community, including prevention type services and also chronic disease management, drug and alcohol treatment, mental health services and the like. Because they are largely delivered into the primary care sector, one of the important contributions that they make is reducing some of what might be preventable hospitalisations. That is very important not only for the health of the community but also for the sustainability of funding in the health system overall.[35]

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33 Ms Cathy Dyer, Director, Corporate Services, Maari Ma Health Aboriginal Corporation, *Committee Hansard*, 10 June 2015, p. 13.

34 Ms Amanda Mitchell, Acting Deputy Chief Executive Officer, Aboriginal Health Council of South Australia Inc, *Committee Hansard*, 11 June 2015, p. 12.

35 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 22.

4.37 Ms Verhoeven warned that cuts to the Flexible Funds and the organisations which rely on them will have real life harmful consequences:

> Ad hoc cuts in flexible funds will damage individuals, will damage organisations and potentially will increase the burden on the hospitals. Because we simply do not know where those cuts are going to be made—we did see in Senate estimates last week some headline figures, but they do not really provide us with great clarity about exactly where those cuts are going to occur—it is very difficult to understand what the impact will be on the overall health budget situation. What we can say, though, is that this is a part of the health sector which is underfunded at the moment anyway—in prevention and chronic disease management—and cuts will hurt.[36]

4.38 Ms Melanie Walker, Acting CEO of the Public Health Association of Australia (PHAA), told the committee that the confusion around how much would be cut from the Flexible Funds had been exacerbated by comments made by the Secretary of the Department of Health, Mr Bowles, during the 2015 Budget lock up:

> We subsequently found out in this budget that another $500 million or so, as announced in the health budget lock-up, was going to come out of the health flexible funds over the next four years. Just last week we found that that was actually another $596.2 million, as the secretary had rounded down in his briefing on budget night. That now means that $197.1 million [due to non-indexation] plus the $596.2 million takes it to the big end of $800 million worth of cuts across the health flexible funds to be applied over the next four financial years.[37]

4.39 Ms Walker outlined the extent of the uncertainty facing organisations receiving funding through Flexible Funds—with some funded for six months and others for 12 months:

> Obviously taking $800 million out of those funds over a period of four years has the capacity to decimate the efforts of the non-government sector in Australia, in our opinion. So we are very, very concerned about the implications of those cuts. Some of the currently funded organisations have received six-month extensions to their current funding agreements that are due to end on 30 June—as in this month—so that will take them up to Christmas. Others of the funds have received a 12-month extension, which will take them to June next year. But, as we understand it, all bets are off after that.[38]

4.40 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health's advice regarding the six and 12 month extensions of funding, provided at Budget Estimates was that:

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36 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 22.

37 Ms Melanie Walker, Acting CEO PHAA, *Committee Hansard*, 9 June 2015, p. 39.

38 Ms Melanie Walker, Acting CEO PHAA, *Committee Hansard*, 9 June 2015, p. 39.

> What is happening at the moment is that these organisations have been notified about extensions for six or 12 months. The reason for that extension is that we are looking to reconfigure the funds, as the secretary has indicated. As part of reconfiguring the funds, we will have to come up with new guidelines and new processes where people apply for funding. Once those processes are completed, everybody will have to reapply. Clearly, when you are looking across 14 flexible funds, you do not want to do them all at once. So we have some that we can do within the six-month period; others will take longer, and that is the 12-month period. That is what we are working through at the moment.[39]

4.41 Upon further questioning, Department officials provided evidence on the way in which funds had been chosen for six or 12 month extensions:

> Dr Bartlett: It was a fairly arbitrary decision.
>
> Senator DI NATALE: Did you draw the names out of a hat? What does 'arbitrary' mean?
>
> Dr Bartlett: No. 'Arbitrary' means that you look at it and decide on relative complexity of process to work through and then length of time that we think it will take us to do it.
>
> Senator DI NATALE: What was the process that you used to do that?
>
> Dr Bartlett: A group of us talked about it, talked to the minister's office about it and got agreement about how we would stage this.
>
> Senator McLUCAS: Was it by fund?
>
> Dr Bartlett: It was by fund.
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> Senator McLUCAS: Organisations funded by certain funds got six months and others that were funded through other flexible funds got 12?
>
> Dr Bartlett: It was done on a fund basis.[40]

4.42 Ms Walker also observed that some of the Flexible Funds that are planned to be cut relate to drug and alcohol dependency:

> It is a little ironic that two of those funds [the Substance Misuse Prevention and Service Improvement Grants Fund; and the Substance Misuse Service Delivery Grants Fund] are specifically in the area of alcohol and other drug treatment and prevention, given that we currently have the National Ice Taskforce working its way around the country looking at issues in terms of addressing the so-called ice epidemic. Whether it is an epidemic or not is up for some debate, but there is definitely a problem there. One would think

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39 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 13.

40 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 13.

> that, at this juncture, removing a big chunk of funding from alcohol and other drug related services would not necessarily be a sensible thing to do in terms of increasing capacity to address those problems, particularly in rural and remote Australia.[41]

4.43 Ms Walker advised the committee that it was her understanding that the drug and alcohol treatment services fund recipients had received a 12 month extension but that 'all bets are off after that'. She noted that with the drug and alcohol dependency services already subject to lengthy waiting lists and difficulty attracting staff, the cuts are ill timed to say the least:

> In terms of the capacity of the sector, I think it is well documented that there are lengthy waiting lists for most funded drug and alcohol treatment services in Australia and there have been for quite some time. It is a serious impediment to families and communities seeking assistance with these problems. Whether we are talking about the use of methamphetamine or alcohol related problems, or indeed any form of drug problems, drug and alcohol treatment services are the front line in providing assistance to families, individuals and communities who are addressing these problems. And when the waiting lists are quite lengthy already, any reduction in funding to these services would only create an additional barrier to people seeking help. At the moment we have seen $20 million go to an advertising campaign to raise awareness in communities around the potential impacts of ice and what that can look like at the pointy end. It seems a little misguided to be spending that money on raising awareness if, when that awareness is raised, there is nowhere to go for help. So, I guess that is our concern around cuts to the treatment sector.[42]

4.44 A concern highlighted by Ms Walker was that the uncertainty around the cuts to the Flexible Funds is making forward planning impossible for organisations, particularly those providing frontline services:

> It is really unclear, and that is what is so disconcerting for the sector at the moment. Everyone is okay today, but no-one really knows about tomorrow. And whether tomorrow is the end of the year or the end of the financial year, it creates a climate of uncertainty in which it is very difficult to do any service planning, particularly for front-line service delivery agencies such as those in the drug and alcohol treatment sector.[43]

4.45 Ms Walker told the committee that for frontline drug and alcohol dependency programs forward planning was vital—without it these services cannot admit people to receive treatment:

> Drug and alcohol rehabilitation is quite a lengthy process, so people stay in rehabilitation for some months. It is not going to be long before it becomes

41 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 39.

42 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, pp 40–41.

43 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 42.

> an issue for admissions. How are these services going to know whether they can accept more people into the programs if they are not sure how long their funding is going to go for and whether their funding is going to continue long enough for the person to complete their treatment?[44]

E-Health

4.46 The 2015 Budget describes the myHealth Record as 'a new direction for electronic health [e-health] records in Australia'.[45] The myHealth Record replaces the previously implemented Personally Controlled Electronic Health Records (PCEHR).

4.47 The change to myHealth Record from the PCEHR outlined in the 2015 Budget is a result of the findings of a review into the PCEHR commissioned on 3 November 2013 by the then Health Minister the Hon Peter Dutton MP.[46] The review handed down its report in December 2013,[47] and the report was made public on 19 May 2014.[48]

4.48 The 2015 Budget provides $485.1 million over four years to 'continue the operation of the eHealth system, make key system and governance improvements and implement trials of opt-out arrangements.'[49] The improvements include renaming the eHealth system, transitioning governance arrangements from the National E-Health Transition Authority to a new Australian Commission for eHealth. Trials of the new system, including an opt-out model will be held in 2016 and new legislation will be introduced to facilitate the changes.[50] This legislation is currently part of a consultation process being conducted by the Department of Health.[51]

4.49 The 2015 Budget notes that 'funding of $699.2 million for the redevelopment of the PCEHR was provisioned for in the contingency reserve at the 2014-15 Budget.'[52] The $485.1 million allocated in the 2015 Budget represents a saving of

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44 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 42.

45 Budget 2015-16, Budget Paper No. 2, pp 104-5.

46 Panel Report, *Review of the Personally Controlled Electronic Health Records*, December 2013, p. 5.

47 Panel Report, *Review of the Personally Controlled Electronic Health Records*, December 2013, p. 5.

48 Department of Health, department website, *Personally Controlled Electronic Health Record (PCEHR) System*, www.health.gov.au/internet/main/publishing.nsf/Content/ehealth-record.

49 Budget 2015-16, Budget Paper No. 2, pp 104–5.

50 Budget 2015-16, Budget Paper No. 2, pp 104–5.

51 Department of Health, department website, *Welcome to ehealth.gov.au*, http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/content/home.

52 Budget 2015-16, Budget Paper No. 2, pp 104–5.

$214.1 million, which will be 'redirected by the Government to fund other Health policy priorities or will be reinvested into the Medical Research Future Fund.'[53]

Commentary

4.50 There has been cautious stakeholder support for the government's changes to e-health records. For example, the RDAA commented:

> The previously announced trial of an opt-out eHealth system, to be renamed the My Health system. We welcome this in-principle, and the Government's recognition of the need to support doctors and practices should an opt-out system be adopted.[54]

4.51 Ms Verhoeven, CEO of the AHHA, told the committee that:

> The AHHA cautiously welcomes the investment in e-health through the funding of the My Health Record program. We argue that the provision of timely access to patient's health records is an essential step in improving health outcomes in Australia and coordinating care. But given the uptake of the Personally Controlled Electronic Health Record was limited, we do think that piecemeal budget responses are not an adequate response.
>
> We encourage the government to implement the recommendations of the AHHA submission to the PCEHR review, such as focusing on enhancing information exchange and the interoperability between systems rather than developing additional data repositories; identifying barriers to participation; providing incentives to engage clinicians; and achieving a suitable balance between the need for information and privacy. These are all challenges that must be addressed. Going forward, new approaches to e-health need to be clear, decisive and capable of delivering more significant results than the staggering steps we have seen in the past.[55]

After-hours Care

4.52 Funding for the Medicare Locals had included the Practice Incentives Programme (PIP) After Hours Payment, with the role of the Medicare Locals being to ensure that after hours care was provided in their areas and GP practices received payment for the service.[56]

4.53 In 2013, the then Health Minister the Hon Peter Dutton MP commissioned a review of the Medicare Locals by Professor John Horvath.[57] The review found that

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53 Budget 2015-16, Budget Paper No. 2, pp 104–5.

54 RDAA, 'Mixed-bag Budget for rural health sector: Rural doctors search for fine details in Health Budget', Media Release, 12 May 2015.

55 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.

56 National Health Reform Process and Delivery Publication, Government Publication, September 2011, p. 18.

57 The committee examined the Review of Medicare Locals in its first interim report. For further reading, see: Senate Select Committee on Health, *First Interim Report*, 2 December 2014, Chapter 4.

stakeholders were largely unsatisfied about the Medicare Locals' administration of the after-hours care programme.[58] As a result of this finding, Professor Horvath recommended that a separate review be conducted to focus on the Medicare Locals' administration of the after-hours care programme.[59]

4.54 The *Review of After Hours Primary Health Care* report, which was conducted by Professor Claire Jackson, was announced on 19 August 2014. In announcing the review, Minister Dutton explained that Professor Jackson would begin the review immediately and hand down her findings to the Government by 31 October 2014.[60] Professor Jackson's report was made public on 15 May 2015.[61]

4.55 Professor Jackson's review recommended, amongst other things that:

> **Recommendation 1**
>
> The Commonwealth resumes responsibility for after hours funding of general practice from Medicare Locals from 1 July 2015.
>
> **Recommendation 2**
>
> A revised Practice Incentives Programme (PIP) After Hours incentive is accessible for accredited general practices from this date.[62]

4.56 The PIP After Hours Payment outlined in the 2015 Budget implements the first two recommendations of the *Review of After Hours Primary Health Care* report. The Budget measure notes that the PIP payments will be available from 1 July 2015. Funding for the PIP will be 'met by redirecting funding from the After Hours GP Helpline and the Medicare Locals After Hours Programme.'[63]

Commentary

4.57 The PIP After Hours Payment was the least criticised component of the 2015 Budget, with the return of the policy that had been scrapped in the 2014 Budget supported by stakeholders:

- The AMA commented in a media release: 'the AMA has been calling for the return of the PIP funding for some time. The new PIP payment structure will

58 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 7.

59 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, recommendation 8, p. v.

60 The Hon Peter Dutton MP, Minister for Health, 'Review of After-Hours Service Delivery', Media Release, 19 August 2014.

61 Ms Marie McInerney, 'Not all “Captain Chaos” but much confusion, concern on post-Budget health issues', *Croakey blog*, 19 May 2015, http://blogs.crikey.com.au/croakey/2015/05/19/not-all-captain-chaos-but-much-confusion-concern-on-post-budget-health-issues/.

62 Professor Claire Jackson, *Review of after hours primary health care – report to the Minister for Health and the Minister for Sport*, 31 October 2014, p. ix.

63 Budget 2015-16, Budget Paper No. 2, pp 109–110.

encourage and support general practices to provide After Hours coverage for their patients, which will in turn ensure continuity of care.[64]

- The RDAA also commented positively: 'The return of the management of after-hours incentive payments to the Practice Incentive Payments program in 2015-16 — we welcome this in general terms, as it should return funding and contract certainty for rural practices in relation to the provision of after-hours services.'[65]
- Similarly, the RACGP President Dr Jones said 'the RACGP genuinely supports the Government's move to return the delivery of after-hours care to GPs via the Practice Incentives Program (PIP) After Hours Payment from July 1 2015. Having GPs coordinate after-hours care is a win for patients who will be able to access the care they need from their regular general practice when they need it – even if it isn't during normal operating hours.'[66]

Removal of the Medicare Healthy Kids Check

4.58 A final budget health measure affecting primary healthcare is the cancellation of funds for the Medicare Healthy Kids Check. The 2015 Budget states that the current health assessments for children provided under the MBS are duplicated by the child health assessments currently provided by states and territories.[67]

4.59 The 2015 Budget notes that this measure will create savings of $144.6 million over four years. The savings will be 'redirected by the Government to fund other Health policy priorities or will be reinvested into the Medical Research Future Fund.'[68]

4.60 The Medicare Healthy Kids Check which began in July 2008:

> …checks physical health, general wellbeing and development in children over the age of three and under the age of five years, to ensure they are healthy, fit and ready for school.[69]

4.61 The 2011 Budget had committed an additional $11 million over five years (to 2015-16) for an expansion of the Medicare Healthy Kids Check to include:

> …development and social and emotional wellbeing, and lower the target age for the Medicare Healthy Kids Check from four to three and a half years.[70]

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64 AMA, 'New arrangements will improve after hours GP services', Media Release, 22 May 2015.

65 RDAA, 'Mixed-bag Budget for rural health sector: Rural doctors search for fine details in Health Budget', Media Release, 12 May 2015.

66 RACGP, 'Budget delivers mixed bag for general practice', Media Release, 12 May 2015.

67 Budget 2015-16, Budget Paper No. 2, p. 103.

68 Budget 2015-16, Budget Paper No. 2, p. 103.

69 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

4.62 The expanded Medicare Health Kids Check commenced in early 2013 with a pilot through eight Medicare Locals under the direction of the Australian Medicare Local Alliance. Included in the pilot was an orientation package for GPs and other health professionals which was aimed at ensuring that those delivering the check had access to the appropriate tools and resources. The pilot was completed in December 2013.

4.63 The Medicare Healthy Kids Check continued to be available in all general practices, however the expanded check was available only in those practices which were included in the pilot areas.[71]

4.64 On 16 December 2013, Minister Dutton announced the Review of Medicare Locals by Professor John Horvath.[72] The Medicare Locals Review, and the implementation of its recommendation to transition Medicare Locals to Primary Health Networks, has meant that the expanded Medicare Healthy Kids Check has remained under the consideration of government.

4.65 In cancelling the Medicare Healthy Kids Check in the 2015 Budget, the Hon Sussan Ley MP, Minister for Health argued that

- similar child health assessments are available under state and territory government funded programs;
- the spending on the Healthy Kids Checks is unsustainable; and
- that the Healthy Kids Checks have been criticised in the past for not being of benefit to children.[73]

Commentary

4.66 Despite the Health Minister's argument in her media release on 19 May 2015 that the Medicare Healthy Kids Check is duplicated by states and territories, there has been criticism of the government's decision to cut funding.

4.67 Most notable has been the strong criticism from the RACGP and Speech Pathology Australia. RACGP President Dr Jones has advocated for GPs to be central in early monitoring of the overall health of children because a GP can take into account family conditions and observable changes in a child's development.[74] Dr Jones argued that:

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70 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

71 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

72 The Hon Peter Dutton MP, Minister for Health, 'Medicare Locals Review', Media Release, 16 December 2013.

73 The Hon Sussan Ley MP, Minister for Health, 'GPs still funded to deliver important kids checks', Media Release, 19 May 2015.

74 RACGP, 'Budget threatens health of Aussie kids', Media Release, 18 May 2015.

> Restricting this service to state based programs will limit access and further fragment care by forcing families to seek care outside their regular general practice… It is disappointing the Federal Government made this decision without discussion or consultation with the profession because we could have provided advice on how to improve the Healthy Kids Check.[75]

4.68 Dr Morton Rawlin, Vice President of the RACGP, enlarged on RACGP public statements at the committee's hearing on 9 June 2015. Dr Rawlin told the committee that there were two reasons for the importance of the Medicare Health Kids Check. The first was the priority the check gave to preventative health:

> …in many ways, it [the Health Kids Check] is actually a signal that preventative health is important. Up until several of these item numbers appeared—and the Healthy Kids Check was probably the main one—preventative health was really done, if you like, under the carpet. It was not recognised within Medicare, item numbers and things like that.[76]

4.69 The second point Dr Rawlin raised related to the government's argument that the federally funded Medicare Healthy Kids Check duplicate the children's assessments provided by states and territories. Dr Rawlin noted that:

> One problem that we have is that the system is both state and federal, where maternal and child health services generally are state funded in most states and, as such, the services are very variable across the states and certainly across a state they are also very variable. We do know that now the distribution of general practice is actually not unreasonable. It does reach virtually all of our population.[77]

4.70 Dr Rawlin also told the committee that the RACGP was pleased that at least the Aboriginal and Torres Strait Islander Healthy Kids Check had been retained.[78]

4.71 Speech Pathology Australia also voiced concerns about the cutting of the Medicare Health Kids Check. It argued that the check is an important referral pathway to speech pathology assessment for young children who are identified as having a delayed communication development.[79] Noting that the government had a process of MBS review in train, Speech Pathology Australia observed that:

> It is of significant concern that the Government has chosen to cease this Medicare item ahead of the actual review of Medicare announced recently. Speech Pathology Australia is evaluating the possible impact on referral

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75 RACGP, 'Budget threatens health of Aussie kids', Media Release, 18 May 2015.

76 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

77 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

78 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

79 Speech Pathology Australia, 'The Budget 2015-2016: What's in it for Speech Pathologists?', Media Release, May 2015.

> pathways for children and options for increased advocacy around these issues.[80]

4.72 Professor Nigel Stocks, the Head of the Discipline of General Practice at the University of Adelaide, contended that the government's cancellation of the Health Kids Check program may not result in an overall savings to Medicare:

> …it is not clear to me as a medical practitioner how much the programs are uniform across Australia for maternal-child health checks run by state systems. Certainly, children would miss out, potentially, in those circumstances. I would like to emphasise that these health checks are often undertaken as part of team work within a general practice. It is not just the GP who is involved; it often is the practice nurse. This is actually a good way of developing primary health care within Australia, and having a team approach to health care. That is particularly pertinent for childhood health checks.
>
> If people expect that general practitioners will take up the slack from not being able to do the health check with an MBS item, it will be difficult, because the nurse will not necessarily be involved, because there will be no direct remuneration for that time against all the other things that the nurses are potentially doing. Therefore, the time allowed for that check will be necessarily decreased. If the time were increased there would still be a cost, because you might go from, say, a level B, when you are doing some immunisations, to a level C or even to a level D, and that is going to cost extra money. So the cost savings may or may not be apparent if you are just switching from a formal health check to a time based formula.[81]

4.73 In a recent opinion piece for Medical Observer, Associate Professor Owler criticised the government's claims that the Medicare Healthy Kids Checks duplicated state child health assessments. He argued that rather than the suddenly cancelling the Healthy Kids Checks in the 2015-16 Budget, the government should have considered the checks as part of the MBS review:

> There have also been cuts of nearly $150 million taken out of general practice from changes to the child health checks, apparently because of 'duplication'. It is very unclear where the so-called duplication occurs. Such a change would have been better dealt with as part of the MBS review, rather than as a hastily conceived budget saving measure.[82]

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80 Speech Pathology Australia, 'The Budget 2015-2016: What's in it for Speech Pathologists?', Media Release, May 2015.

81 Professor Nigel Stocks, Head, Discipline of General Practice, University of Adelaide, *Committee Hansard*, 11 June 2015, p. 31.

82 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

Committee observations

4.74 Associate Professor Owler has written that 'one of the greatest compliments you could pay the 2015 health budget is that it is not the 2014 health budget'.[83] He observes that while the 2015-16 Budget contains few 'bad policies', it continues the detrimental measures of the indexation freeze and the cuts to public hospitals. Worse still, other measures such as the cuts to the Flexible Funds are shrouded in secrecy, and information on just what the cuts will involve is scarce.[84]

4.75 As discussed in this chapter, the main 2015 Budget measures affecting primary healthcare are:

- Review of Medicare Benefits Schedule
- Rationalisation and streamlining of the Flexible Funds
- E-Health: Introduction of the myHealth Record
- Re-introduction of Practice Incentives Programme (PIP) after hours care
- Removal of the Medicare Healthy Kids Check

4.76 The introduction of the myHealth Record (a re-vamped PCEHR) and the re-introduction of the PIP afterhours care funding have received a generally warm reception with stakeholders. These measures represent either decisions long delayed (action on the PCEHR review handed to the government in October 2014) or a reversal of much criticised decisions from the 2014-15 Budget (the removal of PIP funding pending a review).

4.77 Other measures have drawn criticism due to the paucity of detailed information. The MBS review has been welcomed, but only tentatively. In particular, as noted at paragraph 4.19, the AMA has reserved judgement on the review, pending evidence that the government is indeed acting in good faith and not using the review as a means of cutting primary healthcare to achieve budget "savings".

4.78 The "rationalisation and streamlining" of the Flexible Funds has drawn much criticism, in particular for the uncertainty the lack of information is creating amongst groups who rely on these funds for ongoing resourcing. That the government and the Department of Health have yet to decide how the "rationalisation and streamlining" process will occur is a reason for great alarm. With many frontline service organisations reliant on the Flexible Funds, the ongoing uncertainty is highly likely to result in real life consequences for patients and health consumers, as well as those employed by frontline service providers.

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83 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

84 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

4.79 Key among criticisms of the decision to scrap the Medicare Healthy Kids Check is that no consultation was conducted before the measure was announced in the 2015-16 Budget.

4.80 The committee notes that its previous report highlighted the need for the government to make substantial improvement in evidence-based policy making, transparency, and consultation. Given the lack of detail in the 2015 Budget, indications that the government did not consult, and the early reactions of stakeholders, it is reasonable to suppose that the government has not improved in those areas in which it previously failed.

4.81 The committee agrees with the view put by Ms Verhoeven, CEO of AHHA, and strongly suggests the government have regard to the same advice:

> Overall, it is the AHHA's view that the health portfolio continues to have a burning need for strategic vision, for genuine consultation with all stakeholders, and not just a chosen few, and a true partnership with the states and territories and regional health bodes, rather than a penalising approach, in order to deliver what we all want: a healthy productive Australia with healthy contributing citizens.[85]

85 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.

Chapter 5

Related issues

5.1 This chapter examines various other important issues which have been raised in evidence since the committee's first interim report. The specific issues covered in this chapter are:

- General Practice training;
- Workforce matching;
- Patient transport; and
- Paramedics.

General Practice training

5.2 Several GP training providers told the committee of their concerns over the compounding impacts of the government's proposed changes to Medicare, the surfeit of medical graduates compared to the paucity of training positions, and the cancellation of important GP training programs. The evidence demonstrates that these issues are particularly acute in regional and rural areas.

Diminishing attraction of General Practice

5.3 Dr Hespe, a General Practitioner and also an academic at Notre Dame University, foreshadowed the waning interest of medical graduates in becoming general practitioners due to practical consideration of costs, potential income and status:

> At the moment, when I talk to my medical students, they say, 'I love the concept of primary health care. I love how you sell it to me. For me, it is the best specialty I could ever be in. I love the fact that we are involved in the whole part of a patient's health.' We are not just involved in a silo of one bit; we actually very much manage complexity. It is incredibly complex, it is very challenging, and it is a fantastic specialty.
>
> But we are not recognised. We get paid a pittance in comparison to the other specialties which, from my perspective as a personal thing, is not the problem; the problem is about attracting future doctors. They have big debt from going to university. They look at a range of specialties which all interest them. You go through hospitals and you have the specialty silos in front of you. You do not have the primary care in front of you. That is off to the side.[1]

5.4 These mounting disincentives appear to have been compounded by the government's recent detrimental policy changes in primary care. The committee heard evidence from Dr Jomini Cheong, the Chair of the General Practice Registrars

1 Dr Charlotte Hespe, private capacity, *Committee Hansard*, 19 February 2015, p. 30.

Australia which demonstrates that medical students are being dissuaded from specialising in General Practice due to the uncertainty created by the government's proposed co-payment:

> …I think there has been an impression that that [the proposed co-payment] has not been a good sign of government support for general practice. Fortunately, it did not go ahead, and that is a good sign; however, the mere fact that even came up signalled a potential issue to future general practice registrars and future general practitioners in that, if this has come up once, will come up again in the future? That is a thought that is going on in many people's heads and they are all wondering: is it better if I just hang on and do another specialty because the funding will not be as threatened, especially with regard to my ballooning student expenses? Will this be better for me and my family in the long run?[2]

5.5 Dr Cheong's comment about 'ballooning student expenses' was put into perspective by Dr Saxon Smith, the President of the AMA NSW:

> …We are very fearful of the [government's] policy around user pays in an extreme way for university education. For graduates to come out with $100,000 or $150,000 debt to pay back it will make general practice a less attractive option, and you will see a further decline in our ability to provide quality care in that community setting in general practice. We have long said that—since it was on the table, proposed in May 2014. That is a great concern for us.[3]

5.6 Dr Cheong also highlighted similar concerns with the government's proposal to freeze the regular indexation of the MBS for four years:

> …the Medicare rebate freeze...is also a sign that there may be insufficient support for general practice. I know it applies to other specialties, but one of the things that people are thinking is: 'Look, it's going to become a pay cut in the future. Do we want to get into this specialty, knowing that this is going on at the moment and there is currently no support for ceasing that as such?'[4]

Medical graduate numbers compared to training positions

5.7 Although not confined to general practice, significant concerns were raised about the growing number of medical graduates and the looming bottleneck due to a lack of medical training positions. In describing the 'perfect storm' created by the government's recent health policy decisions, Dr Stephen Parnis, the Vice President of the AMA explained in detail the looming challenges for Australia's medical workforce:

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2 Dr Jomini Cheong, Chair, General Practice Registrars Australia, *Committee Hansard*, 9 June 2015, p. 26.

3 Dr Saxon Smith, President, AMA NSW, *Committee Hansard*, 11 March 2015. p. 50.

4 Dr Jomini Cheong, Chair, General Practice Registrars Australia, *Committee Hansard*, 9 June 2015, p. 26.

> Thrown into that storm is an emerging medical workforce crisis. Unlike the position we were in 10 years ago, the crisis we see is not one of too few doctors. Rather, we have a crisis of too many junior doctors for too few training positions. There is a crisis of the Commonwealth government's own making. It is a crisis driven by an absence of planning and coordination and a lack of appreciation of what it takes to train a medical practitioner. We have seen a big increase in medical student numbers across the country. In 2004 there were 1,500 medical graduates per year. It is now 3,732. However, medical training does not end when a student graduates from medical school…
>
> Medical graduates need to go on to complete intern training and one or more prevocational years and then go on to a specialist training program that can last from three to six years—or longer in certain cases. The bulk of medical training is delivered in the public hospitals sector. The former Health Workforce Australia had started to make real progress towards improving medical workforce planning and coordination, delivering two national medical workforce reports and forming the National Medical Training Advisory Network. However, before it could realise its full potential, HWA was disbanded in the 2014-15 [Federal] budget. Its functions were moved into the Department of Health and, in terms of progress, we are yet to recover from that decision. Momentum has been lost and, while the work program continues, it has been considerably delayed.
>
> Health Workforce Australia final medical workforce report…looked ahead until 2030. It said we should be focused on improving the distribution of medical workforce and encouraging future medical graduates to train in the specialties where they are needed—something fully supported by the AMA. That same report also made it clear that Australia is struggling to provide adequate numbers of training positions for junior doctors. In terms of specialist training positions, HWA's workforce modelling said that by 2018 there would be a shortfall of 569 first-year advanced training positions, rising to 689 places in 2024 and rising further to 1,011 places by 2030. HWA did not recommend that Australia needed more doctors. Indeed, its most likely modelling scenario showed that Australia would not have a shortage of doctors by 2030.[5]

5.8 Dr Parnis went on to explain the AMA's concerns regarding the government's recent announcement of $20 million to fund a new medical school at Curtin University in Western Australia:

> …the AMA was extremely disappointed to see the government announce funding to support a new medical school at Curtin University. That decision ignores the previous advice of HWA, and we know the government did not seek the advice of its own medical workforce advisory body, the National Medical Training Advisory Network, before taking that decision. Putting more medical students into the medical training pipeline will just make the above shortages worse; rather than fix the pipeline, it will flood it, particularly if the public hospital funding is inadequate to meet patient

5 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, pp 1–2.

> demand, let alone train our future doctors. It is a decision that has been criticised by the AMA, medical students, the medical deans of Australia and other medical organisations.
>
> This criticism is not born of self-interest. It is backed by a body of evidence, independent modelling and robust advice. In short: the government has failed to address the key challenges identified by HWA and instead will be pumping funding into a medical school that is not needed. It is money that could be better spent supporting other parts of the medical training pipeline and helping to make sure that our future medical workforce is meeting community need.[6]

Cancellation of GP training programs

5.9 Several witnesses raised concerns about the government's decision to abandon programs which directly promoted the specialisation of General Practice. For instance, Associate Professor David Campbell of the Australian College of Rural and Remote Medicine echoed the sentiment of many witnesses regarding the government's decision to cease the Prevocational General Practice Placement Program (PGPPP):

> It was a major [shock] to the whole sector when that program [the PGPPP] was removed… It had been such a successful program, and there is well-documented evidence about how successful it was and has been. The rationale for the removal of the program was that the Commonwealth was no longer going to pay for junior doctors, who are the responsibility of the states, to undertake community practice. That was the rationale for the decision.[7]

5.10 Professor Campbell highlighted the negative impacts to rural general practice that will flow from the cessation of PGPPP and the government's proposed changes to Medicare:

> The combination of that decision [to cease the PGPPP] and the decision about Medicare co-payments or a reduction in the Medicare rebate creates not only issues around the viability of rural general practice as a small business, but it also creates major disincentives within the training system, particularly when we have graduates who may be, if we have the changes to tertiary education structures that are being promoted, emerging with a $100,000 debt that they have to pay back once they graduate as doctors. With that level of debt they are going to be more attracted to the high income sub-specialities. They are not going to be interested in rural practice, which the evidence shows generates a lower income, and particularly rural general practice.[8]
>
> …

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6 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 2.

7 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 27.

8 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 27.

> The other concerning data is that more 50 per cent of rural doctors are now over the age of 50 and are considering their retirement decisions. So how are we going to replace those doctors when they do retire over the next decade to 15 years when we are not steering the increased number of graduates? We have increased the number of medical school places, but we are not incentivising the system to encourage those doctors to undertake rural practice and rural careers.[9]

5.11 Similar concerns were raised about the abolition of a program known as General Practice Training or GPET and the function being taken up by the Department of Health. Dr Saxon Smith told the committee that:

> We have to also take it in the broader construct that [the government has] dissolved the current structure for general practice training in Australia as a whole. Previously we have had education organisations. Sometimes they were Medicare Locals who had that second hat. Sometimes they were stand-alone entities with purely educational viewpoints, which is GPET, the general practice training. That has also had a line put through it—slashed, gone and absorbed back into the department of health and ageing at a federal level. We have great concerns as an organisation for the quality of training, the ability of people to train in general practice, with those training options gone.[10]

5.12 In fact the committee heard the same views everywhere in Australia it held public hearings and spoke to GPs. For example, Dr Emil Djakic, a GP from Ulverstone, Tasmania, told the committee:

> I will speak to capacity in general practice. We have held concern for some time about the workforce that we have available to us. Fortunately, through strategies over the past five to six years federally, there has been increasing training availability, although the loss of the PGPPP program I think represents a large threat to our industry due to the lack of exposure of doctors resident within the hospital system that get to experience a taste of general practice before they choose to move into it as a commitment to a vocational stream. So we lament that loss, but we appreciate the increase in formal general practice training.[11]

Workforce matching

5.13 Coupled with the disruption to training and succession planning caused by the loss of the PGPPP and the GPET has been the loss of the workforce planning work undertaken by the now abolished Health Workforce Australia.

5.14 Dr Parnis, Vice President AMA, told the committee that with only a very few staff from Health Workforce Australia being retained as the remains of the agency transitioned to the Department of Health, much momentum in workforce planning had

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9 Associate Professor David Campbell, Censor-in-Chief, Australian College of Rural and Remote Medicine, *Committee Hansard*, 13 February 2015, p. 28.

10 Dr Saxon Smith, President, AMA NSW, *Committee Hansard*, 11 March 2015, p. 53.

11 Dr Emil Djakic, GP, Ulverstone, Tasmania, *Committee Hansard*, 17 April 2015, p. 25.

been lost. Dr Parnis believed that now the Department of Health is struggling to capture the data needed for workforce planning, particularly in regards to specialties:

> There are many specialities, for example, across the medical workforce in Australia and, as I understand it, the Department of Health is now methodically trying to work through each of those specialties to put data to the decisions that governments at all levels need to make, as well as individuals. We know that that data, in an incredibly complex area, is really important. We have got it wrong decade after decade in Australia with boom and bust—for example, the perception 25 years ago that there were too many doctors and within a decade the acknowledgement that we were profoundly short. That information is really important. Looking specialty by specialty, I believe the department is looking at about three specialties at the moment: psychiatry, general practice and anaesthetics. It would seem to me that the resourcing available to them to pursue these issues is such that it will take many years to get the specialty by specialty information that is required.[12]

5.15 Dr Parnis explained that without information about specialties, there can be little useful work done in collaboration with the states and territories about planning for gaps in numbers of specialists. As a result Dr Parnis feared that the current work was continuing, but very slowly:

> As I said, it is of practical importance. It says to states and territories where they need to resource so that you can get, for example, appropriate numbers of psychiatrists in regional Victoria and so that you can encourage people aspiring to a career in anaesthetics to recognise that they are less likely to get a job if they want to stay in the centre of Sydney or Melbourne. These are the things that, again, we are very supportive of. Doctors are clever people if they recognise, as a junior doctor planning their career, they have a much easier career path if they aspire to general medicine and geriatrics rather than interventional cardiology—that makes sense. The AMA is very supportive of that. So this is again a negative. I am very impressed with the work that is coming out of that area now but, unfortunately, I think is it still taking longer than it should and I think it is a function of the resourcing available and the fact that it lost momentum in the transition.[13]

5.16 An example of Dr Parnis' concerns about the impact on states and territories can been seen in the evidence the committee heard in Burnie from the Rural Clinical School, University of Tasmania. Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania told the committee that recruitment and retention of doctors and specialists in rural areas is a constant problem:

12 Dr Stephen Parnis, Vice President RACGP, *Committee Hansard*, 9 June 2015, p. 3.

13 Dr Stephen Parnis, Vice President RACGP, *Committee Hansard*, 9 June 2015, p. 3.

> One issue that we always have in rural areas is around recruitment and retention of doctors—that is, both for the emergency departments and in general practice…It just takes a long time to recruit and retain doctors.[14]

5.17 Associate Professor Shires explained that the University of Tasmania was looking at ways in which to try and mitigate the problems with recruitment and retention of doctors to rural Tasmania:

> Most of the research now coming out of rural clinical schools or areas where they train people in rural areas is showing that that is working. I suppose the next step is also around doing more specialty training in rural areas so that we have got general specialists working in rural areas as well.[15]

5.18 Some of the approaches the University of Tasmania Rural Clinical School had tried included:

> One thing we do as part of the rural clinical school with the training here…is to encourage more people to come and work here. I think looking at the long term, the best way of increasing access is to increase the number of doctors here and reduce the number of locums.
>
> …I think training is one of the big solutions. I would say that because I am from the rural clinical school and we are part of a movement to train people in rural areas. We have been going for about 10 years. In the olden days, or prior to that, doctors were always trained in cities and then many came from cities and therefore they only chose to work in cities. Over the last decade we have tried to change that so that there is more training in rural areas so that people come out to the rural areas early on in their careers and hopefully will stay on. We know that that works.
>
> Another thing that we know works is recruiting people from rural areas. If we can get more of our young people to do medicine—other health professions as well, but more particularly we are talking about medicine today—we know that they are more likely to come back into the rural areas. These are all long-term solutions, but I think we have not addressed the rural issue in the short term by lots of other measures. So I think we need to take a long-term view on it.[16]

Patient transport

5.19 Witness concerns with the adequacy of patient transport recurred throughout the hearings. For instance Mrs Diana Aspinall, who is a member of the Consumer Reference Group GP Network, Blue Mountains, revealed the cost of transport to be an

14 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

15 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

16 Associate Professor Lizzi Shires, Co-Director, Rural Clinical School, University of Tasmania, *Committee Hansard*, 17 April 2015, p. 3.

overlooked but vital element in the complex interplay of health costs for people with and without a healthcare card:

> We are starting to see that there is a difference and a disparity between urban health consumers and regional and rural consumers in terms of these transport costs and access costs to actually get to the services. Consumers are telling us that increases in the payment of [a] gap for any health service means that they will not be able to afford the service, and we have got clear evidence from our consumers that they are just not going to the doctor. The increases in the gaps are for all sorts of services—we are not just talking about one particular service. Wherever they have to pay a gap on top of the transport costs it means they just do not go. There is plenty of evidence that they just go back to the GP and they have not followed up the referral at all.[17]

5.20 Parts of the disability sector also raised concerns about the challenges posed to access to health services by a lack of adequate and affordable public transport. The CEO of the Central Coast Disability Network, Mrs Jenny MacKellin explained the problems associated with long travel times and delays experienced in accessing Sydney based services from the NSW Central Coast. The cost of transport was also identified as a significant issue. Making reference to the government's co-payment proposal, Mrs MacKellin stated that if patients with a disability 'cannot afford the $2.50 bus fare, they cannot afford a $7 co-payment':

> We are constantly hearing from families who cannot access services here on the Central Coast and are required to travel to Sydney or Newcastle for those services. It is very difficult if you have a child who has sensory needs, who cannot travel on public transport and who cannot wait for long periods of time, and you are told that you have to go to Westmead Children's Hospital or other hospitals to receive services on a very regular basis. If mum or dad do not have access to their own transport to transport the child, or if the child cannot be transported safely in the car with just one person, which is often the case, then they are reliant on other means of travel. Community transport is not affordable to all. Community transport is an expensive form of transport for many people. It is a great service, but you do need to book and plan in advance. If that is your means of transport to get to a medical appointment, you need to be aware of that appointment in advance, which is not always the case.
>
> So people often find that transport is an issue when accessing medical services. Here on the Central Coast, if you live on The Entrance and you need to access a service in Gosford, it is a three-hour bus ride. That is a reality. If we are going to focus services in Gosford and our constituents are at Summerland Point, which is right up on the northern end of the area, that is not a possibility, so they simply will not attend the appointments. They cannot afford the $2.50 bus fare, they cannot afford a $7 co-payment, and they cannot sit for three hours on a bus to get to an appointment to then sit

17 Mrs Diana Aspinall, Consumer Reference Group GP Network Blue Mountains, 12 March 2015, *Committee Hansard*, pp 39–40.

> for two hours waiting for a doctor and then get on another bus to get back home. And it is not one bus; it is two or three buses, so they have to be able to use those buses. We provide support to people for [train travel] and the like. We offer various services where we can assist people with accessing transport to get to medical appointments, but it is very limited.[18]

Paramedics

5.21 The Australian Paramedics Association (APA) told the committee of the serious impacts that increasing resource pressures are having on paramedics. Due to at-capacity emergency departments, ambulances are being forced to 'ramp' until an emergency bed becomes available.[19] Mr Jeff Andrew, Vice President of the APA explained that a two hour ramp at peak periods is not unusual, and that a recent experience of a six hour 'ramp' would become common.[20] Mr Andrew went on to state that 'it is fair to say the whole system is overwhelmed.'[21]

5.22 When asked what additional pressure would result from government's decision to cut $50 billion over 10 years from the hospital system combined with the government's interventions in primary care, Mr Andrew responded:

> I think we will get more sick patients if the primary health care is not attended to. I mentioned some patients, like asthma patients and patients with a chronic disease like emphysema, who have been better managed because there are good strategies and care plans in place for them. Any budget cuts in that area will only reflect to us getting them at a sicker state. There will be a higher burden on the presentations in the health system. On the other end with the co-payment, I know that Medicare Locals on the coast put in advertisements [explaining to patients] that has not happened yet, because immediately the numbers dropped off of people attending.[22]

Committee observations

5.23 The issues outlined in this chapter demonstrate that the government's healthcare policies impact all areas of the healthcare system.

5.24 General practice training and workforce matching not only affect consumers' access to healthcare now, but also into the future. The evidence in this chapter shows that if mechanisms are not in place now, shortages of doctors and specialists will be felt in the future and acutely in rural areas.

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18 Mrs Jenny MacKellin, CEO, Central Coast Disability Network, *Committee Hansard*, 11 March 2015, pp 23–24.

19 In this context "Ramp" refers to an ambulance waiting with a patient until the patient can be received by the Emergency Department.

20 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

21 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 43.

22 Mr Jeff Andrew, Vice President, Australian Paramedics Association, *Committee Hansard*, 11 March 2015, p. 45.

5.25 Patient transport appears at first not to be directly related to healthcare, but in fact it is an exemplar of the issues which can surround access to healthcare. As examined in Chapter 2, without adequate access to healthcare, the management of chronic conditions and preventative health cannot be delivered appropriately. The consequence is that greater stress is placed on acute care, causing more expense to be shifted to state funded facilities. Similarly, the issue of 'ramping' identified by paramedics shows the consequences of an overburdened and underfunded hospital system.

5.26 The committee urges the government to have regard to the evidence such as that outlined in this chapter. This evidence is a timely reminder that the healthcare system is complex and policy change should be considered, evidence-based, consultative, and implemented appropriately, with proper attention given to the consequences on all parts of the system.

Senator Deborah O'Neill

Chair

Appendix 1

Witnesses who appeared before the committee[1]

Thursday, 21 August 2014 – Townsville

Cootharinga North Queensland

Mr Brendan Walsh, Chief Executive Officer

Mental Illness Fellowship NQ Inc.

Ms Alison Fairleigh, Area Manager, Townsville

College of Medicine and Dentistry, James Cook University

Associate Professor Sarah Larkins, Director of Research and Postgraduate Education

Supported Options in Lifestyle and Access Services Limited

Ms Cathy O'Toole, Chief Executive Officer

Thursday, 28 August 2014 – Canberra

South Australian Government

The Hon. Jay Weatherill MP, Premier

Department of Health

Mr Richard Bartlett, Acting Deputy Secretary

Ms Kerry Flanagan, Deputy Secretary

Department of the Treasury

Mrs Leesa Croke, General manager, Social Policy Division, Fiscal Group

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division, Fiscal Group

1 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings

Thursday, 4 September 2014 - Canberra

Organ and Tissue Authority

Ms Yael Cass, Chief Executive Officer

Ms Judy Harrison, Chief Financial Officer

Monday, 15 September 2014 – Lismore

Northern Rivers Women and Children's Services Inc.

Ms Sandra Handley, Manager, Lismore Women's Health and Resource Centre, Wellbeing and Community Division

Individual statements from members of the public including private individuals, allied health practitioners and medical professionals

Dr Jane Barker, private capacity

Ms Elizabeth Doolan, private capacity

Ms Kate Greenaway, private capacity

Dr Danielle Pirera, private capacity

Ms Cathy Ridd, private capacity

Ms Janelle Saffin, private capacity

Mr Gil Wilson, private capacity

Northern Rivers Social Development Council

Mr Tony Davies, Chief Executive Officer

University Centre for Rural Health

Professor Lesley Barclay, Director

Dr Michael Douglas, Deputy Director Education

North Coast NSW Medicare Local

Mr Vahid Saberi, Chief Executive Officer

Dr Dan Ewald, Clinical Advisor

Interrelate

Ms Fleur Bradburn, Personal Helpers and Mentors Service Manager

Ms Julie Leete, Area Manager, Lismore

Tuesday, 16 September 2014 – Moruya

Southern NSW Medicare Local

Ms Kathryn Stonestreet, Chief Executive Officer

Ms Jo Risk, Integration and Planning

Dr Martin Carlson, Moruya General Practitioner and Chair SNSWML

Eurobodalla Shire Council

Ms Kathy Arthur, Divisional Manager, Community, Arts and Recreation

Moruya Chiro and Wellness

Mr Ifo Ahlquist, Chiropractor

Mr Brad Rossiter, private capacity

NSW Nurses' and Midwives' Union

Mrs Annette Alldrick, Secretary and Delegate, Shoalhaven Branch

Dr David Rivett, private capacity

Thursday, 25 September 2014 – Canberra

National Blood Authority

Mr Leigh McJames, General Manager

Mr Peter Executive Director and Chief Information Officer

Tuesday, 30 September 2014 – Canberra

Central Queensland Medicare Local

Mrs Jean McRuvie, Chief Executive Officer

Thursday, 2 October 2014 – Canberra

Consumers Health Forum of Australia

Mr Adam Stankevicius, Chief Executive Officer

Ms Priyanka Rai, Policy and Communications Officer

Tasmania Medicare Local (via teleconference)

Mr Phil Edmondson, Chief Executive Officer

Goldfields-Midwest Medicare Local, Western Australia (via teleconference)

Mrs Brenda Ryan, Chief Executive Officer

Perth South Coastal Medicare Local, Western Australia

Mr Paul Hersey, Chief Executive Officer

Bayside Medicare Local, Victoria

Dr Elizabeth Deveny, Chief Executive Officer

Murrumbidgee Medicare Local, NSW

Mrs Nancye Piercy, Chief Executive Officer

Country North Medicare Local, South Australia

Mr Kim Hosking, Chief Executive Officer

Department of Health

Ms Sharon Appleyard, Assistant Secretary, Primary Health Networks Branch

Ms Mary McDonald, Acting Deputy Secretary

Department of Health

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division

Ms Mary McDonald, Acting Deputy Secretary

Monday, 6 October 2014 – Geelong

Medicare Local Barwon

Mr Jason Trethowan, Chief Executive Officer

Dr Ajeet Singh, private capacity

Colac Area Health

Mr Geoff Iles, Chief Executive Officer

Mrs Marg White, Director Community Services

Lorne Community Hospital

Ms Kate Gillan, Chief Executive Officer

Ms Andrea Russell, Acting Chief Executive Officer

Australian Diabetes Educators Association

Ms Tracy Aylen, President

Tuesday, 7 October 2014 – Melbourne

Victorian Medicare Action Group

Ms Meredith Carter, Spokesperson

Benetas

Mr Stephen Burgess, Innovation, Policy and Research Officer

Ambulance Employees Australia Victoria

Mr Danny Hill, Assistant Secretary

Victorian Health Promotion Foundation (VicHealth)

Dr Bruce Bolam, Executive Manager, Programs Group

Federation of Rural Australian Medical Educators

Professor Judith Walker, Chair

Australian Medical Association (Victoria) Limited

Dr Anthony Bartone, President

Loddon Mallee Murray Medicare Local

Mr Matthew Jones, Chief Executive Officer

Wednesday, 8 October 2014 – Melbourne

Royal Australasian College of Physicians

Professor Nicholas Talley, President

Dr Nick Buckmaster, Policy and Advocacy Committee

Services for Australian Rural and Remote Allied Health

Mr Rod Wellington, Chief Executive Officer

Mr Rob Curry, Deputy Chair (via teleconference)

Australasian College of Emergency Medicine

Dr Anthony Cross, President

Ms Alana Killen, Chief Executive Officer

Dr Simon Judkins, Victorian Councillor

Grattan Institute

Dr Stephen Duckett, Director, Health Program

Mr Peter Breadon, Health Fellow

Allied Health Professions Australia

Ms Lin Oke, Executive Director

Mr Damian Mitsch, Director

Australian Diagnostic Imaging Association

Dr Christian Wriedt, President

Ms Pattie Beerens, Chief Executive Officer

Mr Chris Kane, Senior Policy Adviser

Department of Health

Ms Kerry Flanagan, Deputy Secretary

Ms Mary McDonald, Acting Deputy Secretary (via teleconference)

Mr Richard Bartlett, Acting Deputy Secretary (via teleconference)

Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division (via teleconference)

Treasury (via teleconference)

Mr Peter Robinson, General Manager, Commonwealth-State Relations Division

Mr Rob Montefiore Gardner, Manager, Health and Disability Unit

Department of Finance (via teleconference)

Mr Mark Thomann, First Assistant Secretary, Social Policy Division

Mr Nicholas Hunt, Assistant Secretary, Budget Group

Department of Human Services

Mr Barry Sandison, Deputy Secretary

Thursday, 9 October 2014 – Adelaide

Department of Health and Ageing (South Australia)

Mr Steve Archer, Deputy Chief Executive, Finance and Business Services

Mr Jamin Woolcock, Chief Finance Officer

Ms Skye Jacobi, Director, Intergovernment Relations and Ageing

Medicare Locals (South Australia)

Mr Kim Hosking, Chief Executive Officer, Country North SA Medicare Local

Ms Debra Lee, Chief Executive Officer, Northern Adelaide Medicare Local

Mr Chris Seiboth, Chief Executive Officer, Central Adelaide and Hills

Population Health Research Network

Professor Brendan Kearney, Chair, Management Council

Dr Merran Smith, Chief Executive Officer

Australian Nursing and Midwifery Federation (SA Branch)

Mr Rob Bonner, Director, Operations and Strategy

Ms Jennifer Hurley, Manager, Professional Programs

Adjunct Associate Professor Elizabeth Dabars AM, CEO and Secretary

University Department of Rural Health

Associate Professor Martin Jones, Director

Aboriginal Health Council of South Australia

Mr Shane Mohor, Acting Chief Executive Officer

Ms Amanda Mitchell, Health Development Coordinator

Mr Paul Ryan, Senior Project Officer, Member Support

Health Consumers Alliance of South Australia

Ms Stephanie Miller, Executive Director

Mr Michael Cousins, Manager, Policy and Advocacy

Friday, 10 October 2014 – Perth

Health Consumers' Council of Western Australia

Dr Martin Whitely, Acting Executive Director

Dr Ann Jones, Policy Officer

Medicare Locals Western Australia

Mr Paul Hersey, Chief Executive Officer, Perth South Coastal

Ms Brenda Tyan, Chief Executive Officer, Goldfields-Midwest (via teleconference)

Curtin University, Western Australia

Professor Mike Daube, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth

Western Australian Centre for Rural Health

Professor Sandra Thompson, Director

Associate Professor Judith Katzenellenbogen, Research Associate Professor

Monday, 3 November 2014 – Hobart

Dr Robert Ware, private capacity

Mental Health Coucil Tasmania

Mr Darren Carr, Chief Executive Officer

Ms Elida Meadows, Policy and Research Officer

Royal Australian College of General Practitioners

Dr Bastian Seidel, Deputy Chair, Tasmanian Faculty

Mr Martyn Goddard, private capacity

Social Determinants of Health Advocacy Network

Ms Miriam Herzfeld, Convenor

TasCOSS

Dr Pauline Marsh, Policy Officer

Australian Medical Association Tasmania

Professor Tim Greenaway, President

Aged and Community Services Tasmania

Mr Darren Mathewson, Chief Executive Officer

Tuesday, 4 November 2014 – Launceston

Tasmanian Medicare Local

Mr Phil Edmondson, Chief Executive Officer

Australian Nursing and Midwifery Federation Tasmanian Branch

Mrs Neroli Ellis, Branch Secretary

University of Tasmania

Dr Martin Harris, Lecturer, Centre for Rural Health

Mr Stuart Auckland, Lecturer and Program Manager, Centre for Rural Health

Rural Doctors Association of Tasmania (via teleconference)

Dr Paul Fitzgerald, Treasurer

Family Based Care Association North West Inc.

Ms Justine Barwick, Operations Manager

Thursday, 5 February 2015 – Canberra

Australian Medical Association

Associate Professor Brian Owler, President

Royal Australian College of General Practitioners

Dr Frank Jones, President

Dr Zena Burgess, Chief Executive Officer

Rural Doctors Association of Australia

Ms Jennifer Johnson, Chief Executive Officer

Charlestown Square Medical Centre

Dr Colin Pearce, Clinical Director

Whitebridge Medical Centre

Dr Richard Terry, Practice Principal

Dr Ian Kamerman, private capacity

Graduate School of Medicine, University of Wollongong

Professor Andrew Bonney, Roberta Williams Chair of General Practice

Claremont Village Medical Centre

Dr Graeme Alexander, General Practitioner

Hunter General Practitioners Association

Dr Fiona Van Leeuwen, Vice Chair

Consumers Health Forum of Australia

Mr Adam Stankevicius, Chief Executive Officer

Ms Josephine Root, Policy Manager

Public Health Association of Australia

Professor Michael Moore, Chief Executive Officer

National Rural Health Alliance

Mr Gregory Gordon, Chief Executive Officer

Dr Anne-marie Boxall, Senior Policy Adviser

Australian College for Emergency Medicine

Mrs Alana Killen, Chief Executive Officer

Dr Simon Judkins, Councillor

Australian Healthcare Reform Alliance

Mr Russell McGowan, Secretary

Mr Sebastian Rosenberg, Member, Executive Board

Grattan Institute

Dr Stephen Duckett, Director, Health Program

Doctors Reform Society

Dr Con Costa, President

Dr Tim Woodruff, Vice President

Department of Health

Mr Andrew Stuart, Acting Secretary

Dr Anthony Hobbs, Acting Deputy Secretary

Ms Kirsty Faichney, Acting First Assistant Secretary, Medical Benefits Division

Ms Fifine Cahill, Assistant Secretary, Primary Care and Pathology Branch, Medical Benefits Division

Department of Treasury

Ms Leesa Croke, General Manager

Mr Robert Montefiore-Gardner, Senior Adviser

Department of Finance

Mr Mark Thomann, Acting Deputy Secretary

Mr Nicholas Hunt, Assistant Secretary

Friday, 13 February 2015 – Canberra

Indigenous Allied Health Australia

Ms Donna Murray, Chief Executive Officer

Ms Anna Leditschke, Senior Policy Officer

Kidney Health Australia

Ms Anne Wilson, Chief Executive Officer and Managing Director

Associate Professor Tim Mathew, Medical Director

Mr Luke Toy, General Manager, Public Affairs

Ms Donisha Duff, National Manager, Indigenous Affairs

Central Australian Aboriginal Congress Aboriginal Corporation

Ms Donna Ah Chee, Chief Executive Officer

Dr John Boffa, Chief Medical Officer Public Health

Australian College of Rural and Remote Medicine

Associate Professor David Campbell, Censor-in-Chief

Rural Health Worforce Australia

Mr Greg Mundy, Chief Executive Officer

National Rural Health Students' Network

Ms Danielle Dries, Indigenous Health Officer

Royal Australian College of General Practitioners

Associate Professor Brad Murphy, Chair, National Faculty of Aboriginal and Torres Strait Islander Health

Dr Timothy Senior, Medical Adviser, National Faculty of Aboriginal and Torres Strait Islander Health

Australian Indigenous Doctors' Association Ltd

Dr Tammy Kimpton, President

Ms Kate Thomann, Chief Executive Officer

National Aboriginal Community Controlled Health Organisation

Ms Lisa Briggs, Chief Executive Officer

Department of Health

Mr Martin Bowles PSM, Secretary

Dr Wendy Southern PSM, Deputy Secretary, National Programme Delivery Group

Ms Maria Jolly, Acting First Assistant Secretary, Indigenous and Rural Health Division

Mr Rodney Schreiber, Acting Assistant Secretary, Indigenous Health Reform Task Force, Indigenous and Rural Health Division

Dr Masha Somi, Assistant Secretary

Ms Meredeth Tailor, Assistant Secretary, Rural, Remote and Indigenous Access Branch, Indigenous and Rural Health Division

Ms Alison Killen, Assistant Secretary, Indigenous Health Programmes Branch

Department of the Prime Minister and Cabinet

Ms Caroline Edwards, First Assistant Secretary

Mr Brendan Gibson, Acting Assistant Secretary, Health Branch, Indigenous Affairs Group

Mr Matthew James, Assistant Secretary, Information and Evaluation Branch

Thursday, 19 February 2015 – Strathfield

Inner West Sydney, Medicare Local

Dr Michael Moore, Chief Executive Officer

Aboriginal Health and Medical Research Council of New South Wales

Ms Sandra Bailey, Chief Executive Officer

Ms Victoria Jones, Member, Senior Policy Group

Aboriginal Medical Service Western Sydney

Mr Frank Vincent, Chief Executive Officer

Ms Joanne Delaney, Deputy Chief Executive Officer

Being – Mental Health and Wellbeing Consumer Advisory Group

Ms Ka Ki Ng, Senior Policy Officer

Ms Karina Ko, Policy Officer

Dr Aline Smith, private capacity

Dr Annabel Kain, private capacity

Dr Linda Mann, private capacity

Mr Umesh Garg, private capacity

Dr Marie Healy, private capacity

Dr Charlotte Hespe, private capacity

General Practice New South Wales

Professor Tracey McDonald, Deputy Chair

Mr Ian Sinnett, Interim Executive Director

Ms Agnes Levine, Board Member

National LGBTI Health Alliance

Dr Gavi Ansara, Manager, Research and Policy

Australian Federation of AIDS Organisations

Ms Linda Forbes, manager, Policy and Communications

AIDS Council of New South Wales

Mr Dean Price, Policy Officer

Anwernekenhe National HIV Alliance

Mr Neville Fazulla, Chair Person

Mr Michael Costello-Czak, Executive Officer

Family Planning New South Wales

Ms Ann Brassil, Chief Executive Officer

Ms Ann-Marie Ashburn, Director, Communications, Government and Community Affairs

Dr Deborah Bateson, Medical Director

Tuesday, 10 March 2015 – Rockdale

New South Wales Nurses and Midwives' Association

Mr Brett Holmes, General Secretary

Ms Angela Garvey, Professional Officer

Ms Shirley Lee, Organiser

Ms Renatta Di Staso, Organiser

Mr Stephen Mierendorff, Member

Inner West Sydney Medicare Local

Dr Michael Moore, Chief Executive Officer

University of New South Wales

Professor Mark Harris, Professor of General Practice

South Eastern Sydney Medicare Local

Ms Lynelle Hales, Chief Executive Officer

Dr Wayne Cooper Board Chair

South Eastern Sydney Medicare Local

Dr Wayne Cooper, Board Chair

Dr Sharyn Wilkins, Board Member

Ms Jacky Peile, Occupational Therapist

North Sydney Medicare Local

Mr Paul Hussein, Director, Community and Strategy

Regal Home Health

Adjunct Associate Professor Anna Shepherd, Chief Executive Officer

Ms Jude Foster, Director, Clinical Excellence and Business Development

Cancer Voices New South Wales

Mr Peter Brown, Advocate

Exercise and Sports Science Australia

Ms Mia Kacen, Exercise Physiologist

Leichhardt Women's Community Centre

Ms Roxanne McMurray, Manager

Macarthur Gateway Resource Services

Ms Marilyn Fogarty, Executive Officer

B Miles Women's Housing

Ms Jane Bullen, Secretary, Management Committee

National Heart Foundation of Australia

Mr Rohan Greenland, General Manager, Advocacy

Ms Vicki Wade, Leader, National Aboriginal Health Unit

Wednesday, 11 March 2015 – Gosford

Dr Ian Charlton, General Practition, Kincumber, New South Wales, private capacity

Reliance GP Super Clinic, West Gosford

Dr Rodney Beckwith, Director

Terrigal Medical Centre and Avoca Beach Medical Centre

Dr Karen Douglas, General Practitioner

Dr Paul Duff, General Practitioner

Central Coast Disability Network

Ms Sally Jope, Chairman

Ms Xylia Ingham, Manager

Central Coast Disability Network

Mrs Jenny Mackellin, Chief Executive Officer

Cancer Council Australia

Mr Paul Grogan, Director, Public Policy and Advocacy

Cancer Council New South Wales

Mr Shayne Connell, Regional Manager

Australian Paramedics Association

Mr Jeff Andrew, Vice President

Australian Medical Association (New South Wales)

Dr Saxon Smith, President

New South Wales Nurses and Midwives' Association

Ms Michelle Cashman, Member

Hunter General Practitioners Association

Dr Fiona Van Leeuwen, General Practitioner and Clinical Director, Hunter Medicare Local and Vice Chair, Hunter General Practitioners Association

Dr Colin Pearce, General Practitioner

Dr Stephen De Lyall, General Practitioner

Thursday, 12 March 2015 – Penrith

Nepean-Blue Mountains Medicare Local

Dr Andrew Knight, Board Chair

Mrs Lizz Reay, Chief Executive Officer

Ms Jillian Harrington, Clinical Psychologist, private capacity

GP Synergy

Mr John Oldfield, Chief Executive Officer

Royal Australasian College of Physicians

Dr Tamara Mackean, Chair, Aboriginal and Torres Strait Islander Committee

Mr Paul Wright, Senior Policy Officer

New South Wales Nurses and Midwives' Association

Ms Louise Stammers, Aged Care Nurse

Ms Jocelyn Hofman, Aged Care Nurse

Consumer Reference Group Blue Mountains GP Network

Mr John Haydon, Acting Chair, Blue Mountains

Mrs Diana Aspinall, Member, Blue Mountains

Ms Kerrie Jackson, Member, Blue Mountains

Mr Barry Funnell, Chair, Medicare Local Lithgow

Mr Peter Gooley, Member

Ms Anita Griffiths, Member, Penrith

Doctors Action Group – Supporting Family Doctors

Dr Adrian Sheen, President

Dr Barry Kroll, General Practitioner

Tindale Family Practice

Mr Gary Smith, Practice Manager

Nepean General Practice Division

Dr Stephen Wong, Vice Chairman

Mr Michael Edwards, Company Secretary

University of Western Sydney

Professor Andre Renzaho, Professor of Humanitarian and Development Studies

Tuesday, 14 April 2015 – Canberra

Professor Jacqueline Cumming, private capacity

University of Otago, Dunedin

Professor Robin Gauld, Centre for Health Systems, Department of Preventive and Social Medicine, Dunedin School of Medicine

Canterbury District Health Board

Ms Carolyn Gullery, General Manager, Planning, Funding and Decision Support

Dr Graham McGeoch, Clinical Adviser

Australian Healthcare and Hospitals Association

Ms Alison Verhoeven, Chief Executive Officer

Dr Linc Thurecht, Senior Research Leader

Grattan Institute

Professor Hal Swerissen, Fellow

The Menzies Centre for Health Policy, University of Sydney

Associate Professor Adam Elshaug, HCF Research Foundation Principal Research Fellow; Director, Value in Health Care Division

NPS MedicineWise

Dr Lyn Weekes, Chief Executive Officer

Ms Kerren Hosking, Executive Manager, Corporate Affairs and Governance

Doctors Reform Society

Dr Con Costa, National President

Australian Health Care Reform Alliance

Mr Tony McBride, Chair

Mr Russell McGowan, Secretary

National Association of Primary Care, United Kingdom

Dr Charles Alessi, Co-Chairman

Wednesday, 15 April 2015 – Canberra

Lowitja Institute

Mr Romlie Mokak, Chief Executive Officer

CHIK Services Pty Ltd

Ms Sally Glass, Managing Director

Australian Association for Academic Primary Care

Professor Kirsty Douglas, Professor of General Practice

Dr Katrina Alford, Independent health economist with expertise in Indigenous health services and funding

Consumers Health Forum of Australia

Ms Leanne Wells, Chief Executive Officer

Ms Jo Root, Policy Manager

Australian College of Nursing

Dr Marlene Eggert, Policy Manager

Australian College of Mental Health Nurses

Adjunct Associate Professor Kim Ryan, Chief Executive Officer

Australian College of Midwives

Ms Sarah Stewart, Professional Officer

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Ms Colleen Gibbs, Senior Policy and Research Officer

Professor Roianne West, Board Member

Dr Lesley Russell, private capacity

Centre for Policy Development

Dr Jennifer Doggett, Health Policy Analyst and Consultant

Thursday, 16 April 2015 - Colac

Colac Area Health

Mr Geoff Iles, Chief Executive Officer

Mrs Libby Fifis, Director of Nursing and Midwifery

Corangamarah Residential Aged Care

Ms Pamela Matheson, Manager

Mrs Karen Aucote, Financial Accountant

Mr David Henry, Proprietor, RetireInvest

Mrs Nola Creece, private capacity

Dr Ian Mackay, private capacity

Hume City Council

Councillor Adem Atmaca, Mayor

Mrs Margarita Caddick, Director, City Communities

Ms Elizabeth Young, Prevention Partnership Program Manager

City of Wodonga

Ms Patience Harrington, Chief Executive Officer

Ms Claire Taylor, Coordinator, Healthy Together Wodonga

Knox City Council

Councillor Peter Lockwood, Mayor

Dr Graeme Emonson, Chief Executive Officer

Ms Michelle Hollingworth, Program Manager, Healthy Together Knox

Ms Kathy Parton, Community Wellbeing Department

City of Greater Geelong

Ms Karen Pritchard, Manager, Aged and Disability

Ms Monica Evans, Acing Coordinator, Healthy Together Geelong

Healthy Together Grampians Goldfields

Mrs Sharon Ruyg, Manager, Preventive Health

Ararat Rural City

Councillor Paul Hooper, Mayor

Ms Angela Hunt, Manager, Community Development and Client Services

Ambulance Employees Australia, Victoria

Mr Danny Hill, Assistant Secretary

Health Services Union Victoria No.4 Branch

Mr Paul Elliott, Secretary

Mr Alexander Schlotzer, Communications and Campaigns Officer

Friday, 17 April 2015 – Burnie

Rural Clinical School – University of Tasmania

Associate Professor Lizzi Shires, Co-Director

Dr Marielle Ruigrok, Emergency Staff Specialist

Burnie City Council

Mrs Anita Dow, Mayor

Mr Andrew Wardlaw, General Manager

Rural Health Tasmania

Mr Robert Waterman, Chief Executive Officer

Mrs Sue McTurk, Podiatrist

Dr Emil Djakic, General Practitioner

Dr James Wilson, private capacity

Australian Medical Association Tasmania

Associate Professor Timothy Greenaway, President

Royal Australian College of General Practitioners

Dr Bastian Seidel

Monday, 27 April 2015 - Darwin

Menzies School of Health Research

Professor Alan Cass

Australian Indigenous Doctors' Association Ltd (AIDA)

Dr Kiarna Brown, Board Director

Danila Dilba Health Service

Ms Olga Havnen, Chief Executive Officer

Dr James Stephen, Senior Medical Officer

Ms Joy McLaughlin, Senior Project Officer

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)

Mr John Paterson, Chief Executive Officer

Mr David Cooper, Manager, Research, Advocacy and Policy

Dr Liz Moore, Public Health Medical Officer

Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation

Ms Heather Hall, Manager. Panuku

Mr Lachlan Ross, Indigenous Patient Preceptor and Cultural Adviser

Flinders University, Northern Territory

Professor John Wakerman, Associate Dean

Red Dust

Mr Darren Smith, Chief Executive Officer

Ms Colette Davis, Programs Manager

Mr Jonathan Hermawan, Central Australia Manager

Northern Territory Medicare Local

Dr Andrew Bell, Chair

Ms Judy Davis, Deputy Chief Executive Officer

Ms Debra Blumel, private capacity

Tuesday, 28 April 2015 – Halls Creek

Western Australian Legislative Assembly

Ms Josephine (Josie) Farrer, Member for Kimberley

Halls Creek Health Service

Dr Rajkumar Ramasamy, District Medical Officer

Yura Yungi Medical Service

Ms Donna Smith, Chairperson

Kimberley Language Resource Centre

Mrs Patsy Bedford, Chairperson

Halls Creek Peoples Church Frail Aged Hostel

Mr Peter Vincent, Acting Chief Executive Officer

Mr Greg Tait, private capacity

Halls Creek Hospital

Mrs Robyn Cotterill, Acting Director of Nursing

Dr Dele Orebanwo, Permanent General Practitioner

Ms Angela Llewellyn, Chronic Disease Nurse and Diabetes Educator

Kimberley Population Health Unit

Ms Tama Howard, Community Health Nurse Manager, Halls Creek

Shire of Halls Creek

Mr Rodger Kerr-Newall, Chief Executive Officer

Shire of Halls Creek Council

Councillor Malcolm Edwards

Tuesday, 28 April 2015 - Kununurra

Boab Health Services

Ms Margie Ware, Chief Executive Officer

Ms Tracey Raymond, Allied Health Manager

Wyndham Early Learning Activity Centre

Ms Jane Parker, Manager

Ms Elaine McLean, Assistant Manager

Ord Valley Aboriginal Health Service

Mr Graeme Cooper

Mr Henry Councillor

Wunan

Ms Natasha Short, Staff Member

Kununurra Medical Centre

Dr Stephanie Trust, General Practitioner

Wednesday, 29 April 2015 - Katherine

Sunrise Health Service

Mr Graham Castine, Chief Executive Officer

Binjari Health Clinic

Mr Peter Gazey, Health Service Manager

Roper-Gulf Regional Council

Ms Lara Brennan, Community Services Regional Manager

Wurli-Wurlinjang Health Service

Ms Marion Scrymgour, Chief Executive Officer

Kalano Community Association Incorporated

Mr Rick Fletcher, Chief Executive Officer

Ms Carol Dowling, Treasurer

Thursday, 30 April 2015 – Galiwin'ku

Ms Stephanie Yikaniwuy, Interpreter; private capacity

Miwatj Health

Mr John Morgan, Chairperson

Mr Eddie Mulholland, Chief Executive Officer

Mr Karl Dyason, Acting Deputy Chief Executive Officer and Director of Business Services

Dr Lucas de Toca, Director of Medical Services and Public Health

Ms Paula Myott, Regional Health Reform Director

Mr John Maher, Mental Health Coordinator

Mr Charlie Yibirrir Dhamarrandji

Mr Johny Wurur Dhurrkay

Dr Kylie Strate

Marthakal Homelands Clinic

Ms Yvonne Sutherland, Chief Executive Officer

Ms Helen Nyomba, private capacity

Mr Trevor Gurruwiwi, Interpreter; private capacity

Mr Alan Maratja, Interpreter; private capacity

Dr Elaine Mayptlama, private capacity

Friday, 1 May 2015 – Mt Isa

Mount Isa Centre for Rural and Remote Health, James Cook University

Professor Sabina Knight, Director

Mr Shaun Solomon, Head of Indigenous Health

Gidgee Healing

Mr Shaun Solomon, Chairperson

Mr Dallas Leon, Chief Executive Officer

Ms Diana Terry, Clinical Director

Ms Rachel Yates, Primary Health Care Director, Mount Isa Aboriginal Community Controlled Health Service

North West Hospital and Health Service

Ms Sue Belsham, Chief Executive Officer

Associate Professor Alan Sandford, Executive Director of Medical Services

Mr Brett Oates, Chief Financial Officer

Royal Flying Doctor Service (Queensland Section)

Ms Jaya Ganasan, General Manager – Integrated Operations

Ms Lauren Jesberg, Regional Manager North West

Blue Nursing

Mrs Helen Davis, Multi Service Manager

Laura Johnson Home

Mrs Betty Kiernan, Chief Executive Officer

Miss Loribeth Allison, Director of Nursing

Anglicare North Queensland Mental Health Service

Ms Leeanne Harris, Manager

North West Queensland Indigenous Catholic Social Services

Father Michael Lowcock, Director

Tuesday, 9 June 2015 – Melbourne

Australian Medical Association

Dr Stephen Parnis, Vice President

The Royal Australian College of General Practitioners

Dr Morton Rawlin, Vice President and Victorian Faculty Chair

Hepatitis Australia

Ms Helen Tyrrell, Chief Executive Officer

Australian Healthcare and Hospitals Association

Ms Alison Verhoeven, Chief Executive Officer (via teleconference)

General Practice Registrars Association

Dr Jomini Cheon, Chair

Mrs Sarah Kincaid, Chief Executive Officer

National Complex Needs Alliance

Ms Lyn Morgain, Chair

Public Health Association of Australia

Ms Melanie Walker, Acting Chief Executive Officer

Wednesday, 10 June 2015 – Broken Hill

Broken Hill University Department of Rural Health

Professor David Lyle, Head of Department

Ms Debra Jones, Director of Primary Health Care

Dr Susan Kirby, Senior Research Fellow

Maari Ma Health Aboriginal Corporation

Mr Bob Davis, Chief Executive Officer

Dr Hugh Burke, Director Medical Services

Ms Cathy Dyer, Director Corporate Services

Ms Kaylene Kemp, Manager Community Engagement

Dr Steve Flecknoe-Brown, Consultant Physician and Clinical Pathologist, private capacity

Nachiappans

Dr Ramu Nachiappan MBBS, LLB, FRACGP, FACRRM, Medical Principal

Far West NSW Medicare Local

Mr Stuart Gordon, Chief Executive Officer

Ms Michelle Pitt, Manager for Clinical Services

Outback Pharmacies

Mr Jason Harvey, Partner

Broken Hill City Council

Councillor Wincen Cuy, Mayor

Royal Flying Doctor Service

Dr Malcolm Moore

Thursday, 11 June 2015 – Adelaide

Campbelltown City Council

Ms Tracy Johnstone, Manager, Community Services and Social Development

Mr Gavin Fairbrother, Manager, OPAL

Aboriginal Health Council of South Australia Inc.

Ms Amanda Mitchell, Acting Deputy Chief Executive Officer

Ms Michele Robinson, COAG Workforce Liaison Officer

Australian Nursing and Midwifery Federation, South Australia Branch

Ms Jennifer Hurley, Manager, Professional Programs

Mr Robert Bonner, Director, Operations and Strategy

Department for Health and Ageing, South Australia

Mr Steve Archer, Deputy Chief Executive, Finance and Corporate Services

Ms Skye Jacobi, Director, Intergovernment Relations and Ageing

Ms Rachel Newrick, Manager, Intergovernment Relations

University of Adelaide

Professor Nigel Stocks, Head of the Discipline of General Practice

Health Consumers' Alliance of South Australia

Mr Michael Cousins, Chief Executive

Ms Ellen Kerrins, Manager, Advocacy and Policy

Cancer Voices SA

Ms Julie Marker, Chair

Ms Chris Christensen, Deputy Chair

Mental Health Coalition of South Australia

Ms Sandra Arlidge, Acting Executive Director

Appendix 2

Submissions received by the committee[1]

1 National Health Performance Authority
2 Dr Catherine Pye
3 Cootharinga North Queensland - Ability First
4 Mr Cliff Weder
5 Mr David Gorell
6 HealthChange Australia
7 Exercise & Sports Science Australia
8 Australian Rural Health Education Network
9 Palliative Care Australia
10 Services for Australian Rural and Remote Allied Health
11 Australian Dental Association Inc
12 Australasian Podiatry Council
13 Cancer Drugs Alliance
14 Rural Health Workforce Australia
15 PHHAMAQ
16 Family Planning NSW
17 College of Medicine and Dentistry, James Cook University
18 Positive Ageing Taskforce Southern Fleurieu & Kangaroo Island
19 Alzheimer's Australia
20 The Royal Australian and New Zealand College of Psychiatrists
21 The Dental Hygienists' Association of Australia Inc.
22 St Vincent de Paul Society National Council of Australia
23 NSW Consumer Advisory Group – Mental Health Inc.
24 South Australian Government
25 Wellspect HealthCare

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1 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions

26 Australian Association for Academic Primary Care Inc.
27 Mr Gil Wilson
28 Carers NSW
29 Grattan Institute
30 Rural Doctors Association of Australia
31 Australian Society of Anaesthetists
32 MS Australia
33 Mr Chris Hamill
34 Health Care Consumers Association of the ACT Inc
35 Aged and Community Services Australia
36 General Practice NSW
37 The Royal Australasian College of Physicians
38 Youth Affairs Council of South AustraliaYouth
39 Australian Nursing and Midwifery Federation Australian
40 Name Withheld
41 Social Determinants of Health Advocacy Network
42 Benetas
43 Australian Healthcare & Hospitals Association
44 Queensland Nurses' Union
45 The George Institute for Global Health and the Menzies Centre for Health Policy
46 Health Consumers' Council of WA
47 Allied Health Professions Australia
48 Australian Medical Association
49 Confidential
50 Audiology Australia Ltd
51 Speech Pathology Australia
52 National Stroke Foundation
53 Women's Centre for Health Matters
54 Diabetes Australia
55 NSW Nurses and Midwives Association NSW
56 Australian College of Nursing

57 Leading Age Services Australia Ltd
58 Kidney Health Australia
59 Dietitians Association of Australia
60 Australian Psychological Society (APS)
61 Chiropractors' Association of Australia (National) Ltd
62 National Disability Services
63 Aboriginal Health Council of Western Australia
64 Consumer Reference Group Blue Mountains GP Network
65 Dr Jane Barker
66 Name Withheld
67 Australian Council of Social Service
68 Australian Capital Territory Government
69 Queensland Government
70 Medical Technology Association of Australia
71 National Seniors Australia
72 St Vincent's Health Australia
73 Wakool Indigenous Corporation
74 Consumers Health Forum of Australia
75 GMiA
76 Public Health Association of Australia
77 Illawarra Public Health Society
78 Australian Clinical Trials Alliance
79 Private individual
80 Victorian Health Promotion Foundation (VicHealth)
81 Australian Women's Health Network
82 AML Alliance (In Liquidation)
83 Dr Rachel Mascord
84 Australian Health Promotion Association
85 Doctors Reform Society
86 National Aboriginal Community Controlled Health Organisation
87 Australian meals on Wheels (SA)

88 National LGBTI Health Alliance

89 Australian Catholic University

90 Australian Healthcare Reform Alliance

91 Dr Ajeet Singh

92 Health Consumers Alliance of South Australia Inc

93 Northern Adelaide Medicare Local

94 NPS MEDICINEWISE

95 Heart Foundation

96 HSU National

97 Australian Indigenous Doctors' Association Ltd

98 Macular Disease Foundation Australia

99 Lowitja Institute

100 Medicines Australia

101 Councils on the Ageing Australia

102 Pfizer

103 Hepatitis Australia

104 City of Marion

105 Health Workers Union

106 Australian Dental Industry Association

107 Elizabeth Dolan, Jennifer Smith, Joahnne Brown, Matthew Brown, Sharon Gavioli, Narelle Kelly, Felicity Latchford, Francesca Leaton, Fiona Lotherington, Lee Poole, Kate Robson and Paula Steffensen

108 Australian Federation of AIDS Organisations

109 Optometry Australia

110 Mr Martyn Goddard

111 Aboriginal Health Council of South Australia Inc.

112 TasCOSS

113 Rural Doctors Association of Tasmania

114 Mental Health Council of Tasmania

115 Royal Australian College of General Practitioners

116 Australian College of Rural and Remote Medicine

117 Association of Nursing Recruitment Agencies

118 Mental Health Professionals Network Ltd

119 AIDS Council of NSW

120 Central Australian Aboriginal Congress Aboriginal Corporation

121 Dr Colin Hughes, Midland Family Practice

122 Charlestown Square Medical Centre

123 Hunter General Practitioners Association

124 National Shelter

125 National Aboriginal and Torres Strait Islander Health Worker Association

126 Indigenous Allied Health Australia

127 Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

128 Professor Andrew Bonney, Graduate School of Medicine, University of Wollongong

129 Dr Graeme Alexander, Claremont Village Medical Centre

130 Dr Colin Pearce, Charlestown Square Medical Centre

131 Dr Richard Terry, Whitebridge Medical Centre

132 Australasian College for Emergency Medicine Australasian

133 Dr Ian Kamerman

134 Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)

135 National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)

136 Dr Mike Moynihan

137 Dr Mark Lock

138 Lung Foundation Australia

139 Name Withheld

140 Name Withheld

141 Ms Judith Maher, Health Consumers NSW

142 Dr Lesley Russell

143 Nepean Division of General Practice

144 Red Dust Role Models Ltd

145 Dr Rajkumar Ramasamy

146 Gidgee Healings

147 Aboriginal Medical Service Western Sydney

148 Northern Territory Government

149 Dr Steve Flecknoe-Brown

Appendix 3

Additional information and answers to questions on notice[1]

Additional Documents

1. Tabled by Department of Health (SA) at a public hearing in Adelaide on 9 October. Excerpt - Health portfolio Budget statement 2014-15
2. Tabled by Population Health Research Network at a public hearing in Adelaide on 9 October - Evidence-based improvement
3. Tabled by the Australian Nursing Federation (SA Branch) at a public hearing in Adelaide on 9 October - Opening comments for the Australian Nursing Federation (SA Branch)
4. Tabled by the Aboriginal Health Council of South Australia INC. at a public hearing in Adelaide on 9 October - Submission to Select Committee on Health
5. Tabled by VicHealth at a public hearing in Melbourne on 7 October.
6. Tabled by School of Rural Health, Faculty of Medicine, Nursing and Health Sciences at a public hearing in Melbourne on 7 October 2014
7. Tabled by the School of Rural Health, at a public hearing in Melbourne on 7 October 2014
8. Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Annual Report 2013-2014. The link to the report http://www.swarh2.com.au/cah/documents?Category=Annual Report
9. Tabled by Colac Area Health at a public hearing in Geelong on 6 October 2014 - Quality of Care Report 2013-2014. The link to the report http://www.swarh2.com.au/cah/documents?Category=Quality Reports
10. Tabled by Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch at a public hearing in Launceston on 4 November 2014
11. Tabled by Kidney Health Australia at a public hearing in Canberra on 13 February 2015 - Chronic disease care in remote Aboriginal Australia has been transformed

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1 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents

12. Tabled by Dr Sharyn Wilkins, Board Member, South Eastern Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015 - Barbara Starfield article.
13. Tabled by Ms Lynelle Hales, Chief Executive Officer, South Eastern Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015 - Annual Report 2013/2014
14. Tabled by Professor Anna Shepherd, Chief Executive Officer, Regal Health Services at a public hearing in Rockdale on 10 March 2015.
15. Tabled by Dr Michael Moore, Chief Executive Officer, Inner Western Sydney Medicare Local at a public hearing in Rockdale on 10 March 2015.
16. Tabled by the Heart Foundation at a public hearing in Rockdale in 10 March 2015.
17. Tabled by Central Coast Disability Network at a public hearing in Gosford on 11 March 2015
18. Tabled by Dr Ian Charlton, GP, Tilba Street Family Practice at a public hearing in Gosford on 11 March 2015.
19. Tabled by Central Coast Community Women's Health Centre at a public hearing in Gosford on 11 March 2015
20. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015
21. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Blue Mountains Community Forums on Health - 30 August 2012
22. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Hawkesbury Community Forums on Health - 15 October 2012
23. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Nepean Community Forums on Health - 14 November 2012.
24. Tabled by Consumer Reference Group Blue Mountains GP Network at a public hearing in Penrith on 12 March 2015 - Community Report on the Lithgow Community Forums on Health - 16 November 2012
25. Tabled by Ms Alison Verhoeven, Chief Executive Officer, Australian Healthcare and Hospitals Association at a public hearing in Canberra on 14 April 2015
26. Tabled by NPS MedicineWise at a public hearing in Canberra on 14 April 2015 - Annual Evaluation Report 2014
27. Tabled by Ms Sally Glass, Chief Executive Officer CHIK Services at a public hearing in Canberra on 15 April 2015

28. Tabled by Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) at a public hearing in Canberra on 15 April 2015
29. Tabled by Dr Marlene Eggert for the Australian College of Nursing at a public hearing in Canberra on 15 April 2015
30. Tabled by Ms Sarah Stewart for the Australian College of Midwives at a public hearing in Canberra on 15 April 2015
31. Tabled by Dr Lesley Russell at a public hearing in Canberra on 15 April 2015
32. Tabled by Professor Kirsty Douglas, Professor of General Practice at the Australian National University, Practicing GP and executive member of the Australasian Association for Academic Primary Care at a hearing in Canberra on 15 April 2015
33. Tabled by Consumer Health Forum of Australia at a public hearing in Canberra on 15 April 2015
34. Tabled by Dr Andrew Bell (Chair) and Ms Judy Davis (Deputy CEO) of Northern Territory Medicare Local at a public hearing in Darwin on 27 April 2015
35. Tabled by Mr Graham Castine, Chief Executive Officer for Sunrise Health Service Aboriginal Corporation at a public hearing in Katherine on 29 April 2015 - Annual Report 2013 - 2014
36. Tabled by Mr Graham Castine, Chief Executive Officer, Sunrise Health Service Aboriginal Corporation at a public hearing in Katherine on 29 April 2015
37. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
38. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
39. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
40. Tabled by Mr Peter Gazey, Binjari Health Service at a public hearing in Katherine on 29 April 2015
41. Tabled by Ms Carol Dowling, Treasurer for Kalano Community Association at a public hearing in Katherine on 29 April 2015
42. Tabled by Mr Eddie Mulholland, Chief Executive Officer, Miwatj Health Aboriginal Corporation at a public hearing in Galiwin'ku, Elcho Island NT on 30 April 2015
43. Tabled by Dr Stephen Parnis, Vice President, Australian Medical Association at a public hearing in Melbourne on 9 June 2015.
44. Tabled by Dr Morton Rawlin, Vice President and Victorian Faculty Chair for the Royal Australian College of General Practitioners at a public hearing in Melbourne on 9 June 2015.

45. Tabled by Ms Melanie Walker, Acting Chief Executive Officer, Public Health Association of Australia at a public hearing in Melbourne on 9 June 2015.
46. Tabled by Mr Bob Davis, Chief Executive Officer, Maari Ma Health Aboriginal Corporation at a public hearing on 10 June 2015 in Broken Hill.
47. Tabled by Mr Stuart Gordon, Chief Executive Officer, Far West NSW Medicare Local at a public hearing in Broken Hill on 10 June 2015 - Annual Report 2013-2014. Also tabled Preliminary Needs Assessment 2013
48. Tabled by Ms Amanda Mitchell, Acting Deputy Chief Executive Officer, Aboriginal Health Council of South Australia, at a public hearing in Adelaide on 11 June 2015 - Annual Report 2013-2014
49. Tabled by Mr Steve Archer, Deputy Chief Executive Finance and Corporate Services, SA Health at a public hearing in Adelaide on 11 June 2015.
50. Tabled by Ms Alison Verhoeven, Chief Executive Officer, Australian Healthcare and Hospitals Association at a public hearing in Melbourne on 9 June 2015. (Opening statement via teleconference)
51. Tabled by Mr Michael Cousins, Chief Executive Officer, Health Consumer Alliance of SA at a public hearing in Adelaide on 11 June 2015 - Response to the Transforming Health Discussion Paper
52. Tabled by Mr Michael Cousins, Chief Executive Officer, Health Consumer Alliance of SA at a public hearing in Adelaide on 11 June 2015 - Report on the Community Workshop held to establish the Peak Consumer and Community Engagement Forum and Strategy for Transforming Health - May 2015

Answers to Questions on Notice

1. Answers to questions on notice - public hearing 28 August 2014, Canberra, Premier of South Australia
2. Answers to questions on notice - public hearing 28 August 2014, Canberra, Department of Health
3. Answers to questions on notice - public hearing 28 August 2014, Canberra, Department of Treasury
4. Answers to questions on notice and in writing - public hearing 4 September, Canberra, Organ and Tissue Authority
5. Answers to questions on notice - public hearing 25 September, Canberra, National Blood Authority
6. Answers to questions on notice - public hearing 2 October 2014, Canberra, Department of Health
7. Answers to questions on notice - public hearing 8 October 2014, Melbourne, Department of Health

8. Answer to question on notice - public hearing 16 September 2014, Moruya, NSW - Southern NSW Medicare Local
9. Answers to questions on notice - public hearing 8 October 2014, Melbourne, Allied Health Professions Australia
10. Answers to questions on notice - public hearing 8 October 2014, Melbourne, Royal Australiasian College of Physicians
11. Answers to questions on notice - public hearing 9 October 2014, Adelaide, South Australian Department of Health and Ageing
12. Answers to questions on notice - public hearing 3 November 2014, Hobart, Social Determinants of Health Advocacy Network (Tasmania)
13. Answer to questions on notice - public hearing 9 October 2014, Adelaide, Population Health Research Network
14. Answer to question on notice - public hearing 5 February 2015, Canberra, The Royal Australian College of General Practitioners
15. Answers to questions on notice - public hearing 13 February 2015, Canberra, Department of Prime Minister and Cabinet
16. Answer to question on notice - public hearing 13 February 2015, Canberra, Australian Indigenous Doctors' Association
17. Answers to questions on notice - public hearing 5 February 2015, Canberra, Department of Health
18. Answer to question on notice - public hearing 19 February 2015, Strathfield, BEING
19. Answers to questions on notice - public hearing 13 February 2015, Canberra, Department of Health
20. Answers to questions on notice - public hearing 15 April 2015, Canberra, Dr Katrina Alford
21. Answers to questions on notice - public hearing 27 April 2015, Darwin, CEO Danila Dilba Health Service
22. Answer to question on notice - public hearing 14 April 2015, Canberra, Ms Carolyn Gullery, General Manager, Planning, Funding and Decision Support - Canterbury District Health Board
23. Answer to question on notice - public hearing 16 April 2015, Colac, Ms Marg White, Acting CEO, Colac Area Health
24. Answer to question on notice - public hearing 17 April 2015, Burnie, Mrs Anita Dow, Mayor of Burnie