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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

THURSDAY, 24 AUGUST 2006

PERTH

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Thursday, 24 August 2006

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

Members in attendance: Mr Georganas, Ms Hall and Mr Somlyay

Terms of reference for the inquiry:

To inquire into and report on:

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

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

The Committee shall give particular consideration to:

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

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

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

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

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

WITNESSES

BOW, Mrs Jennifer Lee, Deputy Chief Executive Officer, Shire of Bruce Rock 1

DARBY, Mr Kim, Director, Business Enhancement, WA Country Health Service, Department of Health, Western Australia 29

DOUGLAS, Dr Scott Glen, Treasurer, Doctors Reform Society of Western Australia 15

HANDMER, Mr Jed Douglas, Policy Officer, Western Australian Local Government Association 1

KING, Mr Peter, Acting Chief Finance Officer, Department of Health, Western Australia 29

MacKENZIE, Ms Michelle, Community Policy Manager, Western Australian Local Government Association 1

MILLER, Mr Mark, Manager, Federal Affairs Branch, Department of Health, Western Australia 29

RALLS, Dr Jane, President, Doctors Reform Society of Western Australia 15

STRANGE, Mr Stephen Arthur, Shire President, Shire of Bruce Rock 1

THOMPSON, Mr Barrye Roy, Chief Executive Officer, Shire of Laverton 1

TOWLER, Dr Simon, Executive Director, Health Policy and Clinical Reform, Department of Health, Western Australia 29

XANTHIS, Mr Colin Peter, Acting Executive Director, Health System Support, Department of Health, Western Australia 29

Committee met at 8.50 am

BOW, Mrs Jennifer Lee, Deputy Chief Executive Officer, Shire of Bruce Rock

STRANGE, Mr Stephen Arthur, Shire President, Shire of Bruce Rock

HANDMER, Mr Jed Douglas, Policy Officer, Western Australian Local Government Association

MacKENZIE, Ms Michelle, Community Policy Manager, Western Australian Local Government Association

THOMPSON, Mr Barrye Roy, Chief Executive Officer, Shire of Laverton

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for our inquiry into health funding. The committee is examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. This is the first time the committee has been to WA during the course of this inquiry.

At today's public hearing the committee will hear from the Shire of Laverton on the sustainability of the current health arrangements in remote communities. Also appearing today is the Doctors Reform Society of Western Australia, a leading group of doctors and medical students supporting justice, equity and quality in the provision of health services. The committee will also take evidence from the WA government. The committee welcomes the Western Australian government's contribution to the inquiry. It has not been easy to get some states to cooperate in this inquiry and it is very good of the WA government to participate.

This hearing is open to the public and a transcript of what is said will be placed on the committee's website. If anyone here would like further details about the inquiry or the transcripts, please ask any of the committee staff who are here at the hearing.

I welcome the representatives from local government in Western Australia to give evidence. The committee does not require you to speak under oath, but you should understand that these hearings are a formal part of the proceedings of parliament and giving false or misleading evidence is a serious matter that may be regarded as contempt. Would you like to make a brief introductory statement before we proceed to questions?

Mr Handmer—I first of all would like to announce that Laverton will be making a joint submission with us. I believe Laverton are teleconferenced in. They are not able to be here in person. It is a considerable journey to make here.

CHAIR—Yes, of course it is. As a former minister for local government, I know where it is.

Mr Handmer—In that case you will not be needing one of these handy little maps!

CHAIR—Welcome, Barrye. I have made all my introductory remarks and told people that what happens here today happens under privilege; what you say to us today is covered by parliamentary privilege. You cannot be taken to court and sued, so go to town!

Mr Thompson—Thanks, Alex. I appreciate that.

CHAIR—I was minister for local government some years ago, so I actually know where Laverton is, and I know it is a long way out of town. The over the horizon radar facility is out there, too, isn't it?

Mr Thompson—That is correct, yes. What is the format, Alex?

CHAIR—The format is that now I invite the people that are here, and yourself, to make some opening remarks about the reforms that you see are needed in the health system from the point of view of local government.

Mr Thompson—I put forward a submission to the Canberra office, which I assumed was going to be distributed to the members of the committee.

CHAIR—Yes, we have that.

Mr Thompson—Really, it is a point of view from a very remote area, and the financial effort it would take for a local government in our area to ensure a complete medical service. Our next complete medical service would be Kalgoorlie, which is about 3½ hours away by road. We have no direct air link between Kalgoorlie and Laverton other than by RFDS, which is considered to be an extremely vital service in our area. About 59, maybe 60, per cent of our poor population is Indigenous, and a lot of the medical services are devoted to that race. We also have the pleasure—I suppose you could call it that—of a fly in, fly out population of miners to three major mines in our area. That would build our population up from about 500, 550 to 1,850, maybe 2,000. The fly in, fly out actually have no economic impact upon the town, which is a disappointing part of that practice, but they still have a requirement for medical services.

As the committee can see, the council makes a net contribution of about $171,000 per annum to ensure a complete medical service, and we do receive a contribution from the operating mines of $55,000 but, before that, that is $226,000 that the council outlays to ensure a complete medical service, and this is from a local government with a rate base of about $1.4 million, which is not a very big local government.

CHAIR—For the fly in, fly out people, do the mines have their own medical facilities at all?

Mr Thompson—They have first-class first aid, but they do not have medical practitioners on site, so it is essential for them that a resident GP is available in the town.

Ms HALL—Do you levy them?

Mr Thompson—Yes, three of the mines make a total contribution of $55,000 towards the $110,000 we subsidise the actual cash salary of the doctor.

Mr GEORGANAS—Have you guys done any figures on how much is spent on medical costs on the fly in, fly outs?

Mr Thompson—No. We would not be privy to those figures. That would be within the health service and within the practice of the doctor, which is a private practice.

CHAIR—For the permanent population, what are the problems in remote—I presume I can call Laverton 'remote'—Western Australia? What problems are there there that their cousins in the cities do not have to endure?

Mr Thompson—People still get sick. We do have an increased level of violence, or the results of violence which the hospital has to treat. That is also apparent in city hospitals. It is just that if we did not give subsidies, particularly towards nursing staff, we just would not get a completely staffed hospital which has about four or five major roles that it performs in the medical services here.

CHAIR—And that is provided by the state government?

Mr Thompson—It is, yes. The shire physically contributes an incentive to attract nurses. We pay $2,000 every six months to registered nurses for six months continuous service and $1,500 to enrolled nurses. That has a direct impact, in that we are mostly fully staffed here. We have a pretty good liaison with the hospital, and they are deeply appreciative. Unfortunately, the state department of public health castigated council for putting that incentive in place because it felt it was putting all the rural and remote hospitals at a disadvantage. It is a little bit laughable when you think that, if we did not have that incentive, we would not have staff.

Ms HALL—I notice from your submission that you mention that you have a high Indigenous population within the town. What strain does that place on the provision of health care?

Mr Thompson—Certainly there are high levels of the diseases and sicknesses which are apparent in the Indigenous races. I am just trying to draw them to mind at the moment. I would say over 80 per cent of the hospital services are directed towards the Indigenous community.

Ms HALL—Is there a local Aboriginal medical service?

Mr Thompson—No, there is not. The closest Aboriginal medical service is at Kalgoorlie, 350 kilometres away.

CHAIR—Now we will let the others here participate as well, so we will keep you online, and come in at any stage you want to, Barrye.

Mr Thompson—Thanks, Alex.

CHAIR—Over to you, Jed. Would you like to talk to your paper?

Mr Handmer—To avoid reiterating the submission at length, the Local Government Association will just say a few things to couch the presentation of the other two parties here. To recap—because I know it is not in front of the committee as we speak, due to a slight mix-up—

our presentation deals with, essentially, six key points. From a whole-of-local-government perspective, we believe that those foci are, first, a focus on preventative services and wellness—basically a pre-emptive and positive approach to health in a holistic sense. The key factor threatening the whole of local government or making life difficult is the clarification of roles and responsibilities, obviously. Funding is passing through a lot of hands on the way to where it gets to eventually. Accountability is still elusive despite, of course, the positive steps being taken. Financial assistance funding is still problematic. Increasing the FAGs quantum is, of course, a cry you will have heard over and over and it is, I suppose, still one that we are making.

Special purpose grants to enable that whole-of-community approach to health are a key issue, and continuing with the positive trends in that sense and expanding them is something we see as very important to sustain human capital, improving lifestyles and promoting healthy living. Environmental health is also an area where a considerable cost creep has been happening. It is a very important area to the members as a whole.

CHAIR—What do you mean by 'cost creep'?

Mr Handmer—In terms of prevention and promotion programs and things of the sort that are increasingly part of the profile of a modern health service.

CHAIR—You are being asked to implement that by the state government?

Mr Handmer—Yes.

CHAIR—And there are compliance costs to council.

Mr Handmer—Yes, and of course there are generally funding streams that come with that, but whether they are adequate and representative is another issue, and, as the population ages, obviously those prevention and promotion campaigns increase and increase in profile, particularly for the state-level planners. Environmental health is one of the key areas where that shows up, and that of course is clearly a local government responsibility. It is an issue that needs to be dealt with. Finally, in relation to the health of Aboriginal communities, local government will be the cornerstone in terms of seeing that there are actual outcomes in those communities and ensuring that the innovations and the funds needed go through. It is going to be a very important focus.

Ms MacKenzie—Can I clarify. In our submission we distinguish primary health, which is doctors, nurses. It is not a local government responsibility. Very clearly, in our submission, the reason local government is getting involved is because of the argy-bargy between the Commonwealth and the states, in particular outside Perth, councils like Laverton and Bruce Rock. About 44 of our members are getting involved because no-one is taking responsibility and, whilst GP services are a private practice, it is not viable out there for doctors to have their own private practice, and councils are being looked at by their communities to step in.

Environmental health is a core local government responsibility, and there is a significant shift happening in WA. We are getting a new Public Health Act which will bind the Crown, and that will mean that suddenly local government will have to provide services to Aboriginal communities. But our members accept the responsibility for environmental health.

CHAIR—Just define those services that you are required to deliver.

Ms MacKenzie—The environmental health services?

CHAIR—Yes.

Ms MacKenzie—Food sampling, sampling water, things like vector control—mosquito control, diseases, things like that, which most people take for granted. In WA, the Health Act at present does not bind the Crown and so Aboriginal communities are not getting basic environmental health care. It is a significant issue.

CHAIR—It is just not happening?

Ms MacKenzie—It is not happening. One of our members, the Shire of Halls Creek, was taken to court because they tried to enforce the Health Act on an Aboriginal community, and of course there is significant cost to the state government because these communities are run by the Aboriginal Lands Trust, and when the council said, 'You need to fix up the standard of building control,' the state government said, 'No, we'll take local government to court,' and the Supreme Court ruled that local government could not apply the Health Act to Aboriginal communities in WA. That has made our members fearful of now doing that, because of the implications.

CHAIR—Really, that is what this inquiry is about: the relationship between the Commonwealth and the states, the involvement of local government, how it has worked in the past and how it should work in the future. I have no expertise on Western Australia, but over in the eastern states everybody is sick and tired of the Commonwealth and the states blaming each other. The blame game is very annoying to the public, to members of parliament, to everybody. Hopefully, as a result of the COAG process and the process that our committee is going through, we are going to come up with a system that is dedicated to getting as much of the health dollar for the patient as possible. We have not had empirical evidence, but it has been suggested that only about 20c in the health dollar gets through to the patient, and we think it should be a lot more than that.

Ms HALL—That has been put forward by one witness to this inquiry. I do not think that we can take that as being gospel.

CHAIR—But no-one has disputed it.

Ms HALL—But I think that the point that Alex is making is valid, in that so much money is spent on the administration side as opposed to money getting through to the actual patient.

CHAIR—To patient care.

Ms HALL—Yes, to the actual patient or to the community that looks to the government for support through the funding of health care.

Mr Strange—Chair, could I make a comment about city versus country. If it is 20c, we would suggest it is only 10c in Bruce Rock and Laverton. What is happening is very cloudy to us in the country.

Mr Handmer—I will briefly round off the contextualising with a couple of statistics that might not have landed on your plates yet, but I am sure will. In WA we are looking at potentially up to 55-odd per cent of rural and remote practice being essentially unsustainable by 2008. That may, of course, involve calculations based on the high turnover in the workforce and what have you, but prima facie it is a bit alarming. Half of local government expenditure is now devoted to human services.

Ms HALL—That is in Western Australia?

Mr Handmer—Yes. The latest figures from the Department of Local Government and Regional Development put WA education, health and welfare expenditure for local government at about $91.3 million for the 2004-05 fiscal year. We have heard from Laverton. It is a very indicative example of what remote communities in WA can do and what they have to deal with. Bruce Rock, on the other hand, is indicative of a typical—but atypical in terms of response—rural centre, so I will let the horse's mouth do the talking.

Mr Strange—Thanks, Jed. Mr Chairman and committee members, you have copies of our submission?

Ms HALL—Yes, I have. I have had a look at it.

CHAIR—Yes, we have.

Mr Strange—First of all, some background: we are three hours east of Perth , a typical wheat belt. We have certainly seen farms increase in size as population declines in the farming area. Over the last 15 years there have been initiatives taken to attract population from mainly the city, through setting up factory units for businesses and our free land.

Ms HALL—What is your population?

Mr Strange—A population of 1,200—around 50 per cent in the town and 50 per cent outside. We have had our free land release and those sorts of things and we are now seeing a 'tree change' happening. The first question that is asked when people come to towns like Bruce Rock is, 'Have you got a doctor? What's the health services like? Have you got a school?'—all of those facilities. Bruce Rock, particularly over the last 15 years, has been very involved, first of all, in recognising that the state has let us down and we have to take certain initiatives to prop it up.

In our submission we have shown some of the things that we have done, most of them over the last eight to 10 years. If I can run through them briefly: a health centre, which is about seven years old now, that accommodates the doctor, a dentist—dentists are rare throughout country WA. We have attracted a dentist from another town and built a house for him and his family. I should say from the outset that we have concentrated on a lifestyle town, a place to bring up young families and where older people feel quite secure. They are selling their quite expensive

real estate in other areas and moving to country WA. The infant health nurse is also obviously involved with the health centre.

The council runs a building crew, so we build the infrastructure ourselves. We built the medical centre and we did fit out the dental surgery and the maintenance costs for the year are shown in the submission. These are things that are covered by the council: housing for our doctor, certainly with free rent; we have attracted a physiotherapist to the town, built a house, and he services other areas from Bruce Rock—around a 100-kilometre radius from Bruce Rock. The construction and maintenance costs for all houses are shown. Running costs for vehicles are involved, and we have guaranteed salaries for doctors, which seems fairly common throughout the wheat belt. We also carry the locum costs.

CHAIR—The doctor charges under the MBS—Medicare?

Mr Strange—Yes. It is a private practice.

CHAIR—Do you prop up the salary?

Mr Strange—We have not had to at this point, but he wanted that guarantee before he came to Bruce Rock. We have done joint ventures with the state government—which are shown over the page—with regard to a permanent care wing on our hospital. The state government gave us $100,000 towards this about 10 years ago. They anticipated that we would be matching the funds and getting a private builder in there. We built the wing with our own staff. This is where bureaucracy got involved and said, ‘That can’t be done because you can’t build on hospital land,’ and so on. That tied up the funds for about 18 months. In the end, we did get the service: we built the facility. It was not at a great cash cost to the community, because we do have our own building crew, and we have ended up with an extremely good unit.

Ms HALL—When did you build the hospital?

Mr Strange—The permanent care wing?

Ms HALL—Yes. When was it built?

Mr Strange—About nine years ago. Another joint venture has been to build 19 retirement units—or homes for the aged, as they were called. Our physiotherapist works out of an amenity centre there. He has a consulting room and we have put in a hydrotherapy pool, which is free for use by not only the people in the Bruce Rock area but it is a regional facility. There are a lot of hip and knee replacements which are done and the pool has been very popular for that: the surgery is done down here; they go back for the rehab and travel into Bruce Rock to see the physio and do the work there. We have put in a chairlift which allows people to get in and out, and we have a fully set-up gym and it costs only $5 a year to become a member. That has also become a regional facility and people come in and use that.

We have made comments about where we are and what we do. The council did make the decision that our ratepayers, our electors, our residents should not be disadvantaged by living in Bruce Rock with regard to health and we are finding more and more that people are feeling

isolated, even if they are only an hour or so away from medical services. That should not be the case and so, as has been shown, the council has taken the lead in that area.

It is a two- to three-hour drive to see a specialist, which is an issue. There is no public transport and people have to rely on volunteers to get them there. That is a huge issue. The state government is trying to make Merredin a regional hospital.

Ms HALL—Where is that in relation to you?

Mr Strange—It is 50 kilometres north. It is not that far. But the government has struggled to do that and they are looking at putting salaried doctors into Merredin, which obviously would make us look pretty good. The only concern we have is at what cost to surrounding hospitals, because Merredin is only 50 kilometres away. Perhaps existing services might be cut from Bruce Rock and surrounding towns to finance this.

CHAIR—By the state government?

Mr Strange—Yes. I think it is more than suspicion: it would happen. We have seen over a period of time that a lot of our services have been eroded very slowly and people have made other arrangements to go to northern Perth. They look at it now and say, 'Well, perhaps you don't need that service because you've made alternative arrangements.' There are certainly big gaps in the health system in regard to Aboriginal health and mental health. Mental health, particularly in men, is a huge issue in the farming communities; rural suicides are increasing through pressure mainly in the agricultural industry, I would say, and isolation is also causing huge problems. There are more men's groups being set up around the wheat belt, and Bruce Rock have just got involved with one. We have quite a few strategies in place, but once again they are propped up by local government or the community.

Uncertainty is the issue for us. We want to be more involved as a community, as a council. We would like direct funding from the Commonwealth. A good example of how that sort of funding works is through the Roads to Recovery model. It has been magnificent. The funds have come through. We have done a review of our roads only last week and, within three years, we will have all of our roads up to an acceptable standard. That is quite outstanding, and it is through the Commonwealth that we have been able to do that. That is because we are getting back to the cents in dollar getting on the ground and we can do that through that system. I mentioned before that funds coming from the state and getting out into the country have been a little cloudy. We are very unsure. All we can see is a decline in that funding.

Ms HALL—You mentioned the MBS. It sounds like you would be a really good candidate for an MBS and for your services to operate as such. That requires all levels of government pooling their money and putting it into that facility. You are already operating aged care and the smaller hospital. I think it would be very good for you to operate as an MBS facility.

CHAIR—Have you been involved in the COAG announcements on mental health; the additional funding that has been put in by the Commonwealth?

Mr Strange—No, not that I am aware.

CHAIR—You must do it through your organisations—your statewide organisations—to make sure that that money all goes down to local government. If you are handling mental health issues now and you are happy to pay for it, you would want to make sure that you get access to some of that funding.

Mr Strange—Yes.

Ms HALL—What mental health issues are you handling and paying for?

Mr Strange—At this point, it is not a huge cost. It is a meeting area, food, drinks, accommodation, getting some speakers up, administration and those sorts of things.

CHAIR—But you do have the problem. Whether or not it is being treated is the question we are looking at.

Mr Strange—Yes.

Mr GEORGANAS—You said accommodation. For whom?

Mr Strange—Visiting speakers staying overnight and all those sorts of things. Most of these public functions are held in the evening, so visiting speakers generally stay and travel back the next day. It is something that the council and the community has recognised. They will not shirk the issue and they will be involved.

Mr GEORGANAS—Have you had any episodes within towns, where there just have not been the services to perhaps give people the care that they need whilst they are having a mental episode?

Mr Strange—Yes, we certainly have.

Mr GEORGANAS—What do you do in those situations? Who restrains them and—

Mr Strange—The police are involved in those situations. Our ambulance service is all volunteers, and they leave their businesses and go to those episodes. From there they go to the hospital, which handles them as well as they can, and then they generally come to Perth or Northam.

Ms HALL—Do you have a local mental health crisis team working in your area?

Mr Strange—We have a service out of Northam, but I am not sure how it operates. Once again, we have the time constraints or the problem where something happens and action needs to be taken straightaway. Northam is two hours away.

Ms HALL—You said it was atypical, and it is—building the houses for the doctor, the dentist and the physiotherapist. Maybe the next one you will have to build one for is the psychologist if you are going to access the Commonwealth funds.

Mr Strange—Yes.

Mr Thompson—Can I just butt in for a minute, on mental health.

CHAIR—Yes, go ahead.

Mr Thompson—The council here has recognised that we have a specific mental health problem and we have been negotiating with the state on this, but they really do not want to know about it. We have a lot of problem kids, through dysfunctional families, domestic violence, drug use and alcohol abuse, and we have been trying very hard to get a pilot scheme in, which the council is prepared to administer. That is $100,000 a year for a three-year pilot scheme for the purposes of installing a resident psychologist or a resident senior counsellor. We have had absolutely no luck at this time. We referred it to the federal government and also to the state government, hoping that they might have a whole-of-government approach to it.

Basically, we have the same problem here as Halls Creek, except it is not quite so public, but we have a lot of disturbed children who would be well suited to counselling by an experienced practitioner. However, we just cannot get to first base with it, mainly because they believe that we have a service already, which is an outreach service from Kalgoorlie two days every fortnight. Unfortunately, they allow two days for Laverton, but one day of it is spent getting here and getting back again, so really it is only effectively one day. All they have a chance to do is have a cappuccino, see what the town looks like and go home again. It is very ineffective and there is no recognition of mental health issues out this way.

I can understand what Steve is talking about with the agricultural area. This is just on a different aspect, particularly related to children, and our intention is to get to these children between the ages of six and 14. After that you have basically lost them and they go into the same old pattern which has been occurring for the last 50 to 70 years.

CHAIR—Barrye, you heard Stephen mention the high incidence of suicide in rural areas.

Mr Thompson—Yes.

CHAIR—Is it the same thing in youth suicide?

Mr Thompson—No, different. I can recognise that. My last four shires have been agriculture, and I recognise that is a serious problem in agricultural areas. This is more about trying to put a breaker in with regard to what is happening with our Indigenous children and trying to get them to think that they have worth, that they do not have to go on to CDE or on the dole and that there is another purpose in life.

Ms MacKenzie—I would like to go back to the point about Bruce Rock. When local government is involved, it actually is not atypical. Councils may start off quite slowly, providing maybe a car for a doctor or a house, but we have 45 of our members involved. Generally, it has become a bit of a bidding war. Doctors know that local governments are providing houses, and so they will say, ‘Well, actually, if I go to this shire, I’ll get a house and a car and perhaps a salary subsidy,’ and so it starts to escalate and the expectation on local government increases.

I suppose our members would be a bit cautious with mental health because, yes, local government can get involved, and what happens is local government is often seen as the top-up.

The Commonwealth and the state funding is inadequate, and so they look to the local government—’Well, if you want this in your community, perhaps you need to chuck in some money’—and then that escalates, and that is where that cost shifting creep happens.

Certainly from my experience in the Pilbara, once you provide a service, it is very hard to then retract the service. Community expectation is raised. We have state planning happening from a centralised level in Perth. We have communities on the ground saying, ‘Well, actually, this is what we need,’ and when there is no fit it is the council that has the pressure to provide the service. So the mental health funding is welcome, but certainly our members are cautious in terms of what it means for the future once they get involved. Is mental health provision a local government role?

CHAIR—It should not be paid for by the ratepayers. It is as simple as that.

Ms MacKenzie—But it is.

Mr GEORGANAS—You are saying that local government is becoming a bit like a safety net, where you are very close to the people in terms of the tiers of government—

Ms MacKenzie—Yes.

Mr GEORGANAS—but you are on the ground level with the people at a grassroots level. You are saying that local governments, through necessity, are becoming a safety net for the things that are missed out by the Commonwealth and the states, with no option but to come in. I am seeing that more and more in my area.

Ms HALL—I think Steve made a very good point. I think this is a very good example of cost shifting. The provision of GP services should be made by the Commonwealth. The Commonwealth is shifting the costs to local government. There are other things here, where the state is shifting costs to local government, and these are local governments with very low rate bases. Making sure you have adequate GP services is a Commonwealth area.

Ms MacKenzie—It is not just GPs, as Stephen mentioned. It is ambulance services—

Ms HALL—Ambulance services are a state responsibility.

Ms MacKenzie—Nursing is funded by the state. The state put out a contract, so a non-government agency provided nursing services to rural areas and then the NGO went to 12 different councils saying, ‘If you can’t top up the money, because our funding isn’t indexed and as the nurses get pay rises we can’t keep the number of nurses in your community, we’ll have to withdraw the service.’ So it is nurses, it is doctors, it is ambulances and now we may see mental health.

Ms HALL—And it is the local government authorities that can probably less afford it that are having to pick up the bill, not the big city councils with the high rate bases.

Ms MacKenzie—Yes.

Mr Strange—Our rate base is at around $860,000, which is not a lot.

CHAIR—Can I change the subject. We are inquiring into the health system, and half of the health system is private. Obviously, not many people out your way would have private health insurance, because there are no facilities, but is there any involvement of the private sector, apart from primary care, in remote areas? I do not know what the network of private hospitals is in Western Australia.

Ms HALL—The nearest private hospital?

CHAIR—Yes.

Mr Strange—It would be in the metro area.

Ms MacKenzie—St John of God has some private hospitals in rural WA, but even as a charity they need to not go under. If you mean 'private' in terms of non-government agencies, so your smaller agencies like Silver Chain or people that may pick up—

CHAIR—What happens to people in your area who need elective surgery?

Ms MacKenzie—The visiting medical specialist may go out if there is a regional hospital, or we have got Patient Assisted Travel, which brings people down to Perth.

Mr Strange—It should be pointed out—considering the price of fuel—it is virtually nothing.

CHAIR—But 54 per cent of all elective surgery is now done in private hospitals in Australia.

Mr Strange—You mentioned private health insurance.

CHAIR—Yes.

Mr Strange—I would say that, at a guess, it would be still quite high in the country, certainly in Bruce Rock—well over 50 per cent—because of the isolation and wanting to have access, if something does happen, to those things you mentioned, wanting to get a direct stream to a particular health area or doctor.

Mr GEORGANAS—What are the demographics, Stephen, of Bruce Rock in terms of age? Is it an ageing community?

Mr Strange—It is ageing. Having said that, right at this point we have probably around 15 to 20 per cent of our population who are up to 20 years old—I might be a little off here—and then from 20 to 40 years old. There are quite a few younger families around at this point, for all sorts of different reasons. We have been building factory units, for example, and renting them out to new businesses, so people are moving out for that reason, and security reasons and lifestyle reasons, so that demographic has increased, but the aged population is increasing all the time.

CHAIR—How about aged care? What will you do for aged care, for people who need to go into a nursing home?

Mr Strange—We have certainly had that, but, once again, the facility is not big enough. Aged care has been financed to a fair degree by the community. A lot of volunteers are involved with aged care in-home, in-house.

Mr GEORGANAS—Are you finding that a lot of people that need aged care facilities have to move out to different regions or different areas to find those facilities because there are no beds available locally?

Mr Strange—Yes. We have been fairly lucky to date, but, because of the increased demand in the future, that is what is going to happen, and it just splits up families. They are coming over here, three hours away, and perhaps it might be better if the whole family came down here.

CHAIR—How would you like to see the system change to be able to deliver better outcomes for remote areas such as yours?

Mr Strange—We are very keen on that R2R model with regard to road funding. It works beautifully and we would like to see that happen with health. It will not suit all local governments, but Bruce Rock are very keen to get involved directly with the federal government in that area. We are there, we are set up fairly well, and we can do it. We have made good value out of any funds that come over.

Ms HALL—In the past, I think it was Tony Abbott who floated that the federal government become responsible for state run public hospitals, but the Prime Minister said no to that, and as recently as last night Labor's health spokesperson, Julia Gillard, foreshadowed that that is the way that Labor would go, with the Commonwealth taking over the running of state hospitals and that state responsibility. Would you like to comment on that?

Ms MacKenzie—I think the only comment we would make is that it must be very clear who is responsible and that the roles and responsibilities are very clear, and, if local government is considered to be a player, that there are very clear and identified revenue streams, because at the moment it is happening by default.

CHAIR—Yes. There are several models on the table at the moment. There are two extremes. The first is a Commonwealth takeover—with the cooperation of the states, because you cannot just do it, constitutionally—and the other is that the Commonwealth gets right out of hospitals altogether; it gives the states an increase in general revenue funding and stays right out of hospitals. The answer is somewhere in the middle. That is what the two sides of politics are looking at and we are examining which model would be really best for Australia. We do not have in this country a national health agenda. The Commonwealth government has never come down with an agenda for health in Australia. If we had a national health agenda, the Commonwealth could fund the states to achieve that agenda, but that is not how it works. It is a bucket of money given to the states and then the Commonwealth takes a step backwards and lets the states run it, and we get these very good outcomes in some states and very bad outcomes in others.

Ms HALL—It is political football.

CHAIR—It is.

Ms HALL—It gives every level of government the ability to blame the other, and that is probably what needs to change, because it is all about delivering health care to Australians that look to government to do that.

Ms MacKenzie—The issue for our members is that, where there is a hospital provided by the state, there is the capacity for doctors to become involved because they can get work through the hospital. We have examples here and at Laverton where there is no hospital and it creates a different environment in terms of the viability of a GP practice. I think the issue has to be broader than hospitals. It needs to include the doctor issue, because that is what is affecting our members.

CHAIR—Another issue that comes up at every meeting is medical workforce issues: the shortage of nurses, the shortage of allied health services. My personal belief is that this country should not have to import doctors. A country as affluent as Australia should be producing not only enough doctors for us but doctors for others, so we are also looking at that. Any further comments?

Ms MacKenzie—In closing, you would have received a copy of a publication that we put together for our members, because they are facing retention issues, and some of our key policy points are in this document, so enjoy the read.

CHAIR—Okay. Would anyone else like to make a comment?

Mr Strange—Just to say thanks for the opportunity.

CHAIR—We thank you for all the effort you have gone to in coming here and for the submissions you have made. Thank you very much, and thanks, Barrye.

Mr Thompson—Thank you very much for taking it by teleconference.

CHAIR—Is it the wish of the committee that the submission from Bruce Rock be authorised for publication on the database? There being no objection, it is so ordered.

[9.46 am]

DOUGLAS, Dr Scott Glen, Treasurer, Doctors Reform Society of Western Australia

RALLS, Dr Jane, President, Doctors Reform Society of Western Australia

CHAIR—I welcome Dr Jane Ralls and Dr Scott Douglas from Doctors Reform Society of Western Australia. Do you have any comments to make on the capacity in which you appear?

Dr Ralls—Just that I am also a practising GP in Perth.

Dr Douglas—And I am a doctor at Royal Perth Hospital.

CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the Commonwealth parliament and the giving of false or misleading evidence is a serious matter which may be regarded as contempt of parliament. I invite you to address the committee and to make an opening statement.

Dr Ralls—Firstly I would like to thank the committee for providing the opportunity for DRSWA to contribute to this inquiry. The DRS is an organisation consisting of doctors whose prime focus is equity and social justice. In approaching this complex topic, we would like to commend the terms of reference for specifically relating to 'all Australians'. Indeed, the World Bank in its *World Development Report 2006* considers equity to be the critical issue for future global prosperity.

I would like to draw the committee's attention to two examples of inequity in current Australian health funding. Australia's most notable failing is the poor state of health of many Aboriginal Australians in both rural and urban Australia. We boast statistics similar to those of the poorest nations of the world. This should be the top priority for any future health funding.

Children are our future, and proper funding of child health is essential to the nation's future health and prosperity. DRS members' clinical experiences back up the evidence that, when child mental health issues and abuse are not adequately addressed at the time, those people carry the effects on throughout their lives and often they are not able to become productive members of society. The long-term cost of this gross failure of our current system is multifaceted and enormous. Child mental health is a good example of one of the gaps in the current system which is caused by the artificial split by federal and state health care provision.

The DRS believes that there should be one body coordinating all of health care in Australia and that it should be funded at federal level. This would remove the party political bickering that is affecting real Australian people, whose needs are not being met while the buck is passed.

Need should be the determinant of health care provision. This may sound obvious, but sadly it is not the case at all currently. One of the major obstacles to an appropriate balance of needs based provision is the private health sector. While the DRS recognises that some people will always choose to use private health, and we are quite comfortable with it being available, it can

never substitute for a universal public health care provider. The private sector will always be driven by financial issues above the needs of all Australians. The costs of multiple suppliers far outweigh the costs of a single system, especially if that single system is provided by government and is accountable to taxpayers and not to shareholders.

The private health system is funded by item of care provision of health and, as such, is inevitably driven by the need to investigate and to treat, rather than by prevention and provision of appropriate levels of intervention. It is notable that Medicare has always provided a large amount of the income of the private health system.

The balance of health care funding needs to be moved away from specialist and hospital based care and needs to move towards the community and towards prevention, and this can only be achieved well and equitably by a single, accountable, well-resourced and well-advised public sector. We are in agreement with Stephen Leeder of the Public Health Association. We believe it is imperative that the private health subsidy be withdrawn and that the money be returned to the public health system, where it can provide equitable and needs based care to all Australians.

CHAIR—Wow!

Ms HALL—I cannot disagree with a thing you said. You have stated my position.

CHAIR—Do you want to add to that, Scott, as a person who works in the state health system?

Dr Douglas—Sure. We both have a lot of anecdotal experience in working in the community, and my experience is mostly in the hospital system so far. I am a fairly junior doctor. There are lots of areas. What would you like me to address first?

Ms HALL—What do you think is the biggest priority or the biggest health issue facing Australians today?

Dr Douglas—As Jane said, the difference in health between Indigenous Australians and other Australians is intolerable for a Western nation. I have lived and worked in the Pilbara a fair amount. There are certainly a lot of problems with Indigenous health for urban areas, and I do not know whether you have been to many Indigenous communities, but they are truly third world and it is a very big blight on Australia to have that sort of thing existing.

CHAIR—Are you aware of the recent study in the Northern Territory that shows that there has been a dramatic improvement in outcomes in Aboriginal communities? It came as a surprise to everybody, I think, but a real breath of fresh air. Did that cover the whole of Australia?

Ms HALL—No.

CHAIR—Just the Northern Territory.

Dr Douglas—Sure.

Ms HALL—I think the issue about Indigenous health is that, no matter where Indigenous Australians live, their health outcomes are very similar.

Dr Ralls—Yes.

Ms HALL—That is the thing that I think is so tragic.

Dr Ralls—Yes.

CHAIR—But this latest study showed that there were dramatic improvements. I think that is wonderful.

Dr Douglas—It is wonderful, yes.

Dr Ralls—It is a start. There are lots of small things happening on the ground level, and it is very important, especially as we—as we would hope—move towards one body coordinating care, that advice is taken from on-the-ground situations so that small changes can be made in particular areas. But what is important, as Steve says, is that all of Aboriginal Australian health is looked at. There is no room for complacency.

Ms HALL—No.

Dr Ralls—The main thing that is really important with Aboriginal health is that we look at services to achieve equal outcomes of health, not equal services, and in some ways this is very pertinent to remember in the cities, because there are many documented reasons why the Aboriginal population is not able to use mainstream health.

There are many barriers to it, and it is very important that we look at achieving equal outcomes and, for that reason, Aboriginal health needs to be specifically focused everywhere—all Australians. That is something that we have seen falling through the gaps between federal and state health. In particular, I remember that there were a couple of Aboriginal organisations in Perth who were providing extremely good support to Aboriginal Australians in Perth and the state government became—chose; became—unable to fund those, which left an enormous gap, especially in mental health. These gaps should not exist, where everyone can say, 'Oh, it's federal,' or, 'Oh, it's state.' The buck needs to stop being passed, so that that need can still be assessed at one level and it can be said, 'That need is still there.' Nobody can just drop that service.

Mr GEORGANAS—We heard the previous submitters to the inquiry talking about building houses for doctors to encourage them to go to certain areas. What do you think doctors should be doing in all of this?

Dr Ralls—For providing health rurally?

Mr GEORGANAS—Yes.

Dr Ralls—It is a difficult one, isn't it? You have got more experience in that area.

Mr GEORGANAS—The whole idea is to try and get services out to those rural communities, those Aboriginal communities. The big issue is that doctors do not want to go out there. That is quite clear.

Dr Ralls—Yes.

Mr GEORGANAS—How do we deal with that issue?

Dr Douglas—I am sure you have heard many people talk about this.

Mr GEORGANAS—Is there a responsibility on doctors to—

Dr Douglas—I guess that doctors historically do not like being coerced to do anything really. But you do not become a doctor without caring very deeply about the health of people.

Mr GEORGANAS—That is what I am getting at.

Dr Douglas—Even people who work in affluent areas in private health still care about their patients and still care about the health care that they deliver. I agree that there is a degree of responsibility on doctors to choose to work for people who need their help most and, because there are inclinations such as that, organisations like the Doctors Reform Society exist. I think there have been positive steps in terms of numbers of medical graduates being produced and funding for rural clinical schools. A lot of the issue is exposure to rural areas.

I think one of the main factors is where the doctors come from in the first place. Doctors who are from Newman have a fair chance of going back to Newman, whereas doctors who are from City Beach or Willetton or wherever are likely to go back to those areas, too. In terms of probability, you are less likely to move across the country than to stay where you are, where you are from, with what you are used to. Exposure to those areas is very important because the majority of new doctors of whatever age—we have a lot of mature age people these days—possibly do not have experience in rural areas and need to be made aware of the potential and the need for practising in those places.

CHAIR—That is why we opened up the medical school in Townsville.

Ms HALL—Yesterday we were in the Northern Territory and there was an article in the Northern Territory newspaper that said that people who are undertaking studies in medicine now are paying $200,000-plus to attend universities, and this would work against doctors moving to areas like the Territory—rural and remote areas. Would you like to comment on that, in line with what you were just saying?

Dr Ralls—What pops into my mind is something that particularly Scott was very heavily involved in. We worked as a group on the opening of the Notre Dame Medical School, the private medical school in Perth, and it is something that we are quite fundamentally opposed to because it does inevitably draw more well-off people from backgrounds who are not likely to move to areas of need; some of them will, but they are less likely to move to those areas. But also they end up with a big debt, and you earn more money working in City Beach than working in Fitzroy Crossing. There are big issues there and we were very disappointed to see the emergence of Notre Dame.

Dr Douglas—It has proven to be a complex issue. I last heard that the majority of students at Notre Dame are now HECS funded—I do not know that for sure; I guess it is a bit of hearsay—

and that the $200,000 medical degrees are coming from public universities like Melbourne, UNSW, within their 10 per cent quota of full-fee-paying students, which I do not think is a good outcome. In terms of where you are most likely to be financially rewarded, there is money to be made in the country, depending on what it is and where it is and what you do. We do not want people to just go to the country because they want to make money quickly. There is a lot of money to be made in locum services but that is a very poor way of providing health care: to be in town for two weeks at a time, or not even that; only four days at a time or 48 hours at a time.

Ms HALL—I imagine that it would be pretty stressful kind of work.

Dr Douglas—It is stressful work and there is no continuity.

CHAIR—Clinical training of doctors is done in public hospitals.

Dr Douglas—By and large, but not exclusively.

Dr Ralls—Not with Notre Dame. That was one of our main problems.

CHAIR—I am not aware of Notre Dame. Are you aware of Notre Dame?

Ms HALL—Yes.

Dr Ralls—Sorry. It is a private university.

CHAIR—They do clinical training at a private hospital?

Dr Ralls—Yes. They have not started.

Dr Douglas—They are up to their second or third year of intake. I think this is their second year of intake of a four-year graduate entry program. Notre Dame has used it for maybe 10 years or so doing other things. We do have a large number of concerns about it, and their hospital training at the moment would be largely through the St John of God health care group which is a fairly large private hospital group in Western Australia. The other thing to remember is that not all clinical training takes place in hospitals, although certainly at the moment it is the vast majority. There is clinical training that takes place in general practice and in community health settings, and in other places. Certainly UWA and Notre Dame have always published their intent to do that as well. I do not actually know what they are doing.

CHAIR—In regard to Notre Dame, the present system is that the Commonwealth pays for funded places at university and the clinical training is done under the state budget. We are not producing enough doctors. I believe that it is an absolute tragedy that a country like ours has to import foreign doctors. A country with the affluence of Australia should not be in that position.

Mr GEORGANAS—We used to export doctors once upon a time to Third World countries.

CHAIR—Exactly.

Dr Ralls—Yes.

CHAIR—We should be training people, under our aid budget training, as doctors and sending them. We have the affluence to do it. Why don't we do it? The question is, 'Should the Commonwealth get more involved in the process of training a medical workforce?', because their responsibility really finishes at the graduation from the university. They are not involved in the clinical training side of it, although they fund half of it through the health care agreements.

Dr Douglas—Do you mean clinical training as in registrar level, specialty colleges? Clinical training does occur as an undergraduate as well, and occurs in the state hospital system, and is done within their budgets. We spend the last two to three years of a degree there.

CHAIR—With the cooperation of the states, should the Commonwealth take the lead and say, 'We want more doctors,' and take responsibility for producing more doctors, through the clinical side of it as well as the academic side?

Dr Douglas—The actual numbers of people entering medical school are controlled federally and they have the power to increase those numbers. We are certainly supportive of that. The concern obviously then is that there are adequate resources to train those people, both in pre-clinical basic science training and then in clinical practice in the community and in hospitals. A lot of medical schools around Australia are looking at more community based training because inevitably half of all graduates will end as general practitioners. They are not going to work in the hospital system for the rest of their lives, and even the half that are going to stay in the hospital system are greatly benefited by a better knowledge of community medicine anyway.

There is concern that in WA we have gone from having, I think, in my year just over 100 graduates; in about three years time there are going to be 250. That means that now they are starting to have a bulge of about 250 entering clinical training in their third and fourth years of med school, and exactly how those people are going to be well trained when you have got a system that is understaffed and therefore busy and stressed, who are then going to need to find the time to teach two and a half times as many students, is going to be a very interesting period of time for our health system.

Mr GEORGANAS—Scott, you mentioned just then that you would support the increase of people going through medical school—producing more doctors, obviously—and you said that the ability lies within the federal government to increase those intakes. Why do you think that hasn't been the case in the past? Has there been any particular pressure from particular lobby groups or anything not to increase those numbers?

Dr Douglas—There is a perception that doctors have liked to control their numbers so that there is demand, therefore it gives them a better position in whatever they do, but also—and again this is anecdotal—there is an opinion that in the early nineties we stopped increasing doctor numbers. In fact, I have been told that in some states they were reduced, basically with the aim of reducing costs, because we have the pens and we write all the forms that generate costs in the health system. That is my understanding of it. I was not following politics closely enough in 1996, or whenever it was, to know if that is correct.

Mr GEORGANAS—But we hear of rural and local government areas bidding for doctors by giving them houses or cars. We talk about competition bringing prices down in every other market except for this particular market.

CHAIR—We also have state premiers going to the UK and other countries, price-war bidding for doctors for the public hospital system, and I am saying we should not have to do that in Australia.

Dr Ralls—I would like to bring the conversation back to the problems with having a strong private sector, in particular in the balance of training and clinical provision. When we have a very strong private sector, they are the same clinicians working in the private sector and in the public sector, and they are making more money. What we then see is that, although we may overall have adequate clinicians to train the medical students, if they are all very busy working in the private sector in an uncapped system where they can, say, do three investigations for abdominal pain where actually one would be appropriate, those people are tied up in a way that can make them more money and they are not available to be either teaching junior doctors or to be providing clinical care for patients in the public system, and then we come into a very inequitable balance of health care.

CHAIR—On that point, it is put to us that private hospitals should get involved in training.

Dr Ralls—My point—and again I would come back to private medical schools and talking particularly about providing care in rural locations, Aboriginal care, and in the lower socioeconomic groupings in Australia—is that private sectors do and always will see a skewed population. Where I work, I see a skewed population; I see the people who live in the area where I live. But I have been working for 20 years and I have had lots of experience in different places. I think it is vitally important that medical students and junior doctors see a range of situations and a range of people from different backgrounds with different health challenges right from the start, so training in private hospitals concerns me.

Dr Douglas—Yes, certainly the patient mix in a private hospital is not the same as in a public hospital. They are focused mostly on elective surgery, elective procedures. Medical admissions generally are less acute. The whole hospital is running at a lower acuity, and that is not what teaching is about.

CHAIR—Is this the same on the eastern coast as in WA?

Dr Ralls—I would imagine so.

Dr Douglas—I am a year and a half out of medical school and speak to other students over there. That seems to be the case, yes.

CHAIR—The evidence we have from specialists is that, as a group, they are ageing and there are not going to be the specialists available to keep training.

Dr Douglas—There are not even going to be enough to provide services.

Dr Ralls—Which is why it was great to hear you talking earlier with Laverton about the fact that we do not have a national health agenda. This is so vitally important and cannot be done in the context of a federal-state split. We need a coordinated central body that can be advised nationally but can also be advised at local level, and that body can then look at all the different

needs that are there—the needs of clinical provision and of training—and a national health agenda that coordinates all these different factors, I think, is of crucial importance.

Dr Douglas—As is being able to have national single funding rather than separate health care agreements, Medicare Benefits Schedule funding, PBS funding, all these things coming from different sources and going out via different ways. As we were saying at the start, it does not necessarily mean that money goes to people who need better health care and better outcomes. I was just flicking through other people's submissions and looking at some figures. Per head of population, WA and Northern Territory are significantly under the national average. I am not so sure about WA, but certainly Northern Territory's health outcomes are worse than the rest of the country's, so it seems quite ridiculous that they should be getting less money towards their health care. That decision on funding is probably best done at a national level, based on how much money Australia wants to spend on its health, but the actual decisions on where best to employ that money and how it can be used most effectively are going to be made as close to the ground as possible, where people, in their everyday work and life, know what the health problems are and how best to address them.

Ms HALL—Could I go back to your initial identification of two areas of inequity, and that was Indigenous health and children's mental health. I was wondering if, as an organisation, you have some models that you would like to see introduced in those areas to improve the situation.

Dr Ralls—I am not a child development worker, though obviously I see a lot of children in general practice. The main problem at the moment is that the systems that are there are absolutely grossly inadequate. I do not know if it is the majority or 50 per cent of the child mental health units in Perth that do not have a psychiatrist on their team, but some of the ones that do have a psychiatrist on their team have their psychiatrist for one session once a month.

Dr Douglas—That's a half-day.

Dr Ralls—Yes. A psychiatrist is not the be all and end all of mental health.

Ms HALL—Have they all got psychologists?

Dr Ralls—I cannot answer for what they all have, so I do not know, but I would be surprised if they all have all members of the team. Because I am a doctor, I am aware of the psychiatric deficit, but there will be other ones. Specifically, I was recently involved in the Selby child development unit, which is close to where I live and work, and so professionally I know of people involved there and I know of children who were almost certainly being sexually abused, and possibly the abuse had stopped but no-one knows. In a particular case I am thinking about, they could not get enough evidence from the child to get a criminal conviction, so the child continued to have access visits because they could not prove anything. Then in that situation—which in itself is almost unbelievable because it was not supervised access to the abuser—finally the family worked it out, and it took a long time, but they were getting really good counselling support from the team at the Selby clinic.

They had a very experienced psychologist, I believe—she might have been a social worker with a very strong counselling background—very good support for the mother, for the child; contact with the abuser; helping them to improve the situation. The child was only four. Then

they dramatically cut down that service. They moved most of the services to an outer metropolitan area, away from the western suburbs to somewhere with a higher need. But that child and family were not able to transfer because they were not in the area, and they lost their service. This family, right in the middle of everything that was happening, when things were just starting to improve, suddenly had nothing. They had nowhere to go. This was a single mother, working part time and with a very stressed family, but because the mother was motivated, they started seeing a counsellor at $160 per go, which obviously could not last for very long because Centrelink does not pay sufficiently to do that. That is not an isolated case.

I know of a number of people going to that clinic, and that child mental health unit. There is no-one saying, ‘These children need to have support and care and counselling.’ Is it the state? Is it the government? Where do we need to look overall? We are not going to end up with productive members of society. We are going to end up with very distressed people who then carry their problems right through their lives.

CHAIR—Is it worse now than 20 years ago? You said you have been in practice for 20 years.

Dr Ralls—It is difficult to assess, because experience accumulates. I have been in Australia for only 15 years, and I have also worked in different areas, but it is certainly not better. It is certainly not better; whether it is worse, I am not in a position to say.

Dr Douglas—In terms of how things are funded—I guess we do not have a good example for children’s mental health—there are several state based clinics which have psychiatrists, mental health nurses, psychologists, social workers, all in one building. There are not many of them and they are very busy and it is hard to get people in to them, but they do exist. But there is no private service—although one of them may come close to that. There are very limited private models of service that deliver that kind of holistic care, because mental health is not, as Jane was saying, just about the psychiatrists; it is about mental health nurses who can do visits and check up on people and see how they are going and deliver medications and all that holistic care that is really important in mental health. But, given the way that community services are funded under Medicare benefits or PIPs or whatever it is, they just do not provide that kind of team based care which is so important for mental health. Similar models of team based care are being introduced for other chronic illnesses; some seem to be state initiatives, others seem to be Commonwealth initiatives. I am not always really sure where the money comes from.

Ms HALL—So it is hotchpotch.

Dr Ralls—It is very hotchpotch.

Dr Douglas—But they are very important and very efficient, because the right person is doing the right thing. You do not need to see a vascular surgeon every week if you have got a leg ulcer; you need to see a wound care nurse. There are not many of those in the private sector and they do not work for private vascular surgeons. So you either come to a public clinic or you go to your GP. They might have a practice nurse or they might not, and they might have experience in wound care or they might not. It is quite fragmented and it is not delivering the best kind of care for these people, and you have expensive care instead of efficient care and appropriate care.

CHAIR—Then you have the people at Laverton.

Dr Douglas—Then you have got people at Laverton, yes. It was interesting. One of the rural submissions—was it Laverton?—mentioned the case of the diabetic footwear. The Medicare Benefits Schedule recognises the need for it to be cut off, but it does not provide any funding for podiatrists to stop that happening. Fee-for-service medicine, in combination with private insurance, is not a good model of care, in our opinion. We do not think it delivers good outcomes and we also do not think that it is efficient financially compared to single service, single insurer, coordinated provision of appropriate health care, rather than fragmented.

I do not like to admit it but private doctors run a business, they have a profit motive. They have self-interest in referring patients to each other and back to themselves; they have an interest in overinvestigating things and the people performing the investigations in the private sector have an interest in performing them because they get paid for what they do. At Royal Perth where I work, if you want to get somebody a CT scan of their abdomen, you have to ring up and talk to the duty radiologist and tell him why they need it and why they need it today and it will usually take you a good half an hour to organise it. And they might just refuse because they have got a list of other people who need that CT scan and they decide who needs it first or whether it is needed at all.

I have a friend who was recently working in one of the private hospitals here who, as Jane was mentioning, had a patient with abdominal pain; got a CT scan on admission, had a nuclear medicine scan to see if there were any gall bladder problems. He had an ultrasound of his abdomen—ultrasounds are the hardest things to get in public hospitals. The CT scan initially showed a fracture of one of his vertebrae but the pain did not fit, which is why he continued to get the ultrasound, and he got the HIDA scan—which is the nuclear medicine scan. He then got a gastroscopy from the top and a colonoscopy from the bottom and ended up getting a magnetic resonance scan of his spine to take another look at that vertebral fracture, which they then decided was the cause of his pain.

Ms HALL—Wow!

CHAIR—And I wonder why my MBF goes up by seven per cent every year.

Dr Douglas—Our problem is that we are paying for 30 per cent of your MBF as taxpayers, and all of those things will have MBS item numbers which are being paid for by the taxpayer as well. In the process of those procedures he was being cared for by a general surgeon, had consults from a gastroenterologist, a spinal surgeon and two pain specialists, all of whom would have had Medicare item numbers for their consults. You would never get that kind of care in a public hospital and you would not get it because you do not need it: that is overservicing.

Mr GEORGANAS—What was the outcome for this patient?

Dr Ralls—He had a fractured vertebra.

Dr Douglas—He had a procedure which I have not heard of before, which is called a vertebroplasty where they injected some cement into his fractured vertebra to stick it back together again.

CHAIR—As opposed to a laminectomy.

Dr Ralls—But then the sad thing is that maybe that procedure is evidence based. We do not know. Maybe bed rest and a plain X-ray, which is probably what he would have got in the public system, would have been the best treatment; leave it three months and, if he still had pain, do that. The inequitable system is that somebody in the public system would then have to wait two years for a pain specialist to do that procedure. 'A fair go for all' is really deeply embedded in the Australian psyche, and so respected, and it is not a fair go for all for some to get the procedure straightaway.

Mr GEORGANAS—When it is not needed.

Dr Ralls—Even if it is needed.

Dr Douglas—This person either got more than they needed, which is inefficient and in fact there are risks with all these procedures, or public patients should get them too, and they do not. One of those things is unfair.

Mr GEORGANAS—Why is the decision making different on diagnosis to continue with XYZ treatment in the public hospital and yet you have the same trained doctors that have done the same training, specialised et cetera, and the decision is completely different.

CHAIR—It could have been the same doctor.

Ms HALL—Yes, it could be the same doctor.

Mr GEORGANAS—What causes that difference?

Dr Douglas—I have not been in that position. These are decisions made by the consulting general surgeon who, as you say, is obviously well trained and may well work in the public system. I think a lot of it is access to resources. It is difficult to get those things in the public sector. There is a waiting list and, if you do not have evidence of a bleeding ulcer, you will not get a gastroscopy today, you will not even get it next week, and that is probably reasonable. Nobody is going to die from that. That is how the decisions are made in the public sector: who needs it, how quickly, and is it life threatening or life altering? That is how you have to make decisions when you have limited resources. When you have a fee-for-service model in private medicine, if the ultrasonographer does not scan this person's abdomen they will generate less income, whereas at the public hospital they will be scanning people's bellies all day. It is in the best interests of the salaried person to scan fewer people because they will not have to work as hard to make the same amount of money, but they are going to have to be scanning bellies all day, so there are decisions made as to whose belly they are going to scan because there are limited resources.

Mr GEORGANAS—Are we also more demanding as patients?

Dr Douglas—I have not worked in the private system enough to see, but I think that is the case.

CHAIR—If you have an angioplasty in a public hospital, you will get an untreated stent.

Dr Douglas—We do use some drug-eluting stents here at Royal Perth.

CHAIR—You are in WA?

Dr Douglas—Yes.

Dr Ralls—But there is an equity issue there.

Dr Douglas—There is, yes.

Dr Ralls—The other point we are trying to make is that fiddling with the details and legislating about how the private sector works is never going to fix it because it is a fundamental ingrained problem with item of service provision, and it is partly about the fact that a publicly funded system—a universal system—can provide good teamwork. So the two pain specialists—one of whom did this procedure and the other who did not—in the private system then need another consult, which costs money, before they do it. In the public system, those guys work together. They can talk to each other and say, 'Hey, I reckon he needs this. What do you think?' and it is more streamlined and it is smoother, without all this item of service money, money, money.

A universal health system is economically more sensible. At the end of the day it is all our money. Whether we pay it in tax or whether we pay it to our private funds, it is all part of gross national product, it is all our money, and it is much more efficient for it to go to a universal health system, what we pay for in a health insurance system, which is what Medicare is. It is not free. It is a universal health insurance system which can then deal more equitably and work more as a streamlined team together to provide appropriate care.

Ms HALL—I think we saw the ultimate team yesterday up at Darwin Hospital—their emergency response team.

CHAIR—For the Bali bombings, yes.

Ms HALL—When you were talking about working together and sharing information, I think that is probably one of the best examples that I have seen of working as a team.

CHAIR—Dr Len Notaras, who handled the Bali bomb victims.

Dr Douglas—Yes, we ended up with quite a few of those down here, too.

Ms HALL—I might have interrupted Scott when we was about to say something then.

Dr Douglas—You were mentioning stents, and we came across a study just today, although it is 10 years old, showing that private hospital patients were three times more likely than public hospital patients to get an angio and stent if they have an infarct. If you are looking at highest quality health care for all Australians, either the public patients should have got one or the private patients should not have got one. You cannot have both of those things being true.

At the same time, I was looking at one of the health insurance submissions to this inquiry, saying that you cannot subcontract your waiting list at private hospitals, because where is the incentive to pay your fees? Why would you bother being a member of a private health fund if you did not get a benefit from it? But if you are getting a benefit from it, then there is something wrong with the public system, because you really should not be.

CHAIR—It is the hospital waiting lists, because of lack of funding. I am not saying whether it from the state or Commonwealth, but they ration health services.

Dr Douglas—Part of that, though, as we were saying before, is that it is the same proceduralist. The guy who did the gastroscopy for this fellow probably does a list once a week at Royal Perth and gets paid half as much as he would if he did 10 of them in his own private rooms. Coming back to the training issue, there is a limited pool of doctors. Where are they working most efficiently? Where are they working for the people who need them most? Having these perverse incentives to go and do private work when you would certainly find employment in the public sector is a big problem.

Mr GEORGANAS—The trick is to get that doctor to do more in the public sector.

Dr Douglas—That would be our submission.

CHAIR—You would have to pay them more. It is as simple as that.

Ms HALL—Is some form of rationing good?

Dr Ralls—I think it is inevitable. It needs to be transparent and it needs to be done on a big scale, with a lot of community debate. Like you say, the state governments ration using waiting lists. It is hotchpotch, it is inequitable and it produces strange results. I think rationing is not only inevitable, it is a good thing, and I think the PBS—and I am not saying it is a perfect system by a long way—is great. 'This is what we fund and this is how we can limit what can be spent on pharmaceuticals.' But it must transparent and it must be coordinated on a big scale.

Ms HALL—I think the patient example that you gave between the private and the public hospitals shows that maybe in the public system the kind of rationing that would have been put in place because of funding issues and resource issues may have worked in that patient's favour.

Dr Douglas—Potentially. We do not know.

Dr Ralls—Potentially.

Ms HALL—But in another case it could work against them.

Dr Douglas—Exactly, yes.

Dr Ralls—They decided that patients in Girrawheen and Mirrabooka, which are very low socioeconomic areas in Perth, are more in need of child health services, but that does not mean that there are not children who live here who need them too. That is a very inequitable form of

rationing and it is not transparent and it is not done with public consultation. So rationing is creeping in this way.

Ms HALL—But it should be transparent and everybody should understand it and it should not be something that happens at some subliminal level.

CHAIR—If we had a national health agenda and a limited bucket of money, you would be able to see it. It would be transparent.

Dr Ralls—Yes. I think the PBS, when it was first developed, was a good example. There is not enough public consultation. There are so many things that are difficult about it, but I think fundamentally, if it has the right people advising—which has sadly changed in recent years, where it has become more influenced by drug companies—and if it has proper public input and community consultation, then the PBS is an example of rationing that can work well.

Dr Douglas—That is based on evidence, prescribing drugs which are proven to be of benefit and funding drugs which are proven to make a difference, rather than just because they are new or because they come in a differently shaped pill.

CHAIR—We saw evidence to that effect yesterday. We appreciate you appearing before us and making a submission.

Dr Ralls—Thank you for the opportunity to contribute. We really appreciate it.

CHAIR—We will be tabling our report before the end of the year, I think.

Dr Ralls—Fantastic! We look forward to it.

CHAIR—If you want to submit anything else, or you think of anything else, please do so through the secretariat. Likewise with us; if we need to contact you, we will. Thank you.

Proceedings suspended from 10.33 am to 10.41 am

DARBY, Mr Kim, Director, Business Enhancement, WA Country Health Service, Department of Health, Western Australia

KING, Mr Peter, Acting Chief Finance Officer, Department of Health, Western Australia

MILLER, Mr Mark, Manager, Federal Affairs Branch, Department of Health, Western Australia

TOWLER, Dr Simon, Executive Director, Health Policy and Clinical Reform, Department of Health, Western Australia

XANTHIS, Mr Colin Peter, Acting Executive Director, Health System Support, Department of Health, Western Australia

CHAIR—I welcome the representatives of the Department of Health. The hearings are a formal proceeding of the Commonwealth parliament and giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. Dr Towler, I invite you to make an opening statement to the committee.

Dr Towler—I would like to do so, and I hope you will tolerate the indulgence if I take a few minutes, because I think the material we are covering is very important.

CHAIR—And I put on the record how much we appreciate the fact that WA has agreed to cooperate with this parliamentary inquiry.

Dr Towler—Thank you. Western Australia welcomes the opportunity to present to the hearing of this inquiry. The state government believes the inquiry is timely. Health is consuming a growing proportion of community resources, with the proportion of Australia's gross domestic product spent on health now standing at about 10 per cent, which you well know. The state government's health expenditure is about 25 per cent of the state's recurrent budget. That has been increasing, on average, by about 7½ per cent per annum in recent years. The state has been able to manage this rate of growth in health expenditure because of the state's strong economy.

There are substantial overlaps between state and Commonwealth parts of the health system, with the state relying on Commonwealth grants to assist in funding services. This is particularly the case with public hospitals, an area of shared responsibilities, with the Commonwealth government contributing to funding through the Australian Health Care Agreement—AHCA. The current AHCAs expire on 30 June 2008. Already, some thought is being given to the next AHCAs, and the negotiations will need to begin in earnest in about six months if we are to have new agreements in place to commence in July 2008. The state government is particularly keen that the House of Representatives inquiry consider some matters in relation to the next round of the AHCAs. In addition, we are keen to highlight some issues specific to this state and hope the inquiry will consider recommending the actions to address these issues.

In reference to the AHCAs, I understand that all state governments and the Commonwealth government remain committed to retaining the principles of access to a free public health

service, hospital services, geographic equity and the provision of services based on clinical need that have underpinned previous agreements. In Western Australia we see the renegotiation of the AHCAs will be particularly important in providing a framework for hospital and health service delivery into the future. Within the state, the state government and WA Department of Health continue to work to address the state's unique challenges for service delivery. We realise that a cooperative effort between governments is required and are keen that the next AHCAs can be a vehicle for reform to address our issues.

In the context of the AHCAs, Western Australia has a number of unique features that present significant issues for service delivery. I am sure the standing committee members are already aware of the key geographic and sociodemographic features of Western Australia. To summarise, Western Australia is a geographically vast state, with an area of about two million square kilometres. The state population totals 2.001 million at June 2005, of which 1.4778 million, or 73.5 per cent of the population, are located in the Perth statistical division. Much of the remainder of the population is in the state's south-west corner. What this highlights is that there are marked differences between Western Australia and other jurisdictions. Outside the south-west corner the state's population is sparse and widely scattered, with people living in numerous small towns and Aboriginal communities. Of the state's nine towns of over 10,000 people, only two are located north of Geraldton.

Distance is a key factor in effecting the delivery of government services. Western Australia is distant from other states, and within WA there are large distances between communities. For example, within Western Australia travelling in a straight line from Perth to Kununurra in the state's north is around 2,200 kilometres, nearly as far as the 2,700 kilometres between Perth and Adelaide.

In fact, by road it is actually further from Perth to Kununurra than to Adelaide. Many remote towns and communities are a long distance from a regional centre. For example, there are 1,062 kilometres by road simply from Wyndham to Broome, the nearest town of more than 10,000 people. That is approaching twice the distance between Sydney and Melbourne. In contrast, in other states remote towns are generally an accessible distance from significant regional centres of more than 30,000 people.

Most state provision of health services revolves around a network of state owned public hospitals. Servicing the whole state, the most complex services are provided at the five teaching hospitals based in Perth: Royal Perth Hospital, Sir Charles Gairdner, Fremantle Hospital, the Princess Margaret Hospital for Children, the King Edward Memorial Hospital for Women. All five of the teaching hospitals are located in the metropolitan area and there are 12 significant metropolitan secondary hospitals. Outside of Perth, most services occur in 72 country hospitals of varying sizes, and there are also five multipurpose centres and 32 nursing posts. Because of our own equity objectives and also because we are required to under the Australian Health Care Agreement, the state seeks to provide a full range of hospital services to people living in all parts of the state, wherever possible.

On statewide issues affecting both Perth and regional service delivery, there are issues around fewer doctors per capita in Western Australia than in other states. In this regard, in 2003 the Australian Institute of Health and Welfare *Medical labour force survey* determined that there were 233 clinicians per 100,000 population in Western Australia compared to a national average

of 271, there were 79.6 specialists per 100,000 population compared to a national average of 89.7, and 90 primary care practitioners, or GPs, per 100,000 in Western Australia compared to the national average of 101. The lesser availability of doctors leads the state to have difficulty in recruiting doctors to work in public hospitals. We incur significant costs in recruiting doctors from outside of the state, and even the country, to work in our hospitals.

At the same time, there being fewer doctors in private practice leads to a greater demand falling upon the public system. This is particularly evident in emergency departments, where people are often attending emergency departments because they cannot access general practitioner services. To be specific, between 2001-02 and 2004-05, the number of ED presentations to public sector hospitals increased by 16 per cent by contrast with a population increase of only five per cent in the metropolitan area. Low-acuity cases amount to approximately 40,000 presentations each year. While it is clear that increased presentation of GP-level cases as measured by low acuity does not explain the increased rates of presentations described earlier, further evaluation of these cases may provide insight into how this need can be better met through alternative models of care.

With regard to remote and rural health service delivery, this is an issue both in metropolitan and regional areas. The shortage of doctors is most extreme in remote areas. Outside of the metropolitan area and the south-west region many of the state's hospitals function to make available a minimum level of care. There is either an absence of other medical services or there may only be one private general practitioner. The state also has only two private hospitals located outside the metropolitan area, one in Bunbury and one in Geraldton. The non-government sector is also poorly developed, with few non-government organisations serving to provide health services in many of these areas. For all these reasons, the demand for health services in the rural and remote areas falls predominantly on the public hospital system.

Local public hospitals serve to meet the local community's demand for primary care, emergency, residential aged care and very basic acute care services. Where patients need more complex services, they are transported either to a regional centre or to Perth for treatment. Moving in the opposite direction, Perth and regional centres provide outreach services in regional towns and small communities. In providing outreach services, the challenge is getting the doctor and the patient in the same location at the same time. It may be the case that the state pays for and transports the doctor to run a clinic in a small community. At the same time, the state organises and subsidises travel for the patient to come in from outlying areas to attend the clinic.

Providing services to Aboriginal people is yet another key challenge for the state health system. Aboriginal people have significantly worse health status than the population average; on average, living about 16 years less than other Western Australians and with infant mortality rates that remain two to three times higher than the general population. The incidence of a range of diseases, particularly the chronic diseases such as diabetes, renal disease and conditions like sexually transmitted infections, is much higher among Aboriginal people than the general population.

The state is conscious of these issues in seeking to reform state health services. The state's unique health service delivery environment means that we face additional costs in delivering health care services beyond those typically borne by other states. At the same time, we are

experiencing the same issues of strong growth in demand for health services and escalating costs that are being experienced at a national level. The state's response to these issues has been a combination of increasing the resourcing of health services and reforming to make the system work better. In recent years state government funding devoted to health has typically been increasing at eight per cent or more per year; recurrent public hospital expenditures have been growing by in excess of 10 per cent per year.

In terms of reform, in 2003 the government appointed Professor Mick Reid, former Director-General of Health in New South Wales and now a university academic, to chair a senior-level Health Reform Committee to review all aspects of the state health system. The final report of the Health Reform Committee, presented in March 2004, for the first time provided a long-term vision for the future of health care in Western Australia and sets out a plan for major health reform. It recommended a fundamental reconfiguration of the state's health system, with a 10- to 15-year program.

The review's key recommendations, which the department is now working to implement, include expansion and rationalisation of tertiary hospital services; increased emphasis on prevention and management of chronic disease; improving health and wellness in the population, and reducing demands upon the public health system; creating centres of excellence by providing for tertiary hospitals to specialise in treating certain disease categories; upgrading a number of metropolitan secondary hospitals to make these 300-bed general hospitals; a major investment to upgrade information technology across the state's health facilities to standardise and integrate clinical information systems in all hospitals to allow patient records to be available at multiple points of care; and the purchase of new equipment and upgrading of existing medical technology.

The reforms also extend to country health services. Key initiatives have been developed in the formation of a single country provider. This has been accompanied by a commitment to an extensive capital rebuilding program which has seen new hospitals having been completed or commenced in Geraldton, Port Hedland, Halls Creek, Moora and Ravensthorpe. A 25 per cent increase in medical and medical support services has occurred since 2002-03 and there is an implementation of a range of innovative reforms such as the ocean to outback nurse graduate program which offers insight and hands-on country experience for nurse graduates, an expansion of renal dialysis services in Port Hedland and Kalgoorlie, and the establishment of new services in Albany and Broome.

In mental health, we have developed reform of mental health services as a government priority. The WA Mental Health Strategy 2004-2007 has seen a $173.4 million commitment to both development and, where necessary, construction of new services and the expansion and refining of existing services. The recently released individual implementation plan for Western Australia as part of the National Mental Health Action Plan outlines new spending by this government of more than $252 million over the six years to 2009-10, and this includes $60.7 million for promotion, prevention and early intervention. Integrating and improving health care in the system has also got a substantial final commitment.

Highlights of the comprehensive mental health reform program in Western Australia include significant investment in supported accommodation in the community for people with mental illness, for step-down through community supported residential units to life accommodation in

what is called a community options program. In addition, psychiatric emergency services in the community and hospital emergency departments have been significantly enhanced. Additional investment in community mental health teams in the child and adolescent area and adult sectors has enabled a significant shift towards assertive community treatment capacity, with a particular focus on early intervention.

While we believe that the state's reform programs will enable the system to better the future health needs of the state's population, as we all know the state is one player in a larger system that also, importantly, includes the Commonwealth government and the private sector. Of immediate concern is that the Commonwealth spends significantly less on meeting the health service needs of Western Australians than it spends on people in other states. In 2002-03, the Australian Institute of Health and Welfare reported that the Commonwealth spend was $1,586 per person on health services in Western Australia. This was $105 per person or six per cent below the national average of $1,691 per person. It was also $272 per person less than the Commonwealth spend in South Australia, the jurisdiction where it spent the most per capita.

The major contributor to this shortfall in Commonwealth expenditure is below average expenditures on medical and pharmaceutical benefits. In 2004-05 in WA the Commonwealth spent $420 per person on Medicare benefits, about $68 per person below the national average of $488 per person. For the Pharmaceutical Benefits Scheme, the Commonwealth expenditure in WA in the same year averaged $235 per person compared to the national average of $268 per person.

Although the Commonwealth spends somewhat less in the Perth metropolitan area on these programs than it does in other state capitals, the expenditure shortfall in rural and remote areas is extreme, with per capita MBS expenditure in these areas often less than $100 per person per year and in some areas below $50 per person per year. This low level of expenditure is even more anomalous when we consider that a significant proportion of remote residents are Aboriginal people whose health status is considerably worse than the remainder of the population.

Given WA's unique circumstances, there is a need for greater flexibility in the provision of services, particularly in rural and remote regions. The state government has recently worked cooperatively with the Commonwealth in developing a reform initiative, recognising that the lack of private doctors in small rural and remote communities places additional pressures on public hospitals. Under the initiative, doctors employed in hospitals in communities with populations under 7,000 will be able to bill against the MBS for services delivered to non-admitted patients. We are now working with the Commonwealth Department of Health and Ageing on implementing this initiative. While there will continue to be many remaining challenges in providing services, we anticipate that the section 19(2) exemptions will provide some improvement in service delivery in those communities that have access to a local hospital.

Of course, for many of our remote communities, we do not have a local hospital and the state is keen to work cooperatively with the Commonwealth government to address the shortfall by expanding services in remote areas. An initiative that we think shows considerable promise is the Primary Health Care Access Program—PHCAP—under which funding that might be expected to be spent on primary medical services under the MBS in the metropolitan area is cashed out to fund services that the communities identify as a priority. However, at present, PHCAP is only being trialled in a few remote communities in Western Australia. We would like to see the

approach expanded, and other innovative approaches to expanding services investigated and trialled.

Further, for the next AHCAs providing a vehicle addressing our WA-specific issues, there are a number of concerns with the Australian health care agreements that WA shares with other states that we hope can be addressed in the next set of agreements. We trust that your inquiry will recommend approaches to addressing these issues, which particularly relate to funding. These issues will, no doubt, be the central sticking point in negotiating the next agreements.

We would like to briefly provide a WA perspective. As I have indicated, in recent years Western Australian government resources devoted to health have been increasing on average by 7½ per cent per annum. This has been largely driven by growth in state own-source recurrent public hospital expenditure which have, on average, been increasing by 10.2 per cent per annum since 1998-99. We believe that a factor leading to the state having to increase its own-source public expenditures at such a high rate has been the lack of adequate Commonwealth funding through the Australian health care agreements. That includes inadequacies in the base level of funding and also in the indexation over the period of the agreements.

We estimate that over the five years of the agreements the state will receive around $100 million less than it would had the previous agreements continued compared to the 10.2 per cent growth in state own-source expenditures. Australian Health Care Agreement funding to WA has on average been growing at 5.7 per cent per annum since 1998-99. The concern is that the negotiation of the Australian health care agreements has moved from being an effort to develop a framework on which to deliver public health services in accordance with an agreed set of principles to now, instead, being a more difficult exercise. It would be desirable that there be a set of agreed principles that can form a basis for determining the financial responsibilities of the different levels of government through the Australian health care agreements.

The purpose of indexation is to grow funding in line with the growth in the cost of delivering public hospital services. Under the current Australian health care agreements, Commonwealth funding is indexed using a wage cost index which is a composite of growth in the CPI and then minimum wage safety net adjustments. The wage cost index has been growing at around two per cent per annum. However, wage negotiations are typically yielding outcomes in the four per cent to six per cent per annum range. Accordingly, using the wage cost index is resulting in funding lagging behind the actual cost of delivering services.

The Western Australian government would hope that, in advance of negotiating the next Australian health care agreements, the Commonwealth and the states would commission independent expert analysis to determine the appropriate indexation for the next set of agreements.

We are hopeful that your inquiry will provide a framework for future reform of the health system, including funding arrangements. We believe a good start in reforming Commonwealth-state health arrangements has already been made with the reforms that COAG has agreed that are now being implemented, but we hope that the reforms already agreed will be the start of larger ongoing work on reform.

The issues I have raised in this presentation, and which the state has highlighted in its submission to this inquiry, are those which Western Australia sees as immediate priorities for reform. With the renegotiations of Australian health care agreements to commence shortly, there is now a short window of opportunity for your inquiry to have a real impact on the next round of agreements. Obviously, the key issues for the negotiations will revolve around funding, and Western Australia would hope your inquiry can give government some direction in addressing these issues.

We in Western Australia also have a number of key issues specifically in relation to service delivery in this state, primary care and access to services in rural and remote areas. We have been pursuing opportunities for these issues to be addressed and trust that your inquiry will acknowledge those issues and recommend actions to address them. Thank you for your attention.

CHAIR—Thank you for the most comprehensive presentation I think we have had at this inquiry.

Dr Towler—Thank you.

CHAIR—There are quite a few models on the table, if you look at Podger and all the others.

Dr Towler—Yes.

CHAIR—This inquiry has been going for about 18 months, and we have to report this year. To wind up the inquiry, we will be having a roundtable in Parliament House in Canberra with the major proponents in the industry, both public and private. We will talk to you about possibly participating in that, if you would. There are many arguments from the private side and the public side, and we can probably at a roundtable tease those out and give people a chance to make their views known and other people who think differently can give their views.

The debate going on at the moment is: should the Commonwealth take over public hospitals? That is one extreme. The other extreme is: should the Commonwealth get out of public hospitals—get out of health altogether—and give all the money to the states and let the states have the problem? The general public is tired of the blame game that goes on between the Commonwealth and the states, and I am sure you people who run the health system are tired of it, and we MPs are very tired of it. We want to come up with a genuine solution to this problem between the Commonwealth and the states. With those two extremes, there has to be a solution somewhere in between.

As we said before, we do not really have a national health agenda in Australia and, by providing money to the states for health purposes, we are not really focusing on where we are going. We are possibly coming to the view that the Commonwealth should have a national health agenda and fund the states to achieve that agenda, but that is very much theoretical at this stage. Do you have a comment on a national health agenda? It seems to be crisis management all the time rather than having a plan to work towards and fund and thinking in terms of: the person who has to benefit out of this eventually is the patient.

Dr Towler—In Western Australia we are obviously committed to the delivery of health services to the population of this state. The recent discussions around the COAG agenda have

been environments where jurisdictions have come together and looked at issues which have been identified as common pressures upon the health system. The Western Australian government has been a strong participant in those discussions. We continue to try and address the issues which we see are the drivers for the emerging and additional pressures on the health system as a whole. As I said to you earlier, the issues around chronic disease—the growing incidence of diabetes and the related long-term chronic disease issues—are things which I think we all agree are pressures upon the whole system.

CHAIR—Yes.

Dr Towler—We are very conscious, from the Reid reforms and the initiatives that came out of the report of the Health Reform Committee, that in order for us to address the delivery of health services in this state there needs to be excellent cooperation between hospital services and primary care. I am not in a position to make any comment about the states' attitudes on the approach to dealing with that, but we are very focused on the need to provide an environment for reform which addresses those pressures of the emerging chronic disease epidemic. I think we should be challenged by the successes that are being achieved in other countries, which we are potentially at risk of not matching if we cannot work out how to work together.

Ms HALL—You would be aware that originally, going back a little way before we started this inquiry, Tony Abbott was pushing an agenda that the Commonwealth run all hospitals, and overnight Julia Gillard has come out and said that the Labor Party is looking towards taking control of state-run public hospitals.

Dr Towler—I have not seen that press release, by the way.

Ms HALL—You have it.

Dr Towler—Have I?

Ms HALL—Yes, you most definitely have it there—as well as paying private hospitals to train doctors to take on board elective surgery. They are the two keys factors in what she said overnight. Concentrating on the way hospitals and health are funded, we have looked at a number of models. We have looked at Podger's; we have had managerial and a few others; we have looking at pooling as opposed to the state and the Commonwealth. I think the states have great expertise in running hospitals. It is just how you fund them to be run.

Getting back to what the chair said about blame between state and Commonwealth, Commonwealth and state, maybe it does not just stop with the hospitals. We need to look at that national agenda and fund the services so that people in rural and remote areas are not getting $50 or $100 while people living in Perth or Sydney are getting many more hundreds or thousands of dollars extra. What we are trying to get our heads around is the best way to do that, and I suppose it is a government decision as opposed to a decision within your department.

Dr Towler—Thank you for saying that. I'll accept that out! As I said a moment ago, there is a very clear commitment from this government around reform in health. The agenda that has been set by the report of the Health Reform Committee recognises the important relationship between

the provision of services in the community and the provision of hospital services, and there is an absolute commitment to continue to look at how to do that in the best possible way.

Ms HALL—Throughout this hearing, Western Australia has been thrown up as a model in a couple of areas: mental health, young people in nursing homes. I think you have been very proactive in those areas.

Dr Towler—Yes. We have some excellent policy development people. Some of them work for me, and it has been a great pleasure to be involved in the work that they have been doing around these sorts of initiatives which provide benefit to everybody. The state is proud that it is investing over nine per cent of its budget in mental health. Keith Wilson keeps us very honest.

Ms HALL—What about the impact of people that are waiting for nursing home beds within hospitals? Is that impacting on your health system over here and the availability of beds in aged care facilities in regional, rural and more remote areas?

Dr Towler—There are two sets of comments that need to be made around that particular inquiry. The issues in the metropolitan area are somewhat different to those in the country. I will get Kim to make a comment about rural aged care in a moment. Within the metropolitan area, we have an aged care director who works with the Department of Health who has been extremely proactive in developing and optimising the way in which we provide care for the elderly waiting for a placement. I think that Western Australia does this particularly well. We have a transition care program for which we share funding with the Commonwealth. That has been embedded and it has been effective. We continue to try and ensure that elderly people awaiting placement or during the restorative phase are not cared for in our leading tertiary hospitals, but it still represents a substantial pressure and we need to continue to commit to it.

The Western Australian government has continued to take up the option to increase funding under the HACC program, year upon year over recent years, and we have been—as you have heard—instrumental in helping to develop national policy particularly around the ACAP reforms and the issues of nursing home type patients in hospitals. We recognise the significance of this issue, we understand the pressure that it puts on our system, and we are doing the best that we possibly can to manage it. I think that we probably do a little better than some other states.

CHAIR—I do not understand why the per capita figures come out so badly for WA. The money is available, isn't it?

Dr Towler—It really comes back to the whole difficulty that Western Australia faces by funding health services in the community through a community private sector model, which basically is money that people can access by individual practitioners, and the ability to grow the service is dependent on the ability to grow the number of carers. In our submission we highlighted that the differences in the numbers of practitioners in the state, as you will see, to a substantial extent correlates with the average differences in money, and this was an issue that we raised very strongly in the COAG discussions around mental health reforms where growing opportunity in the community private sector for mental health is not going to help Western Australia. We do not have the psychiatrists, we do not have the general practitioner numbers, and so even though the funding is made available we effectively cannot access it because people are already maximally working as hard as they can in the context that they are in. The reason for

making the comments about the differences between metropolitan and rural is to highlight that the further you go away from the metropolitan area, the more there are issues of attraction of doctors and retention—and I understand local government has been speaking to you already today. You will have heard the difficulty that we have in attracting doctors to work in these locations.

CHAIR—As does every other state.

Ms HALL—It is probably greater in Western Australia because of its size.

Dr Towler—We have many small communities that are very isolated. The reality is that they are not accessing Commonwealth funds because they do not have the practitioners. We have a very well developed program in Western Australia to help place general practitioners in the rural sector. The Australian Medical Association in this state has been an active recruiting agency. We work wherever we can to facilitate those processes but in the end, if the money going to provide services all comes through the activities of private practitioners, and there are not any, you cannot grow the service.

CHAIR—No. But my point is, how can you measure the impact of the population missing out on that service that they would get in other parts of Australia?

Dr Towler—Two things happen. One is that the state picks up some of the responsibilities, and a lot of our rural district medical officers provide primary care services. They are employed through the public sector, so we are hopeful that the section 19(2) reforms on the opportunities for MBS funding for doctors working in small towns will have a positive impact.

The point we made about the PHCAP funding is that you need to use other instruments to create opportunities to provide particularly primary care and, in remote areas where there are substantial numbers of Indigenous patients—in some of the north-west areas they make up in excess of 30 per cent of the patients being treated—the current models are not meeting their needs. That is highlighted by those numbers on expenditure.

With all the will in the world, we could not make the private sector model successful in those small towns and remote locations. We could talk about providing a resource forever; it will not improve the service. We need conjoint processes of some sort. We featured the PHCAP model because in those environments it gives you access to expending equivalent money on providing primary care services using other types of health workers, culturally appropriate to the environment but obviously in a setting where there is good governance and good administration.

CHAIR—How can we get more doctors to WA through the present training program? Every witness we have had has talked about workforce shortages. The Commonwealth is responsible for academic training.

Dr Towler—In Western Australia we have the largest rate of growth in medical student numbers. We have also substantially increased nursing training positions. We are going to go from graduating between 135 to 145 doctors a year to 310 doctors a year by 2010-11. The government has already made commitments around their initial intern placements and training. We are developing a vocational training pathway to support that. There is a very substantial

commitment in this state. We have a new university, the University of Notre Dame, developing a training program which is a graduate school and has a focus on rural. We have developed a rural training school between the two universities, which looks like it is going to be substantially successful in exposing doctors to a different type of training, and we believe that we are doing everything we possibly can, and we are grateful for what the Commonwealth government has done in terms of the additional investment in those places.

The challenging thing is that, even with that growth—and we have taken the opportunity of reading the South Australian submission—we are well aware that the numbers of hours worked by individual practitioners is reducing; there are very large numbers of women in the medical workforce. Even with increased numbers, there are still substantial other pressures around how you get people to work away from metropolitan areas and, with all the will in the world, small communities in Western Australia will never grow.

CHAIR—How do you keep them in WA when Queensland offers them a 20 per cent pay rise?

Dr Towler—I would not like to pre-empt the ongoing discussions around that. That is a challenge for everybody.

CHAIR—Yes.

Dr Towler—Whilst we are currently in an environment where there is a shortage of medical practitioners, we will be under substantial duress about the cost of providing medical practitioner services, and that will need to be met.

Mr GEORGANAS—Simon, I heard you talk about the University of Notre Dame, where the focus will be on training more doctors, obviously, but training doctors for rural areas. How is that going to work?

Dr Towler—Both universities have picked up that issue. The rural clinical school is a conjoint training environment between the two universities, and I think we need to compliment both universities on the effort that they have made. Students will spend a substantial amount of time in the rural setting.

Mr GEORGANAS—To become familiarised with everything.

Dr Towler—Notre Dame has, from the outset, made it clear that the school is a graduate school, so you are dealing with a more mature age student. UWA has opened now a graduate medical stream as well as its traditional undergraduate course. One of the interesting things in Western Australia is that we have such a substantial growth in the number of students. That means that we are having to explore opportunities for them to learn, where they can get their clinical experience, and that has, in one sense, been a bit of a driver towards looking at education in other environments, and we have picked up strongly on the rural sector option.

Ms HALL—What about the suggestion that Julia Gillard made, also in that speech, about private hospitals training doctors? What do you think of that?

Dr Towler—I have met on a couple of occasions with Dr Michael Stanford, who is the executive officer of the St John's organisation. The private sector is equally aware of the issue around workforce pressure and the need to deliver services. The private sector in Perth already employs some doctors and we would look forward to ongoing discussions around opportunities for training. The University of Notre Dame is using the private sector substantially in its teaching model, and the question of vocational training later on, I think, is a discussion that we would continue to embrace.

Ms HALL—Do you have nurse practitioners in Western Australia?

Dr Towler—We do, and we are absolutely dependent on them in some places, because of the issue of remote communities.

Ms HALL—Limited prescribing rights?

Dr Towler—Nurse practitioner legislation was introduced. Limiting prescribing rights are provided, as I understand it. We also have developed nurse practitioner roles in the metropolitan area.

Ms HALL—Good.

Dr Towler—My clinical area of discipline is intensive care, and one of the nurses who worked for me previously was the first nurse practitioner in the state. She is the clinical nurse in hepatology and provides a strong ongoing community support of people with hepatitis. So the model is being explored; it is a structured model which is partnered to a medical governance model. We need to continue to explore options for nurses and I think those issues of workforce change and reform are things which the Productivity Commission has emphasised and we will need to continue to look at.

Ms HALL—You have said that you have five teaching hospitals and they are all in Perth. What about outside Perth? Have you thought of expanding?

Dr Towler—The south-west of Western Australia is one of the most rapidly growing areas in the country. Bunbury is a co-located public/private facility, where the St John's organisation runs a combined hospital. The nature of the hospital service in Bunbury is changing from being a traditional rural hospital to having a much greater specialty activity, and it is becoming much more like a non-tertiary metropolitan hospital. Those environments are being explored and developed; clinical academic placement appointments are being explored for our non-traditional tertiary sector. I suspect that in that process you will see a reform along those lines.

CHAIR—I am no expert on WA, but you do not seem to have the problems over here that the eastern states have. In the newspapers every day in Queensland there is another crisis in the public health system; in New South Wales the media has probably just—

Ms HALL—If you look hard, you can always find one, can't you?

Dr Towler—In Western Australia the government has committed to a very substantial reform agenda. There is a substantial investment program around capital infrastructure. The reform

agenda is to look at the way we care for patients and improve it. We have had a number of reforms going on, particularly around things like elective surgery access, and at the moment, because government has made such strong commitments around health reform, there has been an ongoing dialogue. We have our problems. I am quite sure from the figures that I presented to you that you would appreciate that we are not exactly having a good time of it in our emergency departments when the rate of growth of presentations has been 16 per cent over that period of time, and they present profound challenges for us.

In that regard, the particular thing that I am doing—which is developing things called clinical networks—is to work in a way which ensures that we are working much more cooperatively with the primary care sector in terms of the planning. The Reid reforms went very strongly to things like improving communication with primary care. We have developed an ambulatory care program, which is funded by the state government, to look at care for patients after discharge back into the community, and working on a relationship with general practitioners to ensure that that is effective.

We are reaching out across that traditional divide between hospital care. We have changed in Western Australia from a very hospital-centric view of public health services to an area health service view. The reform agenda in the rural sector and the development of a regional planning model I think is having a profound impact. So there is an ongoing voluntary dialogue in this state about health reform and I suspect that we have our bad days like everybody.

CHAIR—Yes, but the funding is not matched by the Commonwealth.

Dr Towler—The figures are there.

CHAIR—Yes.

Ms HALL—In your submission you talked at length about the health care agreements and the way they impact on Western Australia. Some of the issues that I thought were quite interesting were the transparency and looking at how they pick the fixed terms and looking at putting in the quantum of funding. Regardless of whether or not you go back to your original, there should be a clear mechanism to determine the fair state and Commonwealth financial contribution, the indexation, and looking at a commission to work independently and evaluate appropriate measures and costs and looking at inflation as a cost in the public hospital section. Would you like to expand on that? You talk about dispute resolution in relation to that, and I was wondering if you would like to make some further comments.

Dr Towler—The points that we made in the introductory statements about basically our difficulties with the Australian health care agreements and the way they operate, I think, are a substantial issue. A five-year period is a long time in health.

Ms HALL—It is.

Dr Towler—Economic circumstances change; pressures on health systems change. At the moment, I do not believe that flexibility has been there, which is what the submission is emphasising.

Ms HALL—Exactly.

Dr Towler—We believe that the principle underpinning the Australian health care agreements, which is about giving the best possible equitable access to service in remote and rural settings, is not being achieved. We are reflecting only on what has gone before. We would ask for consideration of a way which meets the needs of people in Western Australia better than is being achieved at the moment. Given that there is a very clear commitment by all governments, particularly around Indigenous health matters, we feel very challenged by the fact that we are struggling to improve those services in the way that we would like to. We see that a lot of that comes back to these agreements. I might ask some of the other members of the department to comment. I have had less personal experience. I have only been in this role for 13 months.

Mr Miller—I can really only reiterate what we have said in the submission and in the introductory comments. We are concerned that the quantum of funding has shifted from being something that was determined based on compensating states for extra costs in supplying services and revenue forgone to being something that is just purely a political determination. It would be desirable if there were some basis for determining how governments should share costs in the agreements. We think that the indexation factors have continued to be a major source of dispute between the Commonwealth and the states, and it would be desirable to be able to draw on some independent expert work in determining how funding should be indexed in the next agreements.

CHAIR—In the private sector reforms that are going on at the moment and the proposition that health funds can spend money outside of the hospital system in order to keep people from going to hospital—preventative measures—that is not possible under the health care agreements at present. Should it be? Should it be flexible enough for you as a state to be able to determine that you are going to use some of this money to introduce measures to stop people going to hospital?

Dr Towler—I have been involved in negotiations around the Australian Better Health Initiative which focuses clearly on the health of middle-aged people. That investment, which is between all governments in Australia, focuses very much on the idea of a strong social marketing agenda around health promotion, the early detection and intervention of disease, and then programs which are around lifestyle modification and encouraging patients to self-manage their disease. Effectively, we have moved into supporting those sorts of activities which underpin avoiding hospital admission, making hospital admission more timely, and facilitating earlier discharge through the activities that are the characteristics of the Australian Better Health Initiative.

I think that it is clear that governments are committed to working in that environment and it comes back to the issue that I pointed out before: the risk that we have in Australia of not being able to promote programs in this interface effectively will actually end up costing us a huge amount of additional money. A recent visitor from Northern Ireland, who was with us for three months last year, very respectfully said, ‘The Australian health system is a very good health system,’ but by world standards we use hospitals just about more than anybody in the OECD, and the reforms that are occurring in primary care in Canada, New Zealand and the UK are focused around the initiatives that you have just talked about.

As to the specific mechanism for dealing with that, I am not sure what the answers are and I would not want to commit my government in any particular way, but I think that the commitments that have been made through the Australian Better Health Initiative, the themes that have emerged out of the COAG discussions on mental health—which has a much stronger community base—say that without question that is the area where we need fundamental reform, and we will pay heavily for not being able to achieve those outcomes.

CHAIR—Jill, I am going to get to the stage where I will have to leave.

Ms HALL—I only have two more questions.

Dr Towler—A very simple example of that, just to finish off, is that under Hospital in the Home programs, where a person has a condition which might traditionally have been treated in an inpatient bed in a hospital, we are treating that particular illness in a home setting, and there are challenges around what happens if the person wants to actually see their GP about something that is completely unrelated. At the moment, you cannot raise a general practice fee because they are deemed to be still under hospital inpatient care. That lack of flexibility creates challenges for us, particularly in the interface between hospital and community based service provision.

CHAIR—Can you give us a note on that, please.

Dr Towler—Particularly the interface issues?

CHAIR—Yes.

Ms HALL—One issue I wish to raise with you is private health insurance and the fact that there are so few opportunities for Western Australians to access private hospitals because there are a limited number of them—only two outside Perth, as you stated in your presentation to us—and the fact that HBF has 70 per cent of the market share here and the impact that that has. I suspect that, of the other 30 per cent, a fair portion of the market would be with Medibank Private.

Dr Towler—Yes, it is just under 30 per cent. It is a very unusual environment in Western Australia for private health insurance.

Ms HALL—How will the sale of Medibank Private further concentrate private health insurance ownership? What impact will that have in Western Australia? As government health bureaucrats, how do you feel the 30 per cent rebate and the fact that there is less access to private health insurance in Western Australia impact on Western Australians? It is a twofold question.

Dr Towler—It is a very complex issue. Let me give you a few figures which may be of value. Something in the order of 54 per cent to 58 per cent of all elective surgery conducted in Western Australia is conducted in the private sector. We have one of the highest private health insurance participation rates in the country. There is surprisingly significant private health insurance participation by people in elements of the rural sector, and that means that they actually come to Perth for their treatment.

In Western Australia we have had a problem with the fact that the Australian Institute of Health and Welfare figures tend to misrepresent our public-private bed ratios, because we have something like 400 beds which are publicly funded but run by private operators at Joondalup and Peel. In fact, we have a low number of private beds compared to other states, and that adds to some of the problems. Regardless of that, there is a busy and robust private sector in this state, which is strongly supported by the community. We recognise the absolute need to work in partnership with the private sector. The reality is that patients are not just our patients or just their patients; they choose to move between the two environments and the clinicians are actually common clinicians.

I am not convinced—and this is purely my personal comment—that the changes to the ownership of Medibank Private will have a profound change in Western Australia, because there is such a high dominance already of the ownership by HBF. But I am certainly not an expert person to comment on that. Western Australians have, in effect, voted with their feet to sustain their involvement in private health insurance.

Ms HALL—With the sale of Medibank Private, less competition, higher premiums: that was the issue I was referring to. There were two parts to the question.

Dr Towler—I am not in a position to make an expert comment.

Mr King—I think that is a question equally of what other market players there are.

Ms HALL—Yes. That is what I was seeking.

Mr King—It depends who buys it.

Dr Towler—Yes. There is a very low presence of other insurers.

CHAIR—I am going to have to excuse myself, because I have to catch that plane for Brisbane.

Ms HALL—I have one more question, and it is to do with red tape.

CHAIR—I am sorry that I have to go. Thank you very much.

ACTING CHAIR (Ms Hall)—I noticed in relation to the special purpose grants you identified bureaucratic duplication, inequities in funding, uncertainty and excessive cost of satisfying reporting requirements. How much do you think health costs in Australia are escalated because of this red tape, the duplication of reporting, and what actions can government take to cut the red tape but at the same time maintain the accountability that is sought through much of the requirements that you have to meet?

Dr Towler—I am not sure I am the most appropriate person to comment on that.

ACTING CHAIR—Mr Miller?

Mr Miller—It is really difficult. I am not aware of any estimates, but we are consistently reminded that there are significant costs. There are some programs, but we as a state go through our whole process of determining which organisations are going to get what funds for delivering particular services and then we submit those to the Commonwealth department and the Commonwealth department in turn does its own exercise and determines whether or not the same services should be getting that level of funding. Ultimately we require a tick from them in order to distribute the funds in accordance with their recommendations, so there are basically two bureaucracies performing the same function.

ACTING CHAIR—There could be more than that, couldn't there? At a state level you prepare the submission. At a Commonwealth level they evaluate the position and give you the funding. Then at the state level you have to administer the funding. Then you give it to the hospital or community health service. Then they have to administer the funding. They are accountable to you, so they have to come back with their accountability and you have to come back with it to the Commonwealth. To me, it seems like there is a lot of the health dollar that is spent in that bureaucracy and red tape, and it is looking at a way to streamline it. I am interested in whether or not you have any ideas of how that can be done.

Mr Miller—You might look at the Public Health Outcomes Funding Agreement as an example of an initiative taken that is quite positive. What that did was basically lump together a whole lot of smaller specific-purpose payments and said the Commonwealth and state will agree on some outputs that the state is going to try to achieve with the use of these funds. So rather than having individual small grants, each with its own set of accountability requirements, we have a larger lump of funds and with that lump of funds we have flexibility to move funds around in order to meet local and regional priorities. As well as drawing on that flexibility, it also reduced a lot of the reporting requirements.

ACTING CHAIR—When I am on this committee and we have people come along and talk to us, I get really excited if I hear of something that is new and innovative—a different way of doing things—so that it is going to improve the health outcomes for Australians. When you are presenting to us, if you have any of those ideas, I would like to hear them.

Dr Towler—The HACC agreements have a strong structure around the way in which we have to report back to the Commonwealth. It is about a 60 to 40 ratio in terms of state expenditure and Commonwealth funding.

In the recent COAG led reforms around investments in the HACC area, there was a move towards what were very substantial additional reporting requirements. It was difficult to understand why that was happening. In the end, a lot of that was tempered and we are very happy to participate in that environment. We regularly provide the information that is required and it is, in the end, information we also require to do our job, so I understand the need for it and I think it can be achieved; but there needs to be an agreement about what the purpose of the reporting framework is and what is a reasonable.

The Australian Better Health Initiative is another example, I think, where we are doing a few things which are a little different. It is quite a complex structure in terms of the way the funds are being administered. Of the $500 million investment, some of it is under mixed administration which is quite unusual, but the purposes are well articulated and there is a clear commitment

around the investment achieving a lot of those interface issues and the activities should come together to achieve more than any one of them individually would do. I think it is an interesting model around what is essentially a combined program where, because you are sharing in the partnership, there is an acknowledgment of the need to manage the thing appropriately.

As a relative newcomer to a role within the health bureaucracy, it seems that we have come from a history where there is a good deal of suspicion between governments about what happens when your money is given to the other party. The theme here, and part of the issue, is that there needs to be much greater understanding of the common ground on which we stand and the fact that we need to ensure that every possible dollar is invested in delivering services within a proper government framework.

ACTING CHAIR—One of the terms of reference of this committee is cost-shifting. It is looking at cost-shifting from the state to the Commonwealth. I have asked questions to bring it out both ways but I suppose that links in with what you are talking about there—that is, the suspicion between levels of government.

Dr Towler—And that is one of the challenges.

ACTING CHAIR—I would like to thank you very much for attending today.

Dr Towler—It is a pleasure, and thank you very much for the opportunity.

ACTING CHAIR—We thank you very much for being involved with the hearings today. We really appreciate it, as I am sure the chair said at the beginning. Not all state governments have presented to the committee and I have to say that you are probably the highest level of state bureaucracy that has attended.

Dr Towler—We see it as a very important issue. We did not realise this inquiry had been going for 18 months.

ACTING CHAIR—We are looking at reporting by the end of this year. That fits in with looking at the issues that you have raised at COAG as well. Is it the wish of the committee that the CD of Dr Len Notaras's presentation, *The Bali Response 36 Redefining Hours*, the Royal Darwin Hospital flyer re Dr Len Notaras's presentation, and the Western Australian Centre for Remote and Rural Medicine information booklet be accepted as exhibits and received as evidence to the inquiry into health funding? There being no objection, it is so ordered.

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

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 11.44 am