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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON PRIMARY INDUSTRIES AND REGIONAL SERVICES

Reference: Infrastructure and regional development

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STANDING COMMITTEE ON PRIMARY INDUSTRIES AND REGIONAL SERVICES

Wednesday, 30 June 1999

Members: Fran Bailey *(Chair)*, Mr Adams *(Deputy Chair)*, Mr Andren, Mr Horne, Mr Katter, Mrs De-Anne Kelly, Mr Ian Macfarlane, Mr Leo McLeay, Mr Nairn, Mr Secker, Mr Sidebottom and Mr Cameron Thompson

Members in attendance: Mr Adams, Mr Andren, Fran Bailey, Mr Horne, Mr Ian Macfarlane, Mr Nairn, Mr Secker, Mr Sidebottom and Mr Cameron Thompson

Terms of reference for the inquiry:

The House of Representatives Standing Committee on Primary Industries and Regional Services will inquire into and report on the role of infrastructure in assisting the economically sustainable development of Australia's regional areas. The committee will, among other matters, consider and make recommendations about:

. deficiencies in infrastructure which currently impede development in Australia's regional areas;

. factors that would enhance development in these areas, including the provision of infrastructure such as energy, transport, telecommunications, water supplies, and facilities that deliver educational, health and financial services;

. the potential for development in regional areas;

. the extent to which infrastructure development would generate employment in regional Australia;

. the role of the different levels of government and the private sector in providing infrastructure in regional areas;

. planning, coordination and cooperation in the provision of infrastructure in regional areas; and

. the benefit to the national economy of developing regional infrastructure.

WITNESSES

GREGORY, Mr Gordon Nigel Fergusson, Executive Director, National Rural

Committee met at 5.25 p.m.

GREGORY, Mr Gordon Nigel Fergusson, Executive Director, National Rural Health Alliance

CHAIR—Welcome. I declare open this public hearing of the inquiry into the infrastructure and development of Australia's regional areas of the Standing Committee on Primary Industries and Regional Services. This is the second public hearing of this inquiry. I advise the witness that committee public hearings are recognised as proceedings of the parliament and warrant the same respect that proceedings in the House of Representatives demand. The witness is protected by parliamentary privilege in respect of the evidence he will give before this committee. The witness will not be asked to take an oath or to make an affirmation, however, he is reminded that false evidence given to a parliamentary committee may be regarded as a contempt of the parliament. The committee prefers that all evidence be given in public, but should the witness at any stage wish to give evidence in private he may ask to do so and the committee will give consideration to that request.

Mr Gregory, we have received a very detailed submission from you and we have authorised its publication. Before we begin our questions, would you like to make a brief opening statement and give an overview.

Mr Gregory—In what is—as you will have seen if you have had a chance to read it—a very broad ranging submission, I thought I needed to pick out four things. The first is why an organisation called the National Rural Health Alliance is particularly interested in infrastructure. I hope and assume that it is obvious to all of you that the matter into which you are inquiring is a fundamental plank of the nature of wellbeing in rural, regional and remote areas, and that part of that wellbeing, of course, is health. Even though we are a health alliance comprising 20 national organisations involved in rural and remote health, we do nevertheless have a strongly supported and legitimate interest in a broad range of things affecting rural communities, as distinct from health issues in the narrow sense. That is the first of the four points.

I thought that I should pick out briefly—and I do not intend to go to them but just to mention what they are—three of the highlights, as we see them, of the submission we have made. The first is that we believe there is great potential to be had from the establishment of what we have proposed should be called a 'Rural Development Commission', about which there is detail in one of the documents which I want to draw to the attention of the secretariat.

CHAIR—You may table the documents and then they will become part of the inquiry.

Mr ADAMS—They are in the submission.

Mr Gregory—I was not aware that you had that attached. It is an even better submission than I realised! The first thing is the establishment of a Rural Development Commission. It would be strategic, fundamental and answer many of the questions which you as a committee are interested in, and for which one needs technical and/or specialist or economic expertise. The second thing I want to highlight is the proposed review of the PATS or IPTAAS or

whatever it is called in the various states. Again, I do not intend to go to the detail of any of these. The third is the clear requirement from our point of view for what I call 'greater policy and public attention to the telecommunications CSO or CSG'. So there are four things. The first is why our health alliance is interested in rural development and rural infrastructure in the broad sense. Then the three specific things I want to pick out are the Rural Development Commission, the review of PATS or its equivalent, and the telecom CSO or CSG.

CHAIR—Would you like to just prioritise some of these issues? Your submission is a very long and very detailed one. Obviously, a tremendous amount of effort has gone into all of the research behind this. Would you like to identify for us what you see as the problem areas that your concept is designed to overcome? Could you prioritise those for us?

Mr Gregory—Let me begin by tabling also a copy of the annual report of the alliance from the financial year ending a year ago today. In that, you will find a list of the member bodies so you will know the organisations which have provided the input into this. Very briefly, they include a range of organisations, from icons of the establishment, if you like, like the RFDS and CWAA, down to small organisations such as the Australian association of rural nurses.

Mr ADAMS—What was the first body that you mentioned?

Mr Gregory—The Royal Flying Doctor Service and the CWAA, which, as I say, are large organisations which are almost icons of the establishment, down to small organisations. This time I am going to get the name right—the Association for Australian Rural Nurses is another of the 20 bodies. In brief, in the National Rural Health Alliance, we have four medical organisations, two indigenous health ones, three nursing ones, one for rural pharmacy, the Royal Flying Doctor Service and four consumer groups. I have missed organisations such as the Australian Community Health Association and the Australian College of Health Service Executives. We have a massive network of organisations and individuals representing both the providers and the consumers of health services.

What this means is that our normal priority issues are those which relate directly to health outcomes. Obviously we are concerned, as are you as local members of parliament, with the shortage of doctors, the shortage of nurses and the shortage of allied health professionals. We are concerned to see that the changing structure of the acute care sector, which is code for all of those things happening with hospitals and with multipurpose services, is done in such a way as to keep access to acute care services in small country areas.

You are all familiar with the necessity in some areas to rationalise hospital functions. You are all familiar with that, and you are all familiar with the generation of multipurpose services in many places in the place of hospitals. Our concern is to see that whatever is put in place in the local community—we are talking about towns here of, say, between 2,000 and 10,000—retains the capacity for acute care. One thing that rural and remote people obviously feel most concerned about is that they may lose the immediate access to someone to staunch the bleeding or intervene in a really serious health event. All of these things

colour the National Rural Health Alliance's view about what I will call the mainstream health issues.

Your purpose, and ours in coming to you, is to try to make the point that we could be putting so much more than we currently do up the front end through health promotion and illness prevention rather than at the acute end. In other words, most of the public attention that you get through your electoral offices and most of the expenditures are at the acute health care end. At the same time, everybody admits that we ought to be doing more for health promotion. We ought to be doing more for illness prevention. We ought to be doing more for lifestyle. We ought to be doing more to mitigate those risk factors which people engage in which lead to ill health. I am talking about things like diet, physical activity, smoking and alcohol abuse and so on and so forth. Where does all this fit in with your inquiry into infrastructure? Of course, these are the mainstream parts of social infrastructure and they are affected significantly by the physical infrastructure. If you do not have physical infrastructure in country areas, you do not have jobs, happy people or cohesive communities.

As chance would have it, today I have been at a meeting convened by NCEPH—the National Centre for Epidemiology and Population Health. This meeting was about the relationship between socioeconomic status and health. As you all know, there is now clear evidence that the greater the inequalities in a society as a whole—this is international evidence that you have seen—the worse is the average level of health, as determined through morbidity and mortality.

This morning's discussion was about what exactly it is about socioeconomic status which leads to poor health. What it seems to be, amongst other things, is employment and, obviously, income. Less obvious and more intriguing is the notion of social cohesion. A researcher from Canada was there who says that he interprets the evidence as saying that something much more generic than simple levels of income determines health, and it is this thing called social cohesion. What exactly it means, I am not sure, but we all have in mind a notion of what it might mean.

Your inquiry into physical, I know, and social, I hope, infrastructure is laying the foundations for life opportunities, wellbeing and health in rural areas, and that is why we come to you on great wings.

CHAIR—You are absolutely right: the definition of infrastructure goes to both economic and social infrastructure. Before I invite my colleagues to begin questioning, I will go to the nub of part of the problem. I take your point about the social cohesion within towns—using the figures that you raised of, say, between 2,000 and 10,000. As I said, I come from Victoria. I can tell you that within a three-kilometre radius of Malvern, which is an inner eastern suburb of Melbourne, you will find 350 GPs registered. If you travel a little more than an hour north of Melbourne to the small town of Nagambie, which has about 2,500 people, there has not been a GP there. Doesn't this go to part of this central core problem of dealing with the access to provision of service in dealing with the acute health problem? Does your organisation, or do you, have any opinions on this?

Mr Gregory—We do. I am delighted and, I must admit, rather surprised to have the chance to speak to your committee with legitimacy apparently about the shortage of doctors

in country areas, because I was not sure that was what you wanted. Before I start on doctors, it would be remiss of me not to make the point that, although the shortage of doctors is critical, it is also well known. I want to make the point that, in many rural areas, we are also acutely short of nurses—especially in some specialities—as well as allied health professionals, dentists, pharmacists and health managers. I am going to talk about doctors, but I want to make the point first that that is the best known part of the shortage of health professionals issue which goes right across the health professions.

Coming to doctors, the good news, as you all know, is that in most states something is being done right now through speeding up the recruitment of overseas trained doctors to country areas. Something is being done to meet the immediate problem. Some states are going to get angry if I miss them out, but I know that in Western Australia, Queensland and New South Wales the systems are nearly ready to roll whereby we will have a path for overseas trained doctors to get into nominated country towns which does not include going through the AMC. This means that it will be quicker. However, this is seen by the doctors who currently support it as being a stopgap because, of course, what they want is for all of your country towns in your electorates to be doctored by professionals trained in Australia.

CHAIR—Or whose training is accredited by the AMC.

Mr Gregory—No. They are fairly—do I want to say chauvinist?—determined in their suggestion that we should, within 10 years, have Australian trained doctors, not just doctors whose training is recognised in Australia. The latter will always apply. These overseas trained doctors will only go to Nagambie if they meet the requirements through the system established in Victoria which gives them an equivalent standard of practice, as if they had gone through the AMC. In other words, there is to be no reduction in quality and standards. That is paramount. We do not want a second-class system for rural areas, as you would all agree. You, as members of parliament, have in your wisdom put in place a number of things which will hopefully result in some improvement in the rural doctor situation in the longer term—and I am referring to the John Flynn scholarship program and undergraduate curriculum changes and placements and so on. There is quite a lot happening in the establishment of university departments of rural health, et cetera.

The key question is whether the federal government wants to bite the bullet in terms of redistributing the existing number of doctors in Australia. What we have in place now—that is, the recruitment at a more speedy rate of overseas trained doctors—is increasing the total number of doctors in Australia. It is therefore welcomed by us, but it is likely to endanger some of the principles that the minister for health has espoused in terms of keeping a cap on the total number of doctors in the nation as a whole, because that is where a large proportion of the health expenditures go. So, if one does not want to fix the shortage of country doctors through overseas trained doctors, one has to bite the bullet and redistribute the doctors. As you implied in your question, Madam Chairperson, some city areas—the better off city areas—are overdoctored. The question that the alliance is interested in is when the profession and the government will agree that now is the time to redistribute doctors—meaning that in some parts of the cities there may be a cap on numbers or possibly even less.

CHAIR—So you are looking at a geographic base to provider numbers.

Mr ADAMS—Good point.

Mr Gregory—There are strong arguments in favour of a geographic basis for provider numbers.

Mr ADAMS—It is an option, isn't it?

Mr ANDREN—It is the control of the supply of doctors, surely, if you control your provider numbers. If they want to hang their shingle in Mosman, they can do so, but if they want a provider number, they go to Collarenebri.

Mr ADAMS—Or Queenstown.

Mr ANDREN—That is where you control the supply. Would you go down that path?

Mr Gregory—Am I allowed to speak off the record for a minute? No, I am not.

Mr ADAMS—You do not have to answer.

Mr Gregory—No, I am trying to—

Mr ADAMS—We want to hear the policy of your organisation.

Mr Gregory—You all understand where I am coming from. Let me put it this way: there are strong arguments in favour of a system which would cap the existing number of provider numbers in areas that are already overdoctored. The easiest response, and perhaps the most acceptable, would be to cap those areas in the cities where there are already lots, and therefore there would be a downwards pressure and then they would squeeze out. The notion of a geographic allocation to Collarenebri or somewhere is faulty because, as you well know, the provider number is attached to a person, a doctor, not to a place. There are as many provider numbers for Collarenebri as there are doctors with provider numbers who want to go there. I know this might sound a bit like playing with words, but it is an important distinction. It does not make sense, say, to allocate a provider number to a place, because that is not how the system works. The provider number is allocated to a person with accredited skills working in a particular place.

Mr ADAMS—You can change the system.

Mr ANDREN—Could I follow up that point, because it is very germane to this whole thing. You spoke about the multipurpose model. It strikes me that we have the answer in this, if the feds and states get together and really work out their responsibilities in aged care, hostel care and acute care. I think again of the instance of Yeoval, which was born of people digging their toes in and saying, 'We are not going to close our hospital,' where the federal and the state government got involved. If you create that model and foster it, it becomes attractive to doctors.

Mr Gregory—Yeoval is a bit different, as you know, Peter, because it is a cooperative and they actually did—

Mr ANDREN—Sure, but if we move on to the multipurpose model in general and offer it in the area of federal takeover of responsibility for the aged care or nursing home type patients who are in our district hospitals at the moment, it will enable you then to provide your acute care and will make it more attractive to doctors who do not want to go to the bush and only look after geriatric patients.

Mr Gregory—I would like to make some comments on the multipurpose service, the MPS. It is not a panacea; there are MPSs in Australia which have gone horribly wrong due to poor negotiation with existing interest groups. But where the multipurpose service works, it has a number of terrific principles. I think the most important of them is the one that Peter mentioned: it allows you to cash out the entitlements that you have from various sources—state, federal and potentially local—and use that financial resource for whatever the local people regard as having the highest priority. It is flexible, rather than sticking with the silo approach to services where you have this much money for aged care and this much money for acute care. Of course, if you keep the silos, the danger is that, if you get below the threshold, the money disappears over the horizon, as you well know, and goes back to Orange.

It is flexible; it allows you to cash out. The alliance for which I work welcomes very much the announcement in the budget for the new regional health service centres, as the MPSs are now going to be called. If all goes well, there are going to be 90 of them within a couple of years, so it will be a very significant program, and it has a lot going for it. We are interested, I suppose, in taking the MPS and the principle of cashing out a lot further, especially in the interests of remote areas. In remote areas, we know that people have much less access to doctors and hospitals—I am talking about quite remote areas like the Territory, northern Western Australia and so on. There are figures to show quite clearly that the average number of calls through the MBS or the PBS or whatever from individuals or families in remote areas is much lower. In a sense, what this means is that they are missing out on an entitlement. If you take the notion of flexibility and cashing out a bit further, the alliance believes that you can actually design a quite new approach to health financing, especially in remote areas. That is something that we would like to see develop.

CHAIR—You also mentioned ‘telehealth’ in your submission. Would you see a possibility of linking that to the model you have just described—of having a telemedicine centre linked to one of these regional health service providers that would actually be able to deliver a service to the more remote areas? Would you see that as part of the structure?

Mr Gregory—Absolutely. We envisage there will be an emphasis on information technology and telehealth in the new regional health service centres. The alliance’s firm view about telehealth—and we prefer the term telehealth to telemedicine because it is multiprofessional and broader—is that it should be an adjunct to personal contact and not a replacement for it. We have all seen the Telstra ad for the cutting edge of telehealth: the ultrasound by remote control. But this requires a bandwidth which is quite beyond most facilities that are engaging in telehealth. Narrow bandwidths carry sufficiently well for education and training and for talking-head seminars, but not well enough for the transmission of moving pictures.

We support developments in telehealth because they have great capacity. We do not see it as being a replacement for personal contact because we think it never will be. We like to couch our support in terms of a warning that, as yet, it is really only the 'you-beaut' cutting edge things that are getting people really excited. Telehealth does not yet pertain to the bulk of interaction between a patient and a health professional, with the possible exception of telepsychiatry because it is about the transfer of ideas rather than pictures—that is, it is mainly through speech and listening.

CHAIR—I have actually seen at Johns Hopkins University a community unit which is interactive where people were changing dressings with what looked like a small fax machine with a tiny little camera and screen attached to it. So there is the technology there but it is very expensive technology.

Mr ADAMS—We have covered all that too. Sending a blood slide down—the graphic stuff—rather than having to take blood from a particular area to a pathology lab is the sort of thing that is reaching that sort of level in telehealth, isn't it?

CHAIR—And ECGs—they can do all of that now.

Mr Gregory—Yes, it is very exciting. The point I want to make is that we support as rapid a development in as many areas as possible. We are not yet at the stage where we can say, 'Everything is right. We have information technology in telehealth,' because it clearly is not that way yet.

Mr ADAMS—I congratulate your organisation on a very fine submission. In the terms of reference, you state:

> Current policy encouraging a greater private sector role in health service delivery may generate even further inequality in access to health services between metropolitan and rural and regional areas. Private hospital beds are much less equitably distributed in rural and regional areas . . .

Would you like to elaborate on that?

Mr Gregory—In a general sense I would. It is all part of the fact that the market does not work in rural areas and especially in remote areas. The more sparse the population, the less good the unfettered market is at delivering outcomes for individuals which are equitable and affordable. The distinction that you have referred to between public hospitals and private hospitals is, in my view, a clear illustration again of the fact that continued interventions of all sorts will be required from governments of all sorts—I am not just talking about the federal government but also state and local government support—if we are to aspire to a pattern of rural settlement in Australia which is sort of Victorian and better; in other words, in the sparser states of Western Australia, the Northern Territory, Queensland and New South Wales it is a greater challenge.

The premise of the alliance's position is that if governments wanted to do something fundamental about rural development, they could. If they wanted to use the big levers, they could. We have just missed, arguably, a major opportunity through the tax system to put in place a tax regime which would have underpinned, fundamentally, rural development and a positive change in rural areas. The possibility that governments are going to take a hands-off

approach and allow rural communities to continue to decline is a troublesome and very worrying one.

Mr ADAMS—The situation of delivery of specialist services in rural and remote areas is always a difficult one: the cost is always high. Have you looked at how to deliver specialist services into these areas?

Mr Gregory—It would have to be said that the representation of specialists is something which is not yet well done in the alliance. We do not have an interest group of rural or remote specialists. We are aware and you are all well aware that specialists are in even shorter supply, as one would expect, than doctors and nurses and allied health professionals. There is a very limited amount of work being done through the Commonwealth Department of Health and Aged Care relating to placement of specialist services. There are one or two outstanding examples of mobile specialists—such as the flying surgeon in Queensland—

CHAIR—And the telepsychiatry that was mentioned.

Mr Gregory—And telepsychiatry. If I end by saying that it is a major issue, I do not want to imply that we think it is possible to have a specialist in every town of 2,000 people. It is not. There is some reasonableness in our expectations. With respect to specialists, I think one has to be reasonable.

Mr SECKER—For the record, I could not quite work out your connection between the recent tax system and—

Mr Gregory—I noted that through your body language. Would you like me to elaborate?

Mr SECKER—No. I am making my comment because, as a country member, I believe that—and I am sorry that I have to get political on this—the tax system has given great benefits to country people. So I cannot agree with your comment there. But I congratulate you on a very lengthy and certainly detailed submission. I was interested, though, in your comment about social cohesion because I did not pick that up in the report—although I have not read it word for word. I wondered whether you relate that to what I would call strength in community. I have always had the feeling that the smaller the community, the stronger the community. When you get into the bigger cities, you lose a lot of that community attitude and perhaps that social cohesion. There is a perverseness in the fact that, if community areas grow because we have provided infrastructure for them to grow in other areas, that affects their social cohesion.

Mr Gregory—There is some truth in the notion that the smaller the community the greater the sense of community, but I do not believe it fully offsets some of the negative aspects of living in a small community. I am not talking simply about the self-evident fact that, if it is small, it has less options, less services and less access. I am talking about some of the intangible things, like the greater stigma that applies. For instance, the smaller the community, the more difficult it is if you have mental health problems or substance abuse difficulties, because not only are you short of services but the perception is that you are marked. On balance, my view—and I think I have to say 'my view', because I am not sure that the alliance has a view on social cohesion—is that it is dangerous to assume—and I

know this is not what you said—that country communities are happier places because they have more community. It is much more complicated than that, as I am sure you would recognise. Where health is concerned, it is fantastically complex. It is not just access to services.

If we go to social cohesion, it is interesting—and I mentioned it because of the meeting that I went to this morning. To me, it is more easily understood that, if you are on a low income, you are likely to be less healthy or less able to access health services—I am not sure which. The morbidity and mortality stats are going to be worse for a cohort on low income, and that makes sense. But the notion proposed this morning was that it is much more complex than that. It may not just be income and it may not just be employment, although they are important. It may be something called social cohesion itself. I find this difficult to grapple with, because social cohesion is a construct and is surely only a combination of specific things like employment, income, jobs and other things.

CHAIR—Wouldn't it also encompass things like self-esteem?

Mr SECKER—Yes, and status.

Mr Gregory—Yes. There was a reference this morning again—I am sorry to keep referring to this meeting—to the way in which this might impact on health. Someone made a reference to a part of the brain. I know nothing about the brain. It is about self-esteem. Is it personality? Probably not. Someone made a reference to all the stuff that happens through the endocrine system and all that sort of stuff. I am elaborating here; I am turning to anecdotes. When you wake up in the morning, if you are a happy little vegemite you will be healthy. The immune system is something even I can understand, but this other stuff in the brain is a bit hard. So it is complex.

Mr HORNE—This is not so much a question as a statement. The thing that I have observed, living in country areas over a long period of time, is that with the decline of the use of hospitals for surgical practices, the need for doctors in rural areas has also declined. Even in the Hunter Valley now, women can only have their babies in about two or three hospitals. They are no longer encouraged to have their children in those small country hospitals—and the hospitals will not even take your appendix out. Because of that, the demand for doctors has declined. There is no point for any doctor who is ambitious in staying there, because all they are doing is rendering good bedside manner and very little else. Is that right? Has the fact that we have concentrated our medical and surgical services in the major regional hospitals taken away the desire for doctors to go to small country towns, where they do not do a lot with the community and they just have to keep passing everything else on?

Mr ADAMS—How do we rectify that and are we looking at that through the university rural doctoring thing?

Mr Gregory—I think that is right if one considers what we might call the old-style rural doctor. One of the reasons why the old-style rural doctors went to rural areas, as you know, was because they had access to all that stuff. They wanted to do anaesthesia, to deliver babies and to do some surgery. I am conjecturing here, but I wonder if that is going to be

the case in the future. I am going to find it difficult not to be judgmental here about medical undergraduates, but one of the problems of getting rural doctors to go to country areas now is that they are no longer willing, apparently, in such great numbers to commit themselves to the 24-hour day, 7-day week, generic and highly skilled practice. What I am hearing from correspondence to the alliance is that we have a new culture of doctoring which is all about working nine to five, guaranteed wages, weekends off, four weeks leave a year—

CHAIR—Fear of litigation.

Mr Gregory—Litigation is a big issue. What this means is that the issues for attracting doctors to country towns in the future may not be so much related to the loss of access to the hospital in which to do other things, but due to lack of a locum, lack of a holiday, lack of certainty and so on.

Mr SIDEBOTTOM—Thank you, Gordon, and congratulations on your submission. It is very comprehensive. I have been particularly interested in the question of rural health through the rural health department in Tasmania, which has been developed as part of both the community services department and also the University of Tasmania. It has some very exciting integrated health services provisions.

I will just draw your attention, if I may, to your report on infrastructure issues and to aged care facilities. For those of you who want to look at this, it is on page 15, under 3.1.2. Your recommendation is:

That the Government seek to apply its targets for aged care facilities on an equitable geographic basis, implying a need for special measures to bring rural and remote provision of those facilities up to metropolitan levels.

I am particularly interested in how you think this recommendation can be achieved and, in particular, again, how some of these special measures will bring rural and remote provision of the facilities up to metropolitan levels? I am also interested to know whether you believe that the latest stage in the coalescence policy of the present government will impact negatively on this recommendation?

Mr Gregory—With your permission, I will not answer the last part because I am not qualified to do so. If the policy officer who worked with me and helped draft this were here, she could answer it, but I will not.

CHAIR—I will just stress also that this is a committee of the parliament—we put political differences aside.

Mr SIDEBOTTOM—It is purely a question of a policy.

Mr Gregory—On the general issue, it is proper for me to acknowledge that some of the additional funding which has been allocated for aged care facilities over the last 12 months has favoured rural areas differentially, and that is good news. The reason that was the case, of course, is because the situation in rural areas was so parlous. You all well know, including in your state, Madam Chair, that the proportion of those places not able to get up

to accreditation standards in rural and, especially, regional areas was very high and was a major problem.

I recognise what has been done. I think this is one area where I really do have to be a little venal and say that nothing is going to solve it, apart from more resources. If we are serious about 'ageing in place', which of course is one of the new policy planks which we support, then one should—and this is a judgment—accommodate ageing in place for rural and regional people as well as for city people.

Mr SIDEBOTTOM—But that concept is complementary to your social cohesion, isn't it? That is what we have been getting in our submissions.

Mr Gregory—Yes. Let us acknowledge what has been done, but I do not believe it is yet enough. There are still major problems with both the supply of places and their standard in rural and regional areas.

CHAIR—Added to that, has your alliance looked at actually having the qualified staff, also trained people, to—

Mr Gregory—This comes back to the general shortage of trained staff for all health and parahealth professionals.

Mr ADAMS—The lack of nurses being able to do the needles and things like that.

Mr NAIRN—Just on that, in relation to the numbers of doctors, one of the other things that is often proposed to overcome the problem—and I know you said there is a shortage of nurses as well—is to have more nurses with the higher qualification. I cannot think of it now, but there is a term where nurses who—

Mr Gregory—Nurse practitioners.

Mr NAIRN—Nurse practitioners—that is it. Thank you.

CHAIR—The Americans call them physician extenders.

Mr Gregory—Do they?

Mr ADAMS—The mind boggles.

Mr NAIRN—Do you see that as also a way in which to improve the services? I think it is opposed by some of the doctor organisations.

Mr Gregory—Because the alliance comprises medical organisations, nursing organisations, consumer organisations and others, we are very interested in policies related to nurse practitioners. Clearly, there is a case for nurse practitioners in remote areas to be properly recognised, properly trained and properly indemnified. We have some current problems with nurse practitioners, with which everyone would agree. The problems include that many of them were not trained for some of the things that they actually practise, and

most of them are not indemnified—and you were talking, Madam Chair, about litigation. There is certainly a role for nurse practitioners in Australia, and the alliance believes that the first place where they should be used more extensively, as indeed is happening in some states, is in the remote areas where there will never be a doctor and where there is no need for concern about whether they are infringing on somebody else's turf. The question of the nurse practitioner in the base hospital is, for obvious reasons, more controversial.

Mr ADAMS—I think the historical precedent was the bush nurse, wasn't it?

Mr Gregory—Yes.

CHAIR—She was jack-of-all-trades, wasn't she?

Mr CAMERON THOMPSON—I wanted to find out a bit about your body and what you represent. You said you had 20 member bodies. Who are they? Where are they located? Have they been through this submission and do they all support it? In attachment C, it referred to NRHA having 12 national bodies. It has obviously grown since then.

Mr Gregory—What attachment is that? It must be very old.

Mr CAMERON THOMPSON—It is the one to Bob Collins. I am saying it must have grown, and I am just wondering who is in it now.

Mr Gregory—That is in a portion of this publication, which was produced in 1998. The National Rural Health Alliance is—

Mr ADAMS—You gave us a breakdown at the beginning of the meeting.

Mr Gregory—But very briefly. I will just respond, if I may. The 20 member bodies are all national organisations, so it is a huge network. They are in nursing, doctoring, and allied health, as well as consumers, the Royal Flying Doctor Service, the country women's association and so on.

Mr CAMERON THOMPSON—Did they all go through the submission?

Mr Gregory—They have all endorsed this submission.

Mr SECKER—Getting back to aged care, what Mr Sidebottom brought up was a good point—and I am not a physician extender or health professional, so I cannot quote a chapter on the different levels. There are something like nine levels in aged care, aren't there?

Mr Gregory—Yes, but don't ask me to talk about them in detail, please. There are nine levels of care requirement.

Mr SECKER—Obviously, each level needs a higher grade of care. The suggestion has been put to me by Lambert Lodge, which is a cheaper, hostel type set-up, that they get involved up to a certain level—level 5 perhaps, but I am not sure what it is—but they have to go through the huge accreditation costs of almost up to level 9. Can you comment on

whether it is possible to have a lower level of accreditation for the lower levels that are needed? This would help a lot of areas.

CHAIR—I think part of the problem is the physical infrastructure as well as the degree to which people are trained.

Mr SECKER—It would actually help places in smaller communities that might be able to use it, where they could be there almost as a transitional stage to a full aged care facility.

Mr Gregory—Are you saying that they cannot get accredited for that lower level which they require?

Mr SECKER—Yes. They have to go through the whole process.

CHAIR—A more flexible approach.

Mr Gregory—I am not across the regulatory or the policy basis but, as the Chairperson has just said, flexibility is everything in a small community, and the smaller it is, the more flexible it has to be. I am sorry that I cannot be more precise.

Mr ADAMS—Can I just get this right? Is this second-class or two levels of—

CHAIR—It is one facility.

Mr SECKER—You could call it second class. It would be a lower class that would be able to look after aged people up to a certain level of care.

CHAIR—Not a class; a category.

Mr SIDEBOTTOM—Not acute care?

Mr ADAMS—Are you talking about three people in a room?

CHAIR—Patrick is talking about the different category of care. Is that right?

Mr SECKER—Yes, so a lower level could have a lower accreditation need and still keep people in their—

Mr ADAMS—That is a flexibility thing.

Mr SECKER—Yes, it is.

CHAIR—The point of the question is: have you done any work looking at perhaps having flexibility in a situation like the one Patrick is referring to in a small rural community? Everyone acknowledges the cost of the physical infrastructure and the difficulty of getting the highly trained health professionals and that facilities in metropolitan areas are often purpose built to cater for specific category levels of aged care residents. In a small rural community, you could have a facility with the flexibility to cater for people at various

levels and that would not have the same restrictions on it that a metropolitan facility might have.

Mr Gregory—We have not done any such work. I do not know what your time line is for the inquiry, but I could certainly make a specific request about that to our network. We have a great network.

Mr SECKER—I would appreciate that.

CHAIR—I think that would be an excellent idea. It goes without saying that the cost of upgrading the physical infrastructure of many of the ideas you have put forward in your submission are huge. Have you, as an organisation, looked at the possibility of the public and private sectors coming together to fund any of the ideas that you are putting forward, or do you see the social infrastructure as being solely the responsibility of government? Do you see a role for the private sector?

Mr Gregory—Absolutely. Clearly, what is required is a true collaboration of governments—all levels of government—with the private sector and the community. The alliance certainly does not subscribe to the 'aorta syndrome'—'Aorta do this' and 'Aorta do that.' The best examples, as you all well know, of rural community services are where you do have collaboration: true local ownership and participation in the community. As a general principle, we would very strongly endorse that. Of course, this is not, as it were, to let any institutional level off the hook. In other words, mutual obligation, or call it what you like, is fine as long as all parties are doing their thing.

To return to the proposal for a rural development commission, we believe that there are so many good ideas around for rural development—ideas which could be chased down, costed, looked at from every which way to see whether they were environmentally sound and whether there was support for them—that there really does need to be a lead agency to do this work.

CHAIR—Do you see that as yet another empire-building exercise where a lot of the very scarce funding from both public and private sectors could be used up in the establishment of such a commission?

Mr Gregory—Yes, it is of course the establishment of a commission, but to call it empire building is pejorative—you did that intentionally; that was the purpose of your question—and rural areas are too important. We have the Industries Commission, which is an example of an organisation which has resources and technical expertise so that, if it is given a reference by government, it can go away and chase down all the detail about that. We know that the Industry Commission tends to have a particular economic colour about it; a particular paradigm that drives it. We are talking about a Rural Development Commission which would have a different paradigm.

As you read about the Rural Development Commission in here, you will see that it is not just the federal government that we propose to run it. It would be a three-government thing, with the community—which reflects its difference. Its paradigm would be: what can we do

with these ideas that are around? Is it more farm tourism? Is it alternative fuels? Is it regional development corridors? Or is it walkways in country areas using—

CHAIR—Don't you think that those sorts of things already exist, but they exist in various different bodies distributed—

Mr Gregory—Do you mean to do the work?

CHAIR—If we dwell on just those examples that you used—where we are going to go with development, whether it is going to be tourism, and what is needed there—do they not already exist? The point I think you are making is that there is no one body that actually—

Mr Gregory—It is not coherent.

CHAIR—It is not cohesive and what you are suggesting is that there is a need for one body. So what do you do with all the other bodies that are currently doing that sort of work?

Mr Gregory—If you want to establish a Rural Development Commission—I am sure I am going beyond my brief here—you have to abolish some of those other bodies whose tasks it might do in a way that is a more favourable paradigm for rural development. I would go along with that. We are talking here about the 30 per cent of Australia which develops a very high proportion of our wealth, and it is far too important to leave to an organisation which is concerned with counting the cost of a limited part of what we do in society but is not interested in, say, the dysfunctional cost of Sydney and Melbourne. Sydney and Melbourne are too big. If we included the costs of dysfunction in those cities in our equations, then it would be much easier for us to justify investing in rural and regional areas. But the IC is not going to tell us this, unless we give them a specific reference. What we are suggesting is that the 30 per cent which is rural, remote and regional Australia is so important that we need a tailored, coherent organisation to look at these things.

CHAIR—Are there any questions from any other members? Mr Gregory, did you want to table some documents?

Mr Gregory—Thank you, Madam Chair. I want to table—and it would have been very remiss of me had I not done so—*Healthy Horizons*, which is the most important strategic document for rural and remote health services for the next five years. I can say this quite unequivocally because it is not the alliance's document. This document has been signed off by all health ministers—by your colleague the federal minister, by all state ministers and by the Northern Territory health minister—and by the alliance. This has the imprimatur of all health departments—federal, state and Northern Territory—and of the 20 member bodies of the alliance. Although it does not say so here, this is the replacement for the old National Rural Health Strategy. You will be familiar with that little green book, which you all loved and knew every page of. This is effectively the new strategic document, but it is not called the 'national health strategy', it is called *Healthy Horizons: A framework for improving the health of rural, regional and remote Australians.* I commend it to you, if you do not already know about it. I can provide you with more copies.

I have tabled *A blueprint for rural development*. I have tabled the annual report for 1997-98 of the National Rural Health Alliance. The last document is a brief one from the meeting that I attended this morning. I brought it along because I am sure it is relevant to you. It is called *The health inequalities research collaboration*. That is being run at NCEPH, the National Centre for Epidemiology and Population Health, based at the ANU. The federal Department of Health and Aged Care is funding the first work that I know of that is being funded by the federal government into the relationship between health outcomes and inequalities. This is the brochure about the work that they are doing. It is important, path breaking, fundamental work in relation to rural and remote infrastructure issues. I also commend that to you. Thank you for receiving them.

CHAIR—Before I formally close the meeting, were there any points that we have not touched upon that you would like to make to the committee?

Mr Gregory—If I may, I would like to offer the services of the alliance. I hope, when you see the list of member bodies, you recognise that it is quite unique in terms of who it is and how collaborative they are. Two or three of the issues that you have been good enough to ask me to talk about are quite controversial and would have been much more controversially stated had they been presented to you by just one of the professions we represent rather than by the collaborative organisation.

One of the magic things about the alliance is that it brings together health service providers and health consumers in a way which allows us to talk about and move towards policy positions on issues like general practice policy, nurse practitioners and tax, which are, if seen in a narrow focus, controversial. I commend to you the organisation for which I am pleased to work. If you want to use the organisation for sending information out about the results of your inquiry or for sucking more information in, then please call on us.

CHAIR—Thank you. Thank you very much for appearing today.

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

That, pursuant to the power conferred by paragraph (a) of standing order 346, this committee authorises publication of the evidence given before it at the public hearing this day.

Committee adjourned at 6.23 p.m.