COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Click here to enter text.

(Public)

FRIDAY, 10 OCTOBER 2014

PERTH

BY AUTHORITY OF THE SENATE

[PROOF COPY]

INTERNET

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

To search the parliamentary database, go to:

http://parlinfo.aph.gov.au

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Friday, 10 October 2014

Members in attendance: Senators Cameron, O'Neill, Siewert.

Terms of Reference for the Inquiry:

To inquire into and report on:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

d. the interaction between elements of the health system, including between aged care and health care;

e. improvements in the provision of health services, including Indigenous health and rural health;

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

g. health workforce planning; and

h. any related matters.

WITNESSES

JONES, Dr Ann, Policy Officer, Health Consumers' Council of Western Australia

WHITELY, Dr Martin, Acting Executive Director, Health Consumers' Council of Western Australia

Committee met at 09:05.

CHAIR (Senator O'Neill): I declare open this public hearing of the Senate Select Committee on Health. This is a public hearing. I remind all witnesses that in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The committee generally prefers evidence to be given in public but under the Senate's resolutions witnesses have the right to request to be heard in private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time.

I invite you now to make a brief opening statement before we go to questions.

Dr Whitely: Thank you for the opportunity to present today. Our concern is that although taxpayers fund the Pharmaceutical Benefits Scheme and the Therapeutic Goods Administration, these agencies frequently act in the best interests of the pharmaceutical companies at the expense of health consumers. Put simply, we end up paying too much in taxes and at the pharmacies for drugs that are too often unsafe or ineffective. We contend that the influence of the pharmaceutical industry on the operations of the PBS and the TGA are classic cases of what economists refer to as 'regulatory capture'. Regulatory capture occurs because those with the great greatest resources and the most foreseeable potential gains or losses from a regulatory policy process seek to dominate that process.

The section of our submission on value for money is not original work. It draws extensively on research led by Professor Stephen Duckett from the Grattan Institute. The Grattan Institute research demonstrates that, unlike New Zealand, our system of purchasing and pricing taxpayer subsidised drugs, the PBS, has not encouraged price competition. As a result, in 2013 the wholesale prices of the most commonly prescribed drugs in Australia were more than six times higher than those equivalent drugs in New Zealand. There has been some limited recognition of the problem in recent months. This month there has been a very modest fall in the cost to taxpayers of PBS subsidised drugs. However, what is clear is that even after this fall in price, Australians will continue to pay way too much in taxes and at the pharmacy for prescription medications. We do not intend talk at length about the Grattan Institute's work except to say that we endorse it. In fact, we regard the implementation of these reforms as a no-brainer in a time of increasing pressure on government expenditure.

Our greatest concern is in the operation of our safety regulator, the Therapeutic Goods Administration. The TGA is far from transparent and effective. When licensing drugs for marketing, the TGA relies on research funded and controlled by the pharmaceutical companies. Too often pharmaceutical companies cherry pick favourable evidence and hide or spin unfavourable evidence to support their commercial interests. Sometimes, as was the case with vioxx and pradaxa, patients pay with their lives.

The TGA's post market monitoring of drugs is equally problematic. Voluntary reporting, inadequate disclosure and a lack of systemic analysis of adverse events results in an over optimistic perception of the safety and efficacy of many drugs.

Furthermore, the privacy provisions in the Health Act 1953 effectively exempt dealings between pharmaceutical companies and Commonwealth government agencies from freedom of information requirements. To address these shortcomings we propose seven reforms to increase the rigour of licensing processes, to increase transparency and to promote informed consent by medication users. They are (1) removing the freedom of information exemption derived from Health Act 1953 extended to corporations that prevents their submissions on the PBS and to the TGA from being FOI'd; (2) requiring full public disclosure of all relevant safety and efficacy data for pharmaceutical products approved for market in Australia; (3) reducing cherry picking of favourable results by the pharmaceutical industry by requiring pre-registration of all new research that may later be used to support licensing and PBS subsidisation applications; (4) strengthening consumer medicine information requirements so that every warning currently included in the information to prescribers is also included in the consumer medicine information made available to the consumers, mandatory inclusion of a CMI inside medication packaging and putting a brief summary of the most serious warnings on the outside packaging of drugs; (5) requiring mandatory reporting of all severe adverse events by health professionals to the TGA; (6) requiring full public disclosure of pharmaceutical industry funding for clinicians, researchers, patient groups,

advisory board members and members of committees involved in regulatory and policy development processes; and finally, (7) the Commonwealth government should commission research into the incident and health impacts of off-label prescribing. Based on the outcome of this research, the Commonwealth government may consider if over time off-label prescribing should be encouraged to become on-label. This could be achieved by gradually limiting PBS subsidisation of medications to those prescribed within approved guidelines.

A significant barrier to these necessary reforms will be the influence of the pharmaceutical industry and their peak body Medicines Australia. We contend that without political leadership on this issue Australians will continue to pay too much, be denied fully informed consent and be exposed to unnecessary risks.

CHAIR: Thank you for your extensive work and the preparation of this submission to us. We did hear from the Grattan Institute earlier this week, from Professor Duckett, with regard to a number of other matters as well. Is there anything in particular you would like to highlight from the seven recommendations that you make in response to my first question?

Dr Whitely: Perhaps if I went through them and gave the basic rationale for each of them it might be—

CHAIR: I think you have done that. Is there one in particular that you want to highlight?

Dr Whitely: There are aspects of all of them that I would like to highlight.

CHAIR: In that case, could I get you to go to (7).

Senator SIEWERT: I want to go there.

Dr Whitely: Very briefly, off-label prescribing is prescribing outside authorised guidelines. Drugs are licensed by the TGA for use based on clinical evidence for a range of parameters—for certain age groups and certain conditions. When drugs are licensed, though, clinicians are free to prescribe in line with their own clinical judgment. There is a massive practice of off-label prescribing occurring in Australia but there has never been a systemic review to determine just how common it is.

Senator SIEWERT: It is not always bad though.

Dr Whitely: No, it is not always bad.

Senator SIEWERT: Because, I am aware of circumstances where it is actually really useful and effective.

Dr Whitely: I agree. It is not always bad. But, what it is always is outside a robust process for which evidence has been collected.

Senator SIEWERT: Yes.

Dr Whitely: What the Health Consumers' Council would like to see in the long term, and this is a change that would have to happen over years, is a shift toward on-label prescribing. Let us have the evidence presented that backs up the practice of prescribing. Sometimes new issues will emerge and new treatments will emerge but many of the off-label prescribing has been going on for decades. There is no real excuse for it not having been through an appropriate process. As you say, it is not always bad, but we at the Health Consumers' Council provide an individual advocacy service and we come across some extreme cases of off-label prescribing.

I will draw some attention to a de-identified case. The family that is involved in this case are prepared to provide in-camera evidence to the committee, if you are interested. It relates to a girl who is not yet a teenager, who suffered severe trauma—extreme trauma—that was not recognised at the time as a young child. Subsequently, she exhibited problematic behaviours and went through a series of diagnoses including for bipolar, ADHD, depression, anxiety, dyslexia and OCD.

As she entered her early teenage years the original source of her trauma was identified and she was diagnosed with post-traumatic stress disorder and lost all the other diagnoses, but along the way the girl had been put on a range of psychotropic drugs, including at one stage being on six psychotropic drugs. She was on lithium for bipolar, she was on Strattera for ADHD, she was on Zoloft as an antidepressant, she was on Effexor which is an antidepressant, she was on Lamictal which is an anticonvulsant and Zyprexa, which is an antipsychotic. Of those drugs, three of them carried a black box warning for suicidal ideation or suicidal thinking. Another carried a lesser warning—a black box warning being the highest warning possible—for suicidal thinking. She actually made several unsuccessful suicide attempts during this time and her family were never informed that the drugs may have been associated with the suicide attempts. Five the medications were not approved for paediatric use, so there was a very clear-cut case of a child whose needs had not been identified. The causes of her problems had not been identified and she was damaged through the process. As well as the suicide attempts there was a massive weight gain, probably associated with the use of antipsychotics. The dosages were very high. The family were not given informed consent about this. This is an extreme-end example of what is a common practice.

Senator SIEWERT: Yes, I was going to say it is not just about off-label use of drugs. It sounds like there are a whole lot of other issues there in terms of inappropriate prescription and all sorts of things.

Dr Whitely: Yes, but if she had been restricted to on-label uses of drugs then she would only have been put on one or possibly two of those drugs.

Senator SIEWERT: Yes, I take your point.

CHAIR: And perhaps it could have caused a trigger for somebody else to oversee the medication and the doctors. During the week we heard about the difficulty in getting data that allows oversight of the interaction between the PBS and the MBS because legislatively it is not allowed, so some triggers that might have kicked in in that case certainly would not kick in.

In addition, we also heard of nurse practitioners who have prescribing capacity in other jurisdictions doing much less of this off-label prescription than GPs or indeed specialists. That opened up for us a whole lot of other questions about the role of GPs and allied health professionals. If I can take you, as consumer advocates, to that conversation, which has been pretty live this week, the medications that are received and generally provided by a GP are at the heart of your submission. One of the concerns that has been raised is access to a GP in the context where a $7 co-payment is being mooted. From a consumer point of view, could you put your view forward?

Dr Whitely: From a consumer point of view the Health Consumers' Council is obviously opposed to the introduction of any increased charges, particularly to vulnerable consumers. I would also put it in the context of the Grattan Institute's work. They identified, very conservatively, savings of about $1.3 billion from one of the papers that I have highlighted in my submission, which translates to $56 per head across Australia, which is eight visits to the GP. So I think there are other ways to save money. Getting a better pharmaceutical deal will save the Commonwealth government a lot more money than it would seek to raise from a GP co-payment. I might point out that the Grattan Institute's work is very conservative, too, because it only was a comparison of Australia and New Zealand for the top 43 per cent by value of PBS prescriptions. If the same pattern continues over the other 57 per cent by value, the savings would be much greater. It is a radical suggestion but if the Kiwis bought our drugs and charged us a 50 per cent mark-up, we would still be way ahead. That is how bad our deal is. I think there are much greater savings to be made through the way we buy pharmaceuticals than money we would raise through a GP co-payment.

CHAIR: Dr Jones, would you like to make a comment around the GP co-payment?

Dr Jones: No, my position is the same as the Health Consumers' Council. I will point out that I have only been on board here for about three months, so I will let Martin speak. I have done a lot of this research and I would totally agree with what Martin said. There are savings to be made in areas other than charging vulnerable consumers, and I think that is who this would get.

Senator SIEWERT: In terms of the co-payment, have you had feedback from your members about their concerns?

Dr Whitely: Yes. We provide an individual advocacy service. Typically people will ring us not about health policy issues though; typically they will ring us because they have a problem with a GP or a service, accessing a hospital or getting adequate mental health services or getting out of medical health facilities. They are the sorts of things we get, so we often deal with people in crisis. The feedback we have had has been that we do not want to pay this, but that is not our primary advocacy function.

Senator SIEWERT: I understand that. Certainly my office has received calls from people who are worried about the impact and so I was wondering if you had as well. People are really worried.

Dr Jones: I think it might change if it actually came in. I think we might have a lot more calls then.

Dr Whitely: We typically respond to people in crisis.

Dr Jones: At the moment it is not a large focus for the Health Consumers' Council.

Senator SIEWERT: In terms of the co-payments on access to using other services—PBS and other pathology services—I presume your comments on co-payment equally relate to those areas as well?

Dr Whitely: We support universal, cheap, free access to health care services. There is no question about that at the Health Consumers' Council. But we also support value for money in the delivery of health services; hence our support for the work of the Grattan Institute in terms of pricing.

Senator SIEWERT: Dr Jones, you made a comment about the most vulnerable. Can you take us through why you made those particular comments and what impact will the co-payments have differential impact on the way certain groups of people access the health services?

Dr Jones: I have not been in the health field all that long, but I am very interested in politics. I have been following the debates, of course. I think it will hit vulnerable people—for instance personally, my mother, who is elderly and goes the doctor. Those groups are going to be affected most. For people with money, it is not going to impact them. It is an across-the-board co-payment, so I think vulnerable groups who tend to go to the doctor more or have more need of medical services and cannot afford it will be the ones hit. That is just my view on it at the moment if it is introduced. I think there are many other ways we can save money and this is a good example. I think it hits those that can least afford it.

Senator SIEWERT: In terms of vulnerable groups, which groups are you particularly referring to?

Dr Whitely: With respect, our submission did not make any reference to the GP co-payment. I know that is a focus of this inquiry but it is a very broad-ranging inquiry and we did frame it in terms of the terms of reference for the inquiry. We made the comments that we can make on the GP co-payment. It is something that we have come across. It is something that we have had an opinion on and we have expressed it. We have had some feedback on it, but it certainly was not a focus of our submission.

Senator SIEWERT: Can I go back to your comments around the PBS and the seven recommendations and your off-label. There are a number of other areas that I want to go back to there but, in terms of off-label, can I ask a question about your particular approach to how you deal with it. You made a comment about putting it back on label and about subsidisation of that process.

Dr Whitely: I think that this continued practice of having things being prescribed off label and some of them being subsidised by the Pharmaceutical Benefits Scheme—not all off-label prescribing is subsidised by the Pharmaceutical Benefits Scheme, but quite a significant proportion is—continuing for decades means that things are being established through precedent without any systemic review. In the cases of some drugs, it is not until well after market that we establish that these things should never have been prescribed in the first place. Vioxx and Pradaxa are two classic examples, but they are by no means the only ones. So what we need is a system that allows some flexibility for off-label prescribing in the short term but has a robust regulatory process that looks at the safety and efficacy of medication. What is one way of encouraging that? Use the economic incentive of the PBS to ensure that, in the long term, only things that have been through a rigorous process are actually subsidised by Australian taxpayers.

Senator SIEWERT: Thank you. Can we also go back to your No. 3 recommendation, which was about the cherry-picking, looking at the pre-registration process. Can you just explain that in a little bit more detail for me.

Dr Whitely: The first three are sort of inter-related, actually, so do you mind if I talk about all three in one?

Senator SIEWERT: Yes, okay.

Dr Whitely: How the system works is that the pharmaceutical industry pays for and conducts its own research. It chooses who is going to do the research, it sets the research parameters and it decides what information is going to be made publicly available. It also has the capacity to influence outcomes so that it will highlight positive outcomes from research rather than the negative outcomes, if you understand what I mean.

Senator SIEWERT: Yes.

Dr Whitely: You might have an unintended secondary outcome that is positive but the primary outcome of the research might be negative. In an ideal world, you would have a system whereby there was a register of all research so that we could know which research was prospectively coming and then we could monitor the research and actually see what it says about safety and efficacy. We recognise the necessity of commercial-in-confidence information, but safety and efficacy data for things that are later funded by taxpayers to be used by consumers and are being badged as safe should go through a rigorous process.

Of those first three recommendations, that is probably the least immediate in terms of impact. I will talk about the other two very briefly. The National Health Act 1953 actually provides exemption from FOI for information that is provided to the health department regulators, the PBAC and the TGA, in the same way that your and my private medical records are protected because they are considered to have status equivalent to that of a person from the point of view of the law. So the first thing that needs to happen is that that exemption needs to be removed. Until that exemption is removed, you cannot actually implement No. 2, which requires full public disclosure of all the relevant safety and efficacy data. You should have a system whereby all of the data on drugs that are approved for use and subsidised in Australia is available for public scrutiny. Consumers will not scrutinise that, but some obscure researcher at Flinders University of South Australia or somewhere like that might troll through it and find stuff that needs to see the light of day. So we need an open and transparent process, and the first step we need to take for that is to remove the FOI protection that there currently is. The third one is important but it is like the cherry on top of the cake, and it is only going to stop prospective problems. There are

international moves for an all-trials register, and I do make reference to that in the submission, but I will not go into it in great detail now.

Senator SIEWERT: Thank you.

Senator CAMERON: Thanks, Dr Whitely and Dr Jones. Dr Whitely, we have had submissions from the Grattan Institute. They did not go to this area specifically with us, but you have indicated they have done research on it. In the overall delivery of services and costs in the health system, what is your calculation of the—let's use the word crudely—rip-off on pharmaceuticals? What is the percentage that contributes to the cost of the system?

Dr Whitely: If we just identify the direct financial costs and I put aside the fact that wasted expenditure leads to suboptimal outcomes—if you look at the Grattan Institute's work, they did a comparison in 2013 of the top 43 per cent by value of pharmaceuticals prescribed in Australia and compared that to New Zealand and compared identical drugs and came up with a cost saving of $1.3 billion. If you multiply that 43 per cent and turn that into 100 per cent, it is probably in the order of $2½ billion a year in savings. This is a back-of-an-envelope calculation, and I would encourage you to speak to Professor Stephen Duckett about it. He will be able to give you greater input, but I think their estimates of savings were really quite conservative because they did not assume that same pattern of behaviour would go for the whole range of drugs. It is that order of magnitude, which then would translate into $130 or $140 per Australian.

Senator CAMERON: I never find that very helpful; per Australian. What is your estimate of the overall cost to the system? You are saying here: this is an area you have focused almost entirely on. I just need to get an understanding: what is the percentage saving in the overall cost of health delivery in this country?

Dr Whitely: As I said in my opening comments, we are endorsing the Grattan Institute's work and I do not pretend to have the same expertise as they do. I have read their work, and my estimate of savings would be somewhere north of $2 billion a year, given their conservative estimate and assuming the same patterns continued. That does not take into account the fact that, if you were to tighten up prescribing processes, reduce ineffective off-label prescribing you would save a lot to the PBS, because you would stop paying for unnecessary medications. I think that is quite a conservative estimate but, as I said, our major focus is on those safety, efficacy and transparency recommendations. That is the unique and original part of our work.

Senator CAMERON: I have had a look at your submission and it is basically about information asymmetry.

Dr Whitely: I am going to plead ignorance. Meaning?

Senator CAMERON: That means if you cannot get the information, you cannot make cohesive and proper decisions.

Dr Whitely: That is right. That is true of regulators. It is true of people who want to oversight the operations of regulators and is also true of consumers, because consumers are not given adequate digestible information when they make these decisions. You need to have transparency to regulators—in other words, all the information is that is available on a particular drug needs to be made available to regulators, not just the information that the pharmaceutical industry chooses to provide them with. It needs to be open to scrutiny by the media, but also we need to have a system in which consumers are actually given proper access to reliable information.

Senator CAMERON: You have actually identified in your recommendations a number of ways to do this. I come back to this power and influence of the pharmaceutical companies: what other players in the health system have got power and influence that you think needs to be open to more scrutiny and have a bit of light shone on it?

Dr Whitely: I think they are pretty big target. The pharmaceutical industry produces some wonderful life-saving products. One of the products that I am critical of is—

Senator CAMERON: That is not what I am asking you. Let me ask it again. You have highlighted the pharmaceutical industry as being an industry that has got power and influence. They are obviously getting a rent out of the Australian government and out of the system based on your submissions. You are an advocacy group and you have to have ideas about other areas as well. In what other areas is there an information asymmetry where the public need to get a light shone on power and influence in the health industry?

Dr Whitely: I do not want to stray beyond our area of expertise. This is a comprehensive submission that concentrates on the operation of the pharmaceutical industry. I can come up—

Senator CAMERON: This is not all you do, is it?

Dr Whitely: No, it is not all we do.

Senator CAMERON: I am asking you about other things you do as well. You are an organisation for health consumers. Consumers do not just do pharmaceuticals. I am interested, while you are here—you have made a terrific submission on this, a detailed submission, that is before us—in other aspects of your health consumerism.

I am asking you: if you have identified this area that needs to be opened up to more scrutiny where power and influence is deleterious to the operation of the health system, what other areas are there? That is all I am asking you.

Dr Whitely: I can give you half-baked thoughts but I do not think they are of great quality. I have not got the authority. I report to a board and I get their authority to speak on particular issues. I also might point out, I have been the acting director of the Health Consumers' Council for three months. A lot of this work is derived from my previous work and my PhD thesis so I do feel comfortable. I am not going to overstep—

Senator CAMERON: So, you are really focusing on your PhD thesis as distinct from your general obligations under your new position?

Dr Whitely: Not at all. We do a lot of advocacy work that drives our work. We do individual advocacy work for people on a daily basis—

CHAIR: In what areas then do you do the advocacy, and what are the areas of concern?

Dr Whitely: We have an Aboriginal advocacy service that advocates across the board in Aboriginal health, access to health et cetera. We also have an individual advocacy service where someone will ring up and they will say, 'I've got a problem with Dr X. Can you help us?' We have made extensive submissions. One of the submissions we made with regard to that, one of the common complaints we get, is people who feel that they are involuntary patients in the mental health sphere and have had their rights violated. We made an extensive submission to the WA parliament on the rights of mental health patients, and trying to protect the rights of involuntary patients there. That is work we do. We are cautious about stepping into big arguments without having an evidence base for what we do. We advocated in that sphere—we made an extensive submission on the mental health bill that is just been debated by the West Australian Parliament—and we are advocating in this sphere at the moment.

Senator CAMERON: Let me come back to pharmaceuticals stuff—and I will be pressing you on other issues because I do not know that you would need a board decision to tell us about well-established policy within your organisation or issues that you deal with. Anyway, that is up to you. I want to ask you about the Medical Research Future Fund. Given the problems and issues you have raised with the pharmaceutical industry, how influential do you think that industry would be in this Medical Research Future Fund? They are the people that do more research than anyone else in this area, so what are the problems of establishing a big fund when you have got an undue influence from the pharmaceutical industry? What are the implications on this issue? This is an area of pharmaceuticals.

Dr Whitely: They are incredibly well-organised and they game the system incredibly well, which I think I detail in our submission and I am prepared to talk about that at length. There will be a big pot of money and based on past history—and it is not just Australian history but internationally—they will game the system incredibly well. They are incredibly good at promoting thought leaders and opinion makers and driving disease awareness campaigns, for instance. I was a member of the Western Australian parliament and one of my former parliamentary colleagues, Alannah MacTiernan, who is now a member of the House of Representatives, was telling me the other day just how inundated she was when she arrived in Canberra by representations from disease awareness support groups and how prevalent that is in Canberra. I am not suggesting all of those disease awareness support groups do the wrong thing but, internationally, two-thirds of disease awareness support groups are directly funded by the pharmaceutical industry. They game the system incredibly well and, unless you put in strong safeguards in place and take a proactive approach to start with, they will game the system incredibly well, if there is a big pot of money there.

Senator CAMERON: It is a bit hypothetical at the moment, because I cannot see this Senate passing legislation that says to the poorest people in the country: 'You will provide $7 every time you go and get a CT scan, MRI or every time you see the doctor.' I do not think we are going to be saying: 'That's okay, so we pass this money onto your future fund that is being gamed by the pharmaceutical industry.' I think the point you are raising here is very important for this inquiry. Do you agree that some of the poorest, most disadvantaged consumers would then be subsidising research that would maybe be done anyway by the pharmaceutical companies and they will game that fund?

Dr Whitely: I think that is a very real possibility. I think it is likely, if you look at history, and I think it already happens in a sense. I have highlighted the fact, as demonstrated by the Grattan Institute, as consumers we pay too much in taxes. I think, if there is another pot of money, they are very good at it and they will game it.

Senator CAMERON: Given your interest and expertise in this area, are you aware if there has been any analysis done or any information available in the public sphere about how this gaming by pharmaceutical

companies of a potential medical research future fund can be dealt with? Are there are checks and balances that you have heard being discussed?

Dr Whitely: No, I have not.

Senator CAMERON: How do you stop the gaming if we put in a fund? It does not have to be the fund that is there now but you have got a big future fund for medical research, how do you stop the gaming by the pharmaceutical companies?

Dr Whitely: I think you would have a process of evaluation that is driven by people who are truly independent, have no conflicts of interest, have multidisciplinary expertise, who assess applications from outside their area of expertise—which may sound a little strange, but, in other words divorce them from not just commercial interests but emotional and professional interest in it—and you would have an open process whereby any decisions that were made, the rationale of it, would be fully open to the public for evaluation. I think transparency is the great guide, and managing and eliminating in that situation conflict of interest is the great guide.

Senator CAMERON: Is there anything you can point us to?

Dr Whitely: No.

Senator CAMERON: Coming back to the budget: we have heard from Grattan; we have heard from the various colleges; and we have heard from other consumer groups looking after people in the health system. Some of the analysis we have heard is that the budget is distressing to many people in the health area, that it is crazy, it is confused, it is peculiar, and it is regressive. Have you given any thought to the budget in terms of it implications on health consumers?

Dr Whitely: We have.

Senator CAMERON: What conclusions have you come to?

Dr Whitely: We have already highlighted that we think the $7 co-payment is potentially regressive. If you have got people on fixed incomes and limited incomes, as Dr Jones pointed out, it is going to be a far greater proportion of their income than people on higher incomes. That is necessarily a regressive outcome.

Senator CAMERON: That would be consistent with 99.9 percent of the submissions we have had. The other area of the budget is the general decline in funding payments. We have had the New South Wales Department of Health—there has been a leaked document to say that this would cost them a huge amount of money. We heard the South Australian government yesterday come in and say that the budget cuts will mean massive amounts of people flooding into their emergency services areas. What are the implications of this for your consumers in Western Australia?

Dr Whitely: I have a feeling you are asking me a question you would like to be asking of people who have been invited but cannot attend. I am not aware of—

Senator CAMERON: You are part of the health consumers. We have had submissions from other health consumer groups. We have had submissions from the Grattan Institute, we have had submissions from governments and they are all saying this is a problem. I am just asking you: do you believe that this is a problem in Western Australia as well; that if the $7 co-payment comes in that there will be an increase in the usage of emergency services at hospitals?

Dr Whitely: I think it is a logical conclusion. It is a price signal, is it not. If there is a merit to the $7 co-payment it is a price signal. The problem will be that it will necessarily encourage people to shift, and that is a form of cost shifting from the Commonwealth expenditure to the state health department. That is just a logical outcome.

Senator CAMERON: When you say if there is merit it is a price signal, but your submission says that you do not see the merit in it.

Dr Whitely: No, in our verbal submission we said we do not see the merit in it and, yes, I think there will be a degree of movement from GPs to people who will go into emergency departments. I think that is a logical outcome. I have not done any extensive research on that but it seems completely and utterly logical to me.

Senator CAMERON: Do you see your organisation having a look at the budget in more general terms rather than this specific area of pharmaceuticals? It is an area I do not underplay for a minute and I appreciate and thank you for bringing that to our attention because it is an area where we have not had a huge focus on. Do you see that you will be doing more work on the broader issue of health funding?

Dr Whitely: Yes, we have a whole bunch of priorities that are on our agenda.

Senator CAMERON: You are both fairly new to the organisation, are you?

Dr Whitely: I have been there since December and Dr Jones has been—

Dr Jones: I have just come on as research and policy so we hope to focus more on that area in the future. Yes, I am fairly new but that is what I have been employed to do.

Senator CAMERON: You are funded through the state government?

Dr Whitely: The West Australian Health Department is our major source of funding.

Senator CAMERON: The—

Dr Whitely: WA health. The WA government. WA Health Department is our major source of funding, but we operate independently and there has never been an issue over that relationship.

Senator CAMERON: There is a tradition that you speak out on behalf of consumers and if that is a problem for the government, so be it.

Dr Whitely: Health Consumers Council has been around for 20 years and has had the same ED for 17 of those years and has a reputation for being fairly robust in its commentary.

Senator CAMERON: Do you have any expertise in the area of digital imaging? Have you had a look at that?

Dr Whitely: No.

Senator CAMERON: People are now focusing on the upfront payment that consumers have to make to digital imaging. You have not looked at that?

Dr Whitely: No, we have not.

CHAIR: One of the things that we have been hearing from those lobbyists in Canberra in recent times is that there has been a significant change in the science around cancer drugs that are now able to be far more targeted because of the reading of the human genome and increasing understandings about how complex proteins interact. For people with a rare cancer or within a cancer group of, say, liver cancer, it is now possible to diagnose 16 or 17 types of cancer that are more responsive to one treatment than another and that there is predictive capacity to do that. Obviously the sample sizes that have been used in the past to determine whether PBS drugs were good value for money—and that is the language you have used and it is the language of common parlance—needs to change if we are looking at smaller populations and estimate the value of the drugs in prolonging life. There must also be good value for the money invested by taxpayers, who may also be recipients of that investment. Do you have anything to add to this conversation about assessing the value for money of new drugs using new technologies for smaller population samples?

Dr Whitely: It is a much easier process for established drugs than it is for new and emerging drugs, and we need to encourage technological innovation. For those of us that follow medical research, there are often breathless claims of imminent breakthroughs that are not backed up in reality. So, yes, we need to have a system that brings to market and subsidises new innovations, but there need to be robust processes around that because, again, one of the drivers is to create new markets and new demand. Also, even if new drugs are brought to market, it would be really sensible to do international comparisons of price, because I think the demonstration from the Grattan Institute's work is that you can get the same drugs at a lower price if you are prepared to negotiate very aggressively. If you go back 25 years, as I highlight in our submission, Australians actually paid less per drugs for their Pharmaceutical Benefits Scheme than people in New Zealand. But there has been this massive explosion because we have negotiated less well and less aggressively for the last 25 years in a sort of mistaken belief that it would lead to a growth in manufacturing of pharmaceuticals in Australia, which simply has not materialised.

What I am saying is many of these drugs will produce benefits and they should be licensed and they should be brought to market; but just because a drug is life saving does not mean you should not still be exploring how much they are paying for it elsewhere in the world. It is a simple comparison to make. Do not just accept it: 'This drug needs to be subsidised.' 'Good, what does it cost?' That is effectively, up until recently, how the pricing system works.

CHAIR: We have had some quite significant changes in the last three or four years, and some evidence I think we received from the Victorian AMA in their submission indicated that the PBS was in fact not one of the crisis points that the government is alluding to in its crisis around health language. Indeed, they made the same comments about the sustainability of Medicare and people's access, and about the sustainability of health funding to the hospitals as well. The language of crisis that is the signature of this government in the area of health has been well and truly disputed in all areas, including in the area of the PBS. Despite the valid points that you make in your submission here, I would not want it to be considered that there is a crisis in this area.

Dr Whitely: I would think that the demonstration of the comparison in the Grattan Institute's work between Australia and New Zealand and between Australia and England and how much we spend for an equivalent service indicates that there is no crisis that cannot be easily fixed by ensuring that we get value for money from our current expenditure. I would agree that we do not need to run around finding new ways of raising money. There is a very obvious way that we can save a significant amount of money while purchasing services that we are currently purchasing.

CHAIR: And by further reform. Thank you very much for your time today, Dr Whitely and Dr Jones. We appreciate the quality of your submission.

HERSEY, Mr Paul, Chief Executive Officer, Perth South Coastal Medicare Local

RYAN, Mrs Brenda, Chief Executive Officer, Goldfields-Midwest Medicare Local

Evidence was taken via teleconference—

[9:54]

CHAIR: Welcome. Mr Hersey and Mrs Ryan, it is good to have you both here because you represent two very different Medicare Locals in terms of where you come from.

Mrs Ryan: I was elected to Medicare Locals advisory committee as a representative for rural WA. I am currently the CEO of the Goldfields-Midwest Medicare local which covers a geographical area of almost 1.4 million square kilometres. The challenges of covering such a vast area are numerous, in particular maintaining workforce in the more remote regions.

The uncertainty of the future at the moment is concerning with many health professionals considering their options moving into 2015. The late announcement of the boundaries caused some concerns for subcontractors and staff alike. To lose staff at this point in time would be problematic to service communities for the future. The board of the Goldfields-Midwest Medicare Local is highly concerned with maintaining service continuity at the current level. The pressure of reduction in funding has not only put more uncertainty into the mix, but there are many of our staff undertaking two or three roles, which we recognise is unsustainable and untenable.

Over the past 2½ years GMML has worked hard to engage with stakeholders and communities. Many of our stakeholders have expressed deep regret that GMML will cease to be funded post June 30, 2015, and many have truly expressed their belief that there has been a significant improvement in primary health care services within our region. Some examples, but not limited to, have been securing dieticians, diabetic educators, physiotherapists and other various allied health services to communities who previously did not have access to these valuable services. Furthermore, GMML has been instrumental in the improvement of after-hours services in both major regional towns of Geraldton and Kalgoorlie. When I hear what the new PHNs are supposed to be doing differently, I cannot help but think that is what GMML has already been doing, and doing extremely well.

The cost of winding up an organisation that is already ticking all the boxes seems such a waste of resources. Furthermore, given the efforts of GMML staff to hit the ground running on 1 January 2012 then to wind them up after such a short time is indicative that, no matter who is in office, all parties could agree that change takes time and this should not be allowed to happen again.

Changing a health system should not be based on political ideology; it should be based on outcomes and, although something is not working well in one area does not mean it is failing in others or in its entirety. GMML has always recognised the importance of GP engagement and, as such, has supported the local GP networks which still exist today by way of administration, organising ongoing CPDs on behalf of the GP networks and welcoming all new health practitioners and students alike. Furthermore, we acknowledge that with more interaction and consultation in the early days, GMML could have tackled things differently; however, the times were moving at such a fast pace we got caught up in a whirlpool of old. Fortunately, it did not take long before we enthusiastically embraced a different tack which enabled us to build on GMML's principles of inclusivity and equality.

Moving forward, GMML accepts that competition is necessary to ensure a legitimate approach to market; we have no problem with that. Provided that consideration is given to the complexities of the large geographical boundaries; socioeconomics; the complexities of community and stakeholder relationships; and, most importantly, the cost of health service delivery in the more remote communities. In the more remote communities it will be costly to adapt a pure purchasing model so therefore further consideration will need to be given to the intricacies of buying a service versus providing a service.

I would like to reiterate in conclusion what I have said before: relationships take time to develop and, during my time as CEO with GMML, I felt in January this year only two years after inception we were on the cusp of cementing a significant change. GMML had begun to change the way primary health care was delivered within the region, and this was done primarily through listening to our consumers. The quantum leap forward was that GMML developed a model of hubs at a local level and forums at a community-regional level. It was through this mechanism that we were able to bring community members and stakeholders to the same table. After two years in the making, the number of attendees had started to increase dramatically and changes were occurring and voices were being heard.

As we are all aware, communities in the primary health care sector are about to see another change, and GMML's prime concern is that our communities and stakeholders will have to endure the uncertainty, disruption

and confusion of further changes. Moreover, we will not be as accepting of change this time as last time. More significant than any of the above is the long-term knowledge, the understanding and the experience that have been accumulated along the way. To lose what has been learnt would fundamentally undermine all that has been gained. I think you for the opportunity to talk to you today.

CHAIR: Thank you, Mrs Ryan. I appreciate you taking the opportunity to put on the record some of the work that you and your staff have been doing with that Medicare Local. We will come back and ask you some more detailed questions. Mr Hersey, my understanding is that you represent a very different part of Western Australia and we would like to hear from you as well.

Mr Hersey: I made an opening statement last week but I would like to provide a little bit more information and context in relation to my own Medicare Local. Perth South Coastal Medicare Local consists of an area of 3,000 square kilometres in outer metro and regional Western Australia and it is an area where there is limited private market activity. As a result of that, the Medicare Local delivers a number of services itself and has established itself as a very cost effective NGO provider, delivering evidence programs within a framework of strong clinical governance. Major achievements include the procurement of after-hour services, which have been brought to the southern parts of the Medicare Local for the first time in memory; strong chronic disease programs; and strong mental health programs. Perth South Coastal's programs are available at no- or low-gap cost to members of the community.

My concern about the transition to Primary Health Networks is that this service continuity needs to be maintained. People accessing services are the most vulnerable in the community and, in many instances, if these types of programs are not available, people will simply not access the healthcare system, which would obviously have a detrimental impact on the individual and, down the line, on the acute care system.

I have gone on the record previously indicating my support for the concept of Primary Health Networks and the opportunities presented through larger organisations, GP-centricity and an ability to take an equal seat at the table with state health and other state-wide bodies. However, my concern in my area is about ensuring a smooth service transition and, in my own case, running a Medicare Local that hopes to transition to a service delivery organisation to continue to be able to deliver those services in spite of losing in excess of $3 million in core funding.

CHAIR: Mrs Ryan, can I ask you to put on the record immediately what your FTE is and how many staff you have, and the wind-up costs for your Medicare Local.

Mrs Ryan: The FTE at 30 May was 66.6. As of yesterday, it was 47.8. Could you repeat the rest of the question, please?

CHAIR: The costs to wind up your Medicare Local?

Mrs Ryan: The cost to wind up our Medicare Local was $900,000.

CHAIR: Does that involve any leases on property?

Mrs Ryan: Yes.

CHAIR: Mr Hersey, just again for the record?

Mr Hersey: Our FTE is a moveable feast. As of today, it sits at a approximately 81. And our wind-up costs are just under $1 million.

CHAIR: Thank you very much. Senator Cameron.

Senator CAMERON: I am happy for either of you to answer questions on these issues. I want to go to the Horvath report. The Horvath report has been described to us as 'confused' and 'peculiar'. In my reading of the Horvath report and my reading of the AMA submission you really cannot put a cigarette paper between the report and the submission. What do you say to the critiques in the Horvath report of the Medicare Locals? I think some of the issues they are talking about are fragmentation of care, ensuring that the role of general practice is paramount and the need for improved financial performance. Can we go to those three points firstly?

Mrs Ryan: I got the general practitioner and I got the cost of service—what was the other one that you wanted to discuss?

Senator CAMERON: The issues were the fragmentation, the role of general practice and the financial issues—that is, improving the financial performance.

Mrs Ryan: Based on the—

Senator CAMERON: Sorry—when I am talking about the financial performance it is really the Deloitte audit. I am not sure if any of you have read that.

Mrs Ryan: I have not, but Mr Hersey was involved in the Deloitte audit so he is probably better to speak about the Deloitte audit.

I would just like to say that from the Goldfields-Midwest Medicare Local point of view, GP engagement has always been high on the agenda. I was also the chief executive officer of the GP Network. What changed between the GP Network and the Medicare Locals as far as our Medicare Local goes was nothing. We maintained the high level of GP engagement that we did at the GP Network. We continued that into the Medicare Local, so there was no difference.

If I talk about cost service—and I have not read the Deloitte report—and look at the cost service in a geographical area, such as Goldfields-Midwest Medicare Local, we are very cost efficient. We mainly employ people; we do provide services. I will use the example of an employed social worker. On average, they cost $55 an hour. If I contract or purchase those services it costs me $140 an hour. When you have to travel six hours to get from point A to point B, the cost of the purchase is still $140 an hour with no clinical engagement, as opposed to sending someone to the remote community at $55 an hour times six. The sums just do not add up.

We are in an area of very high market failure—market failure is yet to be defined by the government, but I know what market failure is in our area. For cost efficiency, we are doing very well.

Fragmentation: it is very difficult to move away from fragmentation as I see it because we have Commonwealth funding primary healthcare services at the state level and then we have primary healthcare services being funded at a Commonwealth level. Some of the Commonwealth funding is going into state health for state health to provide primary care services. The fragmentation that we see lies between those two organisations trying to provide services. Through the hubs and forums mechanism that we started to develop, we started to see the fragmentation reduced. Duplication was being reduced and we were prepared to work with other service providers to take up the service gaps.

That is my view on how we have dealt with those three items. But the most important thing is that GP engagement has always been a priority on our list. In fact, at one stage, 50 per cent of our board were general practitioners.

Mr Hersey: Firstly, in terms of the role of the general practitioner: obviously, I can only make comments about my own Medicare Local. Dr Horvath did not ask me anything, so I am providing a perspective which he probably has not heard. I have already noted that my Medicare Local is a significant deliver of services. We see many patients. Patients simply cannot get into our programs unless they are referred by a local general practitioner. So the fact that we are such a busy health services organisation implies that not only are we engaged with general practice but we also have their confidence in the services that we are delivering.

GPs in our catchment are very busy. It is an area of workforce shortage and the Medicare Local has adopted a business model to try to provide as much support to those GPs as possible, mainly by providing access to ancillary health services so the GP can refocus on their own role as a general practitioner. Obviously, GP practices are small businesses and some GPs have different business models. For example, they may have a focus on chronic disease in their delivery of services. If that is the case we are very adaptable and work closely with the GP. For example, we run a diabetes education scholarship program, whereby we actually pay course fees at Curtin University for diabetes educators who are working as practice nurses in a local practice. So we put the value proposition to the GP, 'If you want to look after the chronic disease management of your patients, you are very welcome to refer to our services. Or if it is something that you want to do yourself within your practice, how can we support you to do that?'

Senator CAMERON: It is a bit difficult to try to come in on these issues. It is one-way; while you are talking we cannot ask you further questions. Can I ask both of you briefly: were you consulted by Professor Horvath? Did Professor Horvath come to any of your Medicare Locals? And where you consulted by Deloitte?

Mrs Ryan: From Goldfields-Midwest Medicare Local, no to both.

Mr Hersey: From my perspective, I was not approached by Professor Horvath. I was, however, part of the Deloitte review, which I think visited at six sites. I think the review made a note that there were no major issues identified. My main concern with the Deloitte process was that it looked at a point in time. It was always firmly in the rear-view mirror and by the time the audit took place it looked at the 2012-13 financial year, which was when Medicare Locals had just been established. With any issues that Deloitte raised with me, a typical conversation would be, 'That may have been the case at that point in time, whereas this year we are doing things differently.' Deloitte acknowledged that throughout.

I joined the Medicare Local from PricewaterhouseCoopers and feel that for a medium-size NGO the financial systems, risk management and internal controls in place are very strong. And that is a view shared by our auditor.

Senator CAMERON: Okay. Can I go to Professor Horvath's recommendations? Mr Hersey, can you just bear with us? The sound is pretty difficult from your side, so I will ask Mrs Ryan to answer and if you have a different point of view or you want to have some input, I am happy for you to come back in—if that is okay?

Mr Hersey: Okay.

Senator CAMERON: Sorry about that. Mrs Ryan, the recommendations from the Horvath review—there are 10 of them, and I want to go through very quickly the recommendations and get your point of view on them.

Recommendation 1: The government should establish organisations tasked to integrate the care of patients across the entire health system in order to improve patient outcomes.

I understand that is what Medicare Locals do anyway.

Mrs Ryan: I would have said that is what we are doing already anyway as well.

Senator CAMERON: Okay. Then:

Recommendation 2: The government should consider calling these organisations Primary Health Organisations (PHOs).

I do not think I need any comment on that. I do not know why that would be the second recommendation but it is.

And then:

Recommendation 3: The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal.

On this one, we have had submissions to say that whereas the GP is very important that they are not the only input to good health care for individuals through Medicare Locals. What is your comment on that?

Mrs Ryan: Holistic health care requires a team of health professionals to improve outcomes. GPs are important but there are other important health professionals that improve health outcomes.

Senator CAMERON: Okay. Recommendation 4 has a number of points and I will go to them very briefly:

Recommendation 4: The principles for the establishment of PHOs should include:

- contestable processes for their establishment;

I am not looking for a comment on that because you guys are established—

- strong skills based regional Boards, each advised by a number of Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;

I thought you were well-based with your regional boards anyway? What is the issue here that Professor Horvath is raising?

Mrs Ryan: As you commented, we are already doing that. We have clinical governance advisory committees, we have a skills based aboard; we have all of those already. That is what we have been working towards over the last 2½ years and they are well in place.

Senator CAMERON: The next one is:

- flexibility of structure to reflect the differing characteristics of regions;

I think that is in place?

Mrs Ryan: Given that we look after 1.4 million square kilometres and that other Medicare Locals cover vast regions as well, that is most definitely in place.

Senator CAMERON: And:

- engagement with jurisdictions to develop PHO structures most appropriate for each region;

Mrs Ryan: We have been engaging with jurisdictions and government bodies to ensure that has happened.

Senator CAMERON: Yes. And:

- broad and meaningful engagement across the health system, including public, private, Indigenous, aged care and NGO sectors; …

Is that being done?

Mrs Ryan: It has been, very much so. But I would admit that we probably have not engaged with private health insurers.

Senator CAMERON: Okay. And:

- clear performance expectations.

Mrs Ryan: Our reporting framework is quite clumsy. It would be better if we had a refined reporting framework, but I do not think it needs any more clarity. We have clarity by how we report to the government and how we plan with the government.

Senator CAMERON: Right:

Recommendation 5: PHOs must engage with established local and national clinical bodies.

Mrs Ryan: We do that already.

Senator CAMERON: Right. And:

Recommendation 6: Government should not fund a national alliance for PHOs.

I am not really asking for a comment on that, unless you want to indicate the benefits of having a national alliance?

Mrs Ryan: No.

Senator CAMERON: And next:

Recommendation 7: The government should establish a limited number of high performing regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs. These organisations would replace and enhance the role of Medicare Locals.

What is happening there?

Mrs Ryan: My feeling, particularly having worked in a region—and GMML covers 1.4 million square kilometres—is that it is hard enough with a big geographical span, without making it even bigger. In order to engage truly and meaningfully, it has to be done from a local level; it cannot be done from miles away. It just cannot happen.

Senator CAMERON: Recommendation 8 is:

Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered.

Do you know what that is about?

Mrs Ryan: Yes, I do. From our Medicare Locals perspective, since the change to the after hours PIP funding payment we have seen a significant increase in the amount of after hours that we have been able to provide within our regions. Talking to some of our stakeholders, they actually prefer this system, as opposed to the system before we got the after hours funding money.

Senator CAMERON: That recommendation also says:

The government should also consider how PHOs, once they are fully established, would best be able to administer a range of additional Commonwealth funded programmes.

I am not sure what that means. Do you have any idea what that recommendation is about?

Mrs Ryan: I do not. But Medicare Locals are currently administering other programs through the Commonwealth funding.

Senator CAMERON: This is one of the contentious ones:

Recommendation 9: PHOs should only provide services where there is a demonstrable market failure, significant economies of scale or absence of services.

What is that about?

Mrs Ryan: From our region there is definitely a market failure, and the cost of providing health services to remote areas via a purchasing model is too costly. The economies of scale come from providing the services within. You could look at where we provide services in the major regional centres, but what works for one will not work for all. You cannot have a holistic statement saying that all PHNs must first of all look at providing a purchasing model. Consideration needs to be given to buying a service versus providing a service, particularly in rural-remote areas. We have a workforce shortage already. We do not want to be flying people in from major regional centres out to the remote because the cost just increases.

Senator CAMERON: Recommendation 10 is:

PHO performance indicators should reflect outcomes that align with national priorities and contribute to a broader primary health care data strategy.

Could you explain that to me?

Mrs Ryan: Medicare Locals are already doing that. We know what the key performance indicators are. A lot of the Medicare Locals were formed from the GP networks where they did not have the flexible funding. We

already know where those key performance indicators are and what they are. We have done comprehensive needs assessments to look at where our gaps are, what our chronic diseases are, and where we need to focus the money. So we have already done that.

Senator CAMERON: Thanks very much, Mrs Ryan. Mr Hersey, do you have any issues that you want to add?

Mr Hersey: Just a couple of brief points. Firstly, the road to get to the point that Mrs Ryan has articulated has been quite long and painful. We did not get everything right from day one, but I think Medicare Locals in general, after two to three years of hard work, are at a point where they are relatively functional and quite strong primary care organisations. After hours care in our catchment is better than it ever was under the PIP scheme in terms of coverage, and it is well supported by local general practitioners.

Just one other point of note: prior to the appointment of Professor Horvath, the department had started a process of putting in place process, output and outcome performance measures against Medicare Locals. I was part of a committee that was working with the department to develop those KPIs. That work stopped once the review into Medicare Locals was announced.

Away from the role of the general practitioner, I do not really think it is relevant to debate how central or otherwise the GP should be. Medicare Locals did what they were directed to do. With the change from the divisions of general practice to Medicare Locals there was an increased Commonwealth focus on primary care. That is quite correct in my opinion, but obviously the Medicare Local can do what it is directed to do from the Commonwealth. If that means greater focus on the GP or even exclusive focus on the GP, that can be done.

CHAIR: One of the areas that has been a site of concern is the area that you both spoke about there: after-hours access. It has been indicated to us—not formally but in conversations off the record—that a number of GPs were upset about the removal of PIP funding when the needs analysis was done in a range of Medicare locals and models of after-hours care were altered. It has been put to me that this pronouncement of GP centred PHNs is a response to GPs not being happy about losing their autonomy in that area and being accountable through Medicare locals. Could you go on the record to say if that is the case in your view or in any situations that you are aware of—not necessarily in your own patch?

Mr Hersey: It is difficult to speak beyond my own patch. In our area there was some disgruntlement from some GPs when Medicare locals became responsible for after-hours. I can confirm your point. But the central principle of the after-hours program is that it has enabled the Medicare local to negotiate very hard with a large pool of funds with, for example, locum services, whereas individual practices do not have that negotiating grunt in their own right. So we have managed to bring to the south—the whole Medicare local catchment—an after-hours service which has simply never been there before. So I agree with your points that there could be some disgruntlement for being taken out of the loop or held more accountable for how after-hours is delivered; but, from a system performance perspective, in our area it has been a massive improvement.

CHAIR: Mrs Ryan, you also indicated that there was an improvement in after-hours because of the changes as you shifted away from the previously constructed PIP distribution of money. Could you speak to the changes in access and outcomes in your region?

Mrs Ryan: Yes. I will use two very good examples. There are many, but I would like to talk about two which we believe are key wins for our Medicare locals. There is one practice in Geraldton that we supported in the infrastructure of this after-hours clinic. He developed it in a low-socioeconomic area. He signed a contract to say that he would only bulk bill pensioners, healthcare card holders and children under 16, and we helped develop his business within the Geraldton region. In Geraldton there was previously only one after-hours service during the week, and that was a commercial business. Low-socioeconomic people just could not access that service. There was no disgruntlement between the commercial entity and the purely bulk billing after-hours services. In particular, the commercial business recognised that there was a need to have a bulk billing clinic, and they were not prepared to go there, so they were quite supportive in that area. That after-hours clinic is now open 15 to 18 hours during the week. It is very well patronised. The same scenario occurred in Kalgoorlie, which is a major regional centre in the Goldfields. After-hours services were limited only to those who could afford it through commercial after-hours MBS item numbers. We did a very similar thing to what we did in Geraldton: helped one of the GPs with infrastructure and advertising and supported him over a period of six months. He now runs an after-hours services clinic that has 24 hours during weekdays and he also opens on Saturday afternoon. They are two very key success stories.

In the beginning, what we did with the PIP payment in the first year was maintain the PIP payment that all GPs got prior to us taking over. Then in the second year we put out for tender and asked the GPs to apply for it.

[inaudible] other areas that were providing after-hours services. So we did not have a lot of disgruntled GPs. Additionally, with change processes they were not happy with, over the 12-month period they lessened their grief and began to like the system. We have had very good feedback from both the commercial and the bulk billing.

CHAIR: I feel like Professor Horvath did not speak to the same GPs.

Mr Hersey: Could I make one more point on after-hours as well? I think there is a misnomer in the report. When we rolled out our after-hours program, we invited existing PIP recipients to continue in a very similar scheme. The response to our scheme was so positive that on day 1 we had 17 providers who wanted to continue receiving PIP-like payments, and today we have one. So all the practices—and they have seen the arrangements we have put in place and supported—have been very happy to fit into that model of care for the delivery of after-hours services across the catchment.

CHAIR: That was very helpful. Senator Siewert.

Senator SIEWERT: I am particularly concerned about the size of the areas in Western Australia that the new arrangements are going to have to deal with. Mrs Ryan, could you give us an update on what you understand are going to be the new arrangements and catchment areas outside the Perth metropolitan area?

Mrs Ryan: As we know, the boundaries have not been announced yet. There is a possibility—this is only hearsay—that there may be one rural PHN in Western Australia. There is a possibility that there may be two, the two being the Goldfields/Mid West/Kimberley/Pilbara regions as one with a population of about 250,000 and the South West Medicare Local boundaries which are already in place. There is a possibility that could end up being one PHN with a population of approximately 400,000. My concern is that it is difficult enough being a Medicare local that has to cover 1.4 million square kilometres. I know we only have a population of 127,000. Geographically it is very demanding and very difficult. For me, I do not believe a whole-of-state PHN would be as functional as two. I do not believe even two is enough for an area such as Western Australia. I believe that the boundaries that are in place are how the PHNs should look in the future. I cannot reiterate enough the costs and difficulties of having a business spread over such a large area.

Senator SIEWERT: Thank you. That is exactly my concern and what I understood was currently on the drawing board. I have had strong concerns expressed to me from the Kimberley about the make-up, and it sounds like it is the same in the southern part of the state. Could you quickly go over the issues that will arise from having such a big area?

Mrs Ryan: Number 1 would definitely be workforce. It is extremely hard to maintain workforce in these regions. It is also costly. My travel and accommodation budget for my clinicians is horrendous. I know that the clinicians will still be in the respective areas, but they are the two major concerns. Also, from an organisational culture point of view, to have an organisation, wherever it may be based—and it will most likely be based in one of the regional centres—it is very hard to maintain the cohesiveness that is required for those who are working in very isolated areas. GMML has people based in Exmouth. I have a lady that was in Laverton. I have a lady in Esperance. They are working very autonomously, and it is very hard to keep them engaged. They feel isolated and quite often leave due to the isolation. I know that Western Australia will always be faced with these isolation issues; but, the bigger an organisation becomes, the more watered down the staff will start to feel as they are further and further away from wherever the main body of the organisation is. So definitely workforce is problematic.

Senator SIEWERT: Could you do a comparison for eastern states people so they understand the distances we are talking about? Geraldton to Esperance is more than the size of Victoria.

Mrs Ryan: It is about 1,200 kilometres. Geraldton to Kalgoorlie is approximately 1,200 kilometres. Geraldton to the NG lands is about 2,000 kilometres. I use Geraldton as the central point because that is where our main office is. Geraldton to Exmouth by road takes about eight hours.

Senator SIEWERT: So, if we were talking about expanding that up to the Kimberley, it would be an entirely different geographic zone and also, I would suggest, some additional, different health issues as well.

Mrs Ryan: Absolutely. What occurs in major regional centres as a prevalence of disease is certainly a lot different from what is more prevalent in the more remote areas. What is important as well is that the transport system in place in rural and remote WA does not exist. We may have a bus that goes every second or third day from point A to point B, but it is unlike Victoria and Sydney, where you can hop on a train and go wherever. I am not sure you can get on a train and go somewhere rural in New South Wales, but for us here it is very difficult. For the rural and remote areas you can go by car. To get to regional centres you can go by plane. I use this as a classic example. We have two SSL professionals who reside in Kalgoorlie, and they provide very much needed mental health services to what is called the NG lands. They travel out there 10 days at a time. They drive through

all these small communities for 10 days, then they come back and have 10 days off. Then they will go again for another 10 days. So they spend 10 days driving through the desert to go to these Aboriginal communities, and the only way to get there is by car. It is very difficult for people who have not traversed the land here in rural WA to see the distances. To get from point A to point B can be quite difficult.

Senator SIEWERT: Thank you. That takes me to my next point. How would the proposals impact on Aboriginal health? Do you have any comments on how it may or may not impact on the delivery of Aboriginal health services? I have certainly had concerns expressed to me about the potential impacts from Aboriginal health services. Have you looked at that in any detail?

Mrs Ryan: Yes we have. Aboriginal health is high on the GMML agenda. We have two Aboriginal health representatives sitting on our board—one for the Kalgoorlie region and one for the Geraldton region. We do not know where GMML is going to sit with the new PHN. We have not come to any firm decision as to the model moving forward. We have been negotiating with other Medicare locals moving forward. Our board, no matter what happens, has Aboriginal health high on its agenda, and we will be advocating, whatever the PHN looks like or whoever will be instrumental in driving the organisational design of the PHN, for Aboriginal representation on the board and at the local level and that there needs to be an Aboriginal health subcommittee. From the GMML's perspective, we do recognise that Aboriginal health is key. We have been working very closely with AMSs in the past and we will continue working with them moving forward, if that is the direction we decide to take.

Senator SIEWERT: What are the dangers if those issues are not taken on board? What are the dangers in delivering quality health services for Aboriginal people in Western Australia? I am also thinking about the requirements of Closing the Gap.

Mrs Ryan: If Aboriginal health is not a part of the new PHN, we are going to end up with a very fragmented primary health system. Aboriginal health will deteriorate and there will be a risk of losing those very important relationships with the local AMSs. The PHN cannot move forward without a partnership arrangement, in some shape or form, with the Aboriginal health sector. It would be absolutely detrimental to what has been achieved through the Aboriginal Medical Services, Closing the Gap programs, COAG programs and all the Aboriginal funding programs.

Senator SIEWERT: Can I ask a question which you may or may not feel comfortable with. What is your take at the moment on how particular Aboriginal health issues, the things you have just mentioned, have been taken on board in any discussions about the network?

Mrs Ryan: When you say 'the network', do you mean the network existing as Medicare Locals?

Senator SIEWERT: No, I mean in terms of what the PHN will look like.

Mrs Ryan: There has been very limited discussion, because organisations do not know where we are moving forward to. If I talk about the Medicare Locals in particular, because the ITA has not been announced yet, my strong recommendation to any primary health organisation would be that Aboriginal health needs to be high on the agenda. There needs to be consultation with the Aboriginal health services.

Senator SIEWERT: Mr Hersey, in the Perth South Coastal area, I am particularly concerned about the impact of the changes on vulnerable families and community members. In terms of the work that you have been doing in chronic health, mental health and after-hours services, what would be the impact of the changes to the PHN that we need to be really careful of in terms of their impact on vulnerable community members? I am aware that on the south coast there are areas that you cover where there is a large number of vulnerable families.

Mr Hersey: Yes. As I have mentioned before, if those many people were not accessing our services across mental health, Aboriginal health, after-hours general practice and chronic disease, they simply would not be accessing the system until they became an acute patient. The challenge is this: Perth South Coastal will likely evolve into a health services delivery business. The actual organisation is very efficient at delivering a lot of health services, because as an NGO there is a constant focus on: the more efficient we are, the more we can do. We will never service the demands of the area with the budget that we have available to us, but we absolutely try to do our best in a very difficult situation.

As the organisation will not be a Medicare Local anymore, the challenge going forward is the loss of significant core funding. So, although we believe we are extremely well positioned to win contracts with the PHN and all the providers, the challenge will be to maintain a level of service delivery in the face of having core funding removed. There is no doubt that there will be a significant impact. When you have an organisation that has a turnover of about $12 million to $13 million, if you rip out $3½ million it is going to have an impact on your ability to continue delivering services.

Secondly, in terms of timing, from a risk management perspective, if the organisation has not secured contracts to deliver services significantly in advance of 1 July next year, the organisation will start churning staff. You cannot continue to retain staff on the off-chance of winning a contract. You have to make the right assessment for the company. My concern with the process is that for Perth South Coastal to maintain that service delivery capability it needs to be signing contracts in April and May. It is challenging enough keeping staff through the uncertainty. As we get to the pointy end at the end of the financial year, we need to make sure that the PHN is well-enough established to run their processes and award contracts very quickly as well as come up with a payment mechanism to support organisations such as mine to continue playing a very important role in an area of market failure where significant core funding has been lost.

Senator SIEWERT: With the loss of some core funding, who are going to be the people in the Perth South Coastal area who are likely to miss out?

Mr Hersey: In terms of what GPs tend to do, there are some private providers in our region across the suite of services I have mentioned—across mental health, chronic disease, Aboriginal health and after-hours general practice. What GPs will tend to do is refer people into our services if they are of the opinion that a person cannot pay the substantial gap to access services. It is those people who really are our core customers, our bread and butter. They are the people we provide services to—that is, those who cannot afford significant gap fees—and GPs are very aware of this cohort we are looking to target.

Senator SIEWERT: Are you anticipating that you are going to lose some core funding anyway? Am I correct in that understanding?

Mr Hersey: Yes, you are correct. As a Medicare Local you receive core funding money, which is basically simply money to open the doors—that is, to perform the whole function of the Medicare Local. It includes running your finance, running your HR and those types of areas. The Medicare Local also receives program money to deliver specific programs. The position our organisation is faced with is that going forward it can pitch for contracts and program money but it is going to have to use some of the program money that it secures to open the door and put in place that backhand administration, because the organisation will no longer be funded to perform core operations. So when we are pitching for contracts we will have to be very aware not only that we need to deliver health services but that we need to be able to run the back office. If the program money dollars available do not go up, obviously we will be able to do less.

Senator SIEWERT: So it is the services you would offer for people who cannot afford the gap payments. In other words, it is the services for the people who are most vulnerable that you are not going to be able to offer when you lose that core funding. You will only be able to stick to the programs you are funded for.

Mr Hersey: Certainly the capability to offer those programs at the same level would be reduced.

Senator SIEWERT: Mrs Ryan, in terms of the areas you think might not survive the change to the PHNs, are there any areas in the Midwest area that you think will suffer?

Mrs Ryan: Some of our core funding is used to provide services. We look at what it takes to run the back office, and then the surplus that goes into services is distributed over a wide area. It is hard to answer that question because it depends on what the PHN is going to do with the existing services that we use our core funding from. At this point in time, if we lose our core funding then some services will be lost. Until such time as we have had negotiations with the new PHN it will be very hard to answer that question.

Senator SIEWERT: So there is a concern that some services will be lost but you do not know which ones yet, until you get more certainty?

Mrs Ryan: Yes, that is correct.

CHAIR: You indicated in your opening remarks that market failure is basically your lived reality out there. I think you compared a cost of $50 or $55 an hour to $140, that being the comparison between somebody you employ to provide a service as opposed to somebody that you would contract to buy a service. Given your experience and your response to what already was diagnosed as market failure, what do you think Professor Horvath's contribution is to the reality you have to deal with? What does market failure mean? What is he talking about? Is it different, is it the same?

Mrs Ryan: I do not think consideration has been given to market failure in inner Western Sydney as opposed to market failure in rural-remote WA. I do not believe that anybody actually sat down and did some sums for Professor Horvath for the cost of service delivery in rural-remote regions throughout the whole of Australia, in particular Western Australia, as opposed to delivering services in inner Western Sydney or any densely populated major part of Australia. Market failure is not just about the dollars—it is about being able to find the work force as well. When you cannot find the workforce, you have to bring a workforce in and that workforce, wherever you

bring them in from, comes at a cost. The cost increases whenever you bring in services that are not already there. There are some towns where the reality is that those health care professionals are not going to be there. If you look at small towns such as Laverton, Leonora and Norseman, for example, in the Goldfields of Western Australia, you would not find a social worker there, you would not find a podiatrist there, you would not find a physiotherapist there. They are areas of market failure.

Even employing somebody at the cost of $55 an hour, it is still costly to send them to Leonora, Laverton and Norseman, et cetera, but when you cannot find that physiotherapist and the other allied health services in the closest major regional town to those much smaller towns, then you have to look further afield. Then you have to start flying in allied health professionals from South Australia or from Perth. They are the people you are paying $140 an hour or more to sit in a plane, plus accommodation and travel costs. That is market failure—that is where market failure is. I do not believe that anybody really looked clearly at that or even asked the question 'What is the difference between providing a cost in-house versus purchasing a service?'

CHAIR: You are right, it was a very brief report and it did not seem to be steeped in academic literature or have an evidence base. That is one of the important questions that need to be answered. Are any of the funds you have for your Medicare Local being used by you or the department of health or anybody else in putting together a tender or a bid for a PHN?

Mrs Ryan: No, we are not allowed to use Commonwealth funding for that.

Senator CAMERON: If that is the case and you are not allowed to use your existing resources to make a bid, that basically means that you are precluded from any future activities in this area.

Mrs Ryan: No all our funding comes through the Commonwealth. We do have funding from other streams from which we also have retained earnings—not a lot, but a small amount.

Senator CAMERON: So, you could make a bid if you wanted to?

Mrs Ryan: It depends on the resources we have available that are not Commonwealth funds.

Senator CAMERON: Even if you did have the funds, you really do not know what you are bidding for yet, do you?

Mrs Ryan: That is correct. Until we see the ITAs it is very hard to answer any questions about the future of bidding for a PHN.

CHAIR: What is the impact of a $7 GP co-payment on the people that you talked about who are being serviced by the GP now in Geraldton and Kalgoorlie?

Mrs Ryan: The majority of people who live in our region are low socioeconomic. Putting a $7 co-payment on a GP visit would see a lot of people going through the accident and emergency system because they simply do not have $7 to pay. We have worked hard over the last 2½ years to reduce the amount of people who present to accident and emergency by improving after hours services, as I mentioned before. To put on a $7 co-payment—in my personal opinion—is counterproductive to what we have achieved in our after-hours program. There will be an increase in people presenting to accident and emergency.

CHAIR: Part of the after-hours changes were to assist integration with the hospitals who were hitting NEST and NEATs as well.

Mrs Ryan: We have had a lot of interaction with our local hospitals who are redirecting the lower triage patients to our after-hours clinics. There has been some relief for our accident and emergency services both in the major regions of Geraldton and Kalgoorlie as a result of the increase in our after-hours services.

CHAIR: You would also be aware that the tearing up of national partnership agreements and the cuts that happened in the budget this year have led to a shortfall of funding for the health sector over here since 1 July. Are you able to make any comment around hospitals or health professionals who are concerned about the impact on hospitals in Western Australia?

Mrs Ryan: No, I am not able to comment—sorry.

CHAIR: Mr Hersey?

Mr Hersey: From the perspective that any reduction in hospital funding will undoubtedly have significant impact on the primary care sector, we have certainly seen here in WA that where activity based funding and the concept of efficient pricing have been rolled out across the system that it has increased presentations to some of our services simply because there is more demand for us to take up services that are no longer taking place in the public system. You could argue that is ABF working and that for patients who do not need to be seen within the system, such as type II diabetics et cetera, it is a good system outcome that they are now being treated in primary

care. But it certainly does mean that we need to make sure that the primary sector is very strong and stable going forward to continue expanding its role and support the hospital system.

CHAIR: It is the very people with chronic illnesses who will have to pay the most to get the services in the primary care setting. This is almost setting them up to go back into the acute setting where they cost a lot more to look after when they are in a more precarious health position.

Mr Hersey: That is right. Our waitlists for our chronic disease programs have increased significantly since the ABF was rolled out in the public system. And you are absolutely right: we are treating our cohort of patients at no cost or very low cost. That absolutely needs to be maintained going forward to prevent these people ending up back in the acute system, but much sicker.

CHAIR: Thank you Mr Hersey and Mrs Ryan for your work and for your contribution to the work of this Senate committee.

Mrs Ryan: Thank you for inviting me.

Mr Hersey: Thank you very much.

Proceedings suspended from 11:00 to 11:16

DAUBE, Professor Mike, Professor of Health Policy and Director, Public Health Advocacy Institute of Western Australia, Curtin University; Director, McCusker Centre for Action on Alcohol and Youth

[11:16]

CHAIR: Welcome. Thank you very much for joining us today. I invite you to make an opening statement.

Prof. Daube: You probably just want a fairly brief statement from me. How long do you want me to run for?

CHAIR: You have quite a degree of expertise, so 10 minutes would be well and truly valuable for us.

Prof. Daube: I will try and keep it to that. The invitation was at fairly short notice, so I will speak fairly briefly. There are a few points I want to make, and my comments will be broadly consistent with the submission of the Public Health Association of Australia, of which I am a former president.

I will focus primarily on prevention and public health. I will just make four preliminary points. The first is that we have extraordinarily high levels of health status in Australia. We are one of the world's longest lived countries, thanks to the mix of public health and hospital health systems. We also have one of the world's best health systems overall. It is imperfect, but it is still one of the world's best, and WA, I think, ranks up with any. So that leads me to two myths. The first myth we have to deal with is that health systems and problems can be fixed, because they cannot. There is no overnight magic bullet. They are big and they are complex here in WA—about $8 billion a year is the cost of running the health system.

The second comment I want to make out of that is the myth that we spend far too much on our health systems. They are expensive because you are dealing with people, buildings, equipment, drugs and public expectations, but that is the way it is. When you are spending about nine per cent of GDP for just about the world's best health, that is very reasonable, especially compared with the US, at about 18 per cent, and it is sustainable. I think we have got to be very cautious about any panic induced approaches that we should, for some reason, reduce our expenditure on health. We are doing pretty well. We should also be very wary of really rather absurd predictions about how much we will be spending in 50 years time.

My third point is that I do have serious concerns about the Commonwealth reducing its contributions to health spend. The implication of that is inevitably that the states will have to carry a greater burden. We are already talking about 28 per cent, or thereabouts, of state budgets and in the unique system that we have in Australia inevitably if one player reduces their contribution, then the burden is going to fall on others and it will fall on the states because the states are the ones who have to face the day-to-day pressures from population, from media and so on. I speak as a former Director-General of Health in this state and I am aware of the day-to-day pressures that we have. The pressures are on the states to address those, much less on people in faraway Canberra.

I also note that I have concerns about the proposed co-payment scheme. Others with more expertise in that area will have spoken with you and will have made submissions. From my perspective, I have to say, firstly, I simply do not understand the rationale for it and, secondly, I have no doubt whatever that it will increase the burdens on the states and territories, everything from increased pressures on EDs to the flow-on there—why would you not go to an ED if you do not have to pay for it, you just have to wait a while? It will impact on prevention. People just will not go to see their GP if it is not urgent and that will, in turn, increase the costs of our system over time. Two supplementary observations: the first is of course I strongly support medical research but I cannot see any reason to tie medical research into the co-payment process. We should be funding more medical research from other sources and there are ready-made sources. Examples would be the $14 billion or so that we get from alcohol and tobacco tax. I have real concerns about the co-payment scheme.

I want to make some brief comments about prevention and public health as I think they fall into your terms of reference. I will make 12 quick points. First, we have to recognise the importance of public health as probably still the major reason for good health and life expectancy in this country but it is always the Cinderella area. There is rhetoric but there is minimal support and that is partly because the results are long term. They do get results. Public health has been defined as saving lives a million at a time. You do get results but it takes time and the pressures on government for public health are not acute. When I was director-general, I can remember any number of late night calls from premiers and ministers asking me about pressures on emergency departments, on waiting lists and so on. I cannot recall one single late night call from a premier asking me why I had not taken action to save tens of thousands of lives, to prevent the deaths.

We need to recognise that prevention currently gets about 1.7 per cent of the government health spend but much of that is on screening and immunisation—it is a very generous definition of prevention. That is down from 2.2 per cent in 2010 and it flows into other areas. Only two per cent of the funding for cancer research goes to prevention. The answers are not all in funding to prevention, taxation, regulation and so on, but we need funding

and I strongly support the view of the Public Health Association that we should be upping the proportion of our health spend that goes to prevention to around four per cent.

My focus is generally on the NCDs and the known risk factors—tobacco, alcohol, obesity and so on—and the frustration is that we know so much of what to do. We pretty much know what needs to be done on all of them around the fringes but there does not seem to be any immediate impetus for action. We are reducing the spend and we are up against the immense power, pressure and lobbying of major industries such as alcohol, tobacco, junk food and so on. So I hope in your recommendations there will be some comment about how frustrating it is that we know so much of what could be done to prevent so much death and disease but it is not happening. Even on tobacco, it is 64 years since the dangers of smoking were evident but we still have 12.8 per cent smoking. That is much better than it was but it is still far too many. With alcohol, there so many problems still. With obesity, I just despair. I do not think we will get to obesity for the next 50 years. So I have real concerns in those areas and the less we do there, the more pressures we build up for the future for our health systems. Obesity is the one area that is predicted to result in causing a reduction of the life expectancy that we now face as a nation and that is a pretty scary legacy. I do need to say that the present government has been very good on tobacco. That is bipartisan and it is terrific. It is great they have carried on with the programs that were developed, including plain packaging, and are strongly supportive of that. However, at the Commonwealth level, I have concerns that we do not seem to see comprehensive action as a priority, especially around alcohol and obesity. If anything, it is the reverse: we are seeing funding cuts—I will come to those in a second—and all the concerns that arise out of sheer uncertainty. People just do not know what is happening around prevention programs, Aboriginal health and so on. We are seeing reductions in central expenditure. We have seen the end of the National Preventive Health Agency. We have seen the end of the public health prevention partnership agreements, which again puts a burden on the states; they have to carry it. And Aboriginal health is immensely uncertain—there seem to be reviews and cuts; there is great uncertainty and nobody really knows what is happening. That is one of the areas where we should be unreservedly throwing money in and that is not happening.

The last two points I want to emphasise—and I hope this will come through from the report too—are that we need to focus especially on disadvantaged groups and how some of the cuts and the uncertainty will affect them. They are the ones who will be most affected by the reductions in spend. They are the ones who will be most affected by the co-payment scheme. They are the ones who should be the greatest priority.

There are two areas I would pick out, and they relate to the life expectancy gap. We know the Aboriginal life expectancy gap has not changed in a decade—not since the Close The Gap campaign started. It was a great effort but we need to do more, not less, and not create uncertainty. The other area is mental health. We have had Mental Health Week. There are very justifiable concerns about mental health, and the life expectancy gap for people with mental health problems is 14 years. That is just for people with general mental health problems. It is much greater for some. It is 12 years for women and 16 years for men, and we are not doing anything about that. Those areas need to be a real focus. These are the people who will be most affected by the sort of cuts we have been seeing.

Having said all of that, my final observation is that I want to see regulation in various areas. I want to see funding. There are alternative ways of funding and of avoiding the cuts, and they are incredibly simple. We could tax unhealthy products—we do it with tobacco. Every time there is an increase, in fact, the tobacco industry increases its prices even more, so it does reduce sales over time. Governments can do it—they can raise the tax and get the halo effect. That would find an alternative source of funding rather than cutting. With alcohol, if we just got rid of the wine equalisation tax that would be several hundred million dollars a year and it would also mean we do not get dirt-cheap cask wine—what the Americans call ' two-buck chuck'. We could get rid of that, which is such a problem for people with alcohol problems and so on. We could look at reform of alcohol tax, tobacco tax and possibly even consider what the Americans call a soda tax—a tax on sweet, sugary beverages that do no good to anybody. There are sources of funding there and I would say that if we looked to those sources of funding, we would improve public health enormously and find the money to enable us to live without the cuts that are being imposed. That is probably all I need to say at this time.

CHAIR: Thank you very much, Professor Daube. We could have a very long conversation on the back of that excellent presentation. Can I take you immediately to the question of prevention, on which you have made a number of important points. It has been put to us in the last few days that a critical part of responding to chronic illness which has developed as a result of failure in prevention is the GP and universal access to the GP through bulk-billing. Do you have a view on that?

Prof. Daube: Yes, I do. There is never one magic bullet, so you always need a comprehensive approach. We need to look at primary prevention: areas like price, and preventing promotion of the product and, with alcohol, making sure the kids don't have access—all those issues. But we need a strong primary care system. If I take

tobacco as an example, there has been good, sound evidence for more than 30 years that simple GP advice when people come in really does make a difference in terms of quitting—that, very often, people who quit do not need expensive aids and gimmicks and so on; they need support from GPs and others. The same applies in obesity and in areas like that. So I have a real worry that if we do not have adequate access, particularly for disadvantaged groups, then we will lose so many of the benefits that primary care can bring.

My understanding from all the GPs I have spoken to—and I spoke to a group of hundred of them a couple of nights ago—is that they are interested in prevention. We have got to enable and encourage people to come to them, rather than put obstacles in people's way, especially for disadvantaged groups.

CHAIR: We heard this morning from two CEOs of two of the Medicare Locals—which did have a primary health focus in their establishment—and are localised in 61 local areas. One of the things that we heard, in addition to the uncertainty which you indicated is a cost, is some uncertainty on their part about the difference between what the Medicare Locals are and what a Primary Health Network is, and how they can respond to the reality of preventative health in their particular context. Do have a view about shifting from 61 Medicare Locals down to the mooted smaller number of PHNs? And do you have a view on Professor Horvath's report?

Prof. Daube: Health systems do get reorganised; that is just one of the realities. And I think that one of the problems with reorganisation is that we sometimes assume there is something better, and we forget all the problems and costs that will come with reorganisation. A system may be imperfect, but when you take all that apart and put something else together again, you end up with increased costs and uncertainty and so on. I think it is, probably, unfortunate that there has been a change in that area. It is not yet clear how the new system is going to work, so we will have to wait to see how that works. I think that sometimes, some aspects of Medicare Locals were a bit optimistic, in terms of assuming that they were going to take a responsibility for all aspects of prevention and so on, when that needs to be worked through with the state government. There were some complexities there. But I think it is a pity that we did not build on that. That said, I think we will have to see what the new system looks like.

Senator SIEWERT: We have talked about access to services with GP co-payments, but of course there are the other co-payments. Have you any comments to make on what impact those are likely to have on the issues we have been talking about?

Prof. Daube: We are in the same territory. We are dealing—and I think Fiona Stanley said this when the GP co-payment scheme was introduced—with something that will most affect the poor and the disadvantaged, and the people who need it most. But those are not the people that we should be taxing more, if you like; or putting more obstacles in their way. If I had my druthers, I would almost be wanting to subsidise people to go and see their GPs for primary care for prevention and so on, because if you do not go early then those problems will just increase. And that will apply to mothers with small children, it will apply to whoever it is out in the community—that is going to apply across whatever form the additional payment is going to take. Unfortunately, too, I think it will do poor things for the relationship between members of the community and their general practitioners.

Senator SIEWERT: We are talking about disadvantaged groups and, I must admit, it is one of the areas that I am particularly focused on and interested in. In terms of the problems we are talking about and the issues you have just been talking about—smoking, alcohol and obesity; three of the key things that are leading to significant disease and costs later on—in terms of the most vulnerable and disadvantaged groups, what is the proportion of disease burden related to those issues of smoking, alcohol and obesity? What impact are we going to have?

Prof. Daube: It is disproportionate and it is clearest with tobacco. Smoking is down to 12.8 per cent in the general population—which is, in some ways, stunning, given that it was up at three quarters of males and so on—but it that is still not enough. Aboriginal people are still somewhere over 40 per cent. It is coming down, and that is great, but it is still over 40 per cent. The program that has been established that is overseen by and Tom Calma, which is the Tackling Indigenous Smoking Initiative, has been in place for about three years and now it is being reviewed. I think that in these incredibly complex areas you have to say, 'Give it some time just to get off the ground and get established before you start trying to review and evaluate and so on!' Smoking kills about 20 per cent of Aboriginal people. The people who smoke these days are, by and large, people of lower educational attainment, people with mental health problems and Aboriginal people. They are it, essentially. Of course, there are exceptions, but they are essentially the problem smokers.

Alcohol goes across the different sectors. There are different drinking patterns and trends. But, again, people who drink heavily are often the disadvantaged. And when we talk about people with mental health problems, the WHO global report on suicide tells us that 22 per cent of suicides are attributable to alcohol and that another 25 or so per cent have alcohol in there as a contributing factor. It is the elephant in the room with so many mental health problems, with homelessness and with so many disadvantaged groups.

Obesity, clearly, is different again. We are an affluent society and I think the trend is that we are all—apart from you!—eating too much! But there is a real concern that there is much greater access now to unhealthy food. There was a report in *PLOS ONE*—a major journal from the UK—just last week showing that the price gap between healthy food and unhealthy food is widening. So unhealthy food is becoming cheaper in comparison with healthy food. Of course, it is more accessible; it is where the junk food outlets and so on predominate in lower socioeconomic areas.

I might wrap that up by saying that, by and large, it is disadvantaged people who are often being targeted by promotion, by price and by access, and who are less able to cope with it—particularly if they do not get the support—and they will suffer the greater burdens. That in turn, will put a greater burden on the health system.

Senator SIEWERT: So the upshot is: co-payment will target and affect mostly the disadvantaged and vulnerable community members and they are the people who bear the disease burden from obesity, alcohol and smoking? Is that a good summary?

Prof. Daube: Yes. And they are the ones, therefore, who will not go in and ask, 'Can I have help with this, or this or this?'

Senator SIEWERT: Can I take you to your myths—the two myths? Can you go through your first one again? Because I do not think I quite understand it.

Prof. Daube: The first myth that I was talking about is that people tend to assume there are quick fixes to dealing with our health system—and there just are not. Frankly, the trap that politicians of all parties, with respect, have fallen into is feeling that they have to develop policies where there will be an instant result. That does not happen in the big, complex animal that is running the health system, let alone changing behaviour and so on. So that was the first concern. The second concern is about an unsustainable health system.

Senator SIEWERT: So the 'quick fix' here is, 'We'll put a co-payment on and therefore people will stop going to the GP'?

Prof. Daube: Either that or, 'We'll put lots of money into medical research that will solve all our problems.' Well, it will not. We need medical research, but we are talking about really long-term stuff here. Of course we need that research but it is not fixed to anything.

Senator SIEWERT: Also, we know what will work—

Prof. Daube: What will work over time.

Senator SIEWERT: Yes, over time. We know what will help with alcohol, obesity and tobacco. The tobacco stuff is working. We know what will work with alcohol. We know what will work with obesity. There is a lack of government will in the face of a whole lot of lobbying from the industries. We know price signals work. We know social programs work.

Prof. Daube: And media and all those kinds of things.

Senator SIEWERT: Yes. But we are not doing those things, so we are looking for other answers, it seems to me. Would that be a fairly accurate reflection of where we are at?

Prof. Daube: Yes, I think so. We tend to see action—this may be unfair—by media statement. For example, there may be a media statement saying, 'There is going to be a new program on such and such and that is going to be the answer.' With those areas, we know the answers. We know they take time. When I speak about tobacco, I sometimes put up a slide that says, 'Overnight success takes time.' We know it takes time, but we know what needs to be done. There is a lack of will there. It is enormously frustrating.

Senator SIEWERT: Would it be fair to say we are taking money out of what works now to put into a research fund—and I am not knocking research; I am very strongly supportive of research—to look for answers down the track? So we are creating more problems into the future by not addressing prevention now.

Prof. Daube: It is one of the reasons why I think the link between co-payments and medical research is very unfortunate. The two should not be sitting together. We want to support medical research, but we should not be taking money from our most disadvantaged people to fund it.

Senator SIEWERT: I want to go to your next myth—that we are spending too much. You made the comment that it is nine per cent of GDP. You compared it to the US where it is 18 per cent of GDP and there is a poor system. People keep running ours down, but you are saying that actually we have quite a good system. That is not to say it could not be improved, but it is quite a good health system.

Prof. Daube: Absolutely. In the US, they have just announced with a fanfare of trumpets that life expectancy is increasing. They are really thrilled about that. It is still less than here. The disparities are greater than here. I

think there has been a myth built up that health systems are going to be so expensive that we are never going to be able to afford them and that costs are going to increase exponentially. It is a little bit like the predictions in the 19th century, when horses were dropping manure all over the place, that if we continued having more and more horses our streets would be knee-high in horse manure. It did not happen.

That is probably a slightly extreme comparison, but even so we see projections about what the increased costs might be and we have to look at what is happening in the real world; we are sticking at around nine per cent. We are better than a whole heap of other OECD countries. We have a complex system, the states, the territories and the Commonwealth need to work together, and there is a lot that needs sorting out. So it is imperfect, but we should not be reducing that spend. If anything, we should be increasing it, because we know so much more about what can be done and we are looking to prevent costs further down the track.

Senator CAMERON: I want to go to some of the more philosophical issues that you have raised, because I think they are important for analysis. Senator Siewert raised the issue that price signals work. Price signals work in terms of prevention, but price signals like the $7 GP tax are a different proposition. So there are two different types of price signals: one is a price signal that stops people accessing health care and there is another price signal that stops people damaging their health. I want to be clear in my mind about those two issues. We are seeing the 'marketisation' of health; if health worked properly as a market, then you would not need to subsidise private health funds, which is another huge cost in the economy. What is your analysis of using health, or considering health, purely as a market where you can send a price signal and save money?

Prof. Daube: I am probably going to duck part of that question. I think you are absolutely right that price signals work from either direction; they work if we are trying to affect people's behaviour in terms of purchasing products, and similarly they will affect people's behaviour if they are purchasing health care—price matters. That takes us to the broader system that we have in Australia. We have private health insurance and, from where I am, I would rather not take a position on the private health insurance system. That is the system that we have and I think that is probably a more political issue that I would rather not get into.

Senator CAMERON: Even though it has huge implications for health cost?

Prof. Daube: It does have huge implications for health cost, but, as I said, that is the system that has developed over time, and I would rather focus my enthusiasm on areas where I think I can actually get some change.

Senator CAMERON: I go back to some of the other things we have heard, and Professor Salkeld from Sydney University speaks about hospital expenditure being $56 billion, primary care expenditure being $53 billion and public health expenditure being $2 billion. Professor Glenn Salkeld has argued that it should be the other way around. If you did it the other way around, you would need to put the price signal on the issues that you have identified this morning. But then you would come into the argument about the nanny state. How do you deal with these nanny state arguments that are being raised by people that have huge vested interests in not promoting healthy lifestyles.

Prof. Daube: Glenn Salkeld is a very distinguished health economist and the only areas where I take slight issue with him—I do not think he would object to that—are, firstly, that I think that $2 billion figure is quite a generous estimate in some of the ways it is constructed, and I would not necessarily turn it right around. I think we have to get away, too, from prevention and treatment care as being either/or scenarios. We need both. The community is entitled to great new hospitals, as we have here. I want the best health care. I want the best hospitals. But I also want a greater input into prevention. That is why I was suggesting ways in which that money can be found additionally, rather than having a competition with the hospital system as to where the funds should come from.

The nanny state was first brought to prominence by a British politician, Iain Macleod. He was noted for announcing the dangers of smoking when he was minister for health in the 1950s and smoking his way through the press conference. He died, I think, at 58 or 59 from a heart attack. He popularised that phrase. It is a lovely catchy phrase. What does it mean? Is the nanny state about having police? Is it about having speed limits? Is it about having safe water? Is it about the way that the sanitary campaigners of the 19th century were pilloried because they wanted to introduce the measures that we now regard as absolutely fundamental? The nanny state tends to get used by commercial interests, or the people who sympathise with them, around tobacco, alcohol and obesity, and it tends to get used by think tanks like the IPA and other groups that have industry funding.

I think the nanny state is a nonsense argument. We have a role as a state; you have a role in government to provide stewardship. You care for people's health and you ensure that public health is good. It is the nanny state that is protecting us from ebola virus. It is the nanny state that means that we have safe food. It is the nanny state

that means that when you go to lunch today you will not be poisoned in the restaurant. I do not have any qualms about defending prevention. Where I do have qualms is with people who are imposing ill-health on us. They are people like the alcohol industry, the food industry, the processed food industry, the tobacco companies and so on. They are, incidentally, particularly in alcohol and tobacco, almost all overseas based companies with no interest in the health of Australians. I think we have to do much more to protect our communities and, if 'nanny' is about protecting health, so be it.

Senator CAMERON: We had some evidence yesterday which I want to go to while I am on the macrolevel issues. It was about the influence of powerful lobby groups to make change. Your response on the health insurance issue I think demonstrates some of the power of these groups to keep things frozen in aspic. Making change is very difficult in health. Professor Jones talked yesterday about the GP issue. The GPs are arguing that they have to be at the core of health prevention. We have had other evidence to say that the GPs are very important but they are not the only group who provides support to the communities, and that the role of Medicare Locals using a wider group of allied health professionals was an argument for not having the GPs simply at the core. But the GPs—that is, the AMA—made a very strong submission to the Horvath inquiry. From my reading of the Horvath inquiry, he basically picked up the AMA submission and turned it into his report. That demonstrates the strength and power of the AMA in the whole health debate. I will come to the point now. What Professor Jones was saying is that GPs in the UK are much more accountable to the state. The service they provide is much more focused on quality. The training and the capacity of GPs is much more focused under the British health system. He expressed some reservations. You can get to a doctor easily in Australia, more easily than you can in the UK, but we do not have these quality and control issues that ensure the standards of GPs. Have you given any thought to that?

Prof. Daube: First I will speak about the powerful industry lobbies. When I look at the billions that are being spent globally in the various countries simply on lobbying I sometimes think we are just babes in the wood in that context. Of course, the most effective lobbying is that which we do not see or hear about. I would like to make a tangential point. With great respect to the senators here, I think it is unfortunate that the lobbyists register is so limited. I would like to see the lobbyists register provide information on the lobbying that is being undertaken, on how much is being spent, on who is being lobbied, and not just on third-party lobbyists but on what specific companies and so on are doing. That is the lobbyists issue.

The next issue is the AMA, and I need to say I work very closely with the AMA and they are terrific in prevention issues. I have great regard for them, so you will not find me criticising the AMA. My next observation is about the role of GPs here—

Senator CAMERON: Is that just because you like them and you work closely with them? Surely there are legitimate issues about the AMA.

Prof. Daube: There will be areas on which we disagree, but I do need to say they have been a tremendous support for prevention. On GPs, I am actually a bit conservative in the area of GPs. I think you are right in what you say—the GP is not the only factor in prevention. We need to get other health professionals more active and more concerned with prevention. I think I would have some reservations about saying that the UK system is significantly better than ours. Everything I have seen about the UK system, especially over the last few years, is that in quality, in bureaucratic complexity and in the outcomes of change it is spiralling downwards rather than upwards. So I think there is a lot we can learn from the UK about what not to do. I do think the quality of general practice here is good, but I think we should be encouraging people to get to their GPs and making it as easy as possible, in funding and other ways.

Senator CAMERON: You can encourage people to get to the GP, but if that GP does not provide a quality service than what is the point?

Prof. Daube: The evidence that I am aware of is that our GPs do provide a quality service and there are standards there and so on. So I think we would want to be very, very cautious before saying that our GPs were not of a similar quality to those elsewhere.

Senator CAMERON: I do not think that is being said. It is the oversight.

Prof. Daube: Even there. I think there are others who have more expertise than I on that. We have to be careful that we do not assume that there are things wrong when they are not wrong.

CHAIR: With regard to the hospital funding, we saw quite a significant structural shift to activity based funding. That has been reversed in the pattern that the government has projected going forward. I would like to get on the record your observations about activity based funding and what changes it has made to practice here.

Prof. Daube: I would probably need to pass on that as an area that I have not really kept up with. I used to run the health system, or try to, but I have not kept enough of an eye on the changes that has generated. So I would rather just not comment on that.

CHAIR: Okay. Could I ask you then about block funding, which is the system we had prior to activity based funding. It looks like what we are returning to, with CPI and population being the two factors that will determine any changes to that. How did block funding work in terms of both the federal government and the state government taking responsibility for health outcomes? How was that working?

Prof. Daube: What you had traditionally was a battle every five years about funding, when Medicare agreements were being negotiated. I think I remember Neal Blewett saying at a health ministers meeting when he was federal health minister, 'Well, it's eight to one, and one wins.' Essentially it is always the funding decision made by the Commonwealth that goes through. I do not think we really keep an eye on who takes responsibility for what health outcomes. It is a funding decision. The cake gets split up as best it can.

CHAIR: I know that Senator Siewert asked you some questions about the second myth that you talked about—that there was too much spending going into health. Clearly that is not what you agree with. On this language of a 'crisis' in health, what do you think the health outcomes of that sort of discursive practice are in terms of general population health and wellbeing?

Prof. Daube: I think they are really worrying. I do not think we need people at any level of government telling us that there is a spending 'crisis' in health. Anybody can do predictions about what costs might be and make the figures look really huge in 50 years time, 30 years or whatever it is. We are looking at year-to-year changes and they are pretty minimal. We are looking at a system that is almost underfunded by OECD standards. So I think we need to be reassuring the community that we are not overspending on health. We could do things better here and there. Of course, there will be issues that influence that. The cost of pharmaceuticals can change. So much of the cost of the health system is people costs.

But I think I am repeating myself, really. I just want to make this point, and Stephen Duckett has made it very well in various pieces from the Grattan Institute: it is an absolute myth that Australia spends too much on the health system. It is a myth that might suit governments that want to cut health, but your specific point was: what is the consequence going to be? The consequence is that, if people believe that myth and we reduce the spending, that will have adverse impacts on health outcomes. It will have adverse impacts on the states because they will have to meet the burden. As ever, the people who suffer most will be disadvantaged people.

CHAIR: With regard to the national preventative health agreement, which has been discarded, what sorts of activities were being undertaken here, in the Western Australian context in particular—you can speak nationally if you wish—as a result of that partnership? What has happened now that it has been torn up?

Prof. Daube: There is a whole lot in limbo now. I must say I think it created distrust of central government, because if you have agreements that are supposed to be lasting and suddenly they are cut then the state governments which had to implement them will have people on contracts and so on, because they would have assumed that the funding would continue. So it creates distrust for them. It creates uncertainty out in the community. What sorts of activities? They are particularly in areas around workplace health and the education system—education programs addressing young people, healthy schools, healthy workplaces and so on. So those are the programs that are being cut, and that is short sighted.

CHAIR: Can you express the impact on the people who are working in the field? What is it doing to the workforce there? We are seeing some distortion in the Medicare Locals.

Prof. Daube: Obviously I cannot speak for the health department, but I can tell you anecdotally what I am hearing, which is there is a lot of distress out there. There are people who are enthusiastic about prevention. There are people who put their lives into this. They were running programs that were going to last. They were not going to be quick-fix programs. You do not have quick fixes for schools and workplaces. They were just developing work in this area, and now that is being cut. I think the health department and the government here in WA have done pretty well in trying to keep a lot of that going. We will have to see what will happened. If they keep it going the money has to come from somewhere else.

CHAIR: It is amazing how a cut on the surface can end up with incredible waste as the consequence.

Prof. Daube: That is an issue with reorganisation, too. As soon as you reorganise you have to recreate the jobs, you have to get the structures going again, you have to pay people out. It is very wasteful.

CHAIR: On the shift from Medicare locals to PHNs, there is some debate about the private health industry—Medibank Private and BUPA, in particular, are doing trials and expressing interest—coming in and tendering for PHNs. Indeed, we have heard that departments of health or entities associated with departments of health, so, in

Victoria local district areas that are a little devolved, are likely to seek to tender for PHNs. What do you think the impact of, say, BUPA or Medibank or other governments coming in to do the PHNs, instead of not-for-profits, as they currently are.

Prof. Daube: First of all, it is going to be another period of great complexity that is going to engender competition between people who probably should not be competing with each other.

CHAIR: Would you explain that? We keep hearing that competition and market failure—this financial language in the health sector—is being prized over the collaboration. I would really like to get on the record your view about the cost of competition in a market organised health structure.

Prof. Daube: I can talk about that in terms of people rather than economics, if you like, and organisations. I do not object to tendering out in various areas and so on, but what can often happen is that you find well-intentioned health groups competing with each other. That can engender breakdowns in relationships between the organisations. What we should be doing is seeing how they can most work closely together and in collaboration. It is not an area I pretend expertise in but the issue about the health funds is going to be really interesting, first, to see whether they can do it and, second, if they get it how they do it and whether they actually do it collaboratively, working with others in the system, or whether they are sitting in silos. I think that still has to be tested. I just don't know enough about how that is going to work to be able to comment on it, but I do worry about too much competition. Sometimes we are dealing with pretty small groups, some of those groups that will be tendering. Sometimes you are dealing with groups that have very specific subject expertise and may not be very good at writing the tender documents. That becomes another issue, because there is an expertise in doing that and the big groups tend to have the better expertise in writing the tender documents—and maybe they have better bulldust expertise than some of the smaller groups.

CHAIR: Thank you, very much, for your frank and fearless participation this morning, Professor Daube. It has been a pleasure to hear you speak and to have you share your insights with us. If there is anything further that you think would be of help to the committee—I think there are the 10 points you went through—if you could formalise in a submission to us that and anything additional that you might consider it would be very, very much welcomed.

Prof. Daube: Thank you.

KATZENELLENBOGEN, Associate Professor Judith, Research Associate Professor, Western Australian Centre for Rural Health

THOMPSON, Professor Sandra Claire, Director, Western Australian Centre for Rural Health

[12:10]

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

Prof. Thompson: I am the Director of the Western Australian Centre for Rural Health, which has its primary office up in Geraldton. I also hold a chair in rural health from the University of Western Australia. The centre basically has a collaborative arrangement with all of the Western Australian universities, and its primary purpose is around rural health workforce and improving population health.

Prof. Katzenellenbogen: I am a researcher at the Western Australian Centre for Rural Health. I lead the Perth based office of the centre. I do research in rural health and Aboriginal cardiovascular health. That is my major interest but I have done other research as well.

CHAIR: Thank you for joining us this morning. We look very much forward to hearing your opening remarks and then we will have some questions.

Prof. Thompson: I thought some of your questions to Professor Daube were really interesting. The area that we felt we had particular opinions and expertise in is around the provision of health services, specifically around rural health, but we have actually had a very long history of working around Indigenous health as well—I know that is a strong interest of yours—and also around health workforce planning, particularly in terms of training for a rural health workforce. We are particularly interested in approaches that move more upstream, around how can we have a more healthy population, the part of your terms of reference that are around health promotion, prevention and early intervention. I know you have seen at least some of the of the university departments of health, so you have heard some of this on the record before—

CHAIR: We know that Western Australia is different. Our Western Australian colleagues are telling us all the time how different you are! That is why we are here, to really hear your perspective, because you do have an incredibly large land mass and a very dispersed population.

Prof. Thompson: I think that is definitely something that preoccupies us quite a lot. Some of the more populated states with a larger land area have three university departments of rural health; we have one. We cannot cover all of rural WA; it would be impossible. The Commonwealth in its wisdom decided it would cut the cake between the 11 university departments of rural health evenly, so we get one-eleventh of the funding, the same as the university department of rural health in Launceston or in Moe or wherever.

We were not always the Western Australian Centre for Rural Health, which is why I stumbled a bit at the start. We have changed our name. We were called the Combined Universities Centre for Rural Health. When it was set up it was going to cover three regions in Western Australia. In a way, that is nonsense. We cannot cover three regions. We cannot do a good job. So over the last few years we basically rethought our business and said, 'We have absolutely no infrastructure and we don't have any staff based in the goldfields. We're not going to pretend that we're doing the goldfields.' We have always had a presence in the Pilbara and some staff up there. One of my observations about that was that you can have a very small office, a long way away from the mother ship, and as a director I would be thinking: 'How do I support my staff better and what are my staff doing that is of value? What is the sustainability of this?' We have completely rethought how we are going to do work in the Pilbara. We do see the Pilbara as an incredibly important area. It has the worst primary health workforce outcomes in all of Australia and it really needs to be rethought. But, again, it is a struggle around resources.

We have put a bit of money that we had from something into the superclinic that is being built in Karratha. I know the tenders are out and I am hoping they will very soon appoint a builder. Then we will run into cyclone season, so whether it gets built or not is unsure. We are hoping that perhaps by the end of next year or early 2016 it will happen. That is the kind of model of how we can do that which we think will be very exciting. It will be very different from the model we have in Geraldton and the way we are working there. But, again, it will be a stretch because we are trying to work in two different regions, really, with the same bucket of funding. I am quite happy to say there needs to be a bit more nuancing of the funding—to accept that rural and remote areas, and the geography and transport routes of WA, do not make it very easy.

I would be arguing that the university departments of rural health do quite a good job. It has taken us time to work some of these things out, but now we have had a lot of learning. We were lucky that we got good infrastructure investment through some of the programs over the last few years, including through Health Workforce Australia. The infrastructure is absolutely critical to being able to deliver good programs. It is not all

that you need but it actually underpins the ability to do it. In fact, earlier this week I was in Shepparton. I was looking at their facility there—their Rural Health Academic Centre in Shepparton—which is amazing. It is absolutely amazing because the university has invested in it. They had the local council on side; they were working very closely with the health service and they have a really incredible facility there. It is strongly medical—it is very much dominated by the medical faculty and does not necessarily have a lot of the nursing and allied health support that we do, but the training in general practice they can offer from within their clinic is likely to be incredible. I wish we had that sort of thinking here.

We really do need to work very closely with our WA country health services. We should be doing that collaborative planning, and that goes to that whole thing about competition. One of the sad things about Health Workforce Australia was that in lots of ways it was set up as competitive. It did not always result in very collaborative things occurring, because funding went particular ways. It would be incredibly naive to think that the universities would all play big happy families. The health service actually got into competition with the universities around some of that in Western Australia, which I do not think was healthy.

CHAIR: Could I just jump in there: we have been getting very mixed information about Health Workforce Australia—that it was doing a vital job—but we have not been able to get anybody to articulate why it seems they are not going to miss Health Workforce Australia as much as they are going to miss the National Preventive Health Agency. We might have just stumbled on part of the reason, so I will come back to that and ask you some more questions. Do you have any other remarks you would like to make before we go to questions?

Prof. Thompson: We should not pretend that people are not going to get sick and die towards the end of their lives, so this idea that even if you increase the longevity of people you will not have a period of time when they get sick and die is wrong. What we need to focus on is how do we give people quality of life for as long as possible, but often we concentrate a lot on mortality outcomes and do not concentrate enough on quality-of-life outcomes. So much of the health system money goes into hospitals and not into primary and community based care. There is lots of evidence around primary health care and how having a strong primary health-care system results in better health for people.

We really need to work on strengthening primary health care. There is the issue about what is the model for primary health care, and I think the model around a very doctor-based delivery is the model that has worked in the metropolitan areas where you can attract doctors and so on. You cannot just say that we are going to have one size that is going to work absolutely everywhere. It is much more difficult to attract doctors into rural areas, sadly. That is still true. Some of the programs that have been invested in around training doctors and other health service providers in rural areas are important, and part of our role as a university department of rural health is to make sure that they have really good quality experiences and that means high-quality support for our students and supervision and providing learning opportunities that they do not get elsewhere, and there is the infrastructure—accommodation and access to vehicles and so on—so they can do the work.

Prof. Katzenellenbogen: Rural support has been quite doctor-centred and the areas of allied health and nursing, but in particular allied health, is not getting sufficient support. We did some reviews of the literature and also looked at the funding, and it is very generous for the medical profession but for other professions, particularly allied health, it is not. There is probably a need to invest more in that area, both in terms of training at universities, so there are more supported rural placements, and scholarships and those kinds of things, and then of course recruitment and retention are essential issues once people qualify. We have to talk about quality of life and not such a doctor-centred approach, because in the end, once your medications are in place and so on there might be a lot of other things that you can do that are not medically based, in terms of quality of life but also with rehabilitation and getting people back to functioning. It is a broader team and we need to invest in rural training for those professions as well.

Senator SIEWERT: I totally understand the issue of getting GPs into the bush. You mentioned allied health. What else do we need to be doing for better outcomes in rural health given that we know that health outcomes in the bush are worse than in the cities? What else could we be doing? What were we doing that has been cut back?

Prof. Thompson: What we need to think about is not how do we always deliver the best care—you can have Rolls-Royce models that work for some people but they do not work for everybody. I think that notion about some equity in health is important as well. Health economics needs to be brought into the equation a bit more. We need to look at how to be more efficient, what we get for the investment that we are putting into things but still with that equity lens. This is a challenge for rural areas, because if you are just about efficiency you never do anything in a rural area, basically, because it is cheaper if you do not. That is not really the point. The point is that we need those rural areas as well and it is an important part of our society. You may not deliver exactly the same thing as you deliver in a metropolitan area, and I guess that is part of what we are trying to train our students in—

we do not want the students to come and we offer them just the same as they can get in a metropolitan hospital; we want them to understand the differences in a rural area about how they have to work. Some of that is about them being more highly skilled as practitioners, because they will have to do a greater variety of things. We talk a lot about 'interprofessional', which is about how do you communicate—the notion of scope of practice but how do you go beyond that scope of practice and how do you work with other colleagues to deliver those good outcomes. Those things are important.

Even in a city like Geraldton you do not get that. But when you go more remote you do get into that realisation about what a small community is. I think it is that whole thing where we often have these divisions in the way we deliver health services. We have different funding streams; we have silos. We talk about integrated health care all the time but, unfortunately, the funding models do not necessarily support very well-integrated care. While you keep making people apply for competitive funding buckets you are not actually getting them to collaborate.

It is really great that in Western Australia, with the demise of the Medicare Locals and the new paradigms of setting up primary health networks, that the Western Australian Medicare Locals are getting together and planning collaboratively, rather than being very defensive and saying, 'We have to keep BUPA out,' or whatever. They are going back to square one and thinking again, 'Look, we've had a whole lot of learning through trying to deliver as Medicare Locals,' and they are trying to work collaboratively amongst themselves but with other people as well, rather than just being locked into doing it themselves. I think that is really quite a healthy thing in terms of us perhaps maturing a little in our approach.

CHAIR: I get that the collaboration part is a positive. But I take your comments from earlier, when you said that you have to come to a realisation that you simply cannot look after these areas because they are so different. You are not pretending anymore that you have a presence in the goldfields and you are completely reshaping what you need to do up in the Pilbara, based on the fact that it has the worst primary health outcomes in the country. One of the things that have been expressed as a concern about the dissolution of Medicare Locals—apart from the cost, the uncertainty, the loss of jobs and the loss of continuity of service care; all of that!—is that while these groups might be at a point where they have been forced to talk to one another, they were already kind of doing that and now they are going to be forced to organise across huge geographical areas. If we go from 61 down to, maybe, 25, or maybe 31 or maybe 32—no one has any clarity, but it is clear that they are going to be reduced—then how do those two things sit together?

Prof. Thompson: That is a very good question. We talked about evidence based medicine; it would be great if we had evidence based policy. You wonder where the idea and why we have gone with this model, because it does not seem to be based on anything like looking at models around the world, 'We've looked at countries that have huge, remote regions, or similar problems and they have implemented this and we could learn lessons from how they have done it and we'll do it that way.' It does not seem to be that at all.

CHAIR: Have you read Professor Horvath's report?

Prof. Thompson: I have read bits of it; I have not read all of it.

CHAIR: It is not a very long list of evidence base at the end of it.

Prof. Thompson: Yes. I think he had his own world view. I would not subscribe to everything he believes, if you know what I mean, I am afraid.

CHAIR: Can you articulate what that world view is? It is creating some pretty interesting structures.

Prof. Thompson: I probably have not engaged with it. I read it some time ago, among many other documents that I read. It is interesting that it is creating so much.

That was about reviewing the Medicare Locals, right? There have been different tranches of Medicare Locals, some of which have been going for a long time and some of which have not been going for a long time. And, hey what? Some of them worked and some of them did not.

Senator SIEWERT: It was the same with the divisions.

Prof. Thompson: Yes, exactly. I think the thing was that some of them had very little time to get their act into gear, then there was a change of government. The big issue to me is: how do you afford it into the long term? Despite what Mike said, I think we do need to think about affordability in the long-term and what we are getting for it. We are putting more money into it; are we getting better health from it?

If we looked at our rates of mental illness, for example, or our rates of drug and alcohol use and things like that, you would not say that we were necessarily turning into a much better and healthier population. We might be living longer and we might be doing more operations, but are we a happier, healthier population? I do not know that you could say that. We have an amazingly good standard of living—or at least, some of us do—

Senator SIEWERT: But surely one of the points there was—and the point Mike was making—that there are a whole lot of other things we should be doing as well. The point is not necessarily that the Medicare Locals are not working but that they were never expected to deliver on their own, that there are a whole lot of other things. I thought that was the point that Mike was making on pricing of alcohol and your preventative health things as well.

I do not think that because we are not necessarily bringing down the rates of alcohol abuse and unhealthy eating et cetera that it means a certain other part of the health system is not working.

Prof. Thompson: No. I agreed with him around the notion of investing to try to get change. There is a huge amount of turmoil that it creates; it takes a long time and it takes even longer in rural and remote areas, usually, because you have to do the recruitment and it is more difficult and expensive, and all those other sorts of things. And then you do not get it all right the first time—of course you do not; you have learning along the way—and then we change the system again when people are just starting to get their heads around that.

There is something around people being insular around their survival as an organisation before they really get to do the business that you want them to do. It did seem very prescriptive; they seemed to have lots of things. They all had to go out and look at after-hours access to services, for example. Well—

CHAIR: And that is not the highest priority in the Pilbara?

Prof. Thompson: It might be a high priority but the thing is that that is what they were told they had to do. There was a master whipping them along around time lines on which they had to deliver all those things. That is not necessarily the thing that would be the most valuable in that region. Surely, I would think that what we want from a primary healthcare organisation is, 'How do we do that connectivity that is so lacking?'

Senator SIEWERT: I thought that there was also supposed to be the idea of more broader community involvement in decision making over what the particular population health issues were that should be dealt with.

Prof. Thompson: Yes. But you keep on consulting with people. For example, in the Midwest, again, we have the whole process of just going and consulting and doing a few rounds of all of that. And sometimes we know so much already but we do not act on what we already know. You can keep consulting people, and maybe it feels good to go through that thin veneer of consultation, but I actually think that we know enough about what we should be doing to be getting on with the job; we just need to do it better. But we are sometimes constrained in that. We are constrained by all sorts of things. Some of those might be what we have to do with the little bucket of funding that we have, or personalities can loom large in lots of these things, I think, as well—the historical relationships and so on. And there are funding models—

Senator SIEWERT: I have some specific questions to ask. One relates to the GP registrars program and the changes to that for rural health. Do you have any comments on that?

Prof. Thompson: It is not an area where I would say I have any great expertise. I know there are changes afoot and I know there have been efforts around getting more teaching posts into rural areas, which I think would be a very good thing. But I am not quite sure which bit of the changes you are referring to.

Senator SIEWERT: My understanding is that they are being shortened to one-year placements. I have had concerns expressed to me by Aboriginal health organisations in the bush that it will affect their ability to be able to attract GPs. Has that been brought up with you at all?

Prof. Thompson: No, but I am not really looking after postgraduate medical education so I would not necessarily expect that it would be. But just a general principle in what we try to do with our program in supporting students is that we do not want all the churn. Churn is not helpful. That is the same whether it is the Medicare Local churn or whatever; you know, it is this flurry of activity but without really getting anywhere.

Prof. Katzenellenbogen: In the Aboriginal health sector there is a workforce turnaround problem, anyway. So if there is anything that is going to make that worse, that is not a good idea.

Senator SIEWERT: Yes. That was part of the point that was raised with me—that we are getting that churn, that it is difficult to attract people, and that you just get some stability, and now this is going to add to it and make it less attractive.

Prof. Katzenellenbogen: That is right.

Prof. Thompson: There are a couple of points I would just make about workforce turnover, and they came out in the literature review that Judy and colleagues did as well: where you have a really well-managed health service where people are well supported and looked after, you don't necessarily have lots of churn and workforce turnover. So management, and how people are looked after and managed, is a really important thing. And that does, I think, pertain to Aboriginal community controlled health services. It certainly pertains to government

health services. I can say that I see these people who have unbelievably good skills coming and doing a training period, and absolutely not being looked after by some small-minded bureaucrat who is kind of penny-pinching—who has no sense of: 'This guy has real talent. I need to reward him, I need to keep him interested; there is a real potential for keeping him here—for him staying'. Unfortunately, our health services have got a bit of a bean-counting mind, I suppose. But it is a very short-sighted bean-counting approach.

Prof. Katzenellenbogen: I suppose more training in rural health system management, at whatever level; just the management aspect of it. And a doctor is not necessarily the right person, but often the accountant is not either. So, yes, some kind of good hybrid.

Senator SIEWERT: Thank you.

Senator SIEWERT: I would like to ask about the impact of the GP co-payment on access to health services in the bush. Do you have any comments there?

Prof. Thompson: Look, I get where it is coming from—the whole thing about, if you have a free service, people do not value it and they can just abuse it. I don't know what the evidence for that is. I think if we are—

CHAIR: You have to be able to get the service first, before you can do that!

Prof. Thompson: Yes; exactly. So what is the evidence for that? I would say we do know, for example, that there are already financial barriers to people accessing health care. We know that health is not evenly distributed across the socioeconomic spectrum: that poorer people are more likely to have ill-health. And you are putting an extra barrier in their way. I think that is a real shame.

There is one other point, which is actually not that point but I think it is worth making, because this has come up quite a bit in our research. We are primarily looking at Aboriginal people and heart disease and, of course, that brings up looking at issues like rurality as well as Aboriginality. I guess some of this started quite a while ago, when an AIHW report came out. The report said, 'well, Aboriginal people are not getting access to the same services—they are going to get access to, say, coronary revascularisation procedures, at a much lower rate'. We have done a lot of work using very sophisticated data and analyses and so on. This goes back to that whole point about, how do we get more investment upstream—and I think Aboriginal people and their health is a really good case in point for this. But if you actually look at that, Aboriginal people do get lower rates, you can see that. But actually, once you adjust for all of the co-morbidities, their rurality, their lack of private health insurance, and those sorts of things, then you can basically say, 'well, that all gets adjusted out'. So in a statistical model, we can account for that. It is not that you are actually treating Aboriginal people any differently; it is that they have got all these things going on—but the reality is that Aboriginal people do have all those things going on in their life.

Senator SIEWERT: Exactly. That is what I was about to say to you: the fact is, that is what happens.

Prof. Thompson: Exactly. So just chucking lots of money into more revascularisation procedures does not solve the problem. They are getting their heart attacks 20 years younger—they are dying 20 years young. This is the whole social determinants of health argument. I guess that goes to that whole question of whether we have the balance right around not only our health policy but also our social policy and where we are putting the investment. We put a lot of investment into health, and I think there is good evidence that, when you have a better distribution, you can have better outcomes. Strengthening primary health care is really important for Aboriginal health and improving health outcomes in rural areas, where people often do not have good access to primary health care.

Probably one of the things that would be most important is getting much better integration between those different parts of the health system. Western Australia do not have a primary healthcare information system for country health services. They do not have one—and it is the most basic thing. They do not have an electronic patient record, really. They have this dinosaur of a DOS based system. We keep talking about doing all of these wonderful things, but we do not have that absolute basic thing right. It is just crazy—and everybody has been saying it for a long time. Often it is, 'Oh, well, that is not on our program; we'll get to that in three years time.' This is my thing about spending money: you do the things that are really important and then, like good infrastructure, it can facilitate people having—

Prof. Katzenellenbogen: You asked what more we could do about rural health. If you are talking about discharge planning, if you do not have a good discharge plan and a discharge summary that gets to the doctor in one shape—electronically—and there is not a plan, those are the things that could make a big difference. For Aboriginal people, in particular, but also for rural people in general, that transition from hospital to home and the continuity after that is where a lot falls down. Infrastructure and some KPIs around that would help a lot.

CHAIR: I have some questions about the cuts to the state, resulting from the changes in the budget and the decision making of the Abbott government. Cuts to health here in Western Australia and indeed to all the states

and the breaking of the national partnership agreements mean that there is less money for the provision of acute services. In your view, how will that impact on the rural part of Western Australia and primary health care?

Prof. Thompson: I do not think I could give you a straight answer. I probably do not know enough about what was in those national partnership agreements in terms of the hospital part of the funding. At the moment, there is a major reorganisation within WA because of the building of Fiona Stanley Hospital—which is consuming a lot of time and many, many more resources than it should be consuming. It is not just that you have that consuming lots of money; because you have to have service reorganisation of the hospitals, it is destroying the morale at those sites as well. It is quite difficult. We do not have a good change management process in place—that is for sure. You can destroy systems and really undermine people's morale.

There is a huge amount of goodwill. A lot of health professionals are very committed to what they do and they are trying to do the best thing for their patient, and if you are in a system that does not support you being able to do that and you do not feel that you are being valued, you do not necessarily want to stick around. The reality of that is that people can go into private practice. We have these different tiers of systems, but those poor people who cannot afford private health insurance or do not necessarily have the health literacy to understand how the system works, do not have those choices.

CHAIR: And they do not have the money.

Prof. Thompson: They are stuck with what the public system provides. I am not saying that the public system is not as good, but I think you can wear out people's goodwill. Mark made the point that he did not think the UK was travelling well. There have been lots of health professional refugees from the UK coming to take up jobs up here. So you parachute those people in because basically the local people realise that they are not very good jobs and some of those positions have not been very well set up. They have quite good clinical competency but they are often coming into management positions with no understanding of the history or the structures that operate.

CHAIR: I took a number of possible recommendations from your opening comments. You essentially said that funding needs to attend to the different physical reality of rural and remote areas. We also need to better manage the KPIs, measurement and establishment of assessment structures—to measure what matters rather than what is easy to measure. You made the distinction between quality of life and mortality, and, while quality of life is harder to measure, it is important especially if we are seeking an evidence based shift to prevention rather than acute intervention. You also spoke about training of the health workforce in rural areas, and I would like you to expand on that.

Prof. Thompson: One of the strengths of WACRH is that it will work with all of the universities. We get a few interstate students as well. As I said, we did not just want students coming to us to do what they could get three miles from home in a metropolitan area. Through the Australian Rural Health Education Network we have had lots of discussions around what we think works. There is the evidence here, but there is also the notion of how we can use students to bring value to the community and how we can work in different places. Many of our training systems are disease based—let's face it—because health professionals treat disease, but how do we shift that to acknowledge that the health system has changed? A lot of it is about people's declining health—people who are living in the community rather than hospitals—and so how do we get models for supporting those people to be healthier in the community?

We have a philosophy around service learning. We mostly get students in their final year—they will graduate in a short period of time—and we want to help meet unmet needs in our community by using those students and giving them a real experience of working as a clinician. They are supervised but they are still adding value. That notion gives them incredible satisfaction. They get into things that you wouldn't think would interest young people in their 20s. They go into a nursing home and they say, 'I never thought I wanted to work in aged care, but I really liked it.' They could see the benefits of what they can do in those settings.

CHAIR: I understand Health Workforce Australia was an agency of 200 people operating out of South Australia. To the best of my knowledge there are now eight people within the Department of Health in Canberra who have replaced those 200 people.

Prof. Thompson: Penny Shakespeare did say they are recruiting. I don't know if many transferred from Adelaide, but I do not think they will leave it at eight.

CHAIR: We are running out of time. I would appreciate it, if you have the time, if you could do a written submission around the ideas you have expressed here, particularly on the Pilbara region. You have indicated that the health outcomes for the Pilbara are the worst in Australia. I think we definitely need to hear more about that.

Prof. Thompson: The waiting times and unfilled positions.

CHAIR: What is a co-payment going to do in that context?

Prof. Thompson: It is not just a two-speed economy; there is a two-tiered health system and we should not pretend that we have a universal healthcare system where everyone is getting equivalent care. A co-payment is one of those barriers. If you are talking prevention and we are treating your blood pressure you are less likely to get Atherosclerosis and less likely to have a heart attack or a stroke. But there are costs to treating people's blood pressure. The first is going to the doctor and having it monitored. You then have to have your prescription filled. You may not have been feeling sick in the first place. So now you are starting to put in extra impediments and it will get to be more difficult.

We can say, 'It is all a drug company conspiracy that we are giving people anti-hypertensives anyway.' I do not think that is true, but evidence has accumulated such that we now talk about absolute risks. So we are not just going to look at someone's blood pressure. We look at their other lifestyle factors and are more nuanced. So we might not treat an isolated mild case of high blood pressure.

It is often difficult. Lots of people do not go to the doctor. This notion that everybody goes to the doctor and wastes the doctor's time is not true. In fact, I was part of a research project around this. It was a rather naive research project, but it was very much around trying to stop people going and using the emergency department for things that might be considered primary care. But everybody makes a reasonable decision. They are not going there just for the sake of it. They are saying, 'I really hurt my wrist. I think it is broken and I need an X-ray.'

CHAIR: That assessment is made retrospectively. We have had that point made a few times as well.

Prof. Thompson: Those triage categories do not necessarily mean you did not need to go there or you did not make a very rational decision around why you went there. I think that is the other risk. If you start charging co-payments for primary health care, people will go and use emergency departments for their primary health care. They are already doing it.

CHAIR: We heard yesterday that in South Australia they have done modelling that indicates there will be 290,000 per annum increased visitations to the emergency department. There is evidence out of New South Wales of 500,000 more. Sadly, we were not able to get anybody from the department of health in Western Australia to come and put on the record any modelling they may have done. Are you aware of any modelling that has been done?

Prof. Thompson: No.

CHAIR: Do you think those numbers would be replicated in similar ways in Western Australia? Is anything unique about Western Australia that would make it any different?

Prof. Thompson: I do not think so. We already know that poorer people go to emergency departments for primary health care.

CHAIR: They will just go there more if they have to pay $7 at the GP.

Prof. Thompson: Or they will delay going. That delay is not always a good thing.

CHAIR: They will go to the emergency department because they will be too sick to go to a doctor.

Prof. Thompson: Yes.

Prof. Katzenellenbogen: It is already a problem. Certainly we know with Aboriginal heart disease that delay is a major problem. It is because of the cost of the ambulance and so on. First of all, they will not go to the GP because of the co-payment and then they might even delay further because of the ambulance cost and so it goes. All of this accumulates and you end up with people with much more complex diseases by the time they get there and then the costs go up.

CHAIR: We had very interesting evidence about diagnostic imaging as well in Victoria that I am sure you would be very interested in. They are hundreds of dollars out of pocket because of the $7 GP change, in addition to 10 per cent and 15 per cent dividends being withdrawn, plus the need to spend up to $1,000 up-front and then go back and claim it independently. So there are lots and lots of issues with diagnostic imaging. Thank you for your time today, Professor Thompson and Professor Katzenellenbogen. Thanks to Hansard, Broadcasting and the secretariat.

Committee adjourned at 12:53