EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 31 AUGUST 2009

SESSION FIVE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 4.10 pm

SWANSON, MR MAURICE GERARD,
Chief Executive Officer, National Heart Foundation,
examined:

ROONEY, MS SUSAN HANNAH,
Chief Executive Officer, Cancer Council WA,
examined:

SULLIVAN, MS DENISE LEONIE,
Director, Tobacco Programs, Cancer Council WA,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into WA's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference. This committee hearing is a committee of the Legislative Assembly of Parliament and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing, and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read an "Information for Witnesses" briefing sheet regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions relating to your appearance before the committee today?

The Witnesses: No.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

[4.15 pm]

The CHAIRMAN: We might start with Susan. Susan, you are aware that the specific terms of reference of this committee are to identify needs and gaps in healthcare services in both the hospital and community sectors. Would you like to start the discussion and then we will move on to Maurice and Denise. The committee, as we have discussed, will interject to clarify points with you.

Ms Rooney: The point I make to start with is that the Cancer Council thinks there is obviously some real issues around prevention and population health, but rather than covering those issues, I will leave them to Maurice. We have discussed this earlier; I will talk about cancer-specific issues. They primarily relate to two areas of real concern. One is the palliative care area. A report was written several years ago that identified what need to happen in palliative care in Western Australia to bring palliative care close to where people live. There has not been much progress on the recommendations of the Reid report on the development of new palliative care units. We are aware that there are to be palliative care beds at the Joondalup Health Campus. Again, we are not sure if that is a unit or not; it is actually really hard to tell what is actually happening. We have been told that it will probably be a unit, but there are some real issues in patient palliative care, and it is important that it is actually a discrete unit, because it will then have a very different quality of care. That will be happening a number of years later than we when we were told it would happen. We were basically told that it would happen in 2011. As the committee will probably be aware, the Cancer Council had a hospice that was closed. We also based some of that closure time line on the time lines of new units opening. There are therefore some issues around that delay.

I also mentioned in the submission that there are palliative care beds at Kalamunda District Community Hospital, but they are actually treating more palliative care patients than the number of beds that are being funded. The Cancer Council does some inreach programs to help boost the palliative program there, but there certainly needs to be more funding of palliative care nurses.

Mr P. ABETZ: Could I just ask a question on that? I have been involved in palliative care work in Victoria. The focus there was not so much on actually having beds, but on providing care in the home.

Ms Rooney: There needs to be both.

Mr P. ABETZ: There is obviously the need for both, because some families cannot cope or whatever the situation may be, but what is the availability of palliative care? If there is insufficient help available in the home, but the patient would prefer care in the home, it will push people into palliative care beds. If the palliative care beds are full, it will push people into hospital beds, which is a total waste of hospital funding. What is the pattern that you see in the community? Is there enough palliative care provided in the home setting for those who want it, at a level that will allow the patient to stay at home right until the end, or is there inadequate funding for that, which results in more pressure on palliative care beds?

Ms Rooney: I do not know whether Silver Chain has made a submission, but Silver Chain provide palliative care in the home, and it is quite stretched. There is certainly a need for more resources to be put into community based services. We are also always going to have a situation in which we will need inpatient units. They need to work hand-in-glove. There are definitely resourcing issues that need to be looked at in the community, I think, that will grow it. Silver Chain is an excellent service provider in that area, and we are very lucky to have it.

The CHAIRMAN: One of the problems with the provision of palliative care by Silver Chain is the fact that it is funded for 60 days within a palliative care unit. If it goes beyond the 60 days, it has to meet the cost required for patient care, and that is why one sometimes hears that it is difficult to get patients into palliative care units. There are obviously concerns that people will go in too soon, and about who is going to meet the additional costs. Something else that has come up in our discussions is diagnosis. The focus of the Cancer Council is obviously on patients who have cancer and require palliative care, and on who identifies patients and the link between the tertiary and community sector for those palliative care services. We had someone from Palliative Care Western Australia who said that an issue is the initial identification in hospital and who they contact when they leave the hospital. Maybe we could talk firstly about the identification and referral process, and any identified needs and gaps that you see in those processes.

[4.20 pm]

Ms Rooney: Some of it depends on the clinical practice. Some people are referred to palliative care services at an earlier stage. Sometimes the issue is that palliative care services are not available. For regional and rural people the issues are much more complex. A different kind of model is needed for regional and rural areas than for the metropolitan area, although the principles are the same. One of the issues is about understanding where palliative care can have a positive impact. Sometimes people refer to palliative care as very end of life. Some of the issues for cancer patients may not be as complex as the issues for motor neurone disease, for example, as to when the end of life needs of a person is determined.

The CHAIRMAN: Or heart failure or emphysema.

Ms Rooney: Exactly. There are some instances when it is more difficult to determine. The issue of when cancer patients are referred to palliative care is important. It has more clarity around it in some ways than with some of the other chronic diseases. I understand that some patients are not even referred to palliative care services at all. That is the same with cancer patients, but that tends to relate to where they are and what the treating clinician is like regarding knowing when active treatment or palliative care is required. The treatment can depend on the clinician. The issue for us is that a lot of work was put into a plan for palliative care that involved a huge number of experts. I am sure that Palliative Care WA would have spoken about that.

The CHAIRMAN: When was that plan done? I am not sure whether we have a copy of it.

Ms Rooney: It was the Department of Health's "Palliative Care in Western Australia" report 2005. It was released in December 2005. It took a lot of discussion to come to a consensus about what was a good position to be in. There is the issue of community versus palliative care units. It was based on some of the national guidelines and some of the evidence. There are quite a few guidelines around it. A lot of work was put into it. The Reid report also identified the need for palliative care units. It is about making sure that there is a level of prioritisation in the implementation of that. The problem with hospitals and palliative care is that sometimes the beds become the identified palliative-care beds and it does not meet the need of a palliative care unit because a palliative care unit requires a different ethos and training. If it is mixed with medical beds where there is curative intent, people get a different level of quality of care.

Mr P. ABETZ: It needs to be physically separated.

Ms Rooney: It does. It needs to be in a unit. There are real benefits for it being located on a hospital ground, otherwise patients would need to be transported for X-rays and for pain relief and those kinds of things. It needs to be incorporated into a hospital. Rather than going over that again, there is a report. The Department of Health has said that it is implementing that report in conjunction with the Reid recommendations, but it seems that it is being done slowly and that it is not necessarily easy for us to get hold of the information about what happens. It depends on who you talk to as to what is actually occurring.

The CHAIRMAN: What information specifically are you having difficulty getting hold of? What information are you after? We can possibly ask those questions.

Ms Rooney: For example, we have heard that there will be a palliative care unit at Joondalup but someone else in the Department of Health will say that it will be a number of beds and that it has not been identified as a unit. It is about what level of commitment there has been to the plans and the planning processes for a palliative care unit at Joondalup. We have received assurances from various areas, but we have not seen that that has been drawn up in the plans. It is important to implement those kinds of things and to address the issues of community based palliative care.

The CHAIRMAN: Going back a few years, palliative care used to be administered on the oncology wards. How does it happen now, and how do you expect it to happen at Joondalup?

Ms Rooney: It varies in different places. There are some beds and there is a palliative care service in Royal Perth Hospital and Sir Charles Gairdner Hospital. It is more of a service than a physical

unit. There is a palliative care specialist there, and there is a palliative care unit—not quite—at Kalamunda, where there are a number of beds. Because they have more patients than the number of beds, it almost forms a unit, but it does not have enough beds in that area nor the number of nursing staff, more than anything else. It varies from place to place. There are some specialised palliative care units. There is one at Murdoch—the Murdoch Community Hospice. However, there are not many specialised palliative care units. That is definitely what needs to happen and that is what the plan says needs to happen.

The CHAIRMAN: Do you see those units being established within the secondary level hospitals and not the tertiary hospitals, or within the tertiary and the secondary hospitals?

Ms Rooney: The plan looks to them being in the secondary hospitals, so the general hospitals more than the tertiary hospitals.

The CHAIRMAN: From the research, are there any guidelines about the base number of beds required for a palliative care unit?

Ms Rooney: The base number is 10 beds. It is more to do with nursing levels. A certain number of beds are needed for the number of nurses there are. It is also about physically making it viable. It is around about 10. There are a lot of standards as to what a palliative care unit should be. They are all agreed to at the national level through Palliative Care Australia and they have been endorsed. The WA plan utilises those guidelines.

The CHAIRMAN: Under the WA plan, would it state that per population there should be a certain number of beds?

Ms Rooney: That is right.

The CHAIRMAN: So we can look at the plan and see that in the north metropolitan region there should be a certain number of beds and we can ask where those beds are or where they will be located?

Ms Rooney: Yes. The issue for us regarding palliative care is about how it is moving forward and the fact that the plan exists and that the number of palliative care units needs to be pushed forward. It seems to be taking a while.

In terms of gaps, in July 2008 we commissioned a report that is an overview of cancer services in Western Australia. That report was paid for by the Cancer Council and the Department of Health. It looked at the gaps in cancer treatment services in Western Australia. I am sure that this is not a cancer issue alone, but there is a huge workforce issue for cancer workers. WA has the lowest number of oncologists per population in Australia, we have a shortage of radiation oncologists, and there are shortages in various other workforce areas that are consistent in radiotherapy across the country and internationally. There are certainly some issues for WA about the number of specialists. The number of people who will need treatment for cancer is growing and will continue to grow because it is a disease of ageing. The committee is certainly aware that the incidence levels are growing. The report identified that that was one of the key issues that needed to be addressed. It takes a while to train people into those positions. Therefore, there needs to be a plan to do that in the future. The Department of Health was looking at the workforce plan at one stage. I am not sure how far that has progressed. The issue of the workforce is a major one.

Another issue that this review identified was that the level of services for cancer patients will not be adequate, even when Fiona Stanley Hospital is built. There will not be enough beds to treat patients. Most cancer ancillary treatment is out-patient based. The report identified that there are not beds. When the cancer centre at Fiona Stanley Hospital opens, it will be full.

The CHAIRMAN: Is that because the patients who are being treated at an intensive level are required to be admitted while they require that treatment and therefore we will not have enough beds?

[4.30 pm]

Ms Rooney: No; we just will not have enough chemotherapy beds. When I talk about chemotherapy beds, that is out-patient beds, so it is a day procedure. With radiotherapy, it is actually the number of machines. When this report was done last year and was looking at the number of projected incidents into the future, the incidents will be greater than what the facilities are by that stage.

The CHAIRMAN: Even with the new machines at Fiona Stanley, we will not be able to —

Ms Rooney: That is right; even with the new machines we will not have enough. There will be waiting lists. That is usually what happens; there are waiting times, and that is usually what the problem is. I attached a copy of Professor Michael Barton's report to our submission. Professor Michael Barton is a professor of radiation oncology from New South Wales, and he wrote the report. His report identifies the population issues and the number of beds that have been planned for, and the fact that the infrastructure for cancer patients in insufficient into the future. That will be a real issue.

Mr P. ABETZ: Especially with the ageing population, it will be huge.

Ms Rooney: Exactly; that is right.

The CHAIRMAN: And the effect of a delay in treatment means what for those patients?

Ms Rooney: It depends on the length of the delay. For example, there are some cancers where it is actually all right to have a delay in your radiotherapy. You might have a lumpectomy of your breast, and then you have to have radiotherapy after. There is a level at which it is all right to have a certain delay, and for other cancers there is not; you need to be seen fairly rapidly. There are national guidelines that will identify whether or not you meet those standards. Professor Barton used those guidelines, the incidence rates projected into the future, and then looked at the number of machines that were planned and identified that there was not sufficient at all. It is the same with the chemotherapy beds—again, when I talk about beds, it is out-patient treatment. It is a real concern that even with the building of a whole new tertiary hospital, there will are still not going to be enough for cancer patients to be treated.

There is certainly some move within the plans to look at decentralising some of the treatments, but radiotherapy has such an expensive infrastructure; you cannot replicate radiotherapy in general hospitals et cetera. It is a real issue that needs to be looked at when planning for the future.

The CHAIRMAN: People come up from Bunbury and all over for day treatment at Sir Charles Gairdner Hospital.

Ms Rooney: They do, and sometimes radiotherapy is six weeks, and so they stay in the Cancer Council lodges. The Cancer Council has two lodges for country cancer patients, and they stay there. There will be a radiotherapy unit in Bunbury that is opening early next year, if it is on track.

The CHAIRMAN: That will service the south west?

Ms Rooney: That is right. That will assist some of that process. But even taking those into account, Michael Barton identified that there needs to be more planning for the future in terms of cancer out-patient infrastructure. The figures in the report will identify the shortages for you as well in terms of workforce, but also the insufficient number of beds that are being planned for out-patients. They do it on a national level and identify different standards.

The CHAIRMAN: We might move round to Maurice, who—for the other members of the committee—introduced himself as the CEO of the Heart Foundation. Maurice was in the Department of Health for many years, and so has a very good picture of public health within the state. Maurice, would you like to give the committee some information about particularly the needs and the gaps that you see.

Mr Swanson: I was going to focus on prevention and Denise and Susan were going to add to what I had to say on prevention. Just before I go to the topic of prevention I would like to say that the Heart Foundation did produce a document in the lead-up to the last state election which was called "Time for Action". It was basically a summary of the gaps that we had identified—I have not provided it to you yet.

The CHAIRMAN: We would like a copy of that as supplementary information.

Mr Swanson: I will provide that. That document identified the gaps, as we saw them, in the provision of cardiovascular health services. Just as an example, there is no comprehensive program for cardiac rehabilitation in Western Australia. It is very patchy. It is good in some areas, but poor in others. We had recommended to the parties contesting the state election that they consider funding a new program that would be comprehensive, that would be statewide, that would consider different models for different patients in different locations. For example, if you were in a far-flung region, then you might have access to telephone coaching. There is a well-evaluated rehabilitation program that is called COACH, and it uses the telephone. The objective of all of those programs for people, post-event, is to ensure that they take their medications, that they have a high level of compliance with their medications, and that they try as hard as they can, with support, to reduce their risk factors.

The CHAIRMAN: Before we move on to that, could I just mention to you that I have had discussions with Brendon about the royalties for regions funding; it is not to supplement current shortages in FTE funding for healthcare services, but it is for the initiation of any new services. We could provide you with a list of the regions where there—Peter probably knows more about this than I do—regional councils which come together on a regular basis. Something like that idea would be very good to take to those regional councils, and they could then possibly tap in to the royalties for regions funding, to get programs like that initiated. We would be more than happy to work with you, following this hearing, perhaps with Peter's assistance, to tell you where those groups are, and then maybe you can approach those groups.

Mr P.B. WATSON: The development commissions.

The CHAIRMAN: I could not think what they were called. I know where they are, I just could not think of the name. That might be a very good initiative under that new funding.

Mr Swanson: That is great. This is based on the evidence that the people who are at highest risk of a follow-up event—that is, another heart attack—are people with existing heart disease. A simple illustration of that is the story in this morning's paper about Geoff Parry. He had a heart attack several years ago, and he admitted in his statement in this morning's paper that he tried hard, but he did not really implement much of the lifestyle change advice that he was given. He probably also was not supported much by the environment in which he works and lives, but that is another issue. Now he is in a tertiary bed at one of our teaching hospitals and he has had a quadruple bypass and he is costing the taxpayer a huge amount of money. I say that a little flippantly, but with a point to make, that the treatment of cardiovascular diseases, because of their high prevalence, or incidence, are very expensive as a group of diseases to treat. One of the points I will be making later is that if we could prevent them from occurring in the first place, we would be able to reallocate those saved resources into other health areas. I will get the document for you; comprehensive cardiac rehab was one of our asks. Under that heading was the development of a program targeting Aboriginal people, because you all know that they have a much higher incidence of disease and they have big gaps when you compare the level of care that they receive in the hospital system with the care that non-Indigenous Western Australians receive. They do not get the same level of intervention, they do not get the same level of follow-up, and they are lost to the treatment path much more than non-Indigenous Western Australians.

[4.40 pm]

Part of the list of asks is a program tailored to the needs of Aboriginal people that is culturally appropriate and also culturally safe for them. There was also an ask for the trial of a new program designed to better manage heart failure patients. They are very much frequent flyers within the tertiary health system because they have a chronic disease that will ultimately kill them and as their condition deteriorates, they cost the health system a large amount of money. Better management of them as patients so that they are better able to cope at home would be a worthwhile investment. We proposed a trial where we appointed, if you like, a patient broker. That broker is assigned to a certain number of heart failure patients and would interact with the system to ensure that the patients are getting the services that they require in the most efficient and clinically effective way. We were proposing that perhaps the heart failure patients that are treated at Sir Charles Gairdner Hospital from a certain area within the metropolitan area would be assigned a broker to act on their behalf. It is a program that has been trialled successfully in New South Wales. Again, we had it on our list as one of our asks.

The CHAIRMAN: Like we have Parkinson nurse specialists and nurse practitioners—someone of that level—specifically looking after patients with heart failure?

Mr Swanson: Yes.

Mr P. ABETZ: And motivating them to do the right thing preventive-wise?

Mr Swanson: And making sure that when they need a clinical service that they get it from the right provider within the system. We want an efficient and effective delivery of the clinical service that that person, because of their chronic condition, requires. We are not trying to run this program to ensure that they do not get what they need because there is a pressure on dollars; it is the opposite.

Mr P. ABETZ: It is getting efficiency.

Mr Swanson: Exactly.

The CHAIRMAN: Have you thought, when looking at such a position, about the divisions of general practice? Divisional money could be used to employ someone, a nurse practitioner, or whatever you wanted to call that person.

Mr Swanson: If I can just jump in there, Janet? In the proposal, the nurse practitioner would engage the divisions in the delivery of care for their population group—their catchment group.

The CHAIRMAN: Obviously there is a state pile of funding and a federal pile of funding and I am looking at how we can tap into that federal funding to help with our services, and the divisions would be one way. I am sure you know the names, but if not I could give you the names of the various divisions, and they could put that out possibly as a research project—depending on what success you have with the state minister. We could try both because it does seem like it would be a very valuable role.

Mr Swanson: It would be one worth evaluating before it was rolled out across the state.

As well as that "Time for Action" document, we have finished off in the past week or so another document that focuses on the disparity of care for Aboriginal people with cardiovascular disease, and I will obtain a copy for the committee. It talks about the changes that need to be made to the system to improve the patient journey for Aboriginal people. For example, put yourself in the shoes of someone living in the Kimberley who is diagnosed with cardiovascular disease and needs to come to Perth for a stenting procedure. For most people in that situation, the environment at Royal Perth Hospital, Charlies or Fremantle Hospital is very foreign, particularly if there is not someone there who is looking after their interests in easing the path for them—usually another Aboriginal person or an Aboriginal health worker who is aware of the challenges that the change in environment poses for the patient. I will supply the committee with that document as well, because it contains some clear recommendations about what could be done.

Before I move on to prevention I should just point out that when we presented that "Time for Action" document to both major parties that contested the last election, no-one committed to funding any of the initiatives on the list. The reason for that was, particularly, when the new government took over and had a look in the cupboard, it was pretty bare, and with the global financial crisis, there was not likely to be lots of new money to apply to these sorts of initiatives. I must stress that the new Minister for Health did express a real interest in working with us on the Aboriginal health issue, and he was aware—more aware than many—about the particular challenge that cardiovascular disease presents for Aboriginal people.

Ms Rooney: I am sorry to interrupt. There would be significantly different issues than the ones related to cardiac issues; however, one of the things for which there is commonality is that Aboriginal people in remote areas have to come down to tertiary hospitals. There are issues for cancer patients as well. Whatever was looked at in that case would need to make sure, from an efficiency and effectiveness purpose, that there are not different models for different conditions. I imagine there are commonalities around the issues. There are probably differences in what needs to be addressed, but separate systems should not be set up depending on one's diagnosis, because those issues would go across any of the chronic diseases.

The CHAIRMAN: I might come back again to the royalties for regions funding in that so much of that funding has been allocated to patient assisted transfers. You are suggesting that we have someone within the metropolitan area—some additional or full-time equivalent position—to assist those patients both pre and post that process or maybe pre the discharge process and as a follow-up on the discharge process. That would require the appointment of some new FTEs in a very new role to try to ensure that any rehabilitation from whatever treatment they had received was fulfilled. Again, it might be worth looking at that as a new approach to health care that could then come under that royalties for regions funding.

Ms Rooney: There is a concept in cancer care called a patient navigator. I think that is probably the sort of thing that you are talking about. There are cancer navigators throughout the system, not necessarily just for people from the regional areas; they are called cancer nurse coordinators. They are a very recent addition to the health system in Western Australia. That concept of patient navigation is probably consistent across all chronic disease issues, particularly with Indigenous people but also people from remote areas. It is a scary process.

The CHAIRMAN: Susan, could we ask you for more information about that patient navigator, and from the articles and the information that you have on that, if you could particularly look at how that patient navigator could be used for the type of model that Maurice has just described? We are looking at health care services in metropolitan and outer metropolitan areas. It may well be that when the committee reviews the patient navigator model we might be able to agree on a recommendation to the minister.

[4.50 pm]

Ms Rooney: I will liaise with Maurice so that there is consistency between that, but certainly the patient navigator model existed in cancer in some countries, like Canada, for a reasonable period of time.

The CHAIRMAN: Have you heard of this, Peter?

Mr P.B. WATSON: No.

Mr Swanson: There has been an evaluation at Royal Perth on the positive outcomes of having an Aboriginal-to-Aboriginal health worker who assists in the patient journey.

Mr P.B. WATSON: Is that from their regional town to —?

Mr Swanson: It has been more, Peter, that when they are admitted to Royal Perth, the Aboriginal health worker becomes the patient advocate and they feel, while it is a very strange environment

and they are probably very anxious about the procedure, it tries to overcome things like "everybody that is sent to Perth never comes home, because they die". That is not entirely true, but that is the perception that you are trying to deal with.

Mr P. ABETZ: It is not entirely wrong either; that is the problem.

Mr Swanson: Depending on the level of their condition. Having an Aboriginal person explain what the procedure is, is so important.

Mr P.B. WATSON: Would it not be better if that was explained before they left?

Mr Swanson: I think it is a combination.

Mr P.B. WATSON: Because they are going on a journey they know nothing about. Someone says, "You've got to go to Perth". If you could have a system where they could be spoken to before they leave, by one of the elders or something like that, saying, "He will come back".

Mr Swanson: This particular evaluation just looked at the impact that having an Aboriginal health worker had on the patient journey and the outcomes of patients at Royal Perth. I can get that for you, because it is part of the evidence that underpins this "disparities of care" paper that we have just prepared for the board of the Heart Foundation as an advocacy tool. I agree with Susan—the patient navigator and the patient advocate is the same role. We would not want to say they are different for cancer or heart disease.

In terms of prevention, you have probably had a chance to read my paper. Basically, what I was saying there is that we need to strike the right balance between the resources allocated for prevention and the resources allocated for clinical care. The challenge for prevention is that it is not demand-driven. I think that the quote that I provided from D'arcy Holman illustrates that beautifully, that the Minister for Health never receives a telephone call from a member of the community thanking him for the heart attack that she or he did not have. It just does not work like that. Whereas, Peter, if your father has a heart attack tonight and you cannot get into Royal Perth within what you think is an acceptable period of time, you will be on the blower within minutes saying, "What the hell is going on?" No-one rings the Minister for Health saying, "You know, that Quit campaign that you got going back in 1983, I quit smoking in the first year of that campaign. You know, I'm 70 now. I'm really grateful for having given up smoking because I understand that it reduces my risk of a whole raft of nasty diseases." That is the difference in the two areas. They are both political but one is very much demand-driven, very much on the front page of *The West*, and the other does not get anywhere near the coverage or the attention. I have set that out in the paper. I have also expressed some concern that both the Cancer Council and the Heart Foundation have about the level of resourcing that is currently going into prevention. We do not think it has even kept pace with inflation compared to the amount of money that the health department dedicated to prevention when I worked in the health promotion services branch. We think it has dropped off from there. We have not got access to the exact figures, but I think I encourage the committee, if they can, to look into this and ask the health department what is the current allocation for dedicated prevention. What happens when you ask health departments that sort of question is that they try to dress up almost everything as prevention, and it is not. You have got to be on the lookout for that. Look at the trend over time, because we suspect very strongly that that has gone down over time.

You could accuse us of having a conflict here, because under the previous government they decided to outsource the health promotion campaigns. We think, for good reasons, it is a lot easier to provide responsive, hard-hitting health promotion campaigns from the non-government sector because you tend not to get bogged down in the approval process. It can be mind-numbing in the government. Both Denise and I have lived through that. It is mind-numbing. That is not to say that the health department does not hold you accountable now with their contracting process, but it is important. I think that both submissions make the point that if you are going to purchase services

through contracting to the non-government sector, then you do need expertise within the health department. We call it "informed purchasing", not "content-free managerialism". That is a threat. We do not mind having an informed purchaser purchase services from us, but what gets our backs up is if we are dealing with content-free managers who get swapped around every five minutes into a different area. That is one of our concerns.

Ms Rooney: Can I just add to that reasoning. The issue is not that it is an irritation but that it actually has some real impact. I know that we have had examples where people have wanted us to bundle things together or do various things that, in fact, you cannot do together. If you do not understand what it is you are asking for, you keep adding another box to tick—"Hang on, we'll cover that and that and that"—when in fact they may actually be two different approaches or two different target audiences almost. The problem with that is that you may end up with less quality because you are being pressured to actually provide something that that content expert would tell you is not what we do, nor would they ask you to do it in the first place.

The CHAIRMAN: Do you see that the problem really goes back to the health department; where public health and health promotion fits within the empire?

Mr Swanson: I think that the level of resourcing for public health has diminished over time quite significantly, within the department, under the previous director general. Now they are trying to rebuild those resources, but of course they are constrained by the three per cent and other pressures that are on departmental budgets. But it is essential that you have got a group of core public health experts within your health department to inform your purchasing. If the government decides, from a policy point of view, that they get good value from outsourcing, then you have got to have those content experts to inform what you are purchasing.

Ms Rooney: They also have to be able to work in with the commonwealth. There has been commonwealth funding from various initiatives. You, as a state, miss out if you do not really understand what it is that you need to do, or you have not got the content within the department to be able to say, "Actually, that's a program that we could access." You have to put submissions in for that, I gather, for commonwealth funding from the health department; is that right?

Ms Sullivan: Certainly, under a number of initiatives that are coming under the federal government there is potential for the state to access increased funding from the commonwealth on the basis that it lifts its game in prevention. But it also means the state health department needs to apply more resources and have the expertise to ensure that they are being applied well.

The CHAIRMAN: We are hoping to get some more information in relation to that commonwealth funding for health. We will particularly ask about preventive health measures. But going back, Maurice, if we look at lots of health areas, you have key performance indicators wherever a target has been met—are you saying that there should be some key performance indicators in terms of the public health branch for that purchasing? How do we ensure that public health is looking at where the money is going; and is that money being well spent?

[5.00 pm]

Mr Swanson: First of all, you need to have a quantum of resources that is realistic for the job that you want to get done. I mention in my paper that if you combined all the resources that are going into public health and compared that with the resources for the rest of the health system in Australia, it is two per cent, or less. That is a pitiful amount of money. That is one of the reasons that the new federal government has established the Preventative—with the extra syllable—Health Taskforce. They have promised—although we have not seen the quantum of money yet—that they are going to pump dedicated resources and many more millions of dollars into prevention, because they have accepted that prevention will impact on the demand for hospital beds to treat chronic diseases. Many of the chronic diseases have a very large behavioural component. It is not just individual behaviour, but it is also the environment in which people make those decisions, so you

have to look at advertising and pricing and taxing and all those other things as well. There is also an issue about balance in terms of investing in prevention while not doing that at the cost of clinical care. It is not an either/or. It is a balance between the two. You then need to have a decent strategic plan, as we had during the 1980s and 1990s—you may remember, Janet—when we had successive publications called "Our State of Health".

The CHAIRMAN: Yes.

Mr Swanson: Those publications set out very clearly, from epidemiological evidence and other criteria, what the health department should be investing in. That then informs your strategic purchasing and your overall strategic plan. You need to have a plan to decide what to invest in. The other point I am making here is that this is not new. The Reid report, which cost several millions of dollars under the previous government, set out very clearly that the costs in health were going up exponentially—they probably still are. He made the finding that the costs in most other government departments were going up at five per cent a year, whereas in health they were going up at a much greater rate each year. I make the point in our submission that if you want to start to control those costs, you need to re-jig your investments to try to put a brake on the demand for the higher-level tertiary care for these chronic diseases.

The CHAIRMAN: To stop the chronic diseases.

Mr Swanson: Yes. That is not going to happen overnight. That is probably a challenge for the political cycle. The problem is that we elect governments on a four-year cycle at the state level and on a three-year cycle at the federal level. Often we do not make investments in prevention unless we are dealing with infectious diseases such as swine flu, for example. With swine flu, there was an immediate response that Roxon had to get on the road—that was buy Tamiflu, or whatever vaccine they are mass-producing at the moment, work out the high risk target groups, and negotiate with local governments to deliver those vaccines, and hope that the mayor of the City of Vincent does not get in your way! That is a classic example of an infectious disease where you have a set of well thought-through and evidence-based strategies, and you can have an immediate impact. With chronic diseases—lung cancer and cardiovascular disease—they are not going to be affected immediately in the next couple of years. You will see changes in the prevalence of smoking from campaigns like the one Denise is running at the Cancer Council—Make Smoking History. You will see the effect that is having on lung cancer rates. It is also making a big contribution to the reduction in risk from coronary heart disease and chronic obstructive lung disease. But often you do not see the immediate responses. All we are, in a sense, pleading for here is a balance in the level of resourcing and informed purchasing, remembering that we are not going to have people marching in the streets for prevention. That happens only when you have a large food poisoning outbreak, where 200 people are poisoned and 50 of them die. A minister can lose his portfolio if something like that happens and it is proved that he has taken resources out of the food protection side of public health—his head will be swinging. But most public health things can be swept under the carpet. They do not show up for a long time.

Ms Rooney: I think that is the point with KPIs. There needs to be almost a set minimum amount that you would actually spend on prevention. Maurice has made the point that you might ask how many FTEs there would be in prevention, and that would depend on what it is that the health department defines as prevention. But, really, there ought to be some cocooning of that money so that it is not actually used to prop up the immediate. There are real political pressures. We understand that. There are also real pressures for director generals. Given that the media does drive a lot of the responses, if there was good policy or practice that identified that funding, and if it was isolated in some way so that there was a minimum level of meaningful investment, that might remove some of that pressure immediately from the director general and the minister at the time.

Mr Swanson: The quarantining of public health funding is essential. The other rule that we tried to implement back in the 1980s and 1990s was the eighty-twenty rule for work in the regions, where

80 per cent of the dedicated public health FTE workload should be directed at the major causes of preventable disease, and 20 per cent should be directed to what might be attracting a lot of attention locally—that is, when you look at the epidemiology, it really does not affect that many people, but it is politically sensitive.

The CHAIRMAN: Can you give me the eighty-twenty again?

Mr Swanson: You would direct this quarantined amount of money for public health across the state. You would be saying that it does vary—Albany is different from the Kimberley—but from your epidemiology, you would insist that 80 per cent of the funding be directed at addressing the major causes of ill-health in that region, and 20 per cent would be flexible to address other issues that might arise from time to time, because it is a political process you have to deal with. We tried to do that in the 1980s and 1990s, and we came unstuck a bit, because it depends on the political flavour of the day with respect to centralisation versus decentralisation. I often thought that it depended on who was advising the minister of the day. I heard an interesting anecdote the other day from an ex-head of Westpac bank. He was 2IC in Western Australia for many years. He was president of our board. When they centralised the bank, he had a not very important job to do here because the decision making had been centralised to Sydney, so they offered him the job of running the bank in Fiji, which he did for four years until the coup. He said that Gail Kelly, the new CEO of Westpac, is now actually undoing the centralisation and giving back to the branch managers the power to make decisions. People do not want to go to a branch manager to do their banking business and be told, "Oh, I really do not have the power to make a decision like that, you know; I have to consult with someone over east". It really pisses people off.

The CHAIRMAN: We might move to Denise, because I know that Denise is going to come in on the prevention side of things.

Ms Sullivan: I suppose Susan and Maurice have really covered most of what I could add. I really just want to reinforce the importance of prevention. There is a real need for government to boost the priority and investment in prevention, not only in terms of what it is purchasing from other sectors, but equally to ensure that it has the critical mass of expertise that it needs to ensure that there is good, high-level policy advice that is guiding priority setting and purchasing, and advice, obviously, to the minister and government of the day around what should be important and high-priority public health issues for the state.

The CHAIRMAN: I just want to ask you about that purchasing from other sectors, because various groups have made submissions to the committee. For instance, it has been explained to the committee that in mental health there is now a great reliance on non-government organisations to care for people in the community with mental health illnesses. With this purchasing from other sectors, we often hear about how many boards and committees and different groups there are.

I guess it goes back to what Maurice said about informed purchasing. Who do you think should be looking at ensuring the funding?

[5.10 pm]

Ms Sullivan: Certainly within the health department, I think there are benefits to having a central area that is responsible for purchasing public health prevention programs, and there needs to be a certain level of expertise within that unit and a certain number of staff to do that well. A much larger number and broader range of services are being purchased from the NGO sector than perhaps has been experienced in the past. We can sometimes experience frustrations when dealing with the department. For example, the Cancer Council has multiple contract managers working in different parts of the department. In some cases a contractor will deliver a campaign or program, and we may be liaising with four different sections around some of the deliverables within that contract. It makes it difficult to, first, be sure there is a common understanding of what is being purchased and,

second, not to have a sense sometimes that those assessing the quality of what is being delivered do not necessarily have the skills or expertise to do that so well.

The CHAIRMAN: The committee might need to call in someone from public health in the health department and ask them to explain to us what purchasing is going on, what statistics are being gathered and what the links are at the moment.

Ms Sullivan: I do not know to what extent there is sharing of information across committees, but certainly the Cancer Council and Heart Foundation made a joint submission to the Economic Audit Committee. We specifically addressed the issue of purchasing from the third sector, which is one of the terms of reference for that particular committee. We raised some of the benefits but also some of the risks that come with purchasing services from the third sector, in that there is a risk, or there is a perception that all services can be purchased through the third sector.

Mr P. ABETZ: What is the third sector?

Ms Sullivan: It refers to both the not-for-profit and the private sector. The reality is that some things may be delivered well by the third sector, but it is based on the understanding that they have the infrastructure expertise to deliver what is wanted. In some instances it may not be appropriate to look to purchase outside government agencies because government still has a clear role to play in delivering some services to the community.

Mr Swanson: The other point within that is that they are very circumspect about acknowledging our costs of business. It is almost as though, because you are in the not-for-profit arena, you do not have to pay rates to the Subiaco council. I raise that because I signed the cheque before I came up here. There are overheads. When we were public servants, we were accommodated at Silver City and there was a reasonable level of accommodation. It was a cost to government to accommodate staff. When they are purchasing, they tend to forget that there are overheads that have legitimate costs. For example, within the Heart Foundation it costs more than $4 000 a year to put a PC on someone's desk. There is the wide area network, software licensing and capital equipment that you purchase to put in a keyboard, a screen et cetera. They are real costs and they would have been similar in magnitude to what government was paying in a different form. When they go to purchasing, sometimes I think they forget that you have to provide a certain amenity; it is not luxurious, as you who have visited our offices all know. But there are certain costs we cannot avoid. One of my frustrations is that they need to recognise that we are not trying to dud them in the negotiation process, but there are real costs for delivering services through the non-government sector. We think we can do a good and high-quality job, but there are some real costs there.

The CHAIRMAN: Denise, was the submission you made to the Economic Audit Committee recent? The committees tend to work very separately and unless we know we are doing similar work —

Ms Sullivan: The deadline for delivery closed today, so we provided our submission late last week.

The CHAIRMAN: As a committee, we are very proactive and our submissions are put on the internet immediately so that people can look at them.

Ms Sullivan: Are we able to provide it direct to you?

The CHAIRMAN: If you have given a submission to the committee, that submission now belongs to that committee and you need that committee's permission to release it. You could ask whether you can give us a copy of that submission. That would be very helpful.

Ms Rooney: That is probably the easiest way. We will do that.

The CHAIRMAN: If you are happy to do that, we could also have a copy and look at it in terms of health.

Mr Swanson: There is a real flavour in the background paper to that request— that the current government is looking at other ways to deliver services that are effective, but also cost effective

from the government's point of view. There are various ways of interpreting that. One might if one were a little cynical say they are looking for —

Mr P. ABETZ: To save money.

Mr Swanson: Exactly.

The CHAIRMAN: If there is any problem we will contact the committee. In view of the time and that we booked Hansard until only 5.00 pm, thank you very much and I am sorry that we have kept you. Hopefully you all met before. Unless there is something else?

Ms Rooney: It has all been covered.

Mr P. ABETZ: You came here to address the preventive issues and the palliative care side of things. Are there any glaring holes in the system at the moment apart from lack of funding?

Mr Swanson: Not from the cardiovascular health point of view as far as I am aware. In preparing that "Time for Action" document, we canvassed quite a few of the cardiologists who sit on the board of the Heart Foundation. They felt that the number of cath labs, for example, was adequate for the population. A formula is applied to work out how many of those facilities are needed. I have noticed some debate in the paper recently about the size of the area allocated in the plans for the new Fiona Stanley Hospital for cardiovascular medicine. I could not work out whether that was evidence based or based on something else. But overall, my impression is that there are adequate services at the teaching hospitals for those procedures. But, of course, as well as ensuring that people get good quality care when they need those interventions, we are also equally interested in preventing them from getting there in the first place or at least delaying for many years the time when they have to call on those services.

Ms Rooney: As I mentioned previously in the report we have done, workforce issues in cancer are huge. It needs to be addressed because of the time frame; it takes years. You cannot just conjure up a couple of oncologists tomorrow. There are some real workforce issues that will put enormous issues on the quality of care for cancer patients if they are not planned for.

The CHAIRMAN: Both for children and adults.

Ms Rooney: I think that is probably the case. I cannot speak so authoritatively on the children because we did not actually address that in this report. Screamingly obvious ones were the adult areas. I imagine it would be the same for children, although the incidence issue does not affect children in the same way as it does adults. It is more because of the ageing that the numbers will increase. Certainly, if that is not addressed, there will be a massive problem in the future.

The CHAIRMAN: I thank you for your evidence before the committee today and thank each of you for the support you have given to the committee in relation to our previous review into the tobacco bill. As you are all aware, that is now in the upper house. I keep asking Peter when we will get it on the agenda up there. Once again I officially thank you very much for the support you have given on that.

A transcript of this hearing will be forwarded to you for correction of minor errors. Any such correction must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. I am very sorry we were late starting. Thank you very much for coming in today.

Mr Swanson: Thank you for the opportunity.

Hearing concluded at 5.19 pm