EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ROLE OF DIET IN TYPE 2 DIABETES PREVENTION AND MANAGEMENT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 28 NOVEMBER 2018

SESSION TWO

Members

Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton

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Hearing commenced at 11.17 am

Dr ANDREW KIRKE
President, Rural Doctors Association of WA, and Director, Rural Clinical School of WA, examined:

The CHAIR: Andrew, thanks very much for coming. I apologise for keeping you waiting. On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's inquiry into the role of diet in type 2 diabetes prevention and management. My name is Janine Freeman and I am the Chair of the Education and Health Standing Committee. The other members of the committee who are here with me are Mr Bill Marmion, who is the Deputy Chair; Josie Farrer, the member for Kimberley; and Sabine Winton, the member for Wanneroo. Shane Love had to leave early and sends his apologies.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings. We also have the research officers with us that you would have been dealing with, and Hansard is taking a record.

Before we begin today, do you have any questions that you would like to ask of us?

Dr Kirke: No. I will just comment that it is a very broad brief and I am not quite sure what you are after, but I will do my best.

The CHAIR: Can you fix diabetes for us? That would be good. Would you like to make a brief opening statement at all or do you just want us to head into some questions?

Dr Kirke: I am happy to go straight into questions.

The CHAIR: Just in terms of the broad brief, I will give you some background. We had the opportunity to have Michael Mosley come and give evidence before us. We also had Jane Martin from the obesity coalition. Michael Mosley is a controversial figure in terms of having that sort of media aspect with things. There was a concern about obesity, but once you start to think about that issue, it is enormous—pardon the pun. Subsequent to speaking with Michael Mosley, we narrowed it down to talking about type 2 diabetes, particularly because it is such a preventable disease. It is a lifestyle disease but we keep dealing with it as an individual issue and not as a system problem. It has a massive impact on our public and private health systems. From the point of view of a parliamentary standing committee, there was a view that we could value-add in this area by looking at the issues. A couple of issues have arisen for us. One is that primary health carers—GPs—are not equipped to be able to assist people in this area if they are prediabetic or in the early stages of diabetes. If you would like to comment on that, that would be good. The second is that even if they were equipped, the information that they may be giving out may not be the best because there is controversy around the Australian Dietary Guidelines and the capacity of that sort of nutritional guidance to really assist people with diabetes. Does that give you some sort of context?

Dr Kirke: Yes. I am happy with that. I am probably less confident around nutritional guidelines and what should or should not be, but I think there are some broad principles that I could certainly talk on. I am a GP. I have trained as a GP. I have worked as a rural GP for 18 years in a number of areas.

Currently I am in the south west in Bunbury, but prior to that I was in the goldfields for eight years and I also had a year in the Kimberley, living and working in Derby. I feel like I have broad rural experience in a wide range of situations. The first thing to take from that is that health in different areas varies widely. The resources that are available vary widely. It is very hard to comment about a one-size-fits-all solution but there are common themes. Maybe I will first touch on GPs. As a GP, I think that GPs sit squarely within primary health care. We are not the only primary healthcare providers. Remote nursing clinics, Aboriginal health services and child health services would all fit under the umbrella of primary health care, but GPs tend to have a coordinating role within that system. If there was one comment to make about primary health care, it is that there is so much more that could be done to have an effect using primary health care. A lot of diabetes care and a lot of medical care focuses on once the patient gets to the secondary effects, or once the problem has arrived. Primary health care is about prevention. It is also about screening and it is also about treatment, but because it is generally embedded within the community, patients have easier access to it and it is more effective if it is provided and available. There is certainly international literature that says that good primary health care gives better outcomes for communities and countries in terms of those outcomes. That is a broad statement about primary health care.

In terms of what GPs do, I have written some notes, which I might refer to. Certainly, as a GP, we are a coordinator of care. We provide the referrals to the other components of diabetes care; for example, referrals to dieticians, diabetic educators, podiatrists, and referrals for eye checks, and then, if there are subsequent complications, obviously referrals into the secondary and tertiary health system for treating those complications. It takes a lot of resources. It takes a lot of follow-up. Speaking as a GP, we are often time poor, but because we have access to those other providers we are an important link in getting people access to that care. The issue around provision means that not all areas get the same access to care. If I take my town where I live now, just out of Bunbury, I would say that we are pretty well provided with health services there. There is not much that we want for. There are a lot of allied health services. All the other components of care are actually available for people and, in most parts, it is relatively cost free. There are a lot of bulk-billing clinics. That is an example of where there is good access. Bunbury is our biggest regional centre but it has a big rural component as well.

If I compare that with Derby, where I lived for a year and where we were providing care to remote clinics outside of Derby, there might be a nursing post in that town or community, but it would be a two-hour drive or more to the town. Anything outside of what can be provided at that clinic and a weekly visit by the GP means that there is a huge investment cost for patients to get access to care. Immediately, there is less access, and then when you get to the centre of the town that might have those services, the actual provision of services is restricted as well. Geography plays a big part in that. But having said that, if you have good primary health care you can have good outcomes. One example that I like to quote is immunisation, which has nothing to do with diabetes but it falls into primary health care. The immunisation rates that were most recently quoted show the worst rates are in the northern Perth suburbs. The best rates were actually in some of our remote Aboriginal communities where there was a concerted program. Primary health care, when it focuses, can provide good care for basic health provision to even the most remote communities. It is a lot about resource allocation. That is probably a fairly broad comment on that area. Maybe if you have some specific questions, we might work into that.

The CHAIR: I do have a specific question. In those areas, if you talk about the analogy that you have given, which is immunisation, if the public state health system employed primary health carers in those remote areas instead of relying on GP services that are small businesses, effectively, would we be better able to address issues around preventing diabetes and treatment, or would they be

better off investing in?—I assume that in terms of ensuring the services that you talked about in your analogy, that that has been done by nurses. Would the public health system be better off employing dieticians or nutritionists in those areas and sending them into those areas so that you can mirror what you have talked about?

Dr Kirke: I think all of those components are important. In terms of a particular model—whether it is a private business or a public service—clearly, in remote areas private businesses are probably not going to work just because of the income level of the communities that are there. There just is not the business to make it viable. But there are lots of examples of publicly funded primary health care. Rather than focussing on who is delivering the care, rather than on what sort of care is provided is probably better. Yes, clinic nurses could do it. Yes, GPs have an important role. Yes, absolutely we need dieticians and diabetes educators. I think—we see that sort of model in a well-run Aboriginal medical service. I am going to quote my wife, who works in the south west Aboriginal medical service, saying that what they have is ideal in the sense that under one roof they have a GP in one room, they have a diabetic educator across the corridor. There is a free exchange of information face-to-face. It is in real time. There is ready access for eye checks, for dieticians and so on. It is the whole package that goes together. Whether they all have to sit in one building under one roof in a small community, you can look at other models where you can visit services or an umbrella service over a district, but I would say, in answer to your question, in those more remote areas certainly, yes, there is a big capacity for public health funding to improve primary health care. I do not think one business model needs to apply in terms of primary health care. I think it can be part of the public utility. I think there is a lot more we could do in that space. From my experience, obviously, a lot of health falls across that federal–state funding divide. That is unfortunate because from a patient's point of view, they do not really care. They just want the service. WA health funding on the state basis probably focuses primarily on hospital services, because that is the big money ticket. That is the thing that people focus on—are there emergency services, surgeons, et cetera, machines that can do the imaging. But in actual fact, value for dollar, if you had more investment in primary health care, you would probably need less of those services and have better outcomes in your communities.

The CHAIR: That would only be the case if those primary health carers had the capacity to treat and there is a question of whether they actually have that capacity because the education of those GPs and primary health carers is not in lifestyle diseases. They are more into once they become chronic or the treatment of things as they become chronic instead of prevention.

[11.30 am]

Dr Kirke: I would disagree with you completely on that. Ninety per cent of what I talk about as a GP is prevention or lifestyle management of disease.

The CHAIR: I am not suggesting you do not do it. I am suggesting that the universities that educate you do not do it.

Dr Kirke: As a university lecturer managing a rural clinical school, I disagree with you on that point as well. It is a huge component of what we talk about.

The CHAIR: Do you have a dietary component at the school that is teaching people about nutrition and assisting people in intensive nutritional choices?

Dr Kirke: Our students, when we get them in the rural clinical school, are doing essentially what is a clinical placement. Their clinical placement will include exposure to all the health professionals and some of the tasks that we set our students are to follow their patients' journey through their access to health services.

The CHAIR: That did not answer my question. Do you have a part of your course that has stuff around nutrition?

Dr Kirke: My point is that students are doing their clinical learning in that setting. They are dealing with dieticians, diabetes educators and primary health care. We do not do lectures from dieticians, if that is what you mean. We are not asking GPs to sit down and make a meal plan for the patients, but the importance of appropriate diet and its relevance to their health is certainly reinforced in the consultation through that, for example, on diabetes or preventing diabetes.

The CHAIR: When we talk to other GPs or peak organisations around GPs, they all say that under the federal government referral system you refer people. If you have diabetes, there is often podiatry you need, and obviously a dietician, some psychology and those sorts of things. You have only got five or six. I thought it was six but someone just said five. You will have one, probably, appointment with the dietician, but you will continue to go back to your doctor for follow-up. You might have that one dietician meeting. How does a GP properly monitor that someone is following the dietician's advice to ensure that this person is getting the appropriate lifestyle treatment or lifestyle changes to be able to meet their disease and prevent it from getting any further progressed?

Dr Kirke: I guess in terms of monitoring the patient, we would probably go back to biochemical tests like glycated haemoglobin, which is probably our best marker of where they are going. That gives an indication when they are going off the rails, and then we would explore why. You have just briefly mentioned psychological services. Diet and nutrition is important, but psychological and psychosocial factors probably have an even bigger impact than lack of or apparent lack of education around health. A lot of poor management of diabetes relates more to the stresses that are going on in people's lives. We see that across the board—adolescents with type 1 diabetes, adults with type II diabetes who have deaths and family and kids that they have to look after. They are less likely to manage their own health when they put other priorities. I know it starts to become a mishmash and a bit of everything, but if you recognise that there are things that you can provide in terms of support services, you actually are going to get better results. We do not do meal plans. We do not monitor what patients are eating. We do have some sense of what is an appropriate diet. The broad rules around diet are more vegetables, more fruit, less refined foods. Some of the data I brought as an example today is from a colleague who has done a survey in the Western Desert around smaller communities there and looked at diets in kids. The outstanding thing that comes out of that is the high proportion of refined carbohydrates that forms their diet, the absence of fruit and vegetables, the number of meals that they miss. The compelling reason why this happens is, maybe kids prefer sweet things, but actually there are no veggies on the shelves. The cost of fruit and veggies is at least twice as much as down the road in Kalgoorlie. There are a whole range of those structural things that are in the way before you just sort of say that people are not eating right, you are not giving them the right advice.

The CHAIR: I am sure that for it to be such a large number of people, there has to be a systemic issue, does there not?

Dr Kirke: Yes, and it starts before you are born. It starts in early childhood and then goes through. In terms of what you might provide, if there was better access, my colleague calls it food insecurity issues —

Mr W.R. MARMION: Is that a paper that we can get access to?

Dr Kirke: At this stage it is unpublished data, but there certainly is data around this. We can find that for you.

The CHAIR: We are happy to take that in camera so that it does not have to be —

Dr Kirke: I guess I would have to discuss it with her. She is happy for me to quote figures in her paper but it has not been published so it has not been reviewed.

The CHAIR: Would you like to quote it?

Dr Kirke: I am happy to quote figures. This was a survey of 75 children from around Mt Magnet, Leonora, and Laverton. Just some figures that stand out—this was a 24-hour survey of the 24 hours before of these kids. Twenty-two per cent had not eaten fruit and 19 per cent had not eaten vegetables in the preceding 24 hours. One in five of these children had missed a meal. The main barriers to increasing fruit and vegetable intake were that families could not afford more fruit and vegetables or could not access the fruit and vegetables and there was an insufficient variety. The prices, as I mentioned earlier, were generally double the price down the road in Kalgoorlie, and Kalgoorlie certainly would not be the cheapest place to find your veggies. There was a lot of highly refined carbohydrates, which did not meet the healthy diet. The kids, interestingly, although they did not know the details, knew they should be eating more fruit and vegetables. Even with the most minimal education, they had a sense of what was right and what was wrong. The other issue that is interesting—and we have not really touched on it yet—but often we go to ethnicity. We know that Aboriginal populations have far worse rates of diabetes, particularly in remote areas, but in this particular study non-Aboriginal children in the same communities were suffering at least as badly. They had as high rates of prediabetes. They were missing as many meals. They were at least at as great a risk, which suggests that this is a common factor in these remote communities. I guess where I am going with this is that remoteness is not just about health and lack of doctors and dieticians; it is actually about a lack of the basic resources. While we might think of poverty historically as causing undernutrition, it is causing poor nutrition and obesity because of the wrong foods being available.

The CHAIR: Would the public health system just be better off buying fruit and vegetables and making sure that they are available in the local stores, and making them almost free, to be able to assist them? Would that be the best preventive medicine that could exist in some of those parts?

Dr Kirke: It would be a great start, particularly for those remote communities. You get a once-a-week delivery and you get a very sad selection of greens and veggies, which are expensive. Nobody is going to buy them. I was in the Kimberley last week and my students commented on the fact that they had to buy up food on the first day they arrived for their year-long placement because the highway was closed and all the food was selling out. They showed me photos of the empty shop shelves. They experienced that for one week, but some of these communities are experiencing that every week. I think that access to what we take for granted as appropriate diet is a factor. I think it goes beyond a certain group. It is a factor of remoteness and poverty. I am not suggesting a system that provides fresh veggies, but clearly, if there was a way to do that, I think it would have an impact.

The CHAIR: We have had evidence also that if some communities, particularly Aboriginal communities, ate wild foods, game foods such as kangaroo, and were given access to go to country to be able to harvest Indigenous foods—the results of that are really positive and saw people lose weight and also reverse diabetes. Are you aware of any of that?

[11.40 am]

Mr W.R. MARMION: In 10 days.

Dr Kirke: In 10 days? I am not sure of the number. I am aware of Kerin O'Dea's work, which goes back to the 1990s, which was exactly this: taking a group for, I think, about six weeks, and all the parameters changed. I do not think there is any argument that more traditional diets—and the communities that were surveyed in this study also recognised that and they developed material for

their own people looking at what they used to eat and how that might relate to what their current diet is.

The CHAIR: Is that material available?

Dr Kirke: I might have to get you to talk to my colleague Christine Jeffries because she has done a PhD on this and she has a lot of material out of this. A lot of it is still being put together.

The CHAIR: That material would be really worthwhile for us.

Dr Kirke: Yes. Part of her program was actually a locally created education program for the local people, and the kids created their own media to project the message.

The CHAIR: That would be fantastic. We would be really interested in that.

Dr Kirke: Okay.

Mr W.R. MARMION: The problem with the other survey that was done, which worked, is that when they went back to Derby, the best person actually went straight down to the pub. How do you get people to have a diet, particularly in the Aboriginal community, and stick to it?

The CHAIR: Josie was just asking is this working with Boab Health Services, or is Boab Health further up?

Dr Kirke: Boab Health is further north.

The CHAIR: She is saying there is some stuff with Boab Health as well. They have given a submission.

Dr Kirke: Yes, there is a lot of stuff going on in the Kimberley as well. I have colleagues in the Kimberley doing work around diabetes, smoking, pregnancy—all of that.

Mr W.R. MARMION: This one is the Leonora–Laverton area, is it?

Dr Kirke: Yes. It is a Western Desert kidney project. There were 11 communities in total, but this particular survey was on three towns near Leonora–Laverton. There is no question that you can get rapid changes.

The CHAIR: Can you comment on private patients and their access to Telehealth and whether that is limited, and what ramifications that has, especially for people who live in remote areas?

Dr Kirke: There are examples where Telehealth is very successful. Generally it has a champion. At the moment PBS funding is available only for specialist services through Telehealth. I understand that there are some allowances coming related to the drought and certain regions in rural areas.

The CHAIR: Can you tell us where there are examples of it being successful?

Dr Kirke: Angus Turner, who is an ophthalmologist, runs a very successful program where he liaises with Aboriginal health workers in remote communities who do eye checks. They take the photographs and send them back and he passes back the information about whether they are fine or they need to be seen at the next visit. It is just one example of where there is a really one-to-one strong liaison and someone is the champion there.

The CHAIR: Can you tell us where there are examples where it is not successful?

Dr Kirke: A lot of this stuff could be done by GPs to people in remote communities, but there is no access for GPs to provide consultations via Telehealth and get remunerated for their time, so it is something that is done over and above their other work, their other clientele.

The CHAIR: Is that just because that is not an arrangement that has been established?

Dr Kirke: It has never been established and there has certainly been a bit of a push recently by our parent organisation, the Rural Doctors Association of Australia, to get more access so that GPs can

do Telehealth. A lot of work has to be done to set up the structure of Telehealth and make sure that it does not get rorted, to just be blunt about it, because that happens when you set up new programs, but there is a lot of potential where GPs in one location can be consulting with patients or with a nursing clinic in another location and providing access that does not require a patient to travel two hours to see them. There are a lot of small towns and small communities where they could benefit from something like that. Other examples in the state where Telehealth has been useful is the emergency Telehealth system. That is a specific service for specific situations. That has certainly boosted the confidence of GPs and clinics in remote areas. I think there is a lot of potential there if it is set up appropriately.

The CHAIR: Has your national organisation done a submission on Telehealth?

Dr Kirke: They have put one in, yes.

The CHAIR: Can you get that sent to us? Is that possible?

Dr Kirke: It should be possible, yes.

The CHAIR: We will follow up with you. We will send you a letter saying, "You said you'd give us this and this and this."

Dr Kirke: All right; that is good.

The CHAIR: And hopefully you can just send that to someone else who can do it for you!

The WA Primary Health Alliance is working with only certain practices. Some GPs are not working with them. Is there some sort of aspect of them being locked out, or are they just not interested in working with them?

Dr Kirke: I do not know if I can speak for all GPs, but I can speak a little bit on the primary health provision within WA. It has gone through a number of iterations within my career. When I started in the goldfields, it was the GP Network, and then it became Medicare Local and then it was changed again. At each of these changes there has been disruption and loss of services, and we are at a point now where there is actually a loss of confidence. A lot of people are probably watching and waiting just to see what WAPHA comes up with. In concept, that is exactly what we need. In the practice I work in we bring in a diabetes educator. We have had dieticians come in. We do have a podiatrist who is readily available, and we use WAPHA services if they are available, but there is a long history of being disappointed with that primary health care service. I think it is a natural fit but it needs security and stability and not to be chopped and changed.

The CHAIR: It gets a lot of money though, does it not?

Dr Kirke: I believe they do.

The CHAIR: Yes. So it is concerning that we have —

Dr Kirke: It has not been around that long though.

The CHAIR: No, not the WA Primary Health Alliance, but are you right: it was Medicare Local before that. The concept of having some sort of peak organisation that can have coordination for GP's services has been there. Do you agree with that concept?

Dr Kirke: Yes, I agree with that concept. There is a lot of merit in it. It means that all those primary healthcare services are available for GPs to refer their patients, without them personally having to incorporate it into their business model or rely on hospital-based primary health care, which tends not to work so well as a community-based one.

The CHAIR: And it does not tend to work so well because of the waitlists?

Dr Kirke: Waitlists—and hospitals tend to hospital business first and the community generally comes second is my experience; outpatient services come second.

The CHAIR: The WA Country Health Service submission mentions the chronic condition self-management upskilling program. It says that it currently sponsors and supports 25 clinicians from across country WA to apply evidence-based Flinders and Benchmarque consumer-centred coaching with customers, including those with or at risk of type 2 diabetes to ensure that these clinicians can effectively embed the chronic condition self-management coaching into regional pathways and the ongoing support that is required. Are you aware of that chronic condition self-management program?

Dr Kirke: I have to say I am not. I do not know whether that is my fault or someone else's, but I am not specifically aware of it.

The CHAIR: The WA Country Health Service is vastly bigger than you are, so we will take that as being an issue that you, as a peak organisation representative, are not aware of.

Dr Kirke: Just on the theme that you have outlined on that topic, it seems to imply that if you just deliver the message in the right way, then everything will be right. I guess the point I made earlier is that it is not necessarily about the message. The message is relatively simple: eat appropriately and exercise. Whatever your concept of that is, most people know it is not a packet of Coco Pops and it probably is fruit and vegetables, and it is less about motivation. We keep going back to motivation. People do not choose to be sick. They might make bad choices that take them there, but there are reasons why they take those bad choices. I am a little bit sceptical if it is about motivation interviewing and that sort of stuff. I think with most GPs—we do it all day—every consultation is about trying to get your patients on the same page. So, whether we have done a particular course or a particular program, we are doing that every time we see patients. I think these other parameters—access to appropriate resources, diet, opportunities for exercise—are probably more important. That is perhaps my slightly jaundiced view on that.

The CHAIR: No; I think that is a great view. I think I put that to the health department before you were in here. In your careers, I said to them, you have seen a chronic condition get worse. That would suggest that there is a pretty important KPI going on here. You know, a preventable chronic condition can get worse, and you can have your strategic frameworks and your this and your that, but what are you doing on the ground that is preventing this? I get what you are trying to say.

In terms of that, there was a diabetes complex care collaborative that was based on a Queensland model. It was happening in the South Metropolitan Health Service area. I do not know if you are aware of it?

Dr Kirke: No, I was not.

The CHAIR: Everyone is starting to pack up because we have to go to Parliament.

Is there anything else you want to add? The stuff around what your colleague has done would be really worthwhile. Is there anything else that you want to add? I apologise that I got you here for such a short period.

Dr Kirke: This is a subset of diabetes. My particular interest is in gestational diabetes. I think there is a lot more work we can do about that. I am involved in a research project in rural areas at the moment looking specifically at how we screen for it. We still have not got the detection right, let alone all the other advice, so we are looking probably at half the cases that we need to pick up in gestational diabetes, which is another subset.

The CHAIR: The impact of gestational diabetes is quite profound, not only on the pregnant woman but also on the —

Dr Kirke: It has implications for the birth—so large babies, complicated births and associated problems there. It has implications for the mother. There is an increased lifetime risk of type 2 diabetes and implications for the child also having type 2 diabetes, often from a very early age. So, yes is the answer.

The CHAIR: You see some of the critical problems there are in diagnosis.

Dr Kirke: Yes.

The CHAIR: Because we do not have the right equipment to diagnose properly?

Dr Kirke: No. There is probably not enough time to go into it, but it is not equipment; it is probably actually the protocols, the tests that we have, on top of problems for the women about the actual test that we are using.

The CHAIR: Is that because they are not getting the right testing in the public health system or in the GP's?

Dr Kirke: There is probably not enough time to go into it, but we think the testing is flawed in what test has been chosen. It is a two-hour fasting test that is difficult for women to do; it is difficult for them to stay there. There are even problems in the way the test is conducted that we have turned up in the research. There are a lot of issues around accessing the screening and then once you have been screened again, and all the issues that we have mentioned about accessing services as well.

The CHAIR: Is it hard to reverse gestational diabetes?

Dr Kirke: Look, a bit like diabetes, if you are able to have a concerted effort, you can see the reversing of the condition and not needing insulin, which is for the more complicated ones. In fact, most cases of gestational diabetes are probably managed by diet and exercise—the vast majority. It is a challenge. The numbers are growing. Again, there is still something wrong out there. The number of gestational diabetes, like type 2 diabetes, are increasing, and they have been increasing year on year for the last 20 years.

Mr W.R. MARMION: Can I finish with a dorothy dixer? How important is a GP to the management of someone with diabetes 2?

Dr Kirke: I think they are integral. Again, I started with the point that they are the contact point for the patient, the coordinator of care, and the access point for all the other services, if they are actually available in that community. I think there is a lot more that could be done for GPs and other primary healthcare practitioners in that role.

The CHAIR: Thank you.

Dr Kirke: You are welcome.

The CHAIR: If we have any other questions, can we come back to you?

Dr Kirke: Sure.

The CHAIR: We will write to you on the few things that you have said you will make available to us. If you have anything else that you would like to make us aware of, if you wanted to send us some more information. I am not sure about the gestational diabetes. Did you make a submission on that to us?

Dr Kirke: No, I have not made a submission.

The CHAIR: We are happy if you want to. You have given us public evidence that is there. You have raised it now. We are happy to receive additional things. It does not have to be too much, even if you want to refer us to a paper that you think is worthwhile our reading.

Dr Kirke: I have a publication that is coming out soon on the screening problem, so there is certainly material there that you can have access to.

Mr W.R. MARMION: Before March?

Dr Kirke: I am hoping so. I am hoping it will come out next month.

The CHAIR: That is fine. That is absolutely within our period of time.

Dr Kirke: It has been accepted, so I can make the data available.

The CHAIR: We can wait a month; it is okay. The report is not due till April. Thank you very much for your time. We really appreciate it.

Hearing concluded at 11.56 am

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