

EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

**TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
FRIDAY, 22 NOVEMBER 2002**

SIXTH SESSION

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

DAUBE, MR MIKE

**Director General, Department of Health,
examined:**

JACKSON, MR MICHAEL

**Executive Director, Population Health,
Department of Health,
examined:**

CHUK, MR ANDREW

**Deputy Director General, Corporate Finance,
Department of Health,
examined:**

O'FARRELL, MRS CHRISTINE

**Executive Director, Country Services,
Department of Health,
examined:**

DELLA, DR PHILLIP

**Principal Nursing Adviser,
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examined:**

AYLWARD, MR PHILIP

**Group Director, Policy and Resources,
Department of Health,
examined:**

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**Chief Medical Officer,
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examined:**

The DEPUTY CHAIRMAN: Welcome to all of you. We are privileged to have you all in the same room at the same time.

This committee constitutes a sitting of the Parliament and, as such, any deliberate misleading of the committee is seen as a contempt of Parliament, although it is fine to express attitudes and opinions. Have you all read and signed the witness sheets?

The Witnesses: Yes.

The DEPUTY CHAIRMAN: Thank you, and the committee thanks you for your submission. This is the second year of the Education and Health Standing Committee. Legislative Assembly standing committees are relatively new. They came about because of a review of the standing orders of the Legislative Assembly. A lot of select committees were held during the term of the previous Government. It appeared logical for the Legislative Assembly to have three major standing committees to which the Parliament could refer legislation. Parliament can refer issues to the committees for consideration in a bipartisan manner and the committees can initiate inquiries

into issues that they want to address on a statewide basis across government and use Parliament as the forum to progress the issues. That is what we are doing.

This committee inquired into dental services in regional areas and we thank members of the Department of Health for their support with that. We are now inquiring into a much bigger issue and we had to toy with the terms of reference. It would have been easy to take on too much and never get anywhere, like wading in quicksand. Across the country, and indeed in many jurisdictions around the world, particularly in education and the delivery of services, different models of health delivery services are emerging. As a result, changes are being made to the nature of the health professions, including the way they relate to one another and work together, the legislation that supports the flexibility of the delivery of those professions, and the career structures within those professions and so forth. This committee will examine world trends and whether the State is ahead of or behind the game. We will examine what we can do to support the changing needs of our community and whether those needs are being met by a difficult system, which is not helped by the difficult relationship between the Commonwealth and the States; and whether our structure is flexible enough. That is our role as legislators. That is the context with which we started.

We have received 50 significant submissions.

[4.15 pm]

Over the past few weeks we have been taking verbal submissions from most of the major players in the health professions representing the nursing profession, allied health, general practice, educators, trainers, unions and various groups to get a handle on their attitudes. We come now to possibly the major player in the whole equation; that is, the Department of Health itself, which is why we are pleased so many of you are here. Given what I have just said and your submission, would you like to open the batting on where we might go with this?

Mr Daube: I would be happy to open the batting since Australia is doing pretty well.

The DEPUTY CHAIRMAN: Yes, I know, 246. Fox Sports is fantastic!

Mr Daube: First of all, we are grateful for the opportunity to be here and we appreciate that you are looking at this broad and complex area in a bipartisan manner, which is very important in areas that will affect this State over decades. It is not simply a matter of what is happening today and tomorrow. Mr Deputy Chairman, you referred to the number of us here. That is in part because we were advised of a range of issues that might be raised.

The DEPUTY CHAIRMAN: It is a compliment to us and we appreciate it.

Mr Daube: We thought we would give you as good a range as we could. The major achievement is that we not only got here but we all got here on time! We are here to answer your questions. The two or three preliminary themes I will address are, first, as you have already indicated, the world in which we are living is changing so fast and nowhere faster than in the areas the committee is considering. In some ways what we are seeing today is perhaps a consequence of the reality that as a community we did not see ahead far enough. Some of our problems are hitting us now that, in retrospect, we could have thought about. That is life and they are here now. Second, in pretty well all of these we have some state peculiarities, which we need to explore. However, in many cases we face similar problems to those of other jurisdictions throughout Australia and internationally. However, they are exacerbated by Western Australia's peculiar circumstances, isolation and historical disadvantage in certain areas, which we can talk about.

The other broad theme is that although, as you said, the Department of Health in Western Australia is in many ways the major player, it is not the major influence. Not only is the department a pimple on a pumpkin in international and national trends but also it is almost entirely dependent in certain areas on decisions made outside its control, particularly often decisions made in Canberra. Medical schools, training places, nurse training and so on are matters on which we must deal with the

immediate consequences, but the decisions that will influence us and what happens here are made out of this State. As a community we need to consider how we can influence those. The third theme I want to address is that in so many areas we must recognise that even if changes are made, some of the outcomes will not be seen for many years ahead. If we started training more doctors today, it would be a decade before we saw those doctors and felt their hands on our clammy foreheads or whatever it might be. It is important in dealing with these issues to recognise those broader contexts. Our task is, nonetheless, to deal with the issues of today as best we can. We felt that we were looking at a pretty open discussion.

The DEPUTY CHAIRMAN: We have a million questions. There is no end to this. You started with this peculiar commonwealth-state situation, which we could talk about all day. Much of what we might do as a committee here will not necessarily change that. Do you believe the current Medicare structure, let alone the commonwealth-state government arrangements, restrict us from being able to deliver a more flexible health system in our own State?

Mr Daube: I can give you a personal view on that and I would be interested to hear my colleagues' views. As you know, we are presently engaged in the next round of negotiations of the Australian health care agreements; that is, the five-yearly ritual that starts in amity and ends with some kind of conclusion that leaves nobody really very satisfied. The present system is way outdated. The commonwealth-state divide does not serve us well. We have different decision-making processes and delivery of services, disputes between the Commonwealth and the State about priorities, argument about whose responsibility lies where and probably more time spent on discussions of cost shifting than on how services can and should be delivered in certain contexts. At some stage in the not too distant future there needs to be a radical rethink of the whole system.

Mr P.W. ANDREWS: What we are trying to do is pose a radical rethink in your language. To use Mike's expression, we are trying to get ahead of the game. We can all identify and are well rehearsed in what is going wrong at the moment. Forgetting about the present constraints, what models of health delivery should we be developing?

Mr Daube: It would help us if it were acknowledged that this is an issue on which we are presenting personal perspectives. We have a group of experienced health professionals and we would be delighted to discuss this as a vital issue.

The DEPUTY CHAIRMAN: Paul Andrews has pointed to a very big subject. To narrow it down, we are looking at the role of health professionals. Under the present arrangements the whole thing is GP-focused in primary health care, which is important. Where do you see the role of the GP in 15 years time and how will it fit into the delivery of health in this State? Your response can be a premise on which to base our direction.

Dr Lloyd: The funding for the models are a disincentive to improvement of the model in that the service provider, in this case general practitioners, are required to do a certain volume of service to receive a certain volume of income. That tends to inhibit change models. We believe, and I think many GPs are coming to the view, that nurse practitioners and allied health people could do a reasonable percentage of a general practitioner's work. That would free up the valuable resource of the general practitioner. That does not demean the work we free up, but as time moves on other people multi-skill. In my speciality of cardiology, about 10 years ago cardiologists did everything in the coronary care unit. They set up special drips, gave the initial injections of whatever and so on. It soon became clear that nurses could do it equally well. Once we defined those issues and agreed and provided the nurses with a little bit of multi-skilling training, they took over those roles, and so they should have. Much of the heart failure management out of hospital is much better done by a nurse. That is supported by some good data. They have the time, the interest and the expertise and they do the job well. My impression is that in 10 or 15 years time, if we could get out of the current constraints about funding on a fee-for-service basis, we could get a much better model

whereby the general practitioner did the more high-level work rather than every bit of work that confronted him or her.

The DEPUTY CHAIRMAN: I agree. You might be pleased to know that the general practice divisions also supported that, although not totally. That being the case, why then are we restricting the capacity for nurse practitioners in the legislation now before the Parliament - I assume you support the legislation - to geographical positions rather than providing flexibility, which would then really open up potential for change.

[4.30 pm]

Dr Della: In order to get our nurse practitioners up and working, the designation of nurse practitioner is based on geographical areas. It has come down to the relationship between the Commonwealth and the States at the present time. Nurse practitioners setting up an independent practice must recoup their money from somewhere, either under the Medicare agreement, provider numbers or pharmaceutical benefit scheme numbers. The commonwealth legislation does not allow that and indications at the moment are that although the Commonwealth is interested in talking about the concept of nurse practitioners, it is not interested in providing provider numbers or access to the PBS. The current designation is for nurse practitioners to finish their course and be registered, so it comes down to employment in those areas. The designations can be made across the whole of the State and they will expand as we go on; that could be in a geographical area or in a speciality. For instance, it could be in cardiology, in a general practitioner's service or, in the first instance, expanding those services within our health service.

The DEPUTY CHAIRMAN: Mr Daube, I do not know whether you want to put on record your initial response to what these designated areas in the metropolitan area might be. The whole direction and flexibility in change that might occur in this area will be a big responsibility for the director general, particularly the area of after hours services and things of that nature. Is your attitude to leave the door open as wide as you can?

Mr Daube: Yes.

Dr Della: In the samples we have been working on we have worked with the health services to try to identify where the greatest need is and in which areas we first need to get nurse practitioners up and running. For example, we have been talking to the health services in the south and they have identified nurse practitioners going into first Armadale, Rockingham and Rottnest Island, and in the second round coming back into the nursing specialties at Fremantle Hospital. The other areas that are being worked up are the remote areas that have designated nurses and we are working very hard at the moment with the specialties. WA already has nurses from the eastern States who have the qualifications of a nurse practitioner. They will, therefore, be the first successes that we get up and running. There is a high demand for the courses at the moment, although we have not advertised the course because Curtin University of Technology has not yet got it through the accreditation process of the Nurses Board of WA. Curtin had to go through its council to the board for accreditation. The demand, however, is high in that 40 people in the health services have indicated that they want to do the course and we are now working with them get that area up for designation. We have also been working with General Practice Divisions of Western Australia Ltd and the Perth and hills areas are very interested in moving to that concept. The question will be about funding arrangements and who will pay for a prescription or investigation raised by a nurse practitioner in a GP's surgery; that definitely must be worked through. Another area is Rockingham, which has a particular problem in after-hours aged care. We are trying to work up our relationship with Dr Penny Flett of the Brightwater Care Group and to have a triage system in the Rockingham area for aged care, especially after hours. Those are the areas that we have up and running.

The DEPUTY CHAIRMAN: Although these are state responsibilities to that degree, how difficult is it to move from being a little behind the game to taking a quantum leap? Western Australia will be ahead of other States in its flexibility.

Dr Della: We will be.

The DEPUTY CHAIRMAN: How difficult will it be to do that when these are national issues that affect every State? Is there a constraint on making incremental changes?

Dr Della: Yes, because we will drag everyone with us. One of the recommendations of the National Review of Nursing Education was to create a national standard for nurse practitioners. Western Australia and New South Wales are the forerunners in nurse practitioner legislation, in that both States have legislation and both are now moving towards having nurse practitioners. New South Wales had a very slow start. One reason for that was that it went in with an independent practice model. It has now come out with a collaboration model of practice with nurse practitioners and medical officers working very closely together. That is what Western Australia is proposing. International experience in the United States and Canada indicates that the system accelerates much faster with collaboration than it does in independent practice. South Australia has nurse practitioner courses up and running but it has not yet passed its legislation. Victoria is trying to do it by amended legislation. The problems we are facing have been placed on the agenda of a meeting of chief nursing officers of each State at which they will meet to formulate and push through this legislation. It is also on the agenda of the health ministers conference on 29 November. There are suggestions that a task force be set up to address these national issues to ensure that the legislation and the practice, especially for nurse practitioners, moves forward in a more coordinated way.

The DEPUTY CHAIRMAN: Moving away from nursing per se and looking only at the medical profession, most of the verbal submissions we received from the various groups, particularly allied health groups, indicates that there is not enough of a career structure, particularly for health professions in the public health system. What do you say about that?

Dr Lloyd: I think things have changed a lot. It is more a question of how far you want to take it. Now, as you are well aware, the structures in hospitals have devolved so that practitioners can apply for positions in management. However, people as a broad group can go only so far. If practitioners in a field all go into management, there comes a time when you have to stop having bosses.

The DEPUTY CHAIRMAN: Do you think it is a good model if sometimes the only way to progress is to leave the practical end of your profession?

Dr Lloyd: No, it probably is not. However, it is a fact of life to some extent that you cannot have everyone up at the top and no-one delivering a hands-on service in the health industry.

The DEPUTY CHAIRMAN: Are we starting to pay people appropriately or to recognise their postgraduate work and accreditation, which is not necessarily linked to a position, or is the system still inflexible?

Mr Aylward: I think there is a designated career path through the functional areas in allied health within health services and hospitals, whether they be physiotherapy, speech pathology and the like. It varies depending on the size and complexity of the health services. They can also sub-specialise. The health service that I come from has developed career paths in speech pathology, cardiology and orthopaedics. The informal responses that I have had from students from Curtin University of Technology to what was traditionally a narrow area has been fairly positive. I have found though that the opportunity to work in other areas of management has been embraced, has worked well within our health system and has actually added a clinical or professional content to some management decisions made in our health services. However, there is always a limited number of those senior positions but certainly a lot of senior managers in our system come from a strong allied health background.

Mr Daube: Many years ago the Department of Health had a principal this, a principal that and a principal everything. Many years ago those principals were essentially phased out. There is a difficulty if you have a principle everything in a central department. First, the numbers build up and they all want deputies and support staff; by the time they have all those, the budget is blown.

We also must look at the roles. Frankly, we have terrific people but they took on a range of additional tasks over and above what they regarded as their professional tasks. In terms of career structure and where to go once you are the top physio, or whatever, there are already some senior roles. However, as Mr Aylward said, there are senior roles in management. A lot of allied health people are moving into those senior roles, contributing significantly and providing considerable expertise.

Mrs O'Farrell: From the country perspective we have gone from back in the 1980s having a very hierarchical streamed system of principled people in the department with their constellations of support, to a completely decentralised and highly fragmented organisation. I have seen a lot of ceilings on career structures and career progressions falling into place because of the low level of fragmentation in 41 separate country health services. It goes beyond just allied health; it affects people in many disciplines. However, within the structure of a single and often quite small health service there is not a lot of progression to be had, and every single one of them is just a mirror image of each other. We have already pegged the possibility of some real benefits of unifying that system from a Western Australia country health service perspective for the development of better career progression structures in that we will not have to offer to, say, scarce clinical practitioners only one option to career progression. To get a pay rise, for example, they have to opt out of clinical work and go into management. That is also an option and it has a value in many cases, as has been pointed out. However, it is much better to give them incentives to remain in their field of clinical practice and to keep adding value to that and rewarding them. Therefore, I think already, just by organisational redevelopment, we have created some scope in the country.

Mr P.W. ANDREWS: What comes to my mind, from the evidence that we have taken and from wide reading, is that each speciality in the health system clearly is saying to us that they want a much better career path. However, I suggest that would result in fewer patients being treated on the basis of a greater career path in each of those professions.

Mrs O'Farrell: I do not see that.

Dr Lloyd: I would have thought yes.

Mrs O'Farrell: I disagree there.

Dr Lloyd: It depends on what they do when they get there. However, if you are treating only 20 000 patients a year in a given unit and you can treat them with the current hierarchy of that service, you will artificially create a new management structure if you add more people with out-of-patient contact. The core business is servicing the patients. I think most of us would prefer not to detract from the clinical service by creating higher supernumerary posts; that goes across the board. You can be the top cardiac surgeon in Royal Perth Hospital but ultimately you will go no higher. If you are the chief cardiac surgeon you have nowhere to go unless you step out of cardiac surgery. There is no other job that you can do and so you get locked unless you step to another component of it.

Mr P.W. ANDREWS: Ms O'Farrell, you were about to disagree with that.

[4.45 pm]

Mrs O'Farrell: Just from a country perspective I guess the point I was thinking of was that the career progression opportunities are more geared around keeping people in the clinical field but giving them a career progression path, not out of the field and into management but more -

Mr P.W. ANDREWS: The ideal situation is a career path that still involves -

Mrs O'Farrell: Yes, that recognises advanced skills, levels of experience and the ability to lead in a field of practice; so perhaps a bit more incentive orientated to keep people at the patient care level.

The DEPUTY CHAIRMAN: If I can change the tack a bit, we want to explore your position and attitude about whether the education and training for the medical profession is adequate. I am not

looking at any one institution, but should there be more generic training for a number of professions so that they have similar first and second years? Some models are being developed in Great Britain in that regard. With these sorts of multi-disciplinary teams, should people have a much greater awareness through curriculum development of other health professions as part of their training, and, if so, how can we make that happen? From the State's perspective, are there things that we could open up that are inflexible at the moment and prevent that from happening?

Dr Della: From the nursing perspective there is cross-fertilisation at the Curtin program, which is the major allied health and nursing school in the State, and there are core units in which the nurses and the allied health members cross over, so there is a philosophy to try to make it as much of a multi-disciplinary area as possible. The other thing we have done to try to help that socialisation - and it is focused particularly on the rural area - is the establishment of the Spinrphex Club at the Western Australian Centre for Remote and Rural Medicine. The Spinrphex Club brings together young student doctors and nurses in both a social and a work experience environment, and it has been very successful. There is definitely an opportunity to expand on that and move forward from the nursing perspective.

The DEPUTY CHAIRMAN: Just to use an example, it has been put to us by a number of groups that a huge developing area of need in the future is aged care. Do we have the right mix of professions to deal with the demands in that area? Is the current model, which we have taken out of clinical and have put into aged care to try to make that work, the right mix or should we be shaping even some new occupations around aged care?

Dr Della: It is definitely an area that we are working on. I sit on the Australian aged care work force committee and we are looking at what needs to be done in the next five or 10 years in that work force. One of the first areas that we have looked at is how can we articulate that through the professions; for example, if we bring in people as carers, should everyone in the aged care area have some certificate 3 qualification in caring, and how can we then articulate that into enrolled nurses and then into registered nurses and into the other health professionals. Early work suggests that we are getting some movement at the bottom end - the level 3 carers end - and there are some good example of how people who have started in that area have gone on to become enrolled nurses and registered nurses and have stayed in health care. The question that we have not got to but that we need to ask is what will that health worker need to look like in 2005 and 2010. That is the question that we are examining in that committee at the moment.

The DEPUTY CHAIRMAN: Some people have put to us that we should have schools of aged care and a whole range of things. That may sound a bit far-fetched, but the reality is that we need to get ahead of the game to some degree. Is the system flexible enough for the Department of Health to get ahead of the game to some degree and create a picture of what we will need in 15 years so that you can be working with training institutions and be shaping the future delivery of health, because you would probably all agree that we tend to be a bit more reactionary than we would like to be?

Mr Daube: To give you again a personal perspective, it is not flexible enough for several reasons. The first is the reason that we discussed earlier; namely, Commonwealth-State issues and the fact that we are not in control of our destiny and that on a whole range of issues, even when we are working with other States or when we are dealing with the Commonwealth, we are not the decision makers. We can develop the best policies that we like, but we can then get a large steamroller driven over them and the policies remain pretty flat.

The DEPUTY CHAIRMAN: How did we ever lose control of health? It is one of those incremental things that has disappeared down the tube so far as the States are concerned.

Mr Daube: That is something that Mr Andrews raised earlier, and it is an enormously important issue that at some stage as a country we will have to deal with. Secondly - and this is not unique to us - the reality is that we are so focused on the day-to-day planning or perhaps even the planning for

next year that the long-term planning is not really a strength of the health system. Health systems produce glossy documents and reports about this and that, and there have been some very good ones, and some good academic work is being done and some good work has been done in our own department over the years. It would be wrong to decry that. Nonetheless, the truth is that even as a senior group, we tend to be focused so much on the day-to-day matters, and sometimes we are hijacked by issues that are raised in various forums, that it is difficult to get the long-term planning right. My belief is that the way that we are developing our organisation now should give us that capacity. The reality now is that we have the capacity for a single system, and that means that we can plan for that single system, we can get the key people together, and we can start working on our common issues and problems and try to get the best people working in those key areas. However, there needs to be a recognition too that if we are to do that long-term planning, it requires a resource. Of course I address you as politicians here: you will always be subject to the criticism that if a resource is going into something like planning, it is not going into direct patient services. That is a real dilemma that I think you face and that we face. You would not be surprised if I grind the axe that I grind in various places; namely, that this applies also to prevention. There often tends to be a sense that if we put a resource into something that is not actually dealing with patients today, it is not really health. However, if we fail to act on prevention today, then we are creating more health problems for ourselves for the future and we are failing our kids and our community. I do not think we are spending enough time looking ahead of the game. Academic groups do a lot of talking in these areas, but as a system we should be seeking to devote more resources to that area. However, that will mean understanding that we need good, highly skilled resources and people with some expertise who will stay in those positions for some time, and that comes at a price.

Dr Lloyd: The issue you have raised is very important; namely, what model for aged care should we be looking at for the future. As you are aware, Penny Flett has very kindly been chairing a state aged care group that comprises a group of people with a wide range of experience who are seeking to deliver a plan to us on that matter. I cannot tell you whether that is specifically one of the issues that they are developing up. The other group that has been looking at a strategic plan for the shorter term is a range of specialists who have been convened under the aged care section of the department and are seeking to find issues that we should be tackling over the next year or two. There has been a move in our subacute plans to begin to have more aged care picked up by allied professionals and nursing professionals in out-of-hospital settings. That move is well under way. With regard to your question about where we should be in 15 years, I am not sure that anyone with whom I am familiar has been working on that, but I can explore whether Penny's group is working on that.

Mr Jackson: If I can make a comment that is relevant to how we can get the best out of the system, last week we had the signing of an agreement between the CEO of the Commonwealth and the Director General of Health on primary care. I think that is an effort to get the best out of the resources that we currently have, and within the restraints that we currently have, such as the number of places and so on. Brian Lloyd put up a drawing on the whiteboard that I think tells a good story; namely, that currently we have general practitioners who are sending patients directly to hospitals, nursing homes or the Silver Chain Nursing Association. We need to build up a link or intermediate step that looks at the prevention side that Mike has talked about - and we really are not doing enough in prevention - and that looks at allied health and at nursing, so that it provides a lot of support for the GPs. At that meeting we brought together GPs from around the metropolitan area. The GPs realise that they cannot cope. Also, we have a different generation of general practitioners who are not willing to work 60 or 70 hours a week.

The DEPUTY CHAIRMAN: That is recognised by their own profession.

Mr Jackson: Yes. That fits into your earlier question about the nurse practitioners and about how best to use the resources, be it community health, allied health or whatever, in dealing with the issues of the health system. We believe we have a lot of support from the Commonwealth for this agreement. It is keen to support both GPs and the, if you like, net that sits around the GPs. We

think it has a lot of merit in actually preventing the immediate transition from GP into an emergency department or a public hospital.

The DEPUTY CHAIRMAN: If we are not ahead of the game because, as you are saying, we cannot plan for 15 years ahead and yet it takes 10 years to get a GP out there, then the reality is that we will still be captive to this situation and to this incredible capping of training. Is the answer to train and find a lot more GPs, or should we be putting resources into widening other occupations and giving them a legislative framework to support that?

Mr Daube: If there is one thing that I have learnt about health it is that we do not need to look at either/or solutions. We need to take a comprehensive approach. I have no doubt that we need to train more doctors in Western Australia. We are worse off than any other State. We just do not have enough doctors. We do not have anything like enough places; and which of the contending universities those places go to is almost immaterial so long as it happens. I have said also that we do not have as much capacity to plan as we would like. We are certainly doing everything we can to push that particular issue. However, this comes back to a comment that I made at the start; namely, we can write as many strong letters to Canberra as we like, and there is a gradually increasing awareness in Canberra that although we may look at the averages across the country, Western Australia has specific needs, and every year that those decisions are not made is another year that it takes. In answer to your question, it is not an either-or situation; it is about exploring all the options but pushing the immediate buttons that need to be pushed.

[5.00 pm]

The DEPUTY CHAIRMAN: Within this State's jurisdiction, what sort of legislation should we address to give you more flexibility in that sense? Should we give the educators and the professions more scope? Should we further amend the Nurses Act so that it has more flexibility? Should we change and widen the scope of the Physiotherapists Act? When should we start to create a framework to allow that flexibility to happen?

Mrs O'Farrell: The services and the models of service delivery within our health system today are very much geared around the frame of reference and the expectations of our current work force. The age demographic of our current work force means that the system is geared around people who are getting on in age and trained in a system based on all the assumptions of yesteryear. Those assumptions are not there for us any more. In terms of getting ahead of the game, there are probably two things to think about. First, we must ask where we want to be in 15 years and, second, we must develop a vision of the things that need to be done, because it takes a long time to train a new cohort of health professionals and have them available to us. We need to do as many things as we can to get them and shape them. In terms of what we can do, we are stuck in a middle zone. What do we do in the meantime? We have an ageing work force with insufficient supply coming on. We have a messy system that is malconfigured and based on the assumptions of yesteryear. One thing that can be done at a state level is to develop an action plan to reconfigure and reshape that system so that it starts to influence the preparation of tomorrow's work force. The first question is: how do we see that being shaped? That is the set of questions that needs to be addressed fairly quickly, because things need to be done urgently. We must ask what legislative mechanisms might be necessary for us to deal with aged care and country and metropolitan practice. Is it necessary to bring a different sort of worker on stream? Are there legislative barriers to nursing medicine that need to be quickly lifted? Are there new expansions in practice and partnerships and the like that enable us to deal with the "now"?

Mr P.W. ANDREWS: You just articulated the reason for our inquiry. We are trying to find the answers to those things.

Mrs O'Farrell: You have it on tape now!

The DEPUTY CHAIRMAN: Which is the body or the group that identifies where we need to be in 15 years and all the things that must be done to make that happen, instead of continuing with incremental and one-off changes? Which is that group?

Mr Jackson: One of the issues that we discussed last week with the Commonwealth was the suggestion that if the Commonwealth gave permanent status to all overseas-trained personnel, it would immediately provide us with additional medical support. That is only a quick-fix scenario. We need to look at all the options.

Another case that arose last week when we were discussing the Rockingham situation is that people, as of Friday afternoon, cannot get in to see a general practitioner. We were asked why a GP locum service could not be based within the Rockingham-Kwinana District Hospital. Health Insurance Commission rules do not allow us to do that.

The DEPUTY CHAIRMAN: I think it stinks.

Mr Jackson: It constrains us.

Mr Daube: Your question about who should do it has all manner of answers to it. One answer is that we should, another is that the Commonwealth should, another is that the academics should, and yet another answer is that the parliamentary committee should. Of course, a lot of planning work is being and has been done. However, if we are to do some serious long-term planning, we will probably need to devise a different approach to it -

The DEPUTY CHAIRMAN: On a commonwealth-state basis.

Mr Daube: Yes. I was wondering whether I should answer your most basic question at the start about the commonwealth-state agreement -

The DEPUTY CHAIRMAN: Go ahead. This is your opportunity.

Mr Daube: My personal view is that at some stage this country must decide that the present division of responsibilities is not working properly. Perhaps I am a little parochial. However, if we were in the United Kingdom, I would not argue on a state or county basis but perhaps on a national basis. The Scottish health system is way better than anyone else's. I would argue on a national basis. However, in Australia I argue that the knowledge of what goes on in a State rests in that State, and that the State Government should have overall responsibility for the health services it provides. It should have the capacity to deliver those services with whatever bucket of funds there may be, and we should not have to face the scenario that, for example, the GPs are facing. In that instance the Commonwealth can make a decision here or there that will fundamentally change the way we operate. Even in other areas such as Aboriginal health, in which we work closely with the Commonwealth, a grant can be made here or there that we know nothing about. Of course, there must be national coordination, standards and policies. A Commonwealth Government is always entitled to demand certain measures of responsibility and accountability and so on. However, my view is that at some stage there will be a decision that the system has to change and it has to focus almost entirely on the state level.

The DEPUTY CHAIRMAN: It certainly needs to be flexible because one hat does not fit all when it comes to Medicare and commonwealth-state agreements. I totally agree with that. Michael made a really good point about what we cannot do and the inflexibility. We run hospitals and are trying to deliver a decent health service but are prevented from so-called cost-shifting. The reality is that there must be ways around that. Obviously, there are. I do not say this because I am in opposition - as members of this committee we take our hats off in that respect. Why has the State not previously fostered the idea of trying to get some of the services out of hospital emergency departments and into privately run clinics so that they can happen on a 24/7 basis?

Mr Daube: We can tell you about what has been occurring during our period in this role. One of the realities we face is that we are currently working off the last Medicare agreement -

The DEPUTY CHAIRMAN: We must have been duded.

Mr Daube: I am particularly worried that my colleague Andrew Chuk has not had the chance to say anything yet. Perhaps he can tell you how we were duded.

The DEPUTY CHAIRMAN: He is like Northerly at the stall; he is ready to go!

Mr Chuk: This is a complex matter and certainly one in which we would like to make some advances as we move through the negotiation of the next health care agreement. My view is that we probably will not get out of that agreement what we would like in terms of enhanced flexibility - at least to the degree that we would like. I do not want to sound too pessimistic, but the reforms in this area will happen some years beyond the pending agreement. Why have we not been able to achieve more on this front? It really comes back to the funding divide between the State and the Commonwealth in this health system and the friction or tetchiness at those funding boundaries. It is commonsense to all in the community that the community cannot access GPs after hours because of the economic viability of running GP clinics, given what a GP can earn and what he believes he deserves to earn if he works until three o'clock on a Sunday morning or whatever. As a result there has been a fairly massive reduction in after-hours and weekend clinics, which puts a severe impost onto the community and the public health system. It disadvantages the community in that the care that it probably gets best from a GP is not provided and disadvantages the public health system because those patients then go to the public health system emergency departments to get service. Most of us understand this fairly well, but the inflexibility in the State not being able to subsidise a GP clinic to enable it to be viable out of hours, which would take people out of the EDs and enable those departments to work more efficiently in dealing with emergencies -

The DEPUTY CHAIRMAN: Is it a specific part of the agreement that you cannot subsidise those GPs?

Mr Chuk: It is a specific part of the agreement. Two parts of the agreement say that we must treat everyone who walks in the door of an ED. Therefore, we cannot say that a patient should go to a GP clinic. We might indicate or suggest it or talk about waiting times. However, the thing that is catching us at the moment is not so much that, but that everyone would be a winner if we could subsidise GP clinics out of hours.

The DEPUTY CHAIRMAN: Everyone would win.

Mr Chuk: Everyone would win. However, the commonwealth and state funding comes together into this one system of continuing care or primary care. At the boundaries, the funding system's interfacing is one common care system -

Mr Jackson: And the public does not see that.

Dr Lloyd: If GPs were subsidised, a view could be taken that if they then bulk-billed, they would be breaching the Health Insurance Commission Act.

The DEPUTY CHAIRMAN: Therefore, a GP cannot be subsidised and bulk-bill at the same time.

Dr Lloyd: No.

The DEPUTY CHAIRMAN: There must be a way around that. Can you not pay part of the doctor's fee?

Dr Lloyd: Oh no, we cannot do that!

The DEPUTY CHAIRMAN: Therefore, you are basically hamstrung in terms of flexibility.

Mr Chuk: I assure the committee that we are actively discussing flexibilities of this kind with the Commonwealth and we hope to gain some added flexibility in the next agreement. However, I did preface my comment by saying that I doubt whether we will achieve the flexibility we desire.

Mr P.W. ANDREWS: Is it legal for the State to try to set up a GP clinic? The GP clinic would bill the Commonwealth - if you want to use that expression - but the doctor's income would be underwritten by the State. In other words, we would offer the doctor \$200 000 a year and, if he does not bill the Commonwealth for services, we would make up the difference.

Dr Lloyd: No, we are not allowed to do that.

Mr P.W. ANDREWS: Is it illegal under the agreement?

Dr Lloyd: Yes, other people can do that in some settings; for example, in the case of a guaranteed income for a practitioner in a rural town or whatever. However, we cannot do it. We have been exploring options for quite some time. We have sat with commonwealth officers to try various models. It looks like one model will gain acceptance, but it is not attached to an emergency department. At this stage that is still not on paper, so we are a bit nervous about it. It is a real threat for the doctors because they, rather than us, are the ones who can breach the Health Insurance Commission rules. We can be in breach of our agreement on cost shifting.

[5.15 pm]

Mr P.W. ANDREWS: A while ago you used the example of Rockingham. My seat is Southern River, which is south east metropolitan. Do you know of anywhere in Australia where there would be a model of health delivery that we could look at that might cover the problem we have with after-hours care?

Dr Lloyd: We have explored that, and so has Queensland. I think it is true to say that neither of us has actually come up with a model. Queensland wants to do what we want to do; that is, subsidise after-hours clinics in a hospital so that people have an option. For the patients or clients it is a big advantage to go to an experienced GP for a problem rather than necessarily be stuck in an ED. We would like to do that. However, the other problem with this, and the reason we need to subsidise it, is that we will not find one general practitioner who wants to run a 24 hour a day, seven day a week clinic. Therefore, we clearly need to get the 10 local GPs to come together. They will not want to do that in their original practice, because that will interfere with their own business, so they will need to set up another practice, and they need help with that, because it is not cost effective for them to have another practice,.

Mr S.R. HILL: Do we not have a similar situation in the Geraldton area at the moment where the doctors come together like that?

Dr Lloyd: No, we do not have that in Geraldton.

Mrs O'Farrell: There was a proposal for something along those lines, where a cooperative of doctors would run an after-hours service. However, it is not in place yet.

Mr P.W. ANDREWS: It is a crazy system, because from my constituents' point of view it is their money that pays the taxes, and this is an artificial creation of Federal versus State.

Mr Jackson: It works in the Murdoch situation, but there is a very large surcharge.

Mr Daube: It is doubly crazy because we all know that and we can all see that, and we all know that we just keep driving into the crash that is ahead of us. Although we have embarked on the AHCA negotiations in the spirit of hope and so on, we are pretty certain that unless there is some huge change in the world, there will be a bit of minor adjustment here or there, but we are doomed to face the same problems in this State.

Mr P.W. ANDREWS: Can you identify any other part of the world that in an urban setting has got its act together? You have mentioned Scotland.

Mr Daube: I was talking about the Scottish health service as opposed to the rest of the British health service.

Dr Della: On our trip with the minister to the United Kingdom and Dublin, when we went to Dublin we looked at the nurse practitioner role. We also looked at what they do with their outpatient clinics after hours. They invite their GPs to service their after-hours clinics at the hospitals. They have a roster of GPs in the local area, and after 5.30 pm they are rostered to service the outpatient clinics. The hospital provides the facility and the clerical support, and the GPs provide the medical service after hours. That system in Dublin works very efficiently. The reason they have done that is so that everyone knows where to find a doctor after hours, and also so that there are no security issues, because a lot of GPs do not want to have to sit in their rooms by themselves. That is the best example I have seen.

The DEPUTY CHAIRMAN: We have not even scratched the surface. We are running out of time.

Mr Daube: We would be happy to come back and talk with you again at some stage.

The DEPUTY CHAIRMAN: We would very much appreciate that. I know it is difficult because many things are controlled by the Commonwealth. It also must be difficult when you are talking to a chairperson who is from the Opposition; I guess that is a bit compromising from a Health Department perspective. However, we have taken off our political hats and we are trying to be proactive. There are things the State can do and there are things that the State Parliament can perhaps help you do. We are trying to hold out an olive branch, in a bipartisan way. We are all faced with a common issue, and our customers, if that is the right term, at the end of the day are the same people. Whether they are paying taxes to the Commonwealth or the State, they are all going to the same hospitals. It seems ludicrous that we do not seem to be able to get it right at the top end. We probably have one of the best health services in the world; if I were to get sick, I would be very happy to get sick here, if I can say that. However, that does not mean that we are well prepared for the future, and nor does it mean that there are not changing models that we should get ahead of. Our system does not seem to be as flexible as it should be. Our role as legislators is to try to assist and to help with the manpower planning and provide a framework for that to happen. I guess the role of standing committees in the Parliament is that the Government or the Parliament can refer things to a committee for further scrutiny, and we can be proactive and get on and do things. We have chosen to try to use our time in the Parliament in a proactive way and to assist in health and education; and health is our major concern at the moment. We would like to talk to you again. As a committee we would like to talk to you regularly, and we do, and we thank you for that. In terms of this inquiry, as we start to formulate some ideas it might be good if we could bounce them off you.

Mr P.W. ANDREWS: We appreciate the fact that you are here as representatives of the Health Department, but we also appreciate you as individuals and the ideas that you put forward.

Mr Daube: One of our problems in coming before you is that you have very broad terms of reference and we were not sure what should be in our submission. We are certainly happy to come back and talk with you again. I want to be a bit careful to not commit people who are already working 23 hours a day to have to produce a paper by Monday, but it might be helpful in focusing your thinking if we were to put up a limited number of initiatives that we think would be useful for you as a committee to pursue or address. That would not necessarily be our answer to all the world's problems, but it would be a few initiatives that we think might be useful and could be considered.

The DEPUTY CHAIRMAN: Yes, that would be useful. We certainly do not want to interrupt your responsibilities to the minister and the minister's responsibility to the Parliament, but we are acting on behalf of the Parliament so I am sure there are issues that we can support in a bipartisan way. More than that, there may also be issues that the State does not have the opportunity to influence to a great degree, such as some of the Commonwealth-State issues, the universities and so forth, but that we can address as part of our report. There may also be other issues in which we can

assist and be proactive. If you want to send us any supplementary information, please do so. Thank you for your time today. It has been very valuable. We appreciate your honesty and straightforwardness and the opportunity of speaking frankly about a wide range of issues.

Committee adjourned at 5.25 pm