



COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

**HOUSE OF  
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH

**Chronic disease prevention and management in primary health care**

(Public)

THURSDAY, 1 OCTOBER 2015

MELBOURNE

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**HOUSE OF REPRESENTATIVES**  
**STANDING COMMITTEE ON HEALTH**

**Thursday, 1 October 2015**

Members in attendance: Mr Irons.

**Terms of Reference for the Inquiry:**

To inquire into and report on:

Best practice in chronic disease prevention and management in primary health care, specifically:

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally;
2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management;
3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;
4. The role of private health insurers in chronic disease prevention and management;
5. The role of State and Territory Governments in chronic disease prevention and management;
6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management.
7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and
8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

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**BEER, Ms Josephine, Relationship Manager, CarePoint Trial, Department of Health and Human Services, Victoria**

**THOMAS, Professor Robert, Chief Advisor Cancer, Principal Investigation CarePoint, Department of Health and Human Services, Victoria**

**Committee met at 09:02**

**CHAIR (Mr Irons):** I declare open this public hearing of the Standing Committee on Health and would like to thank you all for your attendance today. Before we begin, I want to ask a member of the committee to move that the media be allowed to film the proceedings today in accordance with the rules set down for committees, which includes not interfering with committee proceedings, and not taking footage or still images of members, committee staff and witnesses' papers or laptop screens.

**Ms HALL:** So moved.

**CHAIR:** Thank you. I now call the representatives of the Victorian Department of Health and Human Services. I understand that as witnesses appearing before the committee you have no objection to being recorded by media during your participation in this hearing and that you have read the card in front of you with regard to parliamentary privilege. I now invite you to make a short opening statement to the committee.

**Prof. Thomas:** Thank you, Chair. I am pleased to appear before this committee. The issue of better integration of care between primary healthcare systems and tertiary healthcare systems is a key issue for the Australian health system. The Victorian Department of Health and Human Services have been working for a period of time on trying to improve the capacity of patients to traverse between those systems. I am pleased to be able to present to you some of the details of the CarePoint trial, which is a program designed to evaluate the effectiveness of some of the new programs to improve the integration of care in the chronic disease setting.

**CHAIR:** Could you tell us about the CarePoint trial?

**Prof. Thomas:** Yes. The CarePoint trial is a trial which is jointly funded by Medibank Private and the Department of Health and Human Services. It is a program which is designed for people with severe chronic illnesses. In its essence, it is designed to keep people out of hospital. The entrance into this trial are people who have had multiple admissions to hospital—a total of four in the previous two years—with a significant chronic illness. There are other entrance points, also, but I will not mention them now. We then identify those patients through general practice. So general practice is powerfully involved in this project. And, of course, it is very much patient centred. We try to learn a lot about the patients and their social circumstances. Having identified the patients, we put a program of support for those patients in place. We work with the GPs to produce a care pro-forma—

**Ms Beer:** A care plan.

**Prof. Thomas:** A care plan—so this is done together. And we provide supports for the patients alongside that care plan. Will have an outcome of this program in—

**Ms HALL:** What does the program of support include? Can you walk us through that, please?

**Prof. Thomas:** Yes. The program of support includes the development of the care plan, which is done in conjunction with the general practitioner of that patient. So it comes to the general practitioner. It provides the CarePoint trial with the name of the patient. The care plan is constructed with the general practitioner. The supports for that program are, firstly, a clinician who works with a GP to help develop the care plan. Perhaps Josephine might be able to detail the variety of other supports.

**Ms Beer:** As Bob was saying, the first part of the process is that the CarePoint clinician—and that might be an experienced primary care nurse or an allied health professional experienced in primary care—will conduct an assessment in the client's home. Through a structured set of measures, that will then inform our final evaluation. It will also inform the development of the care plan. They typically spend about an hour with each enrolled person to go through that assessment. Part of that is a dialogue with the consumer around their perception of what their needs are. A written report is then produced with the consumer's consent and provided to their GP. That informs the development of the care plan. As Bob has outlined, the care plan is an expand concept beyond the MBS item numbers. It is a multidisciplinary plan of care which includes social aspects of the consumer's needs. The GP will typically have some discussion on that with the consumer just to finalise what is in it. Then it is an e-record that is shared across the team involved in the consumer's care. The various services in the plan are ordered.

Coming back to your question, a couple of examples would be as follows. Say, for example, I am a consumer with heart disease and I have some respiratory problems. Perhaps the GP had suggested to me that it might be

good for me to do some respiratory rehab. At the time when it was suggested, I said, 'Sure', but then, when I went home, I realised that I could not afford more expenses at this point in time. So I have not done that. So part of the assessment gets a strong sense of the consumer's social, financial circumstances, et cetera, and how they are tracking in that regard. We will have a discussion along the lines of, 'This has been identified, but I see that you haven't taken that up. Were there any barriers?' We have found that, particularly for severely ill and chronic consumers, the out-of-pocket costs are a barrier to their engagement with plans to improve their health. For GPs, hunting around to see what could be funded through various streams to that level of detail is something that they often do not have time to do. Also, the practice nurses often do not have time to do that. Part of this program is that CarePoint clinicians spend time on the detailed assessment, identifying the local service options. The program is then supported by the care navigator resource that orders a range of things for me—for example, respiratory rehab at the local community centre or, perhaps, something like daily walks if I am tending toward heart failure so that I can be more aware of those. Then, if the weight is tracking in the wrong direction, I might get a call from a care navigator to say, 'We noticed your weight is starting rise. How are you feeling?' and perhaps they are identifying that I am short of breath. Then they might organise an emergency visit from the general practitioner to intervene before I deteriorate to the level where I would need to go to hospital. It is putting those supports in place for the consumer—as Bob said, for people with serious chronic diseases. There are the gaps in the system at the moment. They are still drawing on the existing system resources but also plugging some of those gaps to keep them healthier in their own homes.

**Ms HALL:** So it is basically a case management model backed up by an interdisciplinary team and services that are needed in the community.

**Ms Beer:** Similar to that. The caseloads for the CarePoint clinicians are 150 enrolled consumers per clinician. When we were looking at the design aspects of the trial, we were looking at what had come out of the diabetes coordinated care trials. Part of the findings was that targeting consumers who could benefit from this approach is important, but, also, designing the model to be cost-effective is very important. That will evolve as the trial goes forward; it is an action learning approach. There is a 150 caseload with risk management and a real-time e-record to inform that risk management, which is backed up by support from the key navigators as well for clinical governance and patient safety. The caseload is higher than some of the existing case management models.

**CHAIR:** How long is the trial expected to last?

**Prof. Thomas:** It will be finished in 2018. We have enrolled some 1,500 patients in this trial now, which is the expected number.

**CHAIR:** Is that just in Victoria?

**Prof. Thomas:** This is in Victoria. It is about half and half Medibank Private patients and so-called public patients. The evaluation is going to be done by an independent group, BCG. They will be evaluating this on the basis of expected reduction in admission rates—we are hoping to get a 25 per cent reduction in admission rates—and also on the basis of patient experience and understanding of what went on and how they feel about the particular process. There is a quite rigid process around it.

**CHAIR:** What are the desired outcomes of the trial? To expand it eventually, once the assessment has been done? To implement it? There has to be a purpose to the trial.

**Prof. Thomas:** That is a good point. There is a purpose to the trial.

**Ms HALL:** If it is successful we would hope that it will be rolled out across the state.

**Prof. Thomas:** Yes, in some form or other. Whether it is would be rolled out exactly in this form, I do not know. There are lots of issues about this trial which are good. I might say that every bit of feedback we have heard, from GPs or consumers and patients and other people that are involved with this, is that they have enjoyed this, that they have felt supported and value the support.

**Ms HALL:** Is the interim data showing that it is actually moving towards achieving its goal?

**Prof. Thomas:** All we have from that at the moment is a lot of personal vignettes saying that people feel supported. One of the really good parts of this project—we have not told you exactly how it works—is that we have a call centre approach to this, which is Medibank Private's experience in this area. We have had examples where people who, at 6 o'clock on a Friday night, have been sick or unwell, and, where they would normally call an ambulance and go to hospital, they ring the call centre and the call centre arranges for a GP, if their own GP is not available, to come and see the patient. They usually see them in a couple of hours and they can usually settle them down. There have been examples where they have not had to go to hospital because of that. We have that—it is not evidence, but it is a feeling that we are on the right track.

**CHAIR:** In an instance like that, if they were going to a hospital, for what sort of time length would they be going to the hospital? By having a GP visit them, what is the saving?

**Prof. Thomas:** The saving is huge because, otherwise, the patient gets an ambulance, they go to hospital and then sit in an emergency department for six hours, and by that time it is midnight, so they will probably be admitted for several days, if not overnight. They would go to a general medical ward. The whole exercise starts again when they are out of hospital. My particular field is more in cancer, but anything which keeps people out of hospital and even out of out-patient departments and keeps them in GP systems and in their home is both cost-effective and good for patients.

**CHAIR:** Are the people who are running the program—the trial—siloes or are they still working in other health areas at the same time? Are they purposefully allocated to this particular trial or do they have other duties outside the trial?

**Prof. Thomas:** The care coordinators and the care navigators are working on this trial. They are essentially full time.

**Ms Beer:** The clinical team that we have described—the CarePoint conditions and the care navigators, and there is also a head of integrated care, who is a GP. We have recruited a GP to the program as well, in Victoria, because being GP-led is an extremely important part of the model.

**Prof. Thomas:** A GP is essential. It is absolutely essential. This is almost seen to be a GP-led program and that has been part of the success, I think.

**Ms Beer:** They work across the whole service delivery system, depending on where the patients are interacting with it. We talked about how they do assessments in patients' homes; they work with the GPs and the consumers in general practice and, if the people are admitted to hospital, they participate in hospital liaison—whatever part of the system is required. We have been working—until the commissioning of the Primary Health Networks—with the Medicare Locals in the trial's areas of operation. That has been really helpful as well, given that Medicare Locals now have the PHN role, with GP engagement and with integration, so that is another part of the system that they are actively engaged with.

**CHAIR:** You said the patients have been valued and I guess that helps in their overall health environment. If they are feeling better about their treatment, that could be bit of a placebo in itself, couldn't it?

**Prof. Thomas:** Oh yes, absolutely.

**Ms HALL:** It is the support; yes, you are right.

**Prof. Thomas:** A very common thing we hear is that, actually, many of these people are lonely and isolated and often not living in very good circumstances, so having somebody who they can talk to about their issues is an elevating process in itself.

**Ms HALL:** And elderly?

**Ms Beer:** It is a mixture of ages. It is 18 years and over. It is largely the older cohort, but there are younger people, who are working. One of the vignettes that we have is a fellow who is a single parent with three children. He has been unable to work because of his various conditions. One of his goals is to have his health stable enough, not to be in and out of hospital, so he can get back to work and be more engaged with his family, and so the clinical team are working through a program to help him get back on track.

**CHAIR:** I was also interested in your comment in regard to finding local clinicians or people to assist with them. Is there any part of the system that says, 'This is my postcode; this is my chronic disease' and they type that in and, bang, they come up with a list. I thought that might have already been available.

**Prof. Thomas:** My experience is in the cancer field. This is such a changing issue and it varies from year to year. You use a book or some sort of web page and then it changes. It is difficult to keep it going.

**Ms HALL:** But diabetes is one of those things where you can type a postcode in and there are clusters.

**Prof. Thomas:** Yes, that is right. In diabetes, of course, the issue is how that person then gets to see those people and have it found.

**CHAIR:** Hopefully the GP.

**Prof. Thomas:** Except for the GP.

**Ms Beer:** There are a range of things that are being progressed in that space, some at the national level, with the National Health Service Directory, looking at what some of the gaps are that could be filled in and which would offer benefits for all Australians, and some at the local level, where we have been working with various

partners involved in this trial, trialling a few different ideas to see what could make that work better and in a more sustainable way.

**CHAIR:** Does the trial, or any portion of it, have part management by the patient themselves in their program, encouraging them to actually participate?

**Prof. Thomas:** Yes, basically letting the patient better understand their condition and deal with their condition is very much part of that process of interaction with the patient. When I look at the vignettes, most of the patients we are dealing with require a lot of support. This is the top end. These are not the people with a bit of chronic illness. These are the people with severe multiple issues, chronic illness. But, of course, self-education, understanding, a healthy lifestyle and all those sorts of things are part of the program.

**Ms HALL:** Absolutely.

**Ms Beer:** As Bob was saying, an aspect of it is literacy, and that can be about consumers and the system. Part of it also is around patient activation. As Bob said, we all have a reasonably basic understanding of healthy behaviours, but are we motivated to put the doughnut down and go for a walk and those sorts of things.

**Ms HALL:** Socioeconomic factors come into it too.

**Ms Beer:** Yes, and environmental factors as well. Looking at the consumer's local environmental, what are the consumer's goals? The first part of the process is stabilising their health condition and dealing with immediate challenges and then setting some goals to improve their health status. It might be exploring their appetite, reducing smoking, taking up an exercise program—all of those types of activities that will improve their health.

**CHAIR:** Is there an incentive portion in the program, or anything like that, besides getting healthier? Is there any reward system for people who are taking—

**Prof. Thomas:** Not in this program. Essentially, if we do this we want to see if we going to make a difference. Also, one of the important things has been the support within general practice. What we have seen is that, almost alongside this, general practice is taking more of an interest in this element of the health of their patients. We have heard stories of practice managers taking patients on walking tours. It was very important to get support to the general practice because they are overloaded with work. They cannot stop and think outside their workload, so putting some sort of care and support into the general practice has been a big issue in making this program work.

**CHAIR:** If the program is successful and you want to roll it out on a national basis, what sorts of changes would need to be made to the MBS system for it to integrate? You must have thought about this before you implemented the program.

**Ms HALL:** The million-dollar question.

**Prof. Thomas:** Absolutely, there needs to be change to the MBS to account for the particular needs of this particular group of patients, moving from the current individual item-of-service fee type of arrangement to an integrated program, a bundle payment, accountable care or paying for outcomes. Theoretically, that is the best way to go, but there a fair step to take before that actually happens. Perhaps I am speaking individually now and not from the department: we could add a few extra item numbers in, if you like, or items of service which might help with coordination. But the reality is that, for a big improvement, you probably need to look at how you can wrap up a whole bunch of services for a patient with a chronic illness and have them managed within one payment program.

**Ms HALL:** Maybe so many thousands of dollars to manage a program, modernise the program, approve the program and then deliver the program. Would that be an approach?

**Prof. Thomas:** That will be the sort of approach. What we do know about these things is that you have to have a cohort of patients. You cannot really put this across for every patient; you have to define the group of patients that you might have. Then you find the outcome you want in a year or in two years. Then you put a payment in place to cover all the particular issues that a patient might have—

**Ms HALL:** Progressive payments.

**Prof. Thomas:** You literally have a rewards system which says: if you do all these things, a patient might have a good outcome. Some form of incentivisation in that sort of process is good.

**Ms HALL:** What sort of incentivisation?

**Prof. Thomas:** There are two sorts: either support for a practice or a business in some form or other or pure monetary incentives.

**Ms HALL:** How would you see the monetary incentives working?

**Prof. Thomas:** Accountable care generally says that you are paying for an outcome—you are not paying for no outcome. The incentive there is to say: 'We did reduce hospitalisations for this particular group base. We did make them more comfortable and happier in their system. We did prevent excessive use of the PBS because we managed their drugs better.' If you can see a benefit in that case then it is reasonable that some of the money that might be saved in that would be given to—I would hesitate to say given to the doctor—the system that surrounds the doctor so that they can live a better life.

**Ms HALL:** Are there tools that have been developed to measure these outcomes to work out a system that you can use for this incentivisation?

**CHAIR:** Established KPIs. I am sure there would be enough data.

**Prof. Thomas:** There is a ton of data out there.

**Ms HALL:** Something you can measure it against if you are going to be making payments.

**Prof. Thomas:** But this is still a difficult area. Even measuring outcomes and value of medical treatment is quite complex. One of the things we are doing in a joint project with the state government and the federal government is looking at the data along a patient pathway. We need a better understanding of what is an optimal pathway for a patient. We do not have that data. The data is there but we have not really done this work. We are doing it. If we can work out exactly what is a good pathway for the patient then we can work out a program of incentivising people who are outside that pathway to get into the pathway. So there are things that are happening but it is quite a complex area.

**Ms HALL:** Do you have any other programs that are operating in Victoria? What are the stats around chronic disease in Victoria—are they increasing or are there clusters?

**Prof. Thomas:** It is a terrible problem. The stat that is around at the moment is that there are 60,000 patients in hospital unnecessarily, if you like, at any one time. These people are in hospital because they do not have a good system of management outside of the hospital. There is a huge interest and pressure in getting those patients good care out of hospital—and I am not saying we should diminish their care. There are other programs that the Victorian government has been working on for a number of years trying to keep people out of hospital, but this is the next step.

**CHAIR:** Does that need more GP focus on people with chronic disease on a daily basis in a GP clinic?

**Prof. Thomas:** I do not think we need to say it is a GP problem. I think the GPs are just overloaded. When a patient with problems comes in in a wheelchair they can give them only 10 minutes or something. That is not really the right way to deal with it. Those patients need a lot of other supports. We have known from the vignettes that people who have lung disease cannot get physiotherapy for their lungs so consequently if they get a chest infection they go to hospital. If you can provide physiotherapy for that group of patients then you can expect to keep them out of hospital. These are the things that are currently not in the mix for funding really and need some more attention.

**Ms HALL:** So rather than the GP being the key case manager is there a role there for a nurse or an allied health professional to be that key case manager, the focal point for the person, the No. 1 contact for that person, and then linking into the GP service or whatever service they need? Does it need to be the GP or a practice nurse?

**CHAIR:** That is what your trial is doing now, isn't it?

**Prof. Thomas:** But it is still GP led. I think still the GP is the centre of the arc of service, if you like. I mentioned practice managers. Many GP practice managers will do this sort of role—'Hello, Mrs Smith. How are you today? Do you have a problem?' Those sorts of things are very effective.

**CHAIR:** Do you have any documents that you can submit to the committee in the future that would explain your CarePoint trial system?

**Ms Beer:** We are exploring that in our authorising environment and will get back to you on that.

**CHAIR:** It would be nice to have it as an exhibit, or an example or submission. We look forward to the outcomes of your trial. If you have been asked to provide additional information, could you please forward it to the secretariat by Thursday 15 October. If the committee has any further questions, they will send these to you in writing through the secretariat. Once again, thank you for coming today—we appreciate it.

**TOY, Mr Luke, General Manager, Public Affairs, Kidney Health Australia**

**USHERWOOD, Professor Timothy, Member, Kidney Check Australia Taskforce, Kidney Health Australia**

**WILSON, Ms Anne, Managing Director and Chief Executive Officer, Kidney Health Australia**

[9.30]

**CHAIR:** I call the representatives of Kidney Health Australia. I understand, as witnesses appearing before the committee, that you have no objection to being recorded by media during your participation in this hearing and that you have read the parliamentary privilege card. Thank you for coming along today. I invite you like to make a short opening statement to the committee.

**Ms Wilson:** First of all, I would like to thank the committee for the opportunity to present to you today from the perspective of Kidney Health Australia. Given the terms of this hearing, we are also willing to talk about our submission under the Vascular Disease Prevention Alliance submission paper. We will be addressing both of those in our discussions.

We are really pleased that Tim can be here. He has mentioned that he has been part of the Kidney Check Australia Taskforce, which is Kidney Health Australia's national GP and allied health initiative that has been running for 14 years. Tim has been very involved with us in the planning and delivery of that program.

I am going to give you a really quick overview of Kidney Health Australia and why this is such an important year for us. We are the national peak body representing people with kidney disease and clinicians in Australia. Our vision is what drives everything we do. Our vision is to save and improve the lives of Australians affected by kidney disease. This is because one in three Australians are at risk, 1.7 million have indicators of chronic kidney disease, it is the ninth leading cause of death, there are no warning signs and we know that less than 10 per cent of people with chronic kidney disease are aware they have the condition. We deliver programs in education, advocacy, research and support, and we are a national healthcare charity with a national structure—we are not a confederation of states. We do not provide dialysis, and we are not a service provider in a clinical sense; however, we provide a national holiday dialysis program here in Victoria in conjunction with Monash Health, which is a national initiative that we are taking to other states. It will be a national program very soon. Our strength in being able to advocate today comes from our strong base in national consumer participation.

We have a framework of state based committees that are made up of people affected with kidney disease. The chairs of those sit on our national consumer council; therefore, we have legitimate advocacy from the consumer base up to the management board, being able to advocate both on a federal and state and territory basis. We are financially independent of government—federal, state and territory—and our advocacy is collaborative and grounded in what we believe is smart, effective, evidence based and cost-appropriate policy.

Very quickly, some of our key programs are: our major program in health professional—that is GP—and allied health professional education, as well as community education, focusing on prevention, detection and treatment of chronic kidney disease; support programs for people around Australia, also adding that we support people with kidney cancer—we look at kidney cancer as a disease of the kidney; holiday dialysis transplant housing; and a whole range of programs that come in under our national programs for children and families.

Our submission considers what we believe would make a difference not just from a systemic perspective and a clinical perspective but also, importantly for us, from a patient and carer perspective. Now I am going to thankfully hand over to Tim, who is going to talk a little bit more. I do apologise.

**Prof. Usherwood:** Good morning. Anne asked if I would talk a bit more about the clinical side of chronic kidney disease. I am, as I said, a general practitioner. My clinical practice is in Aboriginal health in Western Sydney, and I am also the deputy chair of Western Sydney PHN. A bit of background: you are probably aware that chronic kidney disease is common in the community, and affects about 10 per cent of Australian adults, but most have early disease, so do not have symptoms. In fact, the majority of people with chronic kidney disease are not aware that they have the disease, because this requires fairly simple blood tests to diagnose and confirm. There is a socioeconomic gradient. The prevalence is about eight per cent in the highest socioeconomic group, increasing to 14 per cent in the lowest socioeconomic group. There are also some other disparities. In particular, it is far more common amongst Indigenous Australians.

Chronic kidney disease tends to progress, especially if it is untreated, and ultimately will result at end-stage disease that requires dialysis or transplantation for survival. However, kidney disease is also a risk factor for vascular disease such as heart attack, so that people living with chronic kidney disease are 20 times more likely to die from a heart attack or other vascular event than they are to progress to end-stage disease. So management of chronic kidney disease implies proper management of cardiovascular disease. Prompt detection and management

of CKD, even in its early stages, provides the best opportunity to slow progress of the kidney disease and to intervene in reducing vascular disease.

**CHAIR:** In your submission, you talked about the community pharmacy initiatives that identify high-risk individuals and refer appropriately to primary care. What are they? How would they implement those?

**Ms Wilson:** We believe that community pharmacy is an extension of primary care. We believe that community pharmacy involvement in risk assessment is a pathway into primary care: to refer those people who are at increased risk to be able to go and see their GP, and hopefully, leading to being able to undergo an integrated health check, which is part of a National Vascular Disease Prevention Alliance submission. Kidney Health Australia has a product that we brought out. We are not saying this because it is our product. It is just a urine-testing protein strip. It is called KidneyCheck. It is currently on sale exclusively through Sigma pharmacies, but we are soon to develop a partnership with the guild to make that product available. It is like a lot of other products that are out there in the marketplace, where people can go and buy a blood pressure machine, a glucometer et cetera, where those people who may not be necessarily likely to want to go to their GP, but do come in to pick up their prescriptions for hypertension medication, cholesterol et cetera, will be able to be talked to by the pharmacist and asked if they have had a kidney check. The reason for that is that we know that people do not understand where the kidneys are or what they do.

We were just talking about the fact that a lot of people say to us, 'My kidneys are fine. I don't drink a lot of alcohol', or 'I drink a lot of alcohol. Does that mean my kidneys are at risk?' which is not the case. We know that people do not really understand what their kidneys do and where they are. We also know that people do not understand that there is a link between hypertension, diabetes and kidney disease—those three are really wicked partners—and that if you have one you are at an increased risk of getting another.

People who are going into their pharmacies to pick up their medication need to be able to have a risk assessment consult with their pharmacist and be offered the opportunity to take this check home and test their urine for protein, which is a very, very early potential sign of kidney damage. Then, if they have an adverse result—and there are three individual, foil-wrapped testing strips in the box—they need to go and see their GP, or come back and talk to the pharmacist, who will give them a letter of referral to go back to their GP.

A prompt risk assessment is a very superficial thing, but it is a way of capturing those people who may be at present slipping through the net. When you add numbers of people with hypertension, diabetes and chronic kidney disease together, you are talking about a figure of over five million Australians. The tests are very simple. If you go to the doctor, you have a urine test, a blood test and a blood pressure check. We know that those tests are not happening as often they need to be.

**CHAIR:** What would drive the pharmacy to do a consult? Is there an incentive for them?

**Ms Wilson:** It is part of the sixth pharmacy agreement.

**CHAIR:** Do they make money out of them?

**Ms Wilson:** There is margin on the products. But we are not really interested from a business perspective. Our whole desire in getting KidneyCheck in the marketplace is twofold: firstly, kidney disease has no warning signs, and it is a silent killer. It is silent when you compare it to diabetes and cardiovascular disease. It is seen as the poor third cousin, and yet, when you get into dialysis, the cost of kidney disease is one of the most expensive to the health system. So we do a lot for end-stage kidney failure, but we do not do enough for early detection and prevention. That is where the integrated health check is so critical, because it addresses kidney disease as well as the other comorbidity conditions. That is why we are so passionate about advocating for both.

**Ms HALL:** Would you like to walk us through the integrated health check. When and how do you think that should take place?

**Mr Toy:** I might throw to Tim for some of the clinical aspects behind it.

**CHAIR:** We are not clinicians.

**Mr Toy:** No, neither am I. Partnering with the other three organisations—the National Heart Foundation, Diabetes Australia and the National Stroke Foundation—is a recognition that these diseases play together and produce some outcomes. Tim has got some statistics on how they interrelate. From an efficiency perspective, to us it makes sense to do one check for these four diseases. We also have in place absolute risk guidelines that have been NHMRC-endorsed, so we have a tool that is sitting there with them.

What we are proposing as part of the primary care review, the MBS review and presenting to this committee—and I am sure you will hear this from the other three—is that now is an opportunity to put a check like this in place. Previously we did not have a comprehensive check that recognised that all four of these diseases have this

strong relationship with each other. We might have checked for individual risk factors or individual diseases. The submission goes into some detail about how we may potentially have some people on medication who do not need to be and some people who need to be on medication who are not. What we are proposing with this check is a mechanism to realise the guidelines that are in place and draw upon the issues that we are seeing in terms of kidney disease, in particular, slipping through.

Before I hand to Tim, one of the things, from a kidney perspective, that is driving this check is that you can lose 90 per cent of kidney function before you realise it. We run a health service line, and it is not common to have someone ring up and say, 'I went to the doctor with a sore back and now I am told I have to quit work and go on dialysis.' To us that is a big issue. We know from a bench study that 85 per cent or thereabouts go to the GP at least once a year, but only one in 10 with CKD know they have it. We think this is an answer to solving that problem. In terms of the mechanics behind the check, I might hand to Tim, who is a clinician, unlike myself, to talk about that.

**CHAIR:** Just on that: if you have people visiting the doctor once a year and they get to a 90 per cent point without the doctor realising it, is that because doctors are not running health checks for that area?

**Mr Toy:** I think it is the asymptomatic nature of the disease. But I will let Tim answer.

**Prof. Usherwood:** I think it probably is. The challenge is that patients turn up with problems that they need managed—that is obviously why they have come to see the doctor—but at the moment there is not a great incentive to do a more comprehensive vascular, kidney and diabetes assessment, so it often gets missed out. Doctors are busy; there is a high demand from patients, and patients may not always be that inclined to hang around and wait. The full assessment requires a blood pressure check, a urine check and a fasting blood test. That would be the minimum check, as well as some history and height, weight and waist circumference assessment.

The recommendation now is that every adult in Australia should have that every two years from 45 onwards, unless they are an Aboriginal Torres Strait Islander, in which case they should start from 30 years, or earlier if they already have risk factors such as obesity. We are missing out. We are not doing a lot of those things. Part of it is demand on practice services, part of it is the lack of any incentive or recognised item number that would support that, and part of it is the lack of any incentive for continuity of care. I could just point you towards the growing movement for the patient-centred medical home and the idea that a practice should take ongoing responsibility for patients.

**Ms HALL:** What sort of incentives need to be put in place to ensure that these checks take place?

**Prof. Usherwood:** Supporting an MBS item to provide a rebate for patients when they see the GP, to have more than just management of the presenting problem and perhaps some additional health promotion to try to systematise the introduction of health measures. But I think ultimately we need to be looking at thinking through the financing of primary health care—and I can talk about that. It might be a bit off topic, but—

**Ms HALL:** Yes, by all means.

**Prof. Usherwood:** There is the Hamilton review going on at the moment. We have high hopes for that. There is growing thought around the health professions and elsewhere that we really do need to move beyond pure fee-for-service-type reimbursement and look at funding for voluntary patient registration, comprehensive continuous care and also, dare one say, for quality incentive programs—a blended model that supports fee-for-service where it is appropriate for acute care, particularly procedural care, looks at weighted capitation to support an annual cycle of care, particularly for people at high risk, and provides quality payments to support high-quality care in various places.

**Ms HALL:** How would that impact on the health budget?

**Prof. Usherwood:** We have the MBS review, which is going to potentially defund a lot of services. The MBS review is essentially not looking at structural changes. Certainly the one that is being chaired by my dean is not looking at structural change. It is essentially looking at changing the tariff for the MBS items and making some of them zero, potentially. There may well be savings there, and those savings should be looked at as an opportunity to reinvest in health.

The other challenge, as I am sure you are well aware, is that a lot of primary care costs are borne by the Commonwealth; a lot of the downstream costs are borne by the acute states, which is the states and territories. It is always dangerous to say that, ultimately, any preventive intervention will save money in health, because usually other costs crop up. But at the moment we are spending a lot of time pulling people out of the river downstream and not doing enough to repair the bridges upstream, where they are falling in.

**Mr Toy:** On that point, if we detect chronic kidney disease early and it is managed appropriately—which is one of the things we are talking about here—we can reduce the deterioration of kidney function by as much as 50 per cent, and if we keep them off dialysis it is \$80,000 a year.

**Prof. Usherwood:** That is a very good example.

**Mr Toy:** Essentially we are looking at the health curve and the economic curve. In that respect they align with each other, because \$80,000 is the direct cost of providing dialysis in a hospital. To governments—to which the federal government obviously has some contribution—we would like to dramatically reduce that by stopping them from getting to that point. It really depends on how wide an economic view we look at in terms of cost.

**Ms HALL:** In other words, what you are saying is that front-end costs will reduce downstream costs? If you put preventive measures in place then the costs that you incur with acute disease—

**Prof. Usherwood:** I think you could say a bit more than that, actually. That story has been said for a while, and I think it is true—we can repair the bridges upstream and stop people falling off the bridges upstream. But I think there is an opportunity to look at reinvestment in the front end as a result of the MBS review, because it is likely that the tariffs of a number of MBS items will be set to zero or they will be defunded—they will be taken off the schedule. That is an opportunity to look at how that money is used.

**Ms Wilson:** There is a broader issue with that, as well—that once you get people coming onto dialysis, what often happens is that they have to stop work. So you have a whole financial crisis that comes into that for the families, which then becomes an impost. You are not necessarily on the health budget, but on the welfare budget et cetera, so it really is a very whole-of-government view when you are looking at the potential impact.

**Prof. Usherwood:** And it is not just dialysis—

**Ms Wilson:** No.

**Prof. Usherwood:** because only one in 20 people will progress to dialysis; the other 19 will have a vascular event. Again, that can affect economic productivity and it can affect benefits, which may ultimately also impact on the Commonwealth budget because people—

**Ms HALL:** A very good point.

**CHAIR:** Do you think that there should be an holistic view about management programs for chronic health? You are talking about your particular area—vascular and kidney—but there are other chronic diseases, and the government, if we are going to look at the MBS system, need to go across the whole range. There needs to be management programs and prevention programs put in for all chronic diseases. Do you think there is a template for management plans and prevention plans that would cut across all those areas without being chronic disease-specific?

**Prof. Usherwood:** The templates exist. There is a document called *The red book* which is produced by the RAG, funded by the NHMRC and updated every three to five years that provides a template for disease prevention and health promotion across the age range. The front page is by sex and by age—these are the things that these people want to do. We have not systematised health care in Australia sufficiently to make sure that everybody gets everything on that book. They should. So the template is there, and an important part of it is vascular disease prevention. And an important part of vascular disease prevention is kidney disease detection.

**Ms Wilson:** The program that Tim has been part of for 14 years, the Kidney Check Australia Taskforce, has what we call our red book, which is the CKD management handbook that every GP gets. That is in addition to the red book that provides a whole road map for the GP in terms of detection, management and treatment of chronic kidney disease in primary care, so that is an important tool in addition to what you were saying. Tim has said that the road map for chronic disease management actually exists, but even if we used the same processes but grouped chronic diseases together, the vascular area of diseases—if grouped together and addressed from a holistic perspective—would deliver very significant benefits rather than having the ongoing management and treatment of those conditions in silos.

**CHAIR:** So, we have the road maps. What are the roadblocks? Is it because we have got seven states and they all have their own systems?

**Ms HALL:** I was going to ask about the states and the Commonwealth and the uniform thing, so include that in the answer.

**Mr Toy:** It depends where you look at the spectrum. If I take primary care, it is that issue of underdiagnosis because we do not have one check that manages it all. Say you identify someone who is at risk, the next stage is referral. So I think primary health networks have a real opportunity here to support doctors to refer them to

programs that may already exist and may already be funded, such as the diabetes Life! program, a walking program, a smoking cessation program—those kinds of programs.

If you move through the disease spectrum, and you are at the dialysis stage, then, yes, I think there is an issue between different state government arrangements and federal government arrangements, because each state deals with dialysis differently. You have different levels of dialysis usage in each of the states and territories. Some states are very good at home dialysis, which costs less and may mean that a person can return to work, and other states are not. One of the pieces of work we are trying to do is to get a sense of national harmonisation, or best practice, between the different states and territories with regard to dialysis. I am not sure whether you have anything to add to that.

**Prof. Usherwood:** No, I think that is—

**CHAIR:** You agree with that.

**Ms HALL:** Is there a role for COAG in trying to make this work better?

**Mr Toy:** I think so. I think a lot of the work we have been trying to do is dealing with each individual state, where we will highlight where another state may be better at it. Here in Victoria they have a very good system of supporting those on home dialysis. In New South Wales they have a very good system of supporting those who travel for dialysis. Each of the states has various strengths, but really it is about creating some kind of forum where we can say: 'This state does that very well. We are seeing results there that improve health outcomes'—or reduce costs or, as is often the case, both—'Is there scope to how other states adopt that?'

**Ms Wilson:** These are issues of access and equity. That is the challenge in health right across the board. It is certainly the case in the kidney sector. As Luke has just said, one of our biggest areas of activity as a non-government organisation is to ensure that where we have achieved change, on behalf of patients and the sector, in one area we try to work with the other areas and at least bring them up to an even playing field. Realistically, why should someone who chooses to live in Western Australia be disadvantaged, in a whole set of ways, as a result of either not being able to have either access to home dialysis in the same way as other states do or not being necessarily offered a kidney transplant for live organ donation? There is a whole range of issues—a raft of issues. There needs to be standards around provision of dialysis, the pricing of dialysis—which is one of the issues that is nearest and dearest to our hearts. It is very difficult as a national organisation to try to get equity of access when the pricing of dialysis is different for every state around Australia. It is a major challenge.

**CHAIR:** I understand that a lot of Indigenous Western Australians go to Alice Springs for dialysis.

**Mr Toy:** The same goes for South Australia with the APY Lands, because the borders that we have on a map are not necessarily the same borders that Indigenous communities have on a map, so that triborder region has been a real big issue. The other issue in WA, as you know, is the fact that a lot of people come from Broome and the top and end up down in Perth, and they are essentially stuck there undergoing dialysis.

In the Indigenous space, we have just put out a very detailed report on renal disease in Indigenous communities. Where it is possible to provide a flexible model of dialysis delivery at home, it is not only better for the patient; it can reduce costs. If they come to Perth or they come to Darwin or Alice Springs, you are also dealing with the social issues; they are away from family; and you are dealing with accommodation costs as well as the dialysis service delivery. We have some thoughts in that report, and we are certainly happy to submit it after the hearing, if that is of use.

**Prof. Usherwood:** I would say, though, that the other issue there is prevention in the first place.

**Ms Wilson:** Yes, absolutely. It is the early part of the continuum.

**Prof. Usherwood:** Yes, and as I was saying, CKD, chronic kidney disease, is much more common in the Indigenous population than in the non-Indigenous population. That is at least in part due to inequities in access to health care amongst that community as well as housing and so forth.

Can I just go back to your question about whether there is another role for COAG? I think Anne is right: there is the issue of disparities between states in access, for example, to dialysis. The other problem that one sees is the very poor communication and integration between the acute sector on the one hand and primary care on the other—in fact, one has to say also the private specialist space, which is not often not thought about in that integration space. That essentially is paid for by the patient or by their insurer and partly reimbursed by Medicare, but then the primary care is essentially paid for or reimbursed by Medicare and the Commonwealth, and then we have the acute sector, which is the state sector.

It is extraordinary in this day and age, 30 years after we set up a national ATNC, that I still cannot access records from hospitals about my patients' most recent blood tests, and it is often easier to do things again than to

try to get the information out of the hospital. The hospital cannot access my records. I do not know what another doctor has just prescribed for this patient. The patient often has no idea what they have just been prescribed. The patient cannot tell me what they were in the hospital for. The treatment that they got at the hospital for the disease that I have been treating is not the treatment that I would have given, and probably I am going to have to change it back when they come out because I am aware of things that the hospital is not. There is a whole plethora of reasons why care is highly disjointed for people who depend particularly on public hospital services or public acute care services. A GP may not be always the same GP, because there is no patient-centred medical home and/or no voluntary patient registration, and there may be those private specialists who are also advising on their care but are not really integrated either. So we have a very fragmented health system in Australia.

**Ms HALL:** Maybe the fragmentation of the health system is one thing that we need to address. What about electronic health records? Is that improving?

**Prof. Usherwood:** Slowly, but at the moment it is still point to point. Most GPs now have fairly good electronic health records, but they are not integrated with the acute care sector and they are not integrated with the private specialists and their practices, so what you get is point-to-point communication. You get a letter—a discharge letter, a referral letter, an 'I've seen patients in the clinic' letter—but nothing that brings it all together. The myHealth Record is supposed to do that. The challenge is—

**Ms HALL:** Yes. I have registered with eHealth.

**Prof. Usherwood:** Good to hear. So there are a few things that a myHealth Record could do. First of all, I am told we are shifting to an opt-out rather than an opt-in model. That is a very good thing. The people who most need it are the people who currently are not registered.

The second issue is that it does need to be properly curated. That has been one of the challenges, at least with the previous iteration, the PCEHR, because the expectation was that the GP would be the curator. There are two problems there. One is that a lot of people do not always see the same GP all the time, so which GP is going to be responsible for curation? The second problem is that it is actually quite time consuming and risk creating to curate someone's medical record, so that needs to be thought through and worked through and properly reimbursed.

The other problem with the PCEHR, or myHealth Record, is that it is a record of the past rather than a proactive plan for the future. Why on earth do we have these GPMPs that essentially sit as static documents in GP management and get replaced every three months if you are lucky? Why not have an interactive plan? There are a few emerging now. I have to say that at Western Sydney PHN we have developed one that we are now trialling with practices and the LHD. Why not have an interactive, proactive plan that is e-enabled so that, every time somebody sees the patient, they talk to the patient: 'Let's do this; let's change this aspect of your plan; we'll upload it on the web; there it is so everybody else can now see it, including you'?

**Ms HALL:** Our health system is fairly convoluted, isn't it, with the state and the Commonwealth? In some states—in Victoria—even local government has a bit of a role to play, doesn't it?

**Prof. Usherwood:** Yes. It is not a system; it is a web, and it is a web with holes and lumps and bits you can fall out of.

**Ms HALL:** A web is a good analogy.

**Prof. Usherwood:** There are sticky bits you cannot get past. It is not even a nice spider's web; it has holes in it and bits that you cannot squeeze through.

**Ms HALL:** And people fall through those holes.

**Mr Toy:** I guess in that respect we will be reflecting these views into the Federation white-paper process because, again, the federal government fronts a significant proportion of hospital funding, and dialysis alone is 15 per cent of hospitalisations because of its high-frequency nature and high cost. To answer the question: we think that that might be a mechanism for the federal government to start a conversation with the states, going: 'We need to look at how we're going to deal with this issue because the demographic'—

**CHAIR:** How do you motivate them to do that?

**Mr Toy:** Yes.

**Ms Wilson:** Yes, it is a challenge.

**Mr Toy:** It is probably a longer answer than we have time for. It is a challenge, but I think that, if you look at the demographics of those who are on dialysis, for example, and then you transpose the *Intergenerational report* demographics, there is an urgency with which we need to act.

**Ms Wilson:** I guess there is one example—and I know that time is running out—in the organ and tissue area. We now have an Organ and Tissue Authority, and the outcomes of its work are starting to bite right across the country. I guess the strength of it is that you have one authority that is working with the states to deliver the outcomes around organ and tissue donation.

We have in the past advocated strongly that that is the way dialysis should be looked at because of those variations, because of the costs of dialysis to the government and to the community. Where we have models that are already working, you would have to ask yourself why you could not set up those kinds of authorities to address those kinds of issues that in the health space take up one of the most expensive costs to the health budget.

**Ms HALL:** It is just better coordination, everybody talking to each other and all going the same way, isn't it—taking the best practice?

**Ms Wilson:** That is right—and addressing those systemic issues. Here in Victoria, we have a Renal Health Clinical Network that is really probably the best in the country. It runs a state based KPI project, so every one of the hospitals here in Victoria reports on key performance indicators that they have all agreed to. They review them on a quarterly basis to see what hospital is doing best in what areas, and they address those hospitals that are not meeting the KPI standards. It is just a hop, step and jump to say that they are the kinds of standards that we need across Australia, and everybody works to a set of common standards. We try to do that. There is a non-government organisation convening meetings of heads of renal units on a biannual basis to get them to focus and agree on some KPIs, but if there were a way of doing that from a centralised approach in the way that the Organ and Tissue Authority does, where it has done exactly the same thing and that was costed out properly, there would be significant benefits to the system and to patients.

**CHAIR:** Do you think the federal Department of Health should be the one that should be doing more to assist this process of trying to get national programs in conjunction with COAG?

**Mr Toy:** Yes. I think that, if you are looking for a level of national efficiency and national unity, it makes sense for it to come from the national government, and the Department of Health is obviously the logical place to go with that process. One of the things that the Department of Health is doing at the moment is developing a new chronic disease framework, which we have been pushing for for some time. Again, we saw that as a lever which may provide an opportunity to have input into some of this because, at the end of that, that framework essentially gets issued as policy guidance to all the state and territory health departments, so we saw that as a mechanism.

In many ways they do it. Perhaps they just do it at a level too low. But the kind of thing that Anne is talking about with the AOTA model I guess to us demonstrates some level of policy success, because the Organ and Tissue Authority is a federal organisation under the Department of Health portfolio, but it is driving outcomes in state-run hospitals. While it is slow, we have continued to see an increase in organ donation rates since its inception, and we hope that that continues and continues to increase. But, to me, there is a model that has managed to focus on an issue, harness a collective will between governments and between bureaucrats in different governments and drive an outcome. We would like to say that that mechanism might be worth considering when we are talking about 15 per cent of our hospitalisations being from dialysis.

**CHAIR:** But hasn't Professor Usherwood already said that that road map is in place through the RACGP?

**Mr Toy:** I think that, with that road map, we are talking more at a GP level in terms of post identification of someone with disease and where you go. I guess we are taking one step higher and looking at it in terms of hospitalisations, so in many ways we are mirroring: 'Let's have a road map for this.'

I can just give you one example. Home dialysis is something that we advocate for because it takes people out of the hospital system; it is \$30,000 a year less costly to deliver; and, if you do home dialysis, you can have better health outcomes, and some people can actually return to work because they can do it overnight while they are sleeping. We have plenty of examples of journalists and public servants and the like who have returned to work doing home dialysis.

In terms of why coordination is key, the department—

**CHAIR:** Why don't the states—the states that are not doing it—promote home dialysis? Why don't they use it if it is \$30,000 cheaper?

**Mr Toy:** Yes, that is an excellent question because it is coming to my point. The agency, the department, responsible for defraying the cost to the consumer of doing dialysis at home is not in the health portfolio; it is the department of energy and water or the department of resources, because dialysis machines use electricity and water.

**CHAIR:** So it is not even in the health department portfolio?

**Mr Toy:** No. The small lever that you would pull to produce a big economic health and social outcome sits in a different portfolio.

In Victoria, they have a different model. They have said, 'Take that function and put it in the department of health and streamline the payment process.' In Victoria, the Department of Health and Human Services gives you a \$2,000 payment annually to cover your electricity and water bill, which is anywhere between \$1,500 and \$2,200, depending on the mode and your electricity provider. That removes the financial barrier to the individual doing it at home. The outcome of that is a \$28,000 remaining saving to the state government, and potentially, for persons young and fit enough, they dialyse at home; they return to work; and, as a productive member of society, they pay tax. That is what they do in Victoria. In every other state and territory it is a utilities rebate provided through the electricity provider under the mechanisms of the relevant department of energy, mining, resources or water.

**Ms HALL:** Is Victoria the only state that does that?

**Mr Toy:** Yes. What we do as an NGO—

**CHAIR:** Is that part of your submission?

**Mr Toy:** We will send it in. We have it in previous submissions, so we will put it in.

**CHAIR:** Can you send it to us as a submission?

**Mr Toy:** Yes, absolutely, because, as an NGO, we have convened—most recently just up in Queensland—a joint meeting of that department and the Department of Health. We brought them together in a room to discuss how a small saving here generates a large saving there.

**CHAIR:** What was their response?

**Mr Toy:** Positive, and they are looking into it. They have intervened in a couple of minor cases where people were ineligible for strangely baffling reasons.

**CHAIR:** Did they form a committee?

**Mr Toy:** It is an informal committee, but we have actually had a level of engagement because everyone is suddenly looking at it from a whole-of-government perspective. Once you do that, and once you get Treasury involved, you are talking about a 10 per cent up-front cost to get a 90 per cent saving.

**Ms Wilson:** When you look at the cost-benefits, it is just a no-brainer.

**CHAIR:** We have run out of time, but we do appreciate that. We thank you for giving evidence. If you have been asked to provide additional information, can you do so by Thursday, 15 October. If the committee have any further questions, we will send you those in writing through the secretariat. If you feel that there is any other information that would assist us in our inquiry, please feel free to forward it to us through the secretariat. Again, thanks for coming along this morning.

**Prof. Usherwood:** Thank you very much for the opportunity.

**CHAIR:** Thanks for your submission.

**CARBONE, Dr Stephen, Policy, Research and Evaluation Leader, beyondblue**

**HALPIN, Ms Rebecca Ivy, Director of Policy and Partnerships, SANE Australia**

**HEATH, Mr Jack, Chief Executive Officer, SANE Australia**

**NIKOLOSKI, Ms Carolyn, Policy Adviser, beyondblue**

[10:17]

**CHAIR:** I have called the representatives of beyondblue and SANE Australia. Do you, as witnesses appearing before the committee, have any objection to being recorded by the media during participation in this hearing?

**Dr Carbone:** No.

**Ms Halpin:** No.

**CHAIR:** Welcome along today. Thanks for coming. I take it that you have read the card in front of you regarding parliamentary privilege?

**Dr Carbone:** Yes.

**CHAIR:** Thank you. Would you like to make a short opening statement to the committee?

**Dr Carbone:** I might kick off. Thanks for the opportunity to present to the committee. As you know, beyondblue is a national independent organisation which receives funding from the Commonwealth government and each state and territory government as well as donations from the community. Our main focus is on depression, anxiety and suicide prevention. Within that, we have two main areas of interest: the prevention of depression, anxiety and suicide and also assisting and supporting people affected by those conditions to get the right sorts of services at the right time.

As you know, these conditions are extremely common in the community. In our submission we wanted to emphasise that, in some respects, these can be seen as chronic health conditions in their own right. Chronic health conditions do not need to be just physical health conditions. A lot of people with depression and anxiety may experience a one-off episode of that condition in their life, but a large number will experience relapsing and remitting episodes, and anywhere up to 25 or 30 per cent might have chronic and enduring sorts of symptoms.

We believe that these conditions cannot be separated from health conditions and, in fact, to rephrase or coin the phrase used by the World Health Organization, there can be no health without mental health. So we are looking for an integrated approach to understanding management of chronic conditions. We also know that while they are chronic conditions in their own right, they often co-occur with physical health conditions, so many people in the community will be experiencing both. They might have diabetes and depression or asthma and panic disorders. The health care needs to take into account both of those.

We also can see that some mental health conditions may be potentially contributing to some of the risk behaviours that we know lead to physical ill health. So the recent child and adolescent mental health survey showed that amongst the teenagers that were self-diagnosed or diagnosed with depression they had substantially higher rates of smoking, misuse of alcohol or risky use of alcohol, misuse of cannabis and high levels of obesity. So mental health can drive some of the risk conditions and may drive some of the risk factors that lead to physical health problems down the track. We are looking for an integrated, unified approach to managing health and mental health conditions.

**Mr Heath:** Thanks very much for the invitation to present. Just briefly, SANE Australia has been around for almost 30 years. It started when a young man stood up at the Teachers Federation hall in Sydney on a wet and windy night and said, 'My name's Simon Champ and I have schizophrenia.' SANE's work has always been working hand in hand with people affected by mental illness. We work across the spectrum but have more of a focus on the severe end. For us as an organisation, we receive just under half our funding from the government. We are really pleased that this committee is looking at the mental health aspects when looking into chronic disease prevention and also particularly the management in the primary health care setting.

The challenge is that to date there has been no substantive national focus on the physical health of people living with severe mental illness. In that category, if we look at the Mental Health Commission's report, they were saying there are about 65,000 people who arguably will fall under the NDIS. Beyond that there are another 625,000 people who come under the category of severe mental illness. This will be from very acute examples of anxiety and depression, but picking up people with bipolar, schizophrenia and a whole range of other less prevalent conditions. From a SANE perspective it is really important that we focus on this particular cohort, because the costs associated with people with the most severe forms of mental illness are huge to the community

and to individuals as well. When we look at the statistics around this, we see that people with severe mental illness are dying on average 25 years earlier than the general population.

**CHAIR:** Is this through health issues, or is it because of suicide or—

**Mr Heath:** No, it is coming from preventable medical conditions like cardiovascular disease, respiratory disease, cancer and diabetes. There will be some overlap between those things, but the important thing is that these conditions are modifiable risk factors. This goes to the point of things like smoking, obesity, substance abuse and inadequate medical care. So there are a whole lot of things happening here that we can change. One of the big challenges over the years has been that people have said they have a severe mental illness, and doctors and psychiatrists have said, 'We're not going to worry about the physical conditions—let's try and get their minds sorted first, and then we will get to their bodies.' And they never get there. There is this lack of an integrated and holistic approach of considering the person's both physical and mental health needs.

**CHAIR:** Are there any existing programs that are working?

**Mr Heath:** Katrina Bastin is here with us. We have been working with Neami National, which is a national mental health organisation. This is in the context of doing work with peer-to-peer support workers. One of the most powerful things is that if I have a particular condition and I see someone else who I think is just like me, and I see them improving, that is an incredible incentive to be able to shift people. To give you one example in a slightly different context: in New Zealand they found that when they did public messaging campaigns around people who have recovered from ice addiction, that showed about a halving of the rates of usage of ice. The thing that is really important in all this is that we are identifying role models—peers or other people just like me—who have been able to get through that. When I see that situation happening I am then more motivated because I have a sense of what is actually possible, and it is not someone—

When I see that situation happening, I am then more motivated because, in a sense, you know what is actually possible.

**Ms HALL:** There is light at the end of the tunnel.

**Mr Heath:** Yes. It is not someone telling me that I have to do this. It is someone just like me. To digress for a moment: there is a young man—well, not so young now—called Jock who is one of the SANE speakers. He had been diagnosed with schizophrenia and other conditions and he ended up getting more and more medication. His weight got to about 170 kilos and he went to one of the mental health associations here in Victoria. He ended up collapsing and he went and saw a psychiatrist. The psychiatrist took him off all of his medication because when he was not doing well his medication would be ramped up. That man is now running half marathons. He is up there and going out there and speaking. He has stopped smoking and he has stopped drinking. Part of the thing that is really important is to be able to identify examples of people who have had chronic physical health conditions but who with appropriate care and support from the medical profession have been able to get their lives back on track. For us, the area around peer support working is absolutely critical. Katrina and the others at Neami have been involved in training peer health workers around physical health matters so that they are actually training other people with significant mental health issues.

**CHAIR:** It sounds almost like a healthy body a healthy mind.

**Mr Heath:** It is, and this is the whole thing. We have always said it is about how you put the mind and the body together. It would be wonderful if one day when someone goes to see a psychiatrist that the psychiatrist has a stethoscope around their neck so that it becomes a matter of course. One of the things that we have talked about is the need for mandatory implementation of comprehensive and routine physical health checks for people with mental illness. We want to make it a matter of course that weight and other things are checked. At the moment, people who might have metabolic syndrome and who might be quite big because of medication can feel very sensitive in terms of people touching them or even pushing and prodding them. We need to make it part and parcel of the routine so that when you turn up you will have your physical health checked out as well. We think that is absolutely critical.

**Ms HALL:** Rarely is it impossible to separate the two.

**Mr Heath:** Absolutely.

**Ms HALL:** When you do separate the two you probably gain a fail in both areas.

**Mr Heath:** Yes.

**Dr Carbone:** I totally agree. What we see, as Jack has emphasised, is that people tend to partition. In their minds they are focussing on getting the symptoms of the schizophrenia under control but they are forgetting that in doing so, partly, they can be aggregating some other health conditions. A lot of the antipsychotics have

metabolic affects. They can raise cholesterol and they can impact on insulin and sugar levels. It is very important to have that whole-of-person mentality. It is not just about the symptoms either. For us, recovery is about getting back to a good quality of life and getting back to the day-to-day, whether that is back to study, back to work or back to socialising and having a support network. I think that whole-of-person mentality is sometimes a hard one to encourage within clinical practice but that is the way it needs to be. We need to try to help shift towards that by putting in enablers for that sort of whole-of-person centred integrated care.

**CHAIR:** What would you advocate?

**Dr Carbone:** The thing that we can see is a little bit of heterogeneity. You will get people with mental health conditions that are at the milder end of the spectrum so that the acuity or the severity is not necessarily high. For them, the relationship with family and friends, a peer support person or their GP may be sufficient. Then you might need to step up to the next level. They may need to be seeing a psychologist for some counselling service or whatever. At the high acuity end, you are often needing multiple services simultaneously, and I think that is where the breakdown in the system occurs. At that complex end, where a person needs more than any one service provider can provide and someone to help them navigate the system to understand what is out there—because as we have already heard the health and the mental health service system is quite fragmented and a little bit piecemeal—perhaps they are the group that needs a more individualised support package or individualised approach. That does not just mean through health professionals; it means through peer workers and it means through non-health people who can provide a certain level. I guess the notion that was put forward by the national mental health review recently was the concept of step care—that is, there are different tiers of care depending on the acuity or the severity or your needs. At the low end there is self-management, peer support, family and friends and GPs. and at the high end there are multidisciplinary packages with very targeted and intensive assistance directed to the whole person with everything they need to get back on track, back into the community and back into life. We totally agree with what Jack said about taking that holistic approach.

**CHAIR:** Mr Heath, at what point did the psychiatrist or whoever was treating Jock decide that, at 170 kilos, 'We're going to deal with the other issue.'

**Mr Heath:** It was the particular psychiatrist that he was taken to. He had the psychiatrist that was looking after him, and different ones, and they would tend to just say, 'He needs more meds.' It was when he went to Ermha, which is a regional mental health association, and he just collapsed, they took him then to another psychiatrist. That psychiatrist just looked down at his medications and actually wrote all of them off except for one and kept going. That was the shift that started to happen. It was very powerful. I think it is fair to say that the younger psychiatrists coming up have a better appreciation of this. As in the submission that was put forward to this committee by The Royal Australian & New Zealand College of Psychiatrists, the college has a very strong appreciation of the issues around this. We actually quite strongly endorse that. You might have seen that some of the things in our paper picked up on some of those recommendations. We think that is really critical.

One of the biggest challenges that we are going to have off the back of the NDIS is that the NDIS is going to target 55,000 or maybe 65,000 people. As the Mental Health Commission identified, there are 625,000 people who have other forms of severe mental illness. This importance of coordinated care is absolutely critical. We do have an ongoing concern that, if all funding around Partners in Recovery and all that gets tipped into the NDIS, there are hundreds of thousands of people who may have significantly less services available. They are not going to be able to get the coordinated care that is needed. We are very appreciative of the fact that the Mental Health Nurse Incentive Program is there and is going to get additional support. But we see that as a particular area where you can get that coordinated care.

**Ms Halpin:** It is a good example of coordinated care—the Mental Health Nurse Incentive Program.

**Ms HALL:** The point about the NDIS only picking up the most acute people—the 65,000—is important, along with the fact that most state governments have reduced but are saying, 'Okay, well, we are putting our money for disability into the NDIS.' Therefore, what happens to anyone who falls outside that? They have a tier 2—

**Mr Heath:** I sat in this room about 18 months ago at a Victorian parliamentary inquiry and said exactly that same point. Part of the thing is: as a sector, we were well intentioned around the NDIS, and we certainly support what is happening there. But the issue was that people thought there was going to be purely new money that was going to go to people with very severe conditions. What has happened is that some of the existing money seemed to be pushed into that. Our concern is that these people with severe mental illness—and the Mental Health Commission says that there are 625,000 of them—are going to have very substantial physical health issues. If we do not have a sort of coordinated care, we could actually have a problem a little bit down the track. So it is something that we are particularly concerned about.

There is one other thing to mention, if I may, in terms of opening comments. There is a huge need to reduce the stigma—particularly around severe mental illness. This was something that the college of psychiatrists identified in terms of the barriers and attitudes amongst mental health professionals, and also psychiatrists. When another of our speakers, Sandy Jeffs, was diagnosed with schizophrenia, she went to see someone. They said to her, 'Do you realise that this is the end of the road for you?' There are so many people working in the mental health professional who do not have an appreciation of the importance and possibility of people either recovering or actually leading much better lives. We know from work that has been done on stigma reduction in the UK that shifting the stigma within the mental health profession is really, really hard. It is something that Mental Health Australia identified in a report of a few years ago. Reducing stigma within the mental health profession is an absolutely critical area.

Alongside that—and this is something SANE has been advocating for a long time now—we need to reduce the stigma for people living with severe mental illness. Our colleagues at beyondblue have done a phenomenal job in terms of reducing the stigma around depression and anxiety. There have been substantial investments around that, which is a great thing and we applaud it, but we have done virtually nothing to reduce stigma for people who are living with schizophrenia or with bipolar or with other borderline personality disorders. Not only does this have a big impact on people at an individual level; it also has a profound impact on costs in the medical health system. These are the people who are having very intensive care, so it is costing governments as well.

So we need to reduce that stigma, and the reason we need to reduce that stigma is that, if you do not get people to get help early on, late help is always incredibly expensive help both for the individuals and for governments. We strongly believe there is a need to do work around reducing stigma for people living with severe mental illness and trying to replicate what beyondblue has been able to do around depression and anxiety. Of course, there are people with extreme anxiety and extreme depression who would fall into that category of the 625,000, but there are so many people for whom nothing is happening, and that is a really critical issue. What happens then is that, if people are not getting help early, they might be smoking more and their physical condition might be deteriorating, so, by not being able to get those people into a system that is well coordinated, we pay a huge price as individuals and families who care for people and also as a government through budget costs.

**Ms HALL:** Yes, self-medicating. With stigma, you only have to pick up a newspaper and read it. I remember reading an article in the *Herald Sun* here in Melbourne. It said that a service station was held up by a person suffering from schizophrenia. You do not say, 'Service station held up by a person suffering from cancer.' It is putting that negative connotation on mental illness all the time within the media, so I suppose the media is an area that we really need to work with to address that stigma.

**Mr Heath:** It is certainly an area we have been actively involved with. We have a StigmaWatch program. I cannot remember the exact example you are talking about, but—

**Ms HALL:** It was a couple of years back.

**Mr Heath:** normally, what happens is that people in the community notify SANE as part of the StigmaWatch program and then we take it up with the particular newspaper service. We do not know the exact number, but there are maybe 100,000 people living with schizophrenia across the country. Yes, there will be isolated examples where one or two are involved in severe situations, but Sandy Jeffs, who I mentioned to you before, says, 'Every time I hear there's been a shooting or something, I say a prayer that they're not going to mention schizophrenia.' For all those other people—maybe 100,000 people—who are getting on with their lives, working part time or full time or even just finding a way to do things better, that stigma then gets increased. If they or a family member has a condition like schizophrenia or think they might have it, they are going to be worried. They are going to be less likely to seek help. So this shift is absolutely critical.

**Dr Carbone:** That is exactly what we found. You could draw a parallel. The things that promote good physical health are the basics like access to clean water and a food supply. The reduction of stigma is almost on a par with that. It is one seemingly simple but actually complex thing to achieve that will make a huge difference if more can be invested in stigma reduction, as Jack said, across the spectrum of different conditions. We know that you really have to have targeted approaches to stigma. It has to be dealt with condition by condition. You cannot just have an overarching focus on mental illness; it has to be about tackling the stigma around depression and tackling the stigma around schizophrenia. People have different ideas about different conditions and you really have to talk about it case by case and condition by condition. The things that help are people with lived experience and people affected by these conditions talking about them. The more we can get people to come forward and say, 'Yes, I've been affected by depression, but so what? I'm here now,' the better.

The stuff that was in the media recently about Lance 'Buddy' Franklin is a huge step in understanding and acceptance. Here is a normal, everyday guy. He has a mental health condition; he needs time off work; his

employer has said, 'Yes, you take as much time as you need to get better and then come back again'—would that have happened 10 or 15 years ago?

But there is still a long way to go. I think there are particular groups in the population—people with the more serious mental illnesses like schizophrenia or bipolar—where the stigma reduction has not been as rapid as depression and anxiety. But, across the board, a focus on stigma reduction will lead more people to be willing to come forward to get the treatment rather than having their condition take hold and impact their life.

As we said, it is about community attitudes, but it is also about the health professionals. In our regular annual survey called the depression/anxiety monitor people tell us that they still encounter discrimination within health services, within education, within employment and even within their family. They are real barriers to progress, and I think a comprehensive stigma reduction campaign for the country is a worthwhile investment.

**Ms HALL:** That would lead to a reduction in the burden of the disease.

**Dr Carbone:** It would because you get treated and more people coming forward. One of the big problems in mental health is untreated prevalence. You have got so many people with these conditions but only 30 to 50 per cent coming forward. The rest are not, for various reasons, whether or not they are practical barriers like cost, affordability and access. A lot of it is driven by fear, embarrassment and shame. Technically there are effective treatments. If you can give more people those effective treatments, the burden of disease will come down.

**Ms Atman:** By reducing stigma, you are looking at increasing help-seeking behaviour.

**CHAIR:** Are there any international programs going around that you could cite?

**Mr Heath:** There are a number. There is work that has been done in the UK: the Time to Change program. It has been running for about seven or eight years now. The Canadians are doing one—I think it is called Like Minds—and they have been working quite closely with the Mental Health Commission here. They have been drawing on some of the aspects of what Australia has been doing in some areas. But I think there is a misunderstanding. When you talk about a national stigma-reduction campaign, people tend to think you are just talking about billboards and ads out there. No. It is about targeting specific communities like mental health professionals, like schools and like the media. In my view there does need to be some overarching thing that pulls the whole thing together.

**Ms HALL:** Like?

**Mr Heath:** In terms of theme messages such as Like Minds Like Mine or something like that.

**Ms HALL:** Who would coordinate that?

**Mr Heath:** I think you could have a coalition of organisations doing it. SANE would certainly be up for doing that. We are looking to try to replicate in a sense the success of beyondblue but at the more severe end of the spectrum. I think the other thing is that, in terms of the committee around the primary healthcare setting, we know from surveys that have been done that a lot of GPs do not think there is a realistic chance of recovery for people. This is one of the big barriers. It is an effective stigma because it is a lack of understanding and knowledge that some people can actually fully recover but, if they cannot fully recover, a lot of people can manage it in a significantly better condition.

By way of personal confession, I spent 15 years working in youth mental health, setting up the ReachOut service. It had a number of family examples of people with very severe mental illness. It was only when I came to SANE that I realised that there was so much more hope for people living with these conditions than I ever realised. Despite working in mental health for 15 years, I brought a whole lot of notions of stigma around people living with severe mental illness. It was only when I met Sandy Jeffs and Jackie Lane—this is a woman working at the Victorian Equal Opportunity and Human Rights Commission in an important full-time role. I said, 'What do you mean you've got schizophrenia and you're working full-time, part-time or going out advocating?'

This goes to the point about the stigma in the mental health profession. If someone like me had been their associate but did not quite realise, that was because I had not had contact with people who were either fully recovered or managing their condition. This is where the evidence says that, to reduce the stigma, it is very much about that social contact. You see someone who would come and sit here and say: 'Hang on a sec. That person doesn't look that different from me or some of my colleagues.' This is the thing. This is the stigma. If we do not realise how people can actually function and function well then we do not put in place the supports and mechanisms for them to do that.

**Ms HALL:** So there is a definite role for education. I noticed in beyondblue's submission that including enduring mental health conditions in the National Strategic Framework for Chronic Conditions was something

you recommended. I suppose that goes across both organisations. By including that, you are recognising it and lifting it to a new level, saying it is like other chronic diseases.

**Dr Carbone:** Exactly. I think there are certain differences but there are also certain similarities between a chronic physical health condition and a chronic mental health condition. There are certain principles that are the same: you want the person to be at the centre of care, you want care to be targeted and you want prevention first. In the mental health sector our focus is on working with parents to foster healthy child development through school, through the kids' MindMatters programs to build resilience promote mental wellbeing, and through workplaces. But then there is always going to be a group of people who do experience mental health difficulties, and the rules there are, the earlier you can possibly intervene, the better, and then have that person centred focus with the supports and services relevant to what they need.

Because there are a lot of principles in common, it can be thought of within the framework of chronic disease, but you do need some nuanced approaches specific to mental health conditions. As we were talking about, stigma is probably more prevalent around mental health conditions nowadays. Possibly cancer used to be, but it is less so now. So that needs its own special focus because that is one of the big problems in the mental health area.

There are some shared approaches that you can use, whether it is diabetes or depression, as well as some specific approaches that you need for the mental health suite of conditions. We are just highlighting stigma as one particular specific example of what needs to be different for better outcomes for people with mental health conditions.

**Ms HALL:** To summarise: in one sense, mental illness can be a comorbidity or can result from a chronic illness. On the other side you have chronic diseases that can come from an acute form of mental illness like schizophrenia or bipolar. You have this constant interaction where one causes the other and the other causes the one, and how can you separate the two?

**Dr Carbone:** There is an absolute interaction. As we said, there is no split between mind and body; that is an arbitrary sort of thing. But you could arbitrarily suggest that there are a group of people just with mental health conditions and a group of people just with physical health conditions. There is also a large group that will experience both. Whether one caused the other—which direction causality runs—in some ways does not matter. You really have to understand that people need that comprehensive approach to care, but there is also the prevention space.

We know some of the risk factors that drive the risky behaviours we are talking about—smoking et cetera—do also have a common starting point for some of the mental health conditions. Early adverse childhood experiences like abuse, exposure to violence and living in poverty will give you both poor physical health outcomes and poor mental health outcomes. That is why at the prevention space you are looking for what we call the common risk factors—the things that seem to be connected to more than one condition—and start there with the ones that seem to have the biggest impact and seem to be able to change the most. You might not solve just one problem; you might solve multiple problems with that sort of focus. Many conditions start from a common environmental and individual context. Getting things right there will reduce a whole host of things down the track. So a lot of people focus prevention efforts on the early-childhood, childhood-adolescent period, because that is when we are developing—it is when our brain is developing and also our attitudes and behaviours. Your life trajectory is set very, very early on, both from a physical health and a mental health perspective.

You then have to work with people with conditions, if they have developed them. They are an important group; they are a priority group. But I think we sometimes overlook prevention in the mental health space. I think it gets underdone and seen as, 'Can you really prevent these conditions? Really?'—maybe not all mental health conditions, but the high prevalence conditions like depression and anxiety. There is research to suggest that certain strategies can reduce the risk of those conditions. So I think a greater focus on prevention is also needed, as well as fine-tuning and improving the way we go about providing treatment for affected individuals.

**CHAIR:** What would be the best avenue in your sphere for setting up a program or a template as part of the prevention and management of chronic disease?

**Dr Carbone:** I think the focus here is on primary care, and obviously primary care has a role in prevention. Probably there is going to be more work done outside of the health sector to prevent conditions than within the health sector. I think the health sector probably has more of a responsibility to support people and keep them well. But in prevention that is where other sectors need to be brought into the mix.

**CHAIR:** For example?

**Dr Carbone:** Well, schools. The Commonwealth funds us to run the KidsMatter program for primary schools and the MindMatters program for secondary schools. A lot of schools then add on other topics within that

framework. They will do the drug and alcohol education within that. They will do the sex education within that. They will do the respectful relationships, to prevent family violence, in that. There is also the physical health program. It is complex because schools get a little bit overloaded. But, done effectively and done without overburdening the schools, there is evidence of successful intervention, starting from school age. Previously we did have that focus, through the National Partnership Agreement on prevention, with a focus on early childhood centres, schools and workplaces, because they are sensible places to do this sort of work.

**CHAIR:** I will give you an example of what I see as probably overserving on the management side of things, where I see a bit of a scattergun approach. Maybe we need to look at conglomerating some of the services that are provided, because there was a youth suicide in the south-west of Western Australia and five different organisations turned up to assist. There must be efficiencies within the system that can help drive it and be more focused on prevention than management.

**Dr Carbone:** I think that is true, and it is true of any sort of health condition. There are always going to be efficiencies. Sometimes there is duplication—but more often there are gaps—and obviously that is inefficient. Although, different people are providing a slightly different focus. If a state education department counselling team comes in and are working directly with the students but the headspace team comes in and maybe works with the teachers and the school leaders, you could argue that that is duplicating or you could argue that they are just doing different aspects of the same job.

**Mr Heath:** On that, one thing that is important is that we as a sector, particularly around suicide, have been coming together through the National Coalition for Suicide Prevention, which SPA has been chairing. In terms of the situation you identified, I think the sector in the past could have been guilty of saying that we will all go and do our own thing, but there is a concerted effort now being led by Suicide Prevention Australia to have an integrated approach. There will be trials taking place in that. So I think you have a mental health sector now that probably more than ever before is willing to act in a way where we are supporting one another, but we are also working with government. Related to that, I think one of the areas that is quite significant is that we know we have the review taking place around the Medicare schedules. This too is an area where we can look at the sort of supports provided through it to address people with chronic physical conditions.

With your indulgence, the other thing I might invite the committee to consider is whether or not you might make recommendations about what would be a reasonable life expectancy age difference for people living with severe mental illness. We are talking 25 years now. Across a whole range of areas we need to have targets put in place and have it done in a way that is led by the federal health minister, but working with all the state and territory ministers, as well, to say, 'Okay, 25 years difference in life expectancy for people living with severe mental illness is completely unacceptable, but where are we going to hold ourselves accountable. Let's put it 10 years out.' We are not advocating a particular number, but there needs to be a sense of urgency and a focus on delivering outcomes, rather than statements about us wanting to reduce it. Well, how far are we going to reduce it? Is it going to be five years in 10, or whatever. I think it is really important that the committee expresses a view to government about what needs to be done.

**Ms HALL:** That is a very good point.

**Dr Carbone:** I totally agree with Jack, and I think it reflects a little bit on the conversation we were having before with the representatives from Kidney Health Australia. The other core principle that is now a given is that we need to move to more data driven outcomes based approaches. There needs to be the infrastructure to collect that data, but also the ability for that data to feed in at the clinician level to influence practice, and at the planning level to understand how we are tracking and how we are going and whether it is regionally stable or across the Commonwealth. Data is essential to guiding practice. We do not have the infrastructure and we are also not very good at having the right measures in place and then sharing those measures.

As a former GP I can say that one of the things I found really useful was the stuff you get from the National Prescribing Service. They will audit your use of, for example, antibiotics and at regular intervals will send you information on where you sit in comparison with your peers. You might suddenly see that you are over-prescribing antibiotics and you decide to do something about it. That reflection back on the practice, the ability to audit yourself and see where you are going, is extremely helpful at a clinical level. It is clearly also equally helpful at the planning level. We just don't do data well here. We do not collect the right measures and set the right targets and work towards those goals. That is changing. Everyone understands the need for it. It is a new core principle that I think will guide health care.

**CHAIR:** That is interesting, because I know that in the states they are starting to do that with trauma surgery. They are collecting data on it so that they can deal with trauma instances like the Boston bombing by sharing data

from previous experiences. I am sure there are people in the health industry who have diagnosis or management programs that are working. Other people could share in those programs, but they cannot access them.

**Dr Carbone:** Absolutely. Government health insurers and hospitals have a wealth of data. Community based data is where there are a lot of gaps, because there are so many players. There are the GPs, the private psychologists et cetera. Some way of improving what is happening at the community level to get more accurate data would be helpful. Intelligence is important for anything.

**CHAIR:** Do you see any role for private health insurance companies in the prevention area?

**Dr Carbone:** I think they all have a role there. They have taken on that role. Most of the member organisations offer packages for their members, and they have moved into that space for a good reason and they are playing a good role. But I think it needs to be a shared responsibility.

**Ms HALL:** There are often issues around private health insurance and mental illness, though, aren't there?

**Mr Heath:** Yes, there are. I recently went to try to get life insurance and also income protection, and you were basically told that if you had mental illness it was not going to be covered. That is a separate issue and it is something beyondblue has been active on in the past. It is a big issue.

**Dr Carbone:** With insurance discrimination, particularly around travel, life and those sorts of insurances where you have to declare what your conditions are, such as mental health conditions, it means that suddenly it increases the cost or excludes you from certain types of cover. If you make a claim you might not get that claim, so there definitely is continuing insurance discrimination.

**Mr Heath:** One thing that is really critical in all of this is that you have a mental health sector that is speaking with a more unified voice than ever before. That can be challenging, because, if you are in an environment where funding has either been held or decreased, it is a bit hard to expect everyone to speak with the one voice if you are not sure you are going to have funding in 12 months time. As a sector we are wanting accountability and we are wanting to work together with government and with one another, but there has to be a lead from government in terms of where we are wanting to go with those targets and outcomes. They need to be long term. Without that political leadership we are going to flail around, because what tends to happen a little bit is that mental health will be at the front of the agenda for a few years, but it really has fallen off.

**CHAIR:** That is right. There was a big focus about four years ago, wasn't there?

**Mr Heath:** It has dropped off. These sorts of things really shift when you have that political leadership. When I first got involved, almost 15 or 20 years ago, that was what John Howard did around the youth suicide prevention. It made a significant difference. I think we have seen pretty strong bipartisan or cross-party political support around this. I think Mark Butler did a phenomenal job, particularly in getting people who coordinated care out there in the community. I know Minister Ley has a lot of things on her plate at the moment, but we really do need strong political leadership. The upcoming National Mental Health plan is an opportunity for that to be put in place. But we also believe that it is something that needs to be owned by the Prime Minister. For individual people's lives and for the families and people who care, and also for budgetary reasons as well, investing in mental health wisely and focusing on getting the right data and focusing on the outcomes is going to be of benefit. But unless there is that strong political leadership at the top we are going to flail around. That is a big concern.

**CHAIR:** Thank you for coming today. We appreciate the time you have given. If you have been asked to provide additional information could you please forward it to the secretariat by 15 October. If the committee has any further questions they will send you these in writing through the secretariat. If there is anything else that you think would be helpful to the committee in its inquiry, please forward it to the secretariat.

**Proceedings suspended from 11:01 to 11:17**

**RAWLIN, Professor Morton, Vice President, Royal Australian College of General Practitioners.**

**CHAIR:** I welcome Associate Professor Rawlin. Do you, as a witness appearing before the committee, have any objection to being recorded by media during participation in this hearing?

**Prof. Rawlin:** No.

**CHAIR:** I take it you have read the statement in regard to parliamentary privilege—the card in front of you?

**Prof. Rawlin:** Yes I have.

**CHAIR:** Would you like to make a short opening statement to the committee?

**Prof. Rawlin:** Thank you very much for allowing us to come today and talk to the committee. I will quickly outline the role of the college, then talk through a couple of points and then be open to questions at that point. We are the specialty medical college for general practice in Australia. We are responsible for: defining the nature and the discipline and the scope of the profession, setting the standards and the curriculum for education and training within the profession, maintaining the standards for quality practice and quality assurance within general practice, and supporting those GPs in their pursuit of excellence within patient care and community service. We have over 30,000 members working in or towards a career in general practice nationally. I will touch on some of our key points going forward.

GPs are at the forefront of the primary health care sector's effort to support patients to prevent and manage chronic disease. Timely and supported patient access to GPs and their teams are key advantages of the current primary healthcare system. However, there is significant opportunity to better support patients and to support their GPs in their work with patients to prevent and to manage chronic disease, with appropriate indexation of MBS patient rebates being a starting point. As part of our efforts to support GPs in their pursuit of excellence in patient care and community services, we have identified a range of issues associated with current funding arrangements for general practice patient services. While we support fee-for-service models as the cornerstone of general practice funding, we propose that there is scope to enhance the provision of patient care through supplementary funding processes.

Our vision for general practice and a sustainable healthcare system was released by the RACGP president, Dr Frank Jones, at our conference in September. That presents an approach to better support general practices to achieve excellence and contribute to health system sustainability. Key to our vision is better support for general practices to adopt the patient centred medical home model of care, where GP-led teams work in partnership with patients to achieve the best possible health outcomes. The evidence clearly demonstrates that patients benefit from GP-led, coordinated and integrated care, delivered by a mix of health professionals across primary, secondary and tertiary care. GP-led team based care reduces fragmentation and improves continuity of care for patients, which results in reduced hospital presentations and admissions and more efficient care. The RACGP medical home provides an evidence based framework for allocating scarce health resources, supports patients to prevent and manage chronic and complex issues, and will improve the health care of Australia's population. Thanks again for the opportunity to appear before the committee. I am happy to answer your questions.

**CHAIR:** Thank you, Professor, for presenting that opening statement. On your opening statement, is there any evidence based data to tell us that the GP-led teams are better than the current system? Is there anywhere we can find that information at all?

**Prof. Rawlin:** There is. It is actually documented in the college's vision paper, and we would be very happy to provide you with that. It was released about 10 days ago, so it is new. That work has been going on for the last six to 12 months, with some work being done both on the health economics perspective as well as on research into the various models.

**CHAIR:** You mentioned the words 'scarce resources' in your opening statement. Is that part of the overall problem with the health system in delivering better outcomes, because of the inefficient use of scarce resources, or is it because there just are scarce resources?

**Prof. Rawlin:** It is a bit of all of those things. There is some scarcity of resources. There are difficulties with the distribution of not just doctors but other health professionals across rural areas and also in areas of low-socioeconomic need. The other issue, though, is that health does not stand alone. Part of the problem that general practice has is that we cannot influence things around the other determinants of health, like housing, like the community's funding for low-socioeconomic groups and those sorts of things. It is whole of system. If you were to put money into all of that, we would be stretched very, very thinly. There needs to be a debate as to where those boundaries are.

**CHAIR:** In that answer, you talked about lower SES areas. The evidence we have heard is that there tends to be a higher prevalence of chronic disease in the lower SES areas. If you look at the statistics for the concentration of GPs in CBD areas, there tends to be a higher concentration of GPs in the higher SES areas. So, you have a high prevalence of chronic disease in lower SES areas but a lack of GP presence in those areas as well.

**Prof. Rawlin:** To some degree that is correct. However, one also needs to look at the distribution of the other health practitioners. If you look at the demographics amongst psychologists, OTs and physios, it is very much the same. There are various incentives and things that people have used with variable successes. But one of the big problems that we have faced probably over the last 15 to 20 years is a lack of bodies on the ground. That is changing with the increasing numbers of graduates of the medical schools, plus the other health practitioners. We are now seeing people moving into areas where there was underdoctoring, particularly in general practice. It is not quite as marked in, say, specialty practice. It is almost impossible, for instance, to get a psychiatrist in low-socioeconomic areas, particularly one who will not charge significant fees; but it is starting to change.

**CHAIR:** And that change is encouraged by the RACGP?

**Prof. Rawlin:** Yes. In our training program, over half of our trainees are working in rural or outer urban practice. We clearly cannot control where they go once they have finished training, but while in training they have to spend at least half of their training in lower socioeconomic, outer urban or rural practice. Significant numbers of our trainees do all of their training in those areas. There is fairly good evidence—for instance, with our rural and remote GP completions—that the doctors who complete their training in those areas are significantly likely to still be in their rural locations five to 10 years down the track, which is an even higher proportion to the fellowship of the Australian College of Rural and Remote Medicine.

**CHAIR:** We have a couple of regional members here, so they might have some questions.

**Ms HALL:** Can I come in on what Steve was saying there. I will look at the area I come from. I come from the Hunter, so we have—

**Prof. Rawlin:** I know Newcastle well.

**Ms HALL:** a great teaching hospital. We have the university. So the services are available within that area. But definitely there are no more OTs, no more physios and no more GPs in the extremely disadvantaged areas. People who live in the very disadvantaged areas have to travel outside of it, which is an extra expense. Just stepping sideways a little: I think in 2006 this committee did an inquiry into cost-shifting. The head of the Hunter area health service, Terry Clout, made a statement to the committee that the further you were from the Sydney Harbour Bridge in New South Wales, the fewer the resources. As a committee, we have held inquiries into health in regional and remote areas. Yes, more GPs are being trained, but there is still an extreme shortage in those areas. Some of those areas have the highest level of chronic disease, too.

You have talked about a GP-led approach, which I think is an excellent approach. I was going to ask you to talk a little bit about some of the models you have here, but I felt it was important to make the point that, yes, things may be changing but it is still the most disadvantaged areas that suffer, even in a contained area like the Hunter, where you can get the services. In Sydney and the Greater Sydney area, you can get the services. In Melbourne you can get the services. But for those people who live in the lower socioeconomic areas, they are not going to get a psychiatrist to set up there. They are not going to get a gastroenterologist to set up there. They are going to have to travel.

**Prof. Rawlin:** It is a good point well made. The difficulty, I suppose, in health and particularly for chronic illness is that it usually requires a team to be involved; it is not just the doctor.

**Ms HALL:** Absolutely.

**Prof. Rawlin:** It is not just the psychologist. It is not just the hospital. It is all of the things together. When you look at certain health professionals—and a good example would be occupational therapy—they require a fairly significant infrastructure in order to do their work. They have got a lot of bits and pieces and paraphernalia that they require in their assessment and management of people. The further you are away from a unit with all of that, the less they are there—let alone the fact that not enough of them are being trained.

**Ms HALL:** They can compromise. I have worked with OTs in the past and some of the things that they need are very close at hand.

**Prof. Rawlin:** Very simple.

**Ms HALL:** Lisa comes from a more regional area than I do.

**Ms CHESTERS:** I am the federal member for Bendigo. We do have Monash and Melbourne training medical students up there, but they have to go back to Melbourne to do year 5 or sometimes year 4, and then it is the

placement after that. So it is the internship or it is the registrar. It is those next years. Is that the challenge? It is also at a stage in people's lives when they are getting into their late twenties. They may be coming back to Melbourne and settling down and buying a house and so on and so forth. What is your view on those in-between years? You have done your rural exchange, as we call it. You have enjoyed being in Bendigo. You have enjoyed going up to Elmore, Echuca or Mildura, but to finish you have to go back to Melbourne.

**Prof. Rawlin:** Again, I think it depends a little on what you are wanting to do in your career. I certainly cannot control what the university does in terms of where it requires its final years to be done or whatever. I think the program in Bendigo is great. My son was there for four years. He has recently finished through Monash.

**Ms CHESTERS:** Is he coming back to Bendigo?

**Prof. Rawlin:** He has done some work down there. He wants to do—

**Ms CHESTERS:** That is the question. Have they enjoyed the experience enough to want to come back to the regions to practice medicine.

**Prof. Rawlin:** Absolutely. The problem is that he wants to do infectious diseases.

**Ms CHESTERS:** So he is heading to Townsville.

**Prof. Rawlin:** He has just finished his masters through Townsville. As I said, people are individual. One of the things that is happening now with the regional training hubs in all sorts of disciplines, medicine being only one, is that people are putting down roots in those communities and they are much more likely to stay than they were. But, as you quite rightly say, a significant number of them still move away. The difficulty, I suppose, is getting that perception of the 'need to move' out of the requirements—in terms of general practice you can; you can stay. You can do your training. You can do your internship in Bendigo, get into the training program and be part of the regional training provider, whichever one ends up getting the tender up there, and stay there. Train in that region and stay in that region. As a physician or a surgeon, that is actually really hard.

It is probably not general practice per se that is the real problem from the perspective of requiring people to move away, but it is a perception. My view is that the specialists who are also trained rurally are actually better than some of those who have done all of their training at the Royal Melbourne or the Alfred or wherever, because they actually understand patients from the patient journey perspective, because they have had more exposure to general practice and more exposure to their community instead of just working within a tertiary setting.

**Ms CHESTERS:** Do you have an idea—and just as an example, in Bendigo we now have a higher GP ratio per population in Bendigo itself, predominantly because we have had a number of superclinics open up—

**Prof. Rawlin:** A lot of 457s.

**Ms CHESTERS:** Yes, a lot of overseas doctors, and graduates coming through. We still have that divide going 45 minutes north, east and west—Heathcote, for example—and it relates to chronic disease. The rate of diabetes is higher in Heathcote, and the number of health management plans, compared with the city itself, because people will not get on the bus to go into Bendigo. So, do you have any ideas on how we can expand the workforce or basically have the health professionals in those areas, just outside the big regional cities, so that for people who do not get on the bus either because they cannot afford it or they do not have the health literacy, we can help with the workforce gaps in those areas?

**Prof. Rawlin:** I think there are several possibilities. To some degree we actually need to work smarter. There is the ability for us to look at what patients need and deliver it in different ways. Being face to face with an OT or a GP or whatever may not be totally necessary. It could be done over the telephone, or over the internet. There may be certain things that you cannot do over the internet, and we are still learning about that, but the ability to actually provide services remotely is important. Having the models of mobile teams for certain things would be another possible option that moves around. The models around the older retrieval services—the Royal Flying Doctor Service and all those sorts of things—are now moving more into primary care. I have to declare my conflict there. I am also the medical director of the RFDS here in Victoria—for my sins!

So, we are moving into delivering remote primary healthcare services looking at mobile dental, looking at mobile psychology services—all of these sorts of things—to support rural communities, but also realising that the rural communities are not the only issue. I have worked at Mount Druitt and out at Broadmeadow. I trained in Newcastle. So, I have been around. And I was a rural GP for 11 years. There are various models, but there need to be some funding frameworks to make those work, and currently they are not there. There is an issue of what is state and what is federal and who is going to pay for what. The sustainability of those funding streams is probably the thing that is critical in stopping the development of them. If you have funding for 12 months with no guarantee further on, people will not commit.

**Ms HALL:** That is important when we are looking at chronic disease management, isn't it?

**Prof. Rawlin:** Exactly, because it is not going to go away. It is going to continue. If you are going to do a trial you need to look at five years.

**CHAIR:** Do you know about the CarePoint trial?

**Prof. Rawlin:** Which is that one specifically?

**CHAIR:** The Victorian Department of Health is running it and it is due to finish in 2018, I think it is.

**Prof. Rawlin:** That sort of thing is the way to look at these sorts of things with chronic disease. The other issue with chronic disease is that you pick them up into treatment services at various points. What is achievable at the beginning of a chronic illness may be very different to what is achievable later, and the services that are needed early may be very different to those that are needed later. There are those other issues within chronic care management as well.

**Ms HALL:** In your submission you refer to the Team Healthcare Trial, and you refer to Kaiser Permanente Pyramid, and Wagner's Chronic Care Model, which is pretty close to what you were talking about there. The Team Healthcare Trial would be similar to the CarePoint trial that we heard about this morning.

**Prof. Rawlin:** Correct—somewhat similar.

**Ms HALL:** So, you do the trials, but then you have to follow through with them.

**Prof. Rawlin:** That is true, and you have to evaluate them properly, and you have to look at the sustainability aspects of them and at how you fund them and how they work. One of the other problems is that when you look at much of the literature around chronic illness it is largely hospital based from overseas, and that skews how that needs to be perceived. The research here in Australia, which is community based, is relatively fledgling. Some really good stuff is being done, and I am sure you will hear from people espousing their research. We need to learn what works in Australia, not what works in the US or in England, because the systems are a little bit different, and certainly the funding models are different. For instance, in the US they spend around 19 per cent of their GDP on health; we spend about 9.2 per cent. The way England funds primary care is a capitation model. It actually reduces the amount of patient contact with GPs.

**Ms CHESTERS:** Perhaps I could just pick up on two points around funding. Regarding preventive health funding, you mentioned the competitive tender model—it might just be for 12 months or three years—and shift and change, whether it be minister or government or even department: they will rename a program and you have to start all over again, or it is slightly different. It tends to happen a bit, whether it be community services or whatever. Preventive health funding tends to be a bit like that. Do you have any ideas around funding ratios, which you mentioned, or funding models that we need to have? The head of Bendigo Health will say, 'If I could have a split 75/25, with 25 per cent going into preventive health and 75 per cent for the hospital, then I'd reduce the number of people coming in the front door of the hospital.' He says, 'Surely it can be that easy', and I start to think of our health minister—that would be interesting legislation we would put forward. But what ideas do you have from the college's perspective around funding models?

**Prof. Rawlin:** I think it is a vexed and difficult question, because it comes to the crux of where the system gets very clunky, and that is the differential between the hospital system and primary care.

**Ms CHESTERS:** State and Commonwealth.

**Prof. Rawlin:** Yes, state and Commonwealth, basically. Where the communication between state and Commonwealth entities within a region works well, it tends to work quite well—but not always. One of the problems with secondary and tertiary care is that you can give as much money as you like to it and somebody will buy the next whiz-bang whatever, which might benefit half a dozen patients, but, for the benefit of the amount of money that was spent, you could in fact change outcomes for 100,000 people. It is a debate that we have not had in this community. We have been very lucky in that if you wanted to have a half a million dollar drug, you could. Is that sustainable? I do not know.

**Ms CHESTERS:** We are hearing from the nurses later today. When we talk about funding, one of their recommendations, for a Medicare review, is to expand what our nurses can claim as MBS items and increase their role in terms of preventative health and chronic disease. Is that something that the college would be opposed to? Is that something that you can see some conflict with?

**Prof. Rawlin:** I think that there are elements of this that need to be debated and expanded out. The simple reason is that it is actually not quite that simple. One thing that we, as the college of GPs, are really clear with—and it is supported by the evidence both from overseas and here—is that the one thing that really makes a difference to a patient's long-term benefit is continuity of care and having somebody who is coordinating that

care. Traditionally, that has been the GP. We certainly are very supportive of our nursing colleagues working within their scope of practice. The query really is the communication aspects of how they work. The traditional models have been where nurses have been working with the GP clinics, with that sort of communication happening on the ground. Where we get a little more concerned is where you have, for instance, nurse practitioner models where they essentially are autonomous and do not have to report. There are certain areas where those models actually work really well—certainly, in very remote areas and in the Aboriginal health services and things like that, where you cannot get access to GPs. But that is actually very rare.

So we would be supportive of using more nursing staff within general practice, but, again, we would need to have the funding structures to do that. Currently, I actually fund my nursing staff out of my MBS billings. They do not contribute to that. So I think that we need to look at what the funding structure is, at what they are going to do and at how we can actually utilise them within the team. There are various models that are out there, but I would certainly say that we would oppose the fragmentation of care.

**CHAIR:** My question goes back to regional training. We have heard in previous inquiries that we have done that a lot of the training for undergraduates is focused on ED type training. Do you think—particularly in regional areas, as we have talked about with the member for Bendigo—that part of their training could be incorporated into a style of GP, community health and chronic disease program, considering that, if there is a lack of resources, that could be part of the resources attributed to that type of program?

**Prof. Rawlin:** Absolutely. I think that general practice is a very good training for medical students. There are some really good models out there. There is the Riverland in South Australia, and Bendigo and Shepparton have been doing a little in that way as well. The Hunter used to send people out into the community as well. The difficulty, I suppose, is the politics within the universities—the cardiology professor saying, 'I want six weeks of the medical students' time.' There are very good allocations that are significantly in general practice if not totally in general practice. Certainly, patient care is at a premium there. The argument that is run in the universities is that general practice, by its very nature, is things walk in the door and you are not necessarily going to see, even over a year, particular conditions which a particular professor might feel are absolutely critical to the training of their students. So you need to then think smarter as to how they actually get exposure to that within their training time.

**CHAIR:** So we need to enthruse the universities to have chronic health conditions as part of their training programs?

**Prof. Rawlin:** Absolutely. I would also put in a plug for doing things like the Prevocational General Practice Placements Program, where junior doctors were placed in general practice outside of the hospitals. Unfortunately, that funding was lost. That provided a large exposure; once junior doctors get into the hospital system, because they cannot access Medicare, they cannot access general practice. They cannot do general practice unless they decide that they are going to become GPs.

**Ms HALL:** I noticed that among your recommendations are reversing the freeze on the indexation of Medicare and looking at reforming the way that chronic disease management is handled?

**Prof. Rawlin:** Yes. The difficulty with the Medicare indexation freeze is that, essentially, it is reducing the ability for us to continue bulk-billing, and that will push people into having to pay. In terms of the other things, I might send you some documents.

**Ms HALL:** It would be wonderful if you could do that. I see there is something over there. That would be wonderful. We would really appreciate that. Thank you.

**CHAIR:** Thank you for appearing before the committee today. If you have been asked to provide additional information, could you please do so by 15 October? If the committee have any further questions, they will send you them in writing through the secretariat. If you feel that there is any other information that will assist the inquiry or help us in making recommendations to the government, could you please forward that to us as well through the secretariat. We do appreciate you taking the time to appear as a witness today.

**Prof. Rawlin:** I am very happy to. Thank you very much.

**CHAIR:** Thank you for your submission.

**RUSSELL, Professor Grant, Director, Southern Academic Primary Care Research Unit, Monash University**

[11:53]

**CHAIR:** Welcome. Do you, as a witness appearing before the committee, have any objection to being recorded by media during participation in this hearing?

**Prof. Russell:** No, I do not.

**CHAIR:** Have you read the card in reference to parliamentary privilege.

**Prof. Russell:** I have. Thank you.

**CHAIR:** Thank you for appearing today. Would you like to make a short opening statement?

**Prof. Russell:** Thank you very much. I begin by acknowledging the traditional owners of the land. I pay my respects to the elders past and present. I appreciate the committee rescheduling by a day to accommodate Victoria's unusual public holiday.

**Ms CHESTERS:** They have one in New South Wales as well; it is just on the Monday. Don't you have a public holiday on the Monday after the NRL?

**Ms HALL:** Yes, but it has nothing to do with the football. The NRL is on the Sunday. On Monday, it is Labour Day.

**Prof. Russell:** As an expatriate Western Australian, I am very happy to see the streets dotted with a few Eagles fans. I wish that a few Dockers were here as well, but, unfortunately, that is not the case.

**CHAIR:** It is a purple tie, I see.

**Prof. Russell:** The purple tie is very deliberate, actually. I represent the Southern Academic Primary Care Research Unit. It is a health-services-linked primary care research unit. I am the director, I am a GP, I have been a fellow of the college for 25 or more years, and I am the head of the School of Primary Health Care at Monash University. I have worked as a clinician in Australia, and I have worked in Ontario for 6½ years. I understand that earlier deliberations of this committee have looked at the primary care reform model within Ontario. I was a part of some of the evaluations of that model, and I thought that might be of interest to the committee today.

I have read a number of the past submissions on the excellent website, and I noticed how many of them highlighted the link between evidence and policy and the critical part of the link. I do not presume to cover all of the terms of reference, but I am going to focus particularly around the links between primary care, academics, policy and practice. There has been a long-term concern about academics sitting in ivory towers doing arcane research that is not of great relevance to policy and practice, and that is particularly important at times of reform. There have been a number of attempts, over the years, to link academic activities with policy—in particular, in the primary care space in Australia.

I think that one of the reasons that we were invited to provide a submission to this committee came from the fairly unique organisational model that we have within SAPCRU. I just thought I would tell you a little bit about that. Essentially, it is based in Melbourne's south-east, which is an area of fairly profound disadvantage. It ranges from the city of Greater Dandenong—which includes some of Australia's most disadvantaged communities, certainly in the urban sphere—to the classic outer-urban regions of Pakenham, where it is difficult to get any sort of care—certainly when the sun goes down. Partners of Monash University, the original Dandenong Casey division of general practice and Southern Health—the local health authority—have, for a while, had a common interest in trying to bring academic input into practice. So, in 2009, they came together and decided to, as the Canadians say, 'let the rubber hit the road' and put some funding into opening a position where a Monash University academic could work, which sat across what became Monash Health, the division and Monash Uni. Our unit opened in the beginning of 2010. I was the inaugural director, and each one of the groups provided some seed funding, which continued over the next five years. They governed the work, and our submission outlines the work that we have done over the last five or six years.

There are two main themes. Around primary care reform, there have been a cluster of projects—some of them internationally linked, some of them are more locally linked. In particular, we looked at after-hours care delivery and we worked, eventually, with the Medicare Local around that. We looked at nursing roles. We looked at general practice super clinics and did one of Australia's few evaluations of GP super clinics. Then we have another stream around refugee health; we have done a lot of work around refugee health. We also looked at the models of care, including measuring of performance. I guess a lot of that work has culminated in us being the host Australian organisation for the IMPACT Centre of Research Excellence, which is a five-year program of work funded by the NHMRC equivalent in Canada, called the CIHR, and by APHCRI. You have heard from APHCRI,

the Australian Primary Health Care Research Institute, at previous submissions. So we have, really, five years of work in which we are focused on trying to improve access to primary care for vulnerable populations. We are basing it, again, around a model of bringing practice, policy and academics together. We have six jurisdictions that are trying to explore innovations and what might fit with community needs around access to primary care services. So it has been a very interesting project. We are not quite two years into it. We are trying to have the best practice innovations in these scattered communities—three in Canada, three in Australia.

Finally, we made a couple of recommendations. Firstly, the value of formal partnerships between Australia's new Primary Health Networks and academic bodies. There are various models for that sort of activity to occur. Certainly, I would be very happy to have discussions about the unit, the work we have done and the Ontario work, which has been very insightful into challenges around primary care reform in Australia.

**CHAIR:** Through your five years of study, where do you see prevention and management for chronic diseases now and where do you see that needing to go? How big is the quantum step or what changes need to be implemented into the system? I guess you are never going to get a satisfactory system. You talked about treating someone who lives in Pakenham and has chronic disease. How big a change do we need?

**Prof. Russell:** Just at the outset: you should not be totally reassured by this, but Australia does quite well with international comparisons. One of the arms of our centre of excellence is looking at how well Australia does in terms of performance. It does not do too badly, but I do not think it does as well as it could do.

**CHAIR:** Where would you put us on the scale?

**Prof. Russell:** On the scale, we are sort of upper-mid, really. The best performance tends to be in one or two and it varies condition by condition and domain by domain. The Scandinavian countries and the UK will always come out best. Interestingly, the US and Canada, in recent times, have come out particularly poorly in domains around access in particular and a number of dimensions of chronic disease. It is just that data that got the Canadians so agitated into making some really wholesale reforms to the delivery of primary care. In answer to your question, I think that the quality of our providers is pretty good. Comparatively, we have first-class education in all of the different health disciplines. One of our focuses is around the organisation and funding of primary care practices. That is probably still to be optimised. I do not think it is as good as it can be. You have heard endlessly about fee-for-service, capitation and those sorts of issues.

**Ms HALL:** And systemic problems and the relationship between the states and the Commonwealth, as well as all of those other issues.

**Prof. Russell:** Exactly. We struggle with our state and Commonwealth funding streams, and that is a reality of practice. It is interesting to work in Canada where the feds are very separate from on-the-ground delivery of policy and practice. It felt much more unified. However, the other thing—and this also came to me around my time in Canada—is the importance of what we call meso-organisations, which are middle-level organisations like Medicare Locals and now Primary Health Networks, because it adds that coordination function across practices that primary care needs. So you have the individual provider sitting in the practice, you have the practice beyond them and then how to link that to broader sets of services. Morton Rawlin highlighted this earlier and I am sure many of the public health people have also highlighted this to you: the importance of socioeconomic and demographic drivers of outcomes, which would improve society as well.

**CHAIR:** On the countries that you mentioned, the Scandinavian countries and the UK, there is a lot of difference in the size of countries. Do we have a tyranny-of-distance problem in providing the services?

**Prof. Russell:** We do. I think Canada is, ironically, a very similar country in a lot of the dimensions; it is just at the other end of the temperature scale. It has remote indigenous populations but, again, like Australia, it is highly urbanised. As you are aware, Australia is one of the most urbanised countries in the world, so we have to walk that road between equity, depending on where you live, and the needs of these big urban populations.

**Ms HALL:** The funding of the Scandinavian and the UK systems is totally different to the way we fund our health systems.

**Prof. Russell:** In terms of the level of the provider, it does vary across some of the Scandinavian and northern European countries. The UK is the classic capitation model. I guess that is where Ontario is a very interesting experiment.

**Ms HALL:** Tell us about Ontario. I am hanging out to hear about Ontario!

**Prof. Russell:** It just so happens that I was talking to Richard Glazier, a very good colleague of mine who was mentioned in this hearing a month ago, on the phone this morning, and he sent me his most recent article from the

*Canadian Medical Association Journal* which was published last week. There will be some interesting outcomes later on that.

So what happened in Ontario? In around 2001 or 2002, it was very similar to Australian general practice primary care without divisions, Medicare Locals, whatever. There were small practices—a lot of them would have been people running solo practices on the second floor of an inner city office building—and some larger practices, and it was completely fee-for-service. Everything was fee-for-service, but it was free fee-for-service, so it was completely subsidised by the government. You cannot actually charge for normal services in Canada; it is against the law.

They were very stung by the performance challenges that were reflected in some of this comparative international data. It was a very unusual coming together of the AMA equivalent, the Royal Australian College of General Practitioners equivalent and the provincial government. I may be being a bit more reflective that I should be, but they came together for once and recognised they had a common problem.

So they started a series of fairly incremental reforms in the organisation of that practice level of care delivery. The first thing they did was start to give small incentives for people to register within primary care practices. This was particularly targeted at those over the age of 65, to start with. They then incrementally produced new models of primary care delivery. Essentially, it went from one level where you would get about 10 per cent of your income from patients who registered with your practice right up to the most recent and most mature model, which has been out for around five or six years now, which is the family health team. It is an interdisciplinary team essentially paid almost completely—all but 10 per cent—by capitation, and there are incentives for quality primary care management.

The interesting thing as well is that it has been voluntary, but the incentives have been enough to encourage practices to increasingly elect to join the model. Now around a third of Ontarians go to these interdisciplinary practices. I worked in one of them in Ontario. It was a teaching practice, so we had residents as well, but there were a couple of nurse practitioners, a clinical pharmacist, a social worker and diabetes educators. It was essentially a team based approach. We would have internal referrals for some of the difficult mental health problems. The nurse practitioners used to work in teams with the family doctors, and our nurse practitioners would also have a number of families that they would see individually themselves. As Professor Rawlin alluded to earlier, I think the important part of this—at least, if you are speaking from the college's point of view—is that they were integrated into primary care practices.

The evaluation, as you might imagine, has been under the microscope. Up until very recently there had been minimal clinical output benefits, but Rick's paper from just last week showed a 20 per cent improvement in the big team based model and around about a 10 per cent improvement in one of the transitional models when compared to the basic, slightly incentivised model. But that was only in diabetes care. It did not filter across to a number of cancer based screening outcomes. That has been a challenge. There has been a lot of investment put into a better model but minimal evidence in this vast, 13 million patient natural experiment on how to deliver primary care.

**Ms HALL:** Are you going to table that paper for us?

**Prof. Russell:** I would be very happy to.

**Ms CHESTERS:** I have a question on some of the work that you have been doing. You talk about addressing the complex needs of refugees and how the resettlement services can be quite inconsistent. I was hoping you could expand on that. The resettlement services in my part of the world, Bendigo, are done by Bendigo Community Health Services. They have a great synergy with the health services because of who does the resettlement. There is no wrong door in the scenario they have set up. But, from reading this, it seems that that is not the case across the country. Could you expand on that? Also, is cost a factor? These are people who have recently been resettled and the funding package will eventually run out. Then they are trying to manage their own health care. It is cost a factor for those people?

**Prof. Russell:** From the individual's point of view?

**Ms CHESTERS:** For the individual but also for the service.

**Prof. Russell:** Yes. Those are two very good questions. Essentially what our work on refugee models of care looked at was the transition from the settlement service to initial care in Australia, then to enduring care. Doing the numbers, enduring care cannot be managed by high-quality, very focused refugee services like the community health centres. It has actually been a challenge that people tend to get stuck in them, and that creates a barrier to access for those needing to come in. What would be ideal, and what is in our model, is that those people transition into mainstream care. For some of them that is going to mean going to a community health centre, but in other

parts of Australia primary care and traditional general practice is the place to go, but it needs to be helped. We did see a role for primary health networks or Medicare Locals in doing that.

So the answer to the first question is it is quite inconsistent. Indeed, in some cases people virtually transition to try and find somewhere to go. We have been able to map the different services across the different regions. We have a grant application with the NHMRC to try and study a model where you get three to six months of care in one of those centres and then you are helped to transition out, which would make things more consistent. I have forgotten the second question, which was a very quick question.

**Ms CHESTERS:** It was on the cost for the individual refugee or the family once they have been here and settled. We also have quite a number of people out here on a bizarre arrangement of temporary protection. They may not have work rights and so on and so forth and do not have access to those services.

**Prof. Russell:** Yes, thank you. There are slightly different issues with asylum seekers who do not have their refugee status and with refugees. Notwithstanding that, it is a population that has substantial cost barriers to access. What is interesting, though—and we can really only generalise within our own region—is that we found that the availability of bulk-billing within the areas where they live, at least for general practice, is quite high. This has a bit to do with the fact that general practice, I think, is often sensitive to the realities of those that are around it. If those in general practice charge fees that are prohibitive, people do not tend to come and they cannot tend to make a business. We have been looking as well at things like the acceptability of care and language appropriateness. It is a really complex area, and Australia is almost a uniquely vulnerable population. I think quality primary care has got a huge amount, as we know, to offer to these groups.

**CHAIR:** How many of that group would come into the country with a chronic disease?

**Prof. Russell:** Yes, good question.

**CHAIR:** This inquiry is about chronic disease.

**Prof. Russell:** Exactly. It is. It would be more than for the normal population.

**CHAIR:** Is that right?

**Prof. Russell:** The most prevalent chronic diseases are mental health related and post-traumatic stress disorder. Just the whole refugee experience is a real demand, and I think that that really heightens the needs that this group has. The only thing that mitigates that a little bit is that—and it changes virtually year by year—in the last couple of years there has been an increased number of young men who have come to the end of the resettlement process, so they tend to have less ageing related chronic disease. But, again, mental health is the big issue.

**Ms CHESTERS:** Just on chronic disease, I have an anecdotal case here in the housing estate in Flemington. In the camps there is not a high availability of food. Therefore, they did not do exercise. There is now an increasing number of people who, having settled here from Somalia and Eritrea, now have diabetes. Five or 10 years on they have diabetes because they have now got a high-sugar diet and they are not exercising. Is that sort of longer term impact just about literacy when they arrive? Is there a need for that in the resettlement program?

**Prof. Russell:** My understanding of this is that it certainly includes the literacy aspect. The actual refugee experience of a number of people is that they sometimes have a 10-year passage from moving out of their country of origin to getting into Australia, and that fact in itself is a real driver. There has been comparative work done around chronic disease prevalence in age-matched refugee communities, and it is higher, notwithstanding the really disproportionate amount of mental health issues. I am not sure if that really answers your question.

**Ms CHESTERS:** Yes. It goes back to your statement that the settlement services is where the real inconsistency exists. We know that they are required to have a health literacy component but we do not quite know the quality of it, because of the inconsistency with the services that we have.

**Prof. Russell:** Just in my own practice, I do not see a lot of refugees. In fact, it has been a long time since I have seen one. But I have been really struck by the quality of the primary care from those multiple services that help with refugees. That is where the Primary Health Networks are valuable in that they can, hopefully, when they work well—and certainly our Medicare Local used to—bring some of those services together to be responsive to challenges that are emerging.

**Ms HALL:** I have a question around affordability of and access to health care and how GPs not bulk-billing and the lack of affordability will impact on chronic disease. What is the implication of that right across the sector, particularly if we are looking at GP-managed care for people living with chronic illnesses?

**Prof. Russell:** Essentially, some of the co-payment experiments and the big RAND study in the US, which looked really at a marginal co-payment to visits, have had a disproportionate effect on the disadvantaged. Clearly,

cost is a barrier to access. Australia has had many long debates about it and there has been a lot in the academic literature also. I do not bulk-bill all my patients, but essentially there are the realities of what I am sure the college and the AMA would say is a relatively underfunded sector trying to do good quality work. That is the balance of small business. It is absolutely true. I think that the sensitivity to what is happening outside, that with poorer communities there is more likely to be bulk-billing and the market just flows that way. It is probably something that saves us. I think that probably—without wanting to be political about it at all—the anxiety about the co-payment proposal of last year that came from the profession and from academics within the profession could be traced back to one study, and that is the big RAND study in the US. A little bit of co-payment has a disproportionate effect on the disadvantaged. For people like us it does not matter. The rich, the wealthy, the very health-literate will look after themselves, but it is those that are the most disadvantaged that are going to benefit most from primary care—that is where the passion should be.

**Ms HALL:** Quite often people from lower socioeconomic cohorts are the ones who have the greatest burden of disease.

**Prof. Russell:** Exactly.

**CHAIR:** We have run out of time. We thank you for your appearance today. If you have been asked to provide additional information, could you please forward it to the secretariat by Thursday, 15 October. If the committee has any further questions, they will send these to you in writing through the secretariat. If there is any other information you think would help our inquiry or assist us, please feel free to forward it to us.

It is the wish of the committee that the document that had been presented by some of our witnesses earlier be incorporated into the committee's records as an exhibit. There being no objection, it is so ordered.

**Ms HALL:** Can I also ask you to send us a copy of the RAND study?

**Prof. Russell:** I will do that. I have not got the whole paper here so I will send it to you.

**Proceedings suspended from 12:22 to 13:01**

**MITSCH, Mr Damian, Director, Allied Health Professions Australia; and Chief Executive Officer, Australasian Podiatry Council**

**OKE, Ms Lin, Executive Officer, Allied Health Professions Australia**

**WILKINSON, Ms Glenys, Director, Allied Health Professions Australia; and Chief Executive Officer, Australian Association of Social Workers**

**CHAIR:** Welcome. Do you, as witnesses appearing before the committee, have any objection to being recorded by media during participation in this hearing?

**Ms Oke:** No.

**Mr Mitsch:** No.

**Ms Wilkinson:** No.

**CHAIR:** I take it that you have been shown and read the card about parliamentary privilege?

**Ms Wilkinson:** Yes.

**Mr Mitsch:** Yes.

**Ms Oke:** Yes.

**CHAIR:** Would you like to make a short opening statement to the committee?

**Ms Oke:** Yes, we would. We each will speak very briefly. Just to introduce Allied Health Professions Australia—or APAR as we say it in short hand—we are the national peak body for 19 allied health professions. Before we begin, we would like to acknowledge that we are on Wurundjeri land and we acknowledge the custodians of the land.

Just to put us in context, Allied Health Professions form a very large section of the workforce. There are approximately 150,000 allied health professionals working together and alongside doctors and nurses. Each of our 19 professions bring their own specialised knowledge, skills and expertise, which, depending on the nature of the chronic disease that the person has who they are working with, can be integral in achieving the best outcomes. We have documented this in our formal submission, both from Allied Health Professions Australia and from our various member organisations.

In essence, APAR are hopeful that this inquiry will contribute to a realignment of resources with best practice models at the forefront for prevention and management of chronic disease in Australia. We recommend a focus on prevention. As well as the focus on management, clearly seeing that information systems are fundamental in facilitating coordination of care plans, coordination across hospitals and primary care, and linking the essential contributions of Allied Health Professions doctors and nurses in the management for the best outcome for consumers.

**Ms Wilkinson:** I am just going to make some comments about access and funding for people with a chronic condition. Whilst Medicare has funded team care arrangements and has provided funding for individual consultations and some group activities—group education et cetera—many services still limit allied health access and a number of people end up being out of pocket. There are a lot of other expenses along the way. It is a particular concern for people with complex conditions—for obvious reasons—who may require access to treatment and management from a variety of health professionals. These people frequently require access to more specialised allied health services, such as pain management, continence management, renal care—long-term, ongoing—and care that extends over a period of time where the timely access may or may not actually help or can even exacerbate their conditions.

The current Medicare funding has provided a means for limited access to allied health but is constraining the provision of best practice care and efficient use of allied health resources—including care coordination roles—and does not support extended scopes of practice for a number of our professionals. These points are in our submissions, but we would really like to submit that Medicare funding supports new roles so allied health professionals are able to work to their full scope of practice; consumers can be eligible for Medicare funding for services delivered across a variety of care models—one-on-one, groups et cetera; Medicare funding supports a far more extensive use of technology in the provision of services, particularly keeping in mind people in rural and remote areas; and Medicare funding extends the consultation time required for some allied health consultations and the number of sessions per care plan, which should be consistent with best practice.

We also particularly support direct referrals between medical specialists and allied health professionals—not having to go back via the GP either as a gateway into or a management of access to a specialist. Of course, the allied health professions have to work within their scope of practice and the assumption is that there has to be

good communication, good understanding and an agreed scope of practice between the specialist and the allied health professional. But we believe that such a model would significantly positively impact on the Medicare pool of funds. It would also reduce GP administrative burden and ensure early access to appropriate care.

We recommend that Medicare funding be available for the use of telehealth technology for the reasons I have just mentioned—early access, ongoing access and the extent and range that telehealth can provide. We also submit that allied health professionals require full access—read and write access—to digital records, electronic health records, shared care plans et cetera, so that the allied health professional is fully represented and fully able to converse with the specialist in the management and treatment of a particular person.

There is just one other point I would like to make. Funding models need to take into account the non-individual patient attributable portion of health professionals' time that is devoted to important functions such as mentoring, case management, supervision, liaison and those sorts of things. At the moment, the system struggles to recognise that that is an important and valuable contribution to the best practice management of a patient.

**Mr Mitsch:** From AHPA's perspective, there is an absolute lack of investment in preventative health. The investment in health at the moment is far too late, particularly for people with chronic disease. When we do see the investment it tends to be fairly myopic and focused very much on medical intervention. Often there are huge gaps between primary care intervention—which occurs already too late—and hospital. You seem to get a primary care intervention, then nothing, then a hospital intervention. If you can follow a medical pathway you are okay, but if you need services outside of a medical pathway then, quite frankly, the incentives push people to hospitals rather than to the use of allied health and other interventions to try to avoid hospitals. We need to start to shift that investment further forward.

As for Primary Health Networks, we are now seeing Medicare Locals 2.0 and we are still waiting to see where that is headed.

There are some concerns about the fact that there was quite good, intensive engagement around allied health, particularly towards the latter part of Medical Locals. There is a bit of a concern around the make-up of clinical councils. While we recognise that best-practice governance means that boards of directors may take different forms, clinical councils need to represent the broad range of services in a community. We have already spoken to the department about self-regulating professions. We have been told at certain times that they are not to be part of clinical councils and we have had to get the department to collect that. That gets to the heart of the perceptions in the community around the fact that these things need to be medico centric.

The role of health insurance in the primary care space is significantly underdone at the moment. Again, if you look at the legislation around private health insurers, there are deep restrictions on what they can pay for, particularly in their risk-equalised pools. Ancillary, not being risk equalised, is a business driven product. Once you jump into the hospital pool, which is risk equalised, there is not a lot going on outside the hospital gate. In many of the conversations we have had private health insurers they put up a brick walls because of the limitations in legislation.

One of the topical areas at the moment is knee arthroscopies and knee replacements versus an intensive physical therapy program. The hospital can be paid for. The knee arthroscopy and the knee replacement can be paid for. But health insurers will not pay for \$5,000 worth of physio, despite the fact that it is markedly cheaper with just as good outcomes as a knee replacement in many cases. That is ridiculous.

I will move right along to innovative models which incentivise quality care. I was saying earlier that just this morning I had a phone call from a member who told me that doctors in their practice have decided that, because there is a Medicare rebate for doctors on what is known as a TBI or an ABI, which is a test run to check vascular health in the feet, despite the fact that doctors are not all that good at it and they are not really trained to do it well while podiatrists are, all the doctors in the practice have bought a piece of equipment and decided that they are going to do all these tests from now on. Remarkably, they do not want to share those results with podiatrists. That is staggering. That gives you a sense of the perversity in the system. We are required to pay highly skilled, very qualified doctors to do things that could be done by others at a lower cost to capture the rebate, which then means there is an incentive for the patient to go to the doctor for something that should be done elsewhere. It does not make sense.

We also have to get better at the use of multidisciplinary teams in the healthcare space and chronic disease space. We seem to flip-flop from no multidisciplinary teams to what I call Kumbaya based health care, where every man and his dog has to be involved. There is somewhere in the middle that says, 'For some chronic diseases you must at certain stages have a multidisciplinary team approach. Otherwise, you quite frankly send people down rabbit holes and get disjointed, uncoordinated care.' There are big questions about who should be doing the

coordination. If you look at health care as both a clinical system and a healthcare system separate to the clinical, we put doctors and GPs at the heart of it and expect them to help patients get their way through parts of the health care system that are not clinical and to get appointments and that sort of stuff. There are others who can coordinate that much better to allow doctors to focus their time on what they are really good at, which is diagnosis and prescription. So we have to start to get a bit smarter about using primary care nurses, allied health and others as part of that management of a patient within the system—albeit the clinical stuff needs to be led by the doctor.

**Ms CHESTERS:** I am the federal member for Bendigo, and so you have a number of members and people in my part of the world. I have a couple of questions. First I wanted to ask about one of the issues that came through my office recently. A young woman has attempted suicide a couple of times. She has been through Mind Australia. She is now seeing a psychologist on a regular basis. She was recently sent a letter because of the Medicare freeze, saying she has to have \$165 up-front before she can see her psychologist. Of course there will be a Medicare rebate, but here is a young woman of 21 who has attempted suicide a couple of times, is now in a plan but has to have \$165 up-front before she can see her psychologist. So my first question is around the freezing of the Medicare rebate. Is that having a big impact on chronic disease plans and mental health plans for people, not just in the regions? I might start with that question first and then I will go to workforce, which you touched on.

**Mr Mitsch:** I am happy to have a go at that one. Yes. For people like me, I can afford to pay a gap. There are no issues. If I need to access health care, I can afford to buy what I need. But there is a whole chunk of the community, particularly when you look at the social determinants of health, who cannot afford to pay gaps or bills like I can. The problem with a Medicare freeze—and, quite frankly, one of the problems with Medicare in the way it is currently structured—is that I am treated the same way as somebody who does not have the means. That means that the Medicare freeze is starting to push practitioners to say, 'Well, I am not going to bulk-bill anymore; I am going to charge gaps.' I have had a number of those conversations in the last week with people who are teetering on the edge: 'Do I make the break and forget bulk-billing?' It will start to impact quite remarkably on people in low-socioeconomic areas.

**Ms Wilkinson:** And when the service system is built around 10 sessions—

**Ms HALL:** That is what I was saying. I thought that was the main issue for psychologists: the fact that you had a limited number of sessions.

**Ms Wilkinson:** Yes. We also have accredited mental health social workers in exactly the same categories as the psychologists. Per calendar year, it is 10 sessions, and then it has to be reviewed. You go back to the GP for that review, which is an imposition on the client and it is a break in that therapeutic type process that is happening. None of us are trying to say that GPs are not important; we just want to have the best use of GPs' time. Ten sessions is often not enough. When it was reduced down to 10 sessions a couple of years ago, there was a big impact for people with chronic conditions—not episodic. It is the chronic conditions, like the situation I imagine you are describing.

**Ms Oke:** The other issue is the rebate for the enhanced primary care items. They are based on a 20-minute session. Many of the allied health sessions, because of the nature of the work, take longer than that, and yet that is what the rebate is based on. So it is impossible to bulk-bill for that, unless you are prepared to make a donation to patient care. This is then further impacted when the freeze is kept rather than the rebate allowing those costs to escalate a bit.

**Mr Mitsch:** It is a terribly blunt instrument.

**Ms CHESTERS:** My next question was on workforce and development and what can happen in some regional areas. Take the Macedon Ranges, just to the north. St Luke's has a small bucket of funding and there is the local clinic that has a small bucket of funding. Everybody has got one-eighth that they could put into having a podiatrist for one day a week, just as an example, or a psychologist or a social worker. Yet for the entire Macedon Ranges there is no full-time social worker or podiatrist. So we are trying to get all the health players into a room to ask, 'Can we come to an agreement where if everybody pays their day, we could have a full-time person available in the Macedon Ranges?' That way you can actually offer someone a decent job. Who is going to move for one day a week?

**Ms Wilkinson:** That is right.

**Ms CHESTERS:** But it has been incredibly challenging, and I am told it is quite innovative to try to make that happen. Of course then, when we talk about chronic disease, there is just no podiatrist and no social worker in that entire region. Do you have any ideas on how we can better coordinate? Are the primary health clinics enough? To be frank, in my part of the world—it is the Murray; it goes from the Macedon Ranges and takes in all

of northern Victoria—it is going to be a bit hard for them to focus on the Macedon Ranges. Do you have any ideas on how we can pool those resources together better so we can get that full-time person?

**Ms Wilkinson:** I actually think Primary Health Networks have something to contribute here, and they will lead that sort of model development. I used to work in Bendigo. I know exactly the area that you are talking about, and it is partly geography—the distances. You are not going to get someone to come for two days a week, because of all the distances that they have to drive. There are not the incentives to get people out into the rural and particularly the remote areas, and I do think we need incentives. GPs are given incentives to move into those remote areas. So I think models of service delivery can be developed through the Primary Health Networks, which is once again where allied health has to be involved in the management of the Primary Health Network, but then it is also incentives to get people to come, and a Medicare rebate is not an incentive.

**Ms CHESTERS:** So then you compare that to, say, Heathcote. Heathcote Health got some GP superclinic funding. They built a facility. They then started to invite allied health to come and have a consulting practice there but have largely done it through their own block funding to build this primary healthcare clinic and invite people there. One of the recommendations that they had is that there needs to be some kind of funding available to help bring allied health services into the clinic and into the practices, particularly in those regional towns. Is that something that you think also needs to happen?

**Ms Wilkinson:** Yes, and that is what we were talking about: the incentives to get people to come. I can speak with authority about social workers. Social workers will go if there are incentives and reasons to go. But it is not only rural and regional areas. I used to work in Broadmeadows, a part of Melbourne that is one of the most disadvantaged, in a socioeconomic sense, across the country. We could not get allied health professionals to come to Broadmeadows, which is a half-hour drive from here, in metropolitan Melbourne. So once again there have to be incentives. We could only afford to bulk-bill, or rebate based on bulk-billing, to the staff. It is just not enough.

**Ms CHESTERS:** So there have to be incentives. What kind of incentives, do you think? Is it funding to attract them?

**Ms Wilkinson:** Yes, it is funding to attract, it is funding to keep, and often it is money for CPD, for ongoing professional training and development. It is having the supports around them, such as the allied health assistant or somebody like that to make best use of their time. So it is both an individual incentive and then the workplace setting as an incentive as well.

**Ms HALL:** There are some examples Australia-wide where incentives are put in place. If you look in other areas, I think we have seen that over time, haven't we? In different areas there are different incentives.

**Mr Mitsch:** It all comes down to how you remove the barriers to somebody setting up in practice in such a way that their business is sustainable and they can sustain a good lifestyle out of doing what it is that they do. Often you talk to people about why they do not move into regional areas or low-socioeconomic areas. It is because they have looked at the barriers and simply said: 'Well, it's too hard. If I turn up here, this hospital can give me 0.2 days, I can do 0.5 days in private practice, and then I've got to drive 400 kilometres. It's all just too hard.'

**Ms CHESTERS:** Does it come back to the equipment?

**Mr Mitsch:** Sometimes.

**Ms CHESTERS:** For example, take physio. The person in Heathcote, to get physio, has to get on the bus and go to Bendigo and then come back. By the time they have come back, having been on the bus, they have almost undone all of the good work done by the physio, but the physio will not come to Heathcote Health, because there is not the equipment or the necessary facilities. So is it about funding that equipment or having capital works available?

**Ms Wilkinson:** Yes, it is partly that.

**Mr Mitsch:** Or recognising that you cannot just pick up some types of capital and truck it around the country. It is just not practical to do that, and that comes back to the barriers in terms of the business model. They have to buy four sets of everything because they have four satellite offices. You look at it and say, 'Well, my mate down the road's selling a practice that's already going, and I know the business model works, or I can go into this regional area, where I know there's need but it all looks too hard.' The capital is complex. Piecing it together is complex. The business model is complex. They take the easy path, as you would expect. It is low socioeconomic areas as well as areas where distance is a challenge.

**Ms HALL:** Probably we should get back to chronic disease management.

**CHAIR:** This problem has not occurred just overnight. All governments have ignored the issue. It has not just happened today. We just need to clarify that. Have you any suggestions for workable preventive management of chronic disease? We have heard all about the Medicare stuff but have you actually got a plan for how a system would work?

**Mr Mitsch:** The funny thing about chronic disease is one system will not work. That is the nature of the beast. What we do know is that we are seeing more and more evidence based pathways for chronic disease, particularly with the evolution of Medicare Locals. PHNs are now supposedly going to focus on the development of evidence based patient pathways. What is frustrating about those—and we are working on one at the moment—is that we can demonstrate a pathway that patients should follow if they come up risk stratified with diabetes, for example. If you have diabetes and peripheral neuropathy then you should travel along a particular evidence based pathway. We can demonstrate that along that pathway funding stops and it picks up again at the hospital. When you start to map out those pathways, patients go along and then they fall into the abyss and blip back up at the hospital when they are about to get an amputation. If we start to focus on funding evidence based pathways rather than this current model that funds based on profession, quite frankly, and funds based on activity not evidence, then we can start to shift chronic disease, particularly if we also add the prevention into it.

**Ms Oke:** So much of managing chronic disease is something the consumer needs to learn how to manage themselves. A number need support in being able to change their behaviours and sustain that. Again allied health professionals can help in teaching and monitoring those self-management strategies but again how do you pay for those? How in the lower socioeconomic areas do you pay for that? Yet it is so critical. If the person manages well they will keep out of hospital and minimise costs, so they need assistance.

**CHAIR:** There are issues with resources in lower socioeconomic areas, but I am getting a sense from evidence we have heard that the GP should be the focus of it but I am hearing from you guys that the GP should have a lesser role and there should be more management from the carer's role?

**Ms HALL:** I find with Steve's question that the model you are talking about is a case management model. The person who case manages it within that interdisciplinary team that includes the GP should not necessarily be the GP but could be?

**Mr Mitsch:** Could be. Some GPs are fantastic at this stuff. Let us put on the table that there are some brilliant GPs who do this really well.

**Ms Wilkinson:** And then there are some who are not interested at all—at all.

**Mr Mitsch:** The problem is that we assume that all GPs are great at this and that all GPs want to do it, and that is just not the case.

**Ms Wilkinson:** You made points earlier about population health—intervention and prevention are really important—and Damian made points about the care path and the anticipated care path. We need a consistent approach across that care path, and a multidisciplinary team is one of the best ways to do that. We made the point before about GPs not having to be the beginning and the end of the treatment. They are not the gatekeepers. They may be—and it depends on the condition of the particular patient or consumer—but at other times we need a direct relationship between the GP and the allied health professions, because that has efficiencies.

**Ms HALL:** And the persons case managing of a key worker could shift from time-to-time. Is that envisaged in your model?

**Ms Wilkinson:** Yes, of course. We need allied health professionals to be able to work to their full scope of practice and to be funded—so that to be recognised as opposed to it being episodic treatment orientated: this Medicare item number; this is all you can do.

**Mr Mitsch:** If you look at the hospital system, nurses run hospitals. Let's be frank. Doctors do not run hospitals. They like to think they do. The reality is that, on a day-to-day basis, it is the nurse that is calling the doctor and saying, 'We need to see you.' It is the nurse that is making sure that the tests have come in, preparing the things for doctors to look at. It is the nurse that is calling down to the physio department, saying, 'Look, you need to come up and have a look at this.' They are actually really good at doing that in hospitals. In primary care we almost ignore them. Quite frankly, they have some great skills on this front and a lot of that is because the fee-for-service base model service says, 'Doctors have to do the work and there are some delegated roles.' If you tip the whole model on its head and say, 'Well, a health manager and whoever is well-skilled at that should be able to draw in what is it that the doctor is saying is clinically necessary, because no-one is going to second-guess GPs and doctors on their clinical assessments.' But, how do we get that clinical assessment and take the patient through the recommended pathways in a way where the money flows with the evidence to get them to the point where

they are managing as best we can get them to manage and keep them out of the hospital for as long as we can. That type of model is a fundamental shift from where we are at today.

**CHAIR:** Have you seen evidence of where that works anywhere?

**Mr Mitsch:** There are some good models in the US, interestingly, around private health insurance, with some really good examples of managed care, albeit, there are also some really bad ones. So I would not just take that as a wholesale. There are some good examples out of the NHS and some good examples coming out of Canada around capitation-based approaches.

**Ms HALL:** We have heard about Canada.

**Mr Mitsch:** How we get from here to there is going to be an interesting journey but chronic disease is a really good opportunity to start that conversation, because chronic disease does not lend itself well to fee-for-service. It is not an acute intervention.

**CHAIR:** We will let you talk to the RACGP.

**Ms HALL:** We are running out of time but I will ask you one question, if I could. In your presentation, you talk about prevention management. I was wanting to hear your ideas about prevention and how allied health can help in the management—and we have talked a little bit about teams—but also the empowerment of the self-management area and how allied health can link into that.

**Ms Wilkinson:** I think that is where the population health funding models are really, really important. I have seen some really good examples where it has been successfully run out of local councils here in regional Melbourne.

**Ms HALL:** Given that local government is not involved in all states, Victoria is probably one of the standouts there.

**Ms Wilkinson:** Yes, I know. Victoria has also got community health and state funded community health centres in which it has done some great work in early intervention and prevention—running walking groups, for example; those sorts of things. I cannot speak outside of Victoria, I am sorry.

**Mr Mitsch:** The Federation white paper would say, 'Give us a single funder for health care.'

**Ms HALL:** We all agree.

**Mr Mitsch:** I think we would all agree, arguing as to which should be which I do not know that I can nail that. The one thing that we know is coming is that consumers are getting more and more interested in their health care. If someone had said to me three years ago that by 2020 there will be \$15 billion a year in wearables sales—you know, fitbits and all that sort of stuff—I would have laughed at them. The projection is \$15 billion a year by 2020. Patients are taking a much stronger interest but they do not have the tools. For me to get access to my information I would have to scrummage around and go through papers all over the shop. The more we can give patients that information, give them access to manage their own health, give them the ability to take information to health professionals as consultants, the more we are going to empower patients to manage their own health issues.

**CHAIR:** More sharing of data?

**Mr Mitsch:** Yes. And the patient should be at the centre of that. Who says health professionals should be able to hold onto information and say 'It is mine'?

**Ms Oke:** As to the very beginning point of prevention, I cannot understand why all of the food products that are laced with sugar and laced with fats are not labelled very clearly—

**Ms HALL:** A traffic light system.

**Ms Oke:** Yes. Why isn't that available so young parents know each time they serve their child or encourage their child to drink orange juice out of the bottle that they are swallowing seven spoonfuls of sugar with every glass. It is a fundamental contributor to weight gain and obesity.

**CHAIR:** Thank you for appearing today. If you have been asked to provide additional information could you please forward that to the secretariat by Thursday, 15 October. If the committee has any further questions they will send you these in writing through the secretariat. If you have further information that you think could be relevant to our inquiry, please feel free to forward it to us. Again, thanks for coming along today.

**BOOTH, Ms Karen, President, Australian Primary Health Care Nurses Association**

**GIBBS, Ms Colleen, Senior Policy and Research Officer, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives**

**GRANT, Dr Julian, President, Maternal, Child and Family Health Nurses Australia**

**McLAUGHLIN, Ms Kathleen, Acting Chief Executive Officer, Australian College of Nursing**

**RYAN, Ms Kim, Chief Executive Officer, Australian College of Mental Health Nurses**

[13:37]

**CHAIR:** I now welcome representatives of the nursing groups. Do you, as witnesses appearing before the committee, have any objection to being recorded by media during your participation in this hearing?

**Ms McLaughlin:** No, we do not.

**CHAIR:** I take it you have read the card in front of you with regard to parliamentary privilege?

**Ms McLaughlin:** Yes.

**CHAIR:** I now invite you to make a short opening statement to the committee.

**Ms McLaughlin:** Given that there are five of us here today, we are all going to present a very short statement. They will be limited to two minutes each. I start by recognising the traditional owners of the land on which we are meeting and pay respects to elders past and present. Thank you for the opportunity to attend this hearing today. Today you will hear from the key nursing bodies before you that represent nurses working in primary health care across Australia and across a range of key areas of practice. My colleagues and I will each present a two-minute statement highlighting key points for your consideration.

I am the Acting Chief Executive Officer of the Australian College of Nursing, the national professional organisation for nurse leaders. The Australia College of Nursing considers the roles of community and primary health care nurses to be integral to chronic disease prevention and management in primary health care. Community and primary healthcare nurses have a long history of providing health care across communities—often to those who are marginalised or hard to reach or have limited access to traditional healthcare settings—and their services are embedded within communities. Communities, families and individuals engage with community and primary healthcare nurses across the various stages of life: maternal and child health nurses, school nurses, sexual health nurses, community nurses, home visiting nurses or palliative care nurses, just to name a few. The reach of nurses is unmatched by that of any other health profession trying to reach populations. Their interactions with individuals and their visitors, families and communities provide great opportunities for the delivery of health promotion messages and activities—opportunities that are not often harnessed.

As we know, the social determinants of health have a major influence on the health of individuals. Community and primary healthcare nurses provide care within the context of people's living conditions, environments and relationships and through the coordinating role they undertake to link people with services beyond the usual clinical settings to include such services as housing and employment services that the profession has a long history of working with.

People with chronic and complex conditions often require a multidisciplinary approach to care. It is important that the roles of nurses in coordinating and monitoring care for the complex needs of patients and the network of health professions that nurses work with and liaise with are recognised. ACN believes the opportunities exist for governments to enhance the role of community and primary healthcare nurses in the prevention and management of chronic and complex disease.

Healthcare service models in Australia are predominately designed to provide acute, episodic care and lack a strong focus on care integration and health promotion. Models are required that integrate nursing services with general practice and acute services and make better use of the nurse workforce. Medicare funding, which supports an episodic model of care, is no longer suitable for the patterns of chronic ill-health that have emerged in Australia. ACN supports the trialling of mixed funding models that include capitation funding, grants and outcome based payments. Such mixed funding models deliver a range of incentives that would better support the ongoing, multidisciplinary care that much of the community requires.

Lastly, nurse workforce planning is urgently required to support Australia's developing focus on primary health care. To date, no comprehensive data are available on the roles, distribution and number of nurses who work in primary health care. If more health care is to be shifted to the lower-cost primary healthcare settings, workforce

planning will be needed to identify the number of primary healthcare nurses required and to plan for the systematic development of this workforce. Thank you.

**Ms Booth:** I represent APNA, which is the peak professional body for nurses working in primary health care. Our vision is for a healthy Australia through best practice primary healthcare nursing. Our mission is to improve the health of Australians through the delivery of quality, evidence based care by a bold and vibrant primary healthcare nurse workforce. APNA represents a vital cohort of nurses who work across all areas of primary health care, including general practice, and across all areas of Australia, from major cities to rural and remote outback.

Primary healthcare nurses, as Kathleen said, are one of the most widely distributed health workforces and are often the first point of contact that many Australians with chronic and complex illness have with our health care system. Primary healthcare nurses are the key drivers for successful population health and preventative health care in all settings that work in, including general practice, aged care and community health facilities.

Nurses working in primary health care are uniquely placed to manage chronic disease. We possess the skills to deliver comprehensive chronic disease prevention and management programs and are particularly skilled at encouraging, supporting and educating consumers about self-managing and about providing and monitoring feedback on the patient's progress. Primary healthcare nurses also play a pivotal role in early intervention—helping to prevent complications and avoid hospitalisation, which is costly to the person, costly to their families and costly the nation.

As the members of the committee are fully aware, the combination of the ageing population and the increasing burden of chronic disease presents a significant challenge to the sustainable provision of optimal health care in Australia. The contribution that primary healthcare nurses make to the delivery of care, where nurses play an important ongoing role in the management of the individuals' chronic disease—so monitoring, ongoing care, coaching—is already an important part of the solution to this challenge. Realising the potential of the nursing workforce will be critical as the demand for health services continues to grow. More cost-effective ways to improve access, especially for vulnerable groups, and deliver quality care is required.

Primary healthcare nurses are a substantial and growing component of the primary healthcare workforce. They work alongside other health professionals. Using evidence-based approaches, nurses play a major role in improving health outcomes through a multidisciplinary approach to care. One of the key points raised in our submission to the committee is the success of nurse clinics in dealing with chronic and complex care and with the coordination of care. Using a nurse clinical model, healthcare nurses working in multidisciplinary teams have their own caseloads and take lead responsibility for care of the patients. Patients are either referred to them directly by the GP, or the nurses play a key role in identifying patients at risk in their communities who would benefit from a much more coordinated approach to care. This can play a particularly important role in areas of workforce shortage—in rural and remote areas in particular, and in outer-urban fringes. Utilising nurses to their full scope of practice in the care of persons with chronic disease also frees up GP time, so GPs can then go on to see patients with more acute needs.

As my colleagues know, the projected nurse workforce shortage predicts that primary healthcare nurses will experience one of the largest shortfalls in the sector. The HWA paper—the last paper—estimated a workforce shortage of 27,000 by 2025. This comes at a time when the demand for services of these nurses in tackling the issues of complex and chronic disease has never been higher. The real chance of dealing with the looming health crisis is in the need to focus on recruiting and retaining more primary healthcare nurses. More nurses means more consumer-focused care and more cost-effective care, and leads to markedly improved outcomes.

At APNA, we are committed to developing and driving new initiatives which enhance primary care and optimise the role of primary healthcare nurses, particularly in chronic disease management and prevention. We are about to embark on a number of innovative projects aimed at enhancing workforce capabilities, including a number of projects to attract and support nurses transitioning into primary health care—so either new grads coming to the sector or moving from the tertiary sector into the primary healthcare sector, as well as programs to help build the capacity of the current workforce. We have significant expertise in this field. We have run a series of successful chronic disease management workshops for primary healthcare nurses all around the country.

APNA is also currently embarking on an ambitious program to develop an education and career framework for primary healthcare nurses as part of our commitment to growing a sustainable workforce. This is being implemented alongside our other projects aimed at supporting the health of the community by increasing access and encouraging the use of a multidisciplinary approach to care.

**CHAIR:** It was a six-minute introduction. All you are doing is reducing the amount of time we can ask you questions. We are going to run out of time to ask you questions, but you can keep doing your opening statements if you want to.

**Ms Ryan:** I think it is very good point. Can I my colleagues to pick two points out of your submission to hand over to the committee members, and then we will leave it at that. Otherwise, it is not going to work.

**CHAIR:** If you have long introduction statements, we can always take them as exhibits or submissions.

**Ms Gibbs:** Our emphasis is on Aboriginal medical services: wishing to have them supported if not enhanced with respect to any changes to primary healthcare funding arrangements—be it community controlled or publicly funded, because there is a mixture of both right across the country. The advantage that we find with community controlled Aboriginal medical services is that they provide a holistic approach to health, they provide a range of services, they look at the patient totally and they do not rely on fee-for-service, so when they have a patient they look at them all the time. They have a system of providing pathways for their health services and coordinated care, and I think that is important if you are going to deal with chronic diseases. That is the key thing that I would like to promote today.

**CHAIR:** Thanks.

**Dr Grant:** The key point that I would like to make is that a healthy adult life begins in infancy and early childhood. One of the core factors that we want to make prominent is that we need to not lose sight of primary prevention. We have to get in there before chronic disease takes place. Child and family health nurses are well-positioned and underutilised in doing that. At the moment, they are able to reach families—they have a very broad reach—and their reach particularly tends to things like healthy eating, prevention of obesity and prevention of diabetes, which are core beginning statements for chronic disease.

The second important point is that child and family health nurses around the country are presently constrained by different funding arrangements in different states and territories and nationally. We are primary health care but we are often clumped under acute care health provision. Different models mean that nurses do different things and are not enabled to reach the capacity of their scope of practice. What we would like to see are funding models that enable child and family health nurses to reach the potential of their scope of practice and therefore reach the potential of getting to those most-in-need families early in infancy.

**Ms Ryan:** I want to mention two things. In 2014, the World Economic Forum noted that in 2030 mental illness will cost \$6 trillion a year. It is currently costing us \$60 billion a year—13 per cent of our GDP—so we have to do something about mental health. I reinforce the fact that the Mental Health Nurse Incentive Program that you already have in your report is a good program that should be expanded to other areas of health care to enable nurses to manage chronic disease in other areas. I will leave it at that.

**CHAIR:** One of the questions we have here is about e-health, or internet health. We have heard about regional and remote areas. How much of a part can that play in preventive management of chronic health, particularly for remote and regional areas?

**Ms Gibbs:** The Northern Territory has been using e-health for quite some time, particularly in Aboriginal medical services. It allows for more ready-time communication and referral pathways—on time and with updated information of patient's records. It could well and truly be enhanced, but for those areas that do not have services on the ground, yes, e-health is important. It provides an access to services. It should not necessarily be the full substitute, but it does provide services.

**Dr Grant:** E-health covers a whole range of services and constructs, and we cannot assume that we are necessarily talking about the same thing. One of the most important things from a child and family health perspective—and we have looked at e-health records, beginning with infancy—is the challenge that only some members of the health profession are able to enter data on the existing trials. What we need are all members of the health profession, including nurses, to be able to enter data, which has been an absolute gap in some of the existing trials.

**CHAIR:** With regard to a lack of resources in certain areas, we have also heard—and I have given you an example from my home state of Western Australia, where in the CBD or metropolitan area the lower SES areas have less access to GPs—that in the areas where you probably need them less, they tend to migrate to those areas to set up their clinics. How do you, as nurses, play a role in trying to convince GPs to move into areas where you are most needed?

**Ms Ryan:** I want to make a comment on that. I do not know that it is our role to convince GPs—thank you—to do anything, as much it is not theirs to convince us!

**CHAIR:** I understand that.

**Ms Ryan:** I think the whole point is that we need to look at collaborative models of care. We have to stop thinking that GPs, psychiatrists and other people are going to be in those rural places because, effectively, they are not. They have not been to date. There have been many, many incentives to get them to go to those places, but they do not go there.

**CHAIR:** I am not just talking rural and regional.

**Ms Ryan:** No, I am not talking about rural either. I can give you perfect examples of where psychologists work in highly affluent areas, and we do not have psychologists providing better access in those lower SES areas, for all the reasons that you would know. But I think one of the roles that we cannot escape here is the emerging role of nurse practitioners and the ability for them to fill the gaps in regard to services.

I think the thing that is really important about e-health is that it enables people to work together collectively. It should not be any one person's job, and it should not be about, 'You do that, or, if you don't do it, I can do it.' We have to get over turf warfare these days. We have to get past that. Everyone has a role, and, until we actually start coming together at the table, putting our own baggage behind us and saying, 'This is about the community, and we have to collectively work together to make it better for our community and our people,' we are not going to get the goal that we want, which is collaborative and integrated health care, because we are all still worried about whether I have a shingle, I am a doctor, I am a nurse or whatever. We have to get past that. That is the reality.

**CHAIR:** Well said.

**Dr Grant:** I totally agree with what Kim is saying and about the role of nurse practitioners. There are some really exciting models coming out of Vancouver, for example, in early childhood, where there is nurse practitioner led primary-care provision in the hard-to-reach areas, in the homelessness services and in First Nation services. They are not practising independently away from the rest of the team. They are the hub of the team, they incorporate the team, and they are showing really great outcomes for decreasing vulnerability scales and increasing health outcomes.

The second really important point with all of this is the notion of, again, e-health and making sure that e-health is used throughout.

The third one in my mind is scholarships for people who are already living in regional, rural, remote and hard-to-reach populations who want to be able to undertake healthcare education but cannot because of their own circumstances. If we can increase scholarships for that cohort—I say 'cohort', but there are a number of cohorts of people out there—then we are actually training in place and getting people to return to their homes.

**Ms Booth:** I would add that there are already models using quite skilled nurses—not nurse practitioners but highly skilled nurses—particularly in some of the remote communities, where those nurses can follow protocols. Emergency patients come in—or kids with glue ear or kids who are unwell. They have protocols that they can follow. They can prescribe. They use telemedicine to relay any concerns to doctors working in the clinic, whether it be the Royal Darwin Hospital or the Royal Flying Doctor Service, and then convey their concerns and treat the patient on the site, and they do not have to evacuate that patient. So there are already some very innovative models set up.

For those areas of workforce shortage, particularly in outer urban fringes, I think we should also recognise that there is a lot of capacity in the nursing workforce there. There are nurses in those areas who can run those clinics for chronic disease and can do some of the preventative health stuff that does not necessarily need to be seen by the GP immediately. They can manage that. There could even be some prescribing rights for nurses in those areas of workforce shortage, where they can maybe do things like repeat prescriptions. They would not be the primary prescriber, but they could be in contact with the patient's GP and do repeat prescriptions. That might also—

**Ms HALL:** That does happen in some jurisdictions, doesn't it?

**Ms Booth:** It does happen in some jurisdictions but not all of them.

**Ms Gibbs:** I was going to offer up an example from a nurse practitioner role. That is Lesley Salem, one of our members, who actually received the nurse practitioner award this year. She works up in northern New South Wales across two AMSs and does a combination of in-clinic and outreach work, as well as in-home services, and she focuses on chronic disease. A lot of the work that they do does not just involve or target Aboriginal community up there. They reach out to the socioeconomically disadvantaged. They actually go to people and reach out across the board to people who would not be able to afford it. Her funding model and the AMS funding models allow people who could not afford a GP sessional payment to come to them or to access health services. I think there are a lot of advantages in what they want nurse practitioners to do. There are a lot of good models out

there. It is about collaboration. It is working; it is having good referral pathways; it is doing the linking and the coordination roles. It is not like they are autonomous and working in competition. They do fill a gap and provide a very good service. Otherwise there would be a gap.

**Ms HALL:** I will probably roll 10 questions into one here because we are running out of time. We have heard today about the needs of interdisciplinary teams. We have heard about maybe looking outside the current funding model. With the interdisciplinary teams, some of the information we have been given is that they should be GP led. Other information that we have received is that maybe they should be allied health led. I suspect that the information that you would give us is that they should be nurse led.

**Ms McLaughlin:** No!

**Ms HALL:** There was also some information given to us that maybe it should be flexible and should be designed around the need of the person. Then, flicking into that funding models and moving from fee for service to a capitation funding—I can see how capitation funding would work really well with maternal and childcare nursing—then also looking across the funding between states and the Commonwealth. There are all these little silos that exist out there. How do you bring them together to get the best outcome in providing programs, education, prevention and monitoring for somebody living with a chronic health disease?

**Ms McLaughlin:** I think you have probably summed up well what our position would be. For someone with a chronic condition it will differ between people, depending on what their health needs are, as to who, and from which profession, the primary care provider would be. It needs to be specific to the person's or the community's needs.

**Ms HALL:** And that could change?

**Ms McLaughlin:** Absolutely, yes. It might be the mental health nurse. It might be the diabetes nurse educator that takes the lead of the team and is the link to all the necessary services. You are correct in terms of the funding models. We are not able to present today the model that works, but I think exploration and work on developing a model that supports that interdisciplinary working is needed.

**Ms Ryan:** Can I talk about the funding model in regard to the Mental Health Nurse Incentive Program? That is the only program which is funded the way it is funded. It is funded as block funding. The nurse and the GP or psychiatrist collaborate within that funding to do whatever it is that the client requires. Unlike other episodes of funding where it is fee for service, where you do an intervention and you get a particular payment for that, it is not like that. This amount of money goes to the practice, and if you need to see the patient every day for a week you see them; if you do not need to see them for six months—you decide, as a team—GP, psychiatrist, nurse, patient—what is required, and you are able to do within that what is required. That is the perfect type of funding that we need to have for chronic disease management. By virtue of being a chronic disease, there will be ebbs and flows in terms of what people need and who is required within that intervention at that time.

So there have to be different packages of funding in regard to chronic disease, because we cannot afford to keep doing it the way we fund health care. The perverse incentive is that the more people we get through the service, the more funding the service gets. We have to enable the service to do holistic care for people, whatever intervention they require and whoever it is that is needed. I think that the consumer should have more voice on who is leading their care, as opposed to health professionals. In the hospitals we have collaborative arrangements. The thing that people have to remember in terms of nursing, which is different to a lot of other parts of allied health, or maybe more aligned with GPs, is that when you call in a diabetes educator, a psychologist or an OT, you call them in to do a specific intervention. You ask them to do some sessions of CBT or to give some diabetes education. The whole difference between what nurses, and predominantly GPs, do is that they do all of that. If I am a mental health nurse I will also be looking after my mother that is having perinatal health issues; I will be looking after the diabetes because they have diabetes; I will be looking after a whole range of health and mental health conditions, not episodes of care. That is what we really have to focus on when we are looking at chronic disease, because chronic disease is not one thing. If you have cancer, you are 20 per cent more likely than the rest of the community to take your life after the first year after being diagnosed. The mental health nurse has to think about the cancer aspect and the cancer nurse has to think about the mental health aspect. It is about nurses, and predominantly GPs, doing the whole thing, not episodes of care. That is really important to remember in the management of chronic disease.

**Dr Grant:** There is one more thing that we have not said explicitly. I think that current funding models very much look at process outcomes. They are processes—how many times you have seen someone. That is what we measure. We do not measure the health outcomes. Under whatever blended funding model we come up with,

because I do not think one model is going to solve the problems of the universe, it needs to be blended models for different situations.

**CHAIR:** It would be hard to get everyone to agree on it, too.

**Dr Grant:** Exactly. But what we need to be really mindful of is that we need to be measuring the client outcomes. Are they better? Have they had interventions that are working for them, on their terms and from their perspective? So outcome measures, not just process measures.

**Ms CHESTERS:** Just very quickly on the workforce. We have mentioned that. I agree that it is not your responsibility to get the doctors to go to regional areas. I am from Bendigo. We have our own challenges in allied health. But even within nursing there are workforce development challenges. Particularly thinking of the churn in mental health because of the challenging nature of mental health and mental health nursing across the board, particularly in Aboriginal health as well, do you have any ideas on how can we get on top of those workforce issues and encourage nurses to either step up or continue professional development so that we can have the workforce we need to tackle the chronic issues in this area?

**Ms Ryan:** I think there are a number of issues in that. I do think that any of us have an answer to that, to be honest. I can speak from a mental health perspective, because obviously there is a big challenge. Probably the highest predicted workforce shortage into the future is in mental health. That is really troubling, given the increasing rate of chronic disease around mental health. So that is a challenge. We need to provide the nurses to have the requisite skills to work in a particular area. One of the issues for mental health nurses, which does become a challenge, is the way our nursing education works. You do a comprehensive undergraduate degree, then you go and work in whatever area you want to work in. What worries me in some instances is the preparation for nurses to go and work in acute mental health services or in acute intensive care where they do not have the skills. We need to make sure that the nurses that are working in specialty areas—nursing is specialising because it is such a big body of knowledge—have the required skills to be confident to work in that place. That is a challenge for some of those people who do not have those skills.

The other thing that we need to look at in terms of nursing—we do not do it very well—is to allow nurses to move in and out of workplaces. So, for example, if you work in an acute mental health unit, that is where you work. You do not work two days in acute mental health then three days in the community, which would help support people with integration of care through inpatient services and the community, but also give them some down time from the high acuity that happens in inpatient services. There are quite a number of ways that we could look at supporting the nurses to stay in the workplace. I think that is a big challenge. I do not know that I have a solution around nursing. One of the biggest problems of mental health nursing is the stigma that is associated with mental health nursing. We have exactly the same stigma associated with mental health nursing as mental health patients have.

**Ms McLaughlin:** I could add a couple of things about retention in the rural areas, which is what you were talking about. In terms of nursing, to support the nurses working in those areas, often there is a sense of professional isolation and poor access to professional development in order to maintain their skills. There are a number of things, including access to professional development opportunities and also professional networking. The more we have multidisciplinary teams working, the more that sense of professional isolation is reduced and the supports from within a team can give professional satisfaction. Also important is to enable nurses to their full scope of practice—which they often do in rural and remote areas, and I think you will find the most innovative practices are in those areas. Allowing nurses to work to their full scope of practice and for that professional satisfaction also will assist in retention.

**Ms Ryan:** I often say at the moment that nurses are leaving nursing because they are suffering an existential crisis. They are leaving because they are not doing what they want to do. They are compromised every day in services they provide and they give up on it because they say, 'I'm not doing what I actually need to do for the patients.' For example, in the majority of mental health units in Australia, the first question that people ask in the morning, 'Who's going home today?' because they need the bed. That is not about quality care, and after a while the nurses say, 'I'm in a busy surgical ward. I actually haven't had the time to sit down and talk to my patients about what's really important.' I talk to many other nurses and I say to them, 'You've got to think about the mental health,' and they say, 'We haven't got time to ask people about their mental health. We're running around doing all these surgical procedures or medical things, and we're not able to do what we want to do as nurses,' and so they leave because they just cannot do it anymore.

**Dr Grant:** An issue that is not dissimilar is in child and family health nursing. I have mentioned before the issue of the disparate funding models. Those funding models constrain practice. In South Australia, for example, there are a set number of targets that the nurses need to achieve. Those targets are process based—they are not

outcomes based—so the nurses are struggling to get those process targets done and, similarly, they are not able to enact the practice that they know. They have done their postgraduate education, they are skilled and they are knowledgeable, but they cannot enact that because they are having to meet these process targets because of the funding models. They are incredibly frustrated and they leave.

**Ms Booth:** Coming back to the new nursing graduates, that 30 per cent I think is the figure that cannot get a job when they leave university. That is a large number of nurses who are graduated, qualified and registered but cannot get a job. A lot of them tend to focus on trying to get a job in a tertiary sector because they have a really good grounding of background training. Part of the work that we are going to do at APNA is look at pilot programs—and we have government funding to do this—to try to encourage new graduates into primary health care, not just into general practice but into a number of areas, and to set up that education support that they need and some mentoring. Also in the pilot we will be offering some incentives to practices to take those nurses.

At the student level, the issue is enabling them to have experience in private practices. It is not just nurses; it is allied health as well. To get them into small private practices is really hard. You have to negotiate every single placement every time. There is no funding that comes with them. Medical students are funded and interns, if they do placements, get some funding support coming into general practice, but nurses absolutely do not at all. As I said, there is the need to develop those support programs so that, when nurses move into general practice, they feel like they have that mentoring to get them through at least that first year and get used to it.

**Ms Gibbs:** From an Aboriginal health perspective, the issues that we have around the health gap are not dissimilar in the Aboriginal and Torres Strait Islander nursing-midwifery workforce. That is an issue about racism. When we say, 'Close the gap,' a lot of the issues and barriers that people face with respect to getting health outcomes or even working or staying within nursing-midwifery—because we know that the first five years have the highest dropout rate—are issues of discrimination and racism that they face, either as a patient receiving services or as a staff member. A lot of people do not even realise that they are saying things or doing things that are offensive, discriminatory, or harmful, but there is a lot of that around. If you are going to address health and deliver good primary health care you have to do it from a culturally respectful point of view for the staff and the employees. I do not think that we empower general practitioners, community health centres and a lot of services to do it well—we do not enable them to learn to develop a culturally safe environment. I think that is an issue.

The other issue is that, if we want to get a greater experience of Aboriginal health, it is very similar to general practice. Clinical placements are very, very hard to get either as a student or in a job straight out of university as a graduate working in an Aboriginal medical service—you are not going to do it without any background or experience. There is not a lot of support for that. Most clinical placements seem to be focused on acute care—the hospital system. There is not enough of outside into the primary health care. Not enough of that is facilitated, and if a student wants to do that it is not the norm within their school. They have to go and try and achieve that on their own, and they may not necessarily get the support to find those clinical placements. There is not enough of that support. There is more focus on providing support for a medical student to get a rural placement than any other placement around, and I think that needs to be addressed.

**Ms CHESTERS:** Would you say it is also similar for new and emerging communities—some of those cultural barriers that may exist?

**Ms Gibbs:** Yes, a lot of it. If we keep the focus on our nursing or our concept of health from our own perspective and we do not open up our eyes to try and look at health from somebody else's perspective, we are going to close down the communication between the individual and the health professional. That is a big problem. A lot of the problems we have are from that poor communication, so it is an education of the health profession broadly, not just particular health professions. I think there is a lack there.

**CHAIR:** Thank you for coming along today. Your evidence has been valuable. If you have been asked to provide additional information, could you do so by Thursday 15 October. If the committee has any further questions, which I think we might have, we will send them in writing to you from the secretariat. If there is any other information you think would help our inquiry in our report, please feel free to forward it through to us via the secretariat. Once again, thank you for coming along.

**FURLER, Associate Professor John, Research Fellow, Department of General Practice, University of Melbourne**

**GUNN, Professor Jane, Head of Department, Department of General Practice, University of Melbourne**

[14:17]

**CHAIR:** I call the representatives of the University of Melbourne, Department of General Practice. I understand that, as witnesses appearing before the committee, you have no objection to being recorded by media during your participation in this hearing and that you have read the parliamentary privilege card. Thank you for coming along today. I invite you like to make a short opening statement to the committee.

**Prof. Gunn:** Thank you for this opportunity. We were delighted to be able to come and speak with you this afternoon. I will tell you a little bit about our Department of General Practice. We have been established for a number of years. We are in the Melbourne Medical School and we are mostly involved in primary care research and the teaching of medical students. The two things that we would like to talk about mostly today—and from hearing the last submission—are around our community-based teaching. We have students out on placement in general practice across the state of Victoria, and we have links with about 480 general practices. This is a really wonderful program, and it is key to the students seeing that general practice and primary care is a way forward for them to choose as a medical career, but it is not necessarily a No. 1 choice for medical students. I think that might be something that you will want to follow up on, and we are happy to talk about that. Secondly, we are a very well-established research group, and we have focused on research, in particular, into trying to develop models of care that are going to improve health outcomes, reduce waste and avoid duplication in the healthcare system. John and I have been working, along with colleagues, for a long time to really focus on trying to do that, and I think that we have got some—

**Ms HALL:** That is what we are interested in.

**CHAIR:** That is what we really want to hear.

**Prof. Gunn:** Yes, so that is the focus of our department. We see ourselves as knowing that the healthcare system is fragmented. We know that there are a lot of issues with it. We know that what we want to get to is an integrated care system that avoids waste and duplication and improves health outcomes and that we can do it in a way that contains costs.

We think that one of the key planks to that is really developing models of care that are actually going to meet those indicators and that are going to actually work. We think that to do that there are some things that need to happen around the registration that practices will have to know. General practices are well positioned. They are all over the country, even though we have got some workforce shortages. We need to hold them accountable for delivering on outcomes in their geographical region or with their registered populations. That can be done, we think, in a voluntary way. We think that the payment system needs to be relooked at. We need blended payments. We need incentives and we need outcomes-based funding. The development of those is very easy to say, but they are very hard to do well, and we would like to talk a little bit more about that. There needs to be a better way of funding the team that is required to do the multidisciplinary work. That is another thing that we have been working on.

The only other little hobbyhorses that we have are around the use of data and the fact that we need to have a continuously improving system. We need to be using the data that is collected. We have got it at national level and we have got it at local level. At the moment we have got so much data, but we are not actually using it in an intelligent way to improve what we do. We think that there is a really great opportunity there now. The other thing that we have become very interested in is the use of new technologies to really enable primary care to work smarter and not harder and to think about the use of technologies to identify people at risk and to triage people to the right sorts of care at the right time. All these things exist. It is just a matter of putting the different things together in the system to make it work.

Our research is around that and we see it very much as in the field of implementation science, which is very new in Australia. We lag behind Canada and the UK by a long way and we have developed links with those groups to start to do that kind of work here in Australia. Did you want to add to that, John?

**Prof. Furler:** No, I think that is fine. I think we are happy to speak to our submission and Jane's opening statement. We think that these recommendations that we have made, which we are happy to talk to, form the building blocks of a continuously improving system that is more effective and efficient and reduces waste and duplication. We think research can play a big part of that, but optimising clinical care is an important part of that as well.

**CHAIR:** Where is your research at?

**Prof. Gunn:** We have a variety of things that we can talk about. I think one of the things that I would say about where research fits in is that there is too big a gap between research and service providers in Australia. We have not got them working together closely enough. We should definitely, I think, this time around, with the implementation of Primary Health Networks, make sure that those service and academic links are strengthened because that is where we will get good cross-fertilisation.

Regarding the development of interventions, we do a lot of work around developing the interventions up so that they are ones that are going to be able to just go into normal, routine practice without a whole lot of effort. If we want to really change the system, it has to work with the workflow of how doctors and nurses and allied health people do their everyday work. If we are asking them to completely do things differently, it is not going to happen for a very long time. We spend a lot of time what we call 'optimising' the interventions so that they work in with the everyday. I think a good example would be the difference between what the national diabetes trial achieved, which was very expensive—

**Prof. Furler:** The Diabetes Care Project.

**Prof. Gunn:** The Diabetes Care Project. It was very, very expensive and, unfortunately, the outcomes that it yielded were disappointing compared with the work that John's team has done around diabetes, which has been really carefully worked up using the science behind changing behaviour and changing models of care to actually lead to health outcomes. Currently I cannot tell you all the results, because it is—

**Prof. Furler:** Hopefully about to be published.

**Prof. Gunn:** It is hopefully about to be published. But surely we can give a—

**CHAIR:** We look forward to it.

**Ms HALL:** But maybe you can talk about it—

**Prof. Gunn:** I can talk about it in a general sense.

**Ms HALL:** Yes, talk to it a little, please.

**Prof. Furler:** This is really a story about smart investment in primary care research and not just investing in the sequential building blocks of an important program in research but enabling research that is very close to practice, I think. So as a practicing GP, as well as an academic, I have worked in Indigenous communities and overseas in the NHS and I work in a community health centre now. I have my feet very firmly in clinical work, but I am also heavily involved in the research of the department. I have an interest in diabetes, a common and chronic condition. That forms a lot of the day-to-day work of primary care.

Over a period of years we undertook a small amount of qualitative work developing an intervention particularly focused around enhancing the role of practice nurses in starting insulin in general practice. This was a gap in practice; people with diabetes were spending many years with elevated blood sugar levels that could be much better controlled, reducing long-term complications and outcomes. A very simple, effective intervention in the form of insulin was not being used in a timely and appropriate way, so we thought we would experiment with a model of care where the nurses play a stronger role in that. So using existing resources, but through knowing the field quite well, we developed and piloted this model of care intervention. Some educational components and some mentoring and support for practice nurses by diabetes educators showed, in a small number of practices, that that was acceptable and feasible. And so we undertook a larger pilot study funded with some NHMRC money and some industry money in 21 practices with 92 patients and then eventually, with NHMRC funding, we undertook a randomised control trial in 74 practices. That has shown, statistically and clinically, significant improvement in blood sugar levels and control in the people who were in the intervention group receiving the care within this model of care. It took about seven or eight years to develop that program of research and we had to cobble together funding from many different sources, eventually succeeding with NHMRC funding.

There are two messages there: one is that the research was developed closely in collaboration with practitioners, nurses and GPs, so with a strong knowledge of the field. But we think there is a story there about the need to invest in sequential and developmental programs of research. I think we are now in a position where we are talking to primary health networks and the state department of health here about wider implementation of that model of care. It is a translational story building on implementation science.

**Ms HALL:** When your funding runs out, do you plan to find a separate source? I think you just touched on this.

**Prof. Furler:** The funding for the research has nearly run out—

**Ms HALL:** It has finished, yes. So once funding finishes—

**Prof. Furler:** For the research.

**Ms HALL:** and you find out that it is successful, is that going to just lay on the table, like happens so many times where a project has been found—

**Prof. Furler:** There are a number of elements to that. One is we have been back to the practices and some of the practices are generalising the model of care and sustaining their work within it. They are continuing to do it, basically.

**Ms HALL:** That is good.

**Prof. Furler:** The nurses work in this way; they are starting patients on insulin. They need to implement it more widely and provide the educational inputs and support from diabetes educators. It is a changed role for diabetes educators. They are not providing direct patient care; they are mentoring nurses to see patients and do this clinical work. So it is sort of a train-the-trainer rule. But to implement that more widely would require some buy in from state health departments, community health or the profession more widely.

**Ms HALL:** What is the role of the Commonwealth in that?

**Prof. Gunn:** I think it is funding nurses. I think one of the things that is a real need in general practice is in the primary care team. There is no doubt that the primary care nurse is a key part of the team. What you would like to see in 20 years time would be that every nurse in the primary care setting was actually trained to work in primary care, had accreditation to work in primary care and had undertaken specific training for that role, which would include this kind of thing. It would be what they would learn to do. At the moment, there are no requirements for primary care nurses to have a certain level of qualification before they work in primary care.

**Ms CHESTERS:** Therefore, they cannot get the specialisation in primary care.

**Prof. Gunn:** That is right. We developed a course to train primary care nurses many years ago because there is an obvious gap. We have had many nurses go through it, but small numbers in terms of how many nurses there are. They all find it extremely valuable. However, because nurses in primary care are not highly paid, it is very hard for them to afford to pay for their education to work in the sector. I think it is a real problem that could be addressed. If those things were addressed then you could have the workforce to implement these models of care that are developed

**Ms HALL:** Are you talking about nurse practitioners or practice nurses?

**Prof. Gunn:** No, they are not nurse practitioners. They are practice nurses.

**Prof. Furler:** In this work it was practice nurses. They were not prescribing insulin, but they were working in liaison with GPs in their practices to up titrate the doses.

**Prof. Gunn:** Because it was in a research project and funded, they were not doing it on the Medicare item number—the research project is funding that role.

**Prof. Furler:** In response to your question about the Commonwealth role for that, if you are considering bundling up payments for chronic disease on a capitation basis or a population basis, then really you need to consider the real costs of doing comprehensive diabetes care, for example, in general practice. That might include human resources costs, the nurse time and the sort of support that the nurse needs to put in to work with the patients through to do this sort of intensification of treatment work within that model. It probably costs more in the upfront but you will save downstream. You will get better control of sugar levels and other parameters in these patients then downstream you are saving enormous amounts in terms of complications.

**Ms HALL:** Will the savings be seen at the state level or at the Commonwealth level?

**Ms CHESTERS:** Both, you will not have to amputate the foot.

**Prof. Furler:** Certainly, preventable hospitalisations are state-borne costs, but I think on a population level they are experienced across the board.

**Ms HALL:** Can that be a slight problem in that the upfront costs will be borne by the Commonwealth and the savings will be returned to the states?

**Prof. Gunn:** Possibly. I think most of the money the states get for health comes from the Commonwealth—so it is all part of the COAG agreement isn't it? I think you would have to take it there and renegotiate. That is one of the barriers to integrated health care.

**Ms HALL:** Yes it is.

**Ms CHESTERS:** It is interesting where you mention about having the nurse at the centre and not so much prescribing the insulin but then also being able to administer it, because also with that would come the time in talking about eating habits, talking about exercise. Under the current service fee GP model that is not funded—

that extra time it takes to really manage chronic disease, it is the one-on-one changing behaviours. Our current system does not really allow for that.

**Prof. Furler:** Obviously, the Commonwealth invests in practice nursing already. The resource is there in a sense and it is partly providing the evidence about what sort of work practice nurses should be doing within the primary care team.

**Prof. Gunn:** It has not invested largely though. It has removed investment, it has reduced investment. They used to invest more, but it has reduced investment—I am not quite sure why.

**Ms HALL:** I know my GP practices love practice nurses. They love them.

**Prof. Furler:** Absolutely, they are the fastest growing sector in the primary care workforce. They are fundamental to doing this chronic-disease work in general practice.

**CHAIR:** If the committee comes up with some recommendations from all the evidence that we are going to take over the next four or five months and we come along with a model—it is pretty hard in the health industry to get people to all agree—how do you think we could try drive that? Who will be the driver of that model? Do you think the federal Department of Health would have to drive that model or the government through legislation? The implementation of anything that seems to be good and works takes a long time to get implemented. In all the research that you have been doing, have you seen other models implemented overseas, and what drove those implementations?

**Prof. Gunn:** There is the opportunity to think about some innovative ways of funding chronic disease management in general practice. That could be within existing funding models like the practice incentive payment type scheme. It may be a slightly different version of that that you would look at: with, say, John's example around the general practice, looking at what proportion of people with haemoglobin A1c out of range are on insulin. That is going to the detail, too. It is really important that the indicators that you choose for seeing whether the model of care is working or not are really carefully constructed. They are difficult to do well but they are not impossible. So you would construct a key performance indicator that really was the end point of saying that to get to that indicator you could get there any way you like, but the easiest way to get there would be having the nurse involved in the management of insulin and rolling out the program that John's team has developed.

Practices can be rewarded in two ways: capitating a fee for the number of people they have with diabetes so that they get a payment per head or per capita, but then supplementing that with an incentive payment for the fact that they have managed to get however many people out of range onto insulin, and therefore they reduce their out-of-range pool. So I think it is this balancing between just giving payments that might lead to unintended consequences where you actually end up benefiting from having large numbers of people unwell, which you do not want. You want to drive it towards the fact that you are getting those people well, rather than just giving them money to look after large numbers of people that are unwell. Does that make sense?

You can use incentives and funding models, and the other thing that I think is also very important is feeding back data in a very systematic way to the practices so that they see themselves against others, because, inherently, most general practices have GPs and nurses and staff that work in them who want to do a really good job. They care about the outcomes for their patients and we are very lucky to have that workforce; they are really motivated. They like to see how they compare to others and they like to take part in quality improvement processes. I think we need to start to recognise that this is work that is valid and also takes time and money, and the reason that a lot of practices do not do it well is that they are not funded to do that in any way, and so it is difficult for them to do it well.

**Prof. Furler:** As we have said, those are two important building blocks: judiciously chosen, quality outcomes types of frameworks—in the UK they have done it on a larger scale, and that can drive change practice—and good quality use of clinical data and routine feedback to practices. We need to invest a bit more in our data systems.

**Prof. Gunn:** And they need to be reliable. Personally, I think that there is a lot of data that we collect at the national level that could be fed back to practices. It already happens around prescribing, and that has happened for a very long time, but I think there is a very big opportunity to do feedback to practice at a national level as well as the local level, where the practices themselves are doing very micro feedback on exactly what they do. Having some national figures would enable you to see where you sit nationally.

Having said that, the other really important part there is that there is going to be variation in practice. Some of it will be necessary and understandable variation and some of it will be unnecessary. That is another very complex area that requires deep knowledge of the clinical content and the context of the practice, and it needs to be done with the profession so that they are not thinking, 'Oh well, I'm not going to go and work in a really

disadvantaged area because my figures will be really poor and I will be punished.' So you have to do it so that that is—

**CHAIR:** A bit of weighting.

**Prof. Gunn:** A bit of weighting.

**Prof. Furler:** You can weight the payments or you can set indicators that are sensitive to the baseline achievement of a practice. If a practice is working in a very disadvantaged area with a population with fewer resources, lower health literacy and greater difficulty in achieving good quality outcomes for chronic diseases, then their baseline measures will be lower. But if a practice can make a step, then that ought to be incentivised as much as a step up from a high level to a subsequently higher one. Setting those indicators in a very smart way is important to avoid disincentivising people to work in disadvantaged areas.

**Prof. Gunn:** But that is a really complicated area that is worth a lot of thinking. It will continuously need to be improved. It will not be easy. If you look at the UK, they do not get it right. We know people well who were part of the setting of that. They need to continuously go back to look at them, to tweak them and to get rid of some.

**CHAIR:** We can learn from other people's achievements.

**Ms CHESTERS:** Let's also be honest, too: this is not just a challenge for health care. While this inquiry is about chronic disease, we highlight that rural areas and low SES areas—where we are most at risk and have the highest rates of chronic disease—are also the same areas where we have the highest rates of numeracy and literacy issues, the highest rates of problems with drug and alcohol and the highest rates of family domestic violence. These communities are struggling across the scope. Perhaps there could be more integrated work across education and across the police and community services.

**Prof. Gunn:** That is really an area growing in terms of need—the outer metropolitan regions of our major cities. Those regions are really struggling for workforce quality practice. We know from our medical students who are placed in these settings that there are a lot of challenges in the fringes of our growing metropolises.

**Ms CHESTERS:** I just noticed that the role of private health insurers in your submission, and the two-tiered system. Something that has just dawned on me is that will you have physios move into an area where there is a high number of people on private health insurance, because they can have a number of private patients—and, also, they might have public patients. They are not going to move out to Broadmeadows if there is a low number of people on private health insurance.

**Prof. Furler:** The idea of equity based weightings and incentives has, again, been used in the UK to incentivise practitioners to work.

**Ms HALL:** I think that is something for us to keep in mind, don't you, Chair?

**CHAIR:** Yes. Thank you for coming in this afternoon. We really appreciate your time and your submission. If you are asked to provide additional information, could you please forward it to the secretariat by Thursday 15 October. If committee members have any further questions, they will send these to you in writing through the secretariat. But if you have any other information, like a report that is coming out soon and that you think would help us, we would love a copy of that. If you could forward it to the secretariat, then that would be great.

**Ms HALL:** And maybe some more information on equity base loading. That would be of value to us, I think.

**Prof. Furler:** I will do that before the 15th.

**CHAIR:** We will now suspend for a brief break.

**ATHAN, Ms Sophy, Chair, Board of Governance, Health Issues Centre**

**VADASZ, Mr Danny, Chief Executive Officer, Health Issues Centre**

[14:48]

**CHAIR:** I welcome representatives from Health Issues Centre. Do you, as witnesses appearing before the committee, have any objection to being recorded by media during your participation in this hearing?

**Mr Vadasz:** No.

**Ms Athan:** No.

**CHAIR:** I will take it that you have read the card on parliamentary privilege.

**Mr Vadasz:** Yes.

**Ms Athan:** Yes.

**CHAIR:** Would you like to make a short opening statement to the committee?

**Ms Athan:** We are delighted to be able to have the opportunity to come and speak with you today. Thank you for giving us that opportunity. Obviously, we have put in our submission.

We are a little bit different to some of the other organisations that have come today, because our focus is on consumer issues and how to engage effectively with consumers. One of the premises for a lot of the work that we have been undertaking recently has been about how to engage consumers effectively to bring about improvements to the health system and, as a result of that, to bring about better health outcomes for patients and consumers—and, hopefully, as a result of some of that work, to achieve efficiencies, as it would bring about some realignment of some of the programs with some of the funding around what happens with the patient experience.

Ultimately, we would like to see a system which engages the consumer at the very beginning of the process, throughout the health journey and to the outcome for that particular consumer, or groups of consumers, especially when we talk about chronic disease management. It would be critical for any kind of patient who might be defined as being vulnerable to developing a particular chronic condition to be part of the conversation around how a particular model would help to achieve prevention, and, where this prevention has not worked long term, in how to maintain that level of wellness over a period of time rather than ending up having presentations and acuity at the end of that process. That is what we have been working towards: gaining the effective engagement of consumers—we use the broad term 'consumers' for patients—and carers to ensure that they are part of the conversation. If we want to solve issues around health and the health budget, which is exponentially growing, we need to take on board and engage consumers and the community to be part of the solution.

**CHAIR:** Did you want to add to that, or just leave it at that?

**Mr Vadasz:** We will leave it at that.

**CHAIR:** What challenges do consumers who are receiving care for chronic conditions encounter in the current Medicare payments system, and what steps should be taken to ensure that there is an integrated approach to chronic disease management?

**Ms Athan:** You would like me to outline all of the issues?

**CHAIR:** Could you give us an overview. Do you deal with a particular chronic condition, or do you deal with all chronic conditions?

**Ms Athan:** All chronic conditions. We are a generalist organisation rather than a condition-specific one. I can speak from my own experience and involvement with a range of other organisations which I have brought to bear on my role within the Health Issues Centre—

**Ms HALL:** Before you continue, could you tell us a little bit about your organisation. Is your organisation made up of members? I do not quite understand the way you work. Is it like the Consumer Health Forum?

**Ms Athan:** It is similar to the Consumer Health Forum. The organisation has been established since 1985. It has a membership base of consumers. Service providers can also become members.

**Ms HALL:** Peak bodies plus consumers?

**Ms Athan:** Peak bodies plus consumers.

**Mr Vadasz:** Correct.

**Ms Athan:** The membership elects a board, and the board effectively manages and runs it according to directions that have been determined by the membership. At its annual meeting, which is happening in a month's time, it will make determinations and then report back. It is no different to any other organisation.

**Ms HALL:** What kind of staff cohort does it have?

**Ms Athan:** The staff cohort?

**Ms HALL:** Yes. What kind of people?

**Ms Athan:** We have people with different types of expertise who work within the organisation. We do a little bit of policy work. We do a little bit of engaging with particular service providers to assist them working with consumers. We have an understanding. We work with the Department of Health and Human Services to provide strategies for better engagement with consumers and on how the department works and provides funds across the board within the state—with the acute sector, for example—and community advisory committees. Also we do quite a bit of work within community and primary health with the Primary Health Networks, which used to be the Medicare Locals. We also work with community health centres. We provide partnership relationships in terms of developing effective consumer engagement frameworks. Would you like to add anything?

**Mr Vadasz:** Only that part of our expertise, as Sophy indicated, is based on content expertise. But our differentiation is that our expertise is largely based on soliciting the views, needs and interests of consumers and representing those.

**Ms HALL:** And then developing policies and partnerships around that.

**Mr Vadasz:** Correct. To a large degree our role is really to synthesise and echo the opinions, positions and needs of consumers, rather than to—

**Ms HALL:** provide services.

**Mr Vadasz:** Correct.

**CHAIR:** Experience-based policy.

**Mr Vadasz:** Yes.

**CHAIR:** How are you funded?

**Mr Vadasz:** Partly through the state government, through DHHS, but also, significantly and increasingly, through our own fee-for-service services. We provide consultancy, development of frameworks, training capability development. We run the only accredited training courses in Australia on consumer leadership and consumer engagement for health professionals.

**Ms HALL:** That really clarifies it for me. Sorry for interrupting.

**CHAIR:** That is fine. To go back to my question: what are the challenges that are faced by people who have chronic disease in finding their way through the system or developing a good management plan for themselves? That way we are talking about challenges not particular diseases.

**Ms Athan:** What we know and what we hear from consumers and their carers depends on the particular chronic condition. However, let's assume that it is uniform across the board with all the different types of chronic conditions. The issues are around the fragmentation of the system, the lack of effective care coordination, the lack of clarity around the pathways. It means, at the end of the day, that the consumer has to stumble or find their way through the system to try and maintain a level of wellness within the particular condition they have, within the diagnosis of what that been given—and also the medication and treatment and what they need to do to work with the health system.

Consumers are often unclear as to what they have been told. There are issues around the level of literacy and understanding around the complexity of what the condition is and how it impacts on the individual's health. There is a misunderstanding at times between what the professional clinician is saying and what the perception is and what the person is receiving—for example, with diabetes. You are told a range of things, but what you hear is: if you take this pill, you will be okay. Therefore, diabetes is a condition that is fine and okay to manage as long as you take that pill. In effect, we know that that is not strictly speaking correct. It is much more complex than that. The system itself is not geared to have improved coordination and integration around the particular condition and around the needs of the individual. It also does not take into account the living experience of that person. We were talking about social determinants before. They really impact on individuals, depending on their level of capacity to manage particular things around the particular issue. If you have a mental health issue and you also have a chronic condition, say cancer, and you are recovering from cancer and you are also at risk of homelessness and you also have limited income, there is a whole complexity that adds to the issue of how that individual manages and travels through the system.

The system does not seem to take into account any of those issues. Also, over and above that is that even the support person for whoever needs support that individual is not adequately supported. They are not part of the conversation and the solution to ensure that that person is able to navigate through the system through at least having a support person working with them. There are a whole range of things, including the complexity of pharmacology and medication and the implications around which drugs can counter other drugs and the side-effects of some of those things and how they impact on each other. There is a lack of understanding in terms of what they might be taking, how they are taking the dose, the frequency, the time it is taken—there is complexity around all that. It is about how you manage. In order to manage, you need to be in a partnership, to have full understanding and to understand what the implications are in terms of whether you do or do not and what the choices and options are. Often what people are presented with is not as clearly perceived by them as having been given an option. They just seem to hear—and it does not mean that they are being told—that this is what you have to do, and so they follow that particular path.

Other things that can be cumbersome and difficult for people are travel, isolation—if you are further out in rural areas, how do you come in?—and the multiplicity of testing that can often be done repeatedly. Often there is

inadequate reasoning as to why an individual who is frail and older has to repeatedly have some of those additional testings that have to happen for them. I know from my own mother how we had to travel through all of that and how, unless you ask and get an explanation and then you get a review, you might find that you are automatically doing a range of things that maybe you should not have been doing. It causes you stress as a patient but also puts you out of pocket because you still have to fund or pay a gap or whatever it is you have to do. Also, you have to find yourself coming in and coming out, and the more chronic, the older or the more disabled you become, the more difficult it becomes to travel through what I call the meanderings of what the system provides.

**CHAIR:** It sounds like our labyrinth issue again.

**Ms Athan:** Doesn't it?

**CHAIR:** What about outcome expectations? Do you think the patients or the consumers have an adequate understanding of what the outcome expectations of their treatment or their management plan are? Do people think, 'I'm going to be cured,' or do people think, 'I'm going to live with this'?

**Ms Athan:** There are two levels. One of them is that there is an idealised impression out there which says: 'Doctors can cure everything, and as long as I do this, that, that and the other, I will be cured.' Therefore there is a misunderstanding around it not being an absolute science. It is actually the best we can give and offer at the moment for a particular condition. So there is a lack of understanding. As I said before, some people think diabetes is not a terminal condition, is not as complex and has not got as many side-effects as it actually has, for example. What else can I say here?

**CHAIR:** It is just those outcomes, is it—

**Ms Athan:** There is a difference between, 'Did I get cured or not?' and 'I had a terrible experience, even though they have removed the lump.' They removed the lump, but gee that was a dreadful experience. So there are two levels of expectations. One is how I was treated from the moment I was diagnosed to the moment I got discharged, and the other one is, 'Did I get treated and, if I got treated, what does that mean?'

**Ms HALL:** Outcomes can be different for different people or for different people involved in the person's care.

**Ms Athan:** Absolutely.

**Ms HALL:** The outcome for the person could be different to the outcome for the system, and then it is about looking at trying to get probably an optimal outcome for everybody, but taking the person with them.

**Ms HALL:** In your submission you talk a lot about consumer- or person-centred, and it is all about the person and providing information. My big question is: how can you ensure that the consumer is really informed when it comes to your outcome as well? It is being informed about what is happening to them and, by them understanding completely, the outcome for them is determined by exactly their understanding or perceptions of where they are at, and then you have the outcomes that are determined from the perspective of government.

**Ms Athan:** It is a very complex area, because at the moment the way we spend time, with the way time is allocated and paid for between the patient and the provider, is not as generous as it could be in explaining to the patient so they are clear about the options. Often a patient will agree as a result of not fully understanding—which is what we are talking about—and get an outcome that the data and the statistics say is a great outcome, technically speaking, but that the patient does not experience as a great outcome. They might decide, 'If I had known what I know now, I wouldn't have made that choice.' I have an example at the moment where there is a person who is grappling with advanced diabetes, and there is discussion around amputation of a leg. The person is not clear about the implications of doing it or not doing it. They seem to think that they have no options in terms of whether to do it or not to do it and what would happen afterwards. There is not a conversation around what you do if you do not actually do it, what that means, what it means for quality of life afterwards and how it will impact on you as an individual and your life choices. These conversations are very difficult and do not really occur as much as they should, which means that at the end of the day the data does not actually capture the experience and the outcome for the patient.

**Ms HALL:** We have heard a lot today about having a multidisciplinary approach. We have heard a lot about it being GP led, we have heard a lot about it being allied health led and we have heard about it being nurse led. From the person's point of view, what determines which is the best approach? Are we talking person-centred? Does it change according to the different place that person is in at a particular time? Is there one approach that tends to be better for the health consumer?

**Mr Vadasz:** It can vary with the consumer let alone with the condition. Some people do not want to manage their own health and would prefer to have external expertise make the decisions for them. The important thing

that we are saying is that they deserve to be given that choice. In terms of looking at comparative expertise, no-one is suggesting that the specialist expertise of health professionals should be diminished in anyway. We are simply saying that we need to acknowledge that people are the best experts about their own holistic existence. In terms of a good chronic condition management strategy, we need to start thinking of individuals as the objects of that process not the subjects of that process. It should be something that they are active participants and partners in, not something that is done in their best interests.

**Ms HALL:** Done to them rather than them being informed. The secret is how do you inform? How do they get that information?

**Ms Athan:** It is a little bit more than information. It is actually: I make decision about myself and I take responsibility for that. So—rather than having allied health, a nurse practitioner, a GP led clinic, or whatever it is that is doing the coordination—I need to be an active member of that team so I can say, 'You might be suggesting that, but, for me and my circumstances, this is not going to work, so what else can we do that will work for me?'

**Mr Vadasz:** That is right. It is making decisions not just on the basis of treatment options and consequences of treatment but on the values and goals of individuals, which sometimes run counter to best medical outcomes.

**Ms HALL:** The optimal position is that the person themselves is the coordinator at the centre of the multidisciplinary team—

**Mr Vadasz:** With assistance.

**CHAIR:** As long as they understand the consequences of their decisions and they have them explained to them.

**Ms Athan:** Yes, that is it. To take responsibility for my decisions, I need to have a good understanding and I have to have the opportunity to receive that understanding. Health has become a lot more complex. From twenty years ago to today, technology has improved and enhanced. There are a whole range of things that happen now so that a consumer, the very first time that they come across a health system, may not have a full understanding of all of the implications of how it all works. We talk about patient centred care, but in practice it could be improved significantly so it is really patient centred or consumer centred.

**CHAIR:** Is there anything you want to add to that at all?

**Mr Vadasz:** No, I think Sophy has done a very thorough job.

**Ms HALL:** Great submission.

**Ms Athan:** I am a firm believer that if we work with consumers effectively from the very start of the process when they engage—before they even engage with health services—at the end of the day it will achieve efficiencies. It will achieve savings, because often things become established, and they continue for whatever reason that they continue. People think it might be we are seeking more money but patients do not. They want what is better for them and what is simpler for them, so there are some savings there as well.

**CHAIR:** Is there any input from private health insurance people? Do you find they tend to step away, in your patients' experiences, or do they come in and assist?

**Ms Athan:** It varies. We hear of some cases where the private health insurer would contact or communicate with particular consumers who have chronic conditions and say, 'Maybe if we subsidised you for some allied health and physio or this or that, that might alleviate having further presentations.' So there is a bit of that happening out there.

**CHAIR:** That is good to hear. Thank you for coming along today. We really appreciate you coming up and giving some evidence.

**Ms HALL:** And a different perspective, too.

**CHAIR:** A totally different perspective, yes. If you have been asked to provide additional information, could you please forward it to the secretariat by 15 October 2015. If the committee has any further questions they will send you these in writing through the secretariat but, if you feel there is anything else that could assist our inquiry or our report, please feel free to forward it to us and let us know.

**Mr Vadasz:** Thank you.

**Ms Athan:** Thank you for the opportunity.

**CHAIR:** Thanks, Sophy, for opening up. It was great.

**JONES, Mr Matthew, Chief Executive Officer, Murray Primary Health Network**

**LYON, Ms Anne, General Manager and Acting CEO, Primary Health Services, South East Melbourne Primary Health Network**

**TRETHOWAN, Mr Jason, Chief Executive Officer, Western Victoria Primary Health Network**

[15:11]

**CHAIR:** I call the representatives of the health networks. Do you, as witnesses appearing before the committee, have any objection to being recorded by the media during participation of this hearing?

**Ms Lyon:** No.

**Mr Trethowan:** No.

**Ms Jones:** No.

**CHAIR:** Have you read the card in front of you in regard to parliamentary privilege?

**Mr Trethowan:** Yes.

**Ms Lyon:** Yes.

**Ms Jones:** Yes.

**CHAIR:** Would you like to make a short opening statement to the committee?

**Ms Lyon:** I have provided a summary of our submission that was circulated prior to the committee proceedings.

**CHAIR:** It is going to be circulated now.

**Ms Lyon:** We, in the South East Melbourne Primary Health Network, have built on work previously done in our catchment, and have a number of initiatives that we will seek to further develop over the coming year in addressing chronic disease management. That would include a partnership with tertiary hospitals that proactively targets people with emerging morbidity and who rely very much on acute services. This model will rely on a team-based approach to support independent living for those with chronic and complex conditions. A further development for us is a web-based application that allows people in our catchment to access real-time advice at the nearest medical facility available to them, and thus assist them in making other options in an acute facility to address their health needs. We have also done some work in the mental health area, providing mobile support to patients with acute and enduring mental illness that can be addressed in the community. We have also done a lot of work in the area of health literacy and that will be a key focus for us in the future. It is aimed at providers and also consumers, so they have better skills to navigate the health service system.

**CHAIR:** What challenges are there for the primary health networks in filling the treatment gaps in treating chronic disease? How can primary health networks encourage services providers to fill these gaps rather than providing those services themselves?

**Ms Lyon:** I think one of the big challenges is coordination of care. While Medicare provides for team care arrangements, often the coordination of that care is the stumbling block. We need a better system of facilitating team based approaches to care where not so much the responsibility but the effort is shared amongst the team. What we have heard from our general practitioners in our area is that they are often tied up with a lot of paperwork around team care arrangements. I think we need a better system that facilitates a sharing of that practice.

**CHAIR:** Lisa, do you have any questions for Matt?

**Ms CHESTERS:** It would be for the entire group, because you are representing areas of low SES as well. It does not matter whether you are metro, outer or the regions, SES is an issue in access to health care. You are now responsible for helping to coordinate larger areas. I have two parts to my question. The first part is: how are you going, now that you have a larger area that you are trying to integrate and help manage the health partnerships and relationships. How is that going, specifically with regard to chronic disease? The second part is: we know that life expectancy in these areas is less than in some parts of metro. Access to health education, particularly in the space of chronic disease, is one of the factors. What kinds of resources do you believe we need to help get on top of that?

**Mr Jones:** Thank you for the opportunity to speak. Chronic disease management is a particular area of focus in our role as Primary Health Networks. In answering your question, Lisa, a major element associated with the change and transition from Medicare Locals to Primary Health Networks has been the increase in the economy of size and scale. So our primary care coordination efforts are not just looking at individual health service

improvements but looking at systematic change and system improvements across a large region. It offers opportunities of how the health providers can work together, as well how the system can be more integrated and coordinated. The role that we provide in that has been, I think, really well recognised by providers of health services and general practice in the main across our catchment regions. So there are great opportunities in both how we will work with the individual health services and how the individual health services will be more connected across the whole health sector. That is never more apparent than in chronic disease management.

As you have identified, there is a strong correlation between low-socioeconomic groups and disproportionately higher rates of chronic disease. So being to be able ensure that the system is responsive to that, that health providers are working in a coordinated and integrated way, is, I think, a really strong focus of it and an initial area of attention for us as Primary Health Networks.

**CHAIR:** How do you do it?

**Mr Jones:** There is no one magic solution, because if there were it would have already been introduced. It does require engagement and collaboration with existing service providers, but you need more than just harnessing the willingness to work together. We need to have resources and tools that facilitate greater integration. There are a number of activities and initiatives that Primary Health Networks are involved in, particularly in things like health pathways, that enable the utilisation of information that ensures quality clinical care as well as integration of referral options and connection with the range of services.

But I think, importantly, you also need incentives. You need to be able to ensure that the health system is responsive in ways that better improve coordination and integration rather than just expecting it to magically occur. We have got increasing rates of chronic disease. We have got increasing costs in servicing the health system. The way in which we should be addressing that is by trying to make sure that people in the community are healthier for longer. That requires people to manage their own care, particularly for those with chronic disease, and working with their health provider so that the health provider is connected and incentivised to ensure that the patient is able to access the level of care that keeps them healthier for longer in the community.

**Ms CHESTERS:** Part of the challenge that we have in some of our regional areas is that there might be a number of agencies that have limited amounts of funding to deliver some health services. Taking podiatry as an example, in an area like the Macedon Ranges or Heathcote, there might be three or four agencies that have funding for half a day or one day a week, but if you put it all together you might be able to have a full-time podiatrist in that area. Have you had any experience in negotiating, coordinating and pooling those resources—say, the St Luke's part, the local GP part and, if you have some funding, the community health part? Have you had any success?

**Mr Jones:** We have in being able to take that helicopter view of the health system and, within a community, what services are available. I think a big change will be the introduction of the commissioning role that Primary Health Networks will play from 1 July 2016, based upon identification of needs and then commissioning health services to specifically ensure that services are available and, in addition, ensure greater coordination and engagement of those services that are available for those specific health needs. In the context of Medicare Locals, there were some initial efforts and preliminary steps in that direction. I think the introduction of Primary Health Networks offers greater opportunity for that, not only with the capacity to engage but, as I have been suggesting, with incentivising health services to ensure that those services are available locally.

**Mr Trethowan:** I would like to add a bit of additional context to what Matt was talking about around Primary Health Networks. Obviously, this Standing Committee on Health inquiry is a really important one. It is also happening at the same time—I know they have different purposes—as the Primary Health Care Advisory Group, set up by the minister. There is a Medicare Benefits Schedule review set up by the minister. There is also a national mental health report that was tabled with the minister in November 2014. Hopefully, that will receive a response by the end of this year around what will happen in relation to mental health from 1 July 2016.

You add up those various fact-finding missions and detailed reports, and the Western Victoria Primary Health Network has provided a report to you. When I reread that and read another one from a local general practice about wellness coaching in general practice, I guess what I see is a whole lot of really good ideas, a lot of wants and a lot of examples of what can work to improve chronic disease management and, ideally, prevent chronic disease. I do wonder how all this comes together, but there is an opportunity for government to, first of all, acknowledge the federation white paper's response and what was considered in it. That was looking at regions as the new model for getting the most efficient bang for your dollar and also getting the most insightful decision making that you could possibly get around where funds ought to be directed, to whom and for what reason, and have local accountability. The mechanism at the moment, I guess, for the structure and policy in the context of the federal government is around Primary Health Networks. By no means are Primary Health Networks a be-all and end-all,

but they will be effective if they are partnering and very conscious of what is already in existence in local communities.

Going back to what Matt and Anne were saying, everyone will have differences. We did work around access to diabetes education services. We set up a telehealth model which was more equitably distributed across rural parts of the Barwon region as a former Medicare Local. That is just one example and we could list more. But, with structures that are going to be in place across Primary Health Networks—community advisory structures and GP led clinical councils—there is an opportunity, with the commissioning role of Primary Health Networks, for not just funding services but funding models in response to inequitable access to health services, particularly in rural communities and communities of low socioeconomic status. It is one thing to say that Medicare is there for everyone. It is, but, when you are a GP in Murtoa generating a care plan for someone with diabetes, that is great but you need to have access to the optometrist, the diabetes educator and the podiatrist, and they are not always there. The mal-distribution of workforce drives a continuation of inequitable access to services and poorer health outcomes.

So I would encourage this committee to actually take a step back and acknowledge all the great stuff you will hear about what should be done and what ideas we all will have, but look at it from a structural point of view. Regions will know better, and, if they do not, they need to build their community advisory to understand what is going on, and have clinicians with them side by side, make better decisions and get on with it.

**CHAIR:** If the committee comes up with some recommendations, how do you see that would be implemented?

**Ms HALL:** Correction: when the committee comes up with some recommendations!

**CHAIR:** Some people might say they are good and others might say they are bad, because you get differing views within the health industry. The roadblock to or difficulty in coming up with some good recommendations is sometimes the implementation of those recommendations—the liaison with, say, the department of health in implementing those recommendations. Have you seen evidence before of good performance in that area?

**Mr Trethowan:** Yes. Our success has been more so when we have not been told by government to do something. The example Matt used before around health pathways was taken out of when the Canterbury district of New Zealand went live two years ago. That was looking at extensive waiting lists to see paediatricians and orthopaedic surgeons. And what are you going to do about that? Add another outpatient clinic or watch another private medical specialist come in, which adds to the expense through the MBFs—at least that is the current argument, which is not really for today. But if you could actually have better coordination of services locally, because most of the chronic disease management that takes place in Australia is in private businesses. They will do what they will do, and funding will dictate behaviour and it will impact on whether or not you get access, or what cost there will be. So at the local primary care level it will work if the government actually says, 'We have so many silos of funding and maybe we are adding to the fragmentation of care in local communities.' It does. It promotes it.

**Ms CHESTERS:** Can I just pick up on the point about private management of a lot of it. That is because people have private health insurance.

**Mr Trethowan:** No, I am talking about general practice and general practice at a private physio clinic, an optometry clinic and a podiatry clinic. So I am not talking about private health insurance. It is more about community based services. That is what I particularly meant.

**Ms CHESTERS:** One of the things we have had come up today concerns coordination. Who coordinates the care for somebody in regard to their chronic disease management plan? Who funds it and how does it get funded, whether it is a GP, a practising nurse or a clinic? Some of our smaller clinics where there are integrated services in the one building just do it out of their operating grant or whatever. There is no actual Medicare number of whatever it is. So how do you fund that coordination role, because that seems to be pretty critical to chronic disease management?

**Ms Lyon:** That goes back to some eye-opening remarks. I think that is a real gap, and it is often left up to the GP. Is that the best use of the GPs time, skill and expertise? Possibly not. So those team care arrangements need to be better structured and better incentivised—step back and look at them. Picking up on some of the system-level things, I think what we often find on the ground is a bit of a policy and funding run of Commonwealth-led initiatives and state-led initiatives. I think the opportunity for the primary health networks has probably never been better for working more with state governments. Many of the services that we will find on the ground are state funded, particularly here in Victoria. We have a particular model around community health services that are

primarily state funded. There is a wonderful opportunity for us to work closer with the state government through our dual funding streams.

**Ms HALL:** How do you think that division of services between the state and the Commonwealth impacts on the management of people living with a chronic disease?

**Mr Jones:** Fragmentation certainly exists. It is probably a bit of a misnomer to call the health system a health system as it is a collection of providers funded either by the public or the Commonwealth and state governments. There is public and private in all of that mix. So there is a collection of different providers, all with patients' interests at heart, but there is no real capacity for coordination. We believe that primary health networks are in a really strong position to facilitate greater coordination and greater integration. But it is true, in terms of the funding and responsibilities coming from different parts of a federated system, that the communication between the providers and the understanding from the patient in terms of what services are available and how are very fragmented and require greater coordination.

**Mr Trethowan:** There will be many examples where the coordination is done extremely well by nurses in general practice in partnership with their GPs and it works quite well. Where it may not work is where there is limited infrastructure, so they cannot expand their provision of services. They can form virtual teams in primary health care, but where the Primary Health Network can come into play is to look at where there are gaps, perhaps, in coordination—and that is really a major gap—such as what the wrap-around services are that are needed to keep people well and out of hospital, ideally, or if only you could have an extra nurse who may be a coordinator between three or four practices and linked in with the community health centres, or basically having a bit of a helicopter view of who is getting services where and what the waiting lists are, or, again, what the workforce distribution issues are. So I think there will be examples where it works well and where it does not, where perhaps there is market failure or where there is just a lack of collegiality or relationships at the local level—do not underestimate that. Having someone at the middle ground to actually help with that would be really good.

**Ms Lyon:** Yes. I think another aspect of chronic and complex disease management is the opportunity for secondary prevention and secondary consultation with a specialist service. That enhances the capacity of GPs to better respond, particularly to those patients with two, three or four chronic conditions and where they have an emerging complexity. So having a system that facilitates that sort of management I think will enhance the outcomes for patients.

**Ms HALL:** I have a couple of questions coming from this pamphlet that you handed us a little while ago. In it you say that there are many opportunities to reduce high in-hospitalisations and improve the care and prevention of illness in the primary and community centres. Would you like to expand on that?

**Ms Lyon:** I think for us in our respective networks, our needs assessment will tell us where the higher prevalence of hospital admissions is coming from. We will then be able to work with practices on their data to facilitate better coordinated care for those patients and options for treatment outside of an acute setting.

**Ms HALL:** Have you got a model for doing that?

**Ms Lyon:** We have started work on an integrated chronic care service and we have been working with Alfred Health around that and with their general medical unit to work up a proposal. So we have almost got it to a proof-of-concept stage. One of the things that would facilitate that model is better e-health and also an appropriate funding model to support that. So it will bring the specialists into play with GPs and allied health providers to do a wrap-around service around the client, particularly for those ones if the chronic care model looks at whole-of-population, emerging chronic disease, those with three or four different chronic diseases and greater complexity, and it is targeting those particular patient cohorts.

**CHAIR:** Just on that, have you had any experience with the CarePoint trial?

**Ms Lyon:** It is in our area and we sit on the committee, so it is really just starting to get legs.

**CHAIR:** How is it?

**Ms Lyon:** It seems to be going okay at the moment, but I do not have firsthand information.

**Ms CHESTERS:** We also mentioned the gaps and the gaps in the resources. You would be well placed to know where those gaps are because you have got the snapshot about what is going on. A community gym is an example. It does not necessarily get funding, yet we know in some small areas it may be the only gym and it is really important for strength training to help manage chronic disease. Is it having access to funding capital to be able to say, 'Well, here you go, Inglewood. Here's the treadmill and what you need to build the community gym so you've got access to that'? Is that as practical as it gets?

**Mr Trethowan:** Yes. I will give you one example. In Geelong, Eastbrooke medical centre received a \$300,000 primary care infrastructure grant a couple of years ago to put that into place. They put a gymnasium in there for strength training, for all the good reasons we understand, and only a few months ago a neighbouring gymnasium at a community centre had about 400 clients who were survivors of cancer. They were patients with multiple morbidities and I guess high obesity rates in that group of 400—not the ones who want to go to a mainstream gymnasium. That, for all sorts of reasons, closed and the Eastbrooke Medical Centres clinic, which was around the corner, took on the bulk of those clients and with a little bit of help from the Primary Health Network extended the gym to allow for more capacity. From a social connectedness point of view it maintained people's social connections. Most of the participants in the program are over the age of 70 and it has worked really well. It has maintained their enthusiasm for strength training. It is a really good example of where, just with a tweak, they could ensure that the community still had access to these facilities. It is a really affordable example that is doing some really good things with parts of the community who just do not do mainstream gyms.

**Ms CHESTERS:** If you did not make that grant available, what would have happened?

**Mr Trethowan:** There would be 400 people who did not have access to a gym. State and federal MPs were lobbied, as you would all appreciate, all of whom felt pretty powerless and did not know where to go and how to get money, and it was just through a local connection with the Eastbrooke Medical Centres clinic that Primary Health Network linked in with a couple of players in Geelong and it happened. They would say it would not have happened without the Primary Health Network; I would say it would not have happened without Eastbrooke Medical Centres and also the grant that was provided some time ago.

**Ms CHESTERS:** What would have happened to those chronic disease sufferers?

**Mr Trethowan:** You would have seen a rapid deterioration in their health, you would have seen them socially isolated, you would have seen them in hospital and you would have seen unnecessary use of hospitals and probably premature death.

**Mr Jones:** It is not only the provision, the opportunity that that grant provides that can then enable the provision of those services, but it is the connection with the health system. The Primary Health Networks can facilitate more referrals and ensure that these types of services are not just available to those who actually know but are shared, enabling greater accessibility for those clients across a range of different health services too. There really are not only some spinoff benefits directly for that health service, those patients, but also connectedness with other parts of the health system. Then it provides opportunities for that to be seen as examples in other areas as well. Just putting the service in place is useful and obviously provides some benefits but then ensuring it is part of the health system is the really important thing.

**CHAIR:** Was that just a capital grant?

**Mr Trethowan:** Yes.

**CHAIR:** Who posted the ongoing?

**Mr Trethowan:** Eastbrooke Medical Centres posted the ongoing. There was no increase in fees for the clients who were already using the other gym.

**CHAIR:** Are they still paying a fee?

**Mr Trethowan:** They are still paying, but that is alright. It certainly did not prove to be a price signal that prevented them from coming back. There is another example I saw in Horsham, the Goolum Goolum Aboriginal health service there. They have got a gym co-located with their clinic and other services and, again, they were just talking up the benefits of their patients and their community coming together in a place which felt less like a health service and more like a wellness system. It was good.

**Ms HALL:** Your Primary Health Networks all have partnerships with tertiary hospitals. What other partnerships are there? Are there partnerships with private health insurers and organisations like the Kidney Foundation and Diabetes? Do you form partnerships with them or are you just partnering with acute hospitals? If you do have a wider range of partnerships and a wider network, how does that work in relation to managing chronic disease?

**Mr Jones:** One of the things that is really apparent in the regional context that we are operating in—and our region extends from Mildura to Woodend, across to Seymour and up to Albury, so there are readily identifiable communities—there are participants in the private sector that associate quite closely with those regions. We have had really good partnerships with the Bendigo Bank in terms of looking at opportunities for greater prevention, improving the health of the community and not just the wealth of the community.

**Ms HALL:** And you guys partner with them?

**Mr Jones:** We have started that process. As a Primary Health Network we are three months into the role of our organisations. Firstly we need to build the foundations but they see the opportunities I think in terms of looking for partnerships and a way in which they can contribute and participate in improving the health of the community. So I think it is a really fertile ground. There are lots of opportunities for us to explore. Clearly there is a need for greater partnerships in the health system between primary care, acute care, aged care, mental, dental et cetera but it is not confined to that. There are opportunities to bring other parts, particularly looking at early intervention and greater prevention in the community setting. I think there is high willingness and a high level of interest for participation in partnering type arrangements.

**Ms CHESTERS:** The community banking model is based upon money raised in that community going back to the community, so the community bank funds building the pools and building a lot of the community infrastructure. This takes it to the next level.

**Ms HALL:** They operate throughout Australia.

**Mr Jones:** It is just an example of a private sector participant, which there is great scope for.

**Ms HALL:** It is all about developing different approaches to managing chronic disease and helping people living with chronic disease get a better quality of life and better control of their condition.

**Ms Lyon:** I would say the really important partnership for all of us, irrespective of whether we are regional or city based, is working with local government, because local government have a major role in planning, infrastructure and environment development and linking with some of those really well developed facilities in the community—swimming pools and libraries that connect people well with their communities. So that is a great opportunity. Previously we have undertaken what we call a place based initiative and worked with local government schools, particularly through the health organisations, to address chronic disease issues within local settings.

**Mr Jones:** And I would not undersell what Jason was speaking about in terms of the regional connections—having advisory structures where you are drawing the input of the community and drawing the input of providers but looking at ways in which all parts of that system can look to improve the health within a region. It is a really galvanising element associated with how to pull together those partnering efforts. There is really high recognition and appreciation of those services that are working within a regional context. There is a high level of enthusiasm about how we can work together. We are really pleased that our introduction has been met with a high level of willingness of working with us on that basis.

**CHAIR:** That is great. We have run out of time. We do appreciate you coming in today and presenting your evidence and your submissions. If you have been asked to provide additional information, could you do so by 15 October. If the committee have any further questions, they will send you them in writing through the secretariat. If you feel there is anything else that will assist our inquiry, please feel free to submit it to the secretariat. Thank you for making the time to come along.

**Ms CHESTERS:** Thanks for that. You forget it is really basic. The Y joint funded a treadmill in Castlemaine so they could double the number of the people participating in the community gym for strength training. When people have a fall it means they do not have to get a hip replaced.

**Mr Jones:** Small allocations of funding can really make some big improvements.

**CHAIR:** Absolutely.

**BILNEY, Ms Lucinda, Senior Strategy Manager, Medibank Private**

**CONNORS, Mr James Edward, Head of Government and Regulatory Affairs, Medibank Private**

**DUBROWIN, Ms Natalie, Head of Health Programs and Quality, Bupa**

**GRENFELL, Dr Robert, National Medical Director, Bupa**

[15:44]

**CHAIR:** I now call representatives of Medibank Private and Bupa. I must admit that I have got a foot in both camps: I am with Medibank Private and my wife is with Bupa. Do you as witnesses appearing before the committee have any objection to being recorded by media while participating in the hearing?

**Ms Dubrowin:** No.

**Mr Connors:** No.

**Dr Grenfell:** No.

**Ms Bilney:** No.

**CHAIR:** Thank you. Have you read the card on parliamentary privilege?

**Mr Connors:** Yes.

**Ms Bilney:** Yes.

**Dr Grenfell:** Yes.

**Ms Dubrowin:** Yes.

**CHAIR:** Thank you for appearing today. Would you like to make a brief opening statement?

**Mr Connors:** Yes, please.

**CHAIR:** We will start with Medibank.

**Mr Connors:** Thank you for the opportunity to appear before the committee today. It is very important work that you are doing. As you would be aware, Medibank is well known as Australia's largest health insurer, covering approximately four million lives Australia wide. Less well known is our population health business—for example, coordinating the health care for the entire Australian Defence Force. We also operate a telehealth business that provides publicly funded telehealth services and health service delivery and a coordination business that provides chronic disease management services for both public and private patients. It is the experience gained in this last mentioned business that we are here to share with you today.

One of the previous witnesses provided evidence about the challenges associated with chronic disease, some of the shortcomings in the way that Australia manages it and examples from the literature and from overseas on how to do it better. Where I think we can add some value for you is in sharing our experience in developing and managing a growing chronic disease management program that is producing clear benefits for the enrolled patients and their funders, which includes Medibank, other health insurers and local health districts. What I am referring to is a set of programs that Medibank calls our Care Suite. I note the Victorian department of health appeared this morning—or they were on the agenda to do so—so perhaps they discussed our flagship CarePoint program?

**CHAIR:** Yes, they did.

**Mr Connors:** Medibank runs this program for both public and private funders and patients for the patients experiencing chronic and complex conditions. We run it in Victoria, Western Australia now and soon in New South Wales and Queensland. CarePoint patients typically experience high rates of hospital utilisation, so the program is aimed at making primary care more effective for them such that their health improved to the point that they experience less hospital utilisation and reductions in the average length of stay when they do go to hospital.

Care Suite includes some other programs—one called CareFirst, which is a GP-led chronic disease management program that encourages self-treatment and behaviour modification that is supported by health coaching, health system navigation and online education segments. We are currently in the process of expanding this program from its Queensland based trial to be a national program, including Western Australia, where we hope it will have public patients enrolled.

The most recent addition to the Care Suite is our CareTransition program, in which we partner with hospitals to complement existing hospital discharge processes so that patients with a higher risk of readmission to hospital will have a more effective transition from hospital to home. While it is not specifically aimed at people with chronic illness, to date every patient that has been through the program has at least one chronic illness.

Another area in which we may be able to assist you is in understanding the proposal Medibank made in our submission regarding the relaxation of current regulatory restrictions affecting Medibank and other insurers with providing certain types of chronic disease management and prevention programs. These restrictions mean that some programs that would create both individual health benefits and system-wide efficiencies never materialise. That is all I want to say first up, and I am happy to take questions on those topics or anything else you may want to talk about.

**CHAIR:** Thank you. Bupa, do you have an opening statement?

**Ms Dubrowin:** Absolutely. Thank you for the opportunity to attend today. This is a very important inquiry because primary care is critical to the effectiveness and efficiency of chronic disease prevention and management. We know this is a very complex and challenging area and we also know that both public and private health sectors have the same objectives. If we have the same objectives then we should have the same agenda. That agenda is to improve health outcomes for all Australians, including for all Australians living with chronic disease, and to improve the economic outcomes for delivering services for individuals living with chronic disease.

This is our opportunity to collaborate and to integrate components of the healthcare system for high-risk patients with complex health needs. By putting the patient experience and health outcomes at the centre of decision making, Bupa's vision is to work with government to help deliver a more integrated model of care across all health sectors, and preventing and managing the cost of chronic disease is a major factor in preserving the sustainable affordability of private health insurance.

Bupa is a global health and care company, caring for over 29 million people in 190 countries. Our purpose is to achieve longer, healthier and happier lives. We have over 5.7 million customers in Australia and New Zealand, and about two million of these are not health insurance customers. In Australia we are the largest provider of aged-care services. We run a significant network of optical and dental stores. We provide audiology services, GP services, health coaching and visa medical checks. So our purpose is to help achieve better health outcomes for all Australians. I will hand you over to my colleague, who is going to continue to address you.

**Dr Grenfell:** Thanks, Natalie. I guess the problem that we face is that chronic disease continues to represent an ever-increasing portion of the total burden of disease, and the system as it stands is not structured to support this—hence our enthusiasm for being involved in a solution to this perplexing problem, because, importantly, we are here to actually try to prevent the progression of illness and the development of unnecessary death and disability. So the solution that we see in a number of points—and you will see that we certainly concur on a presentation from Medibank on some of the points—is that what we need is a national performance framework in the chronic diseases space, with a realistic set of metrics. Measuring performance in this area is actually complex, and all too often we set ourselves with the final outcome and, after about a 12-month period of piloting, we say we have not achieved it. So I would be talking about the idea of realistic metrics that actually set up a scene for what we can achieve in 12 months, what we can do in 24 months and what we are actually looking at in the long game plan in this space.

There is a wide range of consensus that the fee-for-service model no longer fits the area of chronic disease management. Also, as I mentioned, our enthusiasm for this area is notwithstanding the affordability of health care in this space. From the private insurance perspective, we do not have a lot of visualisation of our policyholders until they actually make a claim at hospitalisation, which is very similar to what the state governments look at with chronic disease and its management or prevention.

We need to explore alternative funding and care management models that actually encourage innovation and also reward outcomes, with an understanding that not one will fit all. The previous presentation demonstrates that we have urban and rural, and that actually needs to have that capacity to stretch and innovate for the context that it is in. The appropriate models for Australia should be tailored to Australian needs and trialled. All too often we think of ourselves as putting in an international model and running that in Australia. The answer is that we are Australia. Our healthcare system is unique. We have a very fascinating blend of private and public supported health services here that in fact makes us unique, so we need to appreciate that and have that context put into what we are trialling and how we are putting it forward.

Our view is that a regional pilot of blended payments would be one way that we would look at this. We agree with Medibank on the idea that rule No. 12 should be more relaxed to allow for some of this to occur. To enable this, our health system needs a complete and timely picture from the individual and the regional health perspective for it to actually work.

**CHAIR:** So how involved should private health insurers be in chronic disease management programs.

**Mr Connors:** Very involved, clearly, if for no other reason than that we are exposed to the costs of poorly managed chronic illness. Chronic illness, as you are probably all aware, if it is poorly managed will end up in hospital admissions and a high rate of hospital utilisation. So, if for no other reason, that is a really strongly compelling reason certainly for Medibank to want to be involved. As you are aware, there are some issues in the way that private health insurance is regulated that prevent us being fully involved in primary care, predominantly around how, when a Medicare payment is made, private health insurers are prohibited from paying a benefit. We do not necessarily think—our programs are evidence, really—that that is an insurmountable obstacle. There are still a lot of possibilities for us to work with primary care, and we are doing that, and I am sure Bupa is doing that.

**Ms HALL:** You gain savings by actually providing those programs that stop people developing the chronic illness and stop the hospitalisations.

**Mr Connors:** Yes.

**Ms HALL:** So there are savings for you from providing that service—

**Mr Connors:** Correct.

**Ms HALL:** without having an MBF number.

**Mr Connors:** Any healthcare funder that funds acute care hospital admissions essentially shares the same interest in trying to reduce or avoid hospital admissions where it is possible. Quite clearly that is in the patient's interest as well. They would prefer not to be in hospital, generally. They would like to live a healthier life. The evidence is in that that involves using primary care more effectively and more efficiently to manage their illness.

**CHAIR:** Where is that evidence?

**Mr Connors:** I think if you look at the worldwide evidence on it—I know from some of the other submissions this committee has received, and it is certainly within Medibank's submission in terms of the worldwide evidence—it shows that chronic illness is more effectively and efficiently managed in primary care. That certainly underpins our approach to the CarePoint trial and the Care Suite program.

**CHAIR:** How much evidence have you got from the CarePoint program so far?

**Mr Connors:** It is early.

**Ms Bilney:** Yes, it has just started. It is a two-year program and whilst there is an evaluation that is ongoing even as it rolls out we have not really got any definitive, formal evaluation data in as yet. We certainly have anecdotal data from GPs' experience and patient experience, which all looks very positive at this stage. But, in terms of published evaluations, we are not at that stage yet in any of the Care Suite programs.

**Mr Connors:** Part of what we are trying to achieve is to demonstrate that they are effective, clinically, and that they have a return on investment for the funder. There is quite a detailed assessment process that is ongoing now and will occur at the conclusion of the pilot period.

**CHAIR:** Are you running any programs similar to that?

**Ms Dubrowin:** We are running many programs at Bupa. We have trialled many programs over the years and we have evaluated many programs over the years. Front and centre is our Bupa Medical TeleHealth business, which is a telephonic coaching program that we provide to our members. We identify them through our hospital claims database. Some of those members have chronic disease management. We also target and assist our members who require further support post hospital discharge to support them in those weeks and months beyond discharge. But, for Bupa, it is recognising that we are more than a health insurer. We have our health insurance business, but we also have many service provision businesses. We see the opportunity for us to work with government, both state and federal, to really be working for all individuals with chronic disease, and that is absolutely our objective that we plan to achieve.

**Dr Grenfell:** To look and think about some of the things that are actually hindering this or the barriers to doing this—and, again, to emphasise, prior to claiming—the prevention of progression of risk factors into the chronic disease space is a space that all of us want to actually be in and to work. The place of Primary Health Networks is that opportunity that it has offered to us for how they can work better with us from a private insurer perspective on coordinating risk prevention and risk management types of programs. In that I include those people who have actually had hospitalisations. How do we actually continue to assist them in taking the healthier choices to minimise the progression or return to hospital? We know the opportunities there are actually great for this country.

Obviously, as you have mentioned, Jill, the point of cost for us is that the reoccurrence of hospital readmission for preventable chronic disease is one that needs to be addressed. Certainly, into the future, it is not sustainable under the current model.

**CHAIR:** Do you think that the health system or the health industries are as focused on chronic disease management plans as the private health insurers are?

**Mr Connors:** It is a good question. I think that increasingly they are. The reviews launched by the current health minister are helping to focus that, and we strongly support all those reviews. I think there has been a real sharpening of the debate in Australia in the last couple of years around the need to address this. It is probably the most addressable area of failure in the health system.

**CHAIR:** I would probably agree with you. I just thought that the industry might not be as focused as you guys are.

**Mr Connors:** There is, and I am sure people would agree—

**Ms HALL:** But you are part of the industry.

**Mr Connors:** Yes, that is right.

**Ms Dubrowin:** That is absolutely right.

**Dr Grenfell:** The complexity of this problem is from individual factors. How engaged into their own care is the person who has the chronic disease and how able are they to actually remember their medication or do healthy choices? Those are problems that are outside a lot of our influence because, again, telling people to do things will not necessarily make them do them. So you need the setting for health promotion and healthy engagement.

The other part of the engagement of the profession is that we have a system that rewards intermittent care. It is a fee-for-service model which does that, which tends to disadvantage parts of the sector that want to look at a longitudinal perspective of care. That is why in part of our submission we talk about the idea that we need to look at how we are funding these things and what examples we can look at internationally, or even from other sectors, to see how we can finance care as it progresses through someone's needs.

**Ms HALL:** That is a good segue into the question that I wanted to ask, because I wanted to ask about blended payments. How do you see that working? What about capitation payments, as opposed to fee-for-service? Just give me a bit of an idea of what both your organisations think about that issue.

**Ms Dubrowin:** We think you should take the approach of a regional pilot of blended payments so that you have a defined population that you can work with. There is no one solution—

**Ms HALL:** You would need to have a control that was working alongside it too.

**Ms Dubrowin:** Absolutely, so at a high level there is a national framework with metrics in place, but you can trial different payments or different funding mechanisms in different regions. There may be a combination of capitation and some fee-for-service, and some paid for performance in relation to outcomes.

**Ms HALL:** If there were different regions, you would probably have a different mix of people. Therefore, the burden of chronic disease or chronic illness would be different. Therefore, you could not get a direct parallel between the two. Wouldn't you need to have a control in each region so that you could compare oranges with oranges and not oranges with apples?

**Ms Dubrowin:** That is definitely important. I think evaluation and ensuring that you have adequate outcome measures in place to be able to compare things is important, but different regions have different health needs and you need to focus on those particular health needs while having similar outcome measures, frameworks and perhaps indicators in place to be able to measure them at a higher level.

Bupa has a business in Spain, and I know we have talked about the international experience, but I think you can also draw on some of those experiences and lessons. We have a business in Spain that has a partnership with a region or province in Valencia. Bupa has taken on that capitation model for a whole region, a whole population, which includes—

**CHAIR:** We need to visit there.

**Ms Dubrowin:** I think that would be a great idea. We will join you! So they have taken on the acute, specialised and long-term care and they have had some great successes in taking that on. For the regional government there, obviously there are a whole lot of benefits around the predictability of the costing and the lessons that have come out of trialling a new funding model.

**Ms HALL:** We have heard a lot today about what has been happening in Ontario. You probably want to say something too.

**Mr Connors:** In terms of the blended payments, we certainly agree that particularly outcome payments need to be introduced into the funding model generally.

**Ms HALL:** Tell us how they will work.

**Mr Connors:** We can talk about our care first model, which includes those sorts of payments. Care first has outcome based payments, which is the chronic disease management program that we offer. It essentially treats the group of patients who are not yet ill enough to become care point patients. They have chronic disease and chronic disease risk factors, but it is a more typical chronic disease management program. It has payments involved in it which both pay a fee to the GP to enrol the patient and then a fee which is pay the able to the GP if they can achieve success or the measures that are indicated in the chronic disease management plan.

It is not a huge amount of money and, because it is new program, we are still working out exactly how much that should be. The initial signs are that it is quite a motivating factor for the GP to make sure that they at least do things like review the management plan—you might have heard already that existing chronic disease management plans have a low rate of review, and we are seeing a much higher rate of review through the life span of the plan—and also incentivise the GP to ensure that they are delivering to the plan and getting their success factors and the agreed sorts of outcomes that the plan has. The way we work that is not to have a per-patient outcome; it is a grouped outcome. If they can achieve a certain rate of success over a basket of patients, then they are able to claim that payment.

**Ms HALL:** It is all about incentivising the GP but also the person. It is a system of putting in place a lot of incentives along the way to actually bring about change, isn't it?

**Mr Connors:** That is right. Activation of the patient is always key to getting any—

**Ms HALL:** So, that would solve just one side of the equation, but you have to do both; you have to incentivise both sides.

**Mr Connors:** Correct.

**Dr Grenfell:** The other component is the packages of care that someone with a chronic disease needs. We certainly know with a number of set conditions what the care needs may be, whether that is to do with physical activity or nutritional advice or whether it is to do with some mental health support. We have seen the formalisation of those types of roles through GP care plans, but the other thing is how those things are supported in the community, how they are actually financed or funded so that we know they will actually occur. We do know that a lot of people will pay out of pocket, but Australians do pay out of pocket for their health care more than other nations do, so it is an issue of where the responsibilities are and how those things can actually be funded. Those are the types of blended payment models that really should be investigated.

**Ms HALL:** On national performance, what do you have in mind for that?

**Dr Grenfell:** One of those is, what are we trying to achieve? And how are we trying to achieve that across established disease or the prevention of disease and how it is moving? What sorts of targets are agreed from a state and a Commonwealth agreement perspective? But the next level, with the Primary Healthcare Networks, is that one would hope that they would have a number of targets that actually set them up for how they are performing. Without defined goals and without a design framework for how we are going to achieve those things, it is very hard to see that we are actually going anywhere or that it is actually working or has meshed. The idea of meshing the framework: you are looking at workforce, you are looking at the funding models, you are looking at the shared data or integrated data systems and you are looking at infrastructure that is required for those as a basis that would actually need to be written into a framework such as this.

**Ms HALL:** So, you have to integrate all those systems. It is very complex system we have in Australia.

**Dr Grenfell:** Absolutely.

**Ms HALL:** And to make it work you have to be able to bring all the players together, including the states and the Commonwealth. Do you have any thoughts on that?

**Mr Connors:** Part of the design principles we have with CarePoint is that it is intended to simply overlay the existing health system; it is not asking for any part of the overall health system to greatly change what it is doing already. It is essentially taking the path of least resistance and saying to those constituent elements, 'Keep doing what you're doing, but we'll put this on top to make it more effective.'

**CHAIR:** Something that has been mentioned to me is the fear that if private health insurers get too involved in the medical system it will get to a point where you will not insure people because they have too many factors. That is what people have voiced. Could you give us your thoughts on that, just for the *Hansard* record?

**Ms Dubrowin:** Obviously we are community rated. Whether you are an 18-year-old who is fit and healthy or an elderly person with multiple chronic diseases, it is the same. And I think it is really important that we inform our community that that is in fact our way and that at Bupa we are very much of the mindset that we have the dual

objective, as the member does, for that person to stay healthy. Our goal is to try to improve the health of our population, absolutely.

**Ms HALL:** If we do not have community rating then we really do have a US-style private insurance industry, and I am sure some private health insurers would like us to not have the community rating, but it does give—

**Mr Connors:** For the record, I am not aware of a single one that does.

**Ms HALL:** Good; that is excellent.

**Mr Connors:** I think there is a general belief in community rating across the private health insurance industry, and I am yet to find anybody who voices anything different.

**Ms HALL:** That is really good, because I think it is so important for our health system the way it works.

**Dr Grenfell:** I think the fairness of our private insurance system here is exemplary, with regard to inclusion, as Natalie has pointed out—the fact that you can be supporting someone with severe chronic illness and they are in fact not penalised for that.

**Ms HALL:** That is right.

**Ms Dubrowin:** But I think we do struggle because we can identify only those of our members once they have been to hospital, so it is very difficult for us to capture those people and identify them early on, where there may be multiple risk factors where we could engage with them on particular programs or health initiatives. We do not find out until really it is—well, not too late to engage, but it would be nice to engage them sooner.

**CHAIR:** When do you think you should find out, and how would you facilitate that?

**Ms Dubrowin:** I think by partnering, as a health and care organisation, with other service providers and with the public sector. In our submission we say that we need to understand what the health of a particular population is. It does not matter whether they are privately insured or otherwise; it is about understanding their needs from prevention right through to management and chronic disease when potentially people do need to go to hospital. So, it is a whole-of-system approach.

**Mr Connors:** If I could just add to that, we think there is capacity with the My Health Record, the renamed PCHR, for private health insurance members to at least opt in to have their My Health Record shared with their private health insurer. Sharing data is quite a good way to do exactly what Natalie was talking about—to be able to identify people earlier in their disease state, when you can make more effective and cost-efficient interventions.

**CHAIR:** My colleague has a plane to catch, which means we have reached the end of our time. Thank you for coming along today. We really appreciate your submissions and your attending the hearing—and changing times, which was good. If you have any further information that you think would be relevant to the committee and the hearing, please feel free to forward it to us. And if you have been asked to provide any additional information please do it by 15 October. If we have any further questions we will send them to you in writing through the secretariat. I know you will keep an eye on all the other evidence we take and the hearings we are going to hold. Again, we really appreciate your coming along today. Thank you.

*Resolved that these proceedings be published.*

**CHAIR:** I thank my colleagues as well as Broadcasting, the secretariat and all witnesses who have appeared today.

**Committee adjourned at 16:12**