LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into ACT Budget 2021-22)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 15 OCTOBER 2021

Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

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WITNESSES

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Amended 20 May 2013

The committee met at 2.45 pm.

CAMPBELL, DR EMMA, Chief Executive Officer, ACT Council of Social Service
WALLACE, MR CRAIG, Head of Policy, ACT Council of Social Service
WILLIAMS, DR BIANCA, Senior Community Assistance Support Program Development and Policy Officer, ACT Council of Social Service

THE CHAIR: Good afternoon, guys, gals and non-binary pals. Welcome to the first virtual public hearing of the Standing Committee on Health and Community Wellbeing into budget estimates for 2021-22. The proceedings today involve a discussion with three community groups.

Before we begin, on behalf of the committee, I would like to acknowledge that we meet on the lands of the Ngunnawal people. We respect their continuing culture and the contribution they make to life in this city and this region.

Please be aware that the proceedings today are being recorded and transcribed by Hansard, and will be published. The proceedings will also be broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses could use these words, "I will take that as a question on notice." This will help the committee secretary and witnesses to confirm questions taken on notice from the transcript.

In this first session today, we will hear from ACTCOSS, the ACT Council of Social Service. Can I remind all witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement? In addition to giving us your name and who you represent today, please confirm that you have read and understood the privilege implications of the statement.

We will start with our witnesses from ACTCOSS. Given the appetite of members of the Assembly to ask questions today, we will not go to opening statements. We will instead go straight to questions, if everybody is agreeable.

As chair, I am happy to kick us off with the first question. It is related to the intersection around climate change and health care. I am interested in the budget submission that you made suggesting that the Health Directorate establish a healthcare sustainability unit. Can you talk about how you see climate change as a healthcare issue? Would this unit be responsible for reducing the climate impacts of health care or responding to the impacts of climate change on the health of Canberrans? More broadly, why does your organisation believe that climate change needs a dedicated health focus?

Dr Campbell: I can confirm that I have read the statement and understand it. I think that particular call would have been the position of one of our members. ACTCOSS, obviously, is very driven by improving the social determinants of health, because we know that issues such as poor housing, low incomes, limited access to education and transport disadvantage all lead to poorer health outcomes.

We are also seeing that the impacts of climate change are disproportionately impacting people on low incomes. People on low incomes tend to live in very poorly insulated housing. They are not able to leave Canberra, for example, during periods of poor air quality. There are higher rates of chronic disease, so they are often more impacted by some of the changes to our climate and weather. Of course, these all add into social determinants of health and poorer outcomes for people who face disadvantage and vulnerability.

At the same time, in our budget submission, whilst we absolutely believe in climate change mitigation, the move towards a zero-carbon economy must be done in a way that does not leave Canberrans on low incomes behind. It should be inclusive of them, given that they already face high costs of energy utilities and poor housing. I will hand over to Mr Wallace, in case he has something to add.

Mr Wallace: I can also confirm that I have read and understood the statement. I think there will be, as Dr Campbell has already said, two dimensions to this. Firstly, vulnerable people are, if you like, the canaries in the coalmine when it comes to natural disasters. We saw after Hurricane Katrina that it was people with disability and chronic health conditions that were left behind, often due to issues that related to their circumstances—their lack of access to transport, informal supports and services to help to get them out of that situation.

In Canberra, during the fires and the heatwave in early 2019, homeless people were the ones occupying concrete spaces, some of them around the Assembly. They were experiencing adverse conditions from the heatwave, and needed to access public spaces like libraries and public transport as a way of simply keeping cool. We also note that, for young people, finding spaces where they can go that do not involve spending money during heatwaves or times of extreme cold in the city are important.

THE CHAIR: I do not have a supplementary, because I can see that there is a long line of people who are keen to ask you questions today. I will move on to the deputy chair, Mr Milligan.

MR MILLIGAN: Thank you, ACTCOSS, for your submission to this committee. I notice that you are making a few appearances; thank you for that effort.

In a media release you made note of a number of issues that have not been addressed in this budget, going forward, particularly gaps in support for older Canberrans, as well as parental health services and community facilities. Also, there is no funding to go towards an ACT carers strategy or a disability health strategy. How important is it to develop a strategy, particularly for carers and disability, in this space? What sort of funding would need to go towards it and what organisations would want to be a part of the development of this strategy?

Dr Campbell: Many thanks, Mr Milligan. The Carers Strategy exists. The frustration for us is that there has not been money assigned to implement it. I might defer to Mr Wallace, to talk in a little bit more detail, particularly about the disability health strategy.

Mr Wallace: I can talk to some extent to both of those. For the Carers Strategy, Carers ACT have good guidance on this. They were really keen to see some funding for the second implementation plan for the strategy. That includes work to ensure that Carers ACT has the capacity it needs to support carers. It includes some money to actually implement the strategy ongoing, and for respite for carers—as a key issue—to do some planning and scoping work on a respite facility for carers who are under stress and duress. These issues have amplified during lockdown.

In terms of the disability health strategy, ACTCOSS, together with partners in the community sector, undertook a set of work over about two years to listen to the voices of patients with a disability and with peaks and consumer organisations, working through them. That set of work unveiled that people with disabilities had issues in terms of physical, sensory and digital access to the health system, and that there was a prevalent medical model of disability operating amongst patient-care staff, which led to things like diagnostic overshadowing. A person with a disability would present in a hospital and they would try and treat the underlying stable condition rather than the critical health condition that the person had.

Cost was a big issue, because many people with disabilities are on lower incomes due to barriers to the employment market. They were often presenting at bulk-billing clinics, which tend to only be able to offer fairly brief consultations. People wanted to be able to sit down for a longer period to talk about how they managed their conditions.

There was also a lack of specific diagnostic services for people managing particular kinds of disability. I will give an example. A person with Down syndrome often presents with issues regarding managing cognitive issues, a heart condition, and in terms of perhaps managing issues around healthy eating and other areas of general practice. What people need is a wraparound service that can provide those issues in the one place.

Other issues that were brought to our attention included a lack of basic kit and infrastructure, such as height adjustable beds, communication boards and appropriate signage. We need a strategy that wraps all of that together and improves the workforce readiness, the cultural adaptions and changes that people need—and to start to see people with disabilities employed within the health system so that change becomes embedded.

There is some work going on within government to scope it, and a disability action plan within the health department. That is fine, but we need outward-facing work, particularly as COVID is, sadly, likely to bring many more people into contact with the health system. I hope that has answered the question.

MR MILLIGAN: Yes, it has; thank you. In terms of that outward focus, what urgency would you put on that? If you were giving a time frame, does something need to be done within the next three to six months—some sort of commitment?

Mr Wallace: Something needs to be done in the next six weeks. If we are going to have people rocking into hospitals with COVID, we need urgent prioritisation of some basic infrastructure so that someone like me could enter into a casualty and be reasonably able to get up on an examination bed. We actually need some of this now.

We did a set of work last year to identify some of the ethical dimensions of treatment during COVID for people with disabilities. It is important that that is disseminated and that there is educational work within ACT Health. This is not something that can wait.

MR PETTERSSON: Could someone tell the committee what effect this budget will have on frontline domestic violence services, and whether there are any questions about funding into the outyears?

Dr Campbell: We had some concerns relating to the safer families levy going into this budget and the proportion of that funding that was going to frontline services. We welcomed the announcement of an increase to the safer families levy, and we have been assured that that increase will lead to revenues that go directly to frontline services.

We welcome additional money for organisations like DVCS. We have also seen additional funding go to the Women's Legal Centre. But we do have concerns that that money will drop off after the first year or the second year, and that there is not ongoing, sustained funding for frontline family violence services.

Organisations need certainty. Unfortunately, we know that often the impacts of major crises, such as COVID, come with a tail, so they will start coming a few months into the future. We need to be certain that we have the services and supports there to respond. Bianca, would you like to add anything?

Dr Williams: I would like to confirm that I have read and understood the statement. I will add to Dr Campbell's statement by saying there should be a focus on particular groups. We know that domestic violence is an issue particularly for women with disability, so we need to be able to focus on and have very specialised needs around specialised groups.

MR PETTERSSON: What effect would a funding reduction have on these service providers? Surely, they have needed to hire more staff or alter their budgets to provide these services at this time. What happens when we reduce the funding to these organisations in a year or two years time?

Dr Campbell: Women and children are unable to access support. They remain in situations of danger and violence, with the consequences that flow from that. Many of these services are also early intervention services. They not only provide support at points of crises, but they help prevent longer term issues. For example, the Women's Legal Centre does a lot of work where women on low incomes maybe are facing relationship breakdown, to ensure that they have a fair share of resources in any separation, or making sure that, if that happens, you are setting up that person—that woman and her children—for the future and perhaps preventing other adverse outcomes. It is about prevention. Also, when people are in crisis situations, they will not be able to leave, and they will remain in those frightening and sometimes, unfortunately, deadly circumstances.

THE CHAIR: Thank you, Dr Campbell. I am conscious that we have five minutes of your time left today, so I now go to one of our visiting members, who has questions for ACTCOSS.

MR PARTON: Dr Campbell, ACTCOSS has long been advocating for the government to adjust more levers so as to allow the community housing sector to play a larger role in social and affordable housing solutions. Certainly, based on the budget, it appears that those calls have not been heeded. What is your opinion on why the government has not listened to you and the rest of the sector? Would you like to see more innovative approaches to bring the community housing sector genuinely to the table to be a part of the solution?

Dr Campbell: Thank you for your question, Mr Parton. We did welcome the significant investment in maintenance of public housing. We think that is really welcome and it will also support jobs. There are some parts of the budget that provide some opportunities for community housing—for example, the research work going into build-to-rent models and the release of future land supply. I would agree with you that this budget does not provide a clear pathway as to how the ACT government will achieve the additional 400 public houses and 600 affordable rentals.

It is difficult to speculate as to why we have not seen more investment in community housing. Land is obviously very expensive in the ACT and a very important source of revenue. I think there is a strong belief in public housing within the ACT government. And that is right; public housing is incredibly important, but it does not need to be an either/or. We can have more public housing, which is targeted at a very particular community, but we also need more community housing, because community housing are our build-to-rent specialists. They are ready to go with many projects. They can deliver quickly. They also provide supports for the people who live in those houses.

We need creative ideas. We need land to be released to them at rates that are affordable. We need rates exemptions and other concessions. We need to ensure that the ACT planning review results in concessional land release and other arrangements to support community-controlled affordable housing.

Let us remember that, currently, given the salaries of people in frontline community service organisations and the average rental in the ACT, if you are a full-time disability support worker or aged-care worker, you are living in rental stress by renting a unit in Canberra. Public housing is not necessarily the right answer to that. We need more community housing and affordable housing. That is why it is so important to have two streams of housing delivery if we are really going to answer the housing crisis in the ACT.

THE CHAIR: I would like to thank all members of ACTCOSS for joining us today and remind you that if you have taken any questions on notice, please provide those to the secretary as soon as possible. We thank you again for your time today.

COX, MS DARLENE, Executive Director, Health Care Consumers Association
MOORE, C, Member, Executive Committee, Health Care Consumers Association

THE CHAIR: We now welcome representatives of the Health Care Consumers Association. Thank you for appearing today. With your first answer, can you confirm for the record that you understand the privilege implications of the statement? We are not having opening statements, given the shortage of time, so we will jump straight to questions.

I am interested in asking about palliative care. I note that there has been some significant investment in palliative care services in this budget, and I am interested in learning from you what specific outcomes you would like to see from that new funding.

Ms Cox: I acknowledge the privilege statement. We were disappointed that we did not see funding for the inpatient palliative care ward. This has been a longstanding matter of advocacy for us because we have heard far too many stories where people have been either moved to Clare Holland House in a rush towards the end or where it is not actually about being supported to have a good death. It is incredibly disruptive.

We want a dedicated inpatient ward at Canberra Hospital where you can have the family go and support people at end of life rather than dealing with quite a traumatic transfer in the last couple of days. While the home-based palliative care funding is good news—we know that there has been increased need, and it is good to see the recurrent funding for the five extra beds through the Clare Holland House expansion—we think that there is still a need for palliative care at Canberra Hospital. That is not to say it is not happening, and palliative care is everyone's business. Every clinician needs to understand palliative care and have the capacity to provide palliative care. It is really about having the space. It is very hard to go through the end-of-life process in a crowded hospital ward where you do not have the space to have your family around you. In COVID times it is even more complicated.

MRS JONES: With the palliative care funding, I heard you say recurrent funding. That is not an increase in beds, is it? The increase has already been achieved. This is just funding them into the outyears; is that correct?

Ms Cox: That is my understanding, but we would have to go and confirm that with the minister. You have a new facility in Clare Holland House with additional beds that have to be funded.

MRS JONES: I can follow that up next week with the health minister. Also, the 24/7 support service that you sought in your submission has not been funded either, I presume?

Ms Cox: No, it has not been funded, but we have seen that it has been introduced in Victoria quite effectively. It is a way of providing additional support to those clinicians and family members who need it. You cannot have a palliative care physician everywhere that you need them all the time. There are not a lot of them and there are certainly not enough to go around. If we could have access to that level of expertise to allay concerns, understand how to change treatment or to address particular issues or exacerbations, that would be amazing.

MRS JONES: For navigation as well—you talk in your submission about navigating the systems.

Ms Cox: Yes. We all know how complicated the system is. It is a fragmented system. Ideally, we would not need navigation services because everything would work so beautifully that it would be joined up.

THE CHAIR: We will go to Mr Milligan.

MR MILLIGAN: I would like to pass my substantive over to Mrs Jones.

MRS JONES: Thank you for appearing. I want to put on the record that it is really important to hear from you. In your submission you talk about mental health access and pathways. I have certainly been contacted a lot lately by carers. Some of them are carers of mental health patients who have taken their lives; some of them are carers of people who are still with us. What are you seeking with the pathways? Is that related to the navigation issue?

Ms Cox: It is not directly related to navigation. We need to have more than an emergency department. We need other front doors and we need to be supporting community services. I note that in the budget there is additional funding. In fact C might be in a position to talk more about that. We need more than an emergency response to ongoing mental health care. Anyone who has had an experience of living with or caring for someone with mental illness understands how challenging that can be and how you need different points of care at different points of time. There needs to be that stepped model, and that is what we are encouraging the government to continue in their commitment. Community-based mental health services provide a really significant role to support people.

MRS JONES: It is about increasing the community services part of mental health care, predominantly?

Ms Cox: And community based, so the community-based teams too.

MRS JONES: Who go out to people's homes?

Ms Cox: Yes.

MR PETTERSSON: Noting the funding in the budget for a patient navigation system and your submission to the budget process to implement a model of patient navigation, what do you think that system should look like?

Ms Cox: Specifically, we were focused on those families whose children are accessing specialist care interstate. We accept that, although we are the nation's capital, we do have in many ways a regional health service, and that is the reality of living here. We do not have a large metropolitan population to support some really specialised services, so we will always be travelling to Sydney or Melbourne to access some of that care.

We want to smooth that as much as possible. We want information to flow. With the parents, when their child is getting sicker and they turn up to the emergency department, we want the staff to be able to listen to the family, understand what is happening, and access the information so that they can shorten the period of time between when they present to the hospital and when they get that care.

For many of them, it might be about supporting them with the education of their other children; they may have housing issues or financial supports that they need. It is about recognising the family as a whole unit, providing them with services and connecting them—t could be some social workers, it could be paediatric nurses, who understand clinical conditions and who can meet clinical needs, while at the same time recognising the family and the needs that they have across their lives.

THE CHAIR: I am curious to talk about data collection. How is the commissioning process unfolding, in your opinion? What opportunities does commissioning present and how should we be thinking about this process at a high level?

Ms Cox: Commissioning is a really exciting step. Instead of historical legacy contracts to deliver the same things year on year, it is an opportunity to make sure that you can fine-tune funding to meet new, emerging needs or continue to honour the commitments of those longstanding needs that we know that we have. The tricky thing about commissioning, as with any of these big events, is that it is a massive change process. It is a change for the NGOs, it is a change for the bureaucrats who have to design and then administer the program, and it is a change for the community to understand that there are different ways of funding.

This is not a big bang. This is not like the digital health record, in that, at the end of next year, they will flick a switch, we will go live and we will have a digital health record that will be amazing and will change health care significantly. This will be an incremental, phased approach to moving from historical contract-based procurement to a really engaging, creative and innovative model of commissioning services for community need.

THE CHAIR: It is great to hear that. We will go to Mr Milligan.

MR MILLIGAN: I notice that Mrs Jones has another substantive, so I am happy to pass over to Mrs Jones again.

MRS JONES: Our approach to healthcare funding in the ACT is that we have this envelope approach—a six per cent a year increase over the budget life and, within that envelope, we have to fund everything. Your submission called for an overall increase in the share of the budget that goes to ACT Health. Can you explain what you think would be a more reasonable approach?

Ms Cox: Our president is passionate about this, and I am sorry that he is not here today. He had hoped to be able to appear, but he is off doing some field research and testing the health system himself! We think we have needed additional funding. In fact one of the things that we heard from the minister in a community sector briefing the other day was a significant increase, to the tune of $500 million or more, over four years.

I think that would be a really good question to ask the minister. From our perspective, and from what we have heard so far, it is very encouraging that not only are we going to see a significant increase in funding for the health system, but also it is about the funding for infrastructure—we have ageing infrastructure that needs to be addressed—workforce for new services and increased intensive care beds, NICU beds and mental health beds.

MRS JONES: I asked last week in the Assembly for a staffing planning exercise to be done over the next few years. The minister removed that in her amendment to my motion. The next day, Mr Pettersson kindly put up the same concept for mental health—that we should have a planning exercise done by government for the staff to make sure that we have enough staff and that they are in the pipeline. Would you support the government doing that planning work for the whole of health care so that we can be brought into the conversation as a community about how we are going to staff our health system over the coming years?

Ms Cox: Workforce planning is critical, and it is a core component of what high performing health systems do. Just as you are planning for your infrastructure and your asset replacement, and how you are planning for your equipment and procurement processes, you also have to plan for your workforce. We want consumer-centred health care, and the consumer-centred health care is so dependent on having a highly trained, well-supported workforce to be able to meet our needs. We are very supportive of a strong workforce for the ACT health services, for sure.

THE CHAIR: As Mrs Jones points out, Mr Pettersson has a strong interest in this area, so I will defer to Mr Pettersson for a substantive.

MR PETTERSSON: I have no doubt you are aware that the government has embraced nursing ratios in recent times. Could you inform the committee of what effect ratios have on the care that patients receive in our healthcare system?

Ms Cox: We are not the ANMF, but we know that the ANMF have been working very hard to negotiate this. We think it is good news because it will mean more nursing staff for consumers, more midwives for consumers, and we are hoping it will alleviate the pressure, improve access for consumers and improve our experience of care.

THE CHAIR: It is one thing to fund new nursing and midwifery positions in a budget; it is another thing to fill them. What do you think are some of the biggest challenges at the moment regarding recruiting qualified professionals to fill those roles in the ACT?

Ms Cox: I do not understand why people do not want to live and work here. What an amazing place to live in, and there is a very well-resourced health system that actually is delivering pretty amazing care. Quite honestly, Mr Davis, I do not understand that. We have had ongoing issues around recruitment and retention of staff. Certainly, some of the work they are doing around culture will address that, you would have to think. We want well-trained, well-supported health staff. We want a positive workplace culture where people feel empowered to speak up, to speak out for safety, to care for their patients, and to be able to do their jobs and feel good about it.

THE CHAIR: We need more proud Canberrans with medical qualifications, by the sound of it. I will defer to Mrs Jones for a final supplementary.

MRS JONES: My question goes to clients' rights in the healthcare system and the vaccine mandates that we have seen. We know that our Human Rights Act makes it very clear that people must not be subjected to medical treatment against their will. In the last little while, we have seen this decision that primary school teachers need to be vaccinated whilst the evidence for case load in young children is not particularly strong. How do you, as the Health Care Consumers Association, stand up for people who want to make a choice about their situation—despite the fact, of course, that we need high levels of vaccine, and that this is a very small group of people in the community?

Ms Cox: It is a question of balance, isn't it? How do you balance the rights of one against the rights of many? We are just at the beginning stages of talking with our membership about that. I do not think we have landed on a definitive position. I am wondering, C, whether there is something from the disability perspective and others. For example, I know some people in our membership have exemptions because they have chronic conditions. They are not getting vaccinated because their rheumatologist, for example, has said that it is important that they continue on their treatment path at the moment without inviting something else into their bodies to potentially threaten it. C, do you want to add something?

C Moore: I would not want to state anything definitive, because it is quite a complex issue. Certainly, we need to make sure that people are able to assert their rights regarding those medical exemptions where they need them and make evidence-based policy decisions as much as possible. We do need to strike that balance about making sure that the vulnerable in our community are not put at additional risk and, where it is reasonable to ask people to be vaccinated, we do so, and look to things like the requirements of the flu vaccine, where that is encouraged. I would not state a definitive position at this stage.

MRS JONES: Your submission also talks about evenings and weekend cancer services rapid testing. You have had conversations with the government about this. Obviously, we have not seen it. We saw the Coroner being funded but we have not seen this particular request funded. Do you have anything you would like to share about the need in that area?

Ms Cox: People do not get sick during business hours; that is something that we have discovered. If you think about business hours, it is about 40 per cent of your week. That means people are still needing to access health care during that other 60 per cent. It is about expanding the rapid assessment unit for cancer services so that they could go through until 8 o'clock or 9 o'clock.

This is often about people who are in active cancer treatment. They might spike a 38-degree temperature at 4 o'clock in the afternoon. Therefore they really need to go to hospital to get treatment, but the rapid assessment unit finishes early, because they have already done their day; so at 4 o'clock or 5 o'clock, it is too late, and you have to go to the emergency department.

MRS JONES: And clog up the emergency department.

Ms Cox: Also, you are susceptible to getting infections from other people. We are interested in rapid, direct admission, so that you can get people onto the cancer ward as quickly as possible.

THE CHAIR: I would like to thank most sincerely our friends from the Health Care Consumers Association for appearing before the committee today. It is very much appreciated. If you have taken any questions on notice or think it is valuable to provide any more information or context, please get that through to the committee secretary within five working days. We thank you again, and enjoy your weekend.

BAVINTON, MR TIM, Executive Director, Sexual Health and Family Planning ACT Inc

THE CHAIR: We will now speak to the representative of Sexual Health and Family Planning ACT. Welcome. Could you confirm that you understand the privilege statement that has been sent to you?

Mr Bavinton: I have read and understood the privilege statement.

THE CHAIR: I understand that funding for disability and sexual health is restored from funding from when the NDIS changes came in. Can you explain what has changed in this field over the last five years since the program was defunded and what workforce development needs to occur in that sector now?

Mr Bavinton: Thank you for the question. A lot has changed under the NDIS conditions in terms of how disability support services are operating and the way that they can support and skill their staff in key areas. The program that we were previously offering under funding from CSD had a big focus on workforce development for disability support services around issues of sexuality, relationships, and sexual and reproductive health.

When that disappeared, and in the new environment of the NDIS, which has very tight margins in terms of funding to support professional development, access to a free training service for the sector disappeared, at a time when we were actually seeing a proliferation of different services trying to respond with new models. We are really pleased and excited, and we are very grateful for the advocacy of ministers, other MLAs and members of our community in this area, to see funding restored.

A big focus of our return to services in that area is to undertake needs assessment around what the workforce needs are today and to then design a combination of training and other workforce development activities that will skill people at the front line in disability services and in aged-care services to deal with those issues.

MR MILLIGAN: Mr Davis, I would like to pass my substantive question over to Ms Lawder.

MS LAWDER: In your budget submission from SHFPACT, Mr Bavinton, you have said that there is a lack of a sufficiently pragmatic approach, and a lack of a reproductive and sexual health policy. Rather than having a narrow STI-BBV focus, you feel there should be a broader policy. Could you run through some of the benefits of having such a broad policy and how it would benefit your work and the ACT generally?

Mr Bavinton: It builds on some things that Ms Cox from Health Care Consumers was speaking about in the last session. We have structured our health systems and thinking largely around clinical disciplines and professions. Of course, it makes sense from that point of view to have infectious diseases and a focus on STI-BBVs together, and other health needs in the sexual health space dealt with by the clinical professions that see them as their core business. But that is not how we live our lives as individuals and as communities. These things are all a messy matrix lived in individuals, in couples, in families and in communities. Just because we structured a health system historically in particular ways does not mean it is the best way to continue to do that.

We see that there is a direct link between the experience of sexual violence that we are looking at in the reinvigoration of sexual assault prevention and response and access to reproductive health care and access to sexual health care, in the sense of a human rights jurisdiction, and being able to have autonomy over our body and our decisions. But we live these things as an integrated whole, not in the silos in which we happen to structure healthcare services.

We missed opportunities to seed a relationship between sexual health issues like STIs and blood-borne viruses, while right next door there is unplanned pregnancy and decisions about choice and control in relationships, in terms of the choice to be sexual or not, and the choice that we are afforded in a community to access healthcare services on our own terms, or through the funnels that we tend to put people through.

There is an opportunity to look more broadly at our community and see how these things are integrated and related with each other. Of course, reproductive and sexual health rights are usually a good bellwether of how well the rest of our system is working. Because they come with a lot of stigma, because they often come with a lot of sense of shame or embarrassment, if we are doing those things well, lots about our system is functioning well. It is an interesting way to look at the peak of all of the difficult things about our health system, as well as when our health system is succeeding; that can be looked at through that lens of reproductive and sexual health access.

MS LAWDER: You make the point in your submission about reducing pressure on some other parts of the health system by having that more integrated approach. You gave a couple of examples there—unplanned pregnancies et cetera. Have you done any work on, or have you spoken with the government about, the quantification of that?

Mr Bavinton: We have had lots of discussions at the conceptual level rather than at the quantification level. A couple of areas that we have identified where we think NGO health service providers may be able to assist to take pressure off the tertiary end of our system are in the women's health space. For example, and without any disregard for the quality and care that are provided in our public health services, we know we have long waiting lists for the gynaecological outpatient clinic, for services that could be provided outside that setting and therefore are taking up space on the waiting list from the services that only that service can provide in our system.

These are the kinds of questions we would like to see answered through the commissioning process that is happening to health and community services at the moment. It is about asking ourselves as a community: what is the range of services that we need? How much do we need, given our population size and particular health profile? Where are the possible and the best places to actually provide that care so that consumers in our community get the best access in the most timely way?

We are quite used to seeing funding going out to NGOs and the services provided in our publicly provided healthcare services as somehow distinct and not talking to each other very often, except at the clinician-to-clinician level.

MRS JONES: Tim, you mentioned the long wait times for gynaecological treatments. Can you give us a bit more information about that? There are so many lobby groups who tell you about the long wait times in certain areas, but this one does not always get as much attention. Would you like to expand a little?

Mr Bavinton: Yes. I will be cautious, because this is what I understand through my clinical team, in terms of referrals to the service. We are talking about things like colposcopy after a cervical screening test, where there has obviously been abnormality detected or something that requires follow-up. People are then moving to wait times of many months. The impact for health consumers is that often people are quite stressed about having a result that requires a follow-up, but they are not necessarily getting time with a clinician to either reassure them or to say, “Yes, we understand the priority that this particular need has,” and to explain that. There is a health counselling aspect, a health information aspect, that is really important.

The other area we are aware of is that we are really good at long-acting reversible—

MRS JONES: You have just frozen for a minute.

Mr Bavinton: We believe we could talk with Canberra Health Services about a referral between our systems. We refer in a lot, but we do not see a lot of referrals out for those services that could actually be provided better in the community.

MRS JONES: Can I take you back for second, because we lost you for a moment. After the health counselling, what was the next bit?

Mr Bavinton: For my organisation, contraception and long-acting reversible contraception, Implanon IUDs, is core business for us. We are very good at that. We do the training for the primary care workforce. We are the only training provider. We refer some of our work in when it exceeds our scope, but we do not necessarily get referrals back out from publicly provided services for things that we could do well, and in a more timely way, for some patients, not for all.

MRS JONES: What could that be, for example? Can you describe—

Mr Bavinton: For IUD insertion, for instance. Leaving someone waiting for months on a public waiting list for IUD insertion when that could be attended to in a community health setting almost immediately opens up risks of unplanned pregnancy, which have big, long consequences, as well as just asking people to wait for care that does not necessarily need to wait.

MRS JONES: Can I ask you to perhaps take on notice to come back to us with a list of all the things that you think people on that list are waiting for that the community sector could implement for the government? We are then in a position to ask for that assistance.

Mr Bavinton: Yes, I will take that on notice.

MR PETTERSSON: In your submission you say that investment in reproductive and sexual services has not kept pace with the growing ACT population, and one that is more geographically dispersed. I have two questions. Could you articulate how great that discrepancy is when it comes to funding?

Mr Bavinton: Again, as others have given evidence about, we have a historical settings approach to contracting for NGO health services. The gap builds over time. We do receive indexation on recurrent funding in the community sector and in NGO health services as well. But when you look at some of the benchmark indices like health costs, you see that there is anywhere between a half through to a couple of per cent difference. In one year that is not very big. That is some thousands or tens of thousands of dollars. But over two decades, when we do not ask ourselves these questions periodically, around how well the funding distribution is reflecting the community health needs in our community, the gap grows over time.

While we have certainly received indexation that allows us to continue to index salaries for our staff, we have not seen that keep pace with overall health costs for healthcare providers. That is a combination of things, in terms of health technology. Sometimes things get cheaper, but other things get more expensive over time. That gap is over the life of decades of funding. It is partly because that taking stock and readjustment does not happen as frequently as it should. We are in an environment where commissioning is trying to look at exactly those kinds of questions.

MR PETTERSSON: You also mentioned that we are more geographically dispersed than we once were. What are some solutions to that problem?

Mr Bavinton: They need to be systemic first. They are not about agency-by-agency responses. For sexual health and family planning, we have had a home base—both our clinic and our office, if you like—in the CBD. That has actually enhanced geographic access, perversely, in one sense, because many more people come in for work or travel through the city in terms of it being a transport hub than if we were located regionally, out in west Belconnen or Tuggeranong. If it was our only location, we would be inaccessible to large parts of the territory.

We know that [*Interruption in sound recording*—] in dispersed health infrastructure in terms of buildings and locations. But we have not necessarily thought about their use for multi-agency in-reach and outreach kinds of activities. We could do a lot more with the infrastructure we have to make it easier for a range of health service providers to collaborate and work from similar locations that already exist. When we are thinking about territory-wide services like ours, and a number of other community-based health service providers, having a home location makes sense in terms of scale and concentration of services. If we are going to provide geographically accessible services, we can [*Interruption in sound recording*—] satellite locations distributed around the territory.

I do not think it would make sense to fund just one agency to have that kind of geographic spread. We can think about this as an infrastructure opportunity for the whole health system, where we build our new walk-in centres, and we build our new or upgraded health services, with a view that it will not just be SHFPACT or the publicly provided community health service operating from there but many other agencies and health professionals potentially could use them as locations to operate from.

MRS JONES: Tim, do the nurse-led walk-in centres currently offer some of the services that you offer, or is that something that is just your specialty?

Mr Bavinton: There is some crossover in the sexual health space in that they offer chlamydia testing and access to emergency contraception. These days those two particular services are almost like getting your blood pressure taken at the GP. Any healthcare provider needs to be able to do that. That is not specialist care. That is standard and run-of-the-mill. If you are in primary health care, those are needs that walk in the door daily and regularly. While there is crossover between, and we both provide those services, the walk-in centres do other things that we absolutely do not, and vice versa.

MRS JONES: Would you be interested in the ability to operate through the walk-in centres or with the walk-in centres, given their geographical spread?

Mr Bavinton: Yes. We have been in conversation with them at various points around requests to offer cervical screening, for example, which is not in their scope of care but is something that we could do, potentially, from those locations.

Our answer to that is: we have to have a big conversation around what makes sense. I am not interested in displacing or disrupting health care for the convenience of some people if it still leaves other needs unmet. While it might be convenient for someone to access, say, cervical screening from a walk-in centre on the way home from work, if that person is already getting regular screening through their GP or some other point of service connection, I am not interested in moving where they get a service to be more convenient; I want to address the under-screened population. We would have to be confident that that would be the outcome.

MRS JONES: In that case, a model could be that it is available but it is not necessarily advertised; it is advertised to particular populations that it is available, and that type of thing. Is that what you are thinking?

Mr Bavinton: That is partly right. The other limitation is that those centres have physically been designed for the provision of one service by one provider. They are not structured to even have access to some of the treatment rooms that would not be confusing for consumers about who provided them with the care, and that is important. That medico-legal issue is important in health care.

THE CHAIR: We heard some evidence, in a different committee this morning, from a group who were advocating for rapid HIV testing in the ACT. My understanding is that rapid HIV testing has not been funded. I want to get SHFPACT's position on rapid HIV testing, and whether you think it would be a valuable addition to free health care in the ACT. How would you see rapid HIV testing rolling out?

Sorry, Tim; can you hear me? It looks like we are losing you. It was bound to happen at some point today.

Mr Bavinton: Sorry. I think I might be back.

MRS JONES: You are back.

Mr Bavinton: I am so sorry about the connection issue. Your question is about rapid testing?

THE CHAIR: That is right. Essentially, do you think we should roll it out? Who is best to roll it out? What would be the impact across the health system more broadly if we did?

Mr Bavinton: It is important that that is part of the mix. We very much take the lead from our partners in Canberra Health Services at the Canberra Sexual Health Centre that it is preferable, when someone needs to access testing for any STI, that their access enables them to be tested for all STIs. Comprehensive testing around sexual health issues is important.

This is an example where I think the conversation needs to move to: what is the unmet need? How can we robustly test the unmet need? If we are talking about some dozens of people who might not access comprehensive testing and be at high risk of HIV then the system as it is just has to do better to serve them. If we are talking about 500 or 1,000 people who are at high risk of HIV not accessing and unwilling to access comprehensive testing through some of the existing avenues, yes, we need to talk about a whole program of work.

The quantity of unmet need is significant in the answer to that question. Until we do the piece of work that says how much of that is really there, rapid testing obviously has a place in terms of HIV testing. But we are not metropolitan Sydney, and we are not metropolitan Melbourne, with some of those rapid testing points of contact in the CBD. My brother is a researcher who has evaluated those programs. We do not have a population size that makes a lot of sense for those kinds of models. Unless we can determine, as I said, both high risk to HIV exposure and an unwillingness to access any other kind of care then, yes, there is a space for that. But the clinical perspective is very much that it is important to provide access to chlamydia testing as well as HIV testing, if there has been a risk of exposure. We follow the lead there from the infectious diseases specialists in our community.

THE CHAIR: That brings us to the end of our committee hearing today. I would like to thank you very much for appearing, and thank everybody for appearing today—the ACT Council of Social Service, the Health Care Consumers Association, and Sexual Health and Family Planning ACT.

I remind everybody who appeared today that if you took any questions on notice or wish to provide further information or context, get that through to the secretary within five working days. The committee's hearing for today is now adjourned.

The committee adjourned at 3.46 pm.