LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Inquiry into Auditor-General's report No 8 of 2004: waiting lists for elective surgery and medical treatment)

Members:

MR R MULCAHY (The Chair)
DR D FOSKEY (The Deputy Chair)
MS K MACDONALD

TRANSCRIPT OF EVIDENCE

SYDNEY

FRIDAY, 28 JULY 2006

Secretary to the committee:
Ms A Cullen (Ph: 6205 0136)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

WITNESSES

CLARK, MS KERREN, Chair, Australian Health Care Reform Alliance **82**

KIDD, PROF MICHAEL, Executive Member, Australian Health Care Reform Alliance **82**

The committee met at 11.48 am.

CLARK, MS KERREN, Chair, Australian Health Care Reform Alliance
KIDD, PROF MICHAEL, Executive Member, Australian Health Care Reform Alliance

THE ACTING CHAIR (Dr Foskey): I formally open this public hearing of the ACT Standing Committee on Public Accounts, which is the inquiry into Auditor-General's report No 8 of 2004, waiting lists for elective surgery and medical treatment. I welcome the witnesses from the Australian Health Care Reform Alliance. To commence, I just need to read to you first of all an outline of the proceedings.

The committee has authorised the recording, broadcasting and re-broadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attached to parliament, its members and others necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

Welcome, Ms Clark and Professor Kidd. Would you mind stating for the transcript your name and the capacity in which you appear?

Ms Clark: Kerren Clark, Chair of the Australian Health Care Reform Alliance.

Mr Kidd: I am Professor Michael Richard Kidd. I am a member of the executive of the Australian Health Care Reform Alliance and I am the President of the Royal Australian College of General Practitioners.

THE ACTING CHAIR: Thank you very much. I wonder whether you would like to make an opening statement before we start asking you questions.

Ms Clark: Thank you, yes. As we represent a broad alliance, I will begin by reading a prepared statement. Professor Kidd and I will then respond to questions within agreed AHCRA positions where available. Where there is no agreed position, we will endeavour to assist the committee by responding based on our own personal experience.

The Australian Health Care Reform Alliance is an independent alliance of 46 consumer, clinician and academic organisations that are working together to help to introduce

urgently needed reforms to improve Australia's health care system so that it better meets the needs of all people of Australia. The alliance is the largest organisation committed to health reform in Australia. The alliance welcomes this opportunity to contribute to the hearing.

In this introductory statement, I will begin by responding on behalf of members of the alliance. This response is based on the position statements developed by members of the alliance at our national forum held last November and submitted to the Council of Australian Governments. The full papers are available on the AHCRA web site.

The vision of the alliance is a health system that assists individuals to be healthy and delivers compassionate and quality health care to all when and where required. The alliance's agreed principles are grouped under six headings: access, primary health care, community engagement, equitable outcomes, work force, and efficiency. Alliance members believe that we need reform to ensure integration of health care. The alliance also has a special focus on rural, remote and indigenous health issues.

The alliance believes that the following features must underpin Australia's health system. Universal access by all people of Australia in a timely fashion to an appropriate service available because of health needs, not because of one's ability to pay. Equity of health outcomes irrespective of socioeconomic status, race, cultural background, disability, mental illness, age, gender or location. Health care services must be focused on the needs of patients and their carers and the needs of Australians wishing to avoid illness. Health promotion, including both preventing disease and maintaining health, must be appropriately emphasised and balanced with our duty to care for those already unwell. Personal and corporate tax contributions should fund our health care. This is the way we wish to provide health insurance to each other. A fair balance of public and private resources and investment is needed to ensure the equitable health outcomes for all Australians.

The health outcomes of Aboriginal and Torres Strait Islander Australians must be improved so that they match those of other Australians. Health services must be appropriate, safe and of high quality. The community, especially consumers and carers, must play an integral part in the development, planning and implementation of our health services. The nation's health work force must be valued and appropriately supported. Finally, our health system should be one that assists individuals to stay healthy and delivers compassionate and quality health care to all when and where required.

We present four key strategies for reducing hospital waiting lists. Number one: hospital avoidance and free up surgeons' time. Better primary care in the community reduces the burden on acute services, freeing up surgeons' time. Targeted investment in primary care will lead to improved health of all people in Australia and long-term reductions in health care costs. The main features of primary health care include: first contact access for each new need; long-term, person-focused, not disease-focused care; comprehensive care for most health needs; and co-ordinated care when care must be sought elsewhere.

Primary care is the only way we will effectively contain rising health care costs, especially through support for preventive care, health promotion and improvements in chronic disease management and the management of co-morbidities. Investment in primary care services will reduce the burden on acute services and reduce or delay the

need for surgical intervention. Non-invasive intervention should be offered to patients in the community, with elective surgery reserved as a last resort. We need to ensure that our primary care services have a focus on meeting the needs of those who belong to specific populations which may be at a higher risk or which may encounter barriers to access.

Secondly, a conversation with the community: engage informed citizens in a dialogue about service provision and service priorities. Experience overseas and more recently in Western Australia shows that when asked to take a community focus, presented with balanced evidence, and given time to discuss and deliberate, citizens juries are able to identify and debate issues of broad principle such as equity. They make sensible decisions that allow politicians to change service priorities with the support of the community. Citizens juries in Western Australia have supported a move from acute services to primary care, which, in the medium term, will have a positive impact on waiting times.

Thirdly, we see that there is a need for better cooperation between the ACT and New South Wales services, fused into a single entity providing seamless care across the jurisdictions. Although an autonomous territory, the ACT is entirely contained within New South Wales and its citizens do not have vastly different health needs to New South Wales citizens. There are cost efficiencies and service improvements to be gained by integrating health service delivery. Planning by demographic need is more efficacious than by jurisdiction.

Equity of access and equity of health outcomes is essential. The alliance firmly believes that jurisdictional inefficiencies associated with Australian and state governments being responsible for different segments of our health care system have produced a major problem. The solutions to these problems have been sought for the last 20 years. The current arrangements are now widely recognised as a serious impediment to the delivery of quality, equitable and cost-effective health care. They represent a major historical mistake. Were we to design a health care system from scratch we would not make that mistake again.

The inefficiencies under discussion are responsible for poorer health outcomes than would otherwise be the case. Many problems are related to the provision of health care across state borders and the difficulty in promoting the essential partnership required in Australia between public and private sector providers of health.

The current arrangements have fuelled a disturbing culture of antagonism between state and federal authorities rather than one of collaboration. Partnership and mutual trust need to continuously improve the health of Australians. Integration of state and federal programs is urgently required and could be assisted with the development of agreements between state governments around specific programs. As a first step towards integration, ACT Health should integrate with New South Wales health.

Fourthly, reduced waiting time to first appointment. Reduced waiting times to first appointment leads to an overall reduction in the time the patient waits for surgery. Changes to referral arrangements will reduce waiting times to first appointment and new triage arrangements will reduce the number of consultations with surgeons that do not convert to surgery.

Allow general practitioner referral direct to allied health practitioners. At present, general practitioners referring patients to public hospitals refer them to medical specialists, even if the GP thinks they need to see another health professional. This is the only way the GP can get a patient to see an allied health professional such as a speech pathologist, but the system increases patient waiting time and uses medical resources unnecessarily. The solution is to change the system to permit allied health departments to accept referrals directly from general practitioners.

Referral for diagnostics and wait listing for surgery. There are many possible ways of performing this part of the system. For example, is it always clinically indicated that surgeons need to wait list all patients for surgery? This current system places an unnecessary burden on surgeons. It is possible that hospitals could permit allied health professionals to order diagnostic tests appropriate to their discipline, as they currently do in the private sector. For example, podiatrists could be able to order foot X-rays, and occupational therapists could be able to order limb X-rays.

Full protocols and guidelines would need to be developed in consultation with all involved health professional groups. Further, when a health professional determines that a patient requires surgical management there could be an arrangement where they could wait list the patient for surgery.

Triage by allied health professionals in appropriate clinics. Significant efficiencies are to be gained by health professionals such as physiotherapists triaging referred patients. The model is being trialled in many hospitals throughout Australia. Most trials involve physiotherapists in orthopaedic clinics or emergency departments.

I now outline a typical model. In orthopaedic clinics, referrals coming into the hospital are reviewed by physiotherapists. Physiotherapists refer patients to physiotherapy—typically about 70 per cent—or to surgical consultation. Waiting times to first appointment with the surgeon are thus dramatically reduced. Two-thirds of the patients the surgeon sees typically require surgery, thus the surgeon is seeing a higher proportion of patients who actually require surgery. All patients get to their first appointment more quickly, and those requiring surgery are also seen more quickly.

Thank you for the opportunity to make this statement to the inquiry. We are happy to respond to your questions but ask that you note that we represent only two of the 46 member organisations which make up the alliance. Some of our responses will reflect our own backgrounds and we may need to take some questions on notice if we are to reflect the views of all members of the alliance on a specific issue.

THE ACTING CHAIR: Thank you very much for that statement. I might just ask my colleague if she has any questions before I start.

MS MacDONALD: Yes. I noted with interest the recommendation that ACT Health should amalgamate with New South Wales health. How do you envisage that that would actually be achieved practically in terms of lines of responsibility to respective ministers—New South Wales versus ACT?

Ms Clark: Our concern is with the health service provided to the patient. We do not have a particular position on how the accountability would come back to the respective

political authorities. Our concern is that the patients receive the most appropriate care.

Prof Kidd: So there could be some form of agreement between the governments of both the state and the territory, and the basis of that agreement determines how the health service runs, who is accountable, where the funding goes and so forth, but it would obviously be up to the governments to decide what works best for them.

We do know that at the health minister level discussions have been held—nothing definitive happening—about whether we could have an integrated health system across Australia, a single system or a system between the Commonwealth and an individual state or territory. There may be the opportunity here for New South Wales and the ACT to take some leadership in that area, and it could lead to improved access to services for everybody. There are some things which I am sure are better in New South Wales with regard to access and some things which I am sure are better in the ACT.

MS MacDONALD: This is a statement more than a question but you might like to comment on it. We do have issues with the fact that we have a large number of patients coming across the border into the ACT—not that there is a problem with that. In our earlier informal meeting today we talked about Queanbeyan hospital, when it is upgraded, and looking at the hope that it might actually pick up some of the surgical waiting list, maybe in small areas not in a particular area.

While I think the notion is admirable to have the two integrated, there is so much argument around who actually controls the purse strings and the dollars. I just wonder, with the integration of the two, whether or not there might be problems with that in terms of, first of all, achieving it and, secondly, how it would be practically implemented and if it would actually have the desired efficiencies.

Ms Clark: There probably is a need for some interim steps. Practically, an integration of the two authorities without some interim stages is probably unrealistic. One option is to fund a pool across a range of specific programs—the example that you cite in relation to Queanbeyan Hospital that you have contributions from both jurisdictions to that hospital. Instead of having jurisdictional control of the services or the determination of service delivery in that area, you could arrange for a citizens panel to be constituted in order to determine the service priorities within that area. So the accountability would then come back to the panel and then, via that panel, to the respective health ministers.

Prof Kidd: The alliance firmly believes that we need some major reform in our health care system in Australia, or our health care systems. The alliance has called for a national health reform council, a body which will actually look at what are the current challenges.

We know that our patients are at significant risk when they cross the current boundaries in our health care system. It is not just the boundary between the state and territories; it is the boundary between public and private medicine, between the community and hospital and tertiary care, between different health care providers. Information about the patient does not travel with them, tests are repeated and important knowledge is lost along the way.

So we have a good health system in this country but we need to look at ways of making it better, making it safer and improving the quality of what we all do. We are all

committed to that, and everybody in every part of the system is committed to quality and safety and, we hope, equity of outcomes for all people in the country. But we do need to look at major reform. This could be an opportunity for these two areas, where there is a logical geographic connection, to lead the way with perhaps trialling some ways of sharing responsibility.

MS MacDONALD: What about the notion—this just occurs to me—of, say, the ACT amalgamating with the Greater Southern Area Health Service and the ACT taking over? Would that be an option that you would think would be worth while?

Prof Kidd: I think that is a possible model, and it would not hurt having people from both groups sitting down and talking together. I think that Kerren has emphasised really strongly the importance that the local community would be involved in any such discussions to ensure that the people of that area were convinced that the service was going to improve, rather than the services being taken away or put at risk.

THE ACTING CHAIR: I am interested, given that we have just come from the Department of Health, to hear your assessment of the processes that have been set in train to manage surgery waiting lists. I know it is a very narrow cut on your broad interests, but I just wondered if you have any comments to make.

Prof Kidd: Can you elaborate for us on what particular elements you have in mind?

THE ACTING CHAIR: In terms of priority listing and turnaround times. Statistically it looks a very successful program, and they have reduced the overdue and the long waiting list, so it does seem to be a cost saving measure and it does seem to be followed with some enthusiasm by some professionals. Our inquiries began out of a particular report on waiting lists, which is a hot political issue in the ACT, as elsewhere. Could we have your comments on that, please?

Prof Kidd: I would have to say up front that the alliance hasn't specifically looked at the initiatives here in New South Wales, so I do not think we can give a high-level response to what is happening there. But the principles are important—the principles of ensuring that everybody who needs it has equal access to, in this example, important elective surgery which can be life-saving and certainly can improve the quality of life for many people. We are very interested to look at the details of what is happening in New South Wales to ensure that it is equally accessible to people in rural and remote locations, and also to ensure that it is equally accessible to those in lower socioeconomic groups and those who belong to more marginalised groups within our community.

As a general practitioner working with a large number of people who are often marginalised, I know that it can be quite difficult to get my patients seen in hospitals, to get appointments for them. The access to publicly funded outpatients has been reduced significantly over recent years in New South Wales, so many people have to go through private consultations and then go onto waiting lists in the public hospitals. That creates a barrier for those who cannot afford even the costs of seeing a private specialist once.

THE ACTING CHAIR: Yes, the gap fee.

Prof Kidd: They cannot afford to pay the gap or they are not willing to get themselves

into debt because they are worried about how much the gap is going to end up being. I have patients who get onto waiting lists and, because of problems with memory and the other co-morbidities which they may have, forget their appointments and do not turn up—it is very difficult to get them back in—or have been through the system of coming into hospital for their elective surgery and getting everything organised and are then sent home because of problems with bed shortages. That of course is common in each of the states and territories across the country.

Ms Clark: The "do not attend" issue is important. In Victoria, most hospitals have had priority waiting lists for some period of time. Yes, that does lead to persons with the most urgent clinical need being seen first, but you also lead to significant degeneration of those who are on the lower end of those waiting lists. Those people often are not provided with the other health care support that they need while they are waiting.

Queensland are looking at a model which is a way of assisting those patients. They have a program called "fit for surgery" for those who are on the bottom part of the waiting lists—the non-urgents. For example, in the case of knee surgery, they are assisted to get the muscles around their knees stabilised so that when they actually attend the surgery they get a better outcome. So there is something for that patient to be doing in the meantime so that it is less of a clinical impost on that patient and they are also not actually waiting so long because they are getting some care in the interim.

But the segregation of the waiting lists does not deal with the "do not attends". One program in Victoria, at Barwon Health, has actually dealt with that issue quite well. They have put on a waiting list clerk. The clerk's responsibility is to contact people who are still on the waiting list in the days leading up to their attendance at the clinic to find out whether they are still going to be coming. They have actually succeeded in removing a number of people from their waiting lists who have simply been sick of waiting and have gone somewhere else or they have moved or whatever. So it has actually shortened their waiting list simply by eliminating those people. But they have also reduced the number of "do not attends" on the day, so it is actually better use of consultant time in the clinics.

In conjunction with introducing that clerk, they have introduced a system where they have, in their orthopaedic clinics, a physio doing the triage of the patients who are coming in. They have had a very good response in terms of the number of patients who are going through to surgery. I have some figures here. Of those who were referred for back pain, none of the patients referred during that period ended up having to see the surgeon; they all went to see the physiotherapist. So all of those people were taken off the waiting list.

THE ACTING CHAIR: We really appreciate that because it is actually a broadening of the perspective that we have so far had on the issue. I think that what you are talking about is taking a more holistic perspective on patients so that they are not just going through that sort of medical and surgical line. I note what you say about the physiotherapist, and there may be other allied health professionals, but, given that we are often talking about orthopaedic issues such as knees and hips, the role does seem fairly clear cut.

MS MacDONALD: I have met with representatives of the Australian Physiotherapy Association about the trials that have been undertaken. They have done that in Victoria.

Did you have some at Newcastle as well?

Ms Clark: I am not aware of the trials in Newcastle. There are a number going on around the country. Certainly there have been quite a number in Victoria. I know that most have been in Victoria.

Prof Kidd: I was recently in the UK looking at some IT initiatives with the National Health Service. They are spending a large amount of money there. I am not sure if you have looked at their "click and pick" program which they have made available through their web site. General practitioners are able to search for available spaces in outpatients and in elective surgery for their patients and, at the time of the consultation with the patient, click on and make the appointments for their patients at that time.

It is being evaluated. I think the evaluations would be useful for you to look at. The system obviously is different there but it means that, where there are several hospitals in a local area, the general practitioner can find out very quickly where the waiting list is shorter. New South Wales did a trial a number of years back providing details about waiting lists in different areas, but it was not really available at the time that the general practitioners were consulting with their patients and it didn't change over time.

We can use new technology. More than 90 per cent of our general practitioners have a computer on their desk, so the capacity is there. However, we have some cultural barriers in that at the moment general practitioners cannot put people onto waiting lists or automatically make appointments for them. Some of those barriers would need to be addressed.

THE ACTING CHAIR: So that would need to be addressed within the profession, or does it need government intervention?

Prof Kidd: It is a barrier within the hospital bureaucracy. The reason for looking at the evaluations coming out of the UK is to see what actually worked and what were the barriers in implementing for the general practitioners and what did not work at the hospital end. You would not want such a system where a lot of people did not turn up to their appointments or did not turn up to their surgery; that could actually lead to your waiting list problem getting worse. Or you may have a hidden waiting list; you don't have a list, you just have a wider group of people in the community with increasing morbidity who are not on the list at all.

Ms Clark: But, by the hospitals working with the health providers and the consumers in the area, you can come up with a model. As Michael says, many of those barriers within hospitals are essentially cultural. There is no particular reason why you cannot choose which hospital the patient should go to and there is no particular reason why the GP should not be able to direct the patient to the part of the hospital that they actually want them to go to; it is just the regulations within the hospital. But if you collaborate with the health care providers, the hospital administrators and the patients in those areas it is quite possible to overcome those invisible barriers

Prof Kidd: Absolutely. Of course, in the ACT you have much more capacity to do that than elsewhere. You have a very strong ACT Division of General Practice that you could work with directly in perhaps initiating some of these reforms.

THE ACTING CHAIR: I just want some clarification about your comments about the UK. There is a program you were talking about, the London Choice project, or is that something different?

Prof Kidd: London Choice may be a sub part of it, I am not sure, but it is part of NHS Connecting for Health, which is the £6 billion investment that the UK government is making into e-health right across the country. I think the "click and pick" sits under their safety and quality council as an initiative

THE ACTING CHAIR: Click and?

Prof Kidd: Click and pick. Click your mouse and then pick the-

THE ACTING CHAIR: Pick and click?

MS MacDONALD: No, it's the other way around.

THE ACTING CHAIR: Click and pick, thank you. Sorry, I thought you were giving us the name of a consultancy firm!

Prof Kidd: No, it's just the procedure. Actually, pick and click may be more sensible.

THE ACTING CHAIR: Google will be able to work it out. It is something that we can look into. Do you know of moves similar to that here in Australia?

Prof Kidd: Certainly in New South Wales a number of the divisions of general practice have worked with the local health services, health authorities, in looking at ways of streamlining access into hospitals and improving access. Newcastle is a great example. It would certainly be worth a visit if you are doing further field tests. Dr Arn Sprogis, who leads the urban division for the Hunter region, has been very proactive in trying to look at innovative ways of breaking down some of the barriers and getting everybody to work together.

THE ACTING CHAIR: And he is making progress, you believe?

Prof Kidd: He is making progress.

THE ACTING CHAIR: Okay, it might be worth having a look at him. There are only about three minutes left. Do you have any specific questions?

MS MacDONALD: I cannot think of any off the top of my head. I will have a look through the transcript when we get back and we might end up sending you further questions.

THE ACTING CHAIR: Thank you very much for your statement. One of the things that you have discussed is more recognition of other therapeutic treatments apart from surgery. You were talking about the actual contacting by phone and keeping stock of waiting lists in that way. It also sounds as though there should be much more cooperation between hospital bureaucracies and practitioners. Is there anyone else that you would add

to that, such as consumers?

Ms Clark: Yes.

THE ACTING CHAIR: You do not have boards like that. Have you got any examples of where you do see that working well that we can have a look at?

Ms Clark: In New Zealand it actually operates quite well. I am not aware of models that work broadly in Australia. In Victoria we have the community health centres, which are governed by community boards, but they are very small scale and they do not access acute services. The model in New Zealand is actually a citizen-directed model. The model essentially involves geographical jurisdictions where there are consumer and provider boards that are responsible for determining the services provided within those areas. That is broadly a model that the alliance would support, and it is a model that the alliance would support particularly as a move towards combining funding. We see it as an opportunity to fund a pool between jurisdictions by using that model.

Prof Kidd: The alliance itself is an example of consumers and clinicians working well together. It includes a large number of organisations. Perhaps we will table a list of the organisations for you as part of the submission. I think that the alliance does focus very strongly, it is true, on the role of primary care and on the importance of all our health systems very actively addressing the needs to improve preventive care and health promotion. Also we focus very strongly on the role of teams in our health care settings and breaking down some of the barriers which have traditionally been there so that we can work together to deliver better health outcomes.

The waiting list is the end point. We know that ACT Health already has a strong focus on primary care.

THE ACTING CHAIR: We could have more, but that is my opinion.

Prof Kidd: It is critical, and it is what the community expects as well.

Ms Clark: Just to elaborate further in terms of the impact on the waiting list, poor chronic disease management is a very, very high indicator for presentation in an emergency department. Presentation in an emergency department and a patient subsequently being admitted to hospital is a factor in elective waiting lists blowing out, because that person being admitted to hospital can mean that a person waiting for elective surgery no longer has a bed available for them. So if we can actually stop the person with a chronic disease presenting to emergency then the person who is on the elective waiting list is more likely to have a bed.

THE ACTING CHAIR: We had better draw this to a close because we are expected at Auburn Hospital at 2.30. Thank you very much for making yourselves available to us today. It has been fantastic.

Prof Kidd: Thanks for the opportunity to be here.

Ms Clark: Thanks on behalf of the alliance.

THE ACTING CHAIR: May we get in touch with you if anything further comes up?

Ms Clark: Certainly.

THE ACTING CHAIR: I would be interested to see which ACT organisations are members of the alliance. Can you tell me?

Ms Clark: We are mostly national organisations but I think we do have one ACT organisation. I just cannot see exactly which it is at the moment. Michael, can you help me?

Prof Kidd: No.

THE ACTING CHAIR: Do you have some work on mental health issues? Do you have some representation on that?

Ms Clark: Yes.

Prof Kidd: A lot of our organisations, of course, are based in Canberra. It is the major centre.

THE ACTING CHAIR: Thank you very much.

The committee adjourned at 12.24 pm.