LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Access to primary healthcare services)

Members:

MR S DOSZPOT (The Chair)
MS J BURCH (The Deputy Chair)
MS A BRESNAN

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 22 JULY 2009

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 21 January 2009

The committee met at 9.15 am.

DUNDAS, MS ROSLYN, Director, ACT Council of Social Service
GIORGI, MS CATERINA, Policy Officer, ACT Council of Social Service

THE CHAIR: Good morning, and welcome to this public hearing of the Standing Committee on Health, Community and Social Services, inquiring into access to primary healthcare services in the ACT. Good morning, Ms Dundas and Ms Giorgi. I think you have both appeared before, so I am not sure if you want me to make you aware of the privilege statement that is available before you. You have read that?

Ms Dundas: We have read the privilege statement.

THE CHAIR: You have obviously read the card, and you understand the privilege implications of the statement. As is customary, Ms Dundas, would you like to make an opening statement?

Ms Dundas: Yes, thank you, Chair. We have provided a written response to the inquiry which had an overview of the broader health policy setting beyond initiatives that target GPs alone. ACTCOSS believes that primary healthcare planning and discussion need to be had at a whole-of-community level. This is needed to ensure that the fragmentation of the health system, both here in the ACT and nationally, does not continue, and does not continue to impact on health service delivery.

ACTCOSS is involved in consultations with ACT Health on a range of health issues. It is through these processes that we have become acutely aware of the fragmentation that is occurring throughout ACT Health, with numerous independent plans, policies and frameworks being developed in isolation within that department. This is why, in our submission to this inquiry, we have chosen to represent a perspective that demonstrates the bigger picture, placing equity, access and the social determinants of health at the forefront of planning.

The segregation between planning and consultation processes occurring throughout ACT Health, and the inconsistency in the development and delivery of health policies, demonstrates a lack of communication, we believe, between different sections of ACT Health. This does not assist moves towards an integrated and intersectoral service delivery. If policies are developed in a segregated way, we believe their implementation is also likely to be fragmented.

Moving specifically to primary healthcare, ACTCOSS believes that primary healthcare services are an integral part of the delivery of healthcare, as they are the main point of access into the healthcare system. Traditionally, the gatekeeper role for healthcare has predominantly been with GPs. However, due to the supply and demand factors that are contributing to the decreasing health workforce, and increasing demands upon primary healthcare services, ACTCOSS feels it is now important that we explore alternative models of healthcare and healthcare provision. The focus of primary healthcare reform cannot lie with GP recruitment and retention strategies alone, as these methods are not sustainable in the environment of global workforce shortages.

It must be noted that we are not opposed to attracting additional GPs to work in the ACT. We would support moves to bring that about. But we acknowledge that a sole focus upon attraction of GPs may not actually result in an increase in GP numbers here in the territory, due to the global challenges that are facing the GP market. So we will argue that the focus of this inquiry needs to be broad—broader than just GPs—to encompass the whole of primary healthcare, and possible changes to improve equity in access to primary healthcare services. This will ensure that one aspect of primary healthcare, such as GPs, does not get discussed in isolation, and it will encourage a multifaceted approach to addressing the challenges that are facing primary healthcare.

We would now like to briefly touch on what we believe is fundamental to primary healthcare and healthcare provision, and that is the social determinants of health. This approach to healthcare planning needs to be truly integrated across all ACT Health approaches, and we encourage you to consider it in your deliberations. The social determinants of health are the conditions in which people are born, grow up, live, work and age, which are in turn shaped by political, social and economic factors.

Significant evidence exists for a social determinants approach to healthcare planning. This approach would encompass all sections within and across all government departments, agencies and organisations to develop and deliver coordinated healthcare processes. By adopting a social determinants of health approach to health planning and services provision, we are acknowledging that people require a range of supports and services to improve their wellbeing and health outcomes. The investment in this approach could contribute to increasing the health outcomes of the people within our communities that are experiencing disadvantage and require the most assistance.

Within our submission we also outlined a number of barriers that exist to hamper people's access to primary healthcare and GP services. I will not go into them in detail again, as they are outlined in our submission, but I will highlight our concern that the campus at the Canberra Hospital appears to be being used as the expanding campus for primary healthcare services in the ACT, and we think that this provides significant barriers to people accessing those healthcare services, and that they do need to be spread more widely across the territory.

We believe that there are longer term solutions out there to address health workforce shortages, and this is through developing more innovative ways of delivering those health services. For example, we support the development of the nurse practitioner-led walk-in centres that are being explored. However, we recognise that more needs to be done to ensure that Canberrans have timely and equitable access to primary healthcare.

We urge you to look at what is happening in other states and territories, as they are implementing strategies to improve access to primary healthcare for consumers. These strategies use a range of service delivery models, including those that do not focus upon GPs alone being the gatekeeper to healthcare, such as expanding the roles of existing health workforces and developing new health positions, and providing incentives for multidisciplinary teams to work together to provide care for consumers.

It must be noted that no one strategy alone will address the challenges facing primary healthcare in the ACT. A variety of primary healthcare initiatives are required to

ensure that the barriers that are stopping consumers accessing primary healthcare are overcome, and that all consumers have access to timely and affordable healthcare provision.

THE CHAIR: Thank you, Ms Dundas. We note your comment regarding the need to broaden the inquiry beyond just GP issues, and I think we do have scope to do that. In fact, the terms of reference refer, as I read out at the beginning, to inquiring into access to primary healthcare services generally in the ACT. But thank you for your thoughts on that.

As an opening question, in your very detailed submission, which we thank you for, you noted a number of issues, but what have you identified as being the most pressing barrier to accessing health services in the ACT for disadvantaged consumers?

Ms Dundas: We have undertaken consultation in the lead-up to the 2009-10 budget, which is our main consultation point, and there were a range of issues raised regarding the barriers to accessing healthcare, including the prohibitive cost, based on lack of access around bulk-billing; limited access to healthcare, with a focus upon the dependence on GPs—and we know, through this inquiry and other inquiries happening, that we do have a shortage of GPs; limited after-hours options; fragmented and irregular public transport, which limits access to those services when they are available; and, as I have already outlined, the location of services, and centralising them around the Canberra Hospital campus. Caterina, did you have other issues you wanted to explore?

Ms Giorgi: No. I think that the greatest barrier is cost, and particularly our lack of bulk-billing GPs in the region, which means that people experiencing disadvantage really need to depend upon waiting in one of the few bulk-billing centres for extended periods of time, or going to the emergency rooms.

Ms Dundas: We believe that, if there are a range of primary healthcare options available across the ACT, this would help to decrease the burden on those GPs and allow people to access a range of primary healthcare services to meet their needs.

THE CHAIR: Thank you. Ms Burch?

MS BURCH: Just on a couple of those barriers to access—and I agree with you that cost is an inhibiting factor, and we do have the lowest bulk-bill rates—do you have any thoughts about how to change the business culture of small business to bulk-bill? General practice is a small business model. They determine their costs and the rates they need to charge to cover their own business. Do you have any thoughts or feedback about how one can make those cultural shifts within the small business model?

Ms Dundas: That is why we are talking about a range of options for how primary healthcare is delivered. The walk-in centres and working with nurse practitioners will provide other options for those people who cannot afford to pay the up-front cost of visiting a GP, and still enable them to get their healthcare services. This may spark some competition, which may cause GPs to re-assess, in the ACT, why their bulk-billing rates are so low. It is not the case across the rest of the nation that GPs do

not bulk-bill; it is something that is specifically quite apparent here in the ACT. So if we can provide other options, it may encourage the GPs, but in the meantime there will be those other options.

MS BURCH: Those provision of services.

Ms Dundas: It will allow more consumers to access the primary healthcare that they need.

MS BURCH: Just on location, you are right: the first walk-in nurse clinic will be initiated at Woden hospital campus. It is my understanding that it is to ensure we get the support and the buy-in from the medical fraternity, and then to put that out into other areas, such as, I think, Belconnen, Tuggeranong and those outreach areas. So you would see that as a good thing, building on the existing community health centres, to have clinical provision as well, in a broader scope?

Ms Giorgi: There are difficulties associated with accessing the Canberra Hospital base, particularly in terms of public transport, for people that do not have their own transportation. This was raised with us during our consultations for our ACT budget submission. There have been a few different suggestions on how this can be fixed, in terms of having more accessible bus services, and even having a shuttle bus running from Woden to the hospital to make it easier for people to access. We are aware of the fact that the walk-in centre is being located at the hospital, but we are saying, for future planning, that we really need to look at those areas that have a lack of primary healthcare facilities, and look at whether we can develop services there, or services that are more easily accessible.

MS BRESNAN: When you mentioned location, access and transport as being major issues, did you find when you were doing your consultations that people would travel long distances? I know there is a large bulk-billing clinic at Phillip. Were people travelling large distances to try and get to such places, or were they, in some instances, not going because they were not able to access a GP or even get to the hospital in some instances?

Ms Giorgi: We heard a range of different things both from other organisations and from consumers who have been involved in our consultations. The main thing that we have heard is that people have to travel further, or they have to invest a lot of their time in trying to work out the best thing for them, which they have developed over time. This is particularly so for people with chronic conditions. They have finally worked out something that accommodates their needs and that suits them. But that takes quite a bit of work, particularly if someone is sick and needs to see someone today. We have heard some concerns around the Phillip Medical Centre and access to that medical centre. We are located in Phillip, and we understand that it is easy to get to Woden. But to go that extra little bit to Phillip is not easy and it is not accessible.

MS BRESNAN: It is not a good location.

Ms Giorgi: No, it is not a great location. As I said earlier, you can get to the medical centre and be waiting for hours.

Ms Dundas: We are looking at developing a preventive approach to our healthcare system. We are seeing more and more people waiting—I hesitate to use the word "acute", because I know that has clinical connotations—at the more dire end of their health needs before they actually take the steps they need to take to access healthcare provision. If we are looking to try and build preventive approaches into our healthcare approach, recognising the social determinants of health that are impacting on people's wellbeing, we really need to be exciting in our thinking around how we deliver primary healthcare services.

Ms Giorgi: Sorry, I have just one more point. There is definitely research—we have discussed this with other organisations—around people who are experiencing disadvantage just not taking medication at all because they cannot afford it. They cannot afford to go to the doctor and they cannot afford to take out a script. There are obviously some real concerns around that. That has been found particularly with older people who are experiencing disadvantage and sometimes need to take a number of medications.

THE CHAIR: Mr Hanson?

MR HANSON: Thanks for coming today. Can I commend you on your submission. I thought it was excellent. I am not sure who put it together but whoever is taking the credit, well done.

The issue of fragmentation and replication was also mentioned in your submission. I think that the conversation generally is about the problems of coordination between state and federal and territory and federal. Can you extrapolate on the problems that you are experiencing? Within the ACT where that coordination is occurring, do you have examples of what you have actually done? Have you alerted ACT Health about this problem? Where are we at?

Ms Dundas: Over 2009 we have been involved in seven different consultations with ACT Health on plans that are being developed this year, separate to this inquiry and separate to ongoing dialogue that we might be having around other issues. That is seven consultations on plans and there are three that we are aware of that are pending. As we see all of them one step removed from the ACT Health system, there is a lack of coordination around what it is that they are aiming for, how they are being developed and how they are being consulted on. I can run you through the list of seven, but they have been made publicly available.

MR HANSON: Maybe we can do that offline and have a chat about it. That would be very useful. Thank you.

Ms Giorgi: Mr Hanson, one example that I am thinking of, just in terms of preparing a response to another submission, is at the moment in mental health they are consulting around the mental health promotion prevention and early intervention framework and the suicide prevention framework and they are finalising the mental health services plan. It is our understanding that that will be out soon. We look at these documents. We are lucky that we have the opportunity to look at all of the documents, whereas we understand the people working within ACT Health often just work on that one project or that one area.

Even trying to find similarities between how the promotion prevention and early intervention framework fits in with the mental health services plan is quite difficult for us. We really need that to be more coordinated so that it occurs in a more coordinated way on the ground so that people do not look at these plans as completely separate things when, in actual fact, they need to be working together.

MR HANSON: They are all interlinked and coordinated.

MS BRESNAN: And I guess there are drug and alcohol plans as well.

Ms Dundas: Yes, there are five separate plans that are being developed or that currently apply to mental health alone. It is hard to see how, in that specific subsector of ACT Health, they all interrelate.

MR HANSON: It is something that we can talk about later then.

Ms Dundas: To tie it back in specifically to the terms of reference of this committee, when we are looking at primary healthcare we are looking at preventive health with the underlying pins of the social determinants of health. If there are five plans overarching mental health and however many other plans across the whole of ACT Health, how are they all working to the social determinants of health framework, which should be underpinning all of these plans and should be articulated through everything that ACT Health is doing?

We are really not seeing that come through. We are just seeing a lot more plans come through that do not really address these needs and do not really address the bigger picture. That is quite disappointing when we believe there is goodwill in ACT Health and across the government to address these needs, but they are not in the plans and they are not being implemented as those plans are rolled out.

THE CHAIR: Having said that we need to be looking at broader than just the GPs, I have a GP specific question to ask you, if you do not mind. How does ACTCOSS believe that the ACT could attract and retain more GPs within the ACT from the discussions that you have had?

Ms Dundas: There is certainly some work that has been going on around picking up on some of the national initiatives that we should apply in the ACT—our space as a regional centre—and working with those kinds of initiatives that are being developed. But I also think that there is more work to be done around the support that is given to the GPs who are working in the ACT.

Ms Burch, you outlined the small business model. Each GP will work to what they believe is the best system for them, but if we were able to co-locate GPs in some of these other primary healthcare models and allow them to work more closely with nurse practitioners, allow them to work more closely with other primary healthcare professionals to increase their capacity to deliver on the health outcomes that they know that their patient needs, we would see that as being a more productive work environment which hopefully leads to happier and healthier GPs.

We also recognise that there are approaches that can be taken, recognising the current workforce that we have in our GPs. It is an older workforce and it is an increasingly feminised workforce. In that co-location with other healthcare professionals you can meet the work-life balance needs of the individual GPs. They can work part time. They can work to a more structured regime that fits their other needs. We can look at other ways of mobilising the GP workforce. I think if we are able to construct more of that flexibility in that provision of GP healthcare then that will attract more people who are looking for those lifestyle components as part of their work-life.

Ms Giorgi: I just want to stress that a lot of the strategies that ACT Health has been adopting have been looking at recruiting more GPs. In our submission we have really tried to focus on looking at things that other jurisdictions are doing—talking to people and finding out other ways that we can get people to access healthcare in a timely way that is affordable. That is why we have provided some examples like HealthOne in New South Wales where the government provides funding for multidisciplinary teams to work better together. That does not necessarily mean co-location, but it means that if I need to see someone I might not necessarily have to go through my GP. If it is just to get a wound dressed or something like that, I can go and see the practice nurse or something to that effect, depending upon the different teams that are in action.

We are really trying to focus on how we can enhance the primary healthcare networks that we have now. There are some really good examples with HealthOne in New South Wales and the primary healthcare network program in Victoria that give us the foundation for doing that.

THE CHAIR: Thank you. Ms Burch?

MS BURCH: Just on scope of practice, you acknowledge that it is a national issue, that the workforce and the restraints around our existing model of primary care with GP focus is problematic and expanding a scope of practice is useful. Just on your earlier comments, I am looking to another solution that is on our website. It was written by the medical fraternity that has not got a lot of faith in alternative models of primary healthcare and other scopes of practice being developed and enhanced and welcomed. So there is a balance around what a sector in the provision of primary healthcare believes is the right thing.

For you to support the broadening of the scope of practice and enhancing primary healthcare providers, is that picked up from your connection with individuals, service provider groups and NGOs providing drug and alcohol care and mental health support? That is from the ground as well? Whilst the medical profession might have one notion, folk who need services have another notion.

Ms Dundas: Absolutely. As we articulate in our submission, we are hearing stories all the time about where the current system does not work and where it falls down in the provision of primary healthcare to those who are living with disadvantage. What we are advocating is an expansion of service delivery options which we believe will better support those who are most vulnerable in our community.

We certainly respect the role of GPs and believe that they have an ongoing role to play, but if we do not expand the model of primary healthcare service delivery in the

ACT then those living with disadvantage, those who are most vulnerable, will continue to face the problems that they do based around access, cost, transport and a range of other issues. That will lead to grave impacts on their health, which we are already seeing and will continue to see expand. It will impact on their ability to work and contribute to our community. It will push them further into disadvantage and make them even more vulnerable.

MS BRESNAN: Just in relation to that, because obviously the National Health and Hospitals Reform Commission are defining who would be included in the expanded type of model, we have talked about the nurse practitioner and you have given the example of the Victorian program as well. What other allied health professionals or even others in the medical services would you see as being included in an expanded model?

Ms Giorgi: Firstly, we need to clarify that we do not think that we will say, "Here are five health professionals and now let's make five primary healthcare centres with these five health professionals." Can I use the example of the Althea Wellness Centre, which is located at Directions ACT. It has a GP, it has access to alternative medicine practitioners, it has nurses and it has drug and alcohol counsellors. That is specific to the population that it is trying to assist.

We acknowledge that people with chronic health conditions will have very different needs to a young person who is generally quite well and has a sniffle on that day. It might be more important to the person with chronic health conditions to have continuity of care and be with the same person. Whereas, for the younger person, as has been stated in the walk-in centres discussion paper, they are quite happy just to walk in and see anybody just to get that fixed on that day.

What I am trying to say is that the models will differ and it will include health professionals. We see with our New South Wales users, like psychologists, GPs, practice nurses and nurse practitioners, that there is room for that to move around. For example, physiotherapists might be included as well.

MS BRESNAN: Do you think that with e-health coming in—I guess in that process consumers are nominating who they would want to access their information as well—the consumer is leading the process more by saying, "This is the person who I involve in my care so I would like them to be a part of my care plan"?

Ms Dundas: It certainly allows the great potential of primary healthcare centres being able to service the needs of one client across the different areas because that individual does not have to continually repeat their medical history and their life story, which is a real barrier, certainly to people continuing to get the different needs of their health looked at. We can see that as a real benefit of an e-health system, especially when a consumer may forget or not understand completely an important part of their medical history which impacts on their further healthcare provision. So being able to direct who is accessing their records for particular needs will, we hope, ease the ability for those individuals to access the healthcare that they need.

THE CHAIR: We started a couple of minutes late, so with your indulgence, Ms Dundas, we will carry on for one more question, if you have time.

Ms Dundas: We serve at the pleasure of the committee.

MR HANSON: Wonderful. The integrated model we have discussed has a lot of attraction to it but we have also discussed the nurse-led model. A concern that I have is that if you have low rates of bulk-billing in the ACT and then you have nurse-led centres which are free, essentially you end up with a two-tiered system where poor people go to nurses because it is free and wealthy people go to doctors because they can afford it. That will not exclusively be the case, but you could see that model occurring. Have you given any consideration to that? Do you think it is a concern, or not?

Ms Dundas: What we are aiming for in our submission and through these conversations is a primary healthcare system that addresses the needs of every Canberran. We would hope that we would develop primary healthcare centres, walk-in centres and nurse-led practices that provide first-class healthcare to Canberrans who need it. It is as simple as that.

Ms Giorgi: We would not support a system that we thought provided suboptimal care. We think that nurse practitioners can provide that level of care. If people living with disadvantage can access a nurse practitioner to get the assistance that they need then that is fantastic. That is much better than them self-medicating, not medicating at all, or just letting their condition worsen. I think it is important to state that we believe that nurse practitioners are quite competent to—

MR HANSON: Indeed. I am not disputing that. I suppose what we discussed was the integrated model where we had people working together and of which practice nurses and nurse practitioners were a part. But the nurse-led—

Ms Dundas: And potentially GPs.

MR HANSON: And GPs working together. As to the nurse-led model, the concern I have is that that is isolated and is not part of an integrated team. Then you have a situation where, because it is free—and I am not saying it is better or worse—people go to the nurse and you have the same sort of situation created where poorer people with less access are not necessarily going where they should be going but are going where it is more accessible. But what you are saying is that accessibility is the most important aspect.

Ms Dundas: We would see the primary healthcare provision being where they need to go because it would allow them to access the primary healthcare support that they need. If it escalated beyond primary healthcare then they would be moving to secondary healthcare options, which would be at the hospital. That would be the same whether they rock up to a GP or whether they rock up to one of these primary healthcare centres. Everybody in that centre would have the responsibility, if it has progressed beyond primary healthcare needs, to refer or support that individual to access secondary healthcare.

THE CHAIR: Thank you, Ms Dundas and Ms Giorgi. I just note that in the final paragraph of your conclusion you encourage the committee "to take this opportunity

to progress significant reform placing the focus on consumers and assisting people in our community that are experiencing the most disadvantage". Can I just make an open offer to you. This committee is going to be meeting for a number of weeks. If examples of issues relating to that crop up in your day-to-day experience we would love to hear of any that you may want to bring to our attention. Likewise, there may be some further questions that the committee may wish to put to you in writing. Thank you for your well-thought-out submission. We hope we will be able to put it to very good use. Thank you for your attendance. A copy of the transcript of this morning's proceedings will be sent to you. Thank you.

Ms Dundas: Thank you for the opportunity.

BRADY, MR PETER, Branch Director, Pharmacy Guild of Australia (ACT branch)
TRAN, MR VINCENT, Pharmacist/Manager, Capital Chemist, Curtin

THE CHAIR: Good morning, Mr Brady and Mr Tran. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. I am not sure whether you have had an opportunity to read the privilege statement that is there before you.

Mr Brady: We have, yes.

THE CHAIR: You understand the privilege implications of the statement?

Mr Brady: We do.

THE CHAIR: Thank you. I presume, Mr Brady, you are the lead in the—

Mr Brady: I will lead off.

THE CHAIR: Would you like to make an opening statement?

Mr Brady: Yes. If I could introduce both of us: Vincent is a community pharmacist; he is an owner and is on our branch committee. Vincent has all the technical expertise regarding those questions that I might find a little more difficult. I am the branch director of the ACT branch of the Pharmacy Guild of Australia.

Very briefly, to ensure members have a good understanding of the guild: we are an employer-based organisation that seeks to look after the interests of our members. We have 5,000 members across Australia. Every pharmacist in Canberra, all 61 of them, is a member of the Pharmacy Guild. We have a federated structure in which there is a national secretary, we have branches in each of the states and territories, and those branches answer to a branch committee that is elected through the Australian Electoral Commission process. That is a little bit about the guild.

I wanted to make a couple of key points that I know are in our submission but I think it will also assist when we get to the key recommendations that we are making. Firstly, it picks up a little bit on the points that were made by the last two witnesses. We are conscious that your committee is looking at the issues of doctor shortages, GP shortages in the territory, and the impact that that is having on the broader community.

We believe that some of the proposals that have been put forward by the government, while some of those have merit, are missing out on a number of other opportunities and models that we believe would be much more effective, much more cost effective as well. I will talk about those as we go through.

The point we would like to make is that community pharmacy plays a very key role in the primary healthcare regime within Canberra and the broader community. They are the kind of touchstone or the face that meets with virtually all of the community across the territory. Surveys that are regularly done of various health professionals of all professions show that pharmacies and pharmacists are up there as number one and

number two in respect in the community. They are assisted by trained pharmacy assistants, who go through quite a deal of accreditation to assist in the work that they are doing.

Pharmacy provides a broad range of services, and I think we will get into this. We might discuss this a little further. It is not just about dispensing medications and scripts that are written by the doctor. They provide triage service, they provide counselling, advice. More and more areas such as diabetes, smoking cessation, weight programs et cetera are delivered through community pharmacies.

Mr Tran: To continue on that point that Peter has mentioned: as you are all aware, you have all been to pharmacies before. When you actually first enter into a community pharmacy, there is always that first point of contact. When you have an inquiry or you are curious about a certain topic or issue, most of the time a patient will actually have contact with the staff assistant and, if they cannot assist with that first initial contact, they will refer them to the pharmacist.

If the pharmacist can assist in that situation, give a person a starting point, "This is the approach that you can take for your particular situation," that is where a rapport is built. If not, obviously the triage service comes into place and then we will refer it to the appropriate health profession, whether it is a doctor, a dentist, in case they have gum issues, a podiatrist et cetera. As you are aware, that initial first point of contact can point a particular patient in a certain direction, particularly if we cannot assist them any further.

Mr Brady: I think it is really important that we should hold that point. Looking at the ACT, I mentioned a little earlier that we have got 61 pharmacists. One of the unique things for the ACT is, because of the territory's planning system—we have got local, group and town centres—essentially most people are in close distance, and some of them are in walking distance, many Canberrans, to their local pharmacist.

One of the issues happening with the GP shortage is not only are we having difficulty in filling the numbers but the fact is that they are actually shrinking into the town centres. So it is not only access from the point of view of being able to get time access but it is actually physical access. For disadvantaged, older people, disabled people, to be able to get access for minor services, it is becoming more and more difficult. Even last week, a number of the members who are here at the committee were at a community meeting. This issue of GPs moving out of their community is just as problematic as the numbers that we have.

Coming back to that pharmacy, if you can picture it in your mind, we have got 61 health clinics all across Canberra that are in really close contact with most of the community. Not only that, they are open six days a week, most of them. They open from 8 o'clock in the morning till six at night. Some of them are open until 11 o'clock at night. We have even got one of our pharmacies that is open 365 days a year. Unlike some other clinics that are open from nine to five, five days a week, our members are open for that quite extensive period. I am just trying to reinforce the fact that the infrastructure that is currently there is providing primary healthcare services.

The concern that we have, the key concern—and I mentioned it a little earlier—is

about some of the solutions or the models or the points being advanced by government. One is a real attempt to bring more GPs into the community, and that is great and we at community pharmacy are supportive of that.

But on the other side, we have got the issue of the concern about our emergency healthcare clinics being clogged up with minor ailments. We have got people going to their GPs for, it might be, medication continuance but for a whole range of things. The question is: do they really need to go to their GP to get that service? Secondly, do they need to go to outpatients to get that service?

At a national level, the guild has put to the commonwealth government—and it is being considered as part of their primary healthcare review that they are doing—two key areas that we believe pharmacy can play an absolutely crucial role in. The first one is about a minor ailment scheme. What we are saying is that community pharmacy can provide those services that are being proposed by nurse practitioners, for example.

The guild is not opposed to that but we have put the question to government and to you: is this really the most cost-effective way of addressing the issues around minor ailments and medication continuance? We would suggest that it is not. We would suggest that community pharmacy provides, particularly in the territory, a much better model to be able to help address that situation.

The other point that I would like to make—and it was included in our submission, but I really would like to raise it—is a concern that we have got, which is that, when models are being developed or issues that we may have, the community pharmacy is not engaged in the ACT, where in some other jurisdictions they very much are.

I can give an example of what has been happening with swine flu, for example. We have had to virtually bang on the door, particularly through the department, to get our voice heard, to get into the tent, so to speak. Everyone is aware that most people would go to their community pharmacist to get their mask or to inquire. As Vincent was saying, that is where they would go. So we have had to actually bang on the door.

In Victoria, for example, in contrast, the department of health is working really closely with community pharmacy. They have actually set up and are using our project STOP. That is the one where people come in and all the computerisation is used for people buying products with pseudoephedrine. We are using that to be able to highlight where the areas of swine flu are and where we should be addressing it, which pharmacy should be delivering the free Tamiflu that is being provided by the commonwealth government.

We are taking this opportunity to talk to your committee to say, on one hand, we have some solutions that we can work on and help the government and help the community. We already provide a range of those services. ACTCOSS a little bit earlier was making the point about bandage and some minor treatment. That is already happening in pharmacy at the moment. That already occurs. That is one side of the points that we want to make about engaging.

The second part is the concern in a number of areas where we just do not feel the

government—and I will use that term but it is probably more the department than the government—is doing enough when these kinds of things happen. Another example is the national registration and accreditation that is going on. That will have a kind of a side effect in respect of GPs. It is not having any direct effect. It is like we have been kept in a vacuum even though, again, we are kind of knocking on the door and saying: "This is absolutely crucial to us. What is happening in regard to the state boards? What is going on there?" At the federal level, we are very engaged with the commonwealth government and the commonwealth bureaucracy in that regard.

New medicines and poisons legislation came out earlier this year. We heard nothing from the government, we heard nothing from the department, about how this is going to be rolled out, what are the issues et cetera. The guild has picked up that and we have provided that.

They are the two points that we are trying to make. One is that we are already providing these services at no cost to the community. We want to expand those. We want to work with the government. We want to work with the community. We believe that we can have a much more effective impact on those minor ailments, medication continuance matters than what I would think a nurse practitioner model would do. Then, on the other hand, we are trying to work through this committee to bang on the door so that we can start being heard about and engage in some of these programs.

THE CHAIR: Thank you, Mr Brady. I thank the guild for the submission that has been put in. It is very comprehensive. You have covered a couple of the questions that I was wanting to address but I will put them to you anyway because there is another angle to my question. In your submission, you outline a number of ways in which the community pharmacy has traditionally offered a range of services to the community. What I would like to know is: what opportunities—and you have already mentioned some—are there currently being missed by failing to utilise your guild services in terms of primary healthcare?

Mr Brady: Opportunities?

THE CHAIR: If you come across other opportunities or issues further to our discussion, we are happy to hear back from you as well. You have talked about the triage, the counselling, the diabetes and all that. To come back to my question, what sort of interaction do you currently have with the health system? Is there an interaction at the moment?

Mr Tran: The current interaction we have is not at pharmacy level. It is pretty much what I mentioned previously. First, people will come with an initial situation and, if we can assist with that initial situation, the problem or the medical issue gets resolved. If need be, the person may try some therapy and come back a week or so later just to make sure the problem is cleared up. If at a pharmacy level a week or so later or if at that point it cannot be resolved, we then interact in the sense that we can refer them to someone else. Hence, by doing that, at a pharmacy level—

THE CHAIR: And can you do that referral directly with the patient or do you contact an agency?

Mr Tran: According to QCPP, which is our standard that each store runs on, we have a referral system. There are two methods. One is where we physically tell the patient: "I think you have an infection. I believe it is probably best you do go and see the doctor as soon as possible." If the patient, elderly patient, is likely to forget, what sometimes happens is we actually call the doctor and say, "Listen, so and so has to come and see you." We will re-emphasise to the patient, "The doctor is expecting you." That is the referral system we have at the moment. That is the interaction we have.

Most of the time, it is just on a doctor basis only. Very few people come in with a dental situation. Some people may come with a physio-related issue but in that situation the person would have a rough idea of what has happened to them. They may have seen the doctor already, they have taken some sort of medication, but it may or may not work and they have come in just to re-assess: is there something better? And in that situation, if we were to refer them back to the doctor, they would either go back to the doctor or go to physiotherapy.

Mr Brady: The other thing supporting what Mr Tran is saying is that the relationship that community pharmacists and pharmacies have with general practice and with all of the other health practitioners is excellent. That relationship is fine. The point that I was trying to make was that it is maybe more a kind of structural situation. On a day-to-day basis, the doctor will prescribe and the pharmacist will provide that prescription, but then there is the situation vice-versa. That communication is happening all the time between the pharmacist and the GP and the GP's surgery, as it will with other health practitioners.

There are programs which the guild has initiated. There are things like the home medicines review—in particular, for older people who have a number of medications and then over time they go to their GP. Of course, the GP has not kept a record of it but they will have all of these various prescriptions and then they are taking complementary medicines without telling their GP and their pharmacist. So we have introduced a program whereby community pharmacy works with general practice on a home medicines review. The pharmacist or the carer can ask for a home medicine review to be done. The GP will initiate that and then the pharmacist will go out to the person's house and see how the medications are stored and what they are taking. They will do a report and it will go back to the GP. So that loop is then closed. There are quite a number of programs and areas where, at the health professional level, the relationship is excellent, and it works very well.

THE CHAIR: Thank you, Mr Brady. Ms Burch?

MS BURCH: Thank you. You made mention of your role in primary care and in your executive summary you commented about under-utilised capacity of the pharmacy workforce and this infrastructure across the place. Would the guild welcome a bit of a public education campaign—

Mr Brady: Yes.

MS BURCH: to say, indeed, go down and see your local pharmacist if you have that skin rash, that cough or a sticky eye or something like that? Have you done much

marketing of that role for yourself as an industry?

Mr Brady: We do. We do an annual thing called "ask your pharmacist", and that will be coming up very shortly, where that whole area is promoted. All of our members are able to provide on the website all the services they might have at their pharmacy. Some pharmacists do, for example, the whole area around diabetes. They have built up a relationship with Diabetes Australia, and it is a program run by the federal government. Not all pharmacists would do that program, but for those that do it, it is on the website. So we have established a pretty sophisticated arrangement. You can click on there and see whether your pharmacist does this. Do they do baby healthcare arrangements and those sorts of things? That is updated all the time by the pharmacy. So, yes, we do promote that arrangement.

Mr Tran: Referring to what Peter was saying, pharmacists week, which normally happens in August, is pretty much the main promotion that the Pharmacy Guild does with respect to letting people know that you can come in and speak to your pharmacist. Again, at the personal pharmacy level, I think a lot of people are aware that they can always come in for that initial point of contact. If we cannot deal with the situation, we will then refer them. In terms of marketing, the answer would probably be no, we do not do anything other than the pharmacists awareness week. But people generally are aware and think, "Okay, I have a medical condition; before seeing the doctor, I'll go and ask the pharmacist first."

MS BURCH: You commented that you have inbuilt existing infrastructure, so people can come in with those minor ailments, and you then referred to the nurse practitioner models. Is it a statement that there is enough demand for those services so that, if you choose to go to a pharmacy or a nurse walk-in clinic, it is around providing choice and diversity for clients?

Mr Brady: The point we are trying to make in that regard is that we are not opposed to the nurse practitioner model. We see that it has merit. But the government has gone over to the UK and has looked at these models and it has come back and then said, "Okay, we're going to set it up." It is very expensive to set up new premises and then bring in staff. You go through that and ask, "Well, what is that going to do?" Essentially, it is going to provide a minor ailments service, or maybe, if there is any prescribing, it would be really minor prescribing.

We are saying that you have 61 of these clinics already established across Canberra, in many cases within walking distance. Why wouldn't you engage that model as part of your thinking? That is all we are saying. We are not being critical of the other one, because there may be some things there. But the thing that is going to happen, for example, with the nurse practitioner model, is that they will be seeking a Medicare number and they will be seeking prescribing rights, but they will not be able to do all the things that a GP would be able to do.

We are not asking for a Medicare number to be able to do what we are doing. Medication continuance is another issue. People with chronic illnesses and older people would go regularly to their GP to get another script. We would say: is that necessary? Could you come up with a situation where, in those sorts of cases, the pharmacist is the health professional that understands that?

We are saying there are a number of different areas in which we think we can help to reduce that load on emergency services, and that we can reduce the GPs' load, and it is cost free, essentially, for the government. Why wouldn't you look at it when you are exploring your various models? That is all I am saying.

MS BRESNAN: You touched on something which I was going to ask about, when you mentioned Medicare item numbers. I was really interested in the two proposals which you have raised in your address here about the treatment of minor ailments and medication continuance. It would, presumably, require some sort of adjustment to the way current practices are put into place. Whether you would want a Medicare number or not, it might be that that is where it would have to move to. So how would you see that working in practice? I know you have touched on a few matters, but probably the treatment of minor ailments would be something which would require some adjustment to the way current practices operate.

Mr Tran: To answer that in a rough overview, I assume there would be a selection of certain items in this ailment scheme that pharmacists can recommend or prescribe. It could range from an anti-inflammatory to antibiotics for certain infections, and certain other prescription-based medication. When a patient comes into a pharmacy, and if the patient fits the criteria for that condition, this would be what we can give out; hence bypassing the need to say, "Go to the doctor". When they go to the doctor, possibly the same diagnosis would be made, they get a script, they come back and we give them the same item. So the adjustment possibly could be a selection similar to what the optometrist system have at the moment. They can prescribe certain antibiotic eye drops, certain anti-inflammatory eye drops. If the situation fits that, we could prescribe it ourselves. I think it would be a similar system regarding the ailments.

Mr Brady: Ms Bresnan, I guess that what you are alluding to is that broader structure as well. What the guild is doing, through the fifth pharmacy agreement, is to look at those two programs as being programs that could be part of that, just as with the dose administration scheme, the diabetic scheme et cetera. It could be picked up as a program. And the home medicines review scheme could be done that way. Again, it is just building on the fact that there is existing infrastructure there. That is what we are putting forward.

MS BRESNAN: I know that pharmacists currently get some funding for distributing CMIs to consumers. What you are saying sounds like a very sensible way to expand the list of certain medications. Would that require some additional funding to pharmacists, if they were to take on additional actions? It would expand the role which you currently do.

Mr Tran: That is on a bit of a global scale. I do not normally do the number crunching.

Mr Brady: I think it would, Ms Bresnan. I certainly think there would be a much more cost-effective way of doing it than a model where you are setting up a whole new clinic and a whole new staffing arrangement. It could be done more effectively, I think, without having any problems around safety or poorer quality service being delivered.

MR HANSON: I think you have highlighted an issue, which is that pharmacies are a really important part of our health system but are not greatly appreciated. I think the role that is played in terms of accessibility—we heard that from ACTCOSS—and what you can do, particularly in the areas of prevention, early intervention and detection, is vital. It needs to be part of that integrated health system. The breakdown in communication with the department concerns me. Is this something that is new? Has this been going on for a while? Can you extrapolate on how this has been played out over the last couple of years?

Mr Brady: I do not think it is a negative thing. The word "breakdown" probably is not—

MR HANSON: Failure, or lack of communication, should I say?

Mr Brady: Yes. I think it is a matter of not being engaged. To give you an example, when the swine flu issue first erupted, everybody went to their pandemic plan that was done in 2007, I think—not that long ago. There is one paragraph that mentions community pharmacy. We have now got this kind of bible or template that we are using. For me, being relatively new to the organisation, I found that a little bit concerning. Why wouldn't it be a major player in that particular issue? As I said a little earlier, I personally have been knocking on doors and saying, "Hey, we're here and we want to be part of it." That is not the case in other jurisdictions where I think that the kind of communication between the guild and the department are better than what we have got.

I do not say that it is a negative thing. If somebody is saying we are not on the list, we are not on the radar; I guess that is probably the way to put it. I have been pressing very much to try and get us in conversation and dialogue around this new registration and accreditation that has come through COAG. I am still trying to get there. I am meeting, after this meeting, with the secretary of the board of the various health professional organisations to try and work out the system a little bit better and see if I can come at it from that angle.

There have been a number of those things. With respect to the new poisons legislation that came out earlier this year—which is a very good piece of work—nothing has been said. We are getting phone calls—and that is okay—from our members asking, "What are we doing with destroying a particular schedule of medicine?" The department, in my view, should have come out and said, "Hey, we've got this new legislation, we're rolling it out, we're going to work together." We could have got together with the chief pharmacist and done a launch, so that not only the pharmacy industry but also the broader community could say, "Yes, I see there is this new legislation coming in that might make some changes to the way I deal with my pharmacist."

THE CHAIR: Mr Brady, I apologise, but time has run out. We have gone a little bit over. Thank you very much. Half an hour does not seem sufficient to pay adequate attention to a submission like yours. You may get some other questions from the committee, and you will get a copy of the transcript of what was discussed here today. If there are any other issues that crop up over the next few weeks, please feel free to

keep us informed of any other initiatives or ideas that come up. We would like to thank you very much for your submission and for your attendance here this morning.

Mr Brady: Thank you very much for giving us this opportunity.

PHILLIPS, DR CHRISTINE, Medical Director, Companion House
RAGLESS, MS KATHY, Director, Companion House

THE CHAIR: Good morning, Ms Ragless and Dr Phillips. Sorry to have kept you waiting. Thank you for your attendance here this morning. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. I want to draw your attention to the privilege statement that is before you. Would you like to take a couple of moments to read it. Are you comfortable with the implications of the statement?

Ms Ragless: Yes, it is fine.

THE CHAIR: Thank you very much for joining us here this morning. Would either of you care to make an opening statement?

Ms Ragless: Yes. We have a little written submission which we will hand to you after this session. I am sorry that you have not had that before. We are both from Companion House—Assisting Survivors of Torture and Trauma, which is an organisation that works with refugees and asylum seekers in the ACT and regional New South Wales. As part of that service, we run a medical service which has always been aimed at newly arrived people and asylum seekers, and a small number of people with complex needs. That practice has been running for about 15 years. Dr Chris has been with that practice for about nine years. So we have seen various trends develop.

The things that are most important for us to flag with you today, I suppose, are that the practice exists, and that it is providing a special service to people with quite complex primary health needs. That has been a particular issue over the last 10 years, with high numbers of people who have arrived out of camps from countries like Sudan and Burma, who have spent very long periods of time in those camps, which, as you can imagine, means they have had quite restricted access to basic needs, including primary healthcare.

Our service has also had an increasing number of asylum seekers accessing it, which really reflects the fact that there are more and more asylum seekers living in the community in Australia, and there are more and more in the ACT community as well. So there is another need that the practice is filling.

For us, the general trend is that we always envisaged ourselves as a transitional service, I think we would call it—a service where newly arrived people access us for the first year, perhaps, or even six months, have their health needs stabilised and then move on to a community general practice nearby to them. That, of course, has become increasingly difficult for us to do, because we do not have places to refer them to. So we have become, against our will, more and more a service that is seeing people in parallel, rather than the transitional model that we would really like to be running.

That has only been possible for us to run because of funding from ACT Health. It would have been an impossible thing for us to do otherwise. I think the ACT government has something to be quite proud of there, in the funding of the service .We were funded for a nurse in the last year, which has really increased our

capacity and made it possible for us to operate like a parallel service; otherwise that would have been impossible.

There are various other primary health needs that we would like to stress today. I will hand over to Chris before I go any further.

Dr Phillips: I am a doctor at Companion House. There are four doctors who work at Companion House on a sessional basis, and we are the equivalent of a 0.4 doctor service. We have a full-time nurse, and the full-time nurse is absolutely critical to service delivery. If we did not have that nurse, we would not be able to provide the level of service that we have at the moment.

Refugee help is a service area where you see all the gaps in a health sector. If anybody is going to fall through a gap that exists in the healthcare system, it is a refugee. So they are like the canaries down the mine. Every failure that exists will be shown very early with refugees, which is one of the reasons why it is really worth looking at refugee health in some detail, because they will show you where the system fails.

As Kathy alluded to, there are a number of particular high needs—although, in general, refugees are actually quite healthy. They are assessed before they come into the country, so they are not an unhealthy population. We are not looking at a population with a large burden of illness. We are looking at a population that are having difficulty negotiating across the services.

Our particular health needs—I will talk about that first—for refugees where we have real issues of providing ongoing care include reproductive health. Refugees have a higher fertility rate than the rest of the community. Having a baby in Australia is very different from having a baby in many of the countries of origin, and there are not extended families to look after the children that are born to very young families who would once have relied upon the extended family to look after them. So we have had a number of near-death cases in the antenatal period in the hospital, and some quite profound post-natal depression to manage afterwards, where women have needed a great deal of support. It cannot be said that that support really exists here, because they are requiring primary care support across a number of different services that do not interlink very well. That would be one issue.

Mental health continues, with all refugees, to be an ongoing issue. Vitamin D deficiency is an emerging issue that everybody working with refugees is finding. Any woman who wears a veil is by definition vitamin D deficient in this climate, and people with very dark skin, in our experience, all become vitamin D deficient by the end of winter. So there is a significant seasonal vitamin D deficiency that occurs in the ACT. One of our services that we have had to increase is providing large-dose vitamin D to refugees from Africa, or from any country where they have got some slight pigmentation, so even from South-East Asia we are finding this. It is one of the needs that is emerging. So there is reproductive healthcare, healthcare for mothers after they have had their babies, vitamin D deficiency, mental health, and the use of interpreters.

It is not recognised by many people that Australia has the most accessible healthcare interpreter system in the world. No other country has anything like the telephone

interpreter service that is run through DIAC, and the ACT also provides on-site interpreters. So we have very accessible interpreter services. One of the challenges we find in terms of accessing primary healthcare is that, across the sector, they are very infrequently used. One of the roles of our nurse is to educate repeatedly the people we refer to about the access that is available to free interpreters within three minutes on a telephone. No other country has that, and yet it is grotesquely under-used. We estimate that an interpreter is used in one in a hundred cases where somebody speaks English poorly around the country, which is very major under-use.

THE CHAIR: Thank you. Dr Phillips, your role is part time, as you have mentioned?

Dr Phillips: Yes.

THE CHAIR: As are the other doctors?

Dr Phillips: Yes.

THE CHAIR: Are you a GP in your normal life?

Dr Phillips: Yes. I work for the Interchange General Practice in my normal life, my un-refugee life. I am employed also to do some of the clinical direction at Companion House, and I have got a half-time position as a senior lecturer at the medical school.

THE CHAIR: Obviously, you are aware of the terms of reference for our inquiry, where we are looking at the shortage of GPs, so it is something that you must be pretty well aware of—the circumstances that exist in Canberra?

Dr Phillips: I live it, and I work it. The shortage of general practitioners is the thing that has placed the greatest stress upon our service—not the health burden of refugees but the shortage of general practitioners in the general community. It has meant that we are unable to follow the model that we used to have when I joined the service, when we could exit patients after a year. So we would transition them into mainstream general practice. We are no longer able to do that. It is very difficult for us to contact a general practitioner and find one who is willing to take one of our newly arrived families. So increasingly we use the corporate services.

That seems not to be a sustainable model. We find that people come back from those services. Because that service runs on quite an acute-care model, they will see people acutely but the patients continue to try to come back to our service. With the ones with complex illnesses who are not suited to that model, we continue to keep them at Companion House, whereas once we would have just exited them to a general practitioner.

THE CHAIR: I have lots more questions, but I will hand over to some of my colleagues. Ms Burch?

MS BURCH: Thank you. With respect to scope of practice and a shortage of GPs, we have heard from other folk about extending the scope of primary practitioners and the burden on GPs being reduced, as it is spread across appropriate care. Would that sort of change in scope of practice be suitable for a service such as yours?

Dr Phillips: The reason that we requested funding for a nurse from the ACT government rather than funding for a doctor was just that issue. The scope of practice is not the issue; it is actually having the staff on the ground. It is not that we need somebody who can prescribe or diagnose. We do not at this stage have a huge need for a nurse practitioner. We have a need, I think in our service, for more nurses. But the reason we need that is because we cannot exit out to general practitioners. I think we need a nurse with reproductive health skills in our practice as well.

Ms Ragless: One of the other important roles that the nurse plays, which was a big gap before, was the whole issue of triage and how we as a service cope with the demands of people ringing us with health needs, and not always having the skills to triage them appropriately, so the nurse plays an extremely important role in that also.

MS BURCH: And triages them into other services or triages them into you—"Come in now, come in tomorrow, come in," that type of thing?

Ms Ragless: Wherever the capacity lies. Sometimes we may need to refer them on, and hopefully we will be able to send those on.

Dr Phillips: That is actually a highly skilled role played by the nurse. She certainly had to increase her skills to be able to triage. The other thing that she does is to offer a resource to the rest of the community. So there are other GPs who will ring in and ask her for advice. I do not think that is a question of expansion of scope of practice. I think a lot of nurses in general practice do not work to their actual capacity, and she, unusually, probably, for a practice nurse, is working to the full scope of her capacity as a nurse. What you often find with practice nurses is that they are not.

MS BRESNAN: You mentioned earlier that with refugees and newly arrived immigrants, if someone is going to fall through the cracks, they are going to be the people that will. What happens with refugees, as an example? A shortage of GPs is one issue. Do you think it is about that issue of the lack of coordination, and maybe having a more holistic approach to the way we approach healthcare and primary healthcare in particular, and about that need to sometimes have those specific-type services, whether it is for people who are refugees, whether it is for people with mental illness or for young people? Do you think the issue is perhaps adopting that more holistic approach to the way we look at how we deliver care to people?

Dr Phillips: I think that is an absolutely critical principle which is met in Canberra. I think the ACT has very much to celebrate with its medical services. It has the only medical service in the country that is integrated into a torture and trauma service. Kathy directs the entire service. I have the medical service. There is an educational service, there is a counselling service, there is a children's service. The provisions for holistic care actually exist in our service. I think it is one of the reasons why there is very little turnover of GPs. That is extremely unusual in the national setting, for a doctor like me to stay for nine years. The previous doctor stayed for 10 years. These doctors stay for a long time, and it is very unusual. Partly it is because we are actually working in a holistic model, with support from counsellors, with support from all of these other services within the entire Companion House.

So the answer is yes, but I think that exists in Canberra. The issue is not really whether the community health services integrate well with us. They actually do. The ACT Dental Service sees our patients very early and is very accessible. ACT public health services actually will see asylum seekers for free and understand that. So the territory-funded services work well for refugees. Sometimes they do not, but the structures work well. Our problem is actually in the private sector. It is the private specialists and private GPs.

Ms Ragless: I can only reiterate that it is a good, integrated model which we have always been very proud of. Our problem is that we are increasingly becoming a parallel system of care, which strains our capacity.

Dr Phillips: It is not actually a good model. The idea is that this group of people would be integrated into the community.

Ms Ragless: There are logistical issues with that. People have to travel from Banks or wherever to O'Connor; it is not really that sustainable.

Dr Phillips: A recent paper has been published on models of primary healthcare delivery to refugees, and the ACT is held up as an example. This service is held up as one of the examples of how to do it.

MS BRESNAN: It is probably a model that other areas should look at, too.

MR HANSON: The model is obviously not working because you cannot put people out to a GP. You said at one stage you could. When did you notice this change? You have been there for nine years. I suppose at some stage the model was working. We could actually do this, but now—

Dr Phillips: It was a beautiful model. When I joined, we had two part-time GPs; that is all we had. Then we put on a worker who is a logistician, so she is the person who ensures that people turn up for appointments, and she is a critical element. Any refugee health service really needs a logistician to make sure people turn up and understand, and that the place they are going to knows about interpreters. So we had her.

About 3½ or four years ago, it became suddenly difficult. Refugee populations change, and they change quite rapidly, but that was not the issue. The issue was just that, when we were not available—remember that there are only two part-time doctors—we could not assure our patients that they could see any of the other general practice services that once upon a time had been available to see our patients in an acute situation. They could no longer do that. Suddenly, we had to expand. We have had to create a GP registrar, a training position. We have had to pull in extra doctors to work there. It is not the case that GPs do not want to work in refugee health; they do. And GPs out in the community want to see our patients. It is just that the practices themselves are so overloaded that they cannot take on these families. These are quite large families. Sometimes we are asking people to take a family of six or seven.

MR HANSON: It is interesting, given that canary model that you talked about earlier, and it is difficult to try and work out when the GP shortage really bit here in Canberra.

Dr Phillips: I would say it was about four years ago, for us, that it really bit. A lot of GPs will tell you that when primary healthcare started, they were suddenly overloaded at that point. I remember at my other service people in wheelchairs turning up almost as soon as that service opened because they were not suited to that particular model, and had to find somewhere else to go. A lot of GPs shut down very rapidly at about the time that that opened. That, similarly, started to have a bite on us, and it was really about the number of GPs who shut down quite quickly in order to go into that particular model.

THE CHAIR: There seems to be a trend towards larger, corporate-style practices and super-clinics that provide a range of primary healthcare services. Do you think that is the solution that could alleviate some of the problems that you are having?

Ms Ragless: In short, no. The dynamic that we have at the moment is that it is actually those big corporate practices that are the only practices that we have the option of referring out to. Of course, I have the unenviable task of trying to push our nurse and administrative staff to do that, and they do it. But because of the nature of that care, people will tend to bounce back. That is really to do with the lack of continuity of care, that interpreters are not used, that people have very long waiting periods and very short appointment times.

THE CHAIR: And they probably do not see the same doctor.

Dr Phillips: They do not, no. One of the things that we always wanted to do with our transitional model was establish a relationship with an ongoing GP. We used to have a counsellor who would go with this family to the new GP to do that transitioning. You cannot do that with the current corporate model. I do not want to suggest that corporate models are necessarily evil. This particular model is really unsuited to our patients. If this were to become a standard model, we will become a parallel service. That is not a good thing for our refugees and it is quite expensive. It is a different model. That is not what we ever wanted—that particular corporate model.

But with a super-clinic that was integrated, had requirements to use interpreters, had some kind of clinical governance arrangements whereby there was better integration with the community, it would be possible to set up a model that would be ideal for us. This model is not it. They would need to be willing to engage with mental health issues, and to do that you need to have ongoing communication with people. You do not want a model that does acute care or episodic care; you actually need some model that is suited to chronic care. If such a model was set up, we could use that and we would collaborate with them.

Ms Ragless: Yes, we would like to. The way the model works at the moment, people with any kind of complexity will bounce back to us.

Dr Phillips: The current model escalates our workload.

MS BURCH: I have one question on models. I do not know if you are aware, because you are north-side, of the Charnwood health cooperative. Have you had any comments on that? They will have GPs there; they are not sessional GPs but from

what I understand they will be regular GPs. so it is a continuance of service in that sense. The cooperative model allows, once you pay $20, I understand, ongoing care, with other providers renting space. So there is a fee cost, but on site.

Ms Ragless: We have certainly had initial talks about how our referral patterns might work, so we will see. I really do not know much about them at this stage because, as far as I know, they are not operating yet.

MS BURCH: Not yet, no. They are in the final stages, I understand.

Ms Ragless: I will be very interested to see it.

Dr Phillips: I know that service is having acute trouble recruiting.

MS BURCH: So it goes to a core workforce shortage.

Dr Phillips: Yes.

Ms Ragless: They are actually slow to open, aren't they?

Dr Phillips: They are very slow. I have been asked to work there.

THE CHAIR: We are running out of time. Are there any issues that you want to bring to our attention that you have not at this point? We have got about four minutes.

Ms Ragless: I think we have covered our core points.

THE CHAIR: Thank you very much to both of you for coming in. Obviously, we are very keen to understand how the issues that you are facing can be fixed. A lot of other people have got exactly the same issues. We are particularly interested in hearing from GPs who are experiencing problems, but we are looking for ideas. So if any further ideas crop up, we would love to hear from you. This inquiry will go on for a couple of months, so you are free to give us some additional information if you wish to. We may also be putting some questions to you in writing. I do not think we have had a chance to look at your submission, so we would like to have a look at that. Thank you once again for taking the time to come in.

Dr Phillips: Thank you.

Ms Ragless: Thank you.

THE CHAIR: You will get a copy of the transcript of what took place here this morning sent out to you.

Meeting adjourned from to 10.46 to 11.02 am.

COX, MS DARLENE, Executive Director, Health Care Consumers Association of the ACT
McGOWAN, MR RUSSELL, Secretary, Health Care Consumers Association of the ACT
STEVENS, DR ADELE, President, Health Care Consumers Association of the ACT

THE CHAIR: Thank you for joining us this morning and welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. There is a privilege card that is there for your perusal. I am not sure if you have had a chance to look at it. Would you like to have a quick look at that?

Dr Stevens: We saw it previously.

THE CHAIR: Thank you. If you are comfortable with the contents I intend to move on, otherwise if you would care to read it I will give you time to read it. Thank you very much for coming and for your submission. I am not quite sure who is leading. Dr Stevens?

Dr Stevens: I am going to start and then Russell and Darlene will add their bits.

THE CHAIR: Dr Stevens, can I invite you to make an opening statement?

Dr Stevens: Yes. We would like to begin by saying a few things about the issues. We see primary healthcare as a critical cornerstone of the healthcare system. Primary healthcare is usually the first point of contact with Australia's healthcare system and it is the area where most people interact most of the time. Access to services needs to be improved to ensure that they are accessible to the most disadvantaged and vulnerable members of our community.

Health Care Consumers believe that approach to primary healthcare services and the role and supply of general practitioners should be addressed in the broad healthcare context and in relation to national healthcare reform initiatives. There are two main considerations that we believe should form an integral part of primary healthcare that are often overlooked in the medical model. Health Care Consumers would encourage the standing committee to consider these further—that is, consumer participation in planning and management of healthcare and an increased focus on safety and quality of healthcare.

As an overarching philosophy, primary healthcare should recognise that input from healthcare consumers provides invaluable guidance and values for the way in which the healthcare system should operate. The consumer voice adds value as a development and operation of healthcare and should be recognised as a necessary and consistent element for the operation of primary healthcare. This input is critical to identifying access issues and barriers as well as providing insight into measuring performance in respect of safety and quality. Perhaps I can now pass over to some of the others.

Mr McGowan: I also have links with general practice through sitting on various

commonwealth committees and boards of organisations set up by the commonwealth in primary healthcare and a particular interest in safety and quality in primary healthcare, which I think is something that has been mentioned in the opening statement, and which we believe is an essential component.

THE CHAIR: Thank you. That is the extent of the opening statement?

Dr Stevens: Yes.

THE CHAIR: Thank you. I will ask the first question. Your submission outlines a number of issues pertinent to the inquiry and on page 4 there is a note that the ratio used to measure GP numbers—that is, GPs per capita—is simplistic. Does the association have a view on whether the ACT is facing a shortage of GPs and what that shortage equates to?

Ms Cox: Certainly, there is a shortage of GPs. Not only do we hear it through what is coming from the ACT government in terms of being 74 full-time GPs short, but also we hear it constantly with consumers contacting us and talking to us about the delays in access to GPs, not only for non-urgent appointments but even urgent appointments. Often people are going to pharmacies and contacting Healthdirect and emergency departments in an attempt to have their primary healthcare needs met. So we agree that there is certainly a shortage.

Mr McGowan: However, that shortage could be addressed by having the more urgent matters dealt with in a more efficient way than they are at the moment. That would involve better triaging of people seeking primary healthcare services. There are various mechanisms that could be employed but are not, including queuing systems within individual general practices. I went to a seminar in Melbourne a couple of months ago. A practice on the far north coast of New South Wales had changed from a three-week wait to a less than three-day wait for their patients seeking GP support. They have a similar excess of demand over supply of GP consultations in that area. It can be done if people set their minds to it.

One of the things is using other resources in the primary healthcare sector to meet some of the demand, not emergency departments, but certainly things like walk-in clinics—the ACT government has indicated that it wishes to look at that—and also to look at telephone support through the Healthdirect program that, again, the ACT subscribes to but does not promote in any meaningful way.

THE CHAIR: What level of involvement is there with pharmacies at this point?

Mr McGowan: The fifth community pharmacy agreement is currently under negotiation between the Pharmacy Guild and the commonwealth. That would obviously be a place where a greater involvement of pharmacists in providing consumer support might be looked at. At this stage it tends to be a commercial-in-confidence discussion between the Pharmacy Guild and the commonwealth and we are disappointed about that. We think consumers have a very important role to play in setting the standards that they seek from their pharmacists in providing health advice because there is certainly a lot of health advice dispensed, along with medications, in community pharmacies, often in less than adequate settings

where privacy issues are not addressed.

THE CHAIR: Thank you. Ms Burch?

MS BURCH: You mentioned the consideration of a GP workforce within the broader primary healthcare system and the walk-in clinics that the government is looking to. How do consumers feel about starting to change the known world around service provision where you go to the chemist or you go to the doctor and you go to the nurse? We are really starting to think about merging those roles and functions. What are you hearing from consumers who would be the users and really at the forefront of the impact of that change as to how they will or will not embrace that?

Mr McGowan: Perhaps I will take it first and then hand over to Darlene and Adele. It really comes back to health literacy. The more involved that you are in accessing services and the more need to access them the more likely you are to be aware of the alternatives that there are to the tried and true methods. Nobody is suggesting that the family general practice of years gone by has not been something that has been valued by members of the community. But we know that there are excessive demands on that family practice setting at the moment and there must therefore be other ways of getting support so that the family general practitioner can provide the best support aligned with the skills that they have. A lot of the things that can be done outside of that general practice setting can be done by others other than medically trained practitioners.

The whole game as we see it, and where government needs to play a role in this, is raising the health literacy standards within the community so that not only consumers understand that there are viable alternatives which are equally safe and equally likely to maintain their wellbeing but which are more accessible and at more reasonable cost. The very important part of all of this is that the health practitioners themselves need this raising in health literacy of understanding of what is possible within the healthcare system, because many of them have been trained in the traditional model. For baby boomers like myself, the doctor was the main source of any advice. That has clearly changed over the last 40 years. There really are enhanced roles for a wide range of allied health practitioners, and particularly nurse practitioners, in the community sector which we are underutilising.

Ms Cox: Similarly, the role of the practice nurse is one that is underutilised. Research has been released just two weeks ago around the need to, at the commonwealth level, come up with a uniform approach and really identify the competencies of a practice nurse. They range from taking the phone calls and doing initial triaging and organising appointments right through to wound management and immunisation. But these are registered nurses who can actually do more. So let us have a look at the system in its total to see how all of the different health professionals can work in a collaborative way.

I want to build on Russell's point around the importance of self-management not only of chronic conditions but increasing consumers' awareness of health and wellbeing so that we can make decisions for ourselves supported by good, reliable information and maybe accessing Healthdirect through telephone to double check. I remember being at home alone with many children. It seemed like I was completely crowded out, and

one of the children had a burn. I did not know what to do. I could not get in to see the GP straightaway. Thankfully the neighbour across the way was able to provide me with good information.

It would have been great if at that point I could have phoned Healthdirect, if I had known about it, to say, "A kid has just burnt their finger, what do I do?" right through to, "I have a respiratory illness and I am just worried because my temperature is elevated. What should my next step be? Should I be contacting my GP or presenting straight at the emergency department?"

We need a whole continuum of care needs for consumers right through from basic common sense, at home-type things through to the self-management of chronic and complex conditions and being empowered to care for ourselves and really take on that self-management.

MS BURCH: So you are saying that consumers are really positioned to embrace that change?

Ms Cox: We need support. The foundation for patient safety in the US has got a new system out called Ask Me 3. It is about encouraging the American population to go to their GP or their health professional and ask three questions around: "What is wrong with me? How can we fix it? And what happens if we do not do that?" So it is about raising that bar of health literacy which is so important, because we will not be able to sustain the system that we have now. Really, the future lies with us taking on more control, that locus of control around our own conditions.

Dr Stevens: But I would also like to say, talking to our members, I have found nobody so far who is not keen to use nurse practitioners. They are keen to have another way of accessing information. I have not yet come across anyone who is not happy with those proposals to move forward.

Ms Cox: Later this year we are going to do some research with the primary healthcare area. There is a masters student there who will do some research with us on consumer attitudes to practice nurses, because we would like to go out beyond our membership to find out about the broader community and how willing they are to take that step. I take your point that for some people it could be big step to let go of the ties to the GP as the first point of contact. It comes back to the appropriateness of the care in the right setting. The GP perhaps is not always the most appropriate first port of call.

Mr McGowan: It is probably worth pointing out that there has been some research done through a major survey of consumer attitudes to healthcare and how much they want to be involved and make decisions about who they access care from. A company called UltraFeedback has segmented the consumer population into about eight different groups. The ones that we mainly deal with that Adele was speaking about are what we call active positivists. They comprise about 25 per cent of the population. There are probably another 25 per cent of the population who are also willing to embrace change but have a less positive attitude to it. And then there are people like my mother's generation who are reluctant to buck the system, who really want to be told what to do. They have to be encouraged by others to take a more active role and probably will never get round to doing that. We recognise that there are different

profiles within the consumer community and that will impact on how willing they are to accept a change in the way things are done. But that does not mean that we should not be attempting to bring everyone along with it.

Dr Stevens: I would have to say, for nurse practitioners, that the people I have talked to do not want to just go along and get some information. Can they go along and get a script? Can they go along and get an order for an X-ray? They do not want to have to go there and then have to go to a general practitioner later. So they need to have an adequate system with nurse practitioners.

Ms Cox: We want an integrated, comprehensive service; we do not want duplication. There is already enough duplication in primary healthcare and we do not need to be continuing that.

Mr McGowan: And that is why we would very much support independent nurse practitioners as well as those who are employed within the hospital system, or within specialty clinics. As important as they are, the notion of an independent nurse practitioner who can actually provide services to people within the community—for example, outreach services in a residential aged-care facility—is really important. And that complements the role that the practice nurse has within general practice, because they are both important roles but they are different. We very much support the notion of independent practitioners complementing each other within the competencies of their scope of practice, as defined and regulated by, hopefully, the national authority.

MS BRESNAN: You mentioned in your submission the survey which you are conducting. I think you said you have had over 500 responses, which is quite incredible. On page 3 you also identified a number of access issues that have been identified as important—primary care for people with chronic conditions and for people on low incomes, the pathways into the health system and also public dental care. Are they things which have come out of the survey initially or have they come from another source?

Ms Cox: That has come from our broader experience in this area, but they have been confirmed by the preliminary findings of the survey. We have had over 600 responses to the survey. I think that indicates there is an incredible level of interest in this issue in the Canberra community. We have had a reasonable spread of people, mostly people between 35 and 65, the majority of whom are women, and more than half are in full-time employment. These people are internet-savvy. They did an online survey; they are accessing the internet for health information, particularly when they cannot get in to see GPs or access primary healthcare.

With respect to the people who responded to our survey, mostly people in Belconnen, Tuggeranong and the inner north completed the survey, but it is coming through with some very solid findings. Overall, people are fairly satisfied and very satisfied with the primary healthcare they are receiving, but there are some areas of concern that we have identified. One of the questions asks them about whether in fact the GP spends enough time with them during the consultation to explain things in a way they can understand, supports them to ask questions, encourages them to asks questions, explains results of diagnostic and pathology tests in a way that they can understand.

The good news is that half the time that always happens; that is fantastic. When we cross-tabulated, and picked out those people who responded who have a chronic condition, it was even higher, because they had a continuity of care with their GP. So in those instances, because of that longer, ongoing relationship with the general practitioner, in even more circumstances they were getting their information needs met and felt more empowered.

We did some cross-tabulation of those people who do not have a regular GP. Eighty per cent of people who completed the survey have a regular GP, so we were very interested in the 20 per cent. Those 20 per cent who did not have a regular GP often were accessing some of these large corporate medical centres, waiting very long periods of time to get to see the first GP available, and did not have that continuity of care, and that is demonstrated in the results around "Did your GP have enough time for you?" We are looking at 20 and 30 per cent who felt that was always their experience.

THE CHAIR: Do you have a geographic indication of where that 20 per cent is?

Ms Cox: We have not drilled down to that level but we certainly can. And it is one of the things that we are interested in, particularly for the GP task force, because they are looking for people in Tuggeranong.

THE CHAIR: We would be very interested in that as well.

Ms Cox: What we will do in the coming weeks is finalise that and we will make sure that you get a full copy; we will send it through.

THE CHAIR: Thank you.

MS BRESNAN: The issue of the pathways, and having those realistic pathways into the system—and I appreciate that they are only preliminary findings—has that come up again as an issue for people?

Ms Cox: Not so much in the survey because we did not really ask questions around that. That is coming up in our conversations with people. We have done consultation for the GP task force. It really came through that we want a system where there is no wrong door: wherever you turn up, you will be looked after and you will get the care that you really need, the appropriate care in the appropriate setting. That is not the general consumer experience at the moment. There is still a whole lot of knocking on doors and telling your story over and over again to try and find the right service.

Mr McGowan: That is where we believe that the person-controlled electronic health record plays a role in integrating the services that people access. If we can ensure that records are controlled by the individual consumer or patient then they can make sure that the people who need to know about their treatment thus far do know about it and can access that information. It is quite a separate thing to the medico-legal medical record which is also necessary and which is in development through national committees and the like.

We believe that it is possible to short-circuit the delays in standardising that medico-legal record by having a person-controlled record which people can opt into so that it will not be forced on them, but where people can start taking more control of their journey or pathway through the health system, and ensure that they are not wasting time and that they are linking up the various service providers that are adding to their health and wellbeing.

MR HANSON: With respect to the Healthdirect number, a problem that we have seen across the health system is that there is an over-utilisation, but what you are suggesting is that for the Healthdirect number, there is an underutilisation. I would be interested in your view of the extent of that and why that is so. The other part of that is: are there any other areas of our health system that are underutilised and, if so, what are they?

Ms Cox: I would be happy to talk to the first point. An interesting thing, in looking at the preliminary results of the survey, is that we do ask people where else they go for health information. A proportion, 10 or 15 per cent of the respondents, accessed Healthdirect, but for the other, you could specify where else and five people specified Health First, and two of them even gave the old phone number. That is an issue because there has been a new phone number for some time and it means that there is still a level of awareness out there that Health First exists and Healthdirect does not. So we do need a communication strategy around alerting the Canberra community to that. We are very interested in Healthdirect. We have been involved with the development of Health First over many years and we think that it will play a really important role in providing people with that information and supporting them.

MR HANSON: Was Health First the predecessor to Healthdirect?

Ms Cox: It was. Healthdirect is a national call centre.

Mr McGowan: The ACT government makes a substantial contribution to have Healthdirect available to ACT residents but there is an opportunity cost in that. What could you use the money for if you were not putting it into that and that would increase access? We know that those sorts of services tend to favour certain sorts of consumers, so they are not an answer to every consumer problem, by any means. But we believe that their reach could be furthered.

MR HANSON: We could get better value for money.

Ms Cox: Yes.

Mr McGowan: We do not think we get good feedback from them about how effectively they are being utilised by ACT residents.

MR HANSON: The consumers that use Healthdirect, do they have a good response? Do they say it is a good product?

Ms Cox: We operate on anecdotal evidence from our organisation. We would like to see some reports to the community, quarterly reports, which they do in Western Australia, on the efficacy of Healthdirect. Who is contacting it? What are the main

reasons? They are collecting this information. Certainly, ACT Health have that information. We think it would be a great opportunity to let the community know about who is using it and what difference it is making.

Mr McGowan: We believe it would take pressure off unnecessary presentations to emergency departments if used properly.

MS BRESNAN: You said that happens in WA; do they report on their Healthdirect? Are they the only state that does that?

Ms Cox: To my knowledge.

Mr McGowan. They have had the service longer than anybody else.

MR HANSON: It could easily form part of the annual report or something like that, couldn't it, or the quarterly reporting?

Ms Cox: It could form part of the quarterly performance reporting of ACT Health.

MR HANSON: Yes, that is a pretty good recommendation.

Mr McGowan: To go on to services that are underutilised, my view is that there are a number of allied health services in the community that people would access, if not for cost barriers, that would in fact deal with some of the problems that turn into acute primary healthcare or acute service problems. So this is all about the preventive agenda—getting people's problems seen to at the time that you can nip them in the bud before they become acute.

MR HANSON: What examples are there?

Mr McGowan: Physiotherapy, psychology support, a range of dietary support and other so-called interventions that could improve food intake and cessation of alcohol and tobacco abuse.

MR HANSON: Is that a cost or is it just a knowledge and "couldn't be bothered" type, or is it a—

Mr McGowan: These services are not well integrated into the medical system.

Ms Cox: And sometimes consumers need more than knowing the services are there. They may need a package of services. I give the example of Kootara Well, which operated out of the Narrabundah primary school in the early 2000s. It was a highly effective holistic health and wellbeing program for the community around that school. That is the kind of thing that we need to be looking at.

We have to recognise that different communities, particularly marginalised communities, may need a little more support than others, and there is nothing wrong with actually providing that. That means doing primary healthcare a little bit differently and maybe building cooperatives, engaging local communities to establish such centres, so that you do get your holistic primary healthcare needs met, rather

than thinking, "I need to access a physiotherapist or podiatrist," and doing it on your own. There are "do not shows", there are people who do not follow through because the cost is a barrier or they do not understand how to access those services.

Mr McGowan: It is a matter of having them set up in a community setting that becomes part of people's thinking. With the west Belconnen co-op that people are talking about, we fully support it as a model. I understand that they have not yet opened their doors but they are operating on that sort of model. There will be GP services available, there will be nurse-led clinic services like wound care and other things, and immunisation will be available there. There will be broader advice available in that community setting. Once people see the benefits of that, and they can access it without it costing an arm and a leg, we believe that the uptake will be greater. It will not suit everybody but it is definitely a part of the mix that is under-utilised at the moment.

The other part of the mix that is under-utilised is the skills of thousands and thousands of nurses who have trained through our hospital system and who are no longer working in healthcare. There are various reasons for that. The shifts around working in the acute care system are obviously not conducive to a good family life, and a lot of people drop out of nursing when they have young children because they have got those family responsibilities. They find other jobs that are better remunerated and they do not utilise their healthcare skills to the same degree.

I think we should encourage people to come back into the healthcare system and utilise those skills, to meet some of these primary healthcare needs that are within their scope of knowledge, perhaps with a bit of boosting. If they have been out of the workforce for some time, they will need some additional training and support in order to be able to perform these new roles. But we need to define those roles and then utilise this underlying knowledge of healthcare within that group.

There are probably some GPs that are not working to capacity as well. I have seen evidence to suggest that many GPs who saw a full-time working week as 50 hours a week are now seeing it as being much less. Maybe if they could work smarter rather than longer hours they could still have the same benefit to the healthcare system by utilising their skills in a more efficient and effective way.

THE CHAIR: We are probably down to our last question. Ms Burch?

MS BURCH: You made mention of models of care or models of business, and cost being a barrier to access. Given that GPs are a private business model, and many in allied health are small private businesses, how do you then reconcile their needs and what they need to do as a small business owner with the barrier of cost to consumers?

Mr McGowan: Obviously this is something that is being addressed by the National Health and Hospitals Reform Commission. One of the things is to have a consistent set of incentives and disincentives within the primary healthcare sector and which models behaviour towards an integrated primary healthcare approach.

That is option A in the interim report of the reform commission. We hope that that will be strengthened in the final report, and that we will look at having incentives for

private practitioners to share information about their patients which is not there at the moment. Often, they feel that if they were to pass on to others information that they have about the consumers that they are dealing with, that will lessen their potential for income from that patient. That is clearly not in the patient's interest, and that really does need to be accountable.

There are ways of providing them with compensation for buying into a more universal primary healthcare system and sharing information that needs to be addressed by a single layer or a single point of funding support for that sort of care. As I say, I believe that that sort of solution is likely to emerge from the Health and Hospitals Reform Commission. I certainly hope so, and we should be looking at supporting that and looking at ways of integrating our public and community-based employees, because there are people who are employed by community organisations like the west Belconnen co-op who can be integrated into that as well, provided we have the right incentives and disincentives.

Ms Cox: Certainly, in the GP snapshot we did, we asked a question about whether you had been referred to other allied health professionals or psychologists or occupational therapists, and if you had followed up on that referral. Of the number of people who did not follow up on the referral, cost was the main issue. So that needs to be—

Mr McGowan: One of the main areas where people do not access care because they think they can do without it is in oral health. There is a need to put oral health services into this overall package because of their potential to have impact on other ongoing issues that will cost more in the long run because they have not had the dental support that they need in advance. So it is important to have the right sort of access to subsidies for care within the private sector as well as having a very strong public sector primary healthcare system.

MS BURCH: Thank you.

THE CHAIR: Thank you, Mr McGowan. Thank you very much for attending here this morning. There were obviously a few other questions that we wanted to ask you but time has run out. We may write to you about some other questions that we may have to put to you, if you would not mind responding.

Ms Cox: We are happy to answer those.

THE CHAIR: We would be particularly interested in the association's view on the trend towards the corporate style of practice, the super-clinics. You may have some information from the survey that could be—

Ms Cox: We are very happy to talk about that, yes.

THE CHAIR: Thank you very much. We thank you for your submission. You will get a copy of the transcript of this morning's proceedings. Thank you for joining us.

GALLAGHER, MS KATY, Treasurer, Minister for Health, Minister for Community Services and Minister for Women
CORMACK, MR MARK, Chief Executive, ACT Health
O'DONOUGHUE, MR ROSS, Executive Director, Policy Division, ACT Health
WILLINGTON, DR CLARE, GP Adviser, Policy Division, ACT Health

THE CHAIR: Good morning and welcome, minister. Thank you for joining us this morning. We had information that you may not be able to, so we appreciate your presence here this morning. We would like to welcome you all to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. I guess you would all be well aware of the privilege card. You are comfortable with it? Thank you. In that case, welcome. I will ask Ms Burch to pose the first question.

MS BURCH: I am happy to. What has come up, not in the discussion paper but through different witnesses, is the need to consider GPs within the broad context of a primary care team, a primary care workforce, which leads to the notion around scope of practice and what that team may be. I would just be interested in hearing what you have collected from the task force and the various forums around—consumers' response to a new world, new models of practice?

Ms Gallagher: I am finding it a bit difficult to talk, so I will keep my comments pretty minimal. Just as a general statement, I think many GPs are prepared to embrace new models of care if that involves additional support for their practice, such as an increased role and increased financial support for something like a practice nurse. I think some GPs work closely with other allied health providers in the city. I genuinely think that at this point in time, with the discussions we have been having with the GP community, there is a genuine willingness to engage and also protect their own profession and professional standards. There is a willingness to engage and talk, but there is a very strong sense of ownership about the services they have always offered and will continue to offer.

THE CHAIR: If I could cut in for a moment, I did neglect to give an opportunity for any of you to make an opening statement.

Ms Gallagher: I was very pleased you did not.

THE CHAIR: The opportunity is there if you want to give an opening statement, but if not, that is fine.

Mr O'Donoughue: I would just support the minister. In our consultations thus far we seem to have tapped into some support, particularly for the role of nurses in the primary healthcare team. There are GP practices which have acknowledged that they have found that practice nurses in particular are a very helpful complement to their service model. There are some structural barriers around the ability of GP practices to access practice nurses and they relate to the commonwealth arrangements primarily. We have also floated the idea of potential new roles, such as nurse practitioners, and how they might play as they become more articulated and as we get access to those sorts of professions. But we strike the barrier too that there are nursing shortages as

well as GP shortages. So there is not a simple solution of one replacing the other. It is a complementary role.

Dr Willington: I would just support my colleagues and say that of course general practice is encouraged and funded through the Medicare arrangements, through the MBS arrangements, to consider people, especially those with chronic illness problems, in terms of their entire team needs. It is pretty typical in general practices for care plans and team care arrangements under the MBS funding to be made and carried through, which is about a virtual team or an offsite team, or the team not being located under the same roof. I think people all over town, if you ask them who is helping them with their condition, would be able to rattle off quite a list of people who constitute their primary healthcare team.

I think there are two issues. One is about the team that is located together physically and the team that is working together. They may not be living under the same roof professionally but they are working together to form the patient's primary healthcare resource. We have a lot of that going on. We are a very well-endowed place in Canberra. We have many people working in private allied health. We have all the allied health disciplines—nurses employed within general practices and nurses employed within community healthcare—all working together. In addition, community pharmacy plays an important role in people's access to primary healthcare and advice.

THE CHAIR: Thank you. Ms Bresnan?

MS BRESNAN: We have just heard from the Health Care Consumers Association. One of the things they said, which I think is generally understood by most people, is that health literacy is a really important issue in terms of consumers understanding that they can take up alternative models of care and not have to go to their GP all the time when they need to access primary healthcare. Has that been something which has come up in the consultation so far? I imagine it is something which has been looked at, but is it something which will form more of a part of whatever comes out of this process or this task force?

Ms Gallagher: Maybe the task force chairs can answer a bit better about what has come up through the task force. I would say that, in putting a discussion paper together, we worked very closely with consumers to make sure that it provided a balance between interests. One of the difficulties in progressing a piece of work like this is that people's motivations and interests are not necessarily on the same page. What will assist a GP to do their job easier will not necessarily empower the healthcare consumer to understand better what other options are out there.

It is a complex piece of work. I think there is a very strong view that part of our providing a holistic healthcare system across the ACT is about ensuring that people are accessing care where they need it—whether that be through a pharmacy, community-based health, allied health options, a GP or a hospital. That has pretty much been directing all of our focus—to make sure that wherever you access healthcare it is the right type of healthcare for what you are seeking assistance to, which I think goes to your point.

There will need to be quite a bit of work done around how we empower consumers to make those decisions. That is part of what is driving our expansion of, say, the nurse-led walk-in centres. Some of the things we see at the emergency department on any day are things that do not necessarily have to be dealt with at an emergency department. They could more appropriately be dealt with elsewhere. It is about creating that capacity and those opportunities for people to have those choices. I think what the GP shortage has done for the patients who are not able to have access is that there are not necessarily all the options open to them to go elsewhere and they may go to the emergency department. We are doing quite a bit of work around that and are working with healthcare consumers. The other thing I would say in response to that is that the e-health initiatives are very much about providing the consumer with the support, information and opportunity to participate in their own healthcare that will assist those choices being made.

Mr Cormack: If I could just add to the minister's comments: a further additional initiative that has been in place over the last couple of budgets—and in fact there is further provision for it in the 2009-10 budget—is our chronic disease management program initiative. It emphasises the availability of information and NGO-delivered services to support the self-care of people who are referred from either ACT Health or general practitioners with reasonably complex chronic disease issues.

Health literacy is a key component of that. Part of the rollout of the chronic disease management program is to move into areas such as telephone coaching and the creation of registers to be able to empower people to access information and manage their own care. I think that is very much in sync with the discussions we have had with Health Care Consumers Association of the ACT.

MR HANSON: Minister, I hope you are not feeling too unwell and have access to a good GP.

Ms Gallagher: Access to a good dental surgeon.

MR HANSON: It is dental, is it? In terms of when this crisis or shortage bit in the ACT, we have had a couple of people in here this morning who have picked a mark about four years ago. Would you share that view?

Ms Gallagher: I certainly think the doctor shortage has taken a long time to create. Certainly the GP shortage has not occurred overnight, that is for sure.

MR HANSON: I have asked this sort of question before, but just moving forward, I do not know if you have more information now because of some of the information that has flown from the task force, but with the influx of doctors that are being trained with test patients and things like the nurse walk-in centres and so on, do you have a view on when the shortage that we have is going to start to reduce, or the trend stops? I think the trend has been that it is a growing gap. Have you been able to come to a view of when that is going to be mitigated? Moving forward, it might be that we still have a shortage, but because of other systems that we bring into place that is no longer such a crisis. Have you been able to work out that sort of trend for going forward?

Ms Gallagher: I think it is—

MR HANSON: I do appreciate it is a bit of a crystal ball. I am not asking for a—

Ms Gallagher: It is difficult because there are a range of variables in it. We know that in about three years time we will start seeing medical graduates coming through faster—I think it is about three years time—than there are perhaps opportunities in hospitals to employ them. That is the catch-up that is being dealt with at the national level through the universities around medical training places.

That gives us the idea that, say, in three to five years time there will be a number of medical graduates. However, that does not translate into general practitioners because of the training requirements that are needed. They will need to do their hospital training; they will need to do a specific GP training program. That is one of the variables. I think it takes about eight years to train as a general practitioner.

The other variable is, of course, the choices that doctors make. Part of our shortage here, I think, is reflective of the fact that traditionally general practice has not been the area of interest for medical graduates to go into. That has been an issue. The task force, I think, is trying to deal with that. Some of our budgeting issues are trying to deal with that in terms of exposing students to life in general practice but also supporting them financially to make the decision to do some time as a general practitioner.

I would love to give you a timetable when we will have 74 full-time equivalent GPs in place in surgeries in the ACT. It is quite genuinely not possible to give you that figure based on the variables that are involved in that, not least of all being individual decision making by our current medical students about what sort of career they would like.

MR HANSON: Can I be very simplistic then? Are we hopeful it is going to get better or are we worried that it is going to get worse?

Ms Gallagher: I think with the fact that we have got some additional GP training places, that we have got some bonded scholarships coming into operation, that we have got more medical graduates—we are graduating 80, 90 medical graduates this year—in a simple way it would lead you to say it is going to get better, but just because of the length of time it takes to train a general practitioner it will not necessarily be better next year. It really is about the time it takes to train. Also, at the time we are dealing with a GP workforce that is ageing, so we will see retirements as well.

THE CHAIR: Thank you, minister. Is the government supportive of enhanced roles for other primary health services, such as community pharmacies and other allied health professionals?

Ms Gallagher: Very much so. We work quite closely with the Pharmacy Guild. I think they have just recently requested to be involved in the steering group of the walk-in centres. They fill other lines very much with some of the business that they do, particularly out of hours. So they are very keen. They have some ideas about what role they would like to see community pharmacies play in years to come, particularly

if the nurse-led clinic is successful. I have had representations from them saying: "We would like you to operate a walk-in centre inside one of our pharmacies. Have you thought of that?" So all of those are very much being considered.

In terms of workforce diversification, which I think is the second angle around allied health having an increased scope of practice, we are already, I think, leading the way in the ACT on that in terms of some of the allied health assistance roles that are being implemented. Obviously the scope that we are looking at is separately around nurses, but we are also looking at the diversification of the role within nursing, going higher and lower, just to make sure that we are creating opportunities to employ people in the health area and employing them across a whole range of skills. It probably needs to be tested in the public health system, perhaps, before private health operators, which are GPs, and other private operators take up those initiatives.

THE CHAIR: We have had some very interesting submissions. One of them was from the Pharmacy Guild. I would be interested in some feedback from the task force and whether you have formed any opinion. They claim that there are still areas where they could be contributing more than they are currently able to under the current system. Have you formed any opinion, or have you met with them yet?

Mr O'Donoughue: The task force has not had the benefit of a direct submission from pharmacy at this stage. We would anticipate that in the course of our consultation period, which does not conclude until 31 July, they would be putting a submission to us. They attended our industry forum on 14 July, but I do not recall that particular aspect being put on the table on that occasion.

Ms Gallagher: They have certainly put it to me that they stand ready, willing and able to do what they can to assist. I meet fairly regularly with the Pharmacy Guild and I have told them I am very happy to consider any proposal they put to us. There are some issues that we would want to work through with them if we were of a mind to look at how we could co-locate ACT health services, but it is not that it has not been done before—the clinic over at Civic pharmacy, where the Civic pharmacy used to operate. I do not think it operates there now. I cannot recall the reason, but it was not through lack of ability to work together. That is where babies could get their injections and things. Our nurses would go and work out of there. I think it works quite well.

THE CHAIR: I am not quite sure what the protocols are between the task force and our committee. We have got submissions that perhaps you may not have. Is there any protocol there? It may be worthwhile to have a look at that.

Ms Gallagher: That is right. We would be looking at the submissions made to the inquiry, along with what recommendations there would be.

MS BURCH: ACTCOSS was in earlier this morning and welcomed a lot of the initiatives but then raised different policies and different strategies that have been ruled out of primary healthcare locally. There is the federal primary healthcare strategy and the National Health and Hospitals Reform Commission, whereas locally we are looking at various plans and strategies. What is the thread that ties them all together with respect to service provision and being a consumer of those services?

Ms Gallagher: We participate in all the national work through health ministers and Minister Roxon has commissioned specific pieces of work through the Health and Hospitals Reform Commission and the health prevention task force, I think it is called. Health ministers have been involved in discussions with the commonwealth about what areas they should focus on and, of course, jurisdiction reports about what we see on the ground here. I would not think there is any disconnect between our planning and the commonwealth's planning. We have not seen the reports that come through those. They will go straight to the federal health minister but I cannot think of one thing where we are going off in a separate direction.

MR HANSON: Their criticisms were actually internally directed at ACT Health, if that is what you were referring to, Joy.

MS BURCH: It was—

MR HANSON: Coordination within ACT Health policies, actually, was what they referred to, I think. Is that what you were talking about, Joy?

MS BURCH: There was mention around the primary healthcare task force and I think mental health was—

Ms Gallagher: Also how we coordinate plans within Health?

MS BURCH: Yes.

Ms Gallagher: Again, all the plans within Health ultimately come through portfolio executives for my sign-off, which represents the whole of ACT Health. I am sure there are individual situations which can be drawn out where one plan might be in conflict with another, and that could be the workforce plan versus a plan of service delivery. I am just trying to think of a situation where that could occur. That could quite easily occur. That does not mean that there is anything wrong with the plans.

MS BURCH: So there is not a disconnect within the planning—that some elements of the planning operate at a different level?

Mr O'Donoughue: I do not think so, Ms Burch. As an example, the ACT is well placed with its primary healthcare strategy. We are one of the very few jurisdictions that actually has a primary healthcare strategy that is signed off in partnership with the Division of General Practice. It does embrace a very broad role for general practice and primary healthcare providers in the ACT. We have got a national chronic disease strategy, and the ACT chronic disease strategy is very sympathetic to it and very consistent with it. We went through a very extensive process recently to derive a mental health services plan, which had extensive consultation with the community sector organisations. I think it very much embraces the role of primary healthcare providers and general practitioners and the non-government sector.

From a policy division perspective, what happens now in ACT Health is that any of these plans or policies that are being developed come through a central process and there are good consultation mechanisms. So I do not think there is really an

opportunity for something to be developed where the right hand does not know what the left hand is doing, as it were.

MS BRESNAN: I think what ACTCOSS was saying is that there is a suicide prevention plan, there is a mental health plan, there is a drug and alcohol plan, there is corrections health—there are all of these different plans happening. They said they were having some issues in terms of recognising how those plans are working together and how they connect, and they had difficulty doing that as an organisation.

MR HANSON: Page 20 of their submission is the reference, if you want to have a look at it. There is probably stuff in the *Hansard* about it. It is difficult, I appreciate, where you have got lots of different things and they tend to be a bit stovepiped. They are concerned that a lot of these are developed in isolation. That is their view.

Mr O'Donoughue: I understand. It is a challenge. There are clearly constituents and stakeholder groups who would desperately want us to have a suicide prevention plan as well as a mental health services plan, along with something else. Where we can, we seek to integrate those things. Certainly, we try to make sure they are consistent and have synergies between them. But it is an ongoing challenge. With the chronic disease strategy, there is always debate about which chronic diseases it is specifically dealing with and whether it should include mental health as well as all the other chronic diseases. So these border issues are tricky.

MS BURCH: Where you are utilising service provision through an NGO, where you contract an NGO, are they captured under the umbrella of those plans?

Ms Gallagher: Normally, yes.

Mr O'Donoughue: Very much so. The two conspicuous examples would be in the drug and alcohol sector and the mental health sector, with very strong engagement with the community organisations.

Ms Gallagher: And the chronic disease one, too.

Mr O'Donoughue: Developing more so, yes.

Ms Gallagher: Yes, the Heart Foundation, Diabetes ACT—all of those.

MS BRESNAN: One of the other issues that has come up through submissions and also from groups we have heard from today is about the need to have that "no wrong door" type policy when you are accessing primary healthcare—being able to go to one point and not having to go through a whole lot of different points. Companion House talked about the model which they use. Their example was that, if anyone is going to fall through the cracks, a refugee is the person that it is going to happen to. They have a very successful model which incorporates those different areas. They work very well with ACT Health and community services. Althea Wellness Centre is another example.

I am wondering about strategies being looked at and developed that will adopt more of that holistic type of model for other areas and other sectors. It has been so

successful for Companion House that people do not want to leave that model. In particular, when you are looking at the corporatisation that is happening with some GP practices, is a holistic model something which will be pursued more?

Mr O'Donoughue: I can certainly say that the task force has been keen to engage with Directions ACT and with Winnunga Nimmityjah health service. Several people in our consultation process have said to us that there are learnings from those particular service models and that, to some extent, some of those niche services, If I can put it that way, are getting it right in terms of providing a very connected and holistic sort of service. So we are trying to take on board those learnings as we go forward.

Mr Cormack: Just to add to what Mr O'Donoughue said, it is also a case of horses for courses. I think that there are some service models that lend themselves more naturally to a tighter coordination because of the complexity of the conditions that people have. Companion House is a very good example where you have a much more all-embracing, wrapped around kind of coordinated model of care. Winnunga Nimmityjah is a very good example of a very integrated primary healthcare model that recognises social determinants in health. It recognises the complexity of conditions and the social interconnectedness of Aboriginal and Torres Strait Islander communities and builds its model around that.

We have also got better general health for mental health, which is a fabulous program that, first in Australia, was funded here. That recognises that we have a group of clients, mental health consumers, and we try to pull together a package of care, case coordination and support and linkages for their mental health conditions. But they also have a whole range of very complex general health concerns. In partnership with general practice, we have put together a much more coordinated program to keep those people linked in with a general practice as well as mental health.

That kind of model does not necessarily suit everybody. In fact, the overwhelming majority of the population do not necessarily need that form of coordination. Indeed, good general practice access will often give you that. But the most overarching thing that we can do, and we are doing, is to pull together a shared electronic health record and a personally held electronic record which really enables the clients, the patients and their families, to be able to be the holder and keeper of that information and empower them to pull a lot of the services together. There are a number of ways of doing it, but I take your point: we have got some excellent models to draw upon and I think Companion House is one of them.

MS BRESNAN: One thing that Health Care Consumers said, in saying that it does not suit everybody, is that if you have those types of community-led health centres, you can use that type of model, but in a different way, to suit whatever community you are directing it to.

Mr Cormack: Indeed.

Ms Gallagher: And the west Belconnen co-op will be an example, if that model goes well. The issue with extending it out more broadly is that there are some general practitioners who like that model, but there are many others—I would say the

majority—working across the ACT who are involved in a different model of primary care, which is through their own private practice or through working for a larger organisation.

MR HANSON: Minister, the issue of health, and particularly GPs, has been subject to what has been called the blame game—the jurisdictional divide between the state and territory responsibilities and the federal. That has happened with the hospitals as well. As we are moving forward, there seem to be a number of options on the table. I think the latest one I heard today was that the federal government would take over responsibility for community healthcare clinics and outpatient services, for example. Do you see that a shift in responsibilities between the ACT and federal in terms of GPs would assist in some regard? Do you think that it needs to be made clearer who is responsible for what? Have you got a view on that?

Ms Gallagher: I do not think the blame game has been about GPs. I think GPs have their own issues with the federal government that do not involve the ACT government, quite happily. I think the blame game language is very much used around the public health system. For many years, indeed since 1998, or it might have been a bit earlier, we have not employed GPs through the public health system here.

In relation to potential changes, it is difficult to say; I have not seen the final report of the Health and Hospitals Reform Commission. I understand that it is with the federal minister now. Reports in the paper today indicate that it may be released next week. I do not know whether that will be the case, but it will be an interesting read. I feel that, from my discussions with the commissioners, there will be some changes proposed through that model.

Anything that cleans up the lines of responsibility will be useful. Under the healthcare agreement, the ACT government's responsibility is to run the public health system and to focus on that. The commonwealth's responsibility is to focus on primary care. That is a crude way of divvying up responsibilities, but the main focus for the territory and, indeed, all the other states has been the hospital system, and if there is a way of better identifying and separating that, outpatients and community health is an obvious place to go.

If the commonwealth and the states and territories want to concentrate on the provision of hospital care then things such as outpatients and community health services should be talked about. Whether it is ultimately the right thing for the ACT is yet to be determined. I know that the level of community health that we have here is superior to some other jurisdictions—indeed, particularly in relation to eligibility. Other jurisdictions have healthcare cardholders only or they do not run a dental program like we do for young children. We have probably got the best young persons dental program in the country without eligibility requirements.

I think those would need to be very carefully considered by the ACT government before we were prepared to say, "You can have all of that back; don't worry anymore, that's part of a national system." What has been driving me is that, if change occurs, whatever change that would be cannot be to the detriment of the people of the ACT . So if what is being proposed is more than building up the services and the commonwealth take it over, that would be easier for the Assembly to consider as

being a good idea than if it was just to standardise the approach. In relation to the community health services that the ACT run, because the quality and access to health services in the ACT have been so good—there are issues with it—I would hate to see us lose that.

It is difficult to speculate. I think there will be some change, though, and I think that has really been driven by demand. The amount of work that is coming through needs to be addressed, through the commonwealth or the states and territories, because the demand is going to continue to grow and pressure is going to continue to build.

THE CHAIR: Minister, in a number of submissions to this inquiry, concerns have been raised about the trend towards the larger corporate-style medical centre or super-clinic model, particularly in relation to the quality of care and continuity of care for individuals. Is the government concerned about this community sentiment?

Ms Gallagher: Yes, I am concerned. We have seen some of the harshest examples of the corporatisation at work, particularly late last year, and we will probably see some more of it. I am concerned. I know I may be opening myself up to criticism here, but I am not sure there is a great deal that the government can do about it.

When I have talked to individual GPs that have made the decision to move to a corporate model, it is for a variety of reasons. It could be the work-life balance. It could be the fact that they are retiring and they do not have enough super and this is one way to build up their future fund. It could be that they are attracted to that model of care. They do not want those long-term relationships; they want medicine based on the model that exists in the corporate setting. So it is not easy to pinpoint exactly why individual GPs make those decisions.

For GPs in some of the smaller surgeries across the ACT, they all do that for a different reason. It is very difficult to say that the corporate model will not continue to grow, but I think we will end up with a mix of ways that GPs operate, in small, medium and large settings. It will be very much dictated by the security that those GPs can get from that model of care.

One thing that gets lost in some of the discussion around access to primary care is that GPs are private business owners and they need to make an income. They make an income by charging for their fees and that helps them to pay for their practice nurse and for some of the other services that they offer. If that private income is jeopardised because the Medicare rebate might not be enough, they cannot afford a nurse, therefore they do not attract people for a whole range of work that is going to the nurse, they will make decisions about their own future. If you talk to GPs in small practices, it is getting harder and harder for them to earn an income, particularly when there is such a huge demand for bulk-billing and patients coming to them are not wanting to pay. If they do not pay, they do not earn an income.

It is a very complicated set of arrangements. But at the heart of it, in order to have a small private business operate, you need to make money. If you are being overwhelmed by work and are not able to make a clear income from that then why wouldn't you go and work for $300,000 or upwards and hand over all those responsibilities? It is a very difficult business decision that people have made, but

they have made it for different reasons.

MR HANSON: Mr Chair, can I ask a supplementary to that?

THE CHAIR: A quick supplementary.

MS BURCH: Well, I have a supplementary as well.

MR HANSON: I do not disagree with what you are saying at all. I think it is not too dissimilar to what I said in Tuggeranong last week. One of the reasons that I have heard from some doctors that they are moving to the bigger centres is the administrative burden that they face. Do you think that there is too much red tape imposed? Is there some way that we can mitigate that?

Ms Gallagher: That is certainly an issue that has been raised with me. Some of the red tape exists in the corporate setting as well. The biggest gripe people have is those care plans they have to fill out, which is not a requirement of the ACT government. It is for complex and chronic patients—the paperwork that they have to go through to get a rebate from the commonwealth. So that red tape will exist.

The areas that we are working on, in response to some of the concerns from general practice that we have control over, are around ensuring that we have processes in place that streamline the time it takes them to get information—things like discharge planning, corresponding with the hospital on a daily basis about their patients, getting in touch with doctors. We do hear stories; they say they have made repeated calls to try and get somebody who is on duty. So we are looking at that very closely, around what processes we can put in place for general practice specifically.

With the e-health initiatives, we are working with them to make sure that when we do roll that out that actually benefits general practice. We have got some quick wins on that in the pipeline. The GPs are very engaged in all of that work. We just need to demonstrate back to them that we can make their lives a bit easier and that we are prepared to. So there is a lot of work going on in that area.

THE CHAIR: Thank you. Ms Burch, do you have a follow-up?

MS BURCH: I am conscious of the time. In many ways you may have already answered it before. Consumers and a lot of people in the community are looking for alternative models, with cost being a barrier to access. You made the point about GPs and allied health being a small business. I was curious to see, with the task force, the discussions and the community forums, how we can get that balance between the needs of the community around low cost, free and easy access and the business models that have to play out. It is like a magnet: it is not going to quite fit together sometimes. Do you have any additional comment on that?

Mr O'Donoughue: Certainly, access for vulnerable groups is one of the specific terms of reference of the task force. There is probably a relatively small sub-population of people for whom cost is a very significant barrier. The task force is looking at models and ways that we might ameliorate their situation.

For a larger group of people in the ACT, cost is not the primary barrier. They would be happy to pay a cost for the service if they could get good access to it. That was the experience that we have had previously in our ED surveys, where 85 per cent of the people who were attending EDs for GP-like presentations indicated that they would willingly pay for a service if it was available and they did not have to wait. It was only a relatively small group of people who felt that they would not be able to pay for an alternative service. We are trying to balance those things up and we certainly have in mind that rather small but important population of people for whom cost is an overwhelming barrier.

MS BURCH: Thank you.

THE CHAIR: Thank you for joining us this morning. A copy of the transcript will be made available to you. We note the discussion paper that the task force has put out and we look forward to your report as well. So good luck with that. Thank you again.

McGRATH, MS DEE, Chief Executive Officer, Carers ACT
ASHTON, MS ANNEMARIE, Policy Adviser, Carers ACT
FLORES, MS NATASHA, Policy Project Officer, Carers ACT

THE CHAIR: Good morning everyone, and welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. There is a privilege statement in front of you. I am not sure if you have had a chance to look at it. If you want to have a look at it, I am quite happy to wait for a couple of minutes.

Ms McGrath: We have, thank you.

THE CHAIR: And you understand the privilege implications? Thank you. Before we proceed to questions from the committee, Ms McGrath, would you like to make an opening statement?

Ms McGrath: Yes. We thank the committee for giving us the opportunity to give carers a voice in this particular inquiry. We hope the submission presents the additional burden of the current system for carers and the additional stress that they are already facing on a day-to-day basis. We hope that that is explained in the submission, and we thank you for the opportunity to talk further to the submission today.

THE CHAIR: Thank you for your submission. It was very comprehensive and it outlines many of the problems that carers face in accessing GP services as well as some means of overcoming these problems. Can you outline for the committee how carers primarily deal with their health problems as their needs dictate?

Ms McGrath: One of the issues we raised in the submission was that, unlike other people in the population, carers often put their own care needs very much secondary to the care recipients' needs. As a result, for a lot of carers, their own health deteriorates, often at a rate more than that of the care recipient, which presents a great risk, not just to the family unit but also to the wider community. We have referenced in the submission a lot of national and other research around the health risks of carers themselves. Annemarie, would you like to add to that?

Ms Ashton: Certainly. We have referenced in our submission the Deakin wellbeing study done by Cummins et al. It looks primarily at the impacts of stress and the injury rate for carers which is very high. A lot of people are providing care in their homes without sufficient equipment or proper lifting, or even just help in an emergency, and they are actually dealing with a very high emotional stress load as well.

We are finding at the moment, because of the pressures of the economy, that people are not living well either now, so they are cutting their individual household budgets. That can often lead to a less healthy diet for them. So we are finding a snowball effect. Past research has confirmed to us that they face very high barriers and a higher risk because the home is a very dangerous workplace for a carer to be in. If we had to put in work safety regulations that we have put across the workplace, just about every home would fail in that capacity, if you put them against such a test.

It is a matter of finding that balance, of course, between a workplace environment, a hospital in the home, and still keeping it as a home, which is critical for many carers. But that risk of injury is very high for them and the stress rates are very high. That has an impact on their health. At the moment we are finding they cannot afford to get to a GP, they cannot afford to eat well, to maintain their diet, they cannot afford things like health club memberships to get out and provide early redress for some of the lifestyle problems that are creeping in. So we are creating the potential for a much bigger burden of disease for the ACT community, especially around heart disease, diabetes and obviously back injury. They are the three highest ones that we are having indications of.

THE CHAIR: Ms Burch?

MS BURCH: Thank you for your submission. You have made a comment around recognising that GPs are getting thin on the ground and needing to look outside the square to other health professionals coming in. You commented about nurse practitioners and allied health. This seems to be welcomed by some level of carers but there is some anxiety from other carers about what the new world may look like as far as health provision is concerned. Can you tell us a bit about the anxiety drivers?

Ms Flores: I spoke to some carers specifically for this submission. There was definitely an understanding that it could improve their situation by making primary healthcare more affordable and also more accessible, but there was a bit of nervousness I suppose about what that new system would be like. With respect to the new responsibilities for nurses, were they trained and well supported in that position? They needed more information about what that would be like so that they could have confidence in the system.

MS BURCH: Health consumers used the phrase "health literacy"—

Ms Flores: Yes.

MS BURCH: for users, so that they have assurance around what those other practitioners and providers can support them with.

Ms Flores: Yes.

Ms Ashton: One thing we find with a lot of carers is that they are a very vulnerable group. Because of the high stress loads they are dealing with, a lot of them have that hesitancy about embracing new systems. So they need reassurance and they need to understand that it is going to work for them, that it is not going to create additional problems. But a lot of them also have a high degree of literacy with the health system. They know that they want these nurses to be well trained and well supported in the role that they do. They also want a good level of communication between nurse practitioners and the GP so that they are not becoming the ping pong ball—going back and forth between the two. I think that was a very legitimate concern, to make sure that a restructure of primary healthcare is embraced, to get people on board and get clarification of who does what and how it can best work, in order to get the best.

When it comes down to it, they want the best outcome for the care recipients and the best outcome, secondary, for their own health and wellbeing. They want the system to support that, not to become another barrier or obstacle in their way. But a lot of them were very interested in the concept, especially for simple things such as injections or getting a wart removed, which can be done routinely and that you do not have to pay a GP for. A lot of the paperwork, too, for the carers payment can be done without having to go to a GP, but it is often a matter of finding somewhere to go to get that assessment done. A lot of carers are unaware that already Centrelink will accept nurses filling in those forms, but they do not know where to access them.

Ms McGrath: One of the things that has come out, not just in the submission but in our ongoing daily contact with carers, is that for most of the population the system is a struggle, anyway, but if a new system with nurse practitioners or allied health professionals were more available and it addressed some of the current blockages in the system, it would help carers—and caring families, we should say—in terms of that consistency that they need.

When you have a child, for example, with high, complex disabilities and complex health problems, or any other dependant, having that inconsistency is very stressful. We cited the case of a misdiagnosis because of a lack of available history. Sometimes getting that history in a short space of time is just not possible because it is often a long or very complex history.

I think a lot of carers saw that having another access point for them for the minor things would then free up doctors to do those more intensive treatments, and that makes sense to most people.

MS BRESNAN: You have pre-empted slightly what I was going to ask you, about that continuity of carer issue and establishing a relationship with a health professional, which is so important, and particularly for carers, where there is that complex history and then having to repeat it over and over again. Is that something which has come a lot from carers who you come in contact with? What are some of the ways in which you think that can be addressed?

Ms McGrath: Last year, as part of the national inquiry into better support for carers, Carers ACT undertook extensive research with over 300 family carers across the ACT. This was one of the biggest pieces of research that has been done for carers in this territory. It was very helpful. We also not just surveyed people but held a number of—I think it was four—different focus groups. This issue came up time and time again. That was in the formal sense, in that formal setting, but informally we also hear it all the time. For me, the issue just has not gone away and they need a solution. It just came across again and again.

Ms Ashton: I have recently been doing some work with the culturally and linguistically diverse communities and carers. One issue is the sheer lack of awareness of a lot of the existing services. We were actually doing a research project on their mental health and looking after their mental health and understanding difficulties that carers of people with mental health issues face in the system when there is also an added barrier of cultural issues.

In a lot of the education around things like Healthdirect, there was very little awareness in the general community of the advantages of using the Healthdirect system, and the fact that it can help to almost fast-track you into a GP. If you get a recommendation from them that you need to see your GP within two hours, you can then tell the receptionist at the clinic, "Look, I spoke to Healthdirect and they said this." That suddenly makes things easier: "Okay, we accept you've been triaged and that this is a genuinely urgent issue."

We have talked with a lot of carers following the research that we did about the idea of the e-health card and moving to the e-health system. There is a lot of genuine interest in that idea. They want to have smartcards, so that they have got the data with them and they are not having to wait while someone accesses a database, the link has gone down and it is a matter of saying, "No, we can't get that." But if they have got the smartcard, they can plug it in with the GP, with the hospital, and have that information there and ready. The care histories are very long and complex and you cannot carry around a load of folders even on the basic stuff, such as when they had particular procedures done, let alone what the current list of drugs is and what you stopped six months ago and what the symptoms were then—all of that clinical depth of information that is required. So they were very interested in this but they were very clear that they did not want a central database; they wanted a smartcard system.

MS BRESNAN: Obviously, depending on the type of technology that is adopted, smartcards may not be, but did they still see that maybe e-health would offer some solution for them in terms of being able to access information themselves, as well as those health professionals?

Ms Ashton: Yes, absolutely. One of the biggest barriers that they often face is getting access to information and getting their information recorded. So if they had a system that worked in that way and supported the carer's role in that way, it would be of benefit. I think the most consistent response we get is that they do not want any system that is going to create additional barriers but they welcome anything that is going to make life easier. It is as simple as that. Access to information and ability for input to be heard is very important for carers.

MR HANSON: The impact of lack of GPs is not just on carers but on those that they care for. I assume that a lack of GPs in the community means that some carers are then saying, "I'm not well enough to continue on if I haven't got a GP." Also, because the GP cannot access the person they are caring for, they get beyond the point where they can be cared for in the home. So I assume that from those two causes the implication is that we have more people institutionalised because they cannot get access to a GP in the community. Is that correct? If so, to what extent would you suggest that is relevant?

Ms Ashton: Certainly, one of the best things about primary care is that it not only prevents unnecessary access to tertiary care, so it stops people ending up in hospital, but also it prevents early entry into a residential care facility. It depends on your particular caring circumstance. Some people can, with good care, remain in the community absolutely forever, but it is where that care breaks down that you get the compounding problems. Once problems get to a specific level, that is it; there is often no more appropriate place for them than in some kind of residential care or higher

level medical care need.

For families as well, they do recognise and they most often want to keep people in the best health and in their own homes for as long as possible. But when that is not possible, they want a smooth transition. They still want the family involvement and engagement, because in the end it is all about maintaining quality of life for the care recipient and it is about maintaining family relationships. Good health, or the best possible health, is essential in that regard. So it does have a roll-on impact. If you have not got access to the GP, if you have missed something that is going to turn into a major infection and land you in hospital for six weeks, that has a huge impact on the system as well.

MR HANSON: As a follow-up to that, anecdotally, I am getting feedback that there are just not enough aged care or appropriate-type facilities for people to go into. So they cannot be cared for at home anymore; there is no appropriate high-end aged care for them to get into. Therefore they end up in hospital because there is nowhere else. Is that an experience that you are—

Ms Ashton: Yes, we have had that experience. Certainly, the data indicates that that is the case nationally. It is a little difficult for us to get the ACT-specific figures on that. The other thing is that, for people with disabilities, there is not enough range of options for either respite or supported accommodation, and obviously for people with mental illness. I know that work is being done in the territory to address that at the moment and develop some solutions, but it is that matter of access. It starts with access to the GPs and access to having options for appropriate respite, but also appropriate permanent care options, when that is needed. And no family makes that decision for someone to go into permanent care lightly.

The other thing is something that Natasha can address: the issue of how people need respite to get to the doctor for their own health needs.

Ms Flores: Maybe there is not as much awareness in the community about the fact that carers, depending on the health status of their care recipient, need temporary respite so that they can get out of the house and get to the doctor. That respite has to be organised through a community organisation and it takes time. It has to be pre-organised and then it goes for a set duration. If the doctor is running late then that appointment may be missed because they have to get back to the care recipient before the respite ends. I do not think members of the community are aware of this. Maybe there are some things that doctors can do just to help to understand that situation and to make a special case.

Ms McGrath: I did make a note to remind myself to raise this issue, because getting access to appropriate support workers as alternative replacement care while the carer is at the doctor often can take a long time, having regard to finding appropriately qualified support workers. You may already know that there is a lot of shortage in the sector for that type of worker. That is why you will find that carers do get more sick than other people in the population because they just do not get to the doctor. Trying to organise that is very difficult and it becomes a barrier. That is another barrier for a lot of carers as well.

Ms Ashton: Unfortunately, the outcome of that is the example we gave in the submission of a real case history—the lady with the pre-cancerous mole. Her respite time ran out. As far as we know, she still has not managed to tee up respite and the doctor at this stage, and it is a couple of months down the track now. Sometimes even weeks can be critical. To leave it for months becomes a neglect of good care for her. If that ends up being malignant then the care recipient has lost their carer and therefore will need entry into a permanent care place. So that creates a dreadful situation. One missed appointment because of a lack of respite has a big impact, potentially.

THE CHAIR: You identified through the submission a number of options to enhance support in a number of these areas. Are you able to prioritise? Is there a number one priority in terms of what you would like attended to at the moment or is that too simplistic a question?

Ms McGrath: It is probably quite simplistic. If we were to address some of the key barriers for caring families, such as addressing the issue of the access and priority type of status, and given the complex home-care needs, that would be really useful. Reducing the need to tell the story again and again would be particularly helpful. I think there needs to be a recognition, particularly by the GP population, that when there is somebody with those high-care needs the family can get some sort of priority. I think having allied health and nurse practitioners will actually free up the GPs to do that critical work.

I gave the example earlier of my own case—and I am not a carer myself—of having to wait 3½ hours in a doctor's surgery to get my son's wart taken off his toe when the nurse said she could not do that. That kind of thing is blocking up the system and it is unnecessary. We need to put caring families in the community as one of the most vulnerable groups having regard to access to the primary care system.

THE CHAIR: Annemarie, were you going to say something?

Ms Ashton: Also, flagging respite-linked appointments; it is as simple as that. Where it is a respite-linked appointment, it has got to become the next level of priority beyond a medical emergency. We understand that often you get an emergency into the surgery and that is it—everything stops. But the respite-linked ones need to be the next level of priority because of the cost involved—the wasted costs for the community. Ultimately, there is funding behind that.

MS BRESNAN: With those peer-support type roles, or having a carer-support person, I know they are funded in New South Wales. They have those sorts of roles in mental health in particular, where there is a peer-carer support role who will help you through this. Do you think having that sort of role might help in those instances where people are having to do the medical appointments for the respite and do all those other things just to get to one point?

Ms Ashton: It is a good idea in principle. Where it would fall down in the ACT is that we just do not have the sheer population to support it. Because we have got very high salaries here, people can get better jobs. We are finding across the board that you are recruiting in the community sector for this level of position, and we are just not

getting the applications at the moment from people who are interested. We have the same situation with all levels of respite workers, whether they are in-home or working in a cottage environment. It is very hard and we have a very high turnover of staff, because we cannot compete on the wage level.

Ms McGrath: I am in a position where I have been able to see the proposed strategy for the ageing population and some initial work being done. One of the suggestions was to look at volunteers to address the work shortage. I think we have got to be very careful. It is the same principle. In some care situations in the home, you really need to have qualified people who know what they are doing, particularly in terms of medication, personal care and all of those things. You really need to have the qualified people. It is not just about getting other people in as a volunteer. I think we have got to be very careful that we do not see volunteers as an alternative to qualified support workers. I think that is a critical thing to mention here.

Ms Ashton: I do not want to be rude about volunteers, but often, in recruiting people for that sort of intensively challenging care work, it requires a lot of support to keep them in that position and keep them well supported so that it does not become detrimental to their health as well. When you are dealing especially with people with complex disabilities, and especially children with complex disabilities, one wrong move, as Dee says, and you can create huge impacts or even kill someone. There is a lot of investment for families in training people to do it appropriately. Also, in cases where you have got people who pass away, in those circumstances, that is hugely impacting on volunteers. So you need to set up the support systems to manage the volunteers.

Again, I would worry that we do not have a sufficient body of volunteers to do the everyday stuff that volunteers do at the moment, like canteen duty, RSPCA et cetera. They are all finding a shortage of volunteers. So to get people in for that more complex level of work, it would take a lot more management perhaps than we have available.

THE CHAIR: Sorry, time has run out. Thank you for both your submission and answering our questions this morning. The committee may wish to ask you some written questions, if you do not mind. If you could give some response, we would appreciate that. But thank you very much for coming in today.

SKIMIN, MR ARTHUR, Parent

THE CHAIR: Good afternoon, Mr Skimin. Thank you for joining us. Have you appeared before a committee or an inquiry before?

Mr Skimin: Yes.

THE CHAIR: There is a privilege statement there. You are aware of the contents of that and you are comfortable with the statement?

Mr Skimin: Yes.

THE CHAIR: Thank you. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiry into access to primary healthcare services in the ACT. In what capacity are you appearing before the committee?

Mr Skimin: I am a carer, a parent and a volunteer with the RSL and their RAAF association for veterans.

THE CHAIR: Would you like to make an opening statement before we ask you some questions?

Mr Skimin: From my point of view, I am seeing it from three different levels—as a parent, a carer of a spouse with cancer, a melanoma-type cancer, and a 40-year-old adopted son with mental issues. But I am also seeing it from the point of view of a volunteer group touching on veterans in aged care, hostel care—whether it is low or high care or palliative care. In some cases, I will go with the veteran to the GP. I am seeing it from the GP room's visit and the CALMS visit.

First of all, we have a shortage of GPs—everyone knows that—because they are a bit like me; they are getting to an age where a lot of them are retiring and there are not enough young ones coming in. But generally, when we look at primary care, we seem to have some sort of dysfunction in the process—getting the patient to the GP, accessing the GP and getting onto the specialist, and the transfer of information between the GP and the specialist, the psychologist and the psychiatrist, whichever it might be.

Invariably, I find from the mental health side that the GP provides the specialist with very little information on the patient. Usually the paper file in the GP's office is yea high, particularly for a long-term chronic condition. But the information that goes to the specialist might be three lines. Somewhere along the line we have to improve that transfer of information or access to information in the referral chain, whether the access is by a specialist at the tertiary level or by a psychiatrist or the psychologist that is part of the loop for mental health.

Witnessing the family side of it rather than the veteran side of it, I often find that there is a high level of risk of misdiagnosis or flawed diagnostic work by the tertiary healthcare provider, primarily because they do not have ready access to the information on the client. The client history or the clinical information is rarely

available to that high level. They have got to go through and draw it all out of the patient again, whether it be in the Sydney cancer clinics or here in mental health.

That does not always give the tertiary health person the best information—unless there is a carer sitting in behind the patient and either nodding or alerting the specialist that they are not getting all the information or that they are getting inaccurate information. So there is this dysfunctional part of the system where the information cannot be accessed because generally it is in paper form—it is not in electronic form—and it cannot be readily accessed at the next level. This results in a much lower level of quality of care because the information is not readily available. With mental health issues, with 40-year-olds, they tend to be hesitant; they tend not to be honest with the health provider. You really have to have a carer with them all the time to make sure that information is drawn out by the tertiary provider.

There also seems to be a dysfunctional linkage of some of the issues between physical health, mental health and dental health. We seem to put them all in different boxes. From what I am seeing, dental health can be just as critical to the wellbeing of the patient as the physical health or the treatment of mental issues, whether it be anxiety, schizophrenia or whatever.

I turn to the veterans' point of view. I see quite a few of the oldies. They would be older than me, in their late 80s. Some of them would be in their 90s. The care providers struggle to get the right quality of skills mix into their staff. When they need a doctor, very few GPs seem to be willing to visit hostel care providers. Invariably, they will be hooked into the CALMS issue. In a recent case, the CALMS medical service did not arrive until 11 pm. A 92-year-old fellow who was a bit tense and a bit agitated only had the night shift people on in a hostel and his GP was not available. The only doctor that he could get access to was through the CALMS system. That can be most unsettling for a person, a lady or a man, in that age group who is waiting at 11 o'clock at night.

We have tried to use the first aid tracking, or first contact. I have only taken over this carer role in recent times. Up until my wife ran into cancer four years ago she was the carer and I was the cared for. In recent times, because I was not travelling well, I tried that first aid contact after I could not get into my GP, but the first aid contact did not work either. The ladies at the other end struggled and did their best, but the first thing they said was: "Try CALMS. Try your GP." I said, "I have done all that, ma'am, and where do we go from here?" In the end, my wife took over. We just rang 000 and the ambulance was there within—I could hear it while they were still talking on the phone virtually.

That was okay in my case, but there are other people with bigger and more complex health problems. It is a trauma for them to get on the phone and find that the first aid system does not work, that their doctor is not available, they are booked out for three days down the track, or that CALMS does not come on till 6 o'clock at night.

We are talking about the shortage of skill bases to make the improvements. The skills have to be available and there have to be budgets to make it happen. With an ageing population I do not know where that mix is going to come from. In many of the aged-care areas we are importing nursing staff from overseas on limited visas. There

is a language problem there. Some of the oldies in their 80s have difficulty relating to those people as well. The people are quite competent. It is just that they have difficulty with the English language and the oldies do not necessarily relate to them as smoothly as you would like. We have got a whole mix of problems and none of them will be easy to solve.

THE CHAIR: Thank you very much for your submission, which is very comprehensive as well. You touch upon areas that other people have not touched on, such as the IT implication of record keeping and the transfer of records. You also touch upon the large group medical centres. Obviously you have a point of view on that which has come through. Do you feel that the impersonal nature of the way that large super-clinics operate is detrimental in your case?

Mr Skimin: In those that I go to those big centres with. I do not go personally to one of the big centres. But for those that I do attend the big centres with, yes, it is detrimental. The patient gets angry and frustrated that there is a different doctor on. Invariably, if you cannot make an appointment at some of the larger centres, which you cannot—Ginninderra is probably an example of that—you can be waiting for three or four hours, and I have been there five hours as a carer. It is a long drag. In the end, you try to keep the patient there, but the patient wants to get up and exit. They may be focused on their efficiencies. They are focused on the turnover of patients, so many per hour and so much per hour. It is profit driven. But the world is changing. It is probably going to be like the United States and Britain and there will be more of them.

THE CHAIR: Unfortunately, it looks like that is the trend at the moment. Ms Burch?

MS BURCH: You made mention of information being critical for carers and care recipients. Are you comfortable with the use of e-health, in the form of either a smartcard or a central database of patient records?

Mr Skimin: I could not be more comfortable. I think it is the only way that—

MS BURCH: You think it is critical.

Mr Skimin: the efficiencies and gains in healthcare will improve.

MS BURCH: You said that the skills in the community are often not there to provide services. This committee is looking at the GP task force. A number of witnesses have spoken of the need to look outside the square of services, not just coming from GPs but from nurses, allied health assistants and so on. As a consumer of those services and as a carer, you would welcome those changes or there would be some reluctance to look for care outside of a doctor?

Mr Skimin: I have a background in the military, and over many years I did not necessarily have to see a doctor every time I needed some sort of medical attention, depending on the severity of the problem. I felt quite comfortable with the nursing staff, male and female, dispensing that information. I would be quite comfortable with working outside of the box of the GP being the sole provider. Talking to my wife, she would be in the same category, and my son would be. A lot of the oldies that I deal

with on a daily basis would be in the same category.

MS BURCH: Thank you.

MS BRESNAN: One of the things you have mentioned already today in your opening statement and also in your submission is that holistic type of care. Mental health in particular is one of those areas where it is quite key. We have already heard from Health Care Consumers who say that dental is often one of the most neglected areas for people. We have also read in other submissions and heard from witnesses today about some particular models of care. Companion House is used as an example and Winnunga. They have that more holistic model of care where you are not just looking at one area of a person's life. If there was a particular centre for mental health where people could go and we did look at that more rounded picture of a person, is that something you think would be a useful addition to the health system?

Mr Skimin: It would certainly contribute to improving the lot of people with mental health issues. We are getting a lot of young ones now in mental health. It used to be something that was related to us oldies, but now you are seeing it in the Defence Force. Young ones in particular are coming back from whatever they might have been doing and they have got all sorts of problems. I would see that holistic thing for mental health as being an important issue. They do not want to acknowledge it; there is a stigma if you say "mental health", but it is just another issue of health, in my view. I think that sort of approach would work for a lot of people.

What worries me in this whole issue—and I heard the ladies mention it in their last presentation—is the cost to the carer. Cost is not a problem to me because—well, I suppose it is. Financially, I am secure enough that I can contribute to the 40-year-old mental health case and I can make sure my wife is right, but there are many in the community that do not have that financial security to draw on if they need dental care or if they need an extra appointment at the psychologist or the psychiatrist. In our case, we can cover it, but it would probably be the minority out there in that real world that are in that position.

MS BRESNAN: So that is a yes, perhaps. The examples we used—Companion House, which is for refugees, and Winnunga, which is for Indigenous people—provide more of a community-type setting.

Mr Skimin: I think that would help in some cases.

MS BRESNAN: Yes, that is right. It tries to benefit people who, as you said, cannot afford care. They can go to that sort of thing.

Mr Skimin: Through veterans' health, we have visited some of these areas. In the ACT, there are a couple on the Woden side. One in particular works very well. There are a lot of people with mental issues in that facility.

MS BRESNAN: Thank you.

THE CHAIR: Mr Hanson?

MR HANSON: No questions. Thank you very much for your evidence today.

Mr Skimin: You can see his back is hurting and he wants to go!

MR HANSON: No. To be honest, I could ask questions, but I think that you have covered most of them or they have been covered today in large part.

THE CHAIR: Mr Skimin, thank you very much. Is there anything else that you have not covered in the preamble that you made?

Mr Skimin: No. I do not envy you in trying to get outcomes in this sort of problem area.

THE CHAIR: But submissions like yours will make it that much easier for us because you have covered it in a very clear and concise way. We thank you very much for that.

Mr Skimin: Thank you.

THE CHAIR: If there is anything else that crops up over the next few weeks or certainly in the next couple of months that you think could be relevant as additional information, we would like to hear from you on that.

Mr Skimin: I have been looking for a magic wand since I got caught as a carer and I am still searching for that magic wand. I only hope that—

MS BURCH: If you find one, send it our way.

Mr Skimin: I hope you fellas and ladies find it first.

THE CHAIR: Thank you once again. That closes our inquiry for 22 July 2009. Thank you all very much for your participation.

The committee adjourned at 1.05 pm.