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, 29 JULY 2009

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

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings.

All witnesses making submissions or giving evidence to an Assembly committee are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution. Witnesses must tell the truth, and giving false or misleading evidence will be treated as a serious matter.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 21 January 2009

The committee met at 9.22 am.

JONES, DR PAUL, President, Australian Medical Association (ACT Division)
KENNEALY, DR STEVE, Treasurer, Australian Medical Association (ACT Division)
SHARP, DR PETER, board member, Australian Medical Association (ACT Division)

THE CHAIR: Good morning, gentlemen. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services into access to primary health services in the ACT. I am not quite sure whether you have appeared before Assembly committees. There is a privilege card that is there for your information. If you are comfortable with the information, that is fine. If you need to read it, we can give you a couple of minutes to read it. But anything you say here is under privilege. We thank you very much for joining us this morning. I invite you to make an opening statement, Dr Jones, if you wish.

Dr Jones: What we thought we would do, if the committee will allow us, is: I will make a few, I guess, preliminary remarks about the system generally, some of which are beyond the scope of the territory to actually deal with because they are federal issues. I am sure you will be aware of many of those. Then Dr Sharp and Dr Kennealy will perhaps talk a bit more specifically about some of the issues locally. We might finish with a few things that we think can be done to improve the system from the point of view of access for our patients particularly to general practice, which is obviously our area.

All three of us are GPs practising in very different practices. I am in a large corporate practice. Dr Sharp is, as you are all, I am sure, aware, the director of Winnunga. Dr Kennealy is in a private practice in Gungahlin. So we have got a different perspective of different parts of the system and how it works.

I guess globally we are working in an environment where there has been, nationally, a shortage of GPs for some time and we struggle to get GPs into the territory and unfortunately it is not really clear why. I talk to my specialist colleagues and the same thing seems to apply. In the emergency department they struggle to attract people permanently, for example. It seems to most of us who live here that Canberra is a pretty good place to live and I do not really understand why it is that we cannot get people to come. But that is a reality of life to some degree. There are various debates about the numbers of GPs that we are short but most people seem to think it is probably somewhere between 40 and 60 full-time equivalents, depending on whom you believe.

One of the real issues—and I guess these are the things that are beyond the territory to do anything about—from an AMA point of view and one of the big problems is that the Medicare benefits schedule has a perverse incentive towards brief, episodic medicine in terms of the way that it rewards GPs and practices and advises against the long and the complicated consultations which are, in fact, the things that increasingly we are going to need as a community over the next five, 10, 15, 20 years as the population becomes more aged, as more of us are obese, as more diseases like

diabetes and hypertension and those sorts of things come into play. We are going to need people who can manage complex conditions and we believe that GPs are the best people to do that sort of work.

There are some system issues with respect to Medicare that we would obviously argue at the federal level with the government there over time. But I guess if the territory can do anything to influence the way that the federal government views things like streamlining Medicare, then that is certainly something that is worth doing.

The other thing that we are nationally very concerned about is the issue of red tape, and that is something that the others will talk about a little bit further with respect to the territory.

But I think, in the context of national issues, we are also waiting a little bit to see what comes out of the National Health and Hospitals Reform Commission report and the federal government's response to that and with respect to the national primary care strategy, the report of which is yet to be released. So there is a little bit of "watch this space" involved from an AMA point of view. I think with that I will hand over to Dr Sharp.

Dr Sharp: Thank you, Paul. I am the Medical Director at the Winnunga Nimmityjah Aboriginal Health Service. At the moment I do not want to talk so much about Aboriginal health issues. Ms Julie Tongs will be in later and can speak better about that. I want to talk more about general concept, general problems in general practice.

I think one of the biggest problems we are facing and will face in the future is the problem of an ageing general practice workforce. At Winnunga we have seven part-time GPs. Three of our doctors are over 70 years old. One turns 80 this week. One doctor, who is 75 years old, does four days a week. Without him, we would be completely lost and unable to provide the services we can.

This is true not only at Winnunga; it is true across the GP workforce in Canberra. And it is going to get worse unless we get younger doctors in. The higher the pressure—as you know particularly at the moment with the influenza epidemic around, there is a lot of pressure on GPs—the more likely the higher the rate of retirement is going to be. I can see this getting worse.

Another problem and another reason, I believe, for the retirement of doctors is low morale amongst general practice. I speak to a lot of my colleagues on a regular basis, and general practice morale is terrible at the moment. People feel undervalued, underrated. There is a feeling that I, we, can be replaced tomorrow by almost anybody else, that specialists are far more highly valued, that nurse practitioners can walk in and do the same job. I do not believe they can. I believe there is a role for nurse practitioners without a doubt but it is a different sort of role.

In an hour in my practice and in all our practices we want to see six patients, four patients, all with extraordinarily different problems. Our first patient might be the 75-year-old with diabetes, hypertension and obesity on 12 medications which we have to manage. The next might be a 21-year-old pregnant lady whom we provide antenatal care to. The next one might be a heroin addict. The next one might have a funny rash.

It is an extraordinary range of conditions that we deal with all the time.

The breadth of general practice and what we do is one of the things I think people have difficulty grasping. I believe we need to lift the level of morale amongst general practitioners to keep them here. We need to support those senior doctors who can provide an enormous service and enormous skills and experience but we cannot expect them to work into their 80s on a regular basis.

As Paul said, a lot of the problems in general practice are commonwealth problems rather than territory problems. There are some things we can do locally, though. I think one of the most useful things is the PGPPP system where we start getting interns into training schemes in general practice. There are two or three in the system at the moment and more have been discussed. I understand at the moment it is a funding problem in getting the interns from the hospital into general practice. This will give the interns enormous and useful experience and early exposure to general practice and how challenging and how worth while it can be and provide support to general practice as well. I will leave it at that for the moment.

Dr Kennealy: I work as a GP in a private practice, a six-doctor clinic in Gungahlin. I really thank you for the opportunity to come here. I am one of the more junior doctors, I guess, working in general practice in Canberra at the moment. I envisage that I have got another 30 years of my career to spend working as a general practitioner. The environment that we are able to set up obviously will influence me, my wife and family and my patients significantly over these next three decades.

I have been working, though, for the last 10 years; so I am starting to feel like I have some experience in the area hopefully to be able to provide some comment to you to assist you in your deliberations. Thank you very much.

But the landscape in which GPs work has changed significantly even for me over this last decade. Patients are increasingly knowledgeable. The bureaucracy that government is bringing down onto GPs, the red tape that we need to work through, the need to do it all in a shorter period of time under the Medicare MBS rebates are all placing us under a significant strain and significant pressure.

I have not come here to whinge about the problem because I actually wake every day and love what I do. I cannot think of anything else that I would rather do. I love the influence that I have on the community. I love the influence positively that I have on my patients every day. I have come here to talk about the positives of my job and I will throw in a couple of little negative brickbats as well if you do not mind.

But I think the focus really needs to be on synergies. I think there is a workforce that is out there that is able to provide a much greater service than what we are currently providing. The synergies I am particularly talking about are in relation to information technology and in relation to interactions between healthcare providers.

In relation to information technology, I think the focus really needs to be on health in the future. I think it provides a way to have portability of a healthcare record. It provides a way for increased communication, not only between healthcare providers, general practitioners and hospitals but also a way to have increased communications

between healthcare providers and their patients, all of which is going to make the system much more efficient.

Every doctor that you speak to will have a horror story of chasing a patient record through the hospital system for 45 minutes only to hit a brick end or trying to chase a pathology result for 25 minutes from an interstate pathologist that they never find. Every time a GP spends an hour on administration that GP is not seeing four patients that they potentially could have seen. So I think there really are efficiencies that can be driven significantly.

I do not know that current IT legislation really mentions primary healthcare very much and I do not know that it mentions general practice specifically very much at all. But the infrastructure costs initially are going to be significant—there is no question about that—but it is a way of providing a long-term solution to what is obviously a current problem. I do understand it is not going to happen in six months time and it will not be here by Christmas. If there is a goal to be working at here I think there is something that we can put in place that will really have sustainable efficiencies in four to five years time.

Dr Sharp has already mentioned the PGPPP program. I think that is perhaps a shorter goal and it can certainly look at fixing some of the workforce shortages till that time.

Dr Sharp has also mentioned—and I am not going to speak for all GPs—there is a recognition of an erosion of community and government support for general practice. That is perceived across the board. There is an issue with morale. There is no question about that. There are issues with attracting general medical graduates into general practice. We actually need to be working fairly hard to try to resolve that issue.

The other significant reason for GP shortages, as I mentioned, is the bureaucracy and regulation. There are eight different medical certificates that we need to complete. There must be something that can be done about that. There are many tiers of the MBS Medicare system which, as Dr Jones has mentioned, actually support shorter consultations. They do not support longer consultations for more complicated problems.

There is a growing perception, as Dr Sharp has mentioned, that a number of other practitioners can do what we do. This actually does undermine my level of training and does undermine how I perceive myself in my job. It will certainly undermine how patients perceive my position as well. I actually think it does disrespect some of what we do, but that is another issue.

Nurse-led clinics is perhaps an example of this, where minor routine problems will be channelled through a separate resource. I have made a couple of quick notes on this. I just cannot name a time when I have done a consultation which is predictably minor. Every general practitioner is going to be able to relate to you the issue of the mother who brings in their irritable six-month-old child and, only after extensive consultation, they have worked out that the mother is unsupported, the mother is suffering from postnatal depression and her husband is interstate or away for a prolonged period of time. This is not an uncommon occurrence.

The idea that my consultations are minor or they are minor issues actually does compartmentalise a patient into a medical problem. It in no way treats a patient holistically. I guess what I am after is holistic medicine and the provision of holistic care. So I do not think that this is the answer. Overseas literature has looked at this—it really has—and it has not shown any improvement in costs; it has not shown any improvement in patient care; and it actually has not shown any improvement in the wait times in emergency departments. I would ask you to give that consideration.

The other synergy I really would like to look at is actually a flow on from that. It is in relation to the healthcare providers and practice nurses. There are 8,000 practice nurses employed in Australia at the moment. Sixty-five per cent of general practices employ practice nurses. There is a scope to improve the role and function of the practice nurse. There is an ability for practice nurses to extend what they do, to be provided for better by Medicare so that more practices feel they are able to employ and provide for them. The efficiencies that can be gained there, I think, are enormous.

The two or three things I think I would look at are the PGPPP program that Dr Sharp has mentioned, the provision of electronic health and the roll out into general practice in particular so that liaison with other healthcare providers, specialists and hospitals is available, and markedly increasing the role of the practice nurse so that GPs feel more able to take on more practice nurses to perhaps fill that void for the issues that are being looked at elsewhere. Thank you for your time.

THE CHAIR: Thank you. They are very interesting insights from each of you. I make this brief observation which will lead to a question. A couple of points have come through, Dr Jones, from you in the first instance about the fact that Canberra is a great place and you are wondering why more GPs do not come here. I think it seems to be the situation that most of our industries that we attract or professions that we attract to Canberra have said, "This is the best-kept secret in town." I am wondering whether there is any way of perhaps having testimonials from doctors like yourselves from various parts of the whole GP practice in Canberra in journals to let people know how good it is here basically or how different it is to some of the bigger cities.

Dr Sharp, you made an observation that GPs may be undervalued. We have heard from quite a number of people now and I can certainly assure you that there is a great demand for the old GP, traditional GP, that people are wanting. Obviously we are all keen to understand how we can initiate better activities in relation to the issues regarding red tape. Obviously we are starting to get a little bit of a handle on that as well.

I do not want to take away from questions my colleagues want to ask but I guess the main question that I would like to start with is: we are looking for ways of enhancing the ability for the territory to either attract GPs or look at ways of capitalising on what we currently have. There is the business about the ageing population and ageing doctors obviously at the same time as well. Is there any one of all the things that have been mentioned which you see as the priority that we would have to look at in order to reverse this current trend?

Dr Jones: It seems to me that I am part of the problem, in a sense. I am one of those people who were in a small general practice. I ran one for 25 years and then, as

I sometimes say to my colleagues, I sold my soul to the corporate devil. I am now working in a very large group practice. That has had consequences for our patients in terms of people moving around, not just in my practice. Others have undergone similar sorts of changes.

The harsh reality is that when I started about 40 per cent of GPs were solo, practising sometimes in houses. The world has changed. The world has moved on. What we need to look at, I think, are ways of continuing to support practices that are relatively smaller so that they can continue to provide services that are located geographically sensibly from the community's point of view.

The most obvious way from my point of view to get GPs feeling less isolated and more supported is to improve their ability to use practice nurses. If I was going to do one thing, I would spend some ACT Health dollars. The minister and the CEO might shoot me for saying this but the reality is that what I would do is say, "Let us expand the program that operates, for example, in mental health where one of the mental health areas has a specific program for mentoring patients and supports the general practices financially to look after that difficult group."

A similar program could be to support general practices to employ a practice nurse. And those practice nurses will then improve the service that the GPs provide, I believe. The one thing that I would probably suggest is support for practice nurses in general practice.

Dr Sharp: I think that one of the things that we need to do is encourage the training of general practitioners in Canberra. It is a really good place to train. It is a small place where people know each other. General practice, AMA, the Division of General Practice, the ANU Medical School, all have close links. There is an enormous variety of things that can be done here.

As you know, I work in Aboriginal health but I also work in the prison service here. I do an enormous amount of drug, heroin, management. There are other doctors who work in refugee work, women's health. There is an enormous range of things within general practice that can be done here. And it is a great place for young doctors to come and learn about general practice, and I think we need to push that.

Dr Kennealy: I concur with the comments which have been made. I think it is a bit of a scenario of "build it and they will come", if that makes sense. I think if we can continue to make this the most attractive place to work, doctors, like any other body, are going to move to locations that they perceive are efficiently run, where they are well trained, where there is good community support and good government support for them.

If there is an excellent IT infrastructure here—I know that is going to be a national program—but if there is any way that we can be a leader for that and roll that out, if there is a way that this government can provide increased incentives for practice nurses, doctors are going to come to locations where it is easy to work and where they feel that they are being used most efficiently and where they feel that their input to patients is being most greatly rewarded.

THE CHAIR: Ms Burch.

MS BURCH: A number of users, consumers, patients, make comment of their fear of becoming part of an all-corporate primary care model in which they would lose the family practice. But on the other side, I hear from the medical profession that it is a small business and it needs to be sustainable and viable so that you are not isolated, your work practice is as good as it can be. Is there room for both? Are there any secrets of how you get the ability to have a relatively small, localised family practice with corporate large practice, which suits some people, is accessible and is a business? But then consumers want that product at a reasonable price as well. It is very complex. There is no easy answer.

Dr Jones: No. It is complex indeed.

MS BURCH: Have you found that answer anywhere?

Dr Jones: Perhaps to answer the question "is there room for both", I do not have any doubt that there is. I think that at different stages of one's career you have a different view about what the priorities are and how you can best look after yourself. And in some senses somebody as grey as I am is starting to look at how do I manage the last 15 or 20 years of my working life rather than how do I build a business. Different people have different priorities.

But I think fundamentally there will always be people who will say, "I would rather have my local GP than travel some distance to get to the large clinic," no matter how efficient that large clinic might be. What I think we need to do is make sure that the infrastructure is in place. And I think some of what Steve said about IT is part of that.

Transport is another issue. Obviously I am not expert on transport but one of the issues that patients often raise with me is the question of how to get to the services, not just general practice but those other services that they need to access.

I might not be viewed favourably by my corporate masters in this sense but if I were doing something with respect, for example, to practice nurses, I would just say, "Okay, the subsidy is one per practice," rather than any kind of pro rata basis. You would in a sense disproportionately support the smaller practices located out in the suburbs where people need them to be.

That is probably the sort of attitude that I think we need to have. Rather than just saying that one size fits all, we need to say, relatively speaking, the smaller practice further out needs more support than the larger practice which has got its own economies of scale and efficiencies built into it.

Dr Kennealy: Can I perhaps add in another solution to an incredibly complicated problem area? I am sorry to come back to it, but the MBS rebates for the promotion for shorter consultation times is an issue here as well. I agree with Paul. There is definitely a place for both. There is no question about that. And we cannot do anything to change that.

But the encouragement of shorter consultation times is actually more of a detriment to

the solo practitioner or the small private practice than it is, I believe, to the large corporate practice. There are a whole lot of reasons for that. Maybe it is the efficiencies of the corporate practice. Often the bulk-billing arrangements are run through corporate practices.

If a financial weight could be given to longer consultation time to deal with more complicated problems, that would be of much greater benefit to private practice, I believe, than potentially it would be to the corporate practice. And it would encourage, I think, more doctors to remain within that private practice field for longer periods of time.

There is no doubt that the financial carrot, or payment, to move into corporate practice has been an enticement for a lot of general practitioners. Not to remove that but to make the private practice not the slog and grind and difficult practice that it truly is, without sometimes that financial reward at the end, is perhaps something I would look at. I know that it is a federal issue. I do understand that. But looking at those MBS rebates would actually be quite significant in maintaining the attractiveness of private practice.

Dr Jones: Can I add that in that respect it would also change the way that the corporate practices operate, I think. I think there is no doubt that within those large practices—the economies of scale are one thing—the pressure for some doctors that they feel to get people through quickly means that those patients may not necessarily get the sort of continuity of care or the length of care that they actually need.

THE CHAIR: Thank you, Dr Jones. Ms Bresnan?

MS BRESNAN: You mentioned the nurse practitioner-led, walk-in centres. Dr Kennealy particularly talked about that. That seemed to somewhat detract from the role of GPs or how they perform. We have had a number of different organisations make submission already and give evidence about making more use of other allied health professionals, based on other different models. The Pharmacy Guild has been one of them. They talked about the community pharmacist who triages. It is basically a continuation of medications.

Do you see that there is value in terms of using those sorts of models without, I guess, detracting from the role of GPs? We are looking at the issues you have already mentioned about the ageing GP workforce and about that pressure that is placed on particular practices. Do you think there is a role to use those sorts of models, particularly making use of other allied health professionals and organisations like pharmacists, that can actually benefit GPs?

Dr Kennealy: Yes, I really do think there is. And I am really not dismissive of the role of allied practitioners at all. I hope that I did not come across that way. What I am saying is that it can lead to a fragmentation of care and a compartmentalisation of a patient's health problems that actually can be very disruptive and dangerous and destroys synergies in the long run.

I really do think there is a role, and I am a huge advocate of practice nurses. I really am. I think they have driven efficiencies for general practitioners and improved health

outcomes for patients beyond what anyone's expectations were. And I think that is why the take-up has actually been quite good without an enormous amount of government support within the regional areas. There are supports in rural areas but not within metropolitan areas.

But I guess it depends on the model that you are trying to set up. I would be against—and speaking purely for myself as a private, general practitioner at the moment—anything that fragments patient care and makes it more difficult for me to manage a patient in their entirety so that I am not chasing a pathology result for 10 minutes and I am not trying to find an X-ray result for five minutes and I am not trying to find out what medication they are on for about six minutes, because there is 20 minutes of my time which has absolutely been wasted. I am very much in terms of allied health practitioners working together, not necessarily independently.

MS BRESNAN: There is an issue which you have mentioned today, and which we have heard about, affordability and people not always being able to access a GP because of various issues. It is about transport, about them being able to get there and the affordability issue. We have heard in some of these other submissions that it is a fact that people are going to their pharmacist. Often that happens. Or they are going to a walk-in clinic. How do you deal with that?

You mentioned the fragmentation of care but we have got those issues that do realistically affect people—affordability and getting access. How do you then take account of that, given that you are saying, "Yes, there is that fragmentation of care but we have got those other aspects"? Is that impacting on what sort of care people seek?

Dr Jones: I guess we are now getting into the sort of territory that we have come back to a few times, the sorts of things that are essentially beyond the control of the ACT AMA and the ACT Assembly. We are talking about the Medicare benefit schedule and how it works.

The reality is that most GPs are acutely aware, I believe, of the impact of the things that they do and that we every day make decisions about referral and those sorts of things. And we unfortunately have to ask our patients, "Do you have private health insurance?" "Can you afford to pay for a physiotherapist privately?" We are acutely aware of the fact that the decisions that we make are based on whether they can afford to get this script filled if it is a private script, not a PBS script.

There are a whole lot of those sorts of tensions that we see every day where we know that, if we want to give people the best care, it may not necessarily be affordable for them. And it is not just in terms of our own fees; it is also in terms of other fees. For example, in the ACT at the moment if you want to have a colonoscopy done and you want to get it done via the public system, you are looking at anything from six to 12 months wait. If you get it done privately, if you are insured and you can afford to pay the specialist's fee, then you are talking about three weeks.

Sadly, in my working lifetime I think the question of people's economic wellbeing has become more important in terms of their accessing healthcare rather than less important. And that is in the context of lots and lots of federal and territory money being spent. But that is, I think, the harsh reality at the moment. We are acutely aware

of the economic impact on patients of the sorts of things that we suggest to them. And I am not sure that I have an answer to that.

THE CHAIR: I am conscious of the time. Are you comfortable to keep going for at least another five or 10 minutes, perhaps?

Dr Jones: Absolutely.

THE CHAIR: We have checked with the other people presenting as well. The issue of red tape has cropped up in various places from all three of you. There are federal parts of that, obviously. What are the particular issues with red tape from a local perspective that could be done better?

Dr Jones: Where to start? Perhaps if we give you a couple of examples: Steve referred to certificates. There are currently, by my calculation, no fewer than eight official certificates that GPs have to have on their shelves somewhere.

THE CHAIR: And this is an ACT requirement?

Dr Jones: This is in the ACT. Most of us deal with patients who are living in the ACT but working in New South Wales; so we need an ACT WorkCover certificate. We deal with people who work for government agencies; so we need Comcare. We deal with people who work in the private sector; so we have to have ACT WorkCover certificates. And these are all legislated. We cannot avoid using them. And they are all subtly different in their own way. As my dad would say, "Each an idiot in his own peculiar way."

One of the most galling ones from an AMA perspective was the recent passage through the Assembly of legislation on third party insurance where there is now an official certificate for third party insurance cases. There was no consultation with the profession, as far as I am aware. There may have been with other organisations but there certainly was not with us. That is just one example that GPs are wrestling with. "Whom do you work for?" "Where do you work?" "Can I find the right form?" Those are the sorts of things.

The other one that is particularly galling for me—and I have raised this with ACT Health several times—is the growing tendency of ACT Health in each of its little silos to have their own referral mechanisms, their own referral patterns, their own referral forms. If I simply write a letter with as much detail as I can muster, I get a fax back saying, "Please complete this form." Most of the information on that form is already in the letter that I have sent. Those are the sorts of things.

Currently if you fall over and break your arm and it obviously needs to be fixed and you happen to drop in to my practice, we get your X-ray done, we can see the fracture is there, it needs to be done, I ring the orthopaedic registrar at the Canberra Hospital and I wait and wait and wait. That is not their fault. These guys are busy and are sometimes in theatre and so on. I then discuss your case with them. They say, "Yes, you can send this patient to the registrar review clinic. Send us a fax. Include the patient's phone number. We will contact the patient." These sorts of processes are incredibly time consuming for GPs.

You can perhaps see the sense of them from the other end but there is little thought given to what impact it has on GPs. In the time that I spend sitting on the phone talking to the registrar and then organising the fax and so on, I could be seeing another patient. It is as simple as that. In terms of access, it has dual effects. It restricts the amount of time I have to see people and it reduces the effectiveness of my practice as far as the economics of it are concerned.

A lot of other areas of red tape are things that the federal government controls. For example, the system of applying for authorities for a number of medications means that we get on the phone and talk to somebody in Gosford to get permission to prescribe certain medications. I am sure all three of us could just about hum the jingle from start to finish, "Your call is important to us." "It is only a couple of minutes" is the answer we get back from the feds but the reality is that that couple of minutes multiplied by four or five times each day, multiplied by 200-odd days in the year, is probably 300 or 400 patients that we could each have seen that we currently cannot see.

So the impact of red tape is real for general practitioners, I think. It is only little bits each time but by the end of the day it might be three patients.

THE CHAIR: I realise it is also unfair to ask you to go through the whole list, but if you feel there is some value in letting us know about the range of red tape issues that confront you we would love to have some further information on the specific cases so that we can include them in our inquiry report. We would invite you to submit some further information on that.

Dr Jones: We could certainly go away, yes.

MS BURCH: On red tape and different forms and communication, you made mention of e-health. In the budget there was a significant amount of money for e-health. You welcome that and that would make some of those processes easier, more time saving?

Dr Jones: We are certainly hoping that that would be the case. For example, there is one public hospital in Sydney that has its outpatient booking system on the web so that the GPs can put their patients directly into spots. Those sorts of opportunities we would hope will come out of the, I think, $90 million that has been earmarked for e-health in the territory.

One of the concerns we have a little is that at least the preliminary documentation that I have seen does not have a lot of reference to general practice. So we would be really keen to make sure that these things are friendly to GPs. But yes, I agree. I think the reason that Steve raised it is that this is an issue that there is obviously funding for but we need to be careful to get it right so that it would—

MS BURCH: And the profession would embrace it and use it rather than have another process as a burden?

Dr Jones: GPs have a—

MS BURCH: So that it would be useful?

Dr Jones: Yes. GPs have a good track record of implementing IT. We are in fact a long way ahead of our specialist colleagues if you look at the rates at which GPs use IT. And certainly the younger GPs in the community are much more IT savvy than some of us who are just about to disappear. But, yes, I think it is a no-brainer for GPs that a push of a button gets the referral sent off rather than having to go out to the front desk to do a fax.

The other issue is that, with almost everything we do, we finish up printing bits of paper so that they can be put on the fax machine and sent somewhere else rather than just transmitting them electronically.

THE CHAIR: And access to records obviously is—

Dr Jones: It is a big, burning issue. You are all aware, no doubt, of the issues on transfer of records that have occurred with the closures of some practices. That is certainly a major factor.

What we really need is a record that you, as a patient, control and that you carry with you wherever you go. As Steve said, that means we avoid this problem of not only us having to chase the records but also the patients having to as well. It is very frustrating from a GP's point of view. I have a patient completely, as the professional jargon says, "worked up", X-rays, blood tests et cetera, and you discover from their discharge referral from the hospital that most of those things have been repeated at enormous costs to both the territory and the federal government.

We have the situation where radiologists in this town working in the public sector will not report on films that have been taken elsewhere if there is no report. If I see you on Saturday afternoon, organise a CT scan, which we could do, I want to send you into the hospital with that CT scan, they ignore it and do another CT scan. These are the sorts of things that drive us crazy, I have to say. And it is a big dose of radiation, from the patient's point of view as well, that they do not need.

THE CHAIR: Ms Bresnan, you have the honour of the last question.

MS BRESNAN: Talking about, e-health, you said that there has not been any notification, any discussions or any funding for GPs in terms of the funding that has come through at the moment in the ACT which, like I said, has been largely based on hospitals. Are there going to be any issues on interoperability with systems which GPs might already have set up and do you think there is going to be some sort of funding or trial to make sure that the systems that we have in the hospitals are then going to be able to talk to the systems which GPs currently have in their practices?

Dr Jones: We would certainly hope that that will be the case. I think it is a bit of a blank canvas at the moment. What we want to avoid is the sort of situation we have at the moment where both public hospitals, both of them, unilaterally decided to move to a system of giving patients X-rays on DVDs. There was no discussion with GPs about how that might interact with our software, no training for GPs about how to use it.

The first time I got one of these I struggled to actually get the report to open. I am not, still to this day, sure whether that was a problem with my software or the disk that I was given. I could see the pictures but I could not see the report. Anything like an MRI, for me as a GP, might as well have been one of my son's AC/DC CDs as far as useful information was concerned. Those are the sorts of things we need to avoid in the roll out of the IT.

I think it is a very good thing that there is so much money available. Whether that will be enough is another matter, I suppose. People will always want more. But one of the things we need to ensure is that it is sensibly interactive with general practice.

Dr Kennealy: The National E-Health Transition Authority is, I think, envisaging that the future is going to be a bit of a buy-in type arrangement, almost like an iPhone, I guess. The way it works at the moment is that they provide a service and, if you want a navman on that, then they buy in and put themselves onto your iPhone. And that is exactly how they are envisaging the future is going to look. The interoperability actually should not be too much of an issue. It is more going to be that they are going to provide the framework for it and, if you want to have your services on that framework, then you will have to buy onto that framework so that the GPs and the hospitals will be able to access that.

I say it is incredibly simplistic. Hopefully, there is not going to be too much of a problem. Apple and iPhone can do it; so I imagine that there is the technology there that enables that to happen with, hopefully, minimal fuss. But the portability of electronic communications is going by the security so that the actual security issues involved with the transmission of health documents and the communication between patients and their GP or their nurse, or their allied health practitioner, as well as the GP back to the hospital and to the specialist, will be enhanced enormously if we can get it right.

In answer to the original question: yes, GPs will use it as long as it is efficient. And there is no doubt the take-up is good. No-one uses their remote control at home if it is not easy to use. But, if it is easy to use, GPs have shown time and time again they would actually take up electronic medicine quite quickly.

THE CHAIR: Thank you. Unfortunately, time has run out for us. It is always difficult to capture all of the ideas that you may want to tell us about as well. I invite you again, if there is any additional information that you feel would benefit all of us in getting to the issues that are confronting us, to please get back to us with any further information you may wish to give us.

Also, a full transcript of our discussion will be sent to you. Obviously you will get a complete copy of the report when it is finally issued, which will be around the December time frame. But we thank you very much for the time you have given us. One other thing, we may also ask further questions, if that is okay, in a written format to you. So thank you for joining us.

TONGS, MS JULIE, Chief Executive Officer, Winnunga Nimmityjah Aborigina Health Service
SHARP, DR PETER, Medical Director, Winnunga Nimmityjah Aboriginal Health Service

THE CHAIR: Welcome back, Dr Sharp. Ms Tongs, thank you for joining us this morning. Welcome to this public hearing of the Standing Committee on Health, Community and Social Services into access to primary healthcare services in the ACT. There is a privilege card that is near you. I am not sure whether you are aware of the contents of that, Ms Tongs. If you are not, would you like to have a quick look at that? So, you are comfortable with the implications of privilege?

Ms Tongs: Yes.

THE CHAIR: The offer is there for an opening statement. Would you like to make an opening statement in regard to your submission?

Ms Tongs: I would like to open by saying that we face many challenges at Winnunga in the ACT, those challenges being the shortage of GPs and other skilled professionals to provide services. Winnunga Nimmityjah Aboriginal Health Service is in its 21st year of service. Dr Sharp has been with us for 20 years. He is our longest serving employee.

In the past we have never had to advertise for GPs or virtually anybody. We had people knocking on our door, wanting to come and work at Winnunga. But times have changed. I have been at Winnunga for 12 years now and in the last 18 months we have had to start advertising for GPs.

It is not easy when you work in an Aboriginal community controlled health service to compete with corporate GP services. We do not get near the amount of funding to employ our GPs as what you get in a private practice, especially now with the super clinics and all the bonuses and benefits that they can offer. So it is really competitive out there.

We know that the ACT has got the least number of doctors throughout the country. We have got fewer doctors now than the Northern Territory. So it is a big issue for us.

THE CHAIR: You have already made it fairly clear that the super clinics are a problem from your point of view. What would you see as the best opportunity to get more GPs? Is there any single fact that could help you?

Ms Tongs: I really believe what we can pay a GP compared to others. We are never going to be able to compete unless there is some equity in that. Doctors come and work in our services because they have a social commitment. They are committed to doing something to assist with Aboriginal health. They are special people that come and work in our services. It is not all doom and gloom but you see a lot of sadness, a lot of chronic disease, working with people from the stolen generation.

There are lots of other issues that impact on an Aboriginal community controlled

health service, particularly a service such as Winnunga. It is not just jurisdictional; it is not just an ACT service; we are a regional Aboriginal community controlled health service. That in itself brings other issues for us. Thirty per cent of our clients now come from New South Wales and 25 per cent of our clients are non-Aboriginal people. That in itself creates issues for us at Winnunga, because we are not funded from New South Wales. We get no funding. We are primarily set up to be an Aboriginal community controlled health service; yet 25 per cent of our clients now are non-Aboriginal people. That is because we see partners of Aboriginal and Torres Strait Islander people.

There are a lot of disadvantaged people in the ACT. That is often covered up. We see a lot of those disadvantaged people. We see a lot of the elderly people, particularly the elderly people from Narrabundah and that particular area. When we first moved into Narrabundah we had a private GP that shared space in our service. Because of the shortage of GPs, that GP has now moved over to Chisholm. That left a gap for the Narrabundah community. We have filled that gap. There is nothing better than seeing elderly, non-Aboriginal people walking down a hallway of an Aboriginal health service, let me tell you. But we need to be resourced to be able to continue to do that.

We run very good programs at Winnunga. We run a really successful diabetes program that we have been running for many years, a quit smoking program, a women's program, a men's program. We are really comprehensive. And we have a dental service within our service, as well as psychiatrists, psychologists, Aboriginal health workers, counsellors. We are more than just a GP service. We have practice nurses, midwives. We do holistic health. It is about the whole person and it is integrated; it is not a body-parts approach to health.

THE CHAIR: Thank you. Ms Burch?

MS BURCH: On the comprehensive primary healthcare you provide to your clients—and you mentioned workforce shortages across nurses and allied health and counsellors—it is a primary care workforce shortage or difficulty you have experienced?

Ms Tongs: It is not just primary healthcare; it is right across the service. It is in administration, to be able to get skilled people to come and work in a service and not be able to compete with mainstream services as far as salary goes. But we are not just competing against other GP services or whatever. We have got a big bureaucracy in this town, with the commonwealth and the ACT government and then you have got a lot of national peak bodies.

Getting good admin staff as well is a problem. Our financial people are as important as a doctor in an Aboriginal medical service because there is so much red tape and there is so much reporting. All we seem to do is report. And we are under such scrutiny because of who we are. Fair enough, we get public money. But it is important for us to be able to get on and do our job without getting bogged down in the red tape and reporting.

MS BURCH: Scope of practice across health professions has been raised in submissions and through witnesses. Do you think your model of holistic care has

some answers in workforce shortages? How do you manage a patient? Who sees whom, who makes that determination about care management?

Ms Tongs: It starts in the reception area, particularly at the moment with the swine flu threat. When the bird flu was a threat, we had a pandemic plan developed by our new medical students that do placements at Winnunga; so we were in good stead when this hit. But it starts with the reception staff doing the triage stuff and then practice nurse and doctor.

Usually people come in and they want to see the doctor because they want to get a prescription or something. Then the doctor will pick up that there are other things not right with that person. They could not be eating properly, they have got no money, they cannot get their script filled, or whatever. Then the GP will refer them off to one of the Aboriginal counsellors.

We do not only look after their health. It could be that they are about to be evicted from their house. They have got no money for their prescriptions or food. We see it all the time. Then they have often got child protection issues or justice probation and parole. It is more than just come in, get your script and leave. It is to do with that holistic approach to health.

Dr Sharp: As a GP, one of the really satisfying things about working at Winnunga is having the team around you to refer people on and to be able to deal with far more than I probably could in a normal general practice. I have all that support there. My general practice practitioner colleagues will appreciate that very much and it is a good place to work because of that.

Equally, they find it very difficult. Speaking to my colleagues in recent months, because we have had a few turnovers of GPs lately, most of them do a couple of sessions a week and say that that is enough. Dealing with the problems of the inequity and injustice in the Aboriginal population is exhausting. They see these incredibly complex problems in patient after patient after patient. And even though there are supports there, they find it hard.

MS BURCH: It is just the workload, the burden of the workload, the new client base?

Dr Sharp: Yes.

Ms Tongs: All of a sudden, it ends in death or long-term illness or whatever. When you are a young doctor and you come out of medical school and you are full of enthusiasm, it can actually impede. I think that it is rewarding but you have got to be resilient to work in a place like Winnunga.

MS BRESNAN: You have mentioned in your submission and here the fact that a fair percentage of your clients are not Indigenous. Do you think people are coming to you because they are disadvantaged in all areas and have a range of things which have to be addressed in their life and might not find that care elsewhere? Do you think people are coming to you because you are offering that holistic care model which they cannot get somewhere else?

Ms Tongs: I probably should make it clear that the more specialised services like dental, psychiatrist, psychologist are only specifically for Aboriginal people, because there is a huge demand out there. But as far as GPs and practice nurses are concerned, that is not an issue. That is also for the partners of Aboriginal and Torres Strait Island people.

But we are hearing more and more non-Aboriginal people say that they want to come to Winnunga's diabetes clinic or they want to access other services. We do not have an issue with that if we have got the resources to do it. But we need to get the resources to do it. With the COAG initiatives, the close the gap and all those other commonwealth initiatives, that leaves us vulnerable again because a lot of that money is going to go to the GPs, the divisions and the super clinics, because we will be competing against the big entities to get access to that money to run our services.

That is a real issue for us, although we have got an excellent working relationship with the AMA in the Division of General Practice here in the ACT. But I am sure that many of the other AMSs around the country will be left very vulnerable, and that has already started.

MS BRESNAN: When you say "it has already started", what has happened in terms of that already?

Ms Tongs: Where a service has become vulnerable, then the divisions have taken over those services. Up the North Coast and down the South Coast there are issues. At the end of the day we need to keep an eye on what is happening in the rest of the country. I know that Winnunga, both locally and nationally, has got a very good name. We are often held up as a shining light in Aboriginal health services, and we want to continue to be able to be that beacon.

MS BRESNAN: In regard to the 30 per cent of your clients from outside the ACT, have there ever been any discussions that you know of or you have been involved in with New South Wales and ACT Health about coming to some arrangement with them?

Ms Tongs: I have been at Winnunga for 12 years and there has been a lot of turnover with CEOs of ACT Health and whatever. I have been raising this issue virtually since day one about why is it so hard to have an agreement between New South Wales and ACT for Aboriginal health when the ACT hospital is a regional hospital and there is an agreement there. We had an arrangement with New South Wales as far as the prison went. I do not know why we cannot have some sort of an arrangement with New South Wales when it comes to this.

THE CHAIR: My question was also related to the fact that you have such a large number. In your submission you say around 25 per cent of your clients are New South Wales residents. There are arrangements in place between ACT and New South Wales Health for cross-benefits. I should imagine, taking up Ms Bresnan's point, that representations could be made to the ACT regarding the level of service you are providing for people from outside the territory. Funding is part of your issues. You keep saying that you cannot compete with the mainstream GPs or the super clinics to attract people. If you were able to get a better funding base to handle this, that would

solve part of your problems, would it?

Ms Tongs: It certainly would, yes. If we could get funded even from the ACT for a GP position, that would help us to be able to attract. Our psychiatrist has been with us for nine years now and we have never been funded for her. Medicare can only stretch so far. Often we see that the policies, programs and initiatives which come down from the top do not always fit. The number one reason why our clients access Winnunga is respiratory disease, and the number two reason is mental health. That is big. Mental health in itself is a big issue for us and it is a big issue for the whole of the country.

THE CHAIR: What about the red tape that you have to contend with? Are there additional red tape issues, apart from what normal GPs would be facing, because of your additional services?

Ms Tongs: Definitely. Because the funding comes from the government, we have to report. There are different indicators for different positions. Out of the 60 positions at Winnunga we have probably got about 40 that we have to report against. You can imagine the burden on a service our size. To be able to report against all those indicators that we are expected to report against is a real dilemma.

It is a national issue about what you really need to know. Are we collecting data for the sake of collecting data or has it got some purpose at the end of the day? Anybody can collect data for that purpose, but we have got to know that it is meaningful data.

The data that we collect at Winnunga is really good data. That determines then how we run our services. So we do not always fit with what is coming down from the top, but often we will run a program from our Medicare funding because our services are determined by the needs that walk through our door and not what has been sent down from up the top.

MS BURCH: They are the service agreement reporting systems, the SARS or DARS?

Ms Tongs: SARS, DARS, service activity report, SDRF, the service development reporting framework, bringing them home, social and emotional wellbeing. You name it and we are reporting.

Dr Sharp: And each one is somewhat different; so it has to be done differently. The waste of resources on these things is horrendous.

Ms Tongs: You almost need a mini bureaucracy to be able to run the service.

MS BURCH: I had a question on your comment that Winnunga is doing 95 per cent of Indigenous Medicare checks. I go to the next point about other mainstream services that are not identifying or not providing space for care for those Medicare items. Do you have a sense of how that is in Canberra?

Ms Tongs: I think that there is a perception that, unless you are black and you live in the Northern Territory, then you are not really Aboriginal. There are a lot of fair-skinned Aboriginal people like me and unless you ask the question you are not

going to know.

But in fairness to GPs, they have got a tough job as well. I feel for those GPs in private practices, those small GP services. It must be an absolute nightmare for them to do their job as a GP and then to have to do the recording of the Medicare. It is all time consuming. The time that you spend entering into the computer and whatever, you could probably see another patient.

Dr Sharp: Going back to I think what Paul was talking about before, there have been some great innovations in Medicare, the healthy for life stuff, adult health checks, paediatric health checks. They are all worth good money for doing it. The trouble is finding the time to do it is just about impossible, particularly if you have got a flu epidemic. If we have got 25 people in the waiting room, coughing, we have not got time to do a paediatric health check. Realistically it is a fine idea, but in practice it just does not work.

MS BURCH: And you have got a good relationship with the AMA in the division and you are working through as much as you can to support those other practices?

Ms Tongs: That is right. I think that is really important. We are probably the only service in the country that does have a relationship, particularly with the AMA. Dr Pete is on the AMA board and he is the only doctor from any Aboriginal medical services on an AMA board. So that is a really good thing for us. They appreciate what we do and we appreciate and respect what they do.

But it is going to be difficult for us now, the way that the government is rolling out COAG. Most of that will go into the primary healthcare division of DOHA and then we will be competing against everybody, to be able to continue to provide our services.

MS BRESNAN: On that, you talked about the various silos within departments and about having to go to different places for different funding sources. Does that then impact on your ability to be able to apply for different funding sources? You said there is this money coming through COAG as well as from different sources. Do you have that situation where you are possibly competing against larger organisations?

Ms Tongs: It will be a tender process, and tender processes are complicated. If you do not have the resources of somebody that is just sitting there writing submissions or tenders all day, it can become an absolute nightmare. Our clients come first and foremost for us. Whatever comes after that comes after that. They are the most important people. We are making sure that their healthcare is being looked after.

But we also get funded from ACT Housing. We provide a housing liaison service. We also get funded from disability services. We have got a lot of other programs within Winnunga.

We even got Centrelink to actually come to Winnunga because we had a lot of problems. A lot of our clients with mental health issues often get breached because they do not put in their forms or they are not on a disability pension or whatever. So we have had Centrelink come in to our service for over seven years now. One of the

actual staff from Winnunga will sit with that client and go through what issues they have with Centrelink.

We have started to do that with ACT Housing now. They come to Winnunga. It is much easier to have those services come to us than to have a staff member out all day, sitting in a Centrelink office trying to sort out somebody's Centrelink payment. And that has been a really positive program.

We also do prison health. Dr Pete has been going to Goulburn jail now for 10 years every fortnight. Then when they reopened Cooma jail, some of the inmates that were in Goulburn low-security prison got moved to Cooma and they wrote to New South Wales Justice and Health and asked that Winnunga provide a service to them. So we also go to Cooma jail. We were going out to BRC. Now we go to Alexander Maconochie.

MS BRESNAN: Do you get any additional funding for doing that?

Ms Tongs: Yes, we do. But it is not a huge amount and we have to squabble about funding for Cooma. We were going to go anyway because we believe that, regardless of whether you are on the inside or the outside, you are entitled to proper healthcare.

Dr Sharp: I think it is a great example of the flexibility of Aboriginal medical services to do these things. You are well aware of the horrendous rates of incarceration of Indigenous people and if we are going to do anything about that we need to get into the system and work in there. I think we are the only AMS working inside the prison system in New South Wales at the moment. But if we are going to change what is going on, the terrible things, we have to be where it is going on.

THE CHAIR: We are running close to the end of time. Are there any issues that you want to bring up that we have not covered at this point?

Ms Tongs: Just that, because the ACT is a fairly small city, there is a lot of disadvantage and we need to work together to try to address that. Services are fragmented. Often it is difficult to even get an appointment for months, and sometimes people need to see somebody straightaway. I guess they are some of the issues that impact on us.

THE CHAIR: This has cropped up from a number of questions that have been addressed to you. You also address in your submission the fact that there is such a great deal of out-of-town impact on your own resources and the scope of your activities. Obviously it brings more expense with each service you provide. I note that you said that these issues have been raised now for 10 years. Are you getting any answers or you are not getting satisfactory answers?

Ms Tongs: Everybody said that they would look into it, and nothing has really happened. My life is so busy, trying to hold it together, and I not only have local commitments but I have national commitments. I just need to get focused and try to work through this not only with the ACT government but with the commonwealth as well.

THE CHAIR: From the ACT point of view, we are certainly here to provide some ability to translate some of your requirements within our inquiry. So if there are any other issues that you feel should be highlighted we would very much appreciate further input from you. The committee may also ask some more questions of you. We will do that in written format, if that is okay.

Ms Tongs: That is fine.

THE CHAIR: I thank you very much for joining us. Obviously it is quite an educational process from our point of view to learn about all of the services you provide.

Dr Sharp: Thank you very much.

Ms Tongs: Thanks a lot.

MS BURCH: Thank you for your time.

THE CHAIR: You will get a complete transcript of what was said here this morning as well. Thank you.

Ms Tongs: Thank you.

LEE, DR CHENAULT DOUGLAS, general practitioner, Erindale Medical Practice

THE CHAIR: Good morning, Dr Lee. It is good to see you again after the wonderful presentation you made to the Tuggeranong Community Council, which both Ms Burch and I were at. We were very impressed with your presentation. Thank you for making a submission to our inquiry as well. I welcome you to the public hearing of the Standing Committee on Health, Community and Social Services into access to primary healthcare services in the ACT. There is a privilege card there. I am not sure whether you have read it.

Dr Lee: I have read and I have signed it and returned it.

THE CHAIR: So you are comfortable with that?

Dr Lee: Yes.

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

Dr Lee: Yes. I am a general practitioner. I have been practising in Wanniassa for 24 years. In today's submission I would like to point out and explain the difference between primary healthcare, secondary healthcare, episodic healthcare and tertiary healthcare and I would like to explain the difference between a GP and a family doctor. While all GPs are able to provide secondary episodic healthcare, I would like to stress that only family doctors can really provide primary healthcare.

The terms primary healthcare and GPs have been mentioned very often but I suspect that they mean very different things to different people. I guess the inquiry today is on the issue of access to primary healthcare and presumably on the issue of GP shortage. If we are looking for a solution to a problem, I think it is important that we all agree that we are talking about the same problem and the same issue, which is why I think it is important to define all these terms first, before we get onto the issue of looking for a solution.

THE CHAIR: The solutions are many, as you have indicated. From the point of view of your own experience, you are well aware of the Tuggeranong area?

Dr Lee: Yes.

THE CHAIR: What would be your major suggestion to improve the situation in your area, which I imagine would be similar to other areas in Canberra?

Dr Lee: Yes. I wonder whether I may be given about five minutes just to explain that first, if I can. Like I say, it makes more sense after we have defined these terms.

THE CHAIR: Of course.

Dr Lee: Primary healthcare really refers to the ongoing preventative and proactive medical care that a GP provides for and in collaboration with her patients, using

evidence-based medical principles. Some examples include encouraging patients to give up smoking, to exercise regularly, to maintain good blood pressure, good body weight, to reduce cardiovascular risk factors, to do screening tests such as mammography, pap smears, prostrate examinations et cetera, in order to prevent serious illness happening. It is important to emphasise that a family doctor can only perform this duty if the family doctor sees the patient regularly and knows the patient's background.

Primary healthcare is what keeps Australia healthy and productive but it is also the most unglamorous and underfunded area of medical policies, for the very reason that, if a doctor is doing her job well, her patients are healthy and happy; they do not turn up at the hospital, bothering the hospital; nobody hears about them; and they are simply forgotten. To give an example, I detected that a patient had high blood pressure just the other day. If it was under an episodic and secondary healthcare situation in a medical centre, the correct thing to do would be to prescribe an antihypertensive. However, because of my knowledge of the patient, because I have known her for years, I know that her blood pressure has always been normal. I also happen to have seen her son a few days ago, and her son told me that this patient's daughter had tried to commit suicide in Melbourne. Armed with that background knowledge, I can understand why her blood pressure is high. Rather than prescribing medication, I consoled her and, at the end of the consultation, her blood pressure was back to normal. We will meet again, to help comfort her. These are the things that a primary care physician can do but a doctor providing just secondary and episodic healthcare cannot possibly do.

General practice and primary healthcare is as much an art as it is a science. Together with clinical acumen, the family doctor must also demonstrate compassion, commitment and humility. Primary healthcare is not a high-tech industry. Being a GP is a job but being a family doctor is a vocation. And it is the family doctors that we are lacking. That is the nature of our problems.

Secondary healthcare is a term that we have not used, that we have not heard of before, but when we talk about primary healthcare, in the media and by the public, we really refer to secondary and episodic healthcare. What the Prime Minister is talking about in terms of a primary care centre is really secondary healthcare and episodic care. They refer to illnesses. Somebody suffering from bronchitis, their blood pressure is high, a complication from diabetes, a complication from asthma, nappy rashes, cuts and so forth, these are really episodic and secondary healthcare. This is what the public think GPs do but that is really not all that GPs do.

If I may make a little illustration, if one's health is kept in a glass like this and the health is easily spilled, what episodic healthcare does is provide implements to mop up the spill. When we are talking about access to primary healthcare, we are talking about access to the implementation and the improvement of various methods to wipe out the spill. If the spill falls down enough and breaks, then tertiary healthcare comes in. Tertiary healthcare is the specialist healthcare, and it requires all the skills and the equipment in the hospital and specialists to repair.

But nobody thinks about what a GP, a real family doctor, does. This is what a real family doctor does: stops it spilling in the first place. I estimate that a real family

doctor can prevent about 40,000 potential episodes at the accident and emergency centre, simply by preventing illnesses before they become evident. If a person is well controlled with the asthma, with the heart failure, with the diabetes, they will not get so sick that they end up in the hospital looking for secondary and episodic care.

So the value of one real, committed family doctor is underestimated. And my proposal is to bring real family doctors to the suburbs, where patients can access them.

MS BURCH: Thank you, Dr Lee. You made mention of secondary care and family physicians. I want to raise two separate things. Regular contact with your doctor is one thing. There is a lot of money in this year's budget for e-health. Other people who appeared before us are looking to e-health to simplify management of patient records, discharge planning and all of that. Do you think that has a role in the understanding of the condition of the patient across different doctors?

Dr Lee: That would as well but, if the patient sees many different doctors, that role will tend to be fragmented. One person does not really know what the others have known. You can say that yes, everything is all in the record; every doctor can pick it up and look at it; but if you are talking about a 70-year-old person with an extended medical history, you are talking about looking at a novel. You cannot expect to pick up a novel and immediately know exactly what has been going on. It is only through time and regular exposure and contact with the patient that the doctor has a picture of the person's health.

It is much like an architect who designs a house. He has got the blueprint; he knows exactly what is going on. It is not easy to just ask another person to suddenly step in and say whether we want air conditioning, if he does not know how the house has been designed.

MS BURCH: In relation to the comment on secondary care or episodic care, where do you see corporate medicine? Is that in primary care or more in secondary, episodic, care?

Dr Lee: Corporate medicine by definition can only provide secondary and episodic care. And they are very good at doing that. So I am not saying that they do not have a place. They have a good place in providing episodic and secondary care for the coughs and colds, minor cuts, injuries and so on. However, if a family doctor is doing his or her job well, as I said, there will be a lot less episodic care and secondary care needed.

The problem that I see with our circumstance is that there are too many so-called walking wounded, category 4 and 5 patients, who are turning up at the accident and emergency centres at the hospital and potentially clogging up a system which is designed to treat tertiary medical care. While we concentrate on, say, efforts to find GPs, even if we find another GP to put in a corporate medical centre, they will be looking at treating the episodic and secondary healthcare, very much like more people, more ways to mop up the spill; whereas the value of one real doctor that is there and knows the patient will prevent so many people from turning up for episodic and tertiary healthcare.

MS BRESNAN: In relation to that point about people going to emergency departments when they do not need to, one of the really interesting comments you made in your submission was about surgery waiting lists and that waiting lists have often been promoted as the reason why our system is not working. As you said, that is often not an accurate measure of that. What do you see as a more accurate measure of how we can look at whether or not a system is being efficient or working?

Dr Lee: The peculiar thing is that it is very hard to measure something that is good, that has not already fallen down, which is one reason why we cannot totally measure that. But I think if one is able to, for example, utilise this measure, if we can, say, bring in five new doctors using the proposal that I am going to outline later, and you similarly look at the number of presentations at the hospital for the category 4 and 5 patients, you will be able to see the difference in numbers. You may not be able to see much with one doctor but, if we are able to find five or 10 new, real, bona fide family doctors starting, within a year you should see an actual drop in numbers of patients presenting to the A and E, and that will be a good measure.

MS BRESNAN: You are talking very much about preventative type medicine, dealing with people's chronic illness and situations so that they do not end up in that situation. Do you think that sort of indicator is useful too? How are we putting more into prevention and dealing with chronic illness and chronic conditions and stopping people ending up in hospital? Do you think that is a useful outlook as well?

Dr Lee: We do not really need to put more into it because a real family doctor is trained to do that. If he is on the ground, if she is on the ground, that is exactly what she does. So there is no need to allocate more funding in terms of performing that function. The function is already being performed. But there is a problem of shortages of dedicated family doctors.

As I explained in the submission, there are a lot of reasons why there are shortages. They include new medical graduates not taking up the work of family doctor as a career. There is a barrier in terms of setting up a business, a barrier in terms of running a business, a barrier of low morale, and there are a lot of negative factors that prevent a medical graduate taking on that career path. As a result, as older family doctors are retiring, there is no-one to fill the gap. And there have been quite a few retiring over the years. There are at least 10 or 15. That is why we are seeing the shortages, because the patients that they used to look after simply have nowhere to go now. And they end up at the hospital.

THE CHAIR: I think you mentioned at the outset that you have been practising here for 24 years?

Dr Lee: Yes.

THE CHAIR: What made you pick Canberra? Did you start as a GP here in Canberra?

Dr Lee: Yes, I did.

THE CHAIR: And what made you pick Canberra as the location you wanted to come

to?

Dr Lee: A couple of reasons. One, I did not like Sydney. It is too crowded. I have always liked country practice. The other more significant reason was: my wife's family is in Canberra. My mother-in-law saw a spot at Wanniassa and said, "Hey, this is a good place for you to set up." And there I was.

THE CHAIR: What I am getting at is: to alleviate the shortage, we need to understand what brings people here, what are the benefits that we can offer, and how can we attract people, even from Sydney, who may be looking for a different lifestyle.

Dr Lee: Indeed, that is it. I think we should put together a kind of package that informs people of what Canberra is. A lot of people outside Canberra do not even want to come here. There is some kind of ignorance, a stigma, attached to Canberra. Only if they come here and see how good a place this is, then they might decide to stay. Perhaps even a free weekend holiday for a doctor and their family to come for a weekend so that they can experience Canberra, just be bathed in the ambience of Canberra, then they will find that this is not such a bad place after all.

THE CHAIR: To perhaps visit with a local GP?

Dr Lee: Yes, that would indeed be a very good idea as well. And then, with my proposal, that would eliminate the risk of the setting up. To set up a surgery is a very major undertaking. Obviously, like I mentioned before, the corporate medical centres are offering huge incentives for doctors to sign up with them. They are paid something between $150,000 and $500,000. They offered me $350,000 to leave my practice to join them. The type of medicine that they practise is not what I trained for. But I must say that refusing $350,000 dangled in front of you is not easy.

If we can compete with the corporate centre to a certain extent by offering some incentive in the form of the interest-free loan that I suggested, which will alleviate the risk faced by a new family doctor in terms of relocating their family to Canberra, that would perhaps change the mind of many potential doctors. $100,000 is still $100,000. Once they come to Canberra, if they come for this weekend visit and they enjoy the place—they look at the place, they like it, they like the traffic conditions, they like our proximity to the snow and they like our nice restaurants—they might just think, "It is not so bad. And if somebody else really helps me set up the surgery, I might just stay here."

THE CHAIR: Ms Burch?

MS BURCH: On the budget line first—and then I would not mind talking on nurse practitioners—how does that play out in a market environment, where some GPs will invest moneys in a practice? How do you think the internal professional debate would work with somebody having an interest-free loan and setting up within close proximity?

Dr Lee: At least at the moment, all the established practices are so flat out—and I am talking about bringing opposition to my own business here—we cannot cope with the number of patients. So it is for the general good of the people living in Canberra that

there are more family doctors. I do not think anybody would mind if a different doctor came in. Part of the proposal—I think it is in front of you—is that the doctor identify an area that does not have a doctor within a five-kilometre area. It is not really treading on anybody's toes.

It is like the difference in an area like Sydney. In Cabramatta, there are 50 doctors within a one-kilometre area. Here, if you have a doctor and there are no other doctors within a five-kilometre area, nobody is going to complain. And the only people who benefit would be the people living around that surgery. They could walk to the surgery. So I think everybody would be quite happy.

In the bad old days, because the doctors had to fork out their own money to decorate the surgery, they tended to cut corners and you tended to have draughty surgeries with dirty carpets and poor furniture and bad equipment. That is not good for the public. Since the money now comes from somebody else, they can afford to put in nice furniture, a nice set-up, and a nice, comfortable surgery. That, again, is conducive to the working environment. They work in a better environment. Patients have a better surgery to visit. The loan, as I suggested, is paid not to the doctor but directly to the tradesmen, to the service and goods providers; so it is a direct injection into the economy. So it is a win-win situation for all.

MS BURCH: Before I get onto the practice, I want to talk about the GP enhancement fund. There is a budget line that allows some incentives and some enhancement for GP practices. Is that along a similar line, to encourage and support—

Dr Lee: Along a similar line, but not nearly enough. For example, there is a slightly increased Medicare rebate for doctors in areas of need et cetera, but that is really amounting to very little. And the up-front cost is a daunting task. Just facing the fact of having to borrow $100,000 or $200,000 to set up a surgery in the unknown, in an area that you have not lived in before, you do not know how it is going to work out, is enough to put off new doctors considering Canberra.

MS BURCH: On models of care, we had Winnunga here just before you. They provide a GP but within a whole scope of others in the workforce. What are your thoughts on nurse practitioners or practice nurses working within the GP environment, with allied health? You would be supportive of that?

Dr Lee: I think that would be very good. In fact, I think that would be better than setting up a nurse clinic. Setting up a nurse clinic is akin to reinventing the wheel. Any clinic like that that is set up can only provide secondary and episodic care. GPs would work very well with nurses within the general practice setting and, if the nurses actually attach to a family doctor, it would have the same effect.

Some of my receptionists have been with me for 25 years. They know the patients by name. Sometimes when a patient dies, they will go to the funeral as well, when they know them that well. Practice nurses would as well.

However, when a GP employs a nurse, the pay comes out of the GP's pocket. It will make the practice more efficient but, for the services provided by the nurses, there is a small charge that they can pay but it normally hardly covers the cost of employing

the nurse. And that is why a lot of GPs do not employ nurses. A simple way, rather than setting up a nurse clinic, would be to perhaps pay for the nurse's wages so that the nurse can work with doctors. I think doctors would welcome that with open arms.

MS BRESNAN: The question I was going to ask—and I have asked it of other people here today—is in relation to what Ms Burch has just mentioned about those nurse practitioner clinics and other models of care. The reality is that there are people who, through disadvantage, through cost or through access issues, whether it is transport, often might choose to go to something like the nurse practitioner or a community health clinic because of those cost issues. That does not address the issue. You are saying that it still might just be providing secondary care and patching up the situation. I know it is a big issue. How do you deal with that situation where there is that disadvantage and cost issue? That might be why someone is not going to a family doctor or a family medical practice, because of cost and access. How do you address that situation then?

Dr Lee: One of the proposals in No 8.1 is that, if we cannot take the doctor to the people, we can take the patients to the doctor. That is an extension of the taxi scheme. Very often, we are now seeing patients who cannot get to the doctor, simply because the doctor is too far away. Or their doctor has retired. There is a doctor further down the road but it is now too far for them to get to.

The taxi scheme currently operating is terribly expensive. It only pays for half and only gives them about 12 usages per three months or something, which does not cover the cost. If the government can provide a taxi scheme that would provide the transport between home and the doctor's surgery, that would at least ease some of the problem of transport and disadvantage faced by the patients.

I have pensioners who are 80 years old, who have to catch three buses to get to me, even though they live only two suburbs away. But that is the way it is. They have to take a bus to Tuggeranong town centre before they can get a bus to Erindale. But if they can catch a taxi, it will make it a lot easier for them to come.

As to the exact financial cost, that is a matter for each doctor, through their own compassion, to decide. Even though my policy is not to bulk-bill, simply because I cannot afford to, I do bulk-bill patients if I know that they are disadvantaged and it is difficult for them to go and claim rebates and so on. I believe most doctors will do that if they see the patients are disadvantaged.

A lot of patients who claim to be disadvantaged are not. If they come in with a packet of cigarettes or come to see a doctor because of a skiing injury, they are not really that disadvantaged, and then I refuse to bulk-bill them. Two packets of cigarettes would pay for a doctor's consultation.

I think in this whole talk about providing care, patients need to take some responsibility as well. And I see in my own practice patients who are genuinely disadvantaged. One single-income family trying to keep four children, even though they are working and have a job, I can see that it is difficult for them. I bulk-bill them. I do not know how but there are a lot of patients who have a healthcare card. They come in dressed in designer clothing. I know the pair of trousers that they have are

more expensive than any I have ever had. So I do not bulk-bill them if I can see that they are not genuinely disadvantaged. A bit of common sense is in play here.

THE CHAIR: Dr Lee, we started late. We started at about 20 to 11. We have got about three minutes of regular time left. If you do not mind, we have to stick to that. Would you like to make any closing remarks in the time that is left?

Dr Lee: I made a brief calculation that if we adopt the proposals that I propose, $100,000 to attract a family doctor to set up in Canberra, $1 million will potentially attract 10 family doctors to settle in Canberra, and they can potentially divert 40,000 patient encounters from the A and E of the Canberra Hospital system per year.

THE CHAIR: That is a pretty good argument. We would have to look at the economics of it, the mathematics of it. Thank you very much. We have heard your submission a couple of times now. We will be including your complete submission in our consideration.

Dr Lee: Thank you. There are a few typos in the one that I sent you and there were a few minor corrections that have been made. This is the final version. I will leave the final version and email you the final version that corrected the typos.

THE CHAIR: We would appreciate that. Thank you very much for taking the time to come and talk to us again. There will be a full transcript given to you of what we talked about this morning. If there is anything else that comes to mind, if some innovation comes to your attention, please do not hesitate to get back to us. We may be addressing further questions in writing to you. But thank you so much for coming in.

Dr Lee: Thank you very much for inviting me.

MS BRESNAN: Thank you.

MS BURCH: Thank you.

Meeting adjourned from 11.08 to 11.32 am.

COSSENS, MR PHILLIP, Branch President—ACT, Australian Physiotherapy Association
KRUGER, MR JONATHON, Manager—Policy and Professional Standards Division, Australian Physiotherapy Association

THE CHAIR: 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. There is a privilege statement in front of you. I am not sure if you have had a chance to have a look at it. If you have not appeared before any committees, you may want to have a look at it. Are you comfortable with that?

Mr Cossets: I went over it previously, yes.

THE CHAIR: Thank you for joining us here this morning and for your submission. Could I invite you to make an opening statement about your submission?

Mr Cossens: Yes, I will read our prepared statement.

The Australian Physiotherapy Association is the peak body that represents the interests of Australian physiotherapists and their patients. I will describe that as the APA. The APA is a national organisation. We have state and territory branches and we have speciality groups in a number of areas. They relate to sports physiotherapy, paediatrics, occupational health, neurology, musculoskeletal, leadership and management, gerontology, education, continence and women's health, cardiorespiratory, business, aquatic and animal physiotherapy.

Our organisation has over 11,000 members. It represents approximately 65 per cent of registered physios in Australia, and 300 of those take up member volunteer positions with the organisation on committees and working parties, and there are approximately 70 staff. The APA has non-autonomous branches in each state and territory which provide assistance, local networks and contacts for their members. The APA is governed by a board of directors which is elected by representatives of each of those stakeholder groups. We also have a branch council elected from local membership in each state and territory.

Our vision is that all Australians will have access to quality physiotherapy when and where required to optimise health and wellbeing. In Australia, physiotherapists are one of the largest groups of primary healthcare professionals. However, they also operate in both secondary—therefore, hospital and tertiary—or specialist settings, as well as other domains such as the disability sector and the education sector. Apart from the treatment of musculoskeletal conditions, physiotherapists also are well-established in the role of treating and maintaining chronic conditions. The examples would be cardiovascular disease, chronic obstructive pulmonary disease, diabetes, osteoporosis, arthritis, obesity and hypertension.

The educative processes that physiotherapists adopt in these areas include self-management techniques, lifestyle and physical activity and counselling, as well as the primary healthcare philosophy of consumer and community involvement. Physiotherapists undertake a university bachelor degree, a masters or professional

doctorate program. Their training and experiences make them valuable members of multidisciplinary teams in primary healthcare settings. They are trained in anatomy, pathology, physiology and rehabilitation techniques. They are superior problem-solvers, skilled in clinical reasoning. They are educators and practice communicators. They are competent researchers, able to plan, implement and evaluate interventions and, as circumstances dictate, they can be independent autonomous practitioners or team players.

As we have outlined in our submission, we believe that the health workforce innovation is a key to optimising the health and wellbeing of Australians in a climate of growing GP shortages in the ACT and around the country. Innovation will require changes to the service delivery modalities and methods across the entire health workforce. This is at both the state and federal levels. We believe that physios have a pivotal role to play in supporting any changes to the current health system arrangements.

Service delivery modalities that involve multidisciplinary teamwork should be encouraged. Consumers and health processionals both stand to benefit from multidisciplinary team approaches. Service delivery to consumers is improved because the expertise of various professionals is more effectively utilised in collaborative working arrangements. Where professionals can share the responsibility of the problem solving and the planning of patient care, this can help to assist professionals in their workload balance as well.

In addition, we believe there is a clear role for the ACT government to lobby the federal government to review and amend the current legislative regulatory and funding barriers that undermine the potential utilisation of physiotherapists and other allied health practitioners. That is particularly relevant in the provision of primary health services in the ACT. While I am not discounting the important role that GPs may play in maintaining the health and wellbeing of the community, the APA considers that other health professionals can also make valuable contributions.

As we have pointed out in our submission, the current shortage of GPs in the ACT is exacerbated by the fact that—and I have a few points here—GPs are forced to generate referrals that could, in some instances, be carried out by other health professionals. As an example of that, physiotherapists have the requisite knowledge, experience and skills to be able to identify patients requiring a referral to an orthopaedic specialist.

Patients are also often forced to consult GPs for conditions that could be managed possibly better by other health professionals, and that is due to the current funding mechanisms. An example of that is the large body of evidence to support the efficacy of physiotherapy for the role of female urinary incontinence and the funding is not there for that sort of treatment through physiotherapy. The complexity of the Medicare benefits schedule consumes an excessive amount of GPs' time and sometimes discourages them from using those items. We believe that that could be a way that physiotherapists could assist.

We contend that these strains on GPs can be alleviated through a number of health workforce innovations and by diverting some of this workload to other team members,

other health professionals. Some innovations may include the establishment of a process that identifies and seeks to remove barriers to innovative practice within the health system, the removal of barriers for physiotherapists being able to directly refer to medical specialists, the removal of barriers for physiotherapists requesting diagnostic imaging services, such as X-rays to the peripheries or diagnostic ultrasound procedures. That has occurred previously for podiatrists, for example.

We would also like to see more extensive use of healthcare assistance, such as allied health assistance, to support the health workforce. The diversity of physio practice should be recognised by governments so that the skills and knowledge of physiotherapists can be fully utilised and so that they can work to the full extent of their professional competence, providing better support to the health system and its users.

The Australian Physiotherapy Association appreciates the consultative process being undertaken by this standing committee in relation to this important issue. We wish to thank you for the opportunity to be present.

THE CHAIR: Thank you, Mr Cossens, and thank you for your submission. It is obviously very useful from our committee's point of view. I have two questions relating to your health workforce innovation aspects. One is about asking the ACT government to lobby the federal government on legislation that you think could assist. Has your federal body, or have you yourselves, made any submissions to the federal government that could be submitted to us as well that would not be in confidence?

Mr Kruger: The committee would be well aware that we are in a period of intense health reform. The National Health and Hospitals Reform Commission released their final report on Monday. I am slowly sifting my way through all 230 recommendations there. We have provided a number of submissions, particularly over the last year, to the federal government. There were two submissions on the National Health and Hospitals Reform Commission. We have provided submissions to the preventative health task force as well as to the primary healthcare task force. I am happy to forward all of those submissions to you. They tend to cover similar areas, though obviously taking different tacks.

THE CHAIR: Thank you. At page 5, I think, of your submission you make reference to health professionals not utilising their full potential and you provide an example of X-ray services. Can you elaborate more on this point and describe what other kinds of barriers are hindering access to services for your members as well as for the patients?

Mr Cossens: Currently, the Medicare benefits schedule provides numbers for certain X-rays. Physiotherapists can refer for an X-ray of the spine or the pelvis and the patient can then receive their Medicare rebate through that. But we cannot refer for an X-ray of any peripheral areas, so arms and legs, in that regard without the patient then paying the full price of that consultation. It is a regular occurrence that we are requiring an X-ray—for my example, I work with hands a lot—of fractures through the fingers. So for that patient to get the appropriate rebate we then refer to the GP and say, "They have this condition in their finger. I would like you to get an X-ray of it. Can you please then refer them for an X-ray?"

THE CHAIR: Thank you. Ms Burch?

MS BURCH: I thank you for your early reference back to the declaration of 1978 where primary care started.

Mr Cossens: Yes, that is what it is all about.

MS BURCH: Yes, thank you. I would not mind hearing your comments on a multidisciplinary team scope of practice, whether it is allied health assistance or a broader multidisciplinary team responding to the care needs of the patient. Are those legislative restrictions impinging on that, or can we move forward on enhancing that separately from some of these other legal practice boundaries?

Mr Kruger: There is a distinct difference between what can occur in the community and what can occur in public facilities. There is a greater scope within public facilities, potentially, to look at scope of practice. You can look at barriers to scope of practice as legislative, financial or cultural. Cultural is what we always hit, particularly with doctors, because—

MS BURCH: A medical or allied approach.

Mr Kruger: Yes, because that is always about people protecting their turf. If the right people are in the right position, say in a public hospital, then you can actually get some really innovative models of care happening. In the primary care setting it is much harder because the legislation restricts it. The financial barriers to, say, a physiotherapist being able to refer for the CT scans, ultrasounds and peripheral joint X-rays are financial. It is not really regulatory because we can do it, but there is a financial impost on the patient if we do that.

When somebody comes to you, you can say, "Well, I could refer you for an X-ray and you could probably get it done this afternoon." If they want to get it done slightly cheaper—though, arguably, whether it is going to be cheaper if you have to pay out-of-pocket fees to go and see a GP depends on who your GP is—that is the choice for the patient.

In relation to the scopes of practice, some of these things do not require physiotherapists to have any extra training. These are things that we are doing now or that we could do now. It is just that we are not doing them because of these other barriers. The legislation would need to change for, say, Medicare.

MS BURCH: For Medicare?

Mr Kruger: Yes.

MS BURCH: It is around that financial burden rather than practice limitations.

Mr Kruger: Yes, but in terms of public hospitals it is a completely separate story. Particularly over the last five to 10 years, physiotherapists have become quite central to the emergency departments and how they run. At the Canberra and Calvary hospitals physiotherapists are there and they can request X-rays. They cannot report

on the X-ray, but certainly physios are well skilled in being able to read an X-ray and they can start the management of a patient before the result technically comes back from the radiologist. Provided the culture is right in a workplace, you can actually get those things happening if people just agree that that is how it is going to occur.

MS BURCH: Predominantly, there are more physios in private practice than there are in public practice?

Mr Kruger: Yes, in Canberra more physiotherapists are employed in the private sector.

MS BURCH: What do you think your membership views would be on moving into a multidisciplinary structured service—so you would have an OT, a physio, a GP? Would that be a welcome addition to your members?

Mr Cossens: Yes, it would. People working in the private sector are getting their living from people paying for that service, but at the same time they realise that they cannot service a lot of the population that are not able to afford that service. We are always happy to say, "Even though I may not be able to help you, you may be able to get that assistance through the public system."

Mr Kruger: Yes.

Mr Cossens: The upcoming walk-in centres that we are looking at in March next year would perhaps be a positive start.

MS BURCH: Good.

Mr Kruger: From my perspective, we tend to think that these are private physiotherapists running private businesses, funded by private health insurance, and that is how it works, and then these are public sector physiotherapists, paid for by the public purse, and that is how they work. I am not sure that that connection between private health insurance and the private setting and the public purse and the public setting necessarily has to exist. We could have models, and we kind of do at the moment, where private practitioners will see patients and that is paid for by the Department of Veterans' Affairs and partly by Medicare for chronic disease management. In the ACT, Comcare might pay for some of these things—as well as people with private health insurance.

Again, in the context of why the health reform, we could have a situation where the federal government takes over all of primary healthcare. It might block-fund the ACT to look after the arthritis needs of the ACT population and say, "We are going to give $50 million to do that." That money could be spent in a variety of ways. I would suspect that fee-for-service is not the best way of doing that. You might contract out to private practitioners to run exercise classes in the community which keep people healthy and out of hospital. You might have a couple of one-on-one individual treatments. An individual patient is entitled to $2,000 worth of care and you will get three individual physio treatments, plus an exercise class once a week for the rest of the year—that sort of thing.

I think we have to be open to those models and not have restrictions on the way that the legislation requires us to work or the funding requires us to work. I think that there is a capacity for consumer-centric or client-centric services where we actually decide that how an individual walks through our system is really important and we need to have a system that caters for them in that regard.

MS BRESNAN: Thank you. We have heard evidence today about there being some concern about the walk-in clinic and expanding beyond the medical model because there would be a sort of fragmentation of care for people. Do you see that as being an issue? Do you see that as involving physios and practitioners instead of using a new model? Do you think it would cause any fragmentation, or do think that it is just a different way, like you said, of a person moving through the system?

Mr Cossens: I think we have that system already because physiotherapists in a private setting are already separated from GPs. I would like to think that I keep a close relationship with a lot of GPs. I guess it would be easier if we had an electronic records management system to be able to maintain that communication quicker and easier, but I think that is a pretty easy transfer—transferring it from the private system into the public system.

Mr Kruger: A significant proportion of health professionals' education occurs in the public sector in bigger hospitals where we all work together—physiotherapists, nurses, doctors et cetera. Certainly from a physiotherapy perspective, that model is easily transferrable into the community. We need to have a respectful relationship with all the health professionals involved, but for me it is about putting the person first: who is the best person for this person to see? Arguably, it is not the GP for some things. It could be a practice nurse, a physiotherapist, a podiatrist, a dietician. Co-locating those people helps for some people but, again, as Phil was saying, if we had a true electronic health record that was easily used and transferrable it would not matter as much if they were co-located. Certainly it is a model which will work in some communities, but we will never be able to have this—or maybe we will—multidisciplinary primary care centre and that is it. There will be people that run businesses in other places.

MS BRESNAN: Yes, that is right. That model is going to suit one person, but it is not going to suit another. It is about allowing people to choose the sort of care they want to receive.

Mr Kruger: Exactly.

THE CHAIR: I have another question regarding the workforce situation. You talked about the public as against the private workforce that you have. Is there an identified shortage in the profession currently?

Mr Kruger: Certainly, nationally there is. There is a big issue for us. We are a quite female profession. Women often leave the workforce for a period of time and we do not have a work re-entry program nationally. There is hope that with the new national registration and accreditation scheme it might make it a bit easier for some of those programs to come online.

In physiotherapy over the last 15 years, we have gone from six programs nationally to 18 programs. There is a physiotherapy program in the ACT which has opened up. We are having more graduates than we have ever had. Unfortunately, we are also having more graduates going to other careers. Physiotherapy is often a stepping stone to people getting into medicine, so we lose a substantial proportion of our new graduates to medicine. Here in the ACT, it is kind of an odd problem.

Mr Cossens: The University of Canberra course runs from midyear. We received a new batch of graduates midyear. They had trouble getting into the hospital system because their transfer is normally over December-January. A number of those wanted to work in the public sector in Canberra, because they are from Canberra, but they have not been able to do so and have headed elsewhere. But that is probably a local problem for that physiotherapy department. They could try and manage it, hopefully within the next 12 months.

THE CHAIR: From an ACT perspective, are your professionals keeping up with the demand or are they struggling to keep up with the demand for their services?

Mr Cossens: Our private physiotherapists are struggling to keep up with demand, yes.

Mr Kruger: Recruitment is a problem. Historically, physios tend to graduate and they like to work in a big public hospital for a year or two to get their skills up, and then if they decide to move out into the community that is what they do. If we do not have those feeder systems occurring where we have new graduate positions available in the public system then they will go elsewhere. New South Wales has an allocation scheme where all of their new graduates are put into hospitals around the state. ACT graduates do not go into that system. There are obviously more hospitals in New South Wales so they go there. Once somebody leaves the ACT it is hard to get them back.

THE CHAIR: This is where I am coming from: if you are looking at innovative services which are going to put an even bigger burden on your profession it is a self-defeating exercise in one sense. It is worth keeping in mind the need to recruit. We are looking at doctors, obviously.

Mr Kruger: Yes. What might keep people in the profession is being able to work to the full scope of their capacity.

THE CHAIR: True.

Mr Kruger: If we have people that can work in innovative, cutting edge, care where they are really stretched in terms of what they have been trained to do then the chances of them staying in the system for longer is greater.

THE CHAIR: Ms Burch?

MS BURCH: As a profession, your thoughts on allied health assistance? We are actually leading the nation in many ways in terms of having formal training and designated positions in the public health sector at the Canberra Hospital. That is a good thing?

Mr Kruger: The Australian Physiotherapy Association has physiotherapy assistants as our members. We see the physiotherapy workforce as being physiotherapists as well as physiotherapy assistants. We actively promote that as part of our membership. There are issues in getting the competency standards up. We think that a cert 4 in allied health assistance is probably where it needs to be pitched at. That is not always being reached in some facilities, but it is an evolving thing. If you are talking about innovative models where we are trying to expand the scope out, somebody needs to do some of the things which we used to do. We are more than happy for differently qualified people to take on board some of those roles.

MS BRESNAN: You mentioned e-health earlier. Has the APA been involved, either in the ACT or nationally, in some of the negotiations that have been going on with e-health?

Mr Kruger: We have had a number of meetings over the last few years with NEHTA, the National E-Health Transition Authority, in relation to this. I think it is fair to say that the federal government historically have focused on general practice when they think about e-health. It has only dawned on them over the last year or so that there are more people out there in terms of primary care for e-health. A number of projects are going on now to look at the ICT infrastructure requirements of the other health professionals.

It is all very well for GPs to be able to talk to each other and maybe even talk to specialists, but if you look at the latest BEACH survey of general practice, physiotherapists are the most referred health professionals that GPs refer to. They will refer to a whole bunch of specialists, but we are larger by ourselves than any single medical specialist—surgeons, physicians et cetera. Ten per cent is quite a large number. If GPs are not going to be able to talk to 10 per cent of the people that they regularly refer to, that is a problem.

MS BRESNAN: Thank you.

THE CHAIR: Do you receive any feedback from your members about whether they suffer any red tape and administrative problems? We are getting some anecdotal evidence from GPs that having to cope with both federal and ACT red tape is causing them a few problems. Is this an issue from your point of view?

Mr Kruger: Certainly, the enhanced primary care program, which the federal government runs through Medicare, is a problem. There were some changes made at the beginning of this year, but it is a rather cumbersome form that a GP has to fill out for what are essentially just five treatments, which can happen very quickly. We have been working with Medicare Australia, the Department of Health and Ageing and the minister's office about how we can streamline that.

The association is not looking for unfettered public access to physiotherapy paid for through Medicare. We agree that there needs to be some form of gate keeping, be it through a GP or through some other model, to access services. What is required now in terms of care planning for enhanced primary care is a substantial burden on GPs from a red tape perspective.

MS BURCH: Would that apply to chronic disease? Do you benefit from chronic disease management items through GPs as well?

Mr Kruger: Yes, that is the chronic disease—

MS BURCH: That is it?

Mr Kruger: Yes. If you have a chronic disease you can get five allied health occasions of service in one year.

THE CHAIR: Thank you. Did you have another question?

MS BURCH: No, I am fine, thank you.

THE CHAIR: I think we have covered most of the questions we wanted to ask you. We may need to write back to you to get some specific questions answered, if you do not mind. Is there anything that we have not covered that you want to talk about before we conclude?

Mr Kruger: From my perspective, I think we have covered things. I thank the committee for the opportunity to come and talk to you today. I am more than happy to forward on those other submissions through to you.

THE CHAIR: Thank you, and thank you for your submission. We will provide a transcript of what took place this morning. If there is anything that comes out of either the discussions that we have had here or other thoughts that occur to you, please do not hesitate to provide us with further information.

Mr Kruger: Sure.

STARK, MR MURRAY JOHN, President, Chiropractors Association of Australia (ACT)
BADHAM, MR MICHAEL ANDREW, Policy Officer-Honorary Secretary, Chiropractors Association of Australia (ACT)

THE CHAIR: 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. There is a privilege card there. I am not sure if you have had a chance to have a look at it. If you have, that is good, but if you need to have a look at it feel free to do so. Are you comfortable with that?

Mr Stark: Yes, we have read it.

THE CHAIR: Thank you. I invite you to make an opening statement about your submission.

Mr Badham: Yes. We belatedly got a submission to you late yesterday and I will address that very shortly in an opening statement, as you suggest. The CAAACT believes that chiropractors can contribute to the improvement of primary healthcare in the ACT community in three ways: by the greater use of health practitioners other than GPs, including chiropractors, to manage conditions which they are competent to handle and, therefore, relieving the pressure experienced by the GP shortage; by permitting ACT low income earners to receive chiropractic treatment under the public health system; and by considering chiropractors as a primary option for referral for certain conditions presenting at walk-in centres.

With regard to the GP shortage, the CAAACT considers that chiropractors are suitably equipped to diagnose and manage a range of spine-related neuro-musculoskeletal conditions. Given the number of people presenting in GPs offices with back pain and headaches and that chiropractors are experienced in treating such conditions, it is reasonable to conclude that chiropractors could be better utilised and so ease the load on GPs.

With chiropractic care in publicly funded facilities, disadvantaged people often do not have equality of access to healthcare. Extending the range of services offered by ACT Health would help address this inequity, provide timely access and achieve better health outcomes and thereby reduce the burden on private and government health services.

With regard to the walk-in centres, the ACT Health discussion paper on the feasibility of the establishment of the walk-in centres anticipates that headaches and musculoskeletal problems are conditions that people using a Canberra WiC are likely to present with. Back pain, headaches and head-neck pain comprise 95 per cent of conditions that chiropractors treat.

In summary, the CAAACT recommends that the inquiry consider what role an expanded role of chiropractors could play in the ACT health system.

THE CHAIR: Thank you. The first question to lead off with is: do most of your

patients who need to have access to your professionals come referred from GPs or do they come directly to you?

Mr Stark: I think we get a mixed bag. The vast majority would be private walk-in patients who elect to attend a chiropractor practice of their own free will. Chiropractors treat a range of conditions that Michael has just outlined—basically back pain, neck pain and headaches. I could not give you an exact percentage, but under the enhanced primary care program that currently exists under commonwealth legislation, we would get a very small amount.

As the physiotherapists alluded to before, it is generally considered to be cumbersome from the GPs' point of view. A lot of paperwork is involved. Patients still have to attend Medicare offices to receive a rebate for the service. There would be another proportion that would attend a chiropractor as a direct referral from a GP as a private patient. Basically, the GP is saying, "The patient presents a range of symptoms." The GP would make the recommendation that they believe that a chiropractor or a person like a chiropractor who can deal with a neuro-musculoskeletal or spondylotic condition would be the best person to see.

On many occasions that patient would be accompanied to a practice with a referral letter from a GP with a brief statement as to their belief on their suitability to receive chiropractic treatment. They are normally left in the hands of the treating chiropractor to carry on from there. The vast majority at this point in time—and I would say 90 per cent plus, without quoting an exact figure—would certainly be private patients walking in on a fee-for-service basis.

THE CHAIR: Thank you. Ms Burch?

MS BURCH: Predominately private? Is there a role or positions within the public sector for chiropractors at the moment?

Mr Badham: We believe there is a role, but none are employed anywhere in Australia that we know of. There are some overseas examples though.

MS BURCH: In each jurisdiction you have registration. There are qualifications and there is an accreditation process, but at the moment that is not utilised within the public sector. You made mention of being under the scope of EPC—so doctors, GPs, are referring to you so you are accessing Medicare through EPC?

Mr Badham: I did an extrapolation of the figures for the second year that the EPC program was planned. I estimated that around only 130 Canberra people would have received chiropractic care under the EPC. That compares to hundreds, probably thousands, who have had chiropractic care from the public purse on referral from a doctor under the veterans' affairs scheme. Even though there are similarities there, you need a doctor's referral to access that rebate. There are very few on the EPC and there are several reasons for that.

MS BURCH: Good, because I was going to ask you the reasons for that.

Mr Badham: Do you want the reasons?

MS BURCH: Yes, please.

Mr Badham: For a start, the gate keeper component of EPC with a GP is limited, so you have got to find a GP who is happy to refer to a chiropractor. There are several GPs who are very happy to but they are not necessarily the ones who are involved with the EPC program. The chronic diseases scheme that the government instituted a few years ago involves a lot of administrative work. I do not know what the take-up rate is, but I think it is very small.

For a start, there are very few GPs who take it up. Secondly, they have to be willing to refer to a particular practitioner. And then there are only five visits available to whoever they refer them to. The GP may say, "Look, why don't you have a bit of physio, a bit of chiro and maybe a bit of podiatry?" But there are still only five visits. You might only go to one chiropractor once, one podiatrist once and one physio once. A psych is in a different category. There are only five visits available.

A person who has got a chronic and complex condition, which is the definition of a person who qualifies under the EPC program, needs far more care from a chiropractor alone than just five visits. If it is appropriate that they go to a chiropractor, they will need more than five chiropractic visits. They would probably need physio as well. They will probably need podiatry. They may need several other forms of therapy. The doctor then has to decide: how do we ration this allotment and apportion it to the appropriate people?

And then there is the chiropractor take-up rate. The chiropractor has to be willing to do their part of it. I am not sure what the stats are on that; I do not think they have been done. In principle, it is a great program but, in practice, it is very limited as to how it can be effective for a certain range of conditions.

Mr Stark: An interesting point to make just from personal experience is that we would get a large number of GP referrals to our clinic and a very small number of those are EPC referrals. The GPs seem to be far more inclined to say, "I believe you need to see a chiropractor to manage this condition." They will just provide us with an appropriate referral and advice on the person to see, and EPC is not even discussed.

MS BURCH: So it is not a matter of needing to educate the general practice workforce on what you do on that referral to you?

Mr Badham: That is a component of it, but within the EPC I think it is a small component because there are those other restrictions, limitations, on—

THE CHAIR: Legislative restrictions?

Mr Badham: Yes, or policy—how far down the track it is, but yes.

MS BURCH: That is the EPC.

Mr Stark: I cannot talk for the other professions, but I would assume that even a physiotherapist would have as many loggerhead jams with the EPC program in their

own private practices as chiropractors do. GPs are busy; they are time poor. Just that extra two or three minutes in filling out paperwork is probably a deterrent in itself.

THE CHAIR: Ms Bresnan?

MS BRESNAN: One of the things you have put to us is a proposal for a pilot project, which has been put to ACT government. That is a 12-week program where people can access a chiropractor. I was just wondering if you could give us a bit more background on that. Have you have had any feedback from ACT Health on that?

Mr Badham: We have. The quick feedback was that we had a meeting with the Chief Executive of ACT Health in October 2007. We had a Canadian expert with us who had been involved in the development of chiropractic care under the public health system in Toronto to outline her program to him. He said he was not making any promises but he suggested, "Put together a proposal for a pilot study," which we did. I believe it was comprehensive and well-costed. The budget came out at around $170,000 to $180,000, basically, to test whether or not it would be popular, worth while and effective in the ACT.

Recently we got a response to that which was rejecting the proposal. Basically, his statement was that ACT Health had no service gaps that could be filled by chiropractors, which was a similar explanation that we were given by the minister for health a couple of years before when we put the proposal to her in a different form.

But the interesting thing was what Mr Cormack, or his officers, did in their response. "Outsource" may be the wrong word, but a university in South Australia, a specialist group looking into allied health, did a literature search, effectively. They came up with certain things for ACT Health to look at which Mr Cormack quoted in his response. If I can quickly go through them?

THE CHAIR: Sure.

Mr Badham: One was that the chiropractors would have to demonstrate that they were able to participate in multimodal packages of care that focused on patient self-management. That would not cause any difficulty to a candidate for a chiropractor in public service. We do it informally now, so that would not be a problem. The second was that chiropractors would have to demonstrate how they would deliver a closed-care approach in the management of ACT patients. A critical part of our proposal for the pilot study was a closed-care approach. So that has already been answered.

The next point was about manual therapy safety and effectiveness. They wanted to know about chiropractic versus physiotherapy safety and effectiveness. I think both of those are demonstrated adequately by statistics available for those who use chiropractors and physiotherapists for manual therapy for their back problems. If it is patient choice, it is a clear answer: chiropractors are much preferred over physios for that particular form of treatment for those particulars problems. I am not suggesting overall—physios, of course, are very competent over a wide range of conditions.

The fourth point was that chiropractors would have to demonstrate their competence

in identifying "at risk of adverse events from manipulation" and their capacity to provide alternative treatments for these patients. That is a basic component of our five-year university training. Once again, being a regulated, registered profession, those sorts of things obviously concern other arms of government in the registration processes.

THE CHAIR: Was this a response that stopped at that point, or has there been further correspondence?

Mr Badham: It has not gone any further because, to be frank, we want to know the status of the report. We have got a copy of the literature review, which we would like to do a critique on, but we are not quite sure of the status of it. It was not marked confidential, but I have not been able to ascertain whether or not we can distribute that further to experts that we would like to get their views on. We will do a response, but we would rather draw on all the resources available to us to make it as qualified a response as we can.

THE CHAIR: My understanding from what your response then was that you have an answer for each of the points that were brought up. Is that correct?

Mr Badham: We have not done it formally, no. This is the first time we have answered it in any way but amongst ourselves. We will do that, but I was hoping to back off until we can get a comprehensive answer to the response to our proposal.

THE CHAIR: The third point you mentioned was that you made a recommendation that chiropractors be designated health professionals to whom nurse practitioners can refer in ACT walk-in centres.

Mr Badham: Yes.

THE CHAIR: Have you received any response to that?

Mr Badham: No. I was not really expecting that we would. We put our proposal in response to the discussion paper that was circulated, and this was prior to the health minister's statement recently about them being set up on the two hospital sites. The nurse practitioner program, I believe, has not been formed yet. I like to think that we may become involved at that stage, but I think it is a bit early for us. The submission only went in earlier this year. I was not expecting a response from that or an invitation yet. We live in hope.

THE CHAIR: Ms Burch?

MS BURCH: I am just interested in your thoughts on the walk-in clinic and your discipline being part of a broader multidisciplinary team. At the moment the connections are not traditionally there, as they may be with an OT or physio. How do your membership see themselves fitting into a multidisciplinary team or extended scope of practice?

Mr Stark: I think with the patients walking in our clinics nowadays we are seeing a lot more chronic disease. Of course, it has been very topical, even this week, from a

national, commonwealth, point of view. As chiropractors, we are finding ourselves having to liaise with other health professionals on the day to day, whether or not we receive a referral directly from the GP. I would very commonly require a patient to go and see a podiatrist for some type of foot care or foot stabilisation that may be impacting on their low-back pain. Or a patient may come in and you find there are some major nutritional issues that may be not allowing their health status to improve at a rate that you believe would be reasonable. I think that indirectly in private practice we are already doing that. Some people choose to do that a lot more than others. I think every profession is always going to have those individual practitioners.

The history is that we have never been able to play with the medical profession. It is a monkey on our back. I think that in 2009 it is time to shed that monkey and say, "Let the past be the past and let's walk forward." We have a tremendous health issue in this country and, as chiropractors, we believe that we have a role to play. As any chiropractor could attest, every day in our practices we see patients improving with the treatment that we provide in a rational and a consistent time frame.

For us, the walk-in centres represent an opportunity in the ACT to start that relationship. We would like to see some interest from the other side, if I can use that example. I never like talking in those terms, but we would like to see some interest that we can engage and be part of a multimodal team. We believe that we have unique skills to offer at the same time. That might mean, initially, just having a chiropractor in a consulting role. The chiropractor goes in as part of a nurse practitioner education session and provides some literature to nurse practitioners so they have an understanding as what chiropractors do. I believe that for many people there is still that grey area between what a physio does and what a chiropractor does. I answer that question almost every day in practice.

The level of understanding that is required at the health professional level is not there. That is one area where we need to make a start in becoming part of that multimodal practice. There is a lot of work to be done. I think that the modern chiropractor will always continue to exist in private practice because we will have people who are choosing to walk through our door. But, at the same time, with more schools opening up—we have now got four accredited courses in Australia—we are getting more young chiropractors coming out of university education. With the workforce shortage, it just makes sense to use those skills. In five years they learn a lot.

MS BURCH: Will chiropractors be included in the national registration process?

Mr Stark: Yes, we will be. At a state level there are members who have been nominated to sit on the board.

Mr Badham: Can I just chip in? I believe that for the walk-in centres to gain their fullest possible benefit for the community nurse practitioners have to be given full autonomy to start with. To be granted full autonomy, they must be suitably educated to justify that and, therefore, be a major point of referral to wherever the patients would best receive service—whether it be their GP or accident and emergency. That is on top of, of course, the problems that they will be suitably qualified to deal with there and then, which is clearly a major reason for them being set up.

After going to the public information days on the walk-in centres, I got the clear impression that those that had operated overseas had benefited the community in a much wider scope than what might be anticipated here—that is, taking the pressure off A and E. There is clearly an opportunity for them to have a much broader function for all sorts of people—not just those people who would otherwise go to A and E.

MS BRESNAN: I refer to some of the figures that you have mentioned in your submissions in terms of people consulting other health professionals. Chiropractors are a particularly high group there. Do you know of information or data that are similar to that in the ACT? I think one of the figures you have quoted was from AIHW. I think it said 21 per cent consulted chiropractors or physios. Do you know of any figures that are similar to those in the ACT?

Mr Badham: The national health survey that I quoted in the AIHW report does not break it down into different jurisdictions. Based on the patterns of chiropractic numbers per capita, we are probably around the middle. There are certainly higher concentrations in Melbourne, Sydney and Brisbane, and probably Adelaide and Perth too, whereas in the country it is a bit like the other health services and health professionals—they are a bit thinner on the ground. From anecdotal evidence and from talking to chiropractors throughout the country, the rates are about the same as they are elsewhere in the country.

MS BRESNAN: Just a quick follow-up: in terms of e-health, have you been involved in any of the discussions that have been happening nationally?

Mr Badham: I do not know whether our national body has. I doubt it. Murray's predecessor and I attended the National Health and Hospitals Reform Commission's community consultation. I know it was a big issue then, but we as an association and as private individuals have not really been involved in that format. I imagine the further integration that we would achieve would be essential and certainly beneficial. It is a crucial issue; there is no question about it.

Mr Stark: I think that as part of record keeping most current practices have gone to computerisation of patient records. We have a paperless office. Everything that comes in on paper—X-ray reports, doctors' referrals—gets scanned and loaded under practice management software and/or record-keeping notes. X-rays and files, are all stored under it. It is happening in the small clinics, but it is part of national plan. I do not think we need to get involved at this stage.

MS BURCH: Just on that, you made mention of X-rays. The physio association before said that when somebody comes in and they think they need an X-ray on certain body parts, if they refer that patient for an X-ray they do not get a rebate but if they refer them to a GP for the X-ray the patient gets the rebate. Does a similar thing apply to you?

MS BRESNAN: They could refer for spine or pelvis, but they could not get any—

MS BURCH: Yes, but they could not refer for, you know, the end bits.

Mr Badham: They have got limited referral rights. We have too but in different

places, I expect.

Mr Stark: Yes. Spine, pelvis and hips, I think—no arms, no legs.

MS BURCH: So it is similar?

Mr Stark: For a chiropractor, yes. We can refer under Medicare. I can fill out an X-ray referral to any of the practices here in town, particularly the larger ones that are bulk-billing. I have a provider number. They are billed directly under Medicare. I think, at the end of day, if a patient comes in who has sustained a fall at school—if a young patient has fallen off the swings and has some real discomfort— you would normally refer to a GP for assessment. Alternatively, if you believe that the patient was stable, you would monitor for 24 or 48 hours, and most of the time you have the answer in that prudent time.

MS BURCH: Thank you.

THE CHAIR: You mention in your submission that currently the ACT branch has 32 members. Is that a conclusive list of members? Are there other people practising or do they have to be members of your association?

Mr Badham: There are between 10 and 12 others. It fluctuates regularly, as it does in most professions. There are a few part-time practitioners in that group. We have 32 paid-up members. There are probably 10 to 12 others registered and practising in Canberra, but there are many more on the register.

THE CHAIR: They are fully accredited.

Mr Stark: Every chiropractor in the ACT has to be registered under ACT law, but with our body, which is obviously the peak professional body, people can choose to be members or not.

THE CHAIR: Is there a bigger demand for chiropractic services than currently you can cope with, or are you coping with the amount of business that is available—for want of a better word?

Mr Badham: I hate to give an inconclusive answer because it changes it. If we base that decision on how many chiropractors in Canberra are looking for associates and job vacancies and how genuine those vacancies are, it is hard to say. At one stage last year there were four of us looking for people to work in our practices and now all those positions have been filled one way or another.

I would suggest that it is a bit of both. There are practices around which are always looking to recruit people. If you rang up and tried to get into a chiropractor, you would get into a chiropractor in Canberra that day. You would probably be in in that region in that day. As far as waiting lists go for getting into a chiropractor, they are very short, if they exist at all. But, by the same token, there are plenty of practices that would like other members of staff. It is a very fluent demand-supply scenario.

THE CHAIR: There are no further questions. Are there any issues that we have not

covered that you would like to finish up with at this point?

Mr Badham: In our compressed submission I think we have made all the points we would like to. As we say right at the end, we would like to accept any further opportunities if you would like to talk to us about issues. We would be more than happy, of course, to expand on things which might come up in the future.

THE CHAIR: If you wanted to give us copies of any of the submissions that you have made to government up until now and the ones that you have mentioned— if you would care to share those with us—we would take them on board.

Mr Badham: I think they came with our initial letter.

THE CHAIR: Okay. Thank you for coming along and thank you for your submission. It was very useful. If there is anything else that comes out as a result of the discussion here or other points crop up, please let us know. We would certainly like to consider it. We are looking at a pretty big picture with the GPs and obviously we would like to consider any additional assistance that can be given. You will receive the full transcript of what has been said.

Mr Badham: Thank you.

The committee adjourned at 12.33 pm.