C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON ECONOMY AND INFRASTRUCTURE

REFERENCES COMMITTEE

Subcommittee

Inquiry into primary health and aged-care services

Melbourne — 2 November 2011

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Mr M. Staaf, and

Ms T. O'Hara, professional officers, Victorian branch, Australian Nursing Federation.

The CHAIR — Thank you very much for joining us. This public hearing today relates to the committee's inquiry into primary health and aged-care services. The committee is specifically examining the measurements, including budget measures, of primary health and aged-care services and outcomes.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same comments, they may not be protected by this privilege. All evidence is being recorded. You will be provided with a proof version of the transcript in the next week. Transcripts will ultimately be public and be posted on the committee's website.

We have 5 to 10 minutes for your presentation, and then we will no doubt have lots of questions for you. If I could ask you, for the record, to start by introducing yourselves and giving a business mailing address for the copy of the transcript.

Mr STAAF — My name is Mark Staaf. I am a professional officer at the Australian Nursing Federation. My colleague Trish O'Hara also has the same title. We are both registered nurses with postgraduate qualifications in advanced nursing practice and have both held senior positions within health; I have in Victoria and Trish has in many jurisdictions around Australia. We work for the Australian Nursing Federation Victorian branch, and our postal address for mail is P.O. Box 12600, A'Beckett Street Post Office, Melbourne 8006, and our office address is 540 Elizabeth Street, Melbourne.

The CHAIR — Would you like to speak to your presentation.

Mr STAAF — I was of the view that I had to speak for 45 minutes, so I have provided a quite lengthy piece of presentation. I do not think we need to go on to it, because I think you are going to ask us a lot of questions.

Overheads shown.

Mr STAAF — Just in terms of an opening statement, the Australian Nursing Federation was established in 1924. It is the largest professional and industrial organisation in Australia. We represent nurses and midwives within Victoria. Our members are predominantly employed in a wide range of enterprises in urban, rural and community care locations in both public and private health agencies and aged care.

Trish and I have responsibility in the Victorian branch. I have responsibility for aged and community care, and Trish more primary care and rural and remote health. That is why we have both come today, because we have crossover expertise in that.

The ANF is also a registered training organisation and contributes to vocational education and training of enrolled nurses and professional development for registered and enrolled nurses and registered midwives in Victoria.

The ANF participates in the development of policy relating to nursing and midwifery, professionalism, regulation, education, training, workforce, socioeconomic welfare, health and aged care, community services, veterans affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform. So we sort of try to have a foot in lots of camps, and we are very pleased to provide comments to the standing committee today.

We also acknowledge that the Victorian government may have little detail of an individual's medical history prior to them presenting at a state-operated health service for treatment. For this reason, we understand previous state governments have committed resources to the development of electronic health records across a number of public hospitals. The complexity with both soft and hardware technology is that some of the operating systems are not capable of interfacing with the data from systems outside the primary source of data collection. We understand that sharing of electronic health records is the major brief of the National E-Health Transition Authority and is the major reason there is a commonwealth government commitment to introduce the personally controlled electronic health record as a secure electronic record of an individual's medical history that will be stored and shared in a network that has interconnecting systems.

The commonwealth government has already invested $466.7 million in the first release of the personally controlled electronic health record system. The aim of that system is to bring key health information from a number of different systems together to present it in one single view.

The ANF is supportive of the notion of the Victorian Department of Health having a clearer picture of how consumers are moving through primary health and aged-care services and having access to robust data to ensure better planning for service delivery and having access to meaningful data and access and equity and service locality where there is a demand.

The notion of developing a standardised classification system that spans the breadth of both primary care and aged care is now quite complex, and consideration of the practicalities of the development of such a system would require a lot of resources and a financial commitment by the state government if they wanted to duplicate something that might already be happening at the commonwealth level. The mandating of such a concept in Victoria may require a large financial outlay to bring existing classification and coding systems into line at a time when there is a national e-health rollout that is already doing, in our opinion, a large piece of that work already.

The Australian government is preparing to establish a national database in relation to people receiving primary health services and treatment associated with the implementation and rollout of that e-health initiative, and therefore this move, in our opinion, would seem like a duplication of that service and a financial burden to the state. It might be more appropriate and logical to us if the state-based services were able to contribute to and access both state and national datasets.

In relation to the term 'mandate' within the context of this inquiry, it is not clear to us whether mandate is to mean legislated and therefore enforceable and to be associated with penalties where the mandate is breached. The ANF would not support a system where penalties were applied to nurses and midwives who could not do this if they were underresourced. That is a key concern of ours.

Should this concept be adopted, consideration must be given to how epidemiological coding would be applied and contextualised within the Victorian health sector and ensure that it is fully funded and there are no additional cost burdens to the already finite services and that the time it takes for data input is fully realised, resourced and funded.

In relation to the waiting time, should Australia mandate the waiting times and lists for primary health services, in theory we think it is a reasonable method to ascertain whether service provision is meeting the demand expectations; however, we are not supportive of a system whereby health professionals or organisations might be penalised. I have already stated that.

In Victoria there has already been a range of problems emerging where this methodology has been applied, especially within emergency departments of public hospitals and where they have been penalised for not meeting targeted throughputs. It is really no fault of the health practitioner that that happens.

Where waiting lists might be affected by a measure of time a consumer waits once placed on a list, it might be more timely than one thinks, so if a person comes in through a primary health service and is waiting for a service and they are put on a waiting list, there is no time measurement of how long it takes to move through that, so if the purpose of collecting that data is to streamline services to make that happen quicker, it might be very useful, but if it is not going to service a purpose, one wonders what it is being collected for.

One of the things that health professionals notice is that individuals have varying medical histories and comorbidities and as a result sometimes longer treatment times might be seen outside of a primary health service, and these new or coexisting comorbidities may blow out waiting times for the next consumer waiting to be seen, and I think that was picked up. We heard the tail end of the last presentation and would agree with that.

Health-care consumers have different outcome measures and cannot be treated as though they all the same and that it might take the same amount of time for them to be seen and treated by a primary health service. Specifically, individuals, aside from having varying comorbidities, may vary in age, gender, nationality and culture, which may all have differing needs based on access to the service, their locality, whether they are in a metropolitan region or a rural or remote setting. Therefore data collection may be flawed and consequently might be quite subjective once it is recorded.

In relation to the term 'mandate', it is not clear to us whether mandate is to mean legislated and therefore enforceable and to be associated with penalties where it is breached. That would require further clarification from our perspective.

The question around should Australia mandate the requirement for the provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in a primary health-care setting, appropriate treatments for asthma in those sorts of settings and so on, when you put it in those contexts, it is really difficult for us to be supportive of that proposal as there is not a defined objective to describe what is meant by the term 'appropriate treatment'. What one health-care professional might deem appropriate may be not what I deem as appropriate or vice versa. Consequently that might have funding difficulties around what I think it is appropriate as opposed to what you do. We are of the view that no health professional is in the business of providing inappropriate treatment, but sometimes it is how it pans out.

All primary and aged care is predominantly planned, implemented and evaluated based on the health professional's educational preparation, their clinical judgement, professional knowledge and skill. They also take into consideration when treating consumers their history, their comorbidities, current condition, what their diagnosis is, what their prognosis might be, what their ability to comply with that regime is, what their mental health ability is, and age, gender, nationality and cultural beliefs all come into play there. It may be more appropriate to consider development or the review of existing guidelines in relation to appropriate treatment or for all patients with specific disease conditions to determine if they are being met, and if they are not, why are they not.

Moving on from that question, to single out diabetes and asthma as a key performance indicator to implement an outcome measure is not supported. There may be other primary and aged-care outcomes that make such data collection prohibitive — for example, whether all that data is only to be collected by health professionals. There is some concern around whether they would have access to IT and whether they have safe and secure IT collection systems, especially in residential aged care. A lot of homes do not even have computers, despite being funded for them. There is the consumer consent to it. There is also the attraction of health professionals, including nurses and midwives, to work in primary and aged-care settings, around employers being able to provide competitive wages for them to be there. This information is likely to be available via the national e-health service in the future anyway. In relation to the term 'mandate', it is not clear to us whether mandate is to mean legislated and enforceable.

The next question is whether conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of our primary health-care system. There are a number of conditions which might lead a person to require hospitalisation when an acute onset or an exacerbation of a condition occurs; therefore to consider a condition as preventable without consideration of all the additional factors and to rely on this as an indicator of adequacy of a primary health-care system is, in our opinion, not really fair.

In circumstances where people are consumers of primary health services, health professionals employed within such services may know their clients well enough to identify changes in their condition and to rescue them or intervene early to prevent or reduce the risk of hospitalisation. However, not all services are the same, particularly in relation to their operational budgets, resources, staffing skill mix and accessibility to ensure the consumer can access the service or health professionals they need on every visit.

Having said all that, we are broadly supportive of team-based primary health care implementation; nonetheless, nurses must be recognised for the contribution they make to quality care and measurable outcomes for consumers. There has been some quite interesting research done by a Professor Aiken around rescuing patients involving the right people being there at the right time to do that. I will refer you to that work rather than talk about it.

The other question this committee has been asking was about whether the actual rates of provision for residential aged care for each community should be provided, as opposed to bed ratios. We were quite confused by that question, I have to say, and I do not know if other people you have spoken to today felt the same way. We support that data being available, and we know that the commonwealth Department of Health and Ageing would be best placed to collect that type of data in accordance with its allocated aged-care beds and community care places within a locality, and that is what they do already. The aged-care sector is already highly regulated,

with a vast range of data already being collected and publicly available. In our view, applying another reporting layer would be detrimental rather than beneficial in some of those areas.

The Aged Care Standards and Accreditation Agency's powers might need to be expanded to implement and monitor systems in community aged care around the delivery of community aged-care packages as well as residential aged care. That is a conversation I have had with their CEO, Mark Brandon, in the past, who also thinks it might be something they should explore. ANF is confused as to whether the term 'ratios' in the question means commonwealth-allocated residential aged-care beds or, rather, any other sorts of ratios. We are not really sure what you meant by that. We understand that the commonwealth government publishes allocated aged-care bed numbers by locality already and those datasets are readily available.

How am I going for time? Do you want me to go on, or do you want to start asking questions? How is the best way to approach this? I will ask the committee. I am not sure if I am giving you what you want or whether this is wasting your time.

Mrs COOTE — No, it is really comprehensive.

The CHAIR — No, it is good.

Mr STAAF — Whether comparable rates of community care alternatives should be provided for these communities was another question. Trish and I were a bit puzzled by that. We did not really know what was meant by the term 'alternatives'. Commonwealth allocated community aged-care packages rather than admission to a residential aged-care bed is what we think you mean, but we are not sure. If that is what you mean, we know there are packages out there, such as EACH, EACH Dementia and HACC of course as compared to residential aged care. 'What are the community care alternatives?' is a question we have to ask the committee because we are not sure what you mean. We know there are already alternatives. If those are the ones you mean, we are happy with them. We are unclear as to whether this point is to mean the uptake of community aged-care packages rather than a person being assessed for a home. I think I will leave it at that point.

The next point was whether quality criteria for residential aged care across a community and for each individual setting should be more clearly available and provided. We felt that this requires a definition of what the expected criteria for that quality should be. The Aged Care Standards and Accreditation Agency already sets down 44 standards, which are currently being reviewed to be made into 33 standards, but that review is not complete yet. There may be a rationale for such criteria to be applied to community aged-care and primary health-care services to set a benchmark for best practice and quality outcomes for consumers, and this information should be available to all consumers in order for them to make informed choices about what service they think they want or need. Is the committee's intention to have a system like a 'My School' or 'My Hospitals' website which people can visit and decide where they should go? That is something we wondered about. They could then compare and contrast services to find out which service they should have.

Of course the question for us was: will the state fund and resource such an initiative over and above what the commonwealth already funds? I would see that as a duplication of services. Unless you can get the money from the feds, I do not know whether you would be in a position to be able to do it anyway.

Who will the information be provided to? That is something that sprung to our minds. You are going to collect the data, but what for? Will it go to consumers, to the services themselves or back to you in order to evaluate whether you need to provide additional services? If that is the purpose of it, it may be useful. Will this be part of a commonwealth aged-care front end and aged-care gateway, as has been proposed under the Productivity Commission guidelines from the review of aged care? Is that what it is intended to be? And will it attract — —

Mr RAMSAY — I thought we were asking the questions.

The CHAIR — Some of your questions are similar to the ones we are grappling with.

Mrs COOTE — It is good to have them in data.

Mr STAAF — Okay. They were things that sprung to our mind.

Mr RAMSAY — I am being a little bit tongue in cheek. It is okay.

Mrs COOTE — You are not alone.

Mr STAAF — Therefore we caution that this may result in a highlighted deficit in services or service delivery in some poorer socioeconomic regions. While it may be an appropriate approach, it could only work if the government is in a position to provide the current situation and service delivery is already in existence; it would be an add-on, not a take-away. That is what we were thinking.

Potentially unnecessary or avoidable hospitalisations of patients in residential aged care should be used as a surrogate indicator for poor care in these settings. When Trish and I thought about this we thought this question was a bit subjective as it may not be a qualified health professional who makes the decision to transfer that person, especially from an aged-care setting or primary care service to an acute hospital, because sometimes these services do not have health professionals employed in them.

The CHAIR — That is a scenario that we have spoken about.

Mr STAAF — Factors like the skill mix of staff in residential aged-care homes are important in the decision-making process for transfers. It is our very strong opinion that if an appropriate healthcare professional is available in the home, they can — —

This is what I was saying about Aiken's research — there is lots of evidence to show that if the right person is in the right place at the right time, a health consumer can be rescued rather than shipped out. By the time they wait on a trolley in an emergency department for the nursing home for several hours it might be too late, but if they have the key staff in the right place at the right time, they might be able to intervene. That is how we thought about that question.

ANF supports a care system that has a mandated nurse-to-patient ratio that provides for staffing and skill mix to be appropriate to the expected health-care condition and care needs of the consumer. We also support adequate nurse-to-patient ratios in all aged-care services to ensure that all potentially unnecessary or clearly avoidable transfers to hospital can be circumvented, and I think I have already said enough on that point.

Other support mechanisms that could be there are the availability of diagnostic services. X-ray and pathology are key indicators for health professionals about whether people need to go somewhere else. It is fundamental to the decision-making process whether to send a person away for care or whether to do it in-house. These issues may be better addressed by ensuring that all primary health services have access to mobile X-ray equipment, qualified personnel to operate that equipment, arrangements with GPs for rapid diagnostic orders, capabilities in terms of responding to whatever the diagnosis is and an increase in funding and initiatives for more nurse practitioners. Advanced practice nurses might be one way to address some of those problems. Another way might be to ensure that there are generalist and specialist nurses in all services to coordinate such services and minimise unnecessary hospitalisation. Rather we should optimise services to maintain people in an environment they choose like aged-care homes or in the community.

The CHAIR — Thank you. That is a really comprehensive answer to many of the questions. I might add, some of the questions you asked about the terms of our inquiry are questions that we are asking ourselves and hoping that you will help us find answers to.

Mrs COOTE — First of all, thank you very much indeed. That was really comprehensive, and I think Robert and his staff will go through and have a close look at a lot of those questions that you posed as well. I think what you did is itemise and dissect a lot of areas, which will be very useful to us as we go through this, so thank you. I have two questions. One is very basic: do you think there is a need to record why people receive primary care? Why is there a need to collect that data? Do you actually think there is a need for that?

Mr STAAF — I will let my primary health expert answer that.

Ms O'HARA — Thank you. Part of my portfolio, apart from primary health care, is practice nurses, rural and remote. I cover that broad sector. I think it is important to identify why the majority of clients go to primary health care. There will be a range of issues from birth to death. There will be a number of issues from birth around immunisation et cetera and around that initial care that the baby and mother need in terms of infection, childhood diseases and all those sorts of things. Then we get to the other end of the complex care of the patient with their comorbidities. Sometimes there are people who never actually go to a GP. They are your young, fit,

athletic sportspeople who may just go to a physiotherapist for muscle massage or some sort of therapy that is required from another allied health professional. I do not think everyone goes to a GP, and I can tell you that categorically because, as part of my portfolio, I sit as a clinical lead with NEHTA and the PCEHR, and I have been one of four nurse experts who have been sitting looking at all these debates about who goes to GPs and how we are going to access those patients who will opt in for a PCEHR. A lot of those questions have been discussed and how we target those people.

I do think it is important on a number of fronts to ascertain how to identify those services people need in the community. Under the health reform initiatives there is lot of work being done from the commonwealth government around Medicare Locals, which you have already talked about. Those Medicare Locals will be tasked, in their brief, with identifying those services that are needed in those areas and what service delivery will be required. That is very much in its infancy, and how they identify those services will be important. That has not been defined, so that is a whole new world. Under the e-health agenda it will be up to the individual whether they opt in or not. In the beginning it will be in its infancy so we will not get a lot of data initially, and it will be very much focused around the privacy in the legislation that currently goes with it. There is legislation before the commonwealth government at the moment around the privacy issues, what will be allowed to be released and how it will be released. I think there are still questions to be answered around that, but certainly the GPs and primary health care will be fundamental in that whole system.

If the nominated health provider for those people opting in will be the registered nurse, the registered midwife, the GP, and also the Aboriginal and Torres Strait Islanders, those will be the groups that will set up that initial health summary. It is from that data — that initial health summary data — that you will eventually glean what the main issues are that people are going to either their GP or their health provider for.

Mrs COOTE — Thank you. I just have one quick — well, I hope it is quick — question, and that is: is there a state in Australia that is doing it well, and is there a world best practice that we perhaps should read up on or study?

Ms O'HARA — Can I tell you that Victoria is doing it best?

Mr STAAF — We are the best.

Ms O'HARA — Victoria is the best. I can say that from having worked in New South Wales, Western Australia and the ACT, and I have worked in the Department of Health in the ACT. Victoria has already demonstrated your health links with your local acute hospitals, and your links with the community, with your aged care, have already been the model for health reform. New South Wales had these massive, big areas that were cumbersome, did not connect with the community and were run by multiple executives who really did not understand what was happening down at the ground, whereas the health system in Victoria has always been linked to the community, community services, primary health care and rural and remote areas. Your linkages have actually been the model for health reform.

Mr STAAF — Our health and community care has been the best in Australia, and when that was all up for review under the national health reform the rest of Australia modelled Victoria. We argued in all our submissions to government that we must not take anything from Victoria, because we have the best now, that in fact you have to bring everyone up to our standard, and that is where it loosely went with that.

Mrs COOTE — Anything international that does that exceedingly — —

Ms O'HARA — We have done a lot of work, particularly with Scotland and also the National Health Service. I have written papers on that. The other comparisons are the Scandinavian countries and New Zealand. New Zealand does it well to a degree, because it has a similar model to what we have where it links its acute hospitals with its community care. Scotland has a similar model; it has a very strong primary health-care and community-care system which is similar to what we have in Victoria.

Mrs COOTE — Thank you very much indeed.

Ms BROAD — You have been very clear in your comments about mandating waiting times, and you list some of the issues you see with doing that. I am one of a number of members of this committee who represents large areas with large rural constituencies where access is certainly an issue. I am including in access

affordability, location — so, travel — and the fact that there are many GP services that are just not open to taking — —

Ms O'HARA — New clients.

Ms BROAD — New clients. So there are a range of access issues. Can you tell us what you think would be a reasonable way of assessing those access issues, not for the sake of doing it but for the sake of identifying where those issues exist? The next step, I guess, for the public policy-makers is what might be done about rectifying that situation.

Mr STAAF — I guess this is a crossover question, isn't it? You can start.

Ms O'HARA — All right, I will start. You have already alluded to the transport distance and the availability of not only allied health but GPs in rural and remote areas. We are very aware of that. There are a number of initiatives that are going on under clinical placements, which I am also involved in, and that again is a unique Victorian initiative in getting health professionals into rural and remote areas and trying to extend their practice. I think it is about a range of solutions. It is about solutions around supporting people in those rural and remote areas, because often they come in as an outsider. There are all sorts of cultures, there is transport, there is access to housing — there is a whole range of issues in just putting people in rural and remote areas. It is also about having a range of services. There are advanced practice nurses, as you already know, in rural and remote areas who practice independently, with a formulae of medication that they can administer and prescribe. There are of course nurse practitioners, and again that is all around funding.

It is not just about money; it is also around how these people are funded and what attracts them there. The MBS and PBS rebates are not equal to what a GP gets and not equal to what an allied health professional gets, so there are incentives there for people not to practice in those areas because they cannot afford to. There is a whole range around even the GP packages and the primary care packages that they deliver to people. There are specific ones for Aboriginal and Torres Strait Islanders, which are fine, but can the people access them? They do not have the transport to get there. I know of cases, and it has been explained to me, where a woman might have 17 urinary tract infections but she cannot get to a GP to see them. Because of the distance, he cannot get out to see her and she is at risk of renal failure.

There are all these issues. There is the goodwill of people, but the access has barriers because of a whole number of reasons. I think it is not a quick-fix answer. I think it is around facilitating these Medicare Locals to say, 'Identify what these services are. See if we can get some sort of transport options in the funding that is coming from the commonwealth to get health professionals out to these people'. It is not a quick-fix answer, but I believe that if we all work together, we can work there to get there. There are going to be a number of answers to the question.

Ms BROAD — I just bring you back to the starting point, which is identifying. You have referred to Medicare Locals, as part of their charter, to identify these places where access is an issue, so what would you see as a reasonable way of assessing access?

Ms O'HARA — Under the framework of the Medicare Locals they are going to have local area boards. The boards will consist of not necessarily just health professionals, although they will be there. There will be local people, there will be people from councils and there will be the people from the community. With the health professionals, it is my ideal that they all sit around the table and say, 'This is the Aboriginal group we have. This is the aged-care group we have'. We can talk to the allied health professionals and the actual general practitioners to say, 'What are the range of conditions that these people have? How many people with mental health conditions do we have in the area? How many do we have with heart disease? How many do we have with renal disease? How many diabetics do we have? How many asthma patients? Don't forget our young people and our children who are being born in that area. What services are we providing for them? All right, now let's look at all of those groups of people and then look at where they live within our Medicare Local'. But the big issue in that is that there are 500 000 people within each population of the Medicare Local, and in Victoria it will go right across the boundary into New South Wales, below Wagga, right across the Murray River and come back into Victoria. So you have all of those jurisdictional issues there. You have legislation around drugs, poisons and controlled substances and OHS legislation. All our states have their own legislation around what you can and cannot do across that. So they have to be able to talk to different councils.

I will give you another example. The councils in Victoria are very good and have maternal and child health services of a high standard. I am not saying that they are not of a high standard in New South Wales, but they are different. They have a different focus; the councils have a different focus. I believe there has to be a very wide and vigorous discussion amongst all those people in the Medicare Locals with all those interests to say, 'What is the best service we can provide for these people?'. It is going to be challenging.

Mr STAAF — So in summary about the access, it is probably a difficult question to know whether the access and equity question — having listened to all of that — is right, because we do not really know what it is now. If we are looking at ways to improve it and if the collection of data might give some indication about the type of people who need a type of service, with some of the reform that is happening around the health workforce Australia and some of the models that are proposed towards 2025, it might be that care is delivered in a different way. There might be a new technology that puts treatment in another format than it currently is in and we might have expanded scopes of practice for current health professionals to enable them to do more. There is a lot of concurrent work going on to probably try to answer that question. My view at this time is that I do not think the committee is going to get a black-and-white answer to it, because there is too much other work happening concurrently. Wouldn't you agree, Trish?

Ms O'HARA — I totally agree.

Mr STAAF — It is a bit of a mess, really, at the moment. That's our opinion.

Ms O'HARA — Both Mark and I cover both health reform and Health Workforce Australia. We have just given Health Workforce Australia a submission on our workforce in rural and remote areas as I said. Plus there is the e-health agenda — it is all working in different silos unfortunately at the moment and some of it is very new.

Mr STAAF — A lot of people are trying to achieve the same outcome but have not taken a minute to actually look over their shoulder and see what the other group is doing, because some of the work might fall into place for the other group.

Ms BROAD — As someone who represents a part of Victoria that has a very long border with New South Wales, I am very familiar with cross-border issues, including the fact that we now have a Victorian health service that is responsible for a hospital in New South Wales and what it took to achieve that arrangement.

Mr STAAF — We know where you are from, then!

Ms BROAD — Perhaps, then, I can bring you back to the remarks you made in responding to the first term of reference, where you indicated that given the development of the national e-health initiative, I think what you are indicating here is that you support Victoria's participation in the development of that rather than adopting a separate approach.

Mr STAAF — Yes, that is exactly right.

Ms O'HARA — Yes.

Ms BROAD — Is it possible to link that to the first set of issues around how you might go about evaluating access issues in terms of the collection of data through that national e-health initiative? In the example that you gave, you have got groups of various health-care providers and practitioners around a table figuring out what might be done.

Mr STAAF — I think that is part of the answer. There will always be disagreement with that group as well. This is the point I was trying to make in my opening statement about people not always wanting to agree that someone's opinion is right. There is the question around appropriate care and appropriate treatment and who thinks something is appropriate. You may be in a rural area versus a regional area — some of your constituents in the Murray Valley might be in this situation — that only has a GP service and a small community hospital, but you have a chronic heart condition and need to be referred to a regional centre like Shepparton or Bendigo or come down to Melbourne, and if you are elderly and cannot drive — those sorts of things — how do you get to that service? That is always fundamental. So therefore you have to have reasonably good support services like a rural ambulance service that can assist to get people backwards and forwards to those sorts of points.

Ms BROAD — Yes, patient transport.

Mr STAAF — You might have to have a good voluntary network in place through the Red Cross auxiliary, so the sorts of people who are prepared to drive people backwards and forwards. They may be elderly, have sight issues and be unable drive at night. It may be a winter's day, their appointment is at 4, it is dark at 5 and they have a 3-hour drive back to Albury-Wodonga or something from Shepparton, or perhaps they have been seen in Bendigo or something like that. These are all issues around access and equity that I acknowledge are problematic for people. I am a country person, too; I am from that Murray Valley region and I have parents who went through all of these issues. So I understand what you are trying to say. There were GP services that could not take new patients. Unless you have a very good relationship with your GP, he is not going to come to your home to visit you, because GPs are just too busy and they have lives to live as well.

This is what Trish and I talk about — having some nurse-led care or nurse-led clinics and other people who can do that. It might be more appropriate that they are seen by an allied health professional and then be referred to a GP for specialist stuff. It might be that if a physiotherapist thinks they need some diagnostic work, then that can be referred to an advanced nurse clinician who can do all of that. They can assess the person and say, 'Yes, you do need this. I know you're going to need this tablet. We can organise you to see the doctor'. With all of the results from the tests they have already ordered, then the doctor can make the decision and say, 'Yes, you do need the prescription for A, B or C'. I think there needs to be some thought about streamlining services and doing things differently to what we do now, and we are quite supportive of that.

Ms O'HARA — Telehealth is here.

Mr STAAF — Telehealth of course is another commonwealth initiative around making sure that perhaps a specialist service is available — you know, the hub-and-spoke model. Shepparton, Goulburn Valley Health, Bendigo Health, for example, or even Melbourne Health, the Alfred or somewhere, they can telehealth up to the GP and have a conversation like we are having now. I can do a consult with you and say, 'Look, don't send them to Melbourne. This is what's wrong with them. Start them on this; give them a week of that. If they don't improve, then I want to see them, but try that first — because our ED is full and we can't see you if you come anyway'. I mean, that's realistic, isn't it?

The CHAIR — It is not so far off into the future anymore either.

Ms O'HARA — Oh, no, it is here. It is actually here and now.

Mr STAAF — No. It is now.

The CHAIR — Yes, that is right. It is just a matter of having the equipment and having people get used to it, I suppose.

Ms O'HARA — That is all part of NEHTA. NEHTA's vendors are talking to all the GPs at the moment about putting down the hardware and the software which is consistent right across the nation, and of course national broadband is going to be the conduit for all of that as well.

Mr STAAF — Panning out of the work that Health Workforce Australia has done about rural and remote workforces — sometimes we accept doctors from international countries. They obviously have had English to pass the registration requirement but they get out to these services and there are cultural abnormalities, and whether people in the community want to accept them — all of those sorts of problems then emerge. It is problematic, it really is, and it is costly.

The CHAIR — Are there any further questions?

Mr STAAF — You poor people; you have probably been listening to this all day and are ready for a Bex and a lie down.

The CHAIR — With answers to these questions we certainly may have our work cut out for us, but we are going to do our level best. Thank you so much for your time today, and also for that time taken in preparing the presentation. We are grateful for the opportunity to flesh these issues out in a bit more detail in person.

Mr STAAF — It was a pleasure. Thank you very much. If we can be of assistance in the future, let us know.

Ms O'HARA — Thank you very much indeed.

Committee adjourned.