CORRECTED VERSION

OUTER SUBURBAN/INTERFACE SERVICES AND DEVELOPMENT COMMITTEE

Inquiry into liveability options in outer suburban Melbourne

Melbourne — 2 May 2011

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Witnesses

Dr J. Garra, general practitioner, and chairperson,
Ms C. Siebel, chief executive officer, and
Mr N. Samara, legal counsel and policy development,
Westgate General Practice Network.
The CHAIR — I extend a very warm welcome to each of you here today. Thank you very much for coming along and for providing a submission. You need to appreciate that this is an all-party parliamentary committee, and today we are hearing evidence into the inquiry into liveability options in outer suburban Melbourne.

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 Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I ask each witness to state their full name and address.

Dr GARRA — I am Dr Joe Garra of 39 Koroneos Drive, Werribee South.

Mr SAMARA — I am Nihal Samara of 9 Brown Avenue, Altona Meadows.

Ms SIEBEL — I am Corinne Siebel of 99 Spencer Street, Essendon.

The CHAIR — The information you provide to the committee will become public, as it is being transcribed by Hansard staff, and will become evidence in due course for the purposes of our inquiry. Have you organised the order of who will be making the verbal submission? I am assuming that each person here today is going to interact with us during the question process.

Dr GARRA — That is correct.

The CHAIR — Who is going to make the overall verbal presentation?

Mr SAMARA — We have actually split it into three sections, being from the chair, from me and from the CEO respectively in each of those areas.

The CHAIR — Who would like to lead off, then, from their perspective?

Dr GARRA — I will start off. I am Joe Garra, the GP chair of the Westgate General Practice Network, and with me is Corrine Siebel and Nihal. On behalf of the network we would like to acknowledge the Wurundjeri people, who are the custodians of the land, and the elders of the Kulin nation. We thank the committee for allowing us to be here today. It is a privilege to be here.

I have been a local GP, particularly in Wyndham, for 23 years, and I have seen a number of challenges over that time that affect liveability for people. We have had rapid growth over that time. There has been demand and strain on all primary health services, not just general practice. We have a high population of people with culturally and linguistically diverse backgrounds and refugees in the area. There is an increased prevalence of mental health, chronic disease and substance abuse issues. We have an ageing GP population, and with that we have a lack of GPs who are doing both home and nursing home visits. We also have a low socioeconomic region out in the west.

Population data indicates that Hobsons Bay is going to age considerably in the next 25 years — 85 per cent are expected to be over 55 years of age, and there will be an over-200 per cent increase in people over 85. Also, Wyndham is now the fastest growing local government area in Australia. We have challenges with chronic and complex diseases, and the difficulty in accessing primary health services is impacting on hospital emergency presentations in the area. This part of Australia is made up over 160 different nationalities, making it one the most culturally diverse communities, requiring specialist health literacy strategies.

The Westgate General Practice Network, as the lead agency in a consortium of 89 partner agencies, has made a submission to the commonwealth to form and establish a Medicare Local model in Melbourne’s west. One of the goals of this local model is to improve liveability by improving access to and coordination of primary health services. Our submission included a comprehensive epidemiological and public health analysis of outer western Melbourne. I will hand over to our CEO, Corriene.

Ms SIEBEL — I am Corinne Siebel, chief executive officer of the Westgate General Practice Network. The Westgate General Practice Network has, over 18 years, provided a range of primary care and prevention services to a rapidly expanding community with highly complex needs.
Within the context of health-care reform we are taking the lead in the development of a sustainable and flexible primary health-care model. This is an important step in improving overall health-care delivery, particularly to disadvantaged and underserviced communities. The Westgate General Practice Network-lead Medicare Local model directly relates to the catchment areas of the western outer metropolitan region, which is a rapidly expanding region with high social and economic disadvantage. This model seeks to address primary health and access to health care, particularly in the rapidly expanding local government areas. The Westgate General Practice Network-lead Medicare Local population health service plan is based on an understanding not just that health is about the absence of disease or illness but that social factors such as belonging to a community, participation in community life, healthy environments, employment and housing are key factors in people’s health and wellbeing.

This understanding is articulated in the World Health Organisation’s definition of health as a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity. The World Health Organisation’s charter for health promotion and the subsequent ‘health for all’ policy shaped what is known as the social model of health. The key element of a social model of health is that it provides opportunities for communities to define what health and social wellbeing mean to them and the key factors that influence or determine health status in their community.

In order to improve liveability, Westgate General Practice Network will demonstrate: high capacity for population health planning; true partnership with a range of organisations and consumers to plan, design and establish a Medicare Local model for the outer west of Melbourne; a strong focus in developing a sustainable model for the servicing of marginalised and underserviced communities; the entrenching of corporate and clinical governance into frameworks to ensure transparency and accountability to the community we serve; use of evidence-based outcomes which will provide a model for application in all growth areas and across Australia; engagement with general practice and recognition of its centrality in primary health-care reform and delivery; partnerships with local hospital networks, lead clinicians and community-based agencies; collaboration with clinical schools and research centres of excellence; use of funding is efficient and transparent in coordinating and ensuring that services covered include Aboriginal and Torres Strait Islander communities, after-hours services, aged care, chronic disease and in accessing new technologies such as e-health and telehealth across all age groups; provision of access for better health options for our communities through strong engagement of a range of primary care providers and consumers; and engagement with the state Department of Health to undertake an epidemiology study for the region.

In this case the committee has access to a tool for the purposes of ensuring liveability from a population health perspective. The model plan includes training more than 1000 new medical and nursing positions to support local GPs to provide after-hours services in Melbourne’s west. The difference here is that this population health plan is based on an understanding that health is not just about the absence of disease or illness, but that social factors such as belonging to a community, participation in community life, healthy environments, employment and housing are key factors in people’s health and wellbeing. This approach is to focus on promoting the maximum wellbeing of people living in the outer western region of Melbourne.

Mr SAMARA — I am Nihal Samara, legal counsel and policy development with Westgate General Practice Network. The plan outlined by Corinne Siebel, the CEO of Westgate General Practice Network, provides guidelines for improving liveability options in the outer regions. We have provided a copy of the service architecture to committee members. I would like to highlight eight of those specific initiatives that are covered in those plans to improve liveability options. These eight ways include: 1) fast-tracking the after-hours GP care reforms to allow patients to receive face-to-face GP services outside normal operational hours; 2) driving telehealth services to enable people to receive health services at home; 3) implementing new program arrangements through single-funding agreements, giving flexibility to address areas of need in the outer western regional and local communities; 4) providing over time the ability to target service gaps in service provision in order to meet the local community’s specific needs; 5) making it easier for patients to navigate the local health-care system; 6) providing more integrated care to improve liveability options; 7) ensuring more responsive local GP primary health-care services that meet the needs and priorities of the 160 different community groups in our local catchment area; and 8) making primary health care work as an effective part of the overall health system. A local response such as this is required in order to improve liveability options certainly in coordination with local hospital networks, local lead clinician groups and incorporating clinical governance frameworks.
There are seven ways in which these liveability options will then be rolled out, certainly in collaboration with 89 partner agencies, which include local governments, all primary schools in the catchment area, local hospital networks and community health services. These seven ways include, one, establishing effective collaborations between the hospital networks and local clinician groups once established to deliver more coordinated, integrated, locally responsive and flexible health services. Two, ensuring that patients and people transition smoothly in and out of hospital and receive the right care at the right place and at the right time. Again this is such an important aspect when we are talking about liveability options in not just the outer metropolitan region of Melbourne, but right across Victoria as well. Three, supporting the development of e-health and health information, including shared electronic health records, data provision, service planning, monitoring and evaluation. Four, improving the planning of primary health-care services to respond to local needs. Five, supporting the ongoing development of primary health-care infrastructure, including GP super clinics. Six, initiatives to increase and enhance the primary health-care workforce to meet local community needs. This has been engaged at the commonwealth level to look at improving access and access to the workforce by looking at 1000 after-hours medical staff to support community needs and improve liveability. Seven, initiatives in general practice and primary health care designed to improve disease prevention and management and improve access to services. These include measures to improve access to after-hours primary care and access to primary health-care services for older Australians. Such a plan could also be used by other agencies located in similar outer suburban interface regions of Melbourne to improve liveability options.

Specifically the Westgate General Practice Network population plan has been drafted in consultation with 89 other partner agencies. It is consistent with the legislative requirements pursuant to the Victorian Local Government Act and assists with the population health coordination between all five local government areas and the 89 partner agencies, which as we mentioned include state-funded primary schools. Such an approach is also reflected in the Victorian government’s 2002 environments for health municipal public health planning framework, and in addition the Westgate General Practice Network-lead Medicare Locals plan considers the influence of urban environments on population health and how urban development and urban renewal can improve health outcomes for communities by using clinical governance and population health indicators. Such an approach is supported by the Victorian Department of Health north-west region office.

We have identified that the western region of Victoria includes two major identified growth corridors and this was certainly covered in our submission both to this committee and to the Australian commonwealth government that we made in April 2011. We draw the committee’s attention to this submission, which considers economic, social and environmental matters that are directly related to a person’s health and wellbeing, but at the same time we stress that it is not an economic development plan or a comprehensive environmental management plan. Rather it provides a population health service plan designed to improve liveability options in the local catchment area. This is achieved through looking at the management of future growth, land use, infrastructure investment, health-care delivery and health-care coordination within the context of the social determinants of health. Such an approach ensures coordination and is designed to avoid population health planning duplication between all 89 partner agencies.

The plan has also identified that there exists health and disability inequities in this region, as the chair, Dr Joe Garra, has identified. Generally the main causes of the burden of disease were cancer, cardiovascular disease, neurological and sense disorders, chronic respiratory disease and diabetes. The main causes of disability were musculoskeletal and connective tissue. It was identified in the recent ABS data that Hobsons Bay City Council had the highest metropolitan rate of emergency department presentations, was well below the average GP-utilisation rate and had the average number of GPs. In order to improve liveability in this region, these inequities need to be addressed.

Such liveability option plans need to address health literacy programs and what we have incorporated as five pillars within the service architecture model. These five pillars are: one, incorporation of recent state planning and health policies; two, an examination of population growth and impacts; three, identification of the provision of medical, health and support services in outer suburban areas; four, classifying national and international best practice in urban renewal as it relates to clinical governance and ensuring quality of population health indicators are directors in the pillars that are used; and five, making recommendations through population health options for the enhanced liveability of residents within the catchment area.

In order to meet these five pillars the Medicare Local population health service plan that was developed in coordination and partnership with 89 partner agencies will cover seven areas and goals. These goals include
population health review; after-hours general practice and support; child youth and family; linkages with community health and hospital networks for strategic plans; mental health and wellbeing; oral health; and population health and chronic complex care programs covering areas such as diabetes and mental health and will also meet the needs of refugees and asylum seekers and the indigenous community. In order to achieve such goals under the population health service plans and improving liveability options, such packages aim to include flexible care packages that will provide the funding, quality and clinical governance requirements of such indicators.

The Westgate General Practice Network-lead Medicare Local population plan demonstrates how people will be able to get the right care at the right place and at the right time, thereby improving liveability options within the catchment area. It also means that people will be able to access better care delivered in the community and will also take pressure off hospitals.

In closing, in the development of this Medicare Local population health plan the Westgate General Practice Network, in consultation with 89 partner agencies, has developed coordination service plans to span the next 10 years. These plans have coupled local hospital networks and Medicare Local structures. This ensures that the primary, GP, community services and hospital parts of the system effectively work more closely together, thereby improving liveability options in the catchment area. The Westgate General Practice Medicare Local service model that has been provided to the committee enables the ability to also be used by other agencies located in similar outer suburbs and interface regions.

On behalf of the Westgate General Practice Network and our 89 partner agencies involved in developing this plan we thank the committee for extending an invitation to us. We hope committee members find this submission informative and thank them for their time.

The CHAIR — Thank you very much, Mr Samara. Before we proceed to ask some questions, I want to know if you have read the guide for witnesses presenting evidence in parliamentary committees?

Dr GARRA — Yes.

Ms SIEBEL — Yes.

Mr SAMARA — Yes.

The CHAIR — If you were given unlimited resources to improve liveability in outer suburban Melbourne, what are the first three things you would focus on?

Mr SAMARA — The key things that we would focus on are covered within our population plans. Certainly it incorporates engagements with partner agencies, and there are seven areas and goals that we would cover off, specifically around the after-hours child, youth and families services, linkages with local hospital networks, providing access to mental health and wellbeing, oral health and also population health and chronic complex care programs. The work that has been undertaken within the Medicare Local submission and also the framework in developing that outlines effectively the framework that we would look at incorporating over the next 10-year period.

Ms GRALEY — I think you mentioned a couple of times the well-below average number of GPs you have in the western region. What sorts of issues does your organisation face in attracting and keeping GPs in the region? I imagine it is just not you — it is the west. Maybe that is something you could contemplate for the whole outer area.

Dr GARRA — It is a good question and a difficult question. Council asked me the same question last year, and I almost said I do not know. One is getting GPs to live out in the west. At a rough guess probably less than half of the GPs practising in the west actually live in the west; most are travelling there. Why are they not living in the west? Often it is because of the same issues that other people do not want to live in the west. It is transport, schools and where they were born and bred. Country Victoria has the same problem — trying to attract GPs to the country. If it were not for overseas doctors the rural workforce would be right down.

We now have the University of Notre Dame Australia, which has set up a clinical school at Werribee Mercy Hospital. The hope there is that by having medical issues exposed more to the west, people will realise that it is
not a bad place to live and you can have a good career and there is plenty of work. It is not the lack of work that is the issue; it is the liveability of the region.

**Mr SAMARA** — In addition it is similar to what you may experience in other areas. There is a workforce shortage.

**Ms GRALEY** — Shortage, yes.

**Mr SAMARA** — There is an ageing workforce. However, in saying that, one of the challenges that the network has worked very closely on with clinical schools, University of Notre Dame Australia, Victoria University, Monash University as well as with our state regional health department office and the commonwealth was to provide and seek to attract clinical training positions for GPs, both medical GPs and medical specialists, and also nursing support staff to try and at least overcome this issue that we have currently with workforce demand. One part of it is certainly around clinical training. The other aspect of it is ensuring that those practitioners who are effectively trained in the area will also remain in the area.

We are expecting though as part of this program, because it is a whole-of-region approach, that while there may be clinical schools established and partnerships set up with a range of providers, it may also create a process for GPs and new trainees to acquire the skills they need. Purely because of the state of affairs of workforce shortage across Australia they may end up moving elsewhere, so we do need to create almost a workforce capacity in this area to address other regions in outer suburban Victoria as well.

**Ms GRALEY** — To follow up on my question, your professional organisations — the AMA, the GP — —

**Dr GARRA** — Training bodies.

**Ms GRALEY** — Yes, training bodies and things like that. I know there are extra medical students going through now — I think through the Tasmanian campus and the Deakin campus. How does the profession and the attached organisations feel about even more students being funded?

**Mr SAMARA** — With more students effectively it is not undergraduate students; it is training a population group of GPs that needs to be upskilled into their specific areas. So we do have partnership arrangements being looked at with New Zealand schools where staff may come from other areas or require upskilling into a particular area — for example, practice nurses who may have left the workforce but who are wanting to come back. Now with the nationalisation of registration boards that look after medical registrations, nurses et cetera, there is the opportunity for other areas and from other states to attract a workforce as well. It is not filling the bucket from one side and taking from the other. What we are actually looking at is to upskill not only the GPs who provide one particular service, but also the entire catchment area such as integration with hospital networks, integration with podiatry and the idea of accessing what they call flexible care packages through the commonwealth initiatives. The entire health system actually needs to be a lot more integrated rather than simply looking at point-of-care only. That is how we are taking a very much system-based approach to looking at improving liveability in the region.

**The CHAIR** — In addition to this integrated approach relating to the shortage of GPs, what about other allied health professionals — dieticians, physiotherapists?

**Dr GARRA** — There is a shortage of those as well — for example, there is a shortage in physiotherapy. The Werribee Mercy Hospital has a long waiting time for people to get into physiotherapy there. Hopefully, with the formation of a coordinated network you then better coordinate the services, so there is better use of the existing services and you then add to them. There is a shortage of allied health in the area.

**Ms SIEBEL** — For example, there is a major shortage in psychiatry. We have two part-time psychiatrists across the Hobsons Bay and Wyndham area. What we have done as a division of general practice is move out of the scope of divisions where divisions just support a general practice. We have set up a primary health-care service that acts as a referral base for all of our GPs in the area. We have brought in people from outside professions — allied health from outside. We take in nursing students. We mentor those students to provide advanced skills in nursing — for example, broader numbers of diabetes educators. The framework is like a super clinic where a patient can come into that service with diabetes, for example, see a diabetes educator, have their insulin managed, have their diet requirements managed and have a podiatrist look at their feet. It is a
team-based approach to care. We are trying to bring in people from outside the area to try to develop a referral base. We know that the community health centre waiting time is very long; to see a podiatrist is something like a three-month wait. Why is there a psychologist? Most of the psychologists charge quite high fees so we have had to bring in people who bulk bill, for example, and who have agreed to bulk bill. There are hardly any exercise physiologists in the area, and the ones who are there do not provide exercise equipment for people to actually have some behaviour modification strategies implemented in their care.

**Mr SAMARA** — As part of a 10-year projection plan we look at population growth, and certainly the newspapers have been favourable in their views about the western growth corridors as well — both of them. When we look at the projected population growth, not just of new houses in the area or developments, effectively what we are looking at is a health system that manages and can cope with that expected growth from the 60-odd nationalities that exist within the area and where effectively the population will be in 2 years, 3 years, 4 years and in a 10-year period and looking at a system that integrates rather than looking at point of care, ensuring that people can effectively get the right care at the right time. We also look at the ageing population too and are already working with aged care and retirement villages in order to forecast what services people in this region will effectively require. Going back to your first question, when we are looking at funding arrangements it is almost looking at setting up a system to allow the virtual infrastructure growth of the population to ensure population sustainability.

**Dr GARRA** — Just to add to that, with the allied health we have also in a submission approached two of the local large private physiotherapy clinics to join, rather than just the public system because they consider that there is also a role for the private sector to help provide services to the region.

**The CHAIR** — Is there any dialogue with, say, Victoria University?

**Dr GARRA** — Yes.

**Ms SIEBEL** — Yes.

**Mr SAMARA** — Yes.

**The CHAIR** — I understand the clinical arrangement with Notre Dame in the setting at the Mercy in terms of encouraging people to have a western region experience, because there are probably some unique health-care elements in that that you could actually put a proposition based on some of the unique elements of the experience there.

**Dr GARRA** — We have placed nursing students in clinics in the western suburbs through Victoria University already.

**Mr SAMARA** — Victoria University is also a signatory partner with this particular — —

**The CHAIR** — Of the 89 — —

**Mr SAMARA** — Of the 89 as well. Certainly they have been very involved in the engagement with the Westgate General Practice Network even in clinical practice programs as well as another health support program such as information technology, research projects, looking at the e-health collaboratives as well. They are certainly involved the Westgate General Practice Network.

**Ms HUTCHINS** — My area is Keilor so it straddles both Brimbank and Melton. My question is pretty specific around those areas — that is, the connection between chronic diseases and liveability in the outer west. Having read the health reports of those two councils I know how severe it is. For the rest of the committee I ask if particularly you, Dr Garra, could make some comments around that.

**Dr GARRA** — About the chronic disease or — —

**Ms HUTCHINS** — About the level of services available.

**Dr GARRA** — Yes, it is definitely increasing dramatically. We are seeing a lot more people with, say, diabetes, and in the ones who are getting older we have people with arthritis and people in nursing home and residential care facilities. Quite a lot more time is required to provide a service to those populations, especially
even just for distance travelling. If you are trying to do a nursing home visit you have to allow sometimes an hour to go and see one person in a nursing home — for the time to get to the nursing home, sort out their multiple issues and then get back. There is the time factor and the distance travel and the level of the multiple diseases.

With the other liveability thing, there are now more people moving into nursing homes who do not have the social support as well in the outer suburbs. A lot of people are what I call socially isolated. Even though there are lots of people out there, often if you ask, both old or young families, ‘Where is your nearest family member?’, they could be on the other side of town or 20 kilometres away.

The CHAIR — If we are looking at issues of social problems and isolation, I would be happy for any one of you sitting here now to make a comment about the effect of family violence and its impact on health services and mental health services.

Dr GARRA — I know from just talking to patients who are policemen that one of their biggest call-outs in the city of Wyndham is for domestic violence rather than other crimes. There are a huge amount of domestic violence issues in the west. Again that leads to social isolation and the depression that follows on from that and the anxiety, and they do not have the ability to access that care; it is not easy to access because it is under so much demand in that area.

Mr SAMARA — On the family violence, effectively that is one of the program plans that we have covered within the population health plan, specifically around trying to alleviate and address those issues as well at a multiple number of levels. It is certainly one of the core areas that we have projected out with the partner agencies.

Ms McLEISH — I want to concentrate a little more on the social factors that Jan was just referring to. What factors do you think are the most important in regard to liveability but also looking at that social element in the outer suburbs?

Dr GARRA — Work, travel — —

Ms SIEBEL — That is right, the travel — —

Dr GARRA — Most people travel out of the western suburbs to work — the majority. The City of Wyndham states that more than two-thirds travel out of the city of Wyndham daily to work. There are a lot of young families where, often, both partners are working. There is the work issue with access to health services.

Ms McLEISH — You hear a lot about the problems that late teenagers and young men have. Is there anything you can comment on with regard to the liveability and services for that group of people?

Mr SAMARA — The issue that we see in the west is that because there is such a wide variety of nationalities, and also with this spread of population, sometimes it is not so much around whether the services exist to support them but whether they are even able to access those services, purely because of the wide spread of the population and based on where the services actually are. In some cases there are community health or hospital-based services to which people are simply not able to travel because of the way the growth corridors are effectively developed. It has been flagged with the Victorian Department of Health, and they are looking at people flow, where you may get people who are located in Melton, for example, who are actually accessing services in Wyndham, and vice versa. The issue is not so much whether the services do not exist but where they actually are and how they could arrive at receiving those services. When they are there they often are sporadic in nature, knee-jerking to try and address an issue they have rather than trying to look at a whole population group.

Ms McLEISH — You were talking about the flow. What are the reasons people are accessing different areas, and vice versa? What are the factors that impact on that?

Mr SAMARA — Where they are located.

Ms McLEISH — Is that — —

Mr SAMARA — In both; where the services may be located as opposed to — —
Ms McLEISH — Are you talking about main roads? Are you talking about in shopping centres?

Mr SAMARA — It is wider than those. It is effectively looking at the linkages between infrastructure development, population health resources — where health services are actually located — as well as the existing communities themselves. Certainly as part of the population health and epidemiological review we even went so far as looking at specific communities within the local government areas. I looked to identify, for example, in Hobsons Bay a specific area that was 55 years or older and what types of nationalities reside in those areas, and then looking to work with local health-care providers in making recommendations and saying, ‘These are possibly the services that need to be placed in those regions’.

Similarly, with respect to what you are speaking about, where we could identify family violence issues or young adults requiring services, again looking at population spread and looking at placing access to services in those regions and effectively providing a varied health literacy-type program by providing services that are not generally health-care related but much more health literacy-based and saying, ‘This is how you access and this is where to access those services’, and effectively finding the services for the right people at the right time. There may well be services that are required but they do not need to be admitted to hospital. Effectively their issues could be addressed by GPs, by local community health centres or even by those services that are run through primary schools at the moment, providing services through the local school mechanism as well. That is what we are looking at here.

The CHAIR — Is there a place for mobile services such as x-rays and opportunities to educate in the area of preventive health?

Mr SAMARA — Absolutely. With mobile services I guess we are taking them to be more than simply a bus that goes to a particular service, although we have looked at those options. One of the other mobile services is now with e-health initiatives where even access to mobile phones could be a mobile service, for example. Certainly a lot of GPs and other health-care providers are exploring those types of initiatives at the moment which will open up new avenues, particularly for children, youth and families, to access those types of services.

Mr ONDARCHIE — Following on from the Deputy Chair’s comments, Dr Garra, many practitioners in general practice tell me, ‘We are just small business people trying to run a small business’ and generally small business people follow the market. I am having trouble understanding why small business people are not following the market out to the west.

Dr GARRA — Because there is no need to. There is enough work in the inner suburbs to keep them going at the moment. There is a general practice shortage everywhere. I will give you just one example — a specialist example. We are short of obstetricians to deliver babies out in the west and one of the local obstetricians convinced a young graduate to come out and work at Werribee Mercy Hospital. He was all enthusiastic when the hospital said, ‘We will pay you $600 for every time you deliver a baby’, and he thought, ‘Okay’. Then he booked his first private patient in town and got $5000 and thought, ‘Hang on a minute. I can do one delivery privately for the price of eight public patients at Werribee’ and he quit. He lasted a month. He did his sums and thought, ‘I do not need to work out in the western suburbs. I can work one-eighth of the time for the same amount of income in the city’. It is market driven. Until there are a few more doctors there is no need for doctors to practise in the outer suburbs or even rural Victoria unless you practise there by choice because you want to, which is what some of us have done.

Mr ONDARCHIE — I would have thought that with 160 different nationalities there might be some family connections.

Dr GARRA — Yes, that is how I got there. I am an ex-Altona boy who ended up working in Werribee, but that is not the case for most of the people there.

Mr SAMARA — In addition it is not just the GPs. Equally you see these long waiting lists in other areas: hospital networks, community health centres and publicly funded services. The primary health-care service chronic disease program run by the network also has a waiting list. It is not a waiting list purely for people to come back and see us again; it is a waiting list for people who have not received services they require. This is the major issue seen right across Victoria and obviously Australia as well. One of the issues we see in outer suburban interface regions is that even from a classification point of view it is not quite metro, it is not quite rural, it is not quite semi-rural; so there is this urban void, if you like, on even trying to attract health-care
providers into the region. This is purely because when you talk about financial benefits some of the incentives provided under previous schemes have effectively focused on either the metro, semi-rural or rural, depending on where the — —

UNIDENTIFIED SPEAKER — (Inaudible).

Mr SAMARA — Exactly.

Ms GRALEY — I think that is true. I was involved in the gallery once and it did not qualify under regional or metropolitan because it was in the interface. It is almost as though you need a pool of funding for interface areas.

I am quite interested in preventive health and I am very pleased that you have adopted WHO’s charter and social model on health. I was wondering if you could take a helicopter view of the western suburbs and not just see all doctors and services but what would the western suburbs, the outer suburbs of Melbourne, look like if you were trying to develop a preventive health environment that people could live in. I remember John Thwaites when he was health minister being out at the Western Hospital saying that if the obesity epidemic were to continue at the current rate — that is, we do not exercise, we get fatter, we eat more, and those sorts of things — they would have to build another Western Hospital within 10 years, I think it was. What sort of planning — —

Mr SAMARA — Did the committee receive the Medicare Local service architecture document as part of the committee documents?

The CHAIR — Yes.

Mr SAMARA — Effectively within that is really the high-level plan we are focusing on. It is more than simply GPs; it is more than hospital acute. It is when we really talk about integrating population health issues. At the highest level what we are looking at doing is for the first time in many years linking the planning policies directly with population and health directives at the Victorian level and at the commonwealth level as well and integrating the education frameworks, utilising such things as the TAFE sector, upskilling the existing workforce so it is almost a three-part approach to population health preventive planning.

Ms GRALEY — Mr Samara, if they wanted to do an extension of Caroline Springs or something like that, one of the new suburbs, would you sit down with the developer and say this is what is needed? I think it should get down to that sort of level.

Dr GARRA — The councils have joined us. All five local councils have agreed to work together with us in the Medicare Local so we would have an input that way. The local schools have joined us.

Mr SAMARA — And certainly from a health and wellbeing plan, from a strategic planning point of view we have worked with and received signatories from the five council regions, which is a big step, and at the highest level in terms of looking at their municipal planning framework, so it is consistent with the planning aspect of it. Secondly, it is around working with local hospital networks — again, strategic planning in how we actually manage that integration from a population health planning point of view; of course with all 54-plus GPs clinics at this stage who have signed in to again work from a preventive population health planning angle; and also involvement with the education side of the region, being the primary schools, the universities and obviously incorporating the clinical schools. You have those three parts being part of a strategic planning framework to address just those issues in preventive medical approaches.

Dr GARRA — And the regional officers of the health department.

Ms SIEBEL — I think the density of the housing — if you look at Werribee, the houses are all sort of clumped together. There are no open parks and gardens. The community festivals could be better utilised for preventive messages, doing health checks or giving out some messages to young people about being smart in the sun or STDs or whatever. You can utilise those community festivals more in terms of getting some of these messages out to people.

Another area would be bicycle tracks — those types of things are needed in the city — or walking groups for young mums who have babies and cannot access child care, for example, because of the long waiting lists for
child care. Could they perhaps take their prams and go for a walk with the pram? It is that type of thing. There are lots of things they can do to get people out there into the community so they do not feel socially isolated, so they can go shopping and have somewhere to park their prams. I think these are the things you can do to get people out there.

Mr SAMARA — And part of it also, when we were looking at planning, is that it is not a one-way plan where we sit down just with councils, hospitals and GPs and look at planning a strategic plan over a 5 or 10-year period. It is also feeding the information back around clinical indicators — and this is in the submission — around what is the live data we are seeing; even population health indicators as well, back to councils, back to the Department of Health, again to enable them to look at liveability options so that they are starting to actually see as-live-as-possible data rather than relying on data that is possibly aged in some way and then trying to build off where we go from there. They should look at effective indicators as well.

The CHAIR — We have come to the end of our time, with the extra allocation to each of you for the later start. I would like to thank Dr Joe Garra, Nihal Samara and Corinne Siebel for their contributions today. There will be a transcript available of these proceedings in about two weeks time. You are entitled to make changes if you find typographical errors but not anything of substance within that transcript. We certainly appreciate the fact that three of you have come to represent the network and for the contributions you have made today, so thank you very much.

Committee adjourned.