Kilaben Bay, NSW 2283
2010-09-15

Productivity Commission
GPO Box 1428
Canberra City ACT 2601, Australia

Dear Ms, Sirs, Drs.

To the best of my knowledge the Productivity Commission is in the process of reviewing "Caring for Older Australians" and "Disability Care and Support". This letter addresses both issues.

I am a biostatistician employed by the NSW Health Department, previously having worked and lived in five other countries, usually within some form of health service. This information is mentioned to provide some type of professional reference. Firstly, a review of some contemporary public domain history of The NSW Health Department will be outlined, then a few suggestions as to its possible amelioration.

In 2005, the State of NSW revamped its entire health system. The appointed Director of Health was a nurse with three years of secondary education and hospital trained. The Directorship was secured by a union payment to the Labour party of two million dollars (Sydney Morning Herald). This one action set the entire agenda for the NSW Health Department to this day. The health model implemented was that of hospital-trained nurses prior to 1978, a process-acute-care model. This model can be summarised as; sick patient, diagnosis, put on conveyer belt for that aliment, and tickety-hoo, outcomes are produced. An entire bureaucracy has been, and will continue to be created to address this process model, and as the present Primer of NSW has stated that in ten -years the entire state budget will be consumed by the Health Department (ABC). Unfortunately, the NSW Premier is correct, the growth in the bureaucracy, not the service providers, has grown and will continue to grow at 30% per year, in five years that is nearly a 200% increase in "administrators" (The Australian). The additional levels of administrators are involved in processing "information". This "information" is internal generated, and processed in a variety of programmes, e.g. the Maggie Programme, Balance Score Card, CHIME, with the exclusive goal to make the 'system look-good.' A former Premier of NSW, Iemma, on TV stated that, "not one word from the Health Department could be believed." The State's Garling report was and still is entirely correct, self-interest is pervasive. The process-acute model functions at the exclusion of all other approaches. An alternative model to the present process procedures can be additive, or ancillary, but any alternative will not be investigated by the present administration, the educational wherewithal is absent coupled with recalcitrance emotive desire.

I conducted, in 2005, a demographic study of one of the eight NSW health regions; by 2012, the State of NSW would consist of 19% of the population being over the age of 65. The state region in question, being a desired retirement area, would be approximately 28-30% populated by people over the age of 65 years. A crude formula places one form of dementia, Alzheimer's disease, at 14% of the aging population. In 2005, the same demographic study, strongly suggested in five years

the system will be over-whelmed by dementia patients costing $40,000 each per year in 2005 dollars, and planning needed to be considered. Basic arithmetic reveal, a approximate population (800,000 x 28% x 14% = 31,360 cases of Alzheimer disease x $40,000.xx) = $12,544,000.xx / year for the acute care of Alzheimer's disease only in just one of NSW eight health regions. This analysis is devoid of the other sixty plus forms of dementia. The acute process model does not plan, it reacts to the immediate needs for more assembly workers and resources, which of course do not exist, and never will exist in the numbers needed by this model. One possible adjunct approach is the person-centred model, a chronic care approach, is in-part pre-emptive via risk-assessment and prevention or delay of onset.

A chronic-care approach will not be contemplated by the present NSW health bureaucracy, quite the opposite, recalcitrance to any change is institutionalised, the Garling report. If the present Health System can every meet the health demands of our aging population is more than doubtful and at what financial cost. Introducing cosmetic changes, another layer of bureaucracy over the present system, or local committees to control the local health service will not sponsor the necessary changes; the present administration is incapable of even rudimentary change. Radical change is needed. New conceptualisation of a health system is needed and implemented.

Suggestions. The present administrative personnel to be resigned back to positions suited to their very basic training. A new administration appointed with fixed varying longevity contracts and will not be reappointed; therefore, decisions will be made for professional service and not to endear and implant myopic self-interest into a permanent position. No administrative permanent positions exist. The administrative head is now a small collective of three, each with different educational backgrounds, differentiated from training, e.g., health sciences, cybernetics, organisational psychology, or information technology. Some form of acute care will be needed, but chronic conditions, identified and serviced before becoming acute, needs to be the focus. As stated before, the present administration lacks the educational wherewithal and the desire to attempt this modest transition to chronic care from pre-1978 acute care.

The above are but a few reflections of a biostatistician and are meant to offer construction changes to a health system in urgent need of redemption. Thank you for reading this letter.

Sincerely,

Ronald Hicks, Ph.D.