Submission to the Legislative Council Select Committee of enquiry into the Resourcing of the State's Hospital system and its ability to deliver acute services.

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I thank the committee for the opportunity to make this submission and to assist your process; I have followed your terms of reference where possible.

However it will be useful for the purposes of the committee and its possible conclusions, if I now place two fundamental themes on the record.

1. Hospitals are a logistical operation.

Most people confuse the operation of hospitals as being like a retail function in that the patient turns up at the hospital, gets served and then goes home.

This is not what happens for the vast majority of Hospital presentations, by Tasmanian Citizens, at Hospitals owned by the Government of Tasmania in other word owned by the Citizens.

This is the fundamental reason that we have waiting lists, because the State owned hospitals cannot cope with the unscheduled demand for treatment.

There is no particular reason to have these waiting lists at all, and failed past policy has caused us to generate misery to fellow Tasmanians, who cannot access acute care surgical or other treatment due to the logistical mistakes.

We have to a large degree brought this upon ourselves, for not recognising that the State of Tasmania does not need to run its hospitals in the way it does.

However no one does anything about this, and it is a more of the same failed policy going forward. It results in the same results and an increasing waiting list that become more and more loaded with chronic patients who turn into emergency surgical patients. Costs thus increase not decrease as emergency surgery costs twice to three times as much as scheduled surgery.

Hospitals operate to treat patients, and mainly for the State Hospitals, this is acute case management, not elective day surgery, case management.

One is not planned and the other one absolutely planned to maximise resource utilisation.

The idea that someone in an ambulance presenting at one of the State owned acute care hospitals, is in anyway similar to private sector hospital admissions, is delusional.

Acute care admissions in Tasmania to public hospitals, are now becoming more acute, and the use of bed stay days becoming longer per patient, as logistically the flow into the hospitals has become to a large extent unpredictable and certainly is becoming unmanageable.

If this is not the case then why are we having this enquiry by the Parliament.

The RHH and the LGH have for the past 2 years been unable to cope without significant escalation functions in place almost daily.

This is not good for patient welfare and for patients read the citizens of Tasmania.

Ambulance ramping is now commonplace, as DEM capacity to service the demand is now constantly breached.

In summary the logistical base of the hospitals has been overwhelmed and clearly the capacity needs to be increased by around 20%.

2. The present Tasmanian Government is managing the problem!

Currently a recurring theme is presented to the public in that the Government of Tasmania is managing the problem of resourcing the major hospitals.

This is clearly not the truth of the matter, and if it was the truth, then this enquiry by the Parliament would not have to be held.

The Government is not managing the problem and the responsible authority the Tasmanian Health Service (THS) has been an abject failure in all respects.

The Government has diverted funding from the hospitals to other areas of their political interest, and it now shows up as a lack of resources to treat Tasmanian Citizens in the hospitals that they own.

Thus in summary terms the Government of Tasmania has failed the very Citizens that it is supposed to look after.

No amount of public relations spin can detract from this basic fact which the community now fully realises.

Your terms of reference and my evidence:

1. The current and projected state demand for acute Health Services.

Firstly Tasmanian population growth is in real terms nonexistent.

Tasmania is 2.1% of the nation, and is only growing at 0.58% pa, where as the rest of Australia is growing at 1.55% or 3 times our growth rate.

The population change in the past decade is thus:

2007	243.7	249.6	493.3	*0.81%*
2016	258.4	260.7	519.1	*0.48%*

In overall terms there has been very little change in the overall population of Tasmania, but what has changed is the composition by age of our citizens.

We like most Western and indeed Asian countries have become older generally, and now Tasmania has the highest by capita component of older Australians per head of population that anywhere else in Australia.

The demand for hospital services is driven largely by this fact.

Projected demand will now continue to rise exponentially against diminished resources. Waiting lists for elective surgery in State Hospitals will grow much greater, and public pressure will see this fact more readily recognised.

In fact this enquiry will go a long way to letting the public know of the lack of commitment in fixing the problem.

It is estimated that the acute medical service demand in Tasmania will grow by 20% over the next 5 years. If current hospital resources are not increased they will be overwhelmed.

We are living longer and diagnostic imaging is becoming much more readily available. Gene shear drug technology is providing treatment options that were not available 2 or 3 years ago.

Projected demand:

This increased demand of around 20% over the next 5 years will impact upon the hospitals with increasingly chronic acute presentations, and mean that there will be no elective surgery performed in the two major hospitals being the LGH and the RHH at all, if resources are not increased.

In essence the resources needed are some 200 medical surgical beds activated and funded and staffed between the RHH and the LGH.

The projected day surgery centre at the MGH is again achieving some gains with lower level procedures, but the costs may exceed such service costs if they were purchased directly from the private sector.

How the Government controls demand:

I now turn to examples for the committee to understand in respect of the impact of the present policies of the Government.

Currently the Government uses bed numbers to control costs, so it ***closes beds*** on the belief that they are doing what the people of Tasmania want.

Of course the citizens feel that the Government do not understand what they want.

They want the hospitals to work properly. The lack of beds means that they do not work properly.

The average citizen no longer believes what the Government says about the Hospitals and clearly this is reflected in this Parliamentary Committee's terms of reference.

Now the committee will look for examples of the lack of funding by the present Government and a simple one is overtime and double shifts.

This is caused by under-staffing especially of nursing positions, due to the decision by the Government to close beds over the past 3 years.

Lack of Medical surgical beds sees all the hospitals under provided and understaffed, for the mean patient loads which are now 98%.

Present Government funding has the Hospitals staffed for a patient load of 83% based on reduced bed numbers.

This manifests itself in double shifts and constant overtime.

If the staff were employed to cover this workload the overtime bills would drop down substantially.

2 - Factors impacting upon the capacity of each hospital to meet the current and projected demand in the provision of acute health services.

(a) Lack of information to the patients General Practitioner at discharge.

The committee may or may not be aware, that very little information is sent to your local GP after you have been in one of the State's Hospitals. No reporting really at all.

Indeed notwithstanding a massive salary bill of some $45m for the Management team at the THS, there are no patient separation reports going to GP's. They spend the money on superfluous management positions that deliver no value care at all.

Usually the GP finds out what has happened, when the patient turns up to see them after being in hospital. There are no records sent to the GP's.

It is estimated that this results in some additional 10,000 presentations per annum alone at the RHH that may or may not have been needed, as the GP has no medical records of treatment provided by the hospitals, and thus has no alternative but to send the patient back to the acute hospital.

This is a relatively easy issue to solve and all medical practitioners have email and fax machines. All private hospitals actually send the GP a discharge report. These reports would be cost effective and remove 10,000 presentations with that attendant cost alone from the RHH annually.

This need is easy to fix and cheap, but clearly not a priority of the THS. Why worry about the citizens of Tasmania?

(b) Ministerial interference in the employment of Specialist Medical Practitioners.

A second factor that impinges upon the capacity of each hospital to meet demand is the lack of understanding by the THS of the real costs of gaining the services of these specialist medical practitioners, and the Minister for Health, who also appears to interfere in staffing matters in respect of the employment of Medical specialists.

The Minister apparently instructed the THS that “there were to be no special deals for doctors” and so the staff carried out this instruction.

The committee should ask for his instruction to be provided to them.

As a result very few were employed. They all jumped on the Locum bandwagon where salaries are appropriate.

The huge increase in locum expenses is the result of the interference of the Minister for Health and now this is the only way Specialist Medical practitioners can be attracted.

Most locum charges are at least double what a high end salaried doctor would be paid.

Recently the LGH has lost its accreditation from the Royal Australian College of Physicians as the THS would not employ another Endocrinologist to supervise training. Endocrinologists are easy to get they said!

The only endocrinologist in the north has now left and now the LGH faces the loss of 25 medical school trainees in 2018, as there is no person left to supervise their training.

Who would want to train at the LGH, when that training is not accredited? Why waste a year and of course inter-state medical schools are now well aware of this.

At the same time the THS has not appointed Physiatrists to the RHH and thus no physiatrist training can now be accredited at the RHH.

It appears to be an own goal as the CEO of the THS is a Psychiatrist.

The THS blame the Government, but the head of DPAC is quite willing to put employment packages together for "hard to find" medical specialists. Thus the THS Board is to blame.

In all respects the THS and its so called Board of Management is totally responsible for this debacle, and no amount of obscuration will change the facts of the matter that they cannot employ salaried medical officers readily.

(c) Lack of capital to replace patient treatment and monitoring equipment.

Lastly the lack of capital for equipment is now impacting upon patient care, across most of the Hospital sector, as vital patient monitoring equipment fails at the end of its life, and is not replaced, as apparently there are no funds.

Charities are now being asked to fund replacement by desperate nursing staff. This has occurred at the RHH.

This means that the huge overspend on the management team at the THS is being paid for by the capex budget for equipment being stripped of funds.

(d) Lack of political understanding of how suffering is inflicted by the cancellation of elective surgery when demand exceeds supply on a daily basis.

Each hospital has a finite capacity to provide services but most are understaffed to the extent that full functionality of the operating theatre suites is impossible.

For example the RHH has around 14 operating theatres but has only staff to open and use on average about 8 of these theatres.

The LGH has a similar constraint, and so although a lot of taxpayer funds have gone into the equipment of these hospitals it is the policies of the Minister for Health, and the present Government that see's them wholly crippled from being able to deliver services to Tasmanian's.

Thus clearly the Government is aware that it is creating misery for a lot of people, indeed over 30,000 are on the waiting list for elective surgery, but yet they are not motivated to actually generate the funding needed to operate the present facilities so that some of this misery can be alleviated.

This is central moral argument and the present Government is quite happy to generate suffering and misery rather than increase the supply of hospital beds within the present facilities and staff then correctly to a 95% loading rather than shut beds.

Indeed it appears to me that the Minister for Health has failed in his duty of care to the people of Tasmania. There can be no other reasonable explanation. He is responsible no one else is responsible.

2. The adequacy of current funding arrangements.

The present funding arrangements have seen $230m stripped out of the Health budget to fund more pressing Government priorities it seems. In real terms based on the caseloads and the real spends reported to Parliament, the Health Budget is now a mess.

If no more tax dollars are available, then $230m of cuts other Government functions needs to found, or else both the North West General and the Mersey General Hospitals need to be shut down to fund health care in the remaining hospitals.

This is the grim choice, which I am sure the committee will identify readily.

(4) Level of engagement with the Private Sector for Acute Services.

The public sector in Tasmania rarely gives any thought to the delivery of Health Services by the private sector and essentially only when the Hospitals are in crisis does the private sector get a phone call.

A constant refrain is that the Hobart Private Hospital gutted beds out of the RHH is a lie, as the Government of the day took the opportunity to not replace the bed space leased to the private sector that spent tens of millions on refurbishing the run down Queen Alexandria Hospital building on the RHH campus.

Thus there have been only recently tentative arrangements made with the private sector to take up the load for elective surgery, as the THS has attempted to spend the last of the Federal funds for elective surgery improvement by engaging the private sector.

Too little and too late!.

One of the prime reasons that we have large elective surgery lists is that no private sector surgical services are sought, quite the contrary.

Perhaps the committee can explore this but it is a THS Board failure with no leadership at all in this area.

(5) The impact and extent of factors contributing to adverse patient outcomes.

This is the blind Freddy question – as you should ask each of the 30,000 plus Tasmanian Citizens on the waiting lists how they feel about an adverse outcome.

Governments are supposed to serve the people, not create misery and adverse patient outcomes.

If the committee can do something about adverse outcomes then it will have achieved its aim.