THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON THE PUBLIC HOSPITAL SYSTEM MET AT HENTY HOUSE, LAUNCESTON, ON THURSDAY, 19 FEBRUARY 2009.

Dr BERNI EINODER, DIRECTOR OF SURGERY, LAUNCESTON GENERAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - A special welcome to you, Professor; it is good to have you here giving evidence to this committee. I think you have been given some information on select committees. I mention that, if at any time you would feel more comfortable about giving evidence in camera, please raise it as we can take evidence in camera in certain circumstances. Everything that is said today to this committee is protected by parliamentary privilege. It is recorded and can be referred to by this committee. Also you are able to speak freely generally about any issues to anyone outside this committee, but please do not refer specifically about the evidence you give to the committee until a report has been published by the Legislative Council.

We have received your written submission and all members have read that written submission. Now you have an opportunity to give us any more information or evidence or to refer to some issues from that submission.

Dr EINODER - Thank you very much for the opportunity to do this. As you know, I came to Launceston in 1975 and, except for 14 months, I have been here ever since. I have a vested interest in the welfare of the people in our society and in particular the Launceston General Hospital. I think it is obvious to everybody that things have changed enormously in the past 20 years. First, we are keeping many more people alive and the ageing population is outnumbering the younger population. The second point is that the change in lifestyle means that there are a multitude of new problems now arising because of the way people live - like quad bikes, fishing, flying, et cetera - so the need for more services is indisputable. Everywhere in the world exactly the same is happening and it is no different here.

Unfortunately, our population has unrealistic expectations of what we can provide for them because before every election the average politician promises more and more for nothing and after the election we get landed with the budgetary restrictions. The patients get promised free treatment and we end up having to select who will get it so. On average, the service providers are the ones who catch the wrath of the patients who have to wait or who get turned away.

The number one problem as I see it and where you can make a significant difference is the governance of the organisation. The problem is it is top-heavy. We have problems not only in the poor communication between the horizontal level of any governance but also the poor communication between the vertical level of the governance. There is too much paperwork and not enough face-to-face discussion where everything could be solved in a free and frank discussion; with paperwork everybody protects themselves so nothing is out of the ordinary. It is all done just well and politically correctly, et cetera. Invariably no information gets through that is going to make any difference because you cannot ruffle feathers in writing, you can only do it when you talk to people face to face.

In the Launceston General Hospital we do not have the resources, either in the CEO's office or in its different corporate sections, to effect and finance a change. We have to do all the homework without any resources, put in business plans without any resources and then we send our proposal with the business plan south where a vast number of bureaucrats scrutinise our proposal, criticise and send it back and say, 'Not good enough'. They have the resources, all the bureaucrats employed to write up a proper proposal, why do I have to do it? I am a surgeon, I want to operate and that is what I am trained for. I get sent back the business plan, for example, to open another theatre or to buy a new steriliser, again and again.

I think a classic example is the Contract Review Committee, to which we put in some years ago 96 proposals and we had to put them in again and again. Eventually we asked the minister if we could have a meeting and at that meeting the then head of the Contract Review Committee said, 'Well, what are you complaining about, Berni, we let 94 of your proposals eventually see the light of day?'. I said, 'The conclusion is obviously you have to give yourself the sack because if there were96 and 94 made it, it means you were only effective in 2 per cent of the time. Fair go. You have an employee who makes a difference in 2 per cent of the time. That whole department should disappear because it is just so obvious it is not cost effective. If I did make a mistake 2 per cent of the time and somebody made me aware of it we would be happy to immediately change it. So that is the problem with governance.

The next one that I want to mention, and I am happy to answer your questions any time you wish to interrupt -

CHAIR - If members do have questions as Berni is going through this summary I think we ought to come in and ask those questions at the time.

Before I commence, I welcome the people in the gallery. This is a public hearing and it is good to see your attendance.

Ms FORREST - I have just one comment. Dr Einoder, in regard to what you said about lack of resources for you as a commission to develop a business plan and budget as you are required to do, you said in your submission that you must include practising surgeons on committees that make decisions about clinical services. There is certainly some merit in that. If you have administrators or bureaucrats prepare the business plans and things that you say that you are required to do but do not have the resources for, is that likely to meet the commission's requirements because they are administrators, not commissioners? Secondly, if you have practising surgeons on all these committees relating to surgical services, are you actually compounding the problem by taking them away from clinical practice?

Dr EINODER - In answer to the first question, if we need a new steriliser because the old steriliser is not functioning normally anymore, we do not mind doing the research of what steriliser is the appropriate one for our hospital considering the increased demand on the steriliser. Then we have to put in the proposal, we have to ask for tender documents, we have to work out the tenders. We have to do all the paperwork. We have an organisation down south that is smart enough to interfere with everything else we do, so surely they could do that for us. Then I would not have to get it back all the time to dot the i's and cross the t's because they can do that. They can come back and say they

have three proposals and ask us which one of the three we think is most appropriate. I might say, 'This one is out but these two we will go for.' Then they might say, 'We are looking for another for the Royal Hobart Hospital. The Royal Hobart Hospital wants to buy this type and you want to buy that; how about we buy two of the same and we will get them cheaper?' Chances are we will say yes, but the fact is that nothing is working together. We are all doing it ourselves and we keep getting bits of information back to say we have not done this right, we have not done that right and six or seven months later we finally get another 'You haven't done this right' and, as with the steriliser, nearly two years later we finally get what we wanted to start with.

We have to get a minimum of three tenders and there is only one business in Australia that makes them. The stuff like that is nonsense. The clinician knows this but the rules are that you need three proposals. We should decide what we need and the bureaucrats should do the paperwork; not the other way around.

Mr WING - I think in the past you probably had problems in having authority to repair equipment. Have you been required to go to the expense of actually replacing equipment that could easily be repaired more economically?

Dr EINODER - I do not know what situation you are talking about but it may be possible that we have had one or two occasions like that. But, as I said before, in 94 out of 96 cases we got what we wanted after all the hard work. If we make a mistake, two out of 96, I would be quite happy to change it if somebody makes us aware of it. I am just talking about the enormous waste of resources, which is the time of the clinicians plus the time of the bureaucrats. They are doing what I should be doing and I am doing what they should be doing. That is just silly.

Ms FORREST - So the second part of the question, about taking clinicians away from the clinical activity by being on committees?

Dr EINODER - I think I just answered that. The average clinician is happy to participate in the committee activities where we make vital decisions. But it is quite ridiculous to get a clinician to do the committee work that any bureaucrat could do just as well if not better.

Mr WING - Has there been any improvement in the last two years in this respect?

Dr EINODER - Every new head of department comes with his or her new paradigms of how things should be done and a promise to devolve decision-making processes to give the people at the coalface more authority to make decisions. Invariably as soon as they get to know the game they start to micro-manage our show and do exactly the opposite. Because they don't understand the game, and because they have come from elsewhere or from another department, such as Education or Health, or from the United Kingdom to Australia, they employ consultants to explain to them how the things work. With a phone call to me or any of my colleagues they would get the information from us for free in five or 10 minutes instead of at great expense from another consultant who doesn't understand the local game either. It is just a waste of money.

If I can I talk about money, we all understand that we would have no trouble at the Launceston General Hospital spending the whole gross national product. If you gave me the opportunity I could do it because we could treat everybody instantly. We could have

lots of people standing by ready to treat whoever might knock on the door and we could do cosmetic surgery and all sorts of things.

Obviously the country can't afford everything for everybody in the nick of time. What we need to do is be selective but the selection of what should be and shouldn't be available in the public hospital is a political community decision, it is not a doctor decision. For example, the Prime Minister of Australia tells everybody you can get your treatment in a public hospital for free; just go there. I am confronted with a situation of having more than 3 000 people on the waiting list with not enough operating theatre space, not enough nurses and not enough doctors. It is not just me personally but all of my surgical colleagues are constantly forced to select who gets it and who doesn't get it. Really that should not be my decision. I should only make a decision on clinical grounds, which is what we do. The more severely ill patient gets in first.

The second point is if they are all equal then the person who has waited the longest gets in first, depending upon which surgeon is on at the time and whether he or she is capable of doing that particular procedure, and there are lots of other things but that is how we are currently rationing services because of the lack of funds for staff and facilities.

So my point is, what is and what isn't available in a free-house public hospital system is a political decision. I will give you an example. Varicose veins that are not associated with complications should not be available in the public hospital system where we cannot afford to do that sort of stuff because we have people who are much more in need of treatment. We are not allowed to say to a patient, because it is a federal decision, that we are not putting them on a waiting list because they are not crook enough because, according to the Federal Medicare agreement, if a patient wants free treatment in our public hospital they are entitled to it. So we should have a category 4. At the moment, for those of you who know, a category 1 on a waiting means that for clinical reasons a patient should be done within a month. Category 2 means for clinical reasons the operation should be done within three months. Category 3 means any time after three months. For heaven's sake, four months and four years is a big difference, so we should have a category 4, in other words where it is perfectly safe for the patient to wait more than a year to get the treatment or indeed forever.

CHAIR - On the category 3 you are saying if you are on that list you may be operated on, there is no limitation on that at all?

Dr EINODER - There is no time limit.

CHAIR - I thought there was a limitation.

Dr EINODER - No.

Category 3 means your condition is such that it is pretty safe to wait for more than three months. In other words, you are not suffering too much and your condition is not going to get a lot worse with time. So we desperately need a category 4. It has to be a Federal decision. We have that in the Launceston General Hospital where we've been running a pilot program of putting patients onto category 4 and telling the patients, 'I have to put you on category 4 because it's safe for you to wait for more than one year, and chances are you'll never be done'. At least I am telling the patient the truth, and the patient might

go and seek their treatment elsewhere, except with the current system the patients on the waiting list think they are going to get something but chances are they're not. That is the first problem.

Ms FORREST - If I were a patient who came along with varicose veins, clearly I understand that's not an urgent procedure. I could wait for 10 years and they might look worse but they might not create any health problems for me. The very fact that you put me on category 4, even though you say that means it might never get done, at least I am on a waiting list.

Dr EINODER - I don't think you understood what I was saying. By law I can't not put you on a waiting list if you insist on getting your treatment in the public hospital system, but the facilities and the infrastructure are not there for me to actually provide it for you because we have too many other things to do. So it's a political decision to say, 'Listen, we can have a category 4'. We will on occasion do it because - and this is something I want to mention later - we have an obligation to teach our young student surgeons to operate, and we have to teach them how to do category 4 cases as well, occasionally, because in private practice that will be the bulk of the cases they're going to do. You can't turn out surgeons who only know how to treat emergencies.

In the current set-up, we have a very lopsided education system for our junior doctors. They are only being taught how to treat disasters and emergency patients where things go wrong and have complications, whereas we should actually teach them also how to treat the relatively benign conditions that nevertheless are uncomfortable or unsightly, and patients want them fixed - like a bunion, for example.

Ms FORREST - How do you choose, then? The clinician has to decide which one on that list they treat, and the clinical powers determine how you put people on the list and where they fit within that. If you have a number of people on a category 4 list, how do you choose? This was one of the issues; you said you were faced with choosing.

Dr EINODER - On average we try to do all the category 1 patients within three months, because they will significantly deteriorate if we don't.

Ms FORREST - I'm talking about the category 3 and 4s.

Dr EINODER - Well, I am getting there.

The first patient on the list that we are definitely going to do is a category 1 patient. Then we might have one or two category 2 patients that need to be done, so we do them. Then we have patients who are commonly on standby and if we have time we will do another one or two cases. We try to make them category 3 because they are not suffering that much and they won't be that disappointed if they get turned away. Occasionally I might pick particular operations that I haven't done for four months with my registrars and that time I teach them how to do that operation. But the way it is at the moment, by the time I have done the category 1 or 2 patients I have precious little time left to put a category 3 on, let alone a category 4.

Another example is that if you have two patients that need an artificial hip operation, you can't do one immediately after the other because we only have one set of gadgets. So we

put some other operation on second. If you look at the statistics, we are doing very well with category 1s and 2s; we are actually keeping up with the game pretty well. Very few patients are suffering on our waiting list because we can't get them in. We are getting category 1s and 2s in. Mind you, we are getting all the emergencies in first, all the urgent patients, then the category 1s to the category 2s, but it is to the detriment of category 3s and category 4s.

CHAIR - Which sometime in the future will probably come under category 1 or category 2.

Dr EINODER - The problem is that with our current limited facilities, without any doubt the category 3s won't get a turn in the future unless we grow or unless we tell people who are category 3, 'Go and get it elsewhere'. You buy a car with three or four years of saving; if you need a total hip replacement then do three or four years of saving and don't buy a car, buy a hip. Everybody is being brainwashed to getting it for nothing, and they insist on it. Since the law says I can't say you're not going to get it, I don't want to be the person who denies the patient an operation when in actual fact the system says I should give it to them. So, of course, we do what we can.

Mr WING - So how many of the theatres are you able to use currently?

Dr EINODER - We have six theatres upstairs and one theatre downstairs that we could use. We usually use four theatres and sometimes the fifth. In December we recruited very well. We have managed to have the fifth theatre open most of the time. It is opened for emergencies and if there are no emergencies we have patients on standby that we do on that list. So if we do not have an emergency to do on Friday morning we might as well have half a dozen patients who have accepted the fact that they may be knocked back, and we do that so that there is no waste of resources. The ideal would be to have an emergency list ready all the time and not to have the emergency activities interfere with elective activities.

Ms FORREST - So how often would you say that happens, that an emergency procedure interrupts your list?

Dr EINODER - Every second time.

Ms FORREST - Every second time that your are operating?

Dr EINODER - Yes.

Ms FORREST - Every second list is interrupted?

Dr EINODER - Yes, on the fifth theatre. If we have four theatres going, usually for the fourth theatre is the one that is constantly being interrupted by emergency. If we get five theatres going, usually the fifth theatre is interrupted. One of the reasons we use it all the time, for example, is that if we have an emergency that is in vascular surgery and we do not have a vascular surgeon available, we can hardly put the vascular case first in the list because we do not have the surgeon. Then the next time you do not have the equipment, and then next time you do not have the nursing staff, so there is constant modification. We accept this in the hospital and that to efficiently use it we have to make decisions. We have, at any given time in the operating theatre suite, the

anaesthetist on duty for the day and the floor manager nurse on the day and they decide on the priority. So if I phone up and they say we have a patient here with a strangulated hernia that needs to be done straightaway, then it is up to the anaesthetist and the floor manger to decide which list is going to get canned. We all have to take it on the chin; mind you, there is a lot of in-fighting going on because nobody wants their list cancelled but that is the only way we can cope with the increase in demand without the increase in facilities.

Ms FORREST - From the demand that you describe it would seem there is almost a case of having a dedicated emergency theatre. I know you cannot get your surgeon because they are specialists and it depends what the emergency is, but with nursing staff and an available anaesthetist you are half-way there with those staff available. Is that something that you would recommend as an option?

Dr EINODER - Yes, this has been our request. This is our justification for getting more nursing staff, anaesthetists and surgeons. I have been here since 1975 and we usually get what we want five years later, by which time we are five years into the future and now need more. It is all this fighting and battling to get resources and when we finally get them, we already need more.

Paul Pielage will be telling you the facts. What we have is too many people knocking on the door wanting public hospital treatment. The access is awful because we do not have the facility to cope with all the people who want to be treated.

There are multiple causes and the ageing population is one, but general practitioners do not do after-hours work and do not do weekends, and because of the specialisation most GPs do not do suturing anymore. They do not set simple fractures anymore because they are worried about being sued, which is total nonsense - hardly anybody gets sued. It is an easy way out to say, 'Listen, I'm not doing this anymore because I might get sued'. But nobody sues; it is a rare event. If somebody sues you can read it in every newspaper in the world. When you think that there are 6 billion people, you still read only one case a month. It is a rare event. Nevertheless, people have been brainwashed. If you have a broken bone, get an orthopaedic surgeon, but 50 per cent of broken bones do not need an orthopaedic surgeon. However, nobody wants to be treated by a GP anymore and no GP wants to treat those people anymore either. So what happens? They come to the hospital and this requires people.

Ms FORREST - Should the role of a GP be revised? This is something that you talk about a bit later on. The GP, in some respects, is the poor cousin here. They do not get paid as much as specialists but if their roles expand to provide the care you are talking about, like doing the suturing, the simple fractures, that keep people out of the emergency department and the hospital potentially, do they need to be paid more and recognised for what they do? What is your view on that?

Dr EINODER - I am glad you mentioned money because most of our doctors don't like talking about money. If a GP fixes a colleague's fracture or a broken arm they get about $230; if a specialist does it he gets $280. I don't see that as a problem. If the specialist got $2 000 and the GP $200 you would have a point, but that is not the point. If I see a private patient in my office, I usually charge them about $120; if a GP sees them he

charges $75, but I usually take two or three times as long over the case. I think that is a furphy.

What should be modified is how much GPs who are in the country, such as in Derby, get where they see half as many patients but they have to be on call every day, every weekend by themselves. They still get paid exactly the same as someone whose practice is outside the railway station in Sydney where people just flit in and out. That is where the system is wrong; it's not the relative cost of GP to a specialist. If you look at the schedule of fees you will see that the difference between what a GP can charge for a service compared with what a specialist can charge for the same service is little, it is not big.

Ms FORREST - Are you suggesting that a rural GP should be paid more? We have a mal-distribution of GPs. The figures clearly show that there are many more per head of population in Hobart than anywhere else in the State and once you get out to the far reaches it becomes more evident.

Dr EINODER - I know what you mean. This is a problem in our society, that everybody is equal. This is nonsense; nobody is equal to anybody else. We may have equal rights but we are not equal in skills, nor are we equal in workload, nor are we equal in family et cetera: everybody is different. If you are good enough to work in Derby, where we did have GPs for a while, and you are prepared to be on-call every night, every weekend but you rarely get called, you make no money but society needs you badly. The Government should provide that person the whole infrastructure so that literally his income is a bonus. Those doctors who practise in the middle of a city where people just drop in for a 'script, drop in for a certificate because they have a hangover and they are all five minute consultations get paid exactly the same as the doctor in Derby or in Swansea who is taking it really tough. That is where the problem is; the relative value of a consultation is considered to be the same everywhere, but it is not. A GP who works in Derby, Swansea or any of those peripheral towns should be promised that the AMA will provide them with a locum for six weeks every year without fail.

Ms FORREST - Should they be paid more? Should they be paid a retainer, as you said, for being there?

Dr EINODER - As I said, they should get paid a wage for being there. I am going to make this suggestion for the sake of being simple. If you see a patient for a normal consult in the city you should get the schedule fee. If you see them in a peripheral town you should get the schedule fee and 50 per cent. If you see them out in the Mulga you should get paid two or three times the schedule fee and on top of that you should be loaded another 10 per cent for any day of the week you are on-call because at the moment we have four out of every five female GPs in our society doing one or two days a week. They don't do any on-call work and they don't do any weekends. Who is supposed to do them? They were dedicated enough to study medicine but they are not dedicated enough, because they have other business - and I understand that - to do nights or weekends and they are only doing two days a week. God knows how they maintain their skills but that is the modern world and I can't change that.

I want the Government to understand that these GPs, who are prepared to work in the country have to be looked after. That is why they are leaving the country; it is not

because they don't want to be there. They went to the country but after six months they realised it was just awful; 'I am getting out of here' and I can understand it.

Mrs JAMIESON - Would you see the reinstatement of the old district medical officer, who was a paid member of the government work force, as a way of helping to get around the problem of GPs in the rural areas?

Dr EINODER - I don't know the answer to the problem, but making every GP a private practitioner discourages anybody from going into the sticks. I have explained that is just not feasible. If you are going to work at Rosebery, I think either the Rosebery corporate business or the Government ought to fund those kids to go to private school because -

CHAIR - I might just interrupt at this stage. We need to be careful to stay within our terms of reference and I think we are probably stretching it a little bit there. I understand that we led into that. It is very clear to me that we are not going to get through the information and evidence that you can provide to us, Professor, so rather than rush this the committee will ask you to return at a date that is convenient to you and us, if you do not mind. We do not want to rush through and I think it is important that we cover this properly.

Mr WING - Could I just go back to the theatre situation? What needs to happen to utilise the theatres at the Launceston General Hospital to the extent that you think is practical and achievable?

Dr EINODER - There are two basic things that we need: one is more staff at all levels so that if somebody does not turn up a team does not fall over. What we have all the time is a minimum number of people on to allow the fifth theatre to open. To give you an example, a couple of days ago at six o'clock we had to stop operating. Everybody was so busy, everything worked so well and we were really happy, we had five theatres buzzing. We had to stop operating because there were people everywhere recovering from surgery and there were no beds to put them into. There was a theatre blockage because there were not enough beds to put the people in. We eventually had places for them to go but the beds were not ready because in the wards there were not enough nursing staff to get the last patient out, clean the bed to put the next patient in. We have 115 per cent bed occupancy which means we are bed hopping, there are two people in the same bed on the one day, thank God not at the same time -

Laughter.

CHAIR - That is heartening, Berni.

Dr EINODER - You have to have fun sometimes.

Laughter.

Dr EINODER - The problem, though, is that the bed needs to be cleaned. We have another set of rules that says that you have to swab the patient in the armpit and everywhere else and if they have multi-antibiotic resistant bacteria you cannot put them into the hospital, you have to find a special bed for them. There is no special bed for them so you literally have to clear a whole four-bed ward to put that one patient into and so we are wasting

three beds. When he gets out by law, we have to terminally clean it and so we need the cleaners in. We have a bunch of cleaners that will only clean up to their chin and a bunch of cleaners that will clean above the chin. How ridiculous is that, but that is the law. That is what we need our bureaucrats to address, not to interfere with the micromanagement of the Department of Surgery, which they are constantly doing. We need them to address the bigger issues for which you do not need a medical degree to make a decision. When it comes to making decisions as to who goes to theatre, when they go to theatre, what operations we are doing, what facilities we need, that ought to be up to the people who actually are educated and trained in that particular situation.

Mr WING - Is the lack of nursing staff due to finance or other factors?

Dr EINODER - Every staff decision has to have a business plan. You must know that we have to write a business plan for every staff position as we would if we wanted to buy a new motor car or a new steriliser. It is horrific that we have to beg for the money to employ somebody so we can do our job properly. What we are doing at the moment, to answer your former question about theatres, is utilising the theatre complex to its absolute maximum to the detriment of the health of the staff, quite often to the detriment of the morale and quite often the in-fighting between surgeons who think their case is more important. The obstetricians always win because when you mention the word 'baby in distress' everybody drops everything. Half the time they are no more in distress than the patients I have but the fact is we are constantly fighting each other for the spot. That is unpleasant and we would not mind a bit of infrastructure so we do not have to do that.

Mr WING - So you need more money to engage more nurses to have greater utilisation of resources?

Dr EINODER - For example, we used to have a nursing pool; something like 10 or 5 per cent of the nurses were in a pool, people who are quite happy to work here and tomorrow et cetera. Well the nursing pool is constantly empty. If we get two nurses sick in theatre we have to cancel the list. People are being told they are on tomorrow and are cancelled because we have the flu or something.

Ms FORREST - You are talking about specialist nurses here, not a nurse who has not specialised? You are talking about scrub nurses and that sort of thing, specialised in the field and that they are sick. You cannot pull someone in off the ward to cover them. Is that what you are suggesting?

Dr EINODER - Exactly. This is just another one of the problems with the modernisation of the work force. It is specialisation of the work force. When you give me a job description what you are giving me is a list of jobs I will do, but everything that is not on that list I refuse to do. The problem is that the job description is not what you need to do; it is everything else I am not going to do. If this job you want me to do now is not there, like clean above my chin in the ward, then I am not going to do it and I have to hire somebody else to clean above that level. You cannot ask nurses to do the dirty work and you cannot ask the cleaners to do the dirty work because they do not want to get infected. It is a bit like asbestos in a way. Nobody wants to do it but in actual fact there is nothing to it but everybody has role delineation.

That is also the problem with specialisation of, say, surgeons. In Melbourne and Sydney there are enough surgeons to specialise in the gall bladder and the knee joint and the ankle and piles and head and what not. In a peripheral hospital like ours most of our surgeons are still multi-skilled and thank God for that otherwise we would not be able to do half the stuff. This insistence of the community that I get the best surgeon to do my operation is just total nonsense. You might want the best mechanic to change the oil and grease in your car but he does not do it any better than somebody who is at least judicious about their job.

Mrs JAMIESON - Have you given any thought as to how we can encourage people - surgeons, medicos, all - to remain more generalists rather than just constantly wanting to specialise and do their professional development and things like that.

Dr EINODER - Right, we do that. If you are a registrar at the Launceston General Hospital you are encouraged to increase the scope of your skills. If you are in the Royal Melbourne Hospital you are encouraged to shrink and become better and better at less and less until you are an expert at nothing. It is a major problem. So what you need is more and more people employed because this fellow works from the hand up to the wrist and the other fellow works on the hand to the elbow et cetera. You need too many people and every one of those persons gets paid the same as a generalist. It is society's change of the work description and of the philosophy of what we want. Everybody wants the best and now, and none of this nonsense about waiting. For example, if every knee problem in Tasmania came to me since I started the thing in Tasmania 35 years ago, nobody else would be any good at it and I would not be able to cope with the workload. When I have dropped dead there would be nobody who even knows how to do it. Specialisation causes de-skilling of the work force, not an increase in their skills because everybody is only good at a little thing. That is the first point. This nonsense that we have that all vascular surgery has got to go to Hobart - somebody believes this rubbish. It is hard to believe that the bureaucrats got sucked into this. Similarly with lap-banding. We have two surgeons who can do lap-banding; there is absolutely nothing to it. The only reason there is a restriction on lap-banding in Launceston is that there is fear in the Government's mind that it is going to cost more money. That is total nonsense. If you have diabetes, hypertension, heart disease or are grossly obese you will cost society five times as much every year as one lap-band because you need to see the doctor all the time. You need medical assistance, all sorts of support because you've got all these diseases related to obesity. Yet they are trying to stop us from doing it in Launceston General Hospital because the short-term problem is that putting in a lap band is going to cost money. In actual fact it costs only $3 000; there's nothing to it. So for the long-term problem it's an enormous saving for 20 years, but the enormous saving for 20 years is a Federal government issue. Lap-banding in the public hospital today is a State government issue.

What I want to talk about while I still have a few minutes is cost-shifting.

CHAIR - You are saying the government is controlling that; you have two doctors here with the expertise to do that though others could do it. Is that what you're saying, Professor?

Dr EINODER - I guarantee you I could teach you how to do a lap band in about five hours.

CHAIR - Are you that good?

Laughter.

Dr EINODER - For somebody who can do, for example, a laparoscopic cholecystectomy, the additional technique would take four or five times of doing it, because it is just another stroke of the same brush, albeit a little different. So the idea of the bureaucrats in our State controlling what we do at the Launceston General Hospital is harebrained. Every hospital should be able to credential their staff to do the operations that they are skilled to do, as long as we have the infrastructure. I am not talking about intracranial computerised monitored brain surgery where we need a $2 million gadget; I am talking about something like vascular surgery or lap-banding where in actual fact we have the whole infrastructure. Now we have two lap-banding people and we have one vascular surgeon who wants to do it, but we don't want to let the Launceston General Hospital do it for fear that it might blow our budget.

CHAIR - So they are failing to see the savings at the end of the whole process and not taking that into account in relation to the surgery?

Dr EINODER - It makes total sense. The long-term saving from preventive care is a Federal issue, whereas the short-term savings of not doing that particular procedure in your hospital is a State government issue, and it's a budgetary issue. The excuse that we want three or four surgeons to rub hands together is lame because all the vascular surgeons in Hobart hardly talk to each other because they are all separate anyhow. It's not like a footy team; you don't need all three together all the time because they all work separately. The only reason we want three or four in the State is so we can have a statewide roster so you have a humane load. We need a statewide service; we don't need a single-site service. The problem we have in the Department of Surgery is that we can't convince the bureaucrats that there is a difference between cooperation, collaboration and discussion and working as a team statewide - you don't have to sit in the same room. A single-site service is totally different. You have a single-site service because you need an angio suite that costs millions to run and we might as well use it efficiently. We don't want to start another one at the Mersey, and that makes sense because it's too expensive. However, when it comes to something that has no added expense, and for some reason or other we decide to restrict it, then that doesn't make any sense. We have decided we're going to start lap-banding anyhow and see what happens.

CHAIR - You said that where you make applications for equipment and changes and so on, some of those decisions are made probably five years later; there is a huge time difference and somebody else makes that decision. How far removed from the Launceston General Hospital is that decision made? Who actually determines whether or not that will happen? Whereabouts in the system?

Dr EINODER - If we decide we want a particular gadget it's harder to get a new gadget than to get an old one that's broken and needs to be replaced. To upgrade something we have to write a business plan. I can appreciate a business plan if we were starting up a brand-new business, where you have to justify why you want to do it but we have to do it for nearly everything that costs money. The business plan then gets scrutinised by the Contract Review Committee in Hobart who, invariably, find fault and then we get it back again. Then we have to do something else, then we have to get tender documents, then we have to write a tender document. Now, a 'calling for tender' document is about a 50-

page document - it is quite a joke - and then when we finally get the stuff we want to buy, we have to write a contract for buying it with the person who was the successful tenderer.

You would think you would use the same flaming document - whatever you wrote in your tender document. 'We'll take it' really ought to be contract - that is what the company says it will provide and that is it. No, we have to start again and do the wheelies around the traps.

Eventually, because we do not put in ambit claims - you know me, I never put in an ambit claim, I might exaggerate so you can understand what I am talking about - ambit claims are not our game. If we say we need a new steriliser, we need a new steriliser. Sometimes it is drawn out for years and then, eventually, we get it.

Instead of spending in this year's budget, we are spending it not in the next year's budget but the budget of the year afterwards and, to our horror and shame, it turns up in April and we do not pay for it until July because everything has shifted in the next year's budget.

You imagine if you were the provider to our department and you got this sort of stuff. It is quite awful, especially if you know the people and you meet them at the races or somewhere else.

Mr DEAN - I was of the belief that the budgets were devolved to the hospital so that the Launceston General Hospital would have a budget devolved to it which it would operate on and that those decisions would be made through your board or through the CEO for the purposes of speeding up these processes. But that is not the case, is that what you are saying?

Dr EINODER - It is the case, but it is how decisions are made that is different. For example, we have on our wish list about $13 million worth of gadgets and things that we need in our hospital and in the handout that I have given you, I have a list that I wrote to Jodie Campbell - for the goodness' sake, if we have $42 billion, how about some of our desperate wish list, which is $150 million worth, approximately, that we need at the Launceston General Hospital to get us up to speed.

This year we will get probably $5 or $6 million and we can decide what to spend it on. So we decide, okay, we will spend it on a new theatre table, which we decided two years ago. Then all this stuff starts.

We made the decision that we would buy a theatre table but then I cannot just say, 'We'll get that one'. I have to get in the tender documents, et cetera, then we have to make the contract for purchase, et cetera, and then it takes one or two years before in actual fact it happens.

That is what I am talking about. If we decide we want the theatre table - that is the one we want, we have thought about it for years, we are not putting in an ambit claim, here it is - it goes to the contract of your committee. You do it, all the fun and paperwork.

Why are we doing it? I should be operating and Geoff should be working out the next business plan.

Ms FORREST - With regard to getting equipment, do you agree that there needs to be a certain amount of paperwork so we are not seen as wasting public money, that there must be a clear case for a need for a new operating table or whatever? Is the issue more the time it takes for the decision to be made by whoever determines that the operating table is needed than the actually delivery of that item? Is that the issue or do you think there is too much paperwork? What is the problem here?

Dr EINODER - Can I answer your question differently? I know what you are asking me but I cannot actually say yes or no to the questions. The problem is that we know that this year we are going to get so much money for equipment, then we have a LEX meeting - that is the hospital executives - and we decide to prioritise what we are going to buy. We decide we'll buy this gadget and then we start the saga of all the paperwork, which should be facilitated, not retarded by the bureaucracy. This toing-and-froing gets too difficult - you didn't get this right, you didn't get that right - it would be the same as me saying 'You didn't do the operation right'. It is not really my job; they are the full-time employees to do this.

Ms FORREST - If one of these people, the bureaucrats or whoever it is, sends the information back, 'You haven't ticked all the boxes here, Berni, we need you to sort this out', if there was someone who actually came and sat with you who has the skills in this area and works through it with you - I know it would take up some time but obviously it has taken up a lot of time anyway - is that how it would be best to proceed so you do not have this toing-and-froing and sitting on someone's desk for three weeks and then coming back to you? I am just trying to think of ways to streamline this because obviously it is a major issue for the efficient functioning of the hospital and it certainly relies on this.

Dr EINODER - It is a difficult issue because there are too many people involved in the game and you have to accept the fact that each bureaucrat in the Health department has a vested interest in making their job indispensable so whatever you do has to go across their desk. Since they do not understand what you have put across their desk they have to ask other people -

Ms FORREST - Shouldn't they come and sit down with you?

Dr EINODER - Yes, that is what I have written in my submission to you. In a simple phone call in five minutes I could save them all the time, all the aggro and all the money that they are spending trying to figure it. What happens is we get in the mail a letter saying, 'You didn't cross the t on the third page in the sixth line' and then I have to mail it back again. Phoning them up is not good enough and the whole thing always takes time then it gets on the backburner and then I will find out -

Ms FORREST - You have answered my question and that is fine. I have just one other question: is there a lead time on this equipment?

CHAIR - I will allow this question and one more from Mr Wing and then the committee would be asking for you, Berni, to come back because there are lots of areas that we would like to cover with you on your submission, so if you would be happy to do that at your convenience and ours we would ask you to do that.

Ms FORREST - Is there a lead time on some of this equipment because that could be a reason for some delays, or is most of the equipment that you are talking about available at relatively short notice?

Dr EINODER - Every new administration promises us that this particular issue of the bureaucracy working much too slow and interfering too much on detail will be fixed.

Ms FORREST - I am not talking about that, I am talking about the supplies of the equipment, the people who make the operating tables and make the sterilisers. I know in some industries there is a big lead time and you have to order your new bogger or your driller for your mine years in advance so I am saying is there a lead time for the supply of this equipment?

Dr EINODER - In comparison to trying to get it, no. Most of the things that we ask for are universally available and we do not have anything special just for us that needs to be made. It is just something that is commonly made and you just order and usually we get it within six weeks of actually asking for it.

Ms FORREST - That is what I wanted to clarify, thanks, Mr Chairman.

Mr WING - Should there be more autonomy in the administration at the Launceston General Hospital do you think?

Dr EINODER - Yes. At the moment we have a significant difference in how the Launceston General Hospital is run within the hospital and it is fairly similar to what it was when I was doing the CEO job. The CEO is very involved in our show rather than being the bearer of bad news from down south and that is a significant difference and I have a feeling that he could be in trouble for that sort of an attitude. He is defending us rather than defending the system and he certainly befriended everybody at the Launceston General Hospital because of it but he is in trouble because of it. He will tell you the story better than I.

The problem is we need devolution and we are always promised devolution but then micro-management turned up. For example, the current secretary of health promised us that he would devolve various issues locally, but the current deputy secretary is right into micro-management. Since he appointed his deputy, I assume she is going it under his direction. This is the problem that we have, interference in things that really we would be much better off doing ourselves. We might get the odd one wrong. I do not know whether I mentioned it but the cost of the total health bureaucracy is the same as the wages bill for all the nurses.

Mr WING - I would like to pursue in the next session.

CHAIR - I think that is a good place to stop, Professor. We can go into that at the next stage if you are able to return. We thank you very much for your appearance today and all the valuable information you are providing. We know you are an extremely busy person.

Dr EINODER - Thanks for listening.

<u>THE WITNESS WITHDREW.</u>

Mr DANIEL WATSON WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Currently this hearing is open to the public. It will be recorded and be part of the transcription of the evidence. This committee has an ownership of that evidence and any explanation that you provide. You have parliamentary privilege. Outside of this committee you can speak generally about any of the information that has been provided, but you must be fairly careful in relation to what you say and you should not refer specifically to some items that were raised in this committee. We want you to speak freely before this committee. Your submission has been read by members and now is an opportunity for you to make any further submission or recap the matters that you have raised.

Mr WATSON - I came here this morning to speak about waiting lists in hospitals.

CHAIR - You have seen the terms of reference and they were publicised at the time of you making your submission.

Mr WATSON - Being a pensioner with no other income, I had to travel from Scamander at a cost of near on $100. It's a two-hour drive here and a two-hour drive back, and I have to have lunch. I asked whether there was any compensation, and the answer was no. I asked if there was any parking and they said no, so I think I am disadvantaged.

I came here this morning not to complain about the hospitals. I have had a triple bypass and a knee replacement since I have been in Tasmania, which is 20 years, and I am very happy with the surgery. The problem I have is the waiting list; it's the system I am complaining about. The doctors and the nurses are marvellous. I came from England in 1970 and it was good there. I have never been unemployed in my life. I have never signed on for any dole and I have always paid the taxes. I believe when you get my age, 76, you need to be looked after and I feel the system is letting those people down.

I have been waiting almost three years for ankle surgery. I went three weeks ago for an assessment, hoping to go in to have the operation. When I arrived they said 'We need X-rays', and I said I had already done them three weeks ago. 'Well, we need them again'. I couldn't understand that, so I had the X-rays. Then there was pathology. I said I had already given blood, but 'We need that again'. I was in Launceston General Hospital for almost six hours waiting to see the anaesthetist because they said I had to see him before I had the operation. I was told to go back at 12 o'clock, but that chap arrived at 20 minutes to four. I know they're extremely busy, I can't expect them to run after me. When I saw him he said, 'You're going in for an arthroscopy'. I don't know whether you know or not, but that's to look inside the ankles. I said, 'No, Dr Nickse and Dr Penn have already decided that both ankles are finished, I need new ankles'. 'Well, not according to this'.

This is my problem, there is paperwork floating everywhere but nobody seems to know what's going on. He said, 'I'll have to go and see the Registrar'. When he came back he said, 'Yes, they know about your case'. I said, 'I've spent three hours getting X-rays and pathology I had three weeks ago, I can't understand this'. I can't talk too much about it, but this is my problem. They seem to duplicate things, there's paperwork all over the place.

The only problem I have is the waiting list. Dr Penn arranged for the ankle specialist, Dr Nickse, to see me. He felt my ankles and he said, 'You've got good skin'. I don't understand what that means, but he said, 'You're a good candidate for replacement'. I said to Dr Penn, 'Do I have to wait another 10 months?' He said, 'No, Mr Watson, we'll have you in the end of this year or early next year'. Early next year is now. When is early this year? Maybe I will have to wait until October; I don't know when. This is the frustrating part; this is the only thing I am complaining about.

CHAIR - Has there been no indication at all as to when they might now be able to operate?

Mr WATSON - No. I rang up and asked if they had any idea about the waiting list, and they said, 'I'm sorry. When the doctors know, you will know', so I am walking around. As I said, this affects my whole life. Everybody in Scamander knows I like to make furniture. I am a fitter and turner by trade, but I love wood and I like my garden. Dinner time comes and I'm finished. I could hardly walk up these steps today it is so difficult.

CHAIR - Thank you, Mr Watson, we appreciate it.

Mrs SMITH - Mr Watson, I noticed in the information you gave us that you had a knee replacement in approximately 1996. Would like to give us a comparison of whether you think the system is the same or worse - it certainly does not sound any better - than the experience you went through in 1996 for a replacement knee now that you looking at ankle replacement?

Mr WATSON - One day you will get to my age I suppose and your memory is not quite as good. I felt it was better then because I had the operation. I am complaining now because I have not had the operation. So maybe I did wait some time for my knee but I felt I was better off then.

Mrs SMITH - So you would be comfortable in saying you think the system is getting worse rather than at the same level it was previously?

Mr WATSON - I would think so, yes.

Mrs JAMIESON - I was going to ask a similar question regarding your thoughts about private hospital treatment compared with public hospital treatment: do you feel things flowed better and you did not have all the duplication, the paperwork and the waiting and all the rest of it?

Mr WATSON - I have never been fortunate enough to have private medical; we couldn't afford it with four children on one wage.

Mrs JAMIESON - I just noticed you had been in the private eye hospital.

Mr WATSON - I don't think I am stretching the boundaries by saying this. The doctor asked whether I had private health. I said 'No, unfortunately, I have not'. He said, 'Mr Watson, I operate sometimes four times a week and in the past three months I have done one person like you on the public system. All the rest have been private'. Then he said to me 'Have you considered private health?' I said, 'Of course we have. We have been in touch

with the insurance company and they don't want to know. If you have existing problems they do not want to know and, of course, I am 119 years old so they don't want to know that either'. He said 'Would you consider taking out a mortgage? Do you own your house?'. I said yes. He suggested I take out - I think he said a back mortgage or something - and join a health thing and then I can get it done within a year. I said I would consider that but we've already been through that scenario. Virtually what they are saying is if you are in private health you will have no problem at all.

I unfortunately went blind in this left eye. I had a stroke last Christmas and I went to the eye hospital and they said they couldn't do anything because it has damaged the optic nerve. I said, 'This eye was injured some years ago when I was a fitter, so can I get something done with this?'. They said, yes, I could have a retina put in or whatever it was, I asked how long I would have to wait for that? He said 18 months. So Pauline, my wife, said 'You can't go on like this, Danny; you're blind in this eye and you can't see out of that one so we have to find $1 800 to pay for this operation'. Eighteen months seems a long time for an eye to be done. Again, all these little things annoy us old people.

Ms FORREST - You were talking about the amount of time you were waiting and you really had no idea. When the decision was made that the surgery was necessary were you told that you were put into a category? Are you aware there are categories for operations?

Mr WATSON - For the eye?

Ms FORREST - No, for your ankle.

Mr WATSON - No, but for the eye they did. I was prompted by my doctor, who said, 'Danny, why don't you put in a complaint?'. I said, 'I am not a person who complains'. She said 'No, but if people like you don’t speak up, nothing will get done'. So I made a complaint. I was on the phone I don’t know how many times, letters came to and fro and at the end of it all I said, 'Has it improved any?'. No, we are still where we were to start with. I thought what's the point in complaining if nothing is going to be done.

Ms FORREST - In relation to your eye, you had it done privately so you paid for it?

Mr WATSON - Yes.

Ms FORREST - You said that with your eye they put you in a category?

Mr WATSON - Yes, they did. They said there were three categories. For instance, if you can read this line you are in this category. If it's life threatening you are in category 3, which you can have done immediately, and then there is category 2, for which you almost have to be blind. I am in this third category, which is an 18-month waiting list.

Ms FORREST - So the situation was not explained to you with your ankle?

Mr WATSON - No, they did not. Alison Bleaney said, 'When you go again, Danny, just ask them if you can be put in a more urgent list'. I said, 'I suppose everybody does that; everybody wants to be first, you know, so I will just have to wait my turn'. But waiting my turn is affecting me.

CHAIR - A question on the duplication that you went through. You were processed through the system and X-rays were taken, and then you went back through it again. Were you told why that was necessary? Did it need to be updated?

Mr WATSON - The chap who was under the surgeon saw me. He said we need some X-rays. I said, 'No, I've already had them done', and he said, 'We need them again'. If I had said, 'Why?', he would have said, 'Well, we need them'.

CHAIR - You were not told why?

Mr WATSON - No. I told him it was only three weeks before that I had had them done.

CHAIR - Three weeks only.

Mr WATSON - You have to stand on one leg for pressure things and I said, 'I've already done this', but they said, 'No, we are doing it again'.

Ms FORREST - You were seeing the anaesthetist at that time or the surgeon?

Mr WATSON - No, I was seeing the understudy, the young doctor. Obviously you do not sit down and talk to a surgeon about it. They have the young fellow and he was interviewing me.

Ms FORREST - So what was the purpose of that appointment?

Mr WATSON - It was at the pre-admission clinic for what they intended doing. In getting this, I thought I was going to have my operation', but it was for an arthroscopy, to look inside. But they have already decided that my ankles are finished so what is the point in looking inside them? I said to the young doctor, 'There is no point in it. I don't want to take up a bed for the doctors to look inside when they have already decided my ankle is finished'.

Ms FORREST - Was that decision made on X-rays alone that the ankle needed to be replaced? You had not had an arthroscopy prior to that?

Mr WATSON - No, I had not. I had so many X-rays and they had already decided there was a problem. I do not suppose it baffles you people but it certainly baffles me.

Ms FORREST - Sometimes there is a requirement for the doctor to prioritise and to make sure that they have done all the required tests. They may have considered an arthroscopy a required test - I do not know, I am just suggesting that could be the case.

Mr WATSON - Yes, I can see where you are coming from. Over three years I would say I have had 20 X-rays on my ankles. I seem to be endlessly going up there and getting X-rays. When it first started, I had to go to a place in Launceston and there was a great big wad of whatever. I had to put my foot in it to get the impression so they could do something for my shoes. They never did another thing after that. They will make this thing for you to go in your shoe. It will cost you $100. I said, 'That's all right, I can

manage that'. They said, 'We will ring and let you know when it's ready'. I have never heard anything since that, not a word, and this is three years ago.

Ms FORREST - So what I am hearing from you, Mr Watson, is that there is a problem with communication. I understand that there are times when you need to repeat blood tests, even in a short time frame like that, for example. But from what you are telling me, when these things are happening it is not being explained why you need to have that extra test or what is likely to be the outcome and how long are you going to have to wait for the result of an X-ray.

Mr WATSON - Maybe when they look at my face they think, 'Well, there's no point in talking this young fellow'.

Laughter.

Mr WATSON - I am not an aggressive person. I would never approach anybody aggressively. I just said to him, 'I can't understand why'. He could have said, 'All right, Mr Watson, I'll explain to you why', but they do not do that. They may have done it to other people, but not to me.

Ms FORREST - Do you think that would help if you had a better understanding of what is expected?

Mr WATSON - Of course, it would, yes. If people say this is the reason we are going to need some more blood in three weeks then I can understand it. But I could not argue; I just went and got the X-rays and I gave the blood. If only they would explain why that would be a little bit better.

Mrs JAMIESON - So Mr Watson, did you see the same staff or were there different staff each time.

Mr WATSON - I think they were completely different staff.

Mrs JAMIESON - It might be one of the reasons.

Mr WATSON - I think now that I had not seen that young doctor before.

Mrs JAMIESON - Communication was missing in between.

Mr WATSON - I had seen Dr Penn a number of times. I had never seen Dr Nickse before. I have just learnt that he is leaving and going into private practice with somebody else now. How true that is I do not know but I think that is true.

Mrs JAMIESON - You might have to go through it all again.

CHAIR - Mr Watson, are you aware of the Health Complaints Commissioner and the opportunities that you have to take your matter up?

Mr WATSON - I have already done that.

CHAIR - You have done that?

Mr WATSON - Yes, I have done that.

CHAIR - Okay, and where is that at this stage?

Mr WATSON - Nowhere. When I rang the last time they said that is as much as they could do. I asked if I was better off and they said no. I asked if they could leave the thing open until I went to the hospital in a few weeks' time, could they keep it open until then and if I was not happy I would carry on with the complaint. No they couldn't do that; they said they had to close it. I asked why, if they were not doing anything. They said that this was how it was, they had to close it, and that when I had been to the hospital if I was not going to be operated on in the near future I could make another complaint. When she said that they had to close the file, I could not understand that.

CHAIR - Going back to your current problem in relation to your ankle. You believe, I think, that you are on category 3.

Ms FORREST - That was his eye.

CHAIR - So for the ankle, what category are you in now?

Mr WATSON - I do not know.

CHAIR - You do not know.

Mr WATSON - I honestly do not know.

CHAIR - Currently, you are obviously in pain and difficulty and you want the operation done but you have no indication as to when that will occur at this stage.

Mr WATSON - No, no.

CHAIR - Have you been told how far you would need to deteriorate before they would do the operation immediately?

Mr WATSON - No, they have not told me that either.

CHAIR - So the prognosis for you, quite obviously, is that there will come a time when you will not be able to get around.

Mr WATSON - Of course, and it is rapidly approaching. I am not exaggerating. I am an honest person. I do not tell lies. My ankles are really, really bad now. They are paining like you would not believe now.

CHAIR - Has it been indicated to you by your doctors that the longer this goes the more serious the operation could become? Does that impact on the seriousness of the operation?

Mr WATSON - For instance, I have had about seven really bad falls. My ankles just give way and down I go, bang. Dr Alison Bleaney said, 'Danny if you broke your hip they would send straight in and get it done. Why don't they fix the problem, then you will not break your hip.' I said that makes sense to me.

CHAIR - - A very good point.

Mr WATSON - I have ramp in the house we bought that goes up into our kitchen and I was coming out a few weeks ago and went straight off the ramp and I thought I had broken my shoulder. I am not a big heavy fellow but it was a bad fall. My shoulder was painful for weeks and weeks.

CHAIR - The system is aware of those circumstances?

Mr WATSON - I do not know whether the system is aware or not. I told my doctor and she said, when I saw her three days ago, 'Danny, I bet you think I am useless. I have done as much as I can do. I complain. I write letters saying this man needs attention now, not in a year's time. You just have to wait.

Mrs JAMIESON - So Mr Watson, were you offered any other information or physiotherapy or anything like that to help fill up the time and keep your muscles in good nick and all the rest of it before you had your operation?

Mr WATSON - Did you say would it improve me?

Mrs JAMIESON - Were you offered anything or was it just come back and see us.

Mr WATSON - No, I have not been to a physio. I do not think physio would help.

Mrs JAMIESON - No, I was just thinking of keeping your muscles in good condition and keeping you physically in good condition pre-operatively.

Mr WATSON - I do not stop work because my ankles are sore. I sit at my bench now. I have to have glasses to read my verniers but I am still working, I am not lying in bed. It is just the ankles that prevent me doing everything I want to.

CHAIR - Mr Watson, is there anything else that you would like to say in conclusion?

Mr WATSON - No, I have whinged on enough.

CHAIR - Thank you very much for the evidence that you have provided to us. It has been very helpful.

Ms FORREST - But we cannot make the operation happen tomorrow.

Mrs SMITH - It is very important that we hear the personal on-the-ground stories as well as from the medical profession and the bureaucracy. It is very important that we hear those personal stories and we do thank you for coming the distance you have to make us aware of it.

Mr WATSON - It is good to talk to people who might change the system, and I hope you do. It was nice meeting you all and thank you very much.

CHAIR - In conclusion, the committee wishes you well and we would hope that you can get your operation and your ankles right very quickly.

THE WITNESSES WITHDREW.

Mr JOHN JERMY WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Thank you very much for being here, Mr Jermy. We look forward to hearing your evidence. In this hearing you have parliamentary privilege which gives you some support with the evidence that you provide us. I need to say that after you have completed your evidence you are able to speak generally about the evidence that you give this committee but you need to be careful about making comments on specific issues that you have raised. Members have your written submission and now is an opportunity for you to expand on that or raise any issues you want to bring to our attention.

Mr JERMY - My submission was probably divided into two parts. One was to highlight inefficiencies and deficiencies in the system as it was operating at the Royal Hobart Hospital and to make improvements on that. Also, within the hospital system itself, the way diagnosis was made and my son was treated. There were two separate issues: getting him in there eventually and how he was processed, treated from then on in. From our experience at the time it was less than satisfactory and I made two complaints to the Health Complaints Commission, one in 2002 and the other in 2006. The one in 2006 wasn't resolved as satisfactorily as I would have liked. It dragged on for a long time until I was at the stage where I felt I could pursue it no further and I ran out of steam. I let it go and we agreed to differ at that stage. At that point my son was living at home, things were changing and we were getting on top of things better.

The original one in 2002 referred to a terrible situation. The details of the admission were spread over two days. As I think I said, he has a bipolar disorder, bipolar spectrum disorder I suppose you could call it. He rang us at home to say that he was elevating and his wife was worried so we got relief teachers in and we drove all the way to his home in Franklin where he was engaged in a psychotic episode. We stayed with him most of the night, until about 5 o'clock in the morning. It was too much, we couldn't stand it any longer so we took him to the Royal at about 5 o'clock in the morning and they said, 'Sorry we can't see you, there's no-one here. Come back later' which was a bit harsh.

We took him up the road to my wife's sister's house where he wandered around and he did various things that he shouldn't have done. He upset some neighbours up the road and they called the police. I managed to get the police off because I had a card from Neville Matthews and I told them he was with Neville. We took him away from that and back to the Royal the following day. It took most of the day to get him admitted. In essence, it took us two days to get him into the Royal. One of the excuses they gave was that his wife works there in the psychological department. That shouldn't necessarily be an impediment - because your wife is a nurse it shouldn't stop you from going there.

Eventually he was admitted about 3.30 in the afternoon after sitting in casualty, wandering around, fetching him from wandering down the road, et cetera. They took him in and he was put into bed. I think they gave him some haloperidol to quieten him down. We went back the next morning and he was sleeping. We had to go back to school, which we did, and they let him out the next day.

Ms FORREST - Did you come back to Wynyard?

Mr JERMY - We came back to Wynyard, they let him out and he went back home to Franklin where he was living.

Mrs SMITH - Do you think there may have been any difference in their admission attitude if he had arrived by ambulance instead of by private car?

Mr JERMY - That's quite possible. There were several people in casualty. There was somebody sitting there with a needle stuck in their arm. I think she looked like a drug addict. Their attitude was very laissez faire, I suppose for want of a better word. Bruce went up and spoke to them several times and they said, 'Wait a minute, wait minute' but then nothing happened until about 3 o'clock in the afternoon. The psychiatrist assessed him and they agreed to take him in by which time he was very annoyed and we were very annoyed. He pulled a code black on them that evening and had to be quietened down.

Ms FORREST - Was that when he was admitted or in A&E?

Mr JERMY - After they admitted him, yes, he was upset and he picked up a fridge and threw it around the room.

CHAIR - During the waiting period within the hospital system where were you in the general waiting area?

Mr JERMY - We waited in the emergency casualty waiting room. Bruce was able to walk out down the street and back again if he wanted to, which he did and we had to go and fetch him back again. He was quite agitated and he needed someone to give him some medicine to quieten him down, basically, which is what has happened in the past.

CHAIR - When you first came in, was he seen by a doctor?

Mr JERMY - No, the triage nurse at the desk said, 'We will write you down and go sit over there'. So we went and sat over there for most of the day until three o'clock.

Ms FORREST - Did he or you tell them that he had bipolar?

Mr JERMY - Oh yes. It was specifically mentioned.

Ms FORREST - So when he was seen, was he seen by the regular doctor in DEM or by someone from the psychiatric unit?

Mr JERMY - From the psychiatric unit. I think she was Russian.

Ms FORREST - So then he was admitted.

Mr JERMY - Then he was admitted.

Ms FORREST - But then in the next day he was discharged but he was told he did not have bipolar?

Mr JERMY - Well, after all of this, I decided to write my complaint and I got some information from the hospital on which it stated that Professor Saxby Pridmore said that he did not have bipolar disorder. He had what they called a narcissistic personality disorder and he did not merit any treatment so they let him out.

Ms FORREST - So did the doctor tell him to stop taking his lithium or did he just stop taking it?

Mr JERMY - Yes, he said the lithium was not necessary. He stopped taking it then.

Mrs JAMIESON - So, John, had he been seen at the hospital before? In other words, was there a past history?

Mr JERMY - No, he had never been to hospital before.

Mrs JAMIESON - So there is nothing for them to refer back to?

Mr JERMY - No, nothing, no history there.

Mrs JAMIESON - Just looking at your submission here, you are suggesting a separate and dedicated team to deal with these matters on admission to DEM. Would you like to expand? Are you suggesting that we have a separate mental health emergency admission section so that you are not in with the general?

Mr JERMY - Not so much a section but somewhere that is dedicated to that, whether it be a room somewhere or suite, or some part or somebody on call in that section who knows the situation.

Mrs JAMIESON - So that you are not out in the general waiting room.

Mr JERMY - So they are not admitted into the general run of things and put in with the rest of the queue, so to speak. If you have a mental condition then sometimes it merits a bit of treatment quickly.

Mrs JAMIESON - Yes, I do agree and it is more appropriate too. So he had been relatively stable before he had this exacerbation of the symptoms?

Mr JERMY - He was originally diagnosed in Townsville about five or six years previously and he had been home, rehabilitated, and he had gone back to work, he bought a house and things were going quite well.

Mrs JAMIESON - So he was relatively stable. Was he having follow-up mental health treatment in the community as well?

Mr JERMY - No, he wasn't.

Mrs JAMIESON - So would that have helped to stop this exacerbation of his symptoms, do you think, had he had more care there?

Mr JERMY - Yes, I think it probably would because the second part of my story relates to that. He probably would have but he was moving around a fair bit in jobs, if you know what I mean.

CHAIR - I just want to remind members here that this is not about the mental health system, as such. It does not form part of this.

Mrs JAMIESON - But we are talking about admissions into casualty.

CHAIR - Yes, it is the admissions part through the hospital system.

Mrs JAMIESON - That is right, and if you have a stable person who is in stable, well health, they do not necessarily end up in admission, so that is where I was coming from.

CHAIR - I see, then I am quite happy.

Ms FORREST - So, John, did he have a treating GP in the Franklin area then? Obviously he would have needed scripts for lithium and stuff.

Mr JERMY - Yes, he did have a GP. But I suppose, due to his condition, he really did not follow things as much as he should have. As you realise, people with bipolar, generally, can be very arrogant and self-opinionated. You know, 'I know best, I want to do this', and there was a certain amount of resistance in his psyche to go to regular meetings with people until things really got bad and that was it. So he would muddle along and then when things got really bad, he would have to do something about it. It was generally us that did.

Mrs JAMIESON - So, John, is he any better now that he has a different diagnosis and maybe different treatment or not?

Mr JERMY - Yes, he is good now. I can come to that later but he is all right now but that is a bit further down the track at the moment. But, as I say, I thought what they did there was very, very poor and it stressed us out a lot at the time.

Ms FORREST - Let us summarise that section of it, you are suggesting that in the Department of Emergency Medicine, whether it be the Royal, the LGH, Burnie or the Mersey, that there should be a separate area for patients with mental health, particularly serious illnesses at the time of presentation can go to be assessed by the appropriate staff.

Mr JERMY - Yes, not sitting there in the main hall with everybody walking around.

Ms FORREST - You think that would be a benefit.

Mr JERMY - I think that would be a good idea, and having someone who is available who has had experience of that. Maybe people these days coming in with drug-affected psychosis; people are taking drugs all the time.

Mrs SMITH - Would you like to expand a little on it, because I have had, fortunately, very little experience with emergency departments, but when I have been there, you are quite correct, there is usually a general collective of all sorts of presentations, and somebody

with your scenario would have to make a judgment. In most of the departments, everyone gets their privacy in little cubicles when they get to a certain stage of some treatment. I am looking at the issue of your son who quite clearly had a bipolar mental health issue, against the drug addict who is sitting there, against the drunk who has been brought in and dumped down by the police because they don't know what to do with them either, and so on.

Do you think the issue of how they diagnosed your son with a medical condition, as against myself who is just drunk out of my mind and really only needs to sleep it off, how staffing and emergency department process can quickly identify the difference between our behaviour, one medical and the other self-imposed?

Mr JERMY - There would have to be some avenue of communication because he did say to them that he was diagnosed at Townsville Hospital. So technically, if they had had a database or they chose to ring Townsville Hospital, they would have found all the information, which I don't think they did. There's no mention of anything in the letter from the hospital about what Townsville had said or done, so they could have checked up on that and taken what we said as read and watched his behaviour. They could have done that, it was very casual.

Ms FORREST - There has been a comment in other spheres that I have heard that the reason we need everyone to go through the same process, as Sue was suggesting, is that someone with a mental health disorder - and they could be having a psychotic crisis - could also have a medical condition. If you just shunt them off into this room for the mental health assessment, their ruptured appendix might be missed.

Mr JERMY - Yes, fair comment. I think you need some people there with a bit of experience, maybe not. A little bit more care and thought about what's going on.

Mrs SMITH - The significant issue, from your point of view, is the time lines of the entire process, and the lack of follow up in that process that still, quite clearly, four years on, it doesn't appear as if they were accepting that diagnosis.

Mr JERMY - No. I think if he'd stuck to his guns and I suppose to some extent they may have marked his card, if you like, because he'd appeared before, years down the track and again he was out of the door, gave him a shot of haloperidol and sent him home. He had had trouble with the police in Huonville and they took him down. I think I mentioned in the letter they took him into hospital and he was back in Huonville before the police got home.

Mrs JAMIESON - Once you actually got treatment, were you satisfied with the treatment that you got within the emergency sector?

Mr JERMY - Not at this stage, because they would not put him on lithium. That didn't happen until about 2006, and I actually had a conversation with one of the registrars there and it took a fair bit of convincing on my part to get him to prescribe the lithium for him to have. Eventually they did because I contacted the Official Visitors Scheme and we wrote various letters to Des Graham and various people about this. By not giving him the lithium, we felt that his patient's rights had been denied, which I suppose actually

they had because it's a medicine that is effective for this condition. By not giving it to him, you could argue that was a breach of faith -

Mrs JAMIESON - As people who have lived with the condition, you do understand the vagaries, if you like, of having medication that might be not correct, and there's a new medicine come along so doctors have changed the treatment, whereas lithium has been -

Mr JERMY - But they've had a proven record of it working, and they hung this on their diagnosis. Their diagnosis was that he was not bipolar, therefore he didn't need it. So that stayed with them, I think, right up until quite recently. My wife's sister, who is a doctor, went there a couple of years ago when he was going in of his own accord and asked to see him and the girl said, 'He's not there'. She said, 'Where is he?'. 'Oh, he's just wandered down the road'. She said to them, 'You know that he has been a patient here in the past?', and they said, 'Well, we haven't got that information'. You should have that information on your database on the front desk.

Ms FORREST - Was he in the psychiatric intensive care unit at one admission, John?

Mr JERMY - Yes, he was in the PICU.

Ms FORREST - And then he was in DPM at the other time?

Mr JERMY - Yes.

Ms FORREST - That has been a documented problem that we have talked about in the past; they are separately funded and operated and have separate notes.

Mr JERMY - Separate database, yes.

Ms FORREST - Yes, separate records.

Mr JERMY - They said they did not know that he had been there before so I think that is another gap in communication somewhere. They should know this.

CHAIR - Within the emergency department, if there were nurses or people in there with the expertise and knowledge required to look at persons with mental health problems, could it be a better system and that you may not have gone through the two-day waiting period that you did for admission and so on?

Mr JERMY - That is fair comment, yes. Maybe the person on duty at the time was lacking in that department.

CHAIR - It has been suggested that with mental health issues unless somebody is demonstrating very strong signs of anxiety and violence et cetera, and it is a sickness you cannot see, they take a back place in the assessment and processes and so on in the emergency department. If somebody comes in with a broken arm then you can see they have a broken arm or if they are bleeding and so on, as against a person with a mental health issue because they are not seen as requiring emergency or quick treatment. Do you see that as the position?

Mr JERMY - Yes, I can see that. The squeaky wheels get the oil. If somebody comes in waving knives and guns they are obviously going to get more treatment than someone who is just sitting there holding their hand.

Mrs SMITH - You made complaints to the Health Complaints Commissioner on two occasions in 2002. Can you tell me whether there were any recommendations out of that about communications or files?

Mr JERMY - I think they more or less stuck to their guns and we did not get them to change any of the diagnoses they made.

Mrs SMITH - Did the Health Complaints Commissioner make comment or judgment or just gave you the information about both parties and left it alone?

Mr JERMY - I think eventually we just let it rest. It started to get protracted and our interest was really more on getting Bruce back on track. Letters went backwards and forwards and eventually I just let them rest rather than carry on and on. It could have gone on and on but fighting a battle on two fronts was not really what I was about.

Ms FORREST - Do you think that is an issue, John? We do hear occasionally from patients with complaints, particularly with conditions that are long-lasting, like mental health disorders that are very cyclical. You might put a complaint in and then it does not really get resolved and it gets drawn out. Because of the tax on you as the person who is making the complaint, and also dealing with the mental health problem with your loved one, a lot of these complaints do not get progressed so we are not really aware of the extent of some of these problems out there.

Mr JERMY - Yes. This would have gone on probably for about four or five years. There were quiet patches in between, but at the moment I have let it rest because we do not have as much to do with the place, if I can help it. He has been admitted to the North West Regional and I must admit that when I took him down that was a lot better. They actually had a little room where they sat us down with a chair and talked to us, away from the general patients.

Ms FORREST - That was in Burnie?

Mr JERMY - Yes.

Ms FORREST - Was that when he arrived in the DEM? They did that immediately?

Mr JERMY - They did it immediately.

Ms FORREST - Who sat down with you and talked with you?

Mr JERMY - It was the nurse on the desk.

Ms FORREST - So it was not the mental health nurse?

Mr JERMY - No. They had to ring up the psychiatrist in Penguin and bring her in. That was about 1 a.m. and she came in and assessed him and they took him in. The whole process probably only took about two hours.

Ms FORREST - That sounds quite different to what happened before.

Mr JERMY - That is different and they get a big tick in the box because of that.

Ms FORREST - So at the Royal you were told that there was no-one there so there was no point in coming in?

Mr JERMY - At 8 o'clock at the Royal I was told nobody was there, so come back later please.

Mrs JAMIESON - John, what have you been told to do should the symptoms, or an exacerbation of the symptoms, pop up again? Go to the Royal, the Lopes Centre or what?

Mr JERMY - At the moment he is more or less in the system with community health and the Lopes. He has finally found somewhere that has got him back on track again. It took him a long way down to the bottom before he found somewhere and somebody who was prepared to listen and do something for him, which the Lopes did and I am very pleased that they did. It was sad that it had to be the Lopes.

Mrs JAMIESON - So you have been happy with the communication with the Lopes Centre?

Mr JERMY - Yes. I have had a lot of communication with them over the last year when he was there and they have been excellent.

Ms FORREST - The Wilfred Lopes, John, as you are well aware, is for forensic patients or patients who cannot be catered for in the normal mental health services. It is only available to a very small sector of the community that have significant mental health disorders. You are saying that Bruce had to get to such a low point or commit a crime to get into the Wilfred Lopes Centre to get the treatment he needs to get him back on track.

Mr JERMY - To get the treatment he needed.

Ms FORREST - That is an accurate assessment?

Mr JERMY - That would be a good assessment, yes. The only way he got the treatment was by doing the deed he did. In itself that is another story because it relates to his abuse as a child, but that is a side issue.

CHAIR - Do think that a lot of the issues that arise and that you have confronted here occurred because of the two separate organisations - mental health and the public hospitals? There are two separate organisations. Do you think it would work better and be a better system if the two were together under the one umbrella?

Mr JERMY - I do not know.

CHAIR - You have not addressed it. That is okay.

Mr JERMY - I can see a case for having them separate and being dedicated, having a separate knowledge base dedicated to mental health. I can also see that they would need to have contact with the other half as well. You cannot really say that here is one, here is the other and never the twain shall meet. You have also to think of other things that are involved, like personalities, ambitions and other things that go on within the department and how people operate. One of the swipes I took at the Royal was that the head of psychiatric medicine in my opinion really did not seem suited to the job. He came over as very arrogant and dictatorial. He should be there caring for people, looking after his department, rather than indulging in venting little ideas of his own and doing his own research. That is just a personal point of view.

CHAIR - Is there anything more you wanted to say?

Mr JERMY - No. We got the complaints as far as I was prepared to go with them and I did not want to go any further. It probably would have been counter-productive to carry on sending letters backwards and forwards. I got a letter from Des Graham to say that, if there should be any problems with Bruce, I should contact him and he would arrange for things if necessary. That helped alleviate some of the problems I had at the time. I had some words with Tony Abel in the parent-visitor scheme and he wrote letters on my behalf to the hospital inquiring why Bruce had been denied his lithium and things like that. He had some input as well.

Ms FORREST - He was involved with the parent visitor scheme, did you say John?

Mr JERMY - The Official Visitors Scheme.

Ms FORREST - The Official Visitor Scheme, yes.

Mr JERMY - When we felt that he hadn't had the right thing done by him -

Ms FORREST - Did you find that system worked well the official visitors?

Mr JERMY - Yes, I think that was good. He was a good advocate I think and he was able to put his case quite well to the right people and I think that is a plus for him anyway.

I think that is really most of the story. The rest is history and side issues. At the moment, as I say, because of what he did last year he is now stable and he is now being looked after, shall we say, by the system and the Mental Health Tribunal report was a big plus too. I think if he had been in the system earlier on we could have avoided a lot of trouble. I don't know when that report was first mooted but I think if he had been in the system he would have gone to that court rather than the magistrates' court and the matter would have been dealt with as a mental health issue rather than a criminal issue, which is the way it should have been.

CHAIR - With the complaints that you made to the Health Complaints Commissioner are you aware whether or not any changes were made within the emergency department in relation to the way they assess patients and look at patients?

Mr JERMY - Not to my knowledge, no. I don't think they were because he had taken himself. He went back himself a few times a couple of years ago. In fact as late as 2007. I think he fronted back for very little effort on their behalf. His name obviously hadn't gone through the system as somebody to keep an eye on.

Ms FORREST - It was only when he was placed on an order that he became part of the system.

Mr JERMY - Yes. It was only when he, unfortunately, committed a crime that he became part of the system and the whole process went through and he ended up where he did. I know it is sad but in a way I think it was a saving grace for him -

Ms FORREST - It was a tragedy as well.

Mr JERMY - because we could have gone on this same roundabout now for years -

Mrs JAMIESON - That's right.

Mr JERMY - with little or no effect.

CHAIR - You have made the comment in your written submission, and I covered it and Ruth covered it to a degree, that a separate and dedicated team to deal with these matters would go a long way to remedying the current problems that you have gone through or your son's gone through.

Mr JERMY - People with a bit more sympathy or care even or a little bit more knowledge of what is going on.

Mrs SMITH - Do you accept that unfortunately in Tasmania, with 500 000 people spread fairly wide, that sometimes in the view of professionals we are bottom of the barrel; it is not as easy as sitting in the middle of Sydney or Melbourne with a lot of support and whilst we would hope always to get the best personalities sometimes we have to accept the professional without the personality? How would you deal with that as a department?

Mr JERMY - To a certain extent I can. A caring attitude doesn't cost - you don't have to pay for that. That is something that comes naturally with the job, surely; a bit of sympathy here and there.

Mrs SMITH - You would hope if they went into that field they would understand how cautious you have to be with people with mental illness and how you deal with them.

Mr JERMY - Yes. Dealing with patients requires sympathy and empathy and all those things. I know probably they are rushed off their feet or things like that but, as I say, that sort of thing is a natural rather than something you can be trained for.

Ms FORREST - Mental health is a specialist area and a lot of the general health population don't know a lot about it. You could into a department of emergency medicine with quite a significant mental health issue but you don't look particularly unwell. You might look a bit spaced out or a bit anxious but you don't look sick - you can walk, you can talk,

mostly. Do you think if there was a greater or more broad education of particularly the front line staff, like the nursing staff and the doctors who work in the emergency department, so that they all had a broader knowledge of mental health disorders, would that help that as well?

Mr JERMY - You would hope that would be something they should go through, really.

Ms FORREST - The public as well could do well with a bit more education.

Mr JERMY - Yes. You get the whole range of people coming into hospital, and you have to be that much aware. It's like teaching; when you have to look at a class of kids and go through 30 different personalities. You have to really look at your people and try to be sensitive to them, and it's part of the job.

CHAIR - Any other questions? Mr Jermy, time is really going. Are there any comments you would like to make in conclusion?

Mr JERMY - I think I have probably covered the main thrust of what I was on about. I did make a point that there should be a sort of access to data perhaps. There is not a lot of data sharing, it may not go on between States for people with mental health or health problems. There should be some sort of system where you can access immediately someone's records. I know there's a bit in the press about this, they want records to be accessed on the Internet, and things, but I think there should be more sharing of data more regularly.

CHAIR - I'm not quite sure with the public hospital medical record. There might be privacy issues there with the exchange of information as well.

Mrs SMITH - I think there are some good examples of how protocols can be set up just in my area to overcome lack of doctors at a weekend. Two surgeries have actually set up a protocol, and somebody out of one or the other is always on duty of a weekend, and they can access my records from the surgery. So they have built up protocols with computer processors that actually allow that small scale, and I would have thought it could be expanded.

Ms FORREST - We are a little way off electronic health records in the public hospital system as yet, but that's a dream that I hope will be realised in my lifetime.

Mr JERMY - I will say, though, in conclusion, I will give another big tick to the Huon Valley Health Centre that's set up down there. It worked very well for him and in latter years it has kept him on track, although they probably didn't see eye to eye as well as they should with the Royal. They did help him out a lot, and that community health centre was a big plus for him and probably anybody else in the area. I think that sort of set-up in towns works quite well, particularly with the right people in it.

CHAIR - Mr Jermy, thank you very much for your attendance today, thank you very much for the evidence you have given this committee. It is very important and we will make a judgment on all of that at the end of this committee, so we thank you very much for that and we wish you a safe trip back. From the north-west coast, isn't it?

Mr JERMY - Yes, the north-west coast, back to the cold. It's a nice place, Wynyard.

THE WITNESS WITHDREW.

Mrs DIANA RUDZIEWICZ WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you very much. First, if at any stage you feel that you prefer to give your evidence in-camera, simply ask the committee and we will make a determination on that. It is open to the public and the committee, at the end, will use the information in a way that we see is right. You have parliamentary privilege in this sitting, which gives you protection and support in many areas. There was a very short submission from you so please talk to us, raise your issues and then members of the committee will ask you questions from that.

Mrs RUDZIEWICZ - I am 61 years old and I have had 43 years' nursing experience. You can take from that that I consider nursing not to be a profession - I do not like that word any more, it is over-used - but I consider nursing to be a vocation. Unfortunately I do not think this is the case in university. I have experience in surgical nursing, paediatrics, general medicine, specifically orthopaedics and psychogeriatric, where I did two years because my mother had dementia so I wanted to know a lot about medication and how to handle such patients. I am now in rehab and I have been there for four years. I have worked in all States in Australia, except South Australia and I have worked in the UK.

I will start by saying that, as a nurse, I was particularly incensed to read in the paper that $60 000 had been spent on a journey to the UK and the USA, to compare Tasmania to those particular areas. I would like to say, because I think it needs mentioning although it did not seem to be in the paper - and I do not know whether other people realise - that Tasmania has a small population, a lower socioeconomic group, a larger number of aged, higher unemployment, lower incomes and more mental health patients. I think it is irrelevant to be comparing Tasmania to anywhere else. It does not have the same statistics.

Another things I feel strongly about is this: I am a level 1 so I work with the patients. I know that people are saying that it is top-heavy, but I would have to say that in our ward it is not top-heavy. It might appear on paper to be top-heavy. There are at least three very senior registered nurses who are probably kept in the office for most of the day doing paperwork and ringing various agencies around Tasmania to try to get our patient services out into the community, because that is so important. It is so much better for people to be in their own home, nicer, easier for them, especially at the end of their life when they have spent so much time working. This requires an enormous amount of paperwork and the time of people who know those agencies and have the contacts. Therefore when you look at the ward on paper it may look like it is top-heavy. It has to be like that, otherwise we would be sending people home to fall over, break something and they would be back in hospital again.

Ms FORREST - I hear what you are saying about the senior nursing staff being tied up doing the paperwork and also trying to access services. In your view, is there a potential role for other staff to be trained to be aware of all the community service, how to access them and what is there to undertake that role so that the nursing staff could be involved only in the direct patient contact?

Mrs RUDZIEWICZ - I think that would be hard because you would need a lot of information regarding the patient and to know the patient fairly intimately to be able to

communicate effectively with the services. I really cannot see that you could have anybody else and I would like to have these people on the floor.

Ms FORREST - If most people are tied up a lot of the time, as you suggest, doing all of this ringing around at that time you are not spending time with the patients.

Mrs RUDZIEWICZ - They are not allocated patients.

Ms FORREST - That is what I am saying, they are actually not in direct patient contact. They need to know a lot of the patients so must get information from the staff who are caring for them. Could we not train other people to be informed by the nursing staff caring for the patients what their needs are and then use those people?

Mrs RUDZIEWICZ - I expect you could do that. It would take a while as long as they were present at the conferences that we have and our handovers and things like that. Providing they had access to all that I think you probably could.

Ms FORREST - Effectively those could be people who are on a lower salary because they are not trained nurses so you can get your trained nurses back to the bedside.

Mrs RUDZIEWICZ - Yes, that would be nice.

Mrs JAMIESON - Further to that, Mr Chairman, you do not need a trained nurse to do the basic stuff anyway, to correlate and have it checked over by the nurse or whoever is in charge of the patient. Discharge planning is most important and there is a lot of very basic work that does not really need to be done by a trained nurse.

Mrs RUDZIEWICZ - No, that is true but from personal experience I have found discharge planning on a lot of the wards, and particularly mental health, to be absolutely appalling. I think they have a phrase 'aggressive discharge and abandonment' and that is exactly how I feel it is done. Particularly on my ward, we are very sensitive to that sort of thing and that is why we spend a lot of time with them. As long as they had access to the charge sister to clarify -

Mrs JAMIESON - Yes, it would need to be signed off by the medical staff.

Mrs RUDZIEWICZ - Yes, you could do that.

My other bone of contention is the recruiting of registered nurses. It would nice if there were more RNs coming through having graduated from the university, however their attrition rate is fairly high. The attrition rate probably for the first five years after graduation I would think is possibly even higher because they come on to the wards, they only do six months on two wards and that is a ridiculous amount of experience -

CHAIR - Do you know what the current attrition rates are?

Mrs RUDZIEWICZ - I do not know what they are. I knew what they were for the university but I cannot remember now. They do six months on two different wards, which could include the rehab ward which is really not considered to be acute although we do have acute patients there and another medical ward, so then they have no

experience with surgical nursing at all. I really find that a fairly poor way to train somebody.

CHAIR - Would they have that experience during their university training?

Mrs RUDZIEWICZ - How? They are only on the wards supervised for six weeks.

CHAIR - Are you talking about post-grad?

Mrs RUDZIEWICZ - I am talking about when they come through in their second and third years.

CHAIR - Sorry, I thought you meant post-grad.

Mrs RUDZIEWICZ - I am also talking about post-grad. They come on to the wards in their second and third years when they are supervised and are with an RN. That in itself is very time consuming. They pick up a reasonable amount of information but they do not do night duty. When they have finished their time on the wards they go back. They often ask in their post-grad year to go back to the same wards because they are familiar with them, unless they have a horrible experience, which happens. They would then just be extending experience on, say, a medical ward or maybe a surgical ward. Surgical nursing is not like medical nursing, it is quite different - very different, in fact. I can see that a lot of people do not know that when they are on the wards because we do get a mixed bunch of patients on our ward.

Mrs SMITH - We had evidence this morning that approximately one-third of nursing students drop out and of those who graduate the hospital nursing staff turnover is 40 per cent every five years. Would you agree with that statement?

Mrs RUDZIEWICZ - I would definitely agree with that because I hear what they say. You ask, 'What are you going to do after you have done your 12 months', 'I think I'll go back to uni and get another degree and get out or get into some management situation'. They still have no experience, which is pretty poor.

Mrs SMITH - Do you have a solution?

Mrs RUDZIEWICZ - Yes. When I came back to Tasmania after seven years in Queensland and, as I said, I have 43 years of experience, I could not get a permanent position for two years. I am a single person, I have to pay a mortgage and things like that, and this seems to be the practice in Tasmania when you apply for a job. I will just go back a bit. When I went to Queensland I walked straight into a job.

Ms FORREST - Was that a permanent position?

Mrs RUDZIEWICZ - A permanent position. I could have taken two different jobs. I chose to go into psychogeriatric and I then went back up into orthopaedic. There was no equivocation, they just looked at what I had done and said, 'Yes, thank you very much, we'll have you. Start tomorrow'. Start last week was more like it.

Here you cannot get permanent work, you are on a contract and it is not satisfactory, especially when families are relying on that income. They do not know when they are going to work and when you do get the work it is usually in pool so you have to be available because at five o'clock in the morning they could ring up, 'Would you come to work now?' It is really very difficult if you have to prepare your family for that sort of thing every day and you do not know whether you are going to work. You just do not know whether you are going to get the work yet it is there. I do not understand why people cannot be employed permanently. It is done in other States, and six-month contracts are just not good enough.

To me, it would be a bonus if the recruiting of experienced RNs were speeded up. I do not know how you can do that although I have a few ideas, but certainly giving them permanent positions if they have the experience would be a good step. It is not really that satisfactory to have a post-grad with, say, two years. I have 30 times their experience and I consider my worth on the ward to be superior to theirs because I can cover a lot more fields, but I am counted at the same level. Really, you would need two of them at least to cover what I do. They are just not experienced and I do not understand how they can keep saying, 'We've got 30 new nurses coming in' and you go, 'Oh yes, and how many of those are experienced?' None of them - and they leave because of the conditions. They leave because - and this is well documented - doing shift work takes 10 years off your life, and I still do shift work. The morning shift I finish at half past ten or maybe eleven, and I am back on at seven o'clock. The patient said, 'You've been there all night', 'No, actually I went home and went to sleep'. That's what happens, and so you go home -

CHAIR - Just on that, what are your current conditions there? What sort of a break between shifts?

Mrs RUDZIEWICZ - I think for the union - it's not because of the hospital - you need to be off for eight hours. You need to have an eight-hour break.

Ms FORREST - That's from the time you leave the hospital to the time you start your shift.

Mrs RUDZIEWICZ - That's right.

Ms FORREST - It doesn't count how long it takes to get home.

Mrs RUDZIEWICZ - No, it doesn't count the travelling time and it doesn't count when you go home. You usually need to wind down. I just find that most of us when we get home watch the same trash on TV. We're all lying there going, 'Uhh', like this.

Ms FORREST - And worried about sleeping in for the morning shift.

Mrs RUDZIEWICZ - As you get older, your sleep pattern is disturbed and you find that you get back at work and you say, 'I had a shocking night last night, I didn't get to sleep until three o'clock', but you are on at seven. And night duty is just a nightmare for most of us, but we have to do it.

CHAIR - A nightmare because of the need to work at night, or other reasons?

Mrs RUDZIEWICZ - No, because we don't sleep during the day and it's just so hard to get into that mode because two days ago you were on a morning shift and now you're on a night shift.

Ms FORREST - So is there another issue? You don't have the access to medical staff at the times you have during the day and other support services? Does that take its toll?

Mrs RUDZIEWICZ - It doesn't with me because, quite frankly, I only ring twice and after the third time I ring the registrar and say, 'Where is the resident, I want somebody down here now'. But it does for other people. Weekends are really difficult. I have to say at the moment it's not the doctors' fault. They have very inexperienced doctors there on the wards, and in particular our ward. Lovely chaps, a couple of them, but English is not their first language. By our standards, for communicating they do very well under ordinary circumstances, but not in a hospital situation they don't.

So you're there trying to say to them - well, I am, because I look old and look fierce, I can get away with it - 'This is what you have to do first, I want you to do that. Don't do that, do this', and then I stand there and I don't walk out. I stand there and say, 'Can you understand? Is that okay, is there anything you want me to do?', and they might say, 'But I don't understand this and this'. These poor people, it's not their fault but they're not properly supervised. They need the registrar to come down and check that they are okay, and I mean check on them nicely.

Ms FORREST - So are you suggesting that this impacts on the attrition of the nurses? Is that what you're saying?

Mrs RUDZIEWICZ - Yes. We waste so much time ringing people and going back over things that should have been done three days ago, writing stuff on our whiteboard, saying, 'There's the whiteboard, it's all up there'. It is very time consuming, and I know that a couple of the girls that are doing the discharge planning just come on at the end of the day and they're pulling their hair out because they've had to walk a doctor through the whole thing, and that is really time consuming. You have to be pleasant about it, even though you feel irritable but you just have to bite your tongue and say, 'Oh, that's great'. And also the doctors are filling out forms from Centrelink, and things like that. It's not easy for them to do that, so they tend to push that paperwork aside. But we're trying to get people out of the hospital.

Mrs JAMIESON - Further to that, is the comprehension of the language by the patient, for example, understanding what the doctor is saying, hearing, and values and things like that. Is that a problem, too?

Mrs RUDZIEWICZ - It is a problem, I don't know how I can measure it in time, but it is a problem. Usually I go back in after the doctor's been to speak to the patient, and shout in the right ear, 'Have you got hearing aids? Put them in!' and that sort of thing. And I say to them, 'Do you understand?', and they usually get the gist of it. Sometimes they don't and then we go through it again.

Mrs JAMIESON - And they don't like to question the doctor, they just agree with what has been said.

Mrs RUDZIEWICZ - No, they will not. That is the culture. They will not question. I didn't like to ask the doctor this - but that is what he is there for. So you do have to be patients' advocates; that is why it is a vocation and that is why, although I have a back injury from nursing and it does impact on my life enormously, I am still at 61 in nursing. But there are times when I walk out that door and I think this is going to be the last time. I am so frustrated with a lot of the things that go on.

Mrs SMITH - You may agree or disagree with this but it appears in the past that Tasmania had financial constraints and that was the reason we had bed closures et cetera.

Mrs RUDZIEWICZ - Yes.

Mrs SMITH - My feeling now is that we are significantly better off, regardless of the issues of the current time financially, and that we have bed closures because of the shortage of nurses. Is that a correct assumption?

Mrs RUDZIEWICZ - I have always thought that it is not bed closures, it is lack of staff. It has always been lack of staff. I don't know where that came out. Well, of course, it sounds better doesn't it to say we are closing beds? The reason we close beds, and that includes other States that I have worked in where they have closed beds, is that we can't put nursing staff on the wards. It is not shortage of beds on the whole; it is shortage of staff.

Mrs SMITH - So we agree on that one then?

Mrs RUDZIEWICZ - Yes, we certainly do.

Mrs SMITH - It's a staffing issue in today's climate?

Mrs RUDZIEWICZ - Yes.

Mrs SMITH - Your evidence seems to suggest that we are losing some because they go to university and then the dream isn't there when they go out into the technicalities of it. Also, there is a lack of permanency and that impacts on their capacity to borrow money for a home and so forth?

Mrs RUDZIEWICZ - The lack of permanency does impact on them. I personally know of several staff who had contracts and had to leave. Also, it's our pay system. I get paid a lot less working in Tasmania than I did in Queensland.

Mrs SMITH - You made the comment that there are bed closures in other States?

Mrs RUDZIEWICZ - Yes.

Mrs SMITH - Yet earlier you said they offer permanency in other States so do you have an opinion on why there are bed closures in other States if they have that permanency?

Mrs RUDZIEWICZ - Well, it's for the same reason. People start nursing and find conditions are just not what they want, what suits them, whether they are permanent or

not, and they leave. If they have a couple of degrees they can get work elsewhere quite easily.

Mrs SMITH - So, in your opinion, if we had the financial capacity to leave all the beds open and we know we need more nursing staff, how do we get them? With your 43 years of experience what do you suggest? What we have done to date clearly hasn't worked in encouraging young people in particular to go into the vocation of nursing. Have you a suggestion to the committee as to how we can encourage more into nursing, which then solves some of the issues I think we have seen before us in bed servicing et cetera?

Mrs RUDZIEWICZ - I really think the system of pay, of holidays, of public holidays et cetera that we have in Tasmania affects our whole rate of pay and does make quite a difference to nursing staff who can and do leave the State and go interstate. As I said, there are still problems interstate but I don't see them as being as great as they have been here. How do we encourage input?

It is very difficult to change the shift system but they do use another system elsewhere. They work five morning shifts one week, whatever you are pro rata working; you work a week of day shifts, a week of evenings and a week of nights rather than chopping and changing from one shift to another. That is supposed to be better for the nursing staff or better for your body clock.

Ms FORREST - Does that require a directive from the Government? Surely that could be worked out at a ward level with your charge nurse?

Mrs RUDZIEWICZ - Yes, it could be.

Ms FORREST - You have to have cooperation and if you don't have cooperation it is not going to work anyway.

Mrs RUDZIEWICZ - No. It could be worked out on a ward, that is quite right. You would find that there would be a lot of resistance to it. Nurses are so entrenched in their own ways. The nursing culture is very hard for me to explain but it is something that I find still exists. Nurses by tradition are resistant to change. They can still be made to do it.

CHAIR - Our next witness is here and I am going to have to finish this part. Mrs Rudziewicz, we encourage you to put a written submission in to us with the remaining information and evidence you would like to give us. I know you have a number of other items to raise.

Mrs RUDZIEWICZ - Yes, that is right. One of the things is that you have nurses running around from the sixth floor to the bottom floor delivering stuff to pharmacies or to pathology and there is a lot of time wasted. A pneumatic tube system would stop that straightaway. There is a lot of time wasted on what are really not nursing duties and nurses don't like doing non-nursing duties.

CHAIR - Mrs Rudziewicz, thank you very much for that. I would still encourage you to put a written submission to this committee and I would also encourage you to indicate to your colleagues that they are able to provide a written submission to us. I think it is vital for this committee to understand from a nursing point of view what the position is and

what recommendations this committee might be able to make at the end of the hearings. If you could encourage your colleagues I would appreciate that as well.

Mrs RUDZIEWICZ - Certainly, thank you.

THE WITNESS WITHDREW.

Dr PAUL PIELAGE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you very much, Dr Pielage, and welcome. This is a public hearing and a recording will be made of this for *Hansard* which will be transcribed in due course. If at any time you feel you would like to give evidence in camera, you can ask this committee to consider that. Any evidence you give today is protected by parliamentary privilege.

The members of the committee have read your submission. Please enlarge on any of the issues in your submission or raise any additional information you might have.

Dr PIELAGE - Thank you for that. First, I am glad you read my original submission because it was a fairly long document.

CHAIR - Yes, it is a very good document, well put together.

Dr PIELAGE - I do not really want to go through that verbatim because you have already seen it. I have circulated another document, which fortunately is shorter. That adds to the previous document and looks at things in a slightly different way. There are a couple of pages in the circulated document which I do not think should become a public document, because there is the potential for patient identification.

CHAIR - Is that the document you have already given us?

Dr PIELAGE - No, it is just the one that has gone around today. Those pages are marked.

CHAIR - That is clearly marked in the document.

Dr PIELAGE - Yes, on the top of the pages. I do not think those pages should be circulated.

I do not have time to cover everything I covered in my original submission, except to say that since then situation has become a lot worse.

As you are probably aware, we were fairly consistent in the number of attendances we had from about when I arrived here in 1991 through to 2003. We averaged about 75 attendances a day with little variation over the year. Since 2003, we have been increasing between 5 per cent and 7.5 per cent per annum. Last year was a bit lower, only 3.5 per cent. Nevertheless we are now at about 37 000 patients a year, from 27 000 patients a year five years ago.

CHAIR - Is that through ageing in the main?

Dr PIELAGE - Yes, there are a lot of things which cause that. Over the period of time the population has grown. It has also significantly aged. We are seeing that in the emergency department the increase in attendances of people over 50 is growing at twice the rate of the increase in attendances of people under 50. There is a definite move towards the older age group and, if you look at the demographic charts of what is happening in Tasmania, there is a very definite ageing population that is occurring very rapidly. Older people generally have a higher incidence of multi-system and complex

disorders so they take up disproportionately more time per attendance than younger people do. They are more complex and they tend to stick around longer in the department.

There are other things that are increasing our attendances. We are getting increasing referrals from the north-west region. The LGH is having a much greater tertiary role than it did 10 or 15 years ago. I have been told, and this is hearsay from very senior sources, that the percentage of in-patients from out of our region is somewhere in the high 20 per cent, so 27 or 28 per cent.

Ms FORREST - What do you classify as out of the region?

Dr PIELAGE - Out of the northern region, so Tasmania north, north-west, south. Our hospital, the LGH, is really the hospital for the northern region.

Mr WING - Is that the telephone boundaries?

Dr PIELAGE - Yes, that is basically the telephone boundaries.

Ms FORREST - Does that include the patients who cannot receive the treatment they need in Burnie?

Dr PIELAGE - Yes, they come to us.

Ms FORREST - They have to come because they have no choice.

Dr PIELAGE - They have no choice but it is this hospital having a tertiary role. We are receiving patients from out of our region for services which cannot be provided. The Royal Hobart Hospital is classified as and sees itself as a tertiary hospital for the State. There are some services for which it undoubtedly is because it is the only hospital to have a burns unit, with neurosurgery, or cardiothoracic surgery and certain levels of paediatric surgery. However, the number of patients it gets from out of region is much smaller than the number of patients we get from out of region. It is almost an order of magnitude difference, because we provide services to the north-west, such as renal medicine, respiratory medicine, urology, haematology, radio-oncology - there is a huge list of services with large numbers of patients that we cover for the north-west region. For many specialties, the catchment is not just under 150 000 for the northern region, it is quarter of a million for the northern part of the State and that seems to be increasing.

Certainly, in the emergency department, the number of patients that are coming through to us from the north-west region has been increasing over the years. Compared to six or seven years ago, we are seeing about 1 000 to 1 200 more patients a year from the north-west. It is a slower increase but we also have a bit of an increase in the number of people from out of State.

CHAIR - Is any of that increase due to some of those services now - and I think that is the case - not being provided on the north-west?

Ms FORREST - Where they once were, you mean?

CHAIR - Yes, where they once were.

Dr PIELAGE - I am not so sure, but I think it is probably a change in philosophy of referral. In other words, instead of things being handled by general physicians they now send them to the sub-specialists and things like that. I think it was a change of practice, more than anything, but I am not sure that there has been any deficiency in particular specialties in the north-west. There are changes in what you refer. Things that used to be handled by general surgeons now go to plastic surgeons or urologists or whatever.

Ms FORREST - Do you think we need to redefine the role of the general practitioner? We heard evidence earlier today that the GPs no longer undertake simple suturing, simple fracture setting, some illnesses that could have been dealt with by them in the past?

Dr PIELAGE - I am not an expert on general practice. I know that the role of general practitioners does vary, depending on their age, but more where they are. General practitioners in some of the rural settings do a lot more practical and procedural work than a lot of the inner city general practitioners.

Mrs JAMIESON - Do you think this is tied up with litigation, for example, or the fact that you have better services within your hospital and it is easier to get rid of them as we can get more patients through in the city than we can out in the country?

Dr PIELAGE - Yes, I think there is a time factor. Some of these procedures are time-consuming, some procedures are expensive - with putting on plasters and stuff, the actual plaster is expensive so it is not particularly remunerative for the general practitioner - sometimes they do not have the skills. If you go to work in the far distant country, you tend to select certain GPs who like doing that sort of thing or feel confident doing that sort of thing. Obviously if there is an easy out, there are specialist facilities available, one tends to refer on. There is definitely a difference between city and rural general practice.

In actual fact, from the emergency department point of view, people continually talk about general practice patients in the emergency department, but we do not have that many true general practice patients. There is always a cross-over. Sure, a child with otitis media in the middle of the night could be seen by a general practitioner, except that not many general practitioners are open for business at 2 a.m. and it is a cross-over. It is an acute problem, it is very painful and it is equally an emergency department problem, but it is a five-minute consultation. It does not take time. The patients with acute minor stuff - or minor for us - that could be classified as being able to be seen by a general practitioner as well, tend to sit in chairs and then go home; they are not long consults. The general practice patients we get are not chronic reviews. We do not get people coming for blood pressure checks or chronic back pain and all sorts of chronic GP things. We get acute problems, fractures, lacerations, severe headaches, rashes.

Ms FORREST - Having said all that, the Federal Government is looking at putting in these GP super clinics. What I am hearing you say, and there is other evidence to support your view, is that the percentage of attendances at the emergency department that could be seen by a GP is very small. If we increase all these after-hours GP services are we going to make an impact on the Department of Emergency Medicine or is it going to be minimal and would the money be better spent elsewhere?

Dr PIELAGE - The impact on the emergency department will be small because these sorts of patients take up little time and little resources. The problem we have in the emergency department, particularly our emergency department and in a lot of emergency departments around the country, is overcrowding due to bed access block.

If I can go back to Mr Dean's question about the increase in attendances, there are other things which impact on that and I will just clear that one out of the way. We have had over the last decade increasing attendances from drug, alcohol and psychiatric disorders and to a large extent that probably reflects the lack of resources in the community, particularly in psychiatry. We have very limited psychiatry in the hospital but also there are virtually no private psychiatrists in Launceston anymore. It is a smallish number but they can be a bit of a worry. We have an increasing number of sick dental patients, again reflecting the lack of dental services. I think I have already mentioned overseas and interstate visitors who put us on their itinerary.

We have changed what we do in the emergency department. There are a lot of changes in work practices, so patients who would have been an automatic admission to an inpatient bed 10 or 15 years ago never get near one. They are treated in the emergency department, they are investigated, they are sent home for follow-up or for further investigation as an outpatient. Patients who used to get to lie on a trolley now get a chair. Sometimes that is appropriate, sometimes it is because we have run out of trolleys and we have no space. We are a lot more efficient but we still block up significantly in the department. We have a few problems. We are a small department and we lack space but we also have severe bed access block. We do have some staffing issues but we are chronically overcrowded at the moment. It has been progressively getting worse. When I wrote my previous submission we had just been through a rather hellish winter with record levels of bed access block. The January just gone has been the worst month ever for bed access block, which is very worrying because the middle of summer is usually not a problem or not as big a problem.

Bed access block actually has an official definition. A patient who has bed access block is a patient who is admitted or transferred to another hospital or dies in the department and who is in the ED for more than eight hours. This is often expressed as a ratio to all deaths, transfers and admissions. I might point out that we average about 2.5 deaths a month so it is not a big component of it. In January 2009 we had the highest ever number of access block patients. It basically was the equivalent of having six trolleys continuously occupied by admitted inpatients waiting for beds every hour of the month. Officially, we have 20 trolleys in our department so that is about a third knocked out of commission. We had the highest ever number of patients spending more than 24 hours in the emergency department. That was 122, which is four patients a day spending more than a full day in the ED. In fact we had 22 patients who spent more than two days in the ED waiting for beds. Our record was actually set I think in August - just over five days waiting for a bed.

Ms FORREST - Five days in the ED?

Dr PIELAGE - Yes, five days and eight hours.

Mrs JAMIESON - On a trolley?

Dr PIELAGE - On a trolley.

Mrs JAMIESON - So what is the legal situation with a person who may have a physical problem lying on a trolley which is not very comfortable at the best of times?

Dr PIELAGE - I don't know.

Ms FORREST - Are these trolleys the older trolleys that I would be used to?

Dr PIELAGE - I honestly don't know what you are used to.

Laughter.

Ms FORREST - The ones that are hard to get on and off. When the sides are up you can't put them down yourself as the patient if you need to go to the toilet or whatever.

Dr PIELAGE - No, you can't put them down yourself. The modern trolley has a pneumatic lifting device. You can lower it so it is not as hard to get on as the trolleys from, say, 20 years ago. The mattresses are reasonably comfortable. We spent quite a bit of money on getting good quality mattresses, but they are still firmish and they are still narrow. An emergency department trolley is designed for patients to be assessed and to be treated and to have procedures done, so they are a bit of a cross between a bed and an operating table. We do procedures on trolleys: we do fracture reductions, we may do anaesthetics, we may do lumbar punctures, we put in complex lines and we do all sorts of things. We basically have full-blown anaesthetics on trolleys. It is not a bed and we can't have beds. Beds are too wide, too soft in the mattress and they are not suitable for the sort of work we do.

Ms FORREST - The access for the staff is the issue?

Dr PIELAGE - Yes, we have to be able to treat the patient and a bed is not the ideal place to do that. So we have trolleys and we have patients lying on trolleys for a long period of time.

CHAIR - There are other health issues associated with that as well with these people on these beds in the emergency department, so what is the position there?

Dr PIELAGE - There are lots of issues with having access block patients in the department. We are not an inpatient ward; we are an emergency department so we have two toilets in the department. Last month we were up to 55 patients but we often have more than 40 patients in the department and we have two toilets. Admittedly there are some more toilets in the waiting room but they are out in the waiting room. We have two showers but they are in the same room as the toilets. When you have lots of inpatients they tend to need showering and often toileting and we don't have the facilities, whereas on an inpatient ward there is at least one toilet and shower for every four patients. Well, we have one for every 20 patients. We don't get inpatient services. We don't have physiotherapists, occupational therapists, speech therapists, pharmacists or dieticians. We don’t have in the emergency department all these other things that go to wards.

Ms FORREST - Do they get meals?

Dr PIELAGE - They do get fed but they don't get all the other services that inpatients need for their treatment and their rehabilitation or whatever.

Ms FORREST - I know in a ward the patient's dietary needs can be easily assessed because they are in a particular bed in a particular area. In the emergency department does that present challenges?

Dr PIELAGE - Very much so; we are not set up for that. I don't think I have seen a dietician in an emergency department in 17 years. There might have been one but I missed her. We are not on the rounds.

CHAIR - With all of these other services that you say are lacking in the ED when all of these people are there, who provides those services to them? Is it the staff working in ED?

Dr PIELAGE - We don't get them.

Mrs JAMIESON - Are family involved?

Dr PIELAGE - The nurses are flat out. The admitted inpatients are extra patients. We have our constant 100 patients a day, plus or minus 20, coming through the door. That is our work. The inpatients are just extra work which we have to deal with. Nurses aren't physiotherapists or occupational therapists; they're nurses. They do have a wide range of skills but they have neither the time nor the specific skills to do stroke rehabilitation. A stroke patient should be on a stroke unit. They should not spend two days in the emergency department but that is what happens. We know from studies in Australia and overseas that patients who spend an excess time in the emergency department have an overall longer length of stay in the hospital, independent of the time of the emergency department. They also have a higher morbidity and mortality. Emergency departments are emergency departments, they are not inpatient wards; we do not provide the services.

There are other issues. We do not have the drugs these patients need, we do not have the place to keep all the drugs these patients need and so our nursing staff have to spend a lot of time tracking down the various medications that they need.

CHAIR - So, doctor, is it right then to say that with all of these patients that remain in the ED who should be out in the wards, because of that, their stay at the end of all this could well be much longer than what it would have otherwise been.

Dr PIELAGE - Yes, absolutely. That is correct.

Mrs JAMIESON - If a person has a disability or is grossly overweight, what happens about their care? They may not be able to hop off a trolley.

Dr PIELAGE - They probably cannot hop off the trolley but if they need to go to the toilet, they are helped to the toilet. We do currently lack lifting devices and we have to get a lifting device from elsewhere if they are really, really heavy.

Mrs JAMIESON - Are family encouraged to stay with people if they have family or is that a hindrance?

Dr PIELAGE - We do not mind family; we encourage family to a certain point but too many people in a very crowded environment - when you have two patients in a room which is designed for a single patient with no dividing curtain, because it is designed for a single patient, it gets very crowded very quickly, and these people are just waiting for an inpatient bed.

Our peak number of patients waiting last month - it could have earlier this month actually - was 22. Officially, we are a 20-bed unit. I came into the department a bit after midnight earlier this month and in that document I have just circulated there is a letter I wrote to the CEO about that and, basically, at that time there were 10 extra trolleys in the emergency department in addition to our normal 20. So some of them were double-bunked in single rooms, our gynaecology room had two patients in there, our paediatric room had two elderly patients awaiting beds in it, our theatre had two patients in it, one of them was being sutured at the time while she was sitting in a chair and the other one was on a trolley. They were both in the same room because there was nowhere else to go, there were patients on trolleys around the staff station, there were patients in corridors, lying on trolleys, there were chairs everywhere. We had no spare trolleys.

So my question to the CEO is what happens if we have a cardiac arrest come in, what do we do? Where do we put them? They are going to deteriorate somewhat while we find somewhere to put them. What if we get a head injury come in? How are we going to do it? We are going to have to bodily lift someone off a trolley and put them on the floor to put the new patient on the trolley.

Ms FORREST - Would you ever consider by-pass? If you know have a cardiac arrest coming in -

Dr PIELAGE - To where?

Ms FORREST - To the Royal.

Dr PIELAGE - They are dead.

Ms FORREST - Yes, I am just asking the question.

Dr PIELAGE - You know, they are dead. There is no by-pass. A by-pass in Launceston does not come into the issue. We cannot go on ambulance by-pass.

Mrs JAMIESON - So you cannot transfer to maybe a private hospital?

Dr PIELAGE - The private hospitals in Launceston make their living out of elective surgery and day procedures. They do not have house medical staff, they do not have intensive care units, they cannot look after very sick people. Also trying to get patients to them at two o'clock in the morning is impossible.

They do not receive acute patients from ambulances, undifferentiated patients - there is no by-pass. We are the only show in town and the only show in the northern region.

Ms FORREST - So is there a way to fix it, in your view? It is not just money; you have to be efficient with the use of the money, surely.

Dr PIELAGE - There are various things. The fixes will cost money. There are various things that have been done and can be done and a lot of them are temporising. First of all, I just want to dismiss the issue of the new emergency department because people look at the new emergency department as a panacea. It is not entirely settled yet but the new emergency department will probably have a total of 42 or thereabouts patient spaces, about double what we have. There will be bigger spaces. One of the problems with our current department is that the cubicles are very small; they were made in Lilliput. We cannot do procedures in cubicles because there is not enough room so whenever we want to do a procedure on somebody we have to move the patient to another room. That used to work in the early 1990s but does not work now because the procedure rooms have patients in them waiting for admission. It becomes an enormous juggle of patients and trolleys and everything every time you want to do something. It is like working in treacle; everything goes very slowly.

With a new emergency department and bigger cubicles we will be able to do procedures in cubicles and we will have more cubicles but if the bed access block continues to grow at the rate it is growing we will be blocked solid from the moment it opens.

Ms FORREST - There need to be more beds available on the wards, is that what you are saying?

Dr PIELAGE - Correct. We need to be able to get the inpatients into inpatient beds. At the moment, the inpatients stick around forever. It is very frustrating. In your document there is a copy of a screen shot of the emergency department information system and it is something which happens very often in the morning. That is a particularly bad one - I put a bad one in for an example, I wasn't going to put a good one in - but it is often that you come in in the morning and you have a list of 10, 12, 15, 18 and that is 21 patients who are all booked, all inpatients, all been admitted, all have bed requests and next to each bed request is the word 'none' - no beds. And that is a very depressing thing to find when you come on in the morning to find all these patients occupying your spaces with no beds available and you know it is going to take all day, and sometimes into the next day, to put those patients into beds. In the meantime, you are going to get your 100 patients coming through the department during the day, and with half your bed stocks already knocked out of action, or more than half.

Ms FORREST - Why are they staying too long in the beds on the wards?

Dr PIELAGE - There are lots of reasons. There is one identifiable group that is in a way the easy pickings and in another way very hard and that is the patients who are waiting for residential care. There are often some delays in assessing them - I think the system is probably a bit overloaded - but there are huge delays in getting them out to residential care. Late last year at a meeting I was at it was said that the average number of days for placement was 76 days, about two-and-a-half months.

Ms FORREST - That is after they have been assessed?

Dr PIELAGE - Yes, apparently. It takes a few days to a week or two to get them assessed but a week or two in the context of 76 days is really neither here nor there. The fact is that for more than two months they are waiting for placement. You can put an awful lot of cholecystectomies through a bed in 76 days and you wonder about the elective surgery list.

We cannot get them out. There is a shortage of nursing home beds really and the other problem is that the ones who stick around in the hospital are usually requiring high care, they are not in low-care beds. If they were low-care, we could probably get them home with lots of assistance but these are high-care cases and beds for them are in short supply. Also there does not seem to be any priority system where, because it is Federal versus State, et cetera, if we have a person sitting in an acute bed in the LGH they do not have supreme priority for nursing home beds. Also there are issues regarding patients' and relatives' choice of nursing homes - there are all sorts of issues around this and because I do not work intimately in this area I hear about these things but I do not know all the details.

Mrs SMITH - Can I just ask a question on that because it comes up consistently. If you gave your hospital patients priority to nursing home beds, though, would there be a fear that people might attempt to use that system, thinking that if they were put in through the hospital they would get into nursing homes more quickly? That would compound the problem.

Dr PIELAGE - It could do. We have become pretty skilled at bouncing people out of the emergency department if they do not need to come in. That is a risk, but the bar is pretty high for the gate-keeping role.

Mrs JAMIESON - Has it changed? Before ACAT would not assess people who were in hospital until they had gone home.

Dr PIELAGE - That is correct. It is extremely difficult when the patient cannot go home. ACAT certainly will not assess people in the emergency department, although sometimes they are in so long you think they should. Getting people out of the hospital is a problem. I must admit that our current CEO has been very good. He has bought beds at St Vincent's, I think, and at what used to be called Philip Oakden House and we're using transitional care beds, although transitional care beds are postponing the agony because they have to get to the end of that road too.

Usually, at any one time we have the equivalent of a full ward of patients awaiting residential care. The hospital only has five general wards and nominally there are about 32 beds in each. The other wards are special purpose wards - obstetrics, gynae, neonates, paediatrics, ICU, psych, that sort of thing. General patients do not go into those wards as a general rule. You often have 30, we have even exceeded 40, patients awaiting residential care. Effectively we have knocked our bed stock for general adult patients down by 20 per cent. This has a huge impact on the ED. It also has a huge impact on general surgery, or on surgery as a whole because they cannot get their elective patients in. That has huge potential problems for the hospital, which maybe Professor Einoder talked about. It has enormous potential implications which could be an absolute disaster.

If we could get the residential patients out quickly and efficiently, then we would probably not have such a bed access problem. However, in the longer term with the ageing population, the increase in referrals from the north-west and other factors, I suspect that even if we did get them all out, in the foreseeable future we would run out of bed stock. The hospital is a lot smaller now than it was when I came here 17 years ago.

Ms FORREST - Is that in bed numbers?

Dr PIELAGE - In bed numbers. Significantly smaller, because when the QV moved over they decreased the number of beds significantly and that closed down a lot of the general wards. Paediatrics has also shrunk. The bed stock is definitely down. Hospital practices have changed enormously in that time, day surgery has exploded and all sorts of other things which has meant that we, for a long time, have not needed so many beds. The problem is that as soon as there is some slack in the system and there are surplus beds that we are not filling, governments tend to chop them off.

Ms FORREST - Are you talking about temporary or permanent bed closures?

Dr PIELAGE - They become permanent and the whole infrastructure shrinks. We have a ward that was closed, then modified so that it would cost probably $500 000 to $1 million to turn it back into a ward and we have to find homes for all the people who live there at the moment.

Ms FORREST - What does it mean for people in that home?

Dr PIELAGE - They are mostly clinics, but we also do not have the beds because all the beds were old so they got rid of them. We do not have spare beds. If we have a flu epidemic or some sort of major situation where there are lots of casualties we do not have spare beds, as in things with mattresses and wheels.

Ms FORREST - Are you saying you cannot pull them out of the storeroom?

Dr PIELAGE - That is exactly what I am saying.

Mrs JAMIESON - If there were a major bus accident, for example, you would not be able to take them.

Dr PIELAGE - The mass casualty policies are a dead letter. If we already have 15 patients in the emergency department waiting for beds, I would like someone to tell me how they would clear enough beds quickly because it is almost farcical. I think in the medium term we will probably have to look at increasing bed numbers. If we can move out those residential care patients more rapidly, we will probably buy time.

There are other issues, things such as discharge planning. They have been banging on about discharge planning for 15 years and I still hear it is not well done. I have been hearing that for a decade-and-a-half. I do not know whether it is solvable. If it is solvable, why hasn't it been solved? I do not know. Again, I am not a ward person, I am an ED person, so this is all hearsay. I hear that it is not well done.

Ms FORREST - Could it be that the patients being discharged, particularly the ageing population, have more complex needs now so arranging for the support they need is more of a challenge?

Dr PIELAGE - Yes, and I hear also from various sources that there are deficiencies in various support facilities and agencies out in the community, so that you start running up against capacity issues there.

Ms FORREST - Potentially another block point is the lack of services, as you cannot discharge someone if there are no services to provide for their needs in the community.

Dr PIELAGE - That is either a problem or will become a problem. I am not sure whether they are at total capacity yet but those are the sorts of things that will happen. People either go into residential care, of which there is not enough, or they go home. If they go home, they need lots of services.

People talk about preventive care and putting money into prevention. Preventive care does not help a great deal because we all have one life, one death, we all know that most of your medical care occurs within two years of your death. If you have great prevention, all you do is push that back a little bit but we all get there in the end.

Ms FORREST - And hopefully you die quickly and quietly at home.

Laughter.

Dr PIELAGE - If we all died the moment we retired, it would be very cheap for the Government but, unfortunately, it does not work that way.

Ms FORREST - It would be very tidy, wouldn't it?

Dr PIELAGE - But the point is also that we do not ration services - we used to but now we do not. It used to be that if you were above a certain age, you did not get into ICU; you were above a certain age you did not get renal dialysis. That does not happen any more.

Ms FORREST - And treating premature babies is the same. They keep bringing that age back too.

Dr PIELAGE - Yes.

Mrs JAMIESON - They keep more people alive longer at the other end too.

Dr PIELAGE - Speaking for the hospital, particularly from the emergency department point of view, the gross overcrowding for us is mainly bed access block. If we got rid of the bed access block, we would be crowded from time to time because we have lots of patients now coming in to a small department. But it is the access block which is killing us. It is the access block which is destroying morale. It is the access block and the intense pressure which are making our senior nurses reduce their hours or look for part-time work elsewhere. We could lose more senior medical staff if it does not improve. The access block is not only bad for staff, it is bad for patients. It has occupational health and safety problems. When we are jam-packed with trolleys everywhere, God

help us if we have a fire, because the fire escapes are all cluttered and littered. We have nowhere else to put people. We have put patients on the floor in the past, we will do it again if we have to, put blankets on the floor with a pillow and lie the patient down. It is real Third World stuff.

CHAIR - Dr Pielage, I think we are going to find the same position as we did with Professor Einoder this morning, and that is we are running out of time. I think the committee may make the decision to ask you to come back at another sitting convenient to yourself. Mr Wing has a question.

Mr WING - Dr Pielage, you have been dealing very well with the situation of patients after they have been seen by professional people in your department, but I just want to ask you about the people who are waiting to see either a doctor or a nurse. Are you able to tell us what the average time is for people waiting to be seen by a professional?

Dr PIELAGE - It varies from month to month. The median waiting time - I do not have annual figures in my head, I have month-to-month figures - is about 30 minutes or thereabouts. In other words, half the patients will be seen within 30 minutes and then there is a tail. The average waiting time is probably out towards the mid-50 minutes. There is an Australia-wide standard of eight hours waiting time and no patient, for many months, has waited eight hours. In fact over the last couple of years most of the patients who have waited that long are usually well-known psychiatry patients who fall asleep in the waiting room and we leave them there overnight. There is no point in waking them up to see them because they are waiting for the psych services.

I do not like to admit this in public but the waiting times have actually improved, which is not really the message I am trying to get across. That is because we have changed our processes. The hospital has supported us by enabling us to get some short-term locum senior medical staff in because we are deficient in senior medical staff. It is a huge problem for us. It is very hard to recruit specialists so we are having some locum specialists and more senior registrar types. By keeping up the senior staff we have managed to keep the system working, albeit under a lot of stress, so that the waiting times have been surprisingly good.

Ms FORREST - Is that not part of the solution, then? If you have clearly identified that having these senior medical staff there, even only in a locum capacity -

Dr PIELAGE - It helps get patients seen but the problem very often is that you go to see them but you cannot do anything with them. I had a lady who came off a cruise ship. She was from Japan on a very expensive four-month cruise through the South Pacific. She was waiting there with her badly fractured wrist for several hours. She had been seen but we just did not have the room to do the anaesthetic and the reduction of her fracture.

Ms FORREST - Do you keep figures on the time from being seen to the time of treatment, that sort of time frame?

Dr PIELAGE - It is very difficult to give a time of treatment because there is no hard and fast marker. We keep times from time of arrival, time seen and time discharged. For patients who actually go home the time span has not changed a great deal, but for patients

who get admitted the time span has just ballooned over the last few years; in other words they are blocking the department up. When it is really busy it is like working in treacle. It really is. You have a doctor waiting to see a patient, the patient is out in the waiting room, you call the patient in and now what do you do? If you need to undress the patient to examine them, and you have to do that sometimes, there is nowhere to put them. They need a trolley and a curtain around them and there is nowhere to do it, so there is this endless shuffling and juggling of patients and trolleys to try to find a space to do it. It all slows things down. It is an intensely frustrating business.

Mr WING - Do you have any policy or practice for a doctor in particular to see patients, particularly children where parents are distressed and not knowing quite what is wrong with the child. I know of a couple of cases in recent times where parents have had to wait with a young child for quite a long time and have not been seen by a doctor and they were getting alarmed. Do you have any practice where the doctor can have a brief look to reassure parents that there is no reason for alarm?

Dr PIELAGE - We do have a process in which we try and do brief initial looks at patients. Patients do go through the triage process and children do as well. The waiting times for children on the whole are shorter than those for adults but when we are very busy we are very busy and very stressed. Sometimes the waiting times blow out for everybody and there is no way around that. The real problem is that when we are really blocked up solid and the waiting times blow out it is then very hard to speed it up again because there is no room to see people.

CHAIR - Dr Pielage, thank you very much for your evidence. It may well be that we would ask you to come back before this committee again for some further questions, if you wouldn't mind.

Dr PIELAGE - I would be quite happy to do that and it would also be helpful if the committee in doing so could pose certain issues which they would like me to address.

CHAIR - We could certainly do that and we will have a committee discussion on that to give you an idea of the issues we are concerned about and want further information on.

<u>THE WITNESS WITHDREW.</u>

Mr LAWRENCE DONALDSON WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Mr Donaldson, we thank you for being here today. We have your submission. I will just give you the opportunity to expand on any of that information or give any additional information that you would like and we will ask questions as we go through that process.

Mr DONALDSON - First of all I would like to extend Professor Jackson's apologies. She is, in fact, the author of this material and she is unable to attend. The other thing I would like to make clear is that I am here as an individual. I have a relevant background in health work force planning but I am not here representing any particular organisation.

If I could just draw your attention to the graph and I will make reference to that. I think it is quite central to the discussion and it would be good if we all had a shared understanding of what this graph actually meant.

Mrs JAMIESON - That is the same as the one we have in our submission.

Mr DONALDSON - Professor Jackson is the demographer with the University of Tasmania, so her particular interest is in population ageing and the effects population ageing will have in major service provision, including health. I have worked with her from time to time in terms of general practice work force planning.

This graph projects patient demand on public hospitals, statistically adjusted for population ageing. It shows that the demand on public hospitals will rise steadily and peak at 650 000 patient days in about 2040. This is in total variance to the crude rates that suggest patient days will remain stable at 400 000. So an older population will make inherently high demands on all levels of the health system. I need to say that Professor Jackson has since amended this data with the latest ABS figures so in fact the figures show that because of interstate migration in recent years in fact the crude rates will show 400 000 bed days will track up to about 490 000. In fact, the overall patient bed days statistically adjusted will in fact be higher and approaching 690 000, but later. This graph quantifies the level of the challenge in our health system and I suppose this will leads in from the conversation you have just had with Dr Pielage about what in fact the State is facing, not only our State but in fact every jurisdiction in Australia, and most westernised countries have a similar projection.

Certainly in discussions with Professor Jackson, by no means are we here to suggest that the State has a capacity to meet this bed day challenge. Even if we had the wherewithal to build the necessary hospital infrastructure, the real challenge would be staffing because of the background challenge that we have in an ageing health work force. Our health work force, in fact, mirrors what is occurring in the population more generally.

Ms FORREST - It's best that we do not get old then.

Mr DONALDSON - That is right.

Mrs SMITH - I would prefer to, thank you.

Mrs JAMIESON - Does the standardisation graph include people with disabilities at all? When you say age, what age are you talking of?

Mr DONALDSON - This is the population of Tasmania in general with no differentiation between disease or need type. Sitting within these figures would be disability, but only in terms of hospital utilisation. Although one would suspect, that if you were to apply this approach to general practice Medicare services you would see a similar divergence. In fact, we have used some of that data to do GP work force projections.

Does anybody have any comment or question about that graph? I am not a statistician. I am processing the information in the same way you would.

CHAIR - The only comment I would make is that you made reference to the crude rates being suggested as 400 000 for a year, and that is a rate set by -

Mr DONALDSON - But that would be based on utilisation as of 2004. So it would say, given our population in 2004, how many patient days were actually consumed. This graph was based on earlier projections where Tasmania's population was thought to have stagnated and remained stable.

CHAIR - It wasn't a figure set by the Health department?

Mr DONALDSON - No, it is statistically determined.

People are happy with this but if we were to adjust the data for population ageing, then it would give a bottom curve. The population in numbers does not change dramatically and therefore the demand for hospital beds doesn't change dramatically. But when you adjust for background population ageing - we are all getting older, but in terms of proportion and also in a numerical sense - older people consume more health services and this is what the figures suggest. Professor Jackson has applied that methodology and has been able to illustrate that, as our population ages, demand for hospital beds will grow exponentially and will in fact peak in the year 2050 with adjusted figures. I will give those adjusted figures to Dr Huntly.

Mr WING - It starts to plateau about 2040, the early 40s.

Mr DONALDSON - Yes.

Mrs JAMIESON - I'll only be 99.

Laughter.

Mr DONALDSON - We have a doctor in his 90s practising at the moment; the retirement tail is wagging in terms of our GP work force, which is reassuring. This is another chart that I wanted to share with you, based on our census. We are able to go to all our GPs in the State and ask them about their age. What we see here is a peak, so most of our GPs are currently in the age group 45 through to 55 - in this case it was 2005. With each decade the peak will move on the graph towards me and of course people will retire.

Mrs SMITH - But surely we should make the same presumption that as some are retiring, there are some coming through the end. Is that factored into your statistics?

Mr DONALDSON - It is. What we are experiencing is a generational change in general practice so as doctors are being trained they are not, en masse, choosing to become GPs, they are choosing to go to more lucrative specialist areas.

Ms FORREST - Should we pay GPs more?

Mr DONALDSON - My view is no, but I am not a doctor.

Ms FORREST - Why do you have that view that we shouldn't?

Mr DONALDSON - Because I think it is not a function of money, I think this reflects part of our society over the last 20 years. Our economy has been flush so we have been awash with money and I think we have taken the view that money is the solution to all problems and that if you pay people more then it will affect their behaviour. But our analysis of the new generation of doctors coming through is that they are not as money motivated as previous generations but they are more influenced by lifestyle choices, and this is what we are seeing with the feminisation of general practice. People are concerned to have a work-life balance that has not been there in other generations and they will often choose to work part-time. That trend has been well established and reasonably well understood but I think what has taken people by surprise is that men coming into general practice are choosing to work part-time as well.

Ms FORREST - So should we pay specialists less then to narrow the gap a bit?

Mrs JAMIESON - Get rid of litigation.

Ms FORREST - There has been some evidence that if GPs took on more of those roles of things that they tend to hand over to specialists for a variety of reasons, fear of litigation being only one of them, there would be less demand for the specialists for a start and potentially less time to wait to see a specialist. However, because there is such a significant gap between the rates of pay of the two, it is difficult to encourage medical students to consider general practice as their life-long area of work as opposed to dermatology

Mr DONALDSON - I think there are a lot of things about general practice that make for a difficult career path. I am sure if you asked a number of GPs, more money would be an attractor but I am still of the view that is only one dimension and we shouldn't concentrate on that. GPs are overworked. It is a very transaction-intensive role. When you are consulting, particularly under the Medicare system, it is skewed towards shorter consults so what we find is that doctors are pushing through maybe five to 10 patients in an hour. In reality, people coming to their GPs are older, they have multiple health issues and the doctor needs more time with them.

We are aware that the Federal Government is thinking about remunerating doctors more for longer consultations. That would be more cost-efficient in an overall sense because the doctor will be able to spend more time with the patient working out what their constellation of problems are and dealing with them in a more decisive way than simply

in a five minute window of opportunity. At the moment, in comes Mrs Bloggs with her list and the doctor will say, 'Give me your list; we will deal with one and two and make another appointment for three, four, and five'.

Ms FORREST - Structurally then, the specialists claim probably quite rightly that they spend more time with the patient because they get a bit more remuneration for a similar consult. If Medicare scheduling and the fee structure were more appropriate designed to reward them for spending time with the patient to sort out their problems before they send them away, do you think that would have a positive impact?

Mr DONALDSON - I think it would but it would require an overall restructuring of the entire general practice environment and also a rethinking of how the specialist would interact. I think if I have any particular message for the group today, it is that if you talk with one individual they will all have a particular view of the system, one experience set, and will suggest, for example, that if you could get rid of the bed block issue then it would be happy days. I think in reality we need to take a whole-of-system view and identifying what suite of mutually re-enforcing reforms are needed to deliver the outcome that everybody, particularly the community, needs. As a health system analyst, I am advocating that the committee takes that helicopter view and works to develop some kind of framework to see the linkages between different strategies and also the cultural differences.

Without being critical of Dr Pielage, I was sitting here when he said that in his view prevention doesn't work. I know that general practice as a profession would take him to task over that, but clearly from Dr Pielage's point of view and from a hospital specialist viewpoint investment in prevention might be perceived to be a waste of money. We know that the Commonwealth on Monday released its Health and Hospitals Reforms Commission and made it very clear that a package of prevention is critical to the overall survival of the health system. Our preoccupation with the bricks and mortar hospital environment has done us an overall disservice. I am of the view that many of the problems, and therefore the solutions within the hospital environment, are to be found within general practice of the primary health care setting and that there does need to be a refocusing of investment if we accept that we can't make the pie any bigger.

Mrs JAMIESON - Would you like to comment on the fact that so many people who go into general practice do not need a doctor, they just need somebody to talk with and maybe a nurse practitioner or somebody who has a working knowledge would also help to relieve the GPs?

Mr DONALDSON - Absolutely, and again it is my view as a non-clinician. I am sure that some GPs would be very angry with my point of view and others who are more progressive might say that this is the way forward. We are seeing tensions within the medical community between GPs and specialists that does create this cultural divide and within professions as well. For example, some GPs are clearly of the view that the way forward is to reform the way services are provided in the practice environment. They advocate very clearly a move towards multidisciplinary teams to work to release latent capacity within our existing work force where, for example, you have very experienced nurses who work with GPs but either the Medicare regulations or cultural impediments within the practice deny the community access to that expertise so effectively you find people are deskilled and there is a huge waste in terms of the overall health economy.

Again, the Health and Hospitals Reforms Commission has said that as an imperative we need very quickly and radically to change the ways of working and develop a skills mix. We see the debate within the Launceston General Hospital about skills mix and that same discussion needs to be had within the general practice environment. If we do that we need to think about the infrastructure within practices. A cottage-style general practice is not going to be a suitable environment for team-based care delivery. There needs to be a clinical infrastructure that supports high volumes - remember our number of patients that are floating around - and it needs to have a productivity focus to move patients through and have a tiered approach so that people are being triaged and gated to the appropriate level of health professional. In some cases it will be gated to a medical assistant who has certain technical competencies, or it could be a nurse who has a range of competencies, to the nurse practitioner who has a whole raft of clinical competencies that will negate the need for the doctor's consult. The view is that in the future the GP will become a consultant within the primary health care environment and you will see a GP for a true medical need, not because you need to have blood taken or your blood pressure measured or your medication reviewed simply because it is time to review it. There is a lot wrong with the UK health system but I think the message is that we need to look to other jurisdictions that have moved down this pathway and see what works and what does not work.

Ms FORREST - The UK system has certainly worked for nurse practitioners. They have nurse practitioners with clinics on their own without a medical practitioner present but they can refer.

Mrs JAMIESON - They have physician assistants and we could use our parameds much more than we do too.

Mr DONALDSON - Absolutely. Cultural impediments stop us having the discussion and I think we have been avoiding the discussion for the best part of a decade now. When you have our hospital, the Launceston General, running at 110 per cent occupancy - and back to that graph - is it going to be 115 per cent next winter, is it going to be 117 per cent? Can we build an A&E on the front that is going to resolve that? No. There is a whole suite of things that need to happen to deal with this.

Ms FORREST - There are figures that clearly show a maldistribution of GPs in Tasmania. The percentage of GPs per head of population in the Hobart area is significantly higher than the rest of the State, particularly compared with more remote areas and the north-west coast. How do we address that as an issue? One could say from that if people cannot get in to a GP in these areas their only other course of action is to go to the hospital. How do we fix this maldistribution of GPs?

Mr DONALDSON - The Commonwealth has been trying, through policy setting over the best part of probably 15 years, to deal with this maldistribution. It has been a policy focus and because we have focused on misdistribution we have in fact forgotten about the background problem, which is the overall reduction in the work force because of ageing.

I have a fairly radical view. In terms of looking at the number of doctors available in Tasmania I think we have ample doctors, but we are not using them in a very clever way.

Mr WING - That is interesting because the general feeling I think in the medical profession is that we do not have enough doctors.

Ms FORREST - GPs are you talking about?

Mr DONALDSON - Probably GPs.

Mr WING - Yes, GPs.

Ms FORREST - There are in some parts of the State.

Mr WING - It is very difficult for many people to get an appointment in any practice because so many lists have closed. I am surprised to hear you saying that.

Mr DONALDSON - It is a radical viewpoint that I hold and that is why I am here as an individual. It comes down to this notion of skills mix. If every person presents at the practice and expects to see a doctor then clearly we are not going to have enough doctors to go around. But if you have a skills mix where a person presents - mum and bub, for example, and child is a bit grizzly - they can be seen by a suitably skilled person who can differentiate between a condition that requires medical attention or one that simply requires a reassurance.

Mr WING - But isn't it a fact that throughout Australia we have a shortage of doctors because we have not trained enough and the governments have not provided enough funds to train the new doctors we need.

Mr DONALDSON - Certainly under this paradigm that everybody in need of a non-acute intervention or some care must see a doctor, then we will never have enough doctors. If you look into the UK paradigm, you will see that a practice actually has a group of registered patients and is funded based on their registered pool, and the GPs are told to keep their registered patients well. I am not going to tell you necessarily how to do that but we will have certain benchmarks that we will monitor in terms of things that we perceive to be best practice in terms of population health. The patients come in and they are filtered. Very rarely would they see a doctor because very rarely do they need to see a person with a medical qualification. What they need is somebody, more often than not, who has a clinical scope that can deal with most of those things that typify general practice.

Ms FORREST - You are talking about work force reform.

Mr DONALDSON - Yes, absolutely.

Ms FORREST - So there are enough doctors if we use them in the way they need to be used if we utilise other skilled health professionals to deal with the issues that do not need a doctor's attention. The people who do need to see a doctor get to see a doctor because they are available then. They are not tied up with all these other people who do not need to see them.

Mr DONALDSON - It is where you have diseased and difficult people getting accelerated access to medical care. If you were to look at what happens in the Launceston General

A&E or Burnie or the Royal what we are seeing, this is what the statistics show, is that people who have passed through this threshold, and they do have chronic disease, are not getting access to the level of care at the GP level. That is often because the doctor's working day is being dictated by patient demand, so it is really first in, best dressed.

Mr WING - So many of the doctors now come from underdeveloped or developing countries and they really should be looking after people in their countries. We seem to be poaching them and taking advantage of the fact that they prefer to live here. If we did not attract such large numbers do you think we would have enough doctors, whom we have provided and who are not really needed in developing countries, to cater for the needs of our own people?

Mr DONALDSON - Without work force reform, overseas doctors really are our only way of meeting the expectation of the health system and patients. If I move to this graph, which is using some of Professor Jackson's techniques, this is a projection of general practice into the future. So based on 2006 what we have is about 50 GPs that we perceive to be the shortfall in terms of numbers of doctors and average hours that they work. What we are seeing is that these lines are diverging, so our demand projection, adjusted for age, shows that we are going to need something like 649 GPs, whereas we only have 545 at the moment, I think.

Mrs SMITH - In what time space?

Mr DONALDSON - This is 2016.

Ms FORREST - This is in the current model?

Mr DONALDSON - Yes.

Ms FORREST - If we keep practising the way we are.

Mr DONALDSON - If we keep practising the way we are. There is a gap to supply, mostly to do with age-based retirements. It shows the level of suffering the community is going to encounter. It will manifest in people increasingly going to their GP asking for a consultation but will not able to get it because there are not even enough GPs to go around now under the current model. If we do not change the model then that is the level of the gap. A lot of these patients who have an expectation of seeing a doctor will either go without or they will track through to your local accident and emergency setting.

Mr WING - Our terms of reference are basically to deal with the hospital system. I acknowledge that if we have a shortage of GPs that does impact on the hospital system because more patients go to outpatients or to hospital. In the hospital system do you think we have an adequate number of doctors or a shortage?

Mr DONALDSON - I would not comment because it has been probably 10 years since I have been a business manager. Looking generally at the nationwide figures about specialist supply, we have similar problems or similar challenges. I think they were talking about a tipping point in about 2012 where we will have more specialist doctors than GPs in the country, and that is clearly inappropriate.

Mr WING - You are not able to comment about the number of doctors and the adequacy of numbers in the hospital systems in Australia?

Mr DONALDSON - I would not attempt to.

Mr WING - Because that is what we are primarily concerned with.

Mrs JAMIESON - Is there a role for general practitioners to work within the hospital system, do you think? I know it has been tried.

Mr DONALDSON - I think, yes. If we are not to go down the road of wholesale work force reform then I think there is a role. Where you have a true accident and emergency service that is really scoped to deal with acutely ill people then a true general practitioner, with their primary health and longitudinal care concerns, is probably out of context. Because the hospital environment is congested, as they say, with GP patients, as an accommodation of the problem we say we will put GPs in there, whereas my view is that we should be perhaps looking at models like the UK's walk-in health centres. Where people cannot, for whatever reason, find access to clinical care - non-acute care - they can go to a walk-in health centre. These are set up around major commuting hubs and people can go in there and say, 'I think I have a viral illness; can somebody have a look at me?'.

Ms FORREST - They would be seen by a nurse practitioner.

Mr DONALDSON - All nurse operated. It creates a buffer where people have a choice to go and have their need met without presenting at an acute accident and emergency service which is clearly inappropriate for their needs.

Mrs JAMIESON - So it could be attached the hospital so you have that flow-through.

Mr DONALDSON - Or you could take your community health centre infrastructure and build annexes on there. It would require refocusing of staff where people might be community nurses and very accustomed to that. It might be a challenge to pick up some acute assessment skills about trying to differentiate between those people who can be reassured or receive a service at that level, or whether they do in fact need to be facilitated through to an acute setting.

I take your point that this is outside of your terms of reference

CHAIR - I am getting a bit concerned about that. I need to keep it inside the terms.

Mr DONALDSON - There really is not the true recognition within the health sector of the inter-relatedness of these sectors - general practice, hospital, aged care, community care - and we need to avoid the risk of tackling this in a mono-dimensional way. In fact solving a problem in one area could in fact compound another and there could still be a lot of tension within the clinical community. We need to be asking people to be understanding and respectful of each other's viewpoints and there needs to be better conversation.

Ms FORREST - The Federal Government have the major running of some of the primary health services, the GP service and that sort of thing and the State Government have the running of the State hospitals. If it were all under the one umbrella so that you had primary and preventive health and acute health services under the one banner you would not have this buck passing and saying, 'They didn't give us enough money', 'You're not spending your money right'. You know how the argument goes. Is that an appropriate way forward and would you then have more chance of that whole-of-health system reform?

Mr DONALDSON - A patient-centred care rather than sector-focused care?

Ms FORREST - Yes.

Mr DONALDSON - I agree, but I think we would need to be a little bit careful. Again, working in a hospital environment and in trying to work through reforms there is a temptation to think that structural change is the job in its entirety. You can see people with goodwill who will make the worst possible structure work because they choose to make it work. Structures can help or hinder but ultimately what it comes down to is meeting of minds between people and people being able to work respectfully with each other and to focus less on -

Ms FORREST - Turf wars.

Mr DONALDSON - turf wars and egos and think very carefully about what ultimately is in the interests of the patient and what is in the interests of the community.

Ms FORREST - Yes, you have answered my question.

CHAIR - I just want to go back to a comment you made a while ago about the need for us to look at other jurisdictions that have gone through this. Have you any other jurisdictions in mind that we ought to be looking at or that have done this and gone through these processes?

Mr DONALDSON - Certainly the UK has gone through significant reform over the last decade and we have been alerted to this because we are bringing in doctors from overseas. Some of them are UK-trained but often they might have come from Africa or the subcontinent via England, so they are bringing a range of perspectives and they alert us to the question of why do you do it this way or why do I need to see every patient, what is the business about fee-for-service medicine, it seems crazy. That has prompted us to go out and look more broadly at other ways of doing things but I do not think one size fits all. Because of our cultural links, clearly the UK system is an obvious area to look but clearly there is a lot wrong with the National Health Service as well and it is not only learning what works well but it is about avoiding the mistakes.

CHAIR - Have you looked at the Singapore system? In recent times they have gone through an absolute and total review of their public hospital systems and so on.

Mr DONALDSON - No, I haven't.

CHAIR - I just mention that one.

Mrs JAMIESON - When you are doing your demographics and things, do you actually use the information that is on the Internet much or is it just one of those things, I will go and check that out. There is a plethora of information on the Internet.

Mr DONALDSON - Personally, I live by the Internet. It is just getting the networking going. I have people in Scotland who are reviewing what we are doing here and they are saying, 'Be careful of this' or 'You need to be aware of that' or 'We do things differently'. There is a potential for a national network and also an international network of thinking that can be brought to bear on the problem. I do not want to denigrate the Department of Health because clearly their health services plans are very good in terms of direction. There is only one criticism - and this is probably the nature of State control - that they would look to those things that they have control over within their bailiwick and that does not include general practice, so I think it is a little bit nonsensical when we talk about reforming the State's health system without putting general practice cheek to jowl with hospital and aged care so that we have participative decision making in what happens and when it happens.

CHAIR - Lawrie, are there any other graphs or anything further that you want to -

Mr DONALDSON - I could talk all day.

CHAIR - We are getting close to time and that is the reason I interjected then.

Ms FORREST - You said we need to be aware of some of the pitfalls if we are looking at other models. What do you suggest the pitfalls of the NHS are?

Mr DONALDSON - I have talked with UK-trained GPs and the reason that they often come here is that they feel that the problems with the health system have been loaded onto their shoulders. So you are effectively in a situation where they, like us, have burgeoning demand and a limited supply so effectively the UK GPs are put in a situation where they have to ration, based on their local budget. They are actually fund holders for services that their registered patients will consume through local hospitals. So if I am a UK GP and you're a patient, you end up in an ambulance and go to the Launceston General then my practice gets a bill for your care from the hospital.

It has a positive incentive because what it means is that as a group of GPs we have a very clear motivation to keep you well, to keep you out of that hospital environment because we will pay for it. What it also means is that sometimes the patients have expectations about level of access to services and investigations and you are the Johnny on the spot who has to say to somebody, 'I know you have read on the Internet that you need to have these investigations or this drug but I am sorry to say that' -

Ms FORREST - My budget won't allow it.

Mr DONALDSON - 'they are not clinically indicated and the budget won't allow it'. I think this is the real conundrum of Health. No society can afford to pay to deliver the services that GPs or doctors would like to provide and patients would like to receive.

Ms FORREST - It is about public expectation isn't it?

Mr DONALDSON - Yes.

Ms FORREST - We had a witness earlier today who said the general public expects more. When I started as a student nurse many years ago, if somebody came in with a pain in the belly you might get an X-ray but now you have an ultrasound, an MRI and possibly a CAT scan -

Mr DONALDSON -And full blood tests.

Ms FORREST - Yes and full bloods, the whole bit, whereas before someone would have a poke around and have a feel of your belly and if everything seemed okay off you went. We have raised the expectations of patients - well, the health profession has and society as a whole has. Do we have to take responsibility for this ourselves? Do we have to take a good hard look at ourselves as a member of the public and say do I really need to have all that just because I know it is there and I can have it? How do you address that?

Mr DONALDSON - I think community education, and that sounds easier said than done.

There are some very serious challenges but coming back to the earlier point, it is the suite of mutually reinforcing things that we do in a very sensible way- talking with the community about their expectations, looking at latent capacity within our existing work force, work force reform, looking at the clinical infrastructure that we have out there. We are throwing millions of dollars at super clinics and the question is whether there appears to be a real philosophy of care behind it, which is worrisome. We need to be working within a regulatory environment because there are constraints within the Poisons Act, for example, that constrain or slow the pace of change. I think that we are playing catch-up football now and the day of reckoning is here.

CHAIR - Thank you very much. Any closing comment that you would like to make?

Mr DONALDSON - I love the soapbox.

Ms FORREST - Many of us would like a soapbox.

CHAIR - Thank you very much for your evidence. You referred to those further graphs. Are you able to make those graphs available to the committee? Thank you very much for your time and the evidence that you have given us.

Mr DONALDSON - Thank you for your audience, I appreciate it.

THE WITNESS WITHDREW.

<u>DR ANDREW DUNCAN MACLAINE-CROSS</u> WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you very much. This is a public hearing, and is all being recorded on *Hansard* to be referred to by this committee to help us complete the report. If at any time you feel there is evidence you would like to give in-camera, please make us aware of that and we will make a consideration. You are protected by parliamentary privilege. You have provided to us a written submission and a number of other documents and I will leave it open to you to go through some of the issues and we will ask questions as we go through the process.

Dr MACLAINE-CROSS - Thank you. You have three documents from me, one is the presentation I am giving today which is a summary document; the second is a speech I gave on rehabilitation services on 24 May last year; and the third is a selective culling from my old file of submissions and letters that I have written. Going through this file which I started 23 years ago, it was interesting to see how the more things changed, the more they stay the same. I thought it would be of interest to members to read some of that correspondence, which is not very long, particularly the submission I made some years ago about special accommodation houses in Victoria and how they make a contribution to the health care system. We could well look towards duplicating that system in Tasmania.

Thank you for giving me the opportunity to express my views about the problems of the public hospital system and how we might improve the service to the public. By way of introduction, I will tell my background and experience, and my part in the public hospital system. I have worked at the Launceston General Hospital since 1978 - 31 years - and I spent most of this time as a visiting consultant physician practising general medicine, geriatrics and rehabilitation.

I would like to briefly list the main problems as I see them. One is inadequate residential care facilities for frail, dependent aged who cannot be supported at home - in short, hostels and nursing homes, although they now like to call them high and low level care. Two is inadequate residential care facilities and community support for the young disabled. Three is inadequate residential care facilities and community support for the mentally ill. Four is inappropriate use of hospital beds for the frail, dependent people who spend long periods of time in public hospitals waiting for residential care. Five is denial of access to public hospitals because of insufficient of beds and staffing, and this is due to a large extent to the failure to acknowledge the growing demand caused by rapid growth of the frail, dependent old, old population cohort. The effective closure of beds by having to provide nursing home care plays a major role in inadequate bed provision. Six is inadequate provision of community support services delaying hospital discharge. Seven is great bureaucracy and great complexity in delivering support services in the community. I will return to elaborate on these matters later in my presentation.

Access to public hospitals these days is usually through the accident and emergency departments and a useful starting point to our discussion is to categorise the intake which is as follows. People with aged and palliative care problems are 40 per cent of the intake. People with exacerbations of chronic diseases are 40 per cent of the intake. Acute medical illness contributes only 20 per cent of the intake. Most in the first two categories are patients who have some dependency on others and the progression or exacerbation of

their often multitude of medical problems increasing their dependency is a major factor in causing admission. In other words, it is the increased dependency that is the final precipitant of admission, not necessarily their acute medical care needs.

The increased dependency is also what delays or prevents hospital discharge. If a person is not coping at their current level of dependency they may not be able to be discharged. If their level of dependency has increased as a consequence of their acute illness and cannot be returned with time and rehabilitation in hospital to their previous level of dependency, there will be problems unless those extra dependency needs can be met in the community. Unless we can access community support services or appropriate residential care that is adequate and provided in a timely fashion, this is going to lead to inappropriate delays in hospital discharge and, in turn, inefficiency.

The core functional units of public hospitals are as follows: accident and emergency departments which we know have been under pressure; surgical service where we know that occupying surgical beds often leads to cancellation of surgery that needs to be done because the beds are not there; medical services; rehabilitation services; outpatient day and hospital-in-the-home services. Hospitals have many departments and co-workers that provide essential support to these core function units, and I acknowledge that these services are essential and just as important.

These units focus on providing medical, surgical and nursing care and meeting patient dependency care needs. Hospitals are good at the first three, that is medical, surgical and nursing care needs, and they have to also identify people's dependency and to try to minimise it by medical and surgical treatment and rehabilitation. They must coordinate their efforts with aged and disability support services outside the hospital to facilitate early discharge from hospital.

It is not the job of hospitals to meet people's long-term dependency and residential care needs. Our hospitals are constantly required to meet these needs and it is often in conflict with the provision of surgical, medical, emergency and rehabilitation services which are the core business. We are increasingly seeing that the same problem now developing in private hospitals. The reason for this is the failure to provide adequate aged and disability services in the community and the failure to meet the need for residential care facilities.

These problems were prevalent in the late 1970s and early 1980s and I attach a copy of some submissions I made 24 years ago. It is sad to see that the problems remain unchanged. These services are the responsibility of Commonwealth Government, often administered by the State. Long-term residential care beds are allocated to a region by the Commonwealth Government. It is then up to a local organisation to raise the capital and take the responsibility for developing a facility. If the terms offered by the Government are thought to be commercially unviable then the much-needed beds are not delivered or delayed. The effect of this will evident after a delay of three to five years and the penalty will be imposed on the whole community but especially on public hospitals that end up having to take patients who cannot get nursing home beds when needed. This situation occurred 25 years ago and it is still happening. It will get worse unless the present system of funding and allocation of residential care beds is reformed.

Many of you will already be aware that the allocation of beds in Tasmania that was offered by the Commonwealth was not taken up because the providers thought it was unviable for them to do so. This is the problem that we should be jumping up and down about. This should not be allowed to stand.

Ms FORREST - Is that money still available or has it gone back into some other bucket?

Dr MACLAINE-CROSS - They are waiting. The way the Commonwealth works is that it says there are so many beds available here, come and make us an offer and negotiate with us. If everybody said we are not prepared to negotiate on these terms or because it is not viable or whatever, then those beds are not provided. It is like when they shrank medical schools years ago; you will pay the penalty not immediately but in three to five years time.

Mr WING - So the difficulty is for the institutions having enough money to build the infrastructure?

Dr MACLAINE-CROSS - That is it, and you will remember that hostels are funded differently from nursing homes. Hostels are funded via bonds which raise the money to build them and those bonds are loaned to the institution interest-free. Nursing homes are not funded on that basis.

Mr WING - It does seem that the Commonwealth has a very major responsibility for the inadequate number of beds in hospitals because they do not have policies and funding to provide adequate aged care beds in particular. You have also mentioned young people and the mentally ill as well but especially aged care; is that your view?

Dr MACLAINE-CROSS - I certainly agree with that. I had to battle the system where we had inadequate beds in Launceston in the early 1980s and I can see the same thing happening now. It has never been good since then but it was even worse then. The problem is that in a big city it is more likely that capital can be raised but in smaller and poorer places it is less likely that there will be the people with the organisational skills to get together to raise the capital and provide it. There is also the fact that the Commonwealth thinks if someone doesn't apply for the beds then it's not their problem. Of course it is their problem; it is a problem for everyone of us.

Mr WING - The Commonwealth is putting money into the economy to create employment so would it be appropriate to put quite a lot of it into aged care facilities?

Dr MACLAINE-CROSS - Considering we know what the future holds it would make a lot of sense.

Mrs SMITH - The aged care facilitators are saying that you have to have 60-bed facilities to make it viable and that appears to be the rationale behind a lot of the amalgams we have seen? We have seen the Salvation Army remove themselves totally from Tasmania, OneCare grows significantly by taking up capacities within the State and the Eliza Purton Home now has Tyler Village. You are not the first person to talk about bed blocks at LGH and it appears to be because of the aged. Is there capacity amongst the service providers at the moment, if the terms were right, to pick that up or do you see there is capacity for an entire new homes system of 60-beds plus?

Dr MACLAINE-CROSS - It is in a way self-evident that there is not that capacity, otherwise all of that bed allocation would have been filled. So the mere fact that the beds are left on the table does indicate that, for whatever reason, the people who have provided these services in the past feel that they are not able to provide them under the terms offered by the Commonwealth.

Mrs SMITH - Significantly your story is backed up by the information I get about Eliza Purton and Tyler House being full up and yet they have bed vacancies on the north-west coast. They are putting that down to the Commonwealth program of keeping people in their homes longer, which means they don't really get their high-care beds, which is the money end of the system, until those people are nearly in their last few months of life. So one policy of the Commonwealth appears in some sectors, and this is a smaller regional sector, to be creating problems of financial viability because the beds now are vacant. It is interesting that in the north, in the city, there are no beds and yet I have had significant evidence in the last couple of weeks about bed vacancies on the north-west coast. That appears to be a general feeling of several providers. This is a significant issue at the Launceston Hospital, quite clearly. Aged care beds are creating problems in bed blockages in that hospital.

Dr MACLAINE-CROSS - I am not familiar with the north-west coast but I am familiar with Launceston. I am familiar with the constant grind of trying to find residential care beds for people who are waiting in hospital for beds because they cannot be discharged. They are too frail and too dependent so it would not be ethical to discharge them home. We have a nurse whose sole job is to lobby nursing homes to see if we can get these people into beds in a reasonable time frame. It frequently is still three months, four months or six months.

Mrs SMITH - We had evidence that aged blocking hospital beds should be given priority with nursing homes.

Dr MACLAINE-CROSS - I could not agree more and they never are.

Mrs SMITH - Do you have a fear - and I asked the same question of a previous witness - that it could compound your situation because people who are desperate may attempt to use that system to put their aged family member in through the hospital system to get on the priority list in the north?

Dr MACLINE-CROSS - I have heard that argument before and I really do not think it is the case. It is hard to get into hospital these days. The 'three strikes and you are in' rule applies. You have to go to casualty and be sent home, go to casualty again and be sent home and if you are lucky you get in the third time. I am joking of course; it is not quite as bad as that. Some people think that is the way the system works.

Mr WING - Unless you find the mortuary on the way.

Dr MACLAINE-CROSS - I have heard that argument. I have heard that argument for 24 years and nobody suggests that hospitals should have some sort of absolute priority. However, as these people are often on the waiting list for six to 12 months to get into a

bed before they came into hospital, and as the reason they are in hospital is that they had to wait too long on the list, it seems to me that they should have some sort of priority.

Mrs JAMIESON - Further to that, what if we had an expansion of transitional care beds so that you can actually see a person's maximum potential over a period of time? They may in fact not necessarily need to go to a nursing home but could be at the hostel level.

Dr MACLAINE-CROSS - We had transitional care beds in Launceston. The Government closed them down through cost-cutting. It is interesting to see that they have now opened transitional care beds in Hobart after having closed ours.

Ms SMITH - What about Philip Oakden House? You have some transitional beds there.

Dr MACLAINE-CROSS - We have just got some. They actually shut the others down. We had them working functionally for over 20 years.

When frail dependent people are discharged from hospital it would be better if there was a single community service agency that could be contacted by hospital staff to negotiate the provision of these services in a simple and timely fashion that does not cause unnecessary delay in hospital discharge. Instead, we have multiple programs, all administered separately, all with different and often illogical exclusion criteria. Frequently there are delays in initiating service or lack of funds, so patients end up going on a waiting list and not getting the help they need because the places have been allocated. The increasing complexity of these services and their large administrative overheads cry out for reform and rationalisation.

Ms FORREST - Are some of these services funded by the State and some by the Commonwealth?

Dr MACLAINE-CROSS - Yes, but the Commonwealth has huge departments that invent new services and complex criteria which exclude you or make you eligible for them. They bring them out regularly and each has to be set up separately with an administrative overhead. The problem with administrative overheads is that if you have too many small compartments, the administrative overheads grow. Just as nursing homes have to be a certain size to be economically viable, you cannot have too many small boxes, particularly if there is no coordination between them. It would be very helpful if there was a single reference point where you could ring up a single person who says, 'Mrs Jones is going home from hospital. The changes that have happened in the time she has been in here are this, this and this; her level of dependency has increased and, for this reason, we think that she will need this extra help'. They say, 'Thank you, we'll get to it. The service will be in place when that patient needs to be discharged'. That would be wonderful but it is not what happens.

Ms FORREST - So the person who would undertake that role, what skills and qualifications will that person need?

Dr MACLAINE-CROSS - There are a number of people that could fill the role. A nursing sister would be probably ideal, and an occupational therapist would do the job - people who are skilled at assessing people's dependency and are good at working out solutions and ways of meeting people's dependency needs.

After all, as I say to my medical students, if you wanted to say in one word what is the problem of old age, it is 'dependency'. If you are not dependent, you are not a problem. If you are dependent, you are still not a problem provided there are people who are willing and able to meet that dependency need. Of course, as dependency increases it becomes increasingly costly and sometimes increasingly difficult to meet those dependency needs in the community. That is why we have residential care facilities. So a person who has worked at the coalface, who has practical experience, like an OT or a nurse, would very ably fill that sort of position.

Mrs SMITH - By if you, as the medical practitioner in the hospital, are going to ring this person and tell them Mrs Jones is leaving the hospital and her needs have been assessed here as requiring this, this and this, why would you take a qualified nursing person out of the loop to do that instead of finding an administrator who can organise this sort of package for that person. Tell me why we need a qualified person?

Dr MACLAINE-CROSS - Yes, because it should be only one person and that person then should be able to network. Secondly, this is a very important role. This saves time and money. Very often the people who will be ringing up will be perhaps the doctors in the hospital, perhaps one of the senior nursing staff, saying, 'We are planning for Mrs Jones to go home on Monday and this is what we assess' - they talk the same language.

Ms FORREST - Would one person be able to do the job with the current workload there is, and how many people would that potentially replace who are running out there in these duplicative services at the moment, with all this exclusion and other criteria? I am looking at the cost-saving in having one person dedicated to the role as opposed to what is currently happening now - or not happening?

Dr MACLAINE-CROSS - The system does not work if there are not the resources on the ground to make it work. This is human services; you cannot put in a machine that does the work. People have to do the work and the person who is filling that role will have to network with a series of other providers, so she may talk to Meals on Wheels, to the people providing home help services or community nursing services, but her job is to bring it all together.

Ms FORREST - Is that person going to be, potentially, replacing a whole swag of other people who are sort of doing that job now, sort of setting up access to services - and some it is working, some of it is not - when that patient goes home?

Dr MACLAINE-CROSS - Yes and no. We often have nurses in hospitals delegated for this enormously complex role of ringing all the different agencies and trying to bring it altogether into a package to meet that person's dependency needs.

Ms FORREST - So they are being taken away from patient care while they are doing this?

Dr MACLAINE-CROSS - Yes.

Ms FORREST - Yes, that is one cost.

Dr MACLAINE-CROSS - A nurse is specifically assigned to try to fight their way through the residential care system to satisfy the number of long-term residential people waiting for nursing homes in a hospital. Without her efforts it would be worse so we are already having people taken off the coalface in the hospital to meet these roles.

Mrs JAMIESON - I know the system does work because that was how I worked for about 20 years in doing exactly that. It does work and we use personal carers for our daily care. We worked out there networking with the community and we used to get referrals from the hospital and it worked really well. But then of course you have to have funding. Then someone comes along, like the Commonwealth, and puts a whole lot of standards on you, a whole lot of other paperwork, and then it starts to kill you.

Dr MACLAINE-CROSS - The bureaucracy is a curse.

Mrs JAMIESON - Absolutely.

Mrs SMITH - All the practitioners seem to say that.

Dr MACLAINE-CROSS - And it is so far away from us in Canberra; they are not accountable.

Ms FORREST - The bureaucracy might say the system would work well if it wasn't for the doctors.

Dr MACLAINE-CROSS - Doctors really only want the patients to get the treatment and the care they need; that is our interest. Yes, at times we are testy and at times we argue with them, but someone has to do that.

Mrs SMITH - You make the comment about bureaucracy in Canberra being so far away et cetera and we have a mix and match of services in our health and hospital systems between the State and the Commonwealth. Do you have an opinion on whether or not the total health system would be better placed with States or with the Commonwealth so that we don't have over-bureaucracy, blame games et cetera?

Dr MACLAINE-CROSS - It is all about having people accountable and not being able to dodge it by saying it is someone else's job. It is all about having clear lines of accountability and responsibility, and of course with that have to be the resources to do the job. You can't be placed in an impossible position so that nobody could stand the job because the resources are never there and they spend all their time apologising. Yes, I think it is so and I think it should be the Commonwealth. There are only two models: one is where the money is all tipped into a bucket and then there is a board with representatives of the Commonwealth and State who get together and administer it, or someone takes the responsibility. I think there is a lot to be said to say it should be the Commonwealth, because they have all the money.

Mrs SMITH - So would you be comfortable, considering your earlier statements about the bureaucracy in Canberra not knowing and understanding, or assured that we could get over that element? It puts the focus on one area but it tends to be that the further away you get from the issue the harder it is for people to understand what is on the ground in the local area.

Dr MACLAINE-CROSS - That is the danger. Considering we in the north have difficulty getting any access to the bureaucracy in Hobart, it is a problem.

Ms FORREST - A typical example is the Mersey hospital, the worst example of pork-barrelling I have seen in my life. The Federal Government came and took over a hospital as a bit of a trial and at the first opportunity dumped it back in the State's lap, saying 'Here is the money; do it', so there is no responsibility.

Mrs JAMIESON - Dr Maclaine-Cross, would you care to comment on the use of information technology, robotic health, e-health and all the rest of it?

Dr MACLAINE-CROSS - I think it has its place but it is peripheral; it is not the main game. Everybody would like to save a heap of money by putting one person in and saying 'You fix it', or by some bit of cheap building or cheap bit of whiz-bang but at the end of the day services are delivered by working teams of people and they have to provide services that cannot be done by a machine. Nobody has invented a machine that can do clinical history, physical examination or exercise clinical judgment; nobody has invented a machine that takes the nurses' roles. Yes, making sure that doctors, nurses and other health professionals have adequate tools to work with can greatly improve the efficiency of the system. A classic example of that was pressure-care beds. For years we fought the budget to get pressure-care beds and they would not budge. Well it cost us a heap. Eventually a breakthrough occurred and we were able to get pressure-care beds and it saved buckets. It was good for the patients, it was good for the nurses but those of us who have been around for a long while will remember how hard it was to fight those battles.

If you can get the system right so that some consultation can take place from a distance, then that cuts down wasted travel time could be of great advantage. It needs to be explored.

Mrs JAMIESON - In Japan, for example, they have these modules that sit on the end of a dressing table. They are called 'care bears' and they are a robotic thing that reports change of temperature and all that sort of thing. So you are reducing the number of staff required to wander around the rooms or wards. Soon we will only need technicians.

Dr MACLAINE-CROSS - I agree it has it is place but I worry that it distracts because it is sometimes seen to be an easy solution. It is a bit like putting computer terminals everywhere. It is seen to be doing something but it isn't necessarily doing much at all.

Ms SMITH - If you could look at a best practice example around Australia to solve some of the issues you have bought forward, is there one there?

Dr MACLAINE-CROSS - I have not been visiting other people in recent times so perhaps I am not the person to ask that question, but I doubt it. I think the anecdotal evidence that you have from colleagues in different parts of Australia is that the system is under pressure to a greater or lesser extent right around Australia.

Ms FORREST - Are any international models working?

Dr MACLAINE-CROSS - They all have their problems. Ministers have a tendency to want to go overseas and find some person who works somewhere and then they import a model. It is not usually a very successful exercise. In particular, modelling on the British National Health Service is not a very successful exercise because that is grossly underfunded.

Mrs JAMIESON - And you cannot always transfer something from overseas to here anyway.

Dr MACLAINE-CROSS - You have to meet local needs.

Mrs JAMIESON - Would you care to comment at all on the use of overseas-trained staff - doctors, nurses - from the point of view of comprehension for patients? Their values may be different et cetera.

Dr MACLAINE-CROSS - I am not quite sure what your question is.

Mrs JAMIESON - Older people or people with a disability may have a hearing impediment, for example, and can miss what the doctor, who might have English as a second language, says.

Dr MACLAINE-CROSS - We must be very grateful that we have been able to fill the gap from overseas after they shrank medical schools 20 years ago and caused this problem, instead of expanding the medical schools. However, in a rich country like Australia we should be able to graduate enough nurses and enough doctors from our own young people. There should not be that need. Of course, communication and language is at the heart of medical and nursing practice. Sometimes I have difficulty in understanding my own registrar and it does create a difficulty. You might say that being in my 60s maybe my hearing is not as acute as it was but that is actually not the problem. So, yes, I think that is a problem but we must be very grateful because we have fluffed it so badly and we need all the help we can get.

Mr WING - What are we doing to redress that at the moment?

Dr MACLAINE-CROSS - They have expanded the output from medical schools.

Ms FORREST - I understand there is some concern that there will not be placements for those graduates. It is okay to educate medical graduates but they have to have somewhere to go at the end of it. Do you believe that to be the case?

Dr MACLAINE-CROSS - It is a concern because when they started the nursing school in Hobart there were one or two years where the Government was cutting down on nurses and where young nurses could not get employment in Tasmania. I thought it was disgraceful. You cannot ask young people to train, to devote their life, to pay their education fees out of their own pocket, and then not provide a job. I think that we should move heaven and earth not to do that.

Mr WING - Are you able to say to what extent there is extra training for medical students?

Dr MACLAINE-CROSS - Again I am not sure that I am qualified to answer that but they have expanded the medical schools and we are going to have an increased number of graduates. That is going to be most welcome. It is a pity it took so long.

Mrs JAMIESON - You have been here for 30-odd years and others have been in the profession now for 30 or more years, so are we going to see that same commitment in the future given that a lot of people now expect to have three or four jobs in a year or only work part-time for lifestyle and all the rest of it, in which case we are going to need more staff?

Dr MACLAINE-CROSS - Every generation has its changes in culture. In the days when GPs practised in one or two-man practices, when they went on holidays their overheads didn't go down one little bit and that encouraged them to work long hours. Now in a group of eight or 10 you go on holidays and it doesn't affect your overhead at all, so there is a tendency to take greater holidays. Is that a bad thing? Not necessarily; it might be a very good thing but it has to be taken into account. When they shrunk the medical schools on the argument that doctors were unnecessary costs and having fewer of them saved money, the counter-arguments were there - more women medical graduates, more things that could be done for people, the increased ageing population - that we should be expanding them. We knew all that then; it is just that that side of the argument didn't win. If you had done it then we would not have had the shortage medical practitioners.

In public hospitals, the reason we have a shortage of specialists is that they would not appoint enough registrar positions. If you don't have registrars funded for public hospitals then you don't get the specialists of tomorrow trained in adequate numbers. So all of that was known.

Mrs JAMIESON - And you lose your training status as a hospital.

Dr MACLAINE-CROSS - There is a need for State and Commonwealth governments to make greater attempts to achieve equitable distribution of resources through the State. This is particularly so as 53 per cent of the population lives in the north and it applies especially to the aged who cannot travel over long distances.

In the 1980s we had an excess of nursing home beds in the south and a shortfall in the north. The situation was worse with hostel beds. It was 21 per 1 000 in the north, 37 per 1 000 in the south and 65 per 1 000 in South Australia. This led to large numbers of hospital beds being blocked. The State Health department tried to blame the LGH management and staff and when presented with the data were angry rather than apologetic for allowing the situation to develop. Nevertheless over the next few years nursing home bed licences were transferred from south to north and the hostel shortfall was gradually diminished but there is this problem of communicating with health departments.

Over recent years we had a similar situation with a progressive run-down in rehabilitation facilities in the north of the State, with a gross deficiency of service provision compared with the south and the rest of Australia. These problems were not addressed despite several reports that skirted the real issue - adequate resources and their allocation. We finally had a report that explicitly stated what we already knew but the

Department of Health sat on this report for almost a year and it only became available because it had to be released under freedom of information legislation.

The Department of Health needs to put much greater emphasis on seeing that there is equitable distribution of resources and that the inequities are identified and corrected in a timely manner. They should have an ongoing open dialogue with service providers in all regions of the State.

In conclusion, the number of hospital beds has decreased over the years; advances in medical and surgical care and in organisation have allowed this. However, the marked increase in the number of frail dependent aged means that there will be a need for regular review and expansion of services in years to come. We need to move to meet these needs. We should certainly not be using the hospital to make up the deficiencies in residential care and community care services, which is what we are doing.

CHAIR - On the resource inequities existing between the south and the north, you spoke passionately about that on 24 May, so there have been no changes at all?

Dr MACLAINE-CROSS - No, there have been changes. An allocation was made in the Budget, the number of rehabilitation beds is being expanded and there have been increases in staffing. There have been improvements. It is like 1984. We talked until we were blue in the face, we had to run a media campaign, we had to make a dreadful noise and we had the Rosser Report. It said, yes, there are staffing deficiencies, so 140 extra staff were appointed as a result of the Rosser Report, but it did not come through logical discussion with the Health department.

CHAIR - Do you find that to be a disappointing situation, that in order to get these things corrected, even though the departments know about it, you have to either go publicly or make other noises to get support and get things changed?

Dr MACLAINE-CROSS - I think it is very disappointing and one can only hope that it will improve in the future. What is required is some vigilance. Because we are not the centre of power in the north of the State, there is a much greater probability that our needs will be overlooked or neglected compared to the south. We have to make sure that people here, who know what is going on, stand up and make a noise. That is why I am very grateful that this committee is being held, because it does give a venue for people.

The argument that always goads us is that Hobart is the teaching hospital and therefore it should be better funded. It has special roles that other hospitals don't have and therefore it should be specially funded. The starting point should be that doctors, nurses, paramedical staff, social workers and services should be distributed equitably throughout the State and then you should have to justify why they are not, not that it just grows like topsy in one place and not another. I think that is the fundamental question.

With rehab services, you cannot argue that there should be more physios, more OTs, more rehabilitation services in the south than in the north. You cannot argue that there should be six geriatricians and four rehab doctors but barely one in the north, because those services have to be provided locally.

Mrs SMITH - I think you have had 31 years in the Launceston hospital, so you have lived through some significant changes. You would have been at the hospital under what was the regional board system where they had community and medical representation. There was a lot of capacity in those days for the community to get behind the locals and fundraise et cetera. Is that better or worse than a system now that has a CEO and a statewide vision and a direction from a department that sounds, on the evidence we are getting, certainly here in the north, somewhat distant from the practicalities on the ground?

Dr MACLAINE-CROSS - Good question, and I think that there is much to be said for going back to the old system. The old system of course will only work if people of independent spirit, who truly represent their local community and are prepared to speak out fearlessly, are prepared to sit on that board and make a contribution. The old hospital board system did have some merit but if you do not appoint the right people on the board, you do not get what you need. For example, CEOs of hospitals are basically appointed from head office in Hobart on five-year contracts. They have to be very careful in what they say. When their contract comes up for renewal, it will not be based on how they are regarded or how they are regarded to have performed by their local community; it will be how they have met what head office in Hobart deems to be the appropriate standard. So when you have that situation, where the appointments are not made by the local community, then you do need a local board overseeing the situation to make sure that the local community is getting its fair share of resources.

Ms FORREST - Would that board, then, be the one who recommended the renewal of the contract?

Dr MACLAINE-CROSS - That is not something that I feel competent to answer. I think the important thing is that if appointments are made from Hobart and not by the local community then someone in the local community needs to be acting as the local advocate so that local people, who are unhappy about services, can complain to him.

Mrs JAMIESON - Given that we are down to three-and-a-half hospitals, virtually, we should be able to draw enough expertise out of the local communities. Once upon a time we had hospitals everywhere and they all had their own boards so there should be enough expertise within regions.

Dr MACLAINE-CROSS - I agree; I am sure there is and I don't think they ever had any trouble filling hospital board positions in the past.

Mrs JAMIESON - Do you have any comment about the current doctor training system that we have, the fact that sometimes you can do the shortened five-year courses and may not get quite as much practical experience before you come out? Are there any improvements or any way we can encourage people to go into the medical field?

Dr MACLAINE-CROSS - I do not think it is a matter of substance whether it is five or six years; I think it is the training involved. I must say I am very encouraged by seeing our young students and young graduates coming on. We do not have any fears for the future provided we have an adequate number to do the job.

Mrs JAMIESON - What about the medico-legal issues; do you think there are more problems now with litigation than there used to be? This may be one reason why people are not taking on some of these tasks?

Dr MACLAINE-CROSS - In certain areas of medicine it is so large that it changes practise but I think for most of us it is just part of life. We get on with it and it doesn't worry us too much. I do not think it is a major issue.

Ms FORREST - You made comment about working in teams. We have had some evidence that there needs to be broad work force reform such that GPs, for example, do not see everybody that walks through the door. Some people do not need to see a doctor; they can easily be sorted out by a nurse or nurse practitioner and can be referred on if that health professional felt they should be seen by a medical practitioner. Again, the GP can see people who do not need to go to a specialist. So the reform enables the skills of that particular person to be used more effectively and appropriately. Thus the doctor shortage issue, particularly GPs, is more about maldistribution and workforce shortage rather than a worker shortage. Do you agree with that?

Dr MACLAINE-CROSS - By and large medicine is about team work. We all work in teams and we often work in a number of different teams. Is there a GP shortage? Yes, there is. Is that part of the doctor shortage? Yes, it is. Do nurses have a role to play? Yes, they do. Should nurse practitioners be a substitute for graduating an adequate number of doctors? No, they shouldn't.

Ms FORREST - No, I am not suggesting that. We have had evidence that there is actually not a shortage of GPs in the State; there is a maldistribution issue. Not every patient who walks through the door has to see the doctor. A nurse practitioner would certainly do. If we reform the work force to that level, where nurse practitioners are recognised as practitioners in their own right to provide that level of service, and you look at the maldistribution issue with GPs in the State, could you alleviate some of those apparent doctor shortages?

Dr MACLAINE-CROSS - I think nurses have a role to play. I do not have the personal experience because I have not been in general practice. I rely on second-hand information from my wife who was in practice for 40 years. Her view was that most of the problems she had were complex and difficult; there were not many that would be easily transferable to a nurse practitioner. As she aged she would have had more older patients so her practice changed over time, as it does, so that perspective may not pertain to all medical practices.

Ms FORREST - If you have a nurse practitioner who specialises in diabetes, for example, you could have a nurse practitioner who actually has a greater breadth of knowledge about diabetes - dietary management, medications, blood tests - than a GP. That person could manage the care of a diabetic and you only send them to the doctor when their diabetes was not being well managed.

Dr MACLAINE-CROSS - That is absolutely true. Those nurse practitioners are often focused in hospitals and they are a resource to all the general practices of the town. It would not necessarily be efficient to have a person with the same expertise in a practice of only five doctors, for example.

Ms FORREST - But if that person was in a community setting, not necessarily linked to a GP practice, so that all the GP practices in the area could access that person -

Dr MACLAINE-CROSS - But that's what happens now.

Ms FORREST - But they are based in a hospital.

Dr MACLAINE-CROSS - What is the difference? People who practise in a hospital also practise in the community. It is merely the venue from which they work. The only problem for patients is the parking at the general hospital. Those nurses go to the private hospitals, public hospitals, visit people at home and they range across the whole community, just as I do.

Ms FORREST - Can they prescribe?

Dr MACLAINE-CROSS - No, they can't prescribe.

Ms FORREST - Do you think that would be a positive step? If they are really managing these patients they could have prescription rights and the capacity to order A1Cs and that sort of thing?

Dr MACLAINE-CROSS - I doubt if that is the core of it because the diabetes specialist nurses do a very good job as they are and their contribution is very valuable. It becomes probably only marginally more valuable if they had prescribing rights. In very peripheral places like country towns where there isn't a doctor, I think that becomes a much more valuable thing. Most of the discussion about nurses prescribing rights is about places where there are no doctors or where doctors are in gross deficiency and always will be. I am not against it; I just think it probably doesn't add much in a situation like Launceston or a large town.

Mrs JAMIESON - We are looking at the whole of Tasmania in this inquiry; we are not just looking at Launceston.

Dr MACLAINE-CROSS - Sure.

Mrs JAMIESON - So when you have peripheral areas like Flinders and King islands there would be a definite role, say, in palliative care for a specialist nurse who could have prescription rights.

Dr MACLAINE-CROSS - Yes - antibiotics for bronchitis or otitis media - I agree.

CHAIR - Dr Maclaine-Cross, thank you very much for coming in today.

<u>THE WITNESS WITHDREW</u>.