PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN THE COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON TUESDAY 20 MARCH 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr SCOTT FLETCHER, VIA TELECONFERENCE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Scott, you probably know about how parliamentary committees work but just for your information, this is being recorded on *Hansard*. The evidence you give may be used as part of our report. It is will transcribed and put on the public website in a few days' time. If you want to discuss anything of a confidential nature you can make that request and we can consider that. Otherwise it will all be part of the public evidence.

You are covered by parliamentary privilege while you are speaking to the committee, but anything you say after that outside this setting you may not be.

Do you have any questions?

Dr FLETCHER - No.

CHAIR - Thanks for sending through your document as well. I expect you intend to speak to that, do you?

Dr FLETCHER - Yes. That will form part of the presentation.

CHAIR - Yes, that will be helpful. It provided us with a lot of good information, so thanks for that. Would you like to lead in and we will ask question as we go?

Dr FLETCHER - I will make a start on the document you have in front of you. Firstly, I have been away for the last six months of last year on sabbatical. I left at a time when these budget cuts weren't around and I have come back early this year and things have changed, and have been changed for some months before I got back, so it is easy for me to see the change. I don't need to remind you of the reason that we needed the change because you know that better than I do. From our point of view, our instructions were that we needed to make substantive changes. That involved closing one of our wards, and there are about 26 beds on a ward. We only have two surgical wards, so it is 50 per cent of our surgical wards that were closed. We were asked to reduce our activity in theatre and that meant a 17 per cent reduction of elective theatre lists. Also, because I am an orthopaedic surgeon, it had a significant impact on the amount of joint arthroplasty that we were doing. Before I left to go on sabbatical we were doing between 20 and 30 - say 24 to 26 joints - per month and now it has been reduced to a meagre four, or one per week, for the whole of the department. The wheels keep on turning so we are

still doing the outpatient sessions and seeing patients who are needy and so we still put them on the waiting list.

CHAIR - You said it is down to only four per month, how many orthopaedic surgeons do we have in Burnie and Mersey now? Is it only your list that has been cut to that extent or is it everybody's?

Dr FLETCHER - We are blessed with the number of orthopaedic surgeons that we have per capita; we have five on the north-west coast. In Launceston there are seven and in Hobart there are about the same number. There is quite a difference between Hobart, Launceston and here insofar as three of our guys are full time, whereas they are all VMOs in Launceston and Hobart. You are aware of this concept called 'FTEs', full-time equivalents, our full-time equivalent is about 3.4. I am told by one of the orthopaedic surgeons in Hobart that theirs is 1.85, so even though they have quite a number they are each only doing a small number of hours themselves in the public hospitals. They have private hospital commitments. The same in Launceston; I reckon their FTE is about 2.2. Ours is 3.4, so because we have full-timers, people who work in the public hospital full time, we have quite a capacity to do a lot of hours of work. We are quite geared up to work and that is why we are able to do as many joints as the other guys in Launceston and Hobart per month and why our waiting list is looking very good in comparison with the other areas. To cut that down from 26, we were geared up to do 26, to four per month - in other words, I only do one joint once per month. In the private system I would do three times that amount per week, so there is a big difference between the amount of joint work I do in the public and the private systems.

We are all twiddling our thumbs in theatre, doing little cases, but nothing of substance at the moment. Having said that, I don't want to mislead you. What the CEO indicated to me last week was that we would increase that from one per week to two per week, so that gives us about eight or 10 per month as opposed to the 26 per month previously. I think the CEO is sympathetic to the cause and if he had the money, he would certainly support us, but the reality is that money is tight at the moment and so we are not doing much.

CHAIR - Scott, you probably didn't see the *Mercury* this morning, but there was a story of a lady who needs some orthopaedic surgery on her ankle who had been put off a number of times at the Royal. With this additional capacity - and I know you can only do what you can do at the moment because of the budget cuts - I think I am hearing you say that there is capacity in the north-west region to undertake more surgery, and if we look at the FTEs you have quoted, 'more surgery than any other part of the State in this area.' So why aren't we doing that?

Dr FLETCHER - We are not doing it for a couple of reasons. One is that we have no money to do it. We have wards and theatres closed but we do have spare personnel capacity, so if we had the money and we reopened the wards and theatres there is some capacity to do extra work, at least back to where we were before, and maybe if we restructured a little bit we could make it even better than that.

The second and probably the bigger issue is this inter-regional transfer. You can do it quite easily for little cases, like arthroscopies or eyes or ENT and that sort of things, but when it comes to joint replacement, this is where the big problem lies in Tasmania. It is much harder for someone from Hobart to come down to Burnie to get their hip replaced

because there is a bit of after-care involved. It involves travelling and then, if they do get a wound infection or they have problems, it is hard to get down from Burnie if you are sick. So we are really relying on a teamwork approach. If you are going to do that you need a teamwork approach whereby Hobart is prepared to after Burnie complications. It becomes a messy area that is hard to manage.

If you are living in Melbourne or Sydney, you can imagine you could run a process whereby joints could be concentrated in one hospital and really go for it because they are in the one town. It is a little harder when you are separated by so many miles.

CHAIR - But do you think it could happen, Scott, if you had a statewide approach to this? Neurosurgical cases are all done in Hobart, as you know, and eventually those patients come back home. If they develop a complication, is there an arrangement that they will be supported by medical staff on the coast or do they have to go back to Hobart?

Dr FLETCHER - I reckon they have to go back to Hobart.

CHAIR - Might lack of expertise perhaps be an issue there?

Dr FLETCHER - The problem here with neurosurgery is that there is no-one with the expertise so obviously they have to go back to Hobart.

I am not saying it is insurmountable but I am just saying that it is a real issue. If, for example, I were to do all the Burnie orthopaedic cases, I know Hicks would expect me to not only take the glory but take all the pain as well, so in other words, if they had complications I would have to deal with them and the mileage between the areas is not great but, nevertheless, it is an issue.

But the three things that need to be satisfied if he was ever going to get up off the ground is that, first, I need to be happy to do it as the receiving surgeon. Second, I think the first surgeon who diagnosed their hip or knee arthritis needs to be comfortable that the patient is allowed to somewhere else. Third, the patient needs to be happy. It is possible if you can get a surgeon who says, 'My workload is just far too great and I am never going to be able to do it, so if there is someone else who is reasonable who can do it, then I am happy as long as the patient is happy', but those three factors need to be fixed up.

Mr WILKINSON - Just briefly, you were doing 24 to 25 joint operations a month, it is now down to four a month, and you have been told that is going to increase to how many a month?

Dr FLETCHER - To eight.

Mr WILKINSON - In relation to the 24 to 26 per month, do you believe that would have been able in the public to increase that with the three full-timers that you have?

Dr FLETCHER - I think there would have been the capacity, Jim, but it would need a restructure or a rethink of how we do things across the north-west coast. As you know, we have this two hospital system and there was a move some years ago to try to rationalise how we deliver services across the coast. Many people have looked into and there has been report after report who have all concluded more or less the same thing.

There are inefficiencies in it, the way we do it is not economically sensible, duplication is bad, and the way forward was the Tasmanian Health Plan.

What the Tasmanian Health Plan suggested was that we have 23-hour type surgery at the Mersey and the major cases at Burnie, so we sort of worked around that a little bit. They have gone part-way towards that but we haven't really brought it home so that it is as efficient as it could be, but I think we could not only get some efficiencies in better work practice or service delivery on the north-west coast, but we could also improve our productivity and part of that would be more surgery and more joints.

Mr WILKINSON - Is there much consultation with the actual practitioners like yourself and others or, alternatively, are these decisions made alien to speaking with the practitioners?

Dr FLETCHER - I think the practitioners know that we need to reform. Everywhere needs to change their practice or reform with time and I think the GPs know that. I think if we were to carry on changing the way we do things we would need to consult not only with GPs but the community, the mayors and the leaders in the town to make sure they understand the reason why we have to change. I think we need to go through that process a little more.

Mr WILKINSON - What concerns me a bit is if you are only doing your four replacements a month up there the orthopaedic surgeons are not going to be in the north-west coast, they are going to go interstate or wherever in order to do more of the work that they want to do.

Dr FLETCHER - This is exactly what the problem is and perhaps my greatest fear. I do feel for the patients in the community who are in pain and have to wait a long time. I have been trying to build up surgery and orthopaedics in particular on the coast here for the last 15 years and there was a time when I was working at one in one or one in two and it was just intolerable. I could do it for four or five years, but eventually it became so onerous that it wasn't possible for me to go on, and over the passage of the last seven years I have managed to get another three helpers - in other words, there are five of us now - and it is actually tolerable and enjoyable to the extent that you are not on every night and every weekend and you get some time out, which is so essential to survive.

With these cutbacks, one of the five told me just last week that he is actively applying for work elsewhere. This is a well-trained orthopaedic surgeon who sat his South African exams and passed. Recently in the last few years he resat his orthopaedic exams in Canada - and it is not a Mickey Mouse set-up over there, they really have well trained orthopaedic surgeons - he passed those exams and came to Australia and has settled here in Burnie with his family, and I can tell you that not only is he well trained but his operating skills are very good and his thinking is very good. He is logical and he is a nice guy and those sorts of guys don't come around very often.

He told me last week that he is applying to various places on the mainland because he can't get the joint surgeries he needs to get his Australian exam. I am supervising him here in Burnie at the moment and he needs to do a certain number of joints per month on a regular basis to be able to be ticked off by the College of Surgeons of Australasia. He is worried now that he is not having the throughput and that he will have to do another year of being supervised or be curtailed in some way to get his full fellowship in

Australia, so he is actively looking to go elsewhere and that is as a direct consequence of these cutbacks.

Sure, I can see why cutbacks need to have been made but I think we can do things smarter by rationalising the service delivery here and getting some productivity improvements and cost savings by other means than just closing wards and theatres. It really is deleterious and that is just one example of someone looking to go elsewhere.

CHAIR - Scott, a couple of things come to mind and one is the impact on a surgeon that would be a disaster to lose in so many ways but also the registrars and other medical team members. Is this creating issues with them in getting their required experience?

Dr FLETCHER - It is, Ruth, because, simply put, they're not getting their experience. We do a ward round every Friday morning where we all get together, so there are five consultants, four registrars - which are the ones beneath the consultants - and then two residents, so you have a team of 11 doctors, and then you have physios, an occupational therapist, nursing staff and medical students, and yet we had just four inpatients to see on this ward round. It looks silly with all these highly trained people trying to keep their work practices together and four patients is just not enough to teach or to keep the doctors busy.

Mr WILKINSON - Gee, the patients would feel important, Scott.

Dr GOODWIN - Or intimidated.

Laughter.

Mr HALL - So what you're saying is that you are potentially losing good people and there's obviously a flow-on deleterious effect from that. I know you've been well-served, as you said, by having five orthopaedic surgeons on the coast at the moment, but if the word is out there the work is not there then down the track you might be doing a lot more yourself.

Dr FLETCHER - In private, you mean?

Mr HALL - Yes.

Dr FLETCHER - It's hard to look someone in the eye when they come in to see you and you say, 'Look, you need a hip replacement and it's unlikely to be done in the public hospital for a long time'. They say, 'How much is it going to cost in the private hospital?', and I say, 'About $20 000', and it is actually quite hard to see them spending $20 000. I know some people have it but Tasmania is not a rich place and a lot of people don't have it.

The other thing about the training issues is that Hobart has a couple of accredited registrars. What that means is that these guys are on the training program for general surgery or orthopaedics - in this case, orthopaedics - so Hobart have two accredited registrars. Launceston have two accredited registrars on the orthopaedic training program. Burnie does not have any and never has had. The reason we don't have any is because you need a certain critical mass to be able to put your hand up and say, 'We have

significant numbers and significant breadth of expertise to be able to take on these guys as trainees'.

As I said before, in the last 15 years I've been building up orthopaedics in this area to try to get these trainees, and they are good quality guys and have been through a lot of hoops already so they are smart, intelligent, keen junior surgeons and it's very good to have them as part of your practice. It's good for us to be challenged by these bright young guys. So the North West Area Health Services get first bid at the end of this month - 30 March or something like that - the guys from Melbourne are coming across. I can tell that we look quite good in all aspects now except for the big cases and, clearly, there's just not enough work for them to be confident that we will be able to train these guys up. So I think what it's going to mean to us, unfortunately at least for the next year and hopefully not for too much longer, we will be put on as an area that may get it sometime but just not yet because of economical issues.

CHAIR - Scott, you talked a bit about the Tasmanian Health Plan and we understand what derailed that, but you also talked about the need to restructure the service delivery and we're focusing on the north-west which is your area of expertise, obviously. How do you see a restructure that could work to increase your capacity, perhaps within the cost constraints that there are? I would also like you to comment on what consultation has occurred with you and other senior clinicians up there in looking to restructure the way the two hospitals operate to create greater efficiencies and then be able to do more surgery or whatever it is within the constraints that are there.

Dr FLETCHER - Ruth, this change has been difficult to achieve because of the political climate up here on the north-west coast, in part. With the turbulence of the Federal Government funding, if there is going to be any change in the Mersey area then it needs to have the approval of the Federal Government, and that makes it a little difficult for the State Government or any department here to push too fast in any one direction. What happened in the UK many years ago was that eventually the colleges stepped in; it was because of their minimum college requirements that forced quite a bit of change in the UK. What has happened here, as you know, is that in terms of surgery we have virtually two groups. They integrate a little bit but not as closely as they should, so there are two lots of on-call consultants, two lots of on-call registrars -

CHAIR - Because they're paid from different buckets of money?

Dr FLETCHER - Yes - because there is an expectation that both hospitals will be available in the acute setting for patients coming in through the door. Unfortunately what that has meant is that, rather than pooling the registrars during the week - we are talking about the two surgical registrars - the general surgery registrars at the Mersey do one in two; they alternate weeknights on call. It is the same with the guys in Burnie, they operate every second night. The colleges step in and say, 'That's no longer acceptable. You don't accept it for truck drivers or airline pilots and we don't accept it for doctors either. You need some time off, it is not healthy or safe to be working those sorts of hours. We want you to pool your registrars and have them do a combined on-call' - so a one in four on-call rather than a one in two.

What we have done to date is pooled the weekends. We have one of the registrars at the Mersey doing on-call in Burnie every third weekend, so the guys here are now doing

what the college considers to be safe hours on the weekend, that is a one in three, but during the week they are still doing the one in two. There is a requirement by the Feds to not change things too much, but it is becoming increasingly unsafe here because if we have pulled a registrar out of the Mersey on the weekend to work here in Burnie, who is going to cover the wards at the Mersey on the weekend he is over here? So not only are there ongoing problems of one in two during the week but it leaves the Mersey a little bit unsteady on the weekends. It has come to a head now where I think I have to speak out more strongly and say this is just not right, it is not safe enough and it doesn't work.

My suggestion is that we realign ourselves with the Tasmanian Health Plan - that is, that we promote the Mersey as a 23-hour-type facility. As you know, 50 per cent or 60 per cent, maybe higher, of surgery these days is 23-hour surgery. This is where the action and excitement is, where all the cutting-edge technology is. We should promote the Mersey as being 23-hour surgery par excellence and work it hard from Monday to Friday in elective 23-hour surgery. It makes no sense to have two lots of on-call on the weekend, or even after five or six o'clock at night.

We need to align ourselves with the college requirements, otherwise we are going to lose our accreditation for general surgery. We need to pool not only the registrars but also the consultants. We need to foster this 23-hour surgery. We can save some on-call money by not having on-call staff after-hours. We don't need two lots of anaesthetists on call after-hours or on weekends. We do not need two lots of general surgeons on call on weekends. We went through this process about five years or so ago with orthopaedics where we now do day surgery over there every day except Friday, which is our quality assurance day, but we do all the acute stuff both during the week and on the weekends in Burnie. It works well, we service the Mersey really well and we do the outpatient clinics there on Monday, Tuesday, Wednesday and Thursday. We do day surgery there on Monday, Tuesday, Wednesday and Thursday. So we have a very healthy, vibrant day surgery type of presence from Mersey but we do not do any big cases there and I suggest that is the way to go with general surgery as well. We do need to relook at what the experts have suggested we do and I think we should follow that and I think that is where we need to get our saving costs from and I think we can get some productivity gains as well.

CHAIR - It is about taking that next step, Scott, are you saying? You have done it with orthopaedics and it needs to expanded across general surgery but does that also mean that, effectively, after-hours is basically bypassed for your acute?

Dr FLETCHER - Yes, so no acute after five or six o'clock at night at the Mersey. We need to bite the bullet and take that step. As I said, I think it is going to be precipitated by the question of safety, driven by the college in terms of hours worked and also the difficulty we have at the moment of abiding by those safe hours and providing cover there after hours. We just do not have the manpower to cover that.

It is not simply a matter of employing more registrars or employing more consultants to provide that after-hours cover because we do not have the numbers on the coast to justify it. These guys, as they are in Burnie now, are going to be sitting around doing nothing. They are on call but they are not going to be doing anything and they are certainly not going to be trained.

CHAIR - They do not enjoy that, I know. Scott, I guess that the issue here is, how do you take that next step and do you have any idea of the cost savings that could create, by getting rid of the double of on-call? Aside from the safety issues which you have articulated well, do you have any idea of the savings and how they could flow into greater access to services for patients?

Dr FLETCHER - The time line goes something like this - I think we are meeting up with the Feds this week or next week to talk about college requirements, safety issues and where we think the North West Area Health Service can go. If they say no, that we want services to be maintained as they are, then it is going to hard for us to change. We would really need to be able to demonstrate that it was too unsafe to continue. I think there is an element of being unsafe about it now. I do not think it is acute but I just think it is at a higher risk than it needs to be.

Hopefully the Commonwealth will see sense in what the clinicians have been saying for many years. We need to get them agreed that the concept is good. Then we need to, I think, go to the local mayor and leaders, the aldermen and say this is what we have in mind, the reason that we are doing it and we need to get them on-side. I think if the Feds say that are happy with the concept then we will, at that stage, do the cost savings. I have not done it and we are just mulling over this at the moment with the CEO. So I think that will be done in the next week or so. So the cost savings that I mentioned will be the closure of wards on the weekends, the savings in personnel salaries because there is no weekend staff there, the closure of the theatres for after hours and the cost savings of having surgeons and anaesthetists and nursing staff on call over the weekend and of a night time. I would imagine that it will not be a small amount of money, it will be quite significant, but I do not know exactly how much it will be.

CHAIR - Scott, who are you dealing with as far as the Commonwealth goes? Who are meeting with?

Dr FLETCHER - I am not of their exact names, Ruth. I have had an e-mail about it but I do know it is imminent. I cannot chase down the e-mail in front of me but it is within the next seven days, I think.

CHAIR - Are you able to provide the details of who you are dealing with to the committee later?

Dr FLETCHER - I can, yes.

CHAIR - I think that the Commonwealth have said that they are not going bail out Tasmania's health service and they are not going to look at a single-funder model at this stage and, as you rightly identified, the challenge here with Mersey and Burnie is that you have two buckets of money that are required to be kept separate pretty much so you would be able to create greater efficiencies and if the Commonwealth are not going to help us, they should not be standing in our way either, you would hope?

Dr FLETCHER - Yes. I am sure what they want is a safe, efficient service from a clinical point of view clinically led and so we are getting that clinical leadership and I think that would be wise to follow.

Mr HALL - Scott, you talked about that wider community consultation and understanding and the need for reform and you talked about talking to aldermen, have you spoken to the Cradle Coast Authority about this issue to try to tie a few loose ends together?

Dr FLETCHER - I have been back four weeks, Greg, so I haven't. I have been a way for a little bit. I know Roger Jaensch quite well.

Mr HALL - I am just thinking out loud that that is probably a role that they should play if they represent the whole coast as a region.

Dr FLETCHER - Yes, I think that is a good point.

CHAIR - They tend to sit on the fence, though, Scott. That will be your challenge, to get them off the fence.

Dr FLETCHER - Yes.

CHAIR - Do you want to go through the rest of this document that you provided, Scott? It talks about the impacts. The figures are all there.

Dr FLETCHER - Yes, I will just run through them. I have the North West Area Health Service, total joints, 90-day rolling average - have you got that in front of you?

CHAIR - Yes.

Dr FLETCHER - The blue and green lines show the reduced activity since September/October last year yet we still continue to put patients on the waiting list and the blue line at the top is we are still putting them on but we are not taking them off as fast so that is a breakaway from trend. The next page that I have is entitled 'Surgical wait list - patients ready for care' so this is just surgery across the North West Area Health Service and you can see the numbers that we have waiting at the North West Regional Hospital are gradually increasing now, whereas there was a definite trend downwards to October 2011.

Dr GOODWIN - Scott, can I just go back. I guess these cuts started to really have an impact in October and that is when it all started to kick off. The percentage of over boundaries has increased in that period from 10 per cent to 25 per cent in February?

Dr FLETCHER - Yes.

Dr GOODWIN - That is a pretty big jump.

Dr FLETCHER - It's a big jump and if you look at the longer time line, we worked really hard over a two-and-a-half year period. When Jane Holden was here we really looked very carefully at what we did and how we could do it better so we put measures in to improve efficiency within the theatres in particular, we had better management of the waiting lists and we made sure that if a surgeon was away we plugged that space with other surgeons, so we really worked the system quite hard. Over that two-and-a-half year period prior to October we got our waiting lists and waiting numbers down so they were looking quite healthy. We chased the Federal dollar. There were some Federal

initiatives to reduce waiting lists and we worked hard to get that additional money to fund the additional work we did but over the last five months we have undone all the work we did over those previous two-and-a-half years.

Dr GOODWIN - It must be very disheartening to be in that position.

Dr FLETCHER - It is and it is reflected in the morale of the place. When we were working hard you could see the attitude in theatre, that people would turn up on time and be keen to work, and now the morale is not as good and as a result the productivity is not as good.

CHAIR - It's a double whammy in lots of ways, isn't it?

Dr FLETCHER - It is a double whammy, yes.

CHAIR - Scott, you can keep moving through it, if you like.

Dr FLETCHER - The next line we will jump over as it doesn't tell us anything different. I want to move on to the total joint replacement waiting list and that reflects what I have just said, that we worked hard to get those waiting numbers down and we got down to 100 on the waiting list and now it is back up to 200 on the list. I did compare that with Launceston and Hobart because I was quite interested. Launceston has about the same number and maybe slightly more and Hobart have about 300 joints on the waiting list. Our waiting times are about half that of Hobart and Launceston perhaps a little bit more but not much at the moment.

CHAIR - Scott, before you move on, are the figures you have put together here publicly available? Where have you drawn these from?

Dr FLETCHER - This is from the information carried by the department. These are available from what we call the Business Intelligence Unit based in Ulverstone but they had statewide figures.

CHAIR - The Business Intelligent or Intelligence Unit?

Mr HARRISS - That was the previous name for it but it's called something else now.

Dr FLETCHER - I thought the name was a bit broad but, anyway. These are the official State figures I'm giving you rather than in-house figures.

CHAIR - Right.

Dr FLETCHER - I think Gavin, the CEO, was comfortable with me presenting these here.

The next slide shows the medium wait time and we worked hard to get it down over a two-and-a-half year period and now it has just jumped up.

Dr GOODWIN - Once gain, that's a big jump from October where it was 71 to 156 in February.

Dr FLETCHER - Yes, it is a sharp jump. The question is what happens now? Will this doubling-up from one to two joints a week flatten it out so that it doesn't become ridiculous or will it continue to trend? I can only imagine that it'll go up at a slower rate and continue to drift up. It's not a happy situation to be in. What you have to realise is these patients just don't go away; they don't just get better. They sit there with a degree of discomfort, obviously, and they need to be done. So if they're not done now - it's like a debt that's owed to the bank; it doesn't go away, it needs to be paid at some time.

CHAIR - And the interest payments increase - the principal increases ultimately, doesn't it?

Dr GOODWIN - You mean their condition worsens?

CHAIR - That's right. This is what we're hearing, Scott, from other witnesses as well, that these people come in less fit for surgery when they do come in and often require longer hospital stays, tying up the beds which there are less of - is that how you see it happening?

Dr FLETCHER - I think it's possible to overplay that card, Ruth, but there is an element of truth in it. You know, the old ladies who have bad hips fall over because they have sore hips and then they fracture their hip, so there is increased morbidity associated with not doing them, but the world is not going to fall in. But it isn't good news for the patients and I don't think it makes good economic sense when you still have the load that needs to be processed while at the same time you have all these doctors sitting around doing nothing, not doing the job. It makes no sense to me. I think we need to be smarter than that and I think we need to reform, particularly on the north-west coast, where we have the capacity, to get some cost savings and allow us to continue to do the work.

Mr WILKINSON - So, Scott, I suppose all you do is say, 'Take some Nurofen or Panadol and grin and bear it' - that's all you can do, isn't it?

Dr FLETCHER - Yes, and that's what they do in third-world countries.

Mr WILKINSON - That's right.

Dr GOODWIN - It must impact on people's quality of life. I mean, I can only imagine how I'd feel if I were in that situation where you are waiting and waiting, you're in pain, you can't do all the things that you want to do - maybe you can't work. It has to have an impact on people's quality of life but also mentally.

Dr FLETCHER - You're right, they've looked into various forms of surgery and how they impact on quality of life and total hip and knee joint replacements are at the top of the list. As an operative intervention, it gives the biggest improvement in quality of life compared to all other surgeries. It's an expensive exercise, sure, but with a great reward at the end of the day.

CHAIR - Okay, keep moving through if you like, Scott.

Dr FLETCHER - I am on over-boundaries now. We had it down to 10 per cent over-boundary and now that's moved up to 50 per cent. I notice that while that looks like a crazy graph with the deterioration since September-October from a very healthy 10 per

cent over-boundary back up to 50 per cent of our patients on the waiting list and waiting longer than clinically recommended. I noticed that Hobart is at about 100 per cent; everyone is over-boundary, as opposed to our 50 per cent. This is not just a Burnie issue.

CHAIR - The issue, Scott, is that you had it down 10 per cent or thereabouts, and at times 9 per cent, Gavin Austen the CEO said, but now it has gone up to over 50 per cent.

Dr FLETCHER - It's crazy.

Mr WILKINSON - And they are just joints, Scott, aren't they, as opposed to everything else?

Dr FLETCHER - Yes. If you look at the next page, Jim, you will see some tables and the joint component is 49.5 per cent over-boundary but, in general, orthopaedics is 36 per cent over-boundary so there is a bit of an issue with the number of patients on the waiting list. General surgery is down to 10 per cent, ENT is 3 per cent, ophthalmology used to be more of an issue than it is now and it is down to 7 per cent. So overall the figures are quite reasonable. It is just a little out of control with orthopaedics and that is due to the joints.

CHAIR - But that's where the cuts were made, Scott, wasn't it? It was a grab for the quick savings because it was an expensive area.

Dr FLETCHER - Yes. This might be being a little bit unfair to half of you, but the Federal Government, when the GFC hit, needed a quick response so it spent money on schools. It was possible to do it quickly but I am not so sure it was the smartest thing to do. As I said, I might be offending half of you there, but I think that is what we did here in this hospital. I think the Premier was looking for a quick saving, an immediate saving, so it was the simplest thing to do. I think a better solution would be the more complex arrangement where we change the way we structure our service delivery. That is where we need to get back to, particularly if we are going to ramp up productivity again.

CHAIR - Scott, that is very applicable in the North West Area Health Service, and you may not be able to comment on the north and the south, but you only have one major hospital in each of those areas. Do you think there are ways those hospitals could restructure to achieve significant savings too?

Dr FLETCHER - Almost certainly, and it is not in one spot. As you say, I don't know the Launceston and Hobart scenes as well as I do here, but I do know Launceston has a good lead. If you look at what you do critically, there are lots of spots where things can be made better. It could be due to the way you organise theatre. From a joint perspective, it might be the way you choose your joints or you organise the theatre or the team. You might have specific waiting list reduction processes or lists. There are lots of ways of doing it. Like every company, we need to change over time to improve productivity. We did that in Burnie over the last two or three years and got things moving quite nicely. Now we are stymied by these cuts and have fallen apart, basically. I am sure in Launceston and Hobart it is possible to make things better and they need to look at what they do and report back as to how they would like to do it differently and be given the opportunity and responsibility to make it better.

Mr HARRISS - Scott, on that theme, you worked as a group and a team to reduce all those waiting lists and get stuck in as a team, I presume that in deciding on the cuts that needed to be made they were done without that team approach or consulting the clinical experts. Am I right in that presumption? I think I am, given the evidence we have taken previously. That being the case, what consultation has there been with the clinical experts since those decisions were made at the more ministerial-CEO level, for instance?

Dr FLETCHER - I think you're right, I think it was seen as somewhat of an emergency. I am not sure it was and I don't really understand why it came to be such a sudden, dramatic change. I understand that things can deteriorate reasonably quickly from a State revenue perspective but really, I hate these short-terms measures. I think you need good, solid, responsible, long-term vision that can be kept reasonably consistent year after year. I like that approach better.

Mr HARRISS - But you hit the nail on the head there because the rub is, back in 2008, with the onset of the global financial crisis, the then Treasurer and Premier decided that there were all sorts of efficiency measures required but just did not address them and let them roll on again until the real crunch came with GST revenues falling dramatically and then, all of sudden, the now Premier/Treasurer had to make the announcements that she did. So you could have had a steady approach had it been addressed properly back in 2008.

Dr FLETCHER - There is no question, as I said before, that the steady approach is the one I would take, but I was not there and I do not know what they were faced with. I just know that these acute changes caused so much secondary disruption that people do not understand. I have been talking about people leaving the hospital, good quality guys leaving the hospital. When you factor in acute cuts like that, you just do not see it. You see a dollar saving but you do not see the secondary knock-on effects -

CHAIR - And the costs, the later costs.

Dr FLETCHER - and the costs. If he does leave and we cannot work things out, it is going to set us back three to five years. It is going to set us back quite a bit.

In terms of clinical consultation, I think all the modern CEOs do realise the importance of clinical input. Really, they have no clinical expertise. They need clinical input to be able to make sensible decisions. The CEO here obviously looked at our waiting list and said, 'They look all right, we've worked hard but they have it under control. We can target them because things are under control. We can certainly save some money here. Joints are expensive so let us just stop joints. I can see the rationale, but to me, the secondary effects are unacceptable and I do think, as I have told you before, there is an alternative, something that needs to be worked through a little bit more carefully to make things better for the region. While it may not have been possible to do that immediately, I think it is possible to do that hopefully over the next three to four months. I think come the beginning of the next financial year we need to have some changes in place.

The CEO certainly listens to me and I am comfortable that he does listen and the reason I have increased one joint to two joints a week is that we have discussed the statistics together and we see the issues together.

Mr HARRISS - As a statistic, that will sound great. You have doubled the output.

CHAIR - You make numbers say whatever you like.

Dr FLETCHER - Yes, that is right. The next slide I have is a statewide joint replacement waiting list and this is called Ready for Care. I have been telling you there are 200 joints on the waiting list at present. What these statistics are telling me is that there is only 160. The reason for that brief is that these are ready for care. So while there are 200, only 160 of those 200 are ready for care. These statistics do reflect the true load.

Dr GOODWIN - What does that mean, Scott, the ready for care?

Dr FLETCHER - Let us say you have high blood pressure or you have some diabetes, which probably should be reviewed by a physician, you get put aside from the waiting list until that is sorted out.

CHAIR - Sometimes lose a bit of weight and that sort of thing?

Dr FLETCHER - Yes, and then you get accepted as ready for care. The actual numbers on the waiting list are greater than those but you can see the numbers in Hobart there. There are 350 in Hobart ready for care. There are 200 in Launceston. So the load across the State is reasonable. I am not sure how that compares per capita with other States but I think it would be comparable.

The next slide I have is mismatching the workforce and I have spoken about the inefficiencies that we have here at the moment. I told you about the ward round where we had about four times as many staff as patients who look after these patients. Regarding the next slide, I told you about how well trained Corey Berger is and how happy we are with him and he is looking for a job interstate. I have told you about the impact on our orthopaedic accreditation which visits you at the end of the month.

CHAIR - Scott, on that accreditation issue, is that orthopaedic surgery accreditation?

Dr FLETCHER - Yes. In the general surgery here, Ruth, we have two accredited positions in the North West Regional Hospital. We have one accredited general surgery position at the moment at the Mersey but there are none in orthopaedics. Despite the orthopaedic surgeons we have here, we needed greater numbers of fully trained FRACS or, in other words, fully qualified Australasian-trained orthopaedic surgeons. You need at least three to apply for a set trainee and we now have three but, unfortunately, with the loss of the major cases the success is at risk. Our chances of getting accepted at the end of the month is at least no question.

CHAIR - We will be interested to hear what happens after that.

Dr FLETCHER - The last slide there I have is college requirements and knock-on effects. I have told you about the issue that the college have with the registrars and they have had the same issue with the consultants. In order to comply with the college and comply with accreditation requirements we will need to pull our general surgery registrars into one acute on-call group. That currently does put the Mersey hospital at some risk after hours because emergency patients are still needing to be looked after but there is actually

no-one to look after them on the weekends. As I said, that is not unsafe but I see it as a risk.

CHAIR - That is something you will discuss with the Commonwealth people obviously.

Dr FLETCHER - That is what we are discussing with the Commonwealth and come July, I am hoping that we will have a single on-call roster.

CHAIR - It's going to take some political will up there, isn't it?

Dr FLETCHER - Yes, it will and it might not get up again.

CHAIR - Again, and the same circle we go. Thank you, Scott, that has been very helpful and you have provided a lot of information in a short space of time. We appreciate your input and your passion for the region and the job. Thanks.

THE WITNESS WITHDREW.

Dr ROSS LAMPLUGH, CHAIRMAN, OCHRE GROUP, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Ross, we have half an hour to have a chat about the term of reference. This interview is being recorded on *Hansard* and will be transcribed and part of the record of the committee and made available on the public website. You are covered by parliamentary privilege while you are speaking with the committee but if you repeat things outside you may not be. If you want to discuss anything of a confidential nature, you can make that request to the committee and we will consider it. We will prepare reports from this committee and this may form part of that report. Do you have any questions before we proceed?

Dr LAMPLUGH - No, that sounds fine.

CHAIR - I know you've seen the terms of reference, which is focusing particularly on the cuts to frontline services and predominately elective surgery. The inquiry is looking at the impact of those cuts on the broader delivery of health services, as well as just that area. Would you like to make an opening statement on your views on the term of reference?

Dr LAMPLUGH - Just for context, I came to Tasmania as an intern in 1991. I became a surgical resident and then after three years I left medicine and opened a restaurant in Hobart. I worked for the next couple of years half-time in medical administration and then took another role half-time in the department doing some project work. I worked in medical administration in the department for two or three years.

I then headed up to Queensland and went back to clinical medicine. I became a rural GP and worked as a GP/anesthetist for the best part of the next 10 years. During that time I cofounded two companies that are now called Ochre Health and Ochre Recruitment. Ochre Recruitment is based in Hobart and would be one of Australia's biggest medical recruitment companies and the biggest rural medical recruitment company. Ochre Health is based in Sydney and it manages about 15 different clinics, after-hours services and emergency departments mainly in New South Wales but also some in Canberra and the Northern Territory, and previously ran Evandale in Tasmania.

Obviously I am somewhat removed from the cuts and the current clinical system in Tasmania, so my comments are going to be more general and historical and perhaps a little bit of an outsider's looking through a looking glass. I would probably say that from looking at the cuts that have been made and reading through them, they appear to me at first glance to be very broad-brush, with some bits of savings here and bits of savings there, and increased costs to the public in various places. Obviously that is one way to save money but, from a business perspective, and if I needed to save a few percent on my budget I would probably do that, but if I needed to save 10 per cent or more on my budget, instead of doing that sort of thing I would probably take a knife to one part of the business rather than upsetting the entire business.

To take 10-15 per cent out of something tends to leave you with very unhappy staff, very disloyal people and very unhappy customers. If you do that across the board, effectively you're just making everyone unhappy with the consequence that you are probably going

to have recruitment and retention issues going forward and you are probably going to spiral. It smells like a business going broke when you make across-the-board cuts like that.

Mr HALL - Ross, it is a difficult question there. As you say, from an outsider looking through the looking glass, where would you have made the cuts?

Dr LAMPLUGH - Greg, in a similar way we were having some problems in Ochre not that long ago and rather than do exactly what your Tasmanian health system's done, I actually hived off one division of Ochre that was not performing very well.

I suppose in a similar way I probably would have done a few things. The first thing I would have done is gone to the clinicians and said, 'We need to save 10 per cent in clinical services and can you guys tell me how to do that?'. Obviously that would have created a lot more bounce. You would have got better cuts. There are lots of things in amongst those cuts that are really going to have pretty serious and significant effects on some of the least advantaged in Tasmania, particularly some of the things in the mental health area and a few others.

If you'd gone to the clinicians they would talk to you about the fact that although the general public think that cardiac surgery services are lifesaving, the research perhaps doesn't think cardiac surgery services are as lifesaving as you might think they are - but they are bloody expensive. So the first thing I would do is talk to the clinicians and say to them, 'What do we need to stop doing in this State?', because by pinching a bit out of ICU and a bit out of each different service in the hospital, effectively, for example, you put your cardiac services at risk anyway. So it is death by a thousand cuts rather than saying, 'We're going to send some of the work to Victoria or stop doing some of the things that we're currently doing'.

So that's the first thing I probably would have done; ask the clinicians to be really serious and to tell you how they could save 10 per cent. Another thing they might have talked about is things like admission policies for mental health patients. I'm sure things haven't changed from my day but politically if a mental health patient was not admitted to the hospital and subsequently suicided - and that was front page for the newspaper - it is very obvious and very abrupt and it makes for a good news story. But by filling the hospital with mental health patients who may or may not be at risk of suicide, because you're a bit frightened to send them home, obviously that blocks beds for other services.

CHAIR - It's not always the best treatment either, is it?

Dr LAMPLUGH - No, it's absolutely not. Of course the other thing is when you send someone home who has a chronic disease or a non-mental health chronic disease and they quietly die at home, that doesn't make the front page of the newspaper so much. So I suspect that if your clinicians are involved, they'd be talking to you about things like admissions policies in mental health and some of the more expensive services, such as some of the cardiac services and different things like that.

The first thing I would have done was close the Mersey. I think keeping the Mersey hospital open was one of the biggest disgraces I've seen in political history, but there you go.

CHAIR - On that, Ross, we've had significant evidence from the North West Area Health Service CEO and others to indicate that it's not an option to close the Mersey because the demand on the services could not be met by the one facility in Burnie.

Dr LAMPLUGH - It won't be. At least half of your patients in Devonport are going to go to Launceston. I mean you'll have patients in Ulverstone who will go to Launceston, there's no doubt about that at all.

CHAIR - But the capacity's not there in Launceston either.

Dr LAMPLUGH - But creating or increasing the capacity of two hospitals has to be cheaper than keeping open three hospitals. It can't be cheaper to keep a dysfunctional hospital that struggles to recruit staff and relies on locums and, I hate to say it, doesn't produce the same clinical outcomes as other hospitals in the State. I just can't see that that is good public use of money.

CHAIR - The minister would say, as I have heard her say, that if you close the Mersey that would take $70 million out of health in Tasmania.

Dr LAMPLUGH - Yes, that is the problem. If you close the Mersey you have to try to get the money from the feds to actually prop up the rest of the health system and whoever can negotiate that deal should be in private industry.

Laughter.

CHAIR - We need them in the public system.

Dr LAMPLUGH - That's right. That is obviously the problem with closing the Mersey. If the money is just going to go back to Canberra then there is no benefit to Tasmania. If that were the case that the money went back to Canberra, then it would be anti what we are trying to achieve, so I would agree with that. In the overall interests of the Australian health system, you would think commonsense might prevail. Using the money that is propping that hospital up to increase the services at Burnie and Launceston would produce better outcomes and save money, I would think, but that is just a gentle personal view.

CHAIR - With your experience in medical recruitment, do you do recruitment in Tasmania?

Dr LAMPLUGH - We don't do much in Tasmania, funnily enough. We find Tasmania a difficult market to recruit to for two reasons. One is that doctors are not paid as much as they are interstate, so getting doctors to come down to Tasmania is quite an ask, and then Tasmania is just a funny system. There are probably a hundred historical reasons and there are local people who would know them better than me, but the divisions years ago in Tasmania used to have quite a good system of providing leave, particularly for rural GPs, who are the ones that we were especially concentrating on. That was a very cheap system of provision of a couple of weeks of leave. They had these rotating locums who moved around the State and it didn't cost the practices very much. So a practice would look for a locum and we would find them one. We had something like a 10 per cent fallover rate on sending locums into Tasmania compared to probably about 1 per cent on

the mainland. By that I mean you would have a doctor lined up to go and work in a town in Tasmania and two weeks out from the placement the practice would ring you up and say, 'Actually we don't think we need that doctor anymore'. That was happening up towards 10 per cent of the time so you would obviously have to ring your locum and say, 'The job that you were planning to do is no longer available'. I think the reason for that was the cost of bringing the locums in. The practice traditionally would be paying for all of the transport of the doctor into Tasmania and the cost of the doctor is likely to be more than what is traditionally paid in Tasmania. I think when it got close to the time the local GPs were perhaps panicking a bit and thinking, 'This is going to cost me a fortune so I won't proceed with this locum'.

We found that we were having placements fall over. As I say, we were also finding it a bit harder to attract people to Tasmania because the rates on offer are generally lower. In fact yesterday I got an e-mail from one of my recruiters - I am one of the doctors on the distribution list so I can see what they are sending out all the time - and I noticed that a lot of the Gemini or River Medical clinics were advertised on there. The rates that are being paid are $1 700 a day, whereas up in Queensland you are talking about $2 000 to $3 000 a day. So we are not talking about $100 here or there; even without procedural you are up in the mid-$2 000s for med supers and things like that, which is an equivalent position. So that is a little bit hard there.

Mr HALL - Does that mince the term 'fat as a doctor's wallet', do you think?

Laughter.

Dr LAMPLUGH - It is a disgrace, to be honest, what is happening Queensland and that has flown over into WA and New South Wales. The rates that doctors are being paid is, in my mind, one of the biggest reasons that we are closing a lot of small country hospitals. The doctors are being paid ridiculous amounts of money to work in them and they still have their hands out asking for more and more. I will probably regret saying that now that I have remembered this will be on the public record.

Laughter.

Mr HALL - You were led astray, I am sorry.

Dr LAMPLUGH - There is no doubt that the rates up there have become ridiculously high. I think the rates in Tasmania are more than reasonable. The problem is they are just not competitive with what is being offered interstate and that makes it hard. There is also a very complex, complicated system for recruitment of doctors into the hospital system in Tasmania. Tasmania has toyed with a whole variety of systems. At one stage they put out a tender looking for companies that wanted to recruit doctors into Tasmania. We were based in Tasmania and we have a tender alert system - this is going back quite a number of years - and we didn't know that this tender was out. The word we heard was that at the end of this tender quite a number of the companies that were doing a lot of recruiting into Tasmania and others who were based in Tasmania didn't apply because they didn't know about it. There was a panel of recruiting companies that weren't doing much medical recruiting and that quickly was seen to be a failure and so another tender was issued three or four years ago for people to join that recruiting panel. We applied, and it has only been four years, but I still haven't had a response as to whether we made

it onto that panel or not. At one stage I had been to Germany to do some recruiting and found some really good anaesthetists who were keen to relocate to Australia. I bought their CVs back and was told constantly around the State that they couldn't employ these German anaesthetists because Ochre wasn't on the recruiting panel. It was all very strange.

CHAIR - Who is this recruiting panel?

Dr LAMPLUGH - I don't even know if it exists anymore. This is going back probably three or fours years, but it was a recruiting panel and the hospitals were told they could only use the recruiting companies that were on the panel. Tasmania is not the only State that has tried this. It has been tried in a number of States to set the recruitment fees, but it is a halfway attempt to fix recruiting. I think I might have had this conversation with Greg, which possibly prompted him to ask me to come and talk to this committee. If BHP was looking for a senior executive, it would go to some sort of head-hunting organisation and give them all the details of the person it was after - salary, supports, bonus system et cetera - and send them out to find the right executive to fill that role. The idea of BHP putting an advertisement in the *Weekend Australian* for a CEO would be farcical, and yet that is how we do medical recruitment. We want an new cardiologist at the Royal Hobart Hospital and so we basically put an advertisement out there or let recruitment companies know. What happens is that none of the recruitment companies spend significant time trying to fill a single position because if you happen to find the right person there is no guarantee you will be paid for filling the position and there is no guarantee that someone else won't have filled it before you. Medical recruiting tends to be a bit slaphappy, especially in the hospital system.

CHAIR - In Tasmania?

Dr LAMPLUGH - Across Australia really. Hospital specialist-type recruiting used to be atrocious. People would send out CVs over an e-mail, get 100 CVs and send them all to a hospital and anyone who was employed attracted a fee. It is not perhaps quite so bad now but it is certainly not strategic. It doesn't involve head-hunting in general, but it does occur occasionally. I tried to have a chat to some people in Tasmania at one stage. I talked to some old contacts from the old days and went around the State, and I was appalled. Again, this is going back two or three years ago. I reckon I spoke to eight or 10 different people in Hobart who were all tied in with recruitment of doctors to the Royal. Some of them did not know each other existed. Some were in the department and some were in the Royal. At that stage, and I do not know if it still exists, there was someone funded by the State and someone funded by the Commonwealth trying to recruit specialists for the Royal who did not particularly like each other and did not cooperate, as far as I could tell. It is a pretty bizarre system.

Again, going back to your question, Greg, how would I fix the problem, I think I would really stand back, pull the system apart from its very toes and perhaps try to rethink about how it has been done. Going back to what I said originally, pulling 10 or 15 per cent out of everything, you going to have really unhappy staff and I note somewhere there is going to be money saved in recruitment, in locums and things. I think that it is a bit farcical. With all the other changes they made, you are going to have unhappy people, you are going to have it harder to fill jobs and I would have thought that your locum bill is going to go up if you want to maintain services.

CHAIR - Ross, just on another point, we know that we are going to have three THOs put into place soon - on 1 July - and some people have suggested that that will create a perverse incentive, in a way, to try to streamline things in Tasmania. You have been here, you have been away, you have come back. What do you think about that? Is it going to create any cost savings, is it going to create cost increases or what is the issue?

Dr LAMPLUGH - I do not know much about this. Is this basically a local area health network type of thing like they are doing in New South Wales where you get local management group running the local health services?

CHAIR - Yes, it is the Federal Government reform but Tasmania, in its wisdom, decided to have three THOs as opposed to one for the population we have.

Dr LAMPLUGH - Yes, that is another problem with Tasmania. You know the job that I did in the department, going back 20 years ago, was to get the specialists in the three regions to come together and talk about cooperating. Up until that point, some of these guys who worked in the same profession, same type of specialty, hardly ever spoke to one another.

I am a bit unsure about the whole concept of local management. Unfortunately, health is probably the most complicated business there is out there. You have this real duality, if you like, of clinicians who are trying to make people better in a system that is racing along, costing 10 or 15 per cent more every year because of technology and other factors, and then you have a group of managers trying to rein those costs in. To expect that a local group of managers with less health management experience can manage a health service, my gut feeling is that that is going way down the wrong track.

I would like to see the health system made Federal and I know that lots of other people have mooted that in Tasmania. I think the problem in Tasmania is that we are all sitting here saying, 'We are broke, so have our system' and the Feds have said, 'We're not stupid' -

Dr GOODWIN - It is not much of a deal, is it?

Laughter.

Dr LAMPLUGH - That is right. But, at the end of the day, health is ultra complicated and the only way it is going to be run well I think is to have a really solid management structure so that it can make changes across the entire national system without having to replicate services.

No disrespect to Tasmania or Tasmanians at all, and I have this argument in my business regularly when I get told by Sydney people that all the senior people should be in Sydney because that is where all the clever people are or that is, effectively, what I think they are trying to say, but there is no doubt that we have fewer people down here and a smaller pool to select managers from and I do not think that running the Tasmanian health system is much easier than running the New South Wales health system or any other health system. You still have to keep up with all of the international changes in health. You still have to be right on top of your game of managing everything involved in the

system and yet we have a much smaller population of people to try to find the secretary of health and then all of the layers that then have to fit under those people. To be honest, I think we are always going to struggle with our population to run a health system with four public hospitals. It would be bad enough if it were three, I think.

CHAIR - Any other comments you would like to make, Ross?

Dr LAMPLUGH - Most people in health are reasonably intelligent and most of them realise that it is unsustainable to just keep pumping more and more money into health. There is a lot of emotion in health. I do hear people whom I respect making some unsustainable comments at times, however I think most people understand that there is a budget that has to be met and that we can't keep increasing costs. What needs to be remembered through all of this is that it is not necessarily expensive to keep your people happy. One thing that jumped out at me in there was that they were going to make savings from the cafeteria. Back at the Royal when I first went into medical admin we were relying on lots of locums, especially to fill some of the junior doctors jobs. One of the things I did was that on a Saturday morning I started to order in a box of fresh fruit, some bacon and eggs and some ice cream and a few bits and pieces that probably cost me about $150 and I paid for it out of the residents' own money anyway. It was quite strange; you started to get doctors coming in on Saturday mornings who did not normally come in to do rounds. I put a big table in the residents' quarters. I pulled out a door and a wall and made it a much more communal space and tidied up the quarters and put in some carpet and some beer in the fridge and all the rest of it. The year after that - and I am not trying to lay claim to all of this - was the first year that the Royal was fully staffed with junior staff for as long as anyone could remember. In fact we had a bit of a problem because we had some really good overseas-trained doctors we could not find positions for. The following year we had to let them go because most of the locals wanted to stay and we had other people coming in.

I am a big fan of sending people on holidays and things like that. One of the things we offer our doctors is a flight to an international conference once a year. Things like that stand out and seem like wonderful offers but against what you are paying them they are actually insignificant. Now I don't think we can do that in the Tasmanian system because the papers would be all up in arms and the political fallout would be terrible, but there is nothing stopping us doing nice, simple things like making sure there is fresh fruit available in the doctors' quarters and just doing nice simple things. Having someone remember people's birthdays and Christmas time and a simple birthday card or something from the Director of Medical Services, or a thank you when you have had a bad day and a sorry when things have been mucked up. I think that has perhaps been the secret of Ochre's success in filling its towns. I learnt that right back in my early Royal days that you didn't have to spend a lot of money to keep staff happy and inspired.

CHAIR - You are talking about valuing people.

Dr LAMPLUGH - It is and I think that is going to be more important in the face of all of these changes than it has ever been. I would be really encouraging that in the face of everything else, all these changes that I absolutely agree need to happen - an extra effort to spend a few dollars on trying to just value people, as you say.

I think the education changes that they mooted last year - and I might get into a heated discussion with a couple of people on this one - were quite good. At the end of the day they needed to save money in the education system and there are only two ways to do it. Either you take a bit of money out of every school or you actually close some where students can get to other schools. Whilst perhaps the way that it was all handled was very poor, the concept of looking at the education system from the ground up, pulling it apart and deciding whether the system was still relevant today, I think was a good idea. I think the same thing needs to be done in health.

CHAIR - Okay. Thanks very much for your time, Ross, and your input.

THE WITNESS WITHDREW.