PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET AT CRADLE COAST AUTHORITY BOARDROOM, BURNIE, ON TUESDAY 10 OCTOBER 2017.

ACUTE HALTH SERVICES IN TASMANIA

Dr CHRIS WAREING WAS CALLED, MADE THE STATUTORY DECLARATION ANDWAS EXAMINED.

CHAIR (Mr Valentine) - Welcome, Dr Wareing. All evidence taken at the hearing is protected by parliamentary privilege. Any comments you make outside the hearing may not be covered by parliamentary privilege. The evidence you present is being recorded and the report will be published on the committee's website when it becomes available. We are seeking information specifically relating to acute health services in Tasmania. If you wish to provide any evidence in camera, you need to request of the committee that it be heard in camera and we can have a discussion about that. If the committee agrees, we would go into camera.

Would you like to make an opening statement?

Dr WAREING - Thank you for the extension of time available to provide my submission. There are two typos on the first page of my submission, which again reflects the nature of the problem. Under (2), the north-west, at dot point 3, it should read 'incidence of teenage sexual abuse'. The other one is in the last paragraph on that page, where it is quite clearly not accretive follow up, but 'assertive' follow-up, which is the practice of going out and following up on something when you are unsure of it or you need to follow up something like someone's non-attendance rather than just do nothing and let the problem get worse.

Ms FORREST - I did wonder what that was.

Dr WAREING - With very good reason.

Mr FINCH - Chris, you may have been corrected by Jenny but it is not a Tasmanian Government inquiry. This is a Legislative Council inquiry at arm's length to the Government.

Dr WAREING - Thank you for that. I was not entirely clear. It was either get it in or miss the deadline, so I guessed and for that I apologise.

I am fairly clear about the introduction and the north-west. The situation otherwise has been that I may as well talk about where I come into all this. I am originally English, as must be very clear from my accent. I am originally ex-Cambridge and I spent a lot of time in New Zealand at one point in the 1980s. Then I went to work for the Centre for Mental Health Services Development in Britain, which was involved in the development of community alternatives to psychiatric hospitals. The large psychiatric hospitals at that stage, towards the end of the 1980s, were beginning to close. The first one I ever worked in the 1977 was one of the first ones to close and that was in Lincoln in 1988. There were a group of us who were interested in these matters who did get together and became known Centre for Mental Health Services Development.

I came to it from Auckland. There were Carrington and Kingsley Psychiatric Hospitals which were not functioning particularly well. There had been a collection of public inquiries into the ones in Auckland. It started in 1983 and went through to 1988. I am the end somewhat participant in supplying a lot of information to the 1988 inquiry. I started the crisis service in West Auckland with the aim of priming the pump to get the flow going to gradually develop other services and eventually to the closure of the hospital. That was a model I was very much involved in.

I was involved in bit of that in Britain. I came from that and went back to New Zealand for a short time to work for a non-government organisation which did not go very well. I went to Brisbane about 20 years ago, where I ended up as the deputy director for forensic services, looking at a range of statewide developments at that point. That fell apart for various reasons I am not going to go into here as it would be a great long tale.

I spent the rest of my time after that, going back to Britain and spending a lot of time doing locums and generally troubleshooting issues like picking up some service that was not working or being asked to deal with a problem like how you sort out after a consultant has committed suicide and various other things of that kind. I would get phoned a lot, 'Can you come and deal with this one?'

That is the background I came from before I came here. I was used to looking at developments and solutions to problems. What I did find here -

Mr FINCH - Was that in 2012 you came here?

Dr WAREING - Yes, in July 2012. It took a while to start getting used things. I would argue it takes at least a year to get the beginnings of understanding what Tasmanian culture would be like and I did not presume anything faster than that. My aim was to start looking at a development agenda that was fairly similar, as soon as it became very clear there was a lack of accommodation services; there was a considerable lack of skill; and there was a huge recruitment and retention problem. As soon as I arrived here one of the managers was trying to get me to drop a consultant position, which made no sense to me. I then took over the CAP team essentially because if you sit in an internal managerial position as a doctor you rapidly get divorced from your workforce. You are not then involved at the coalface and that is a situation in which I cannot function. In fact, in which I refuse to function; it is not an appropriate way.

Basically, I found there were a whole lot of these difficulties. The first thing I did was get onto [Mark?] Brown who was then the Chief Psychiatrist. I said, 'What are we going to do about staffing, because we just don't have anybody up here.' So we set up an arrangement with him to get substantially compatible international medical graduates known as SIMGs and we had a plan to get these folks. It took a long -

Mr VALENTINE - SIMGs?

Dr WAREING - SIMGs. An SIMG is somebody who is a consultant in Britain, for example, who cannot get directly into the Fellowship of the Royal Australian College of Psychiatrists. I did mine in 1982 when I was in New Zealand. They impose a series of conditions and supervision conditions in particular. At that time the situation was a bit more fluid than it is now. It has now become almost impossible. At that point you could still negotiate these conditions and I acted as supervisor to about three folks of whom two did get through. One did

what they promptly do and took off and left for Western Australia and the other one stayed around here.

Mr VALENTINE - Just for the record, the letters SIMG, can you just explain?

Dr WAREING - Substantially Compatible International Medical Graduate. It is a mouthful.

CHAIR - Chris, when you came in 2012 where was the Mental Health Service located? Where it is now?

Dr WAREING - It was located where it is now. It was partly at Spencer, where it is now. Child and Family Services were at Reece House; Parkside was where the Adult Community Mental Health Centre was. The only difference in terms of location since then was Care of the Elderly, which was in Cattley Street in a building which they vacated, which is still not let. They are now in the bottom of Parkside. That is the only sort of move.

Ms FORREST - Which one was that, the CAMS?

Dr WAREING - No, that was Care of the Elderly. CAMS is at the top of Reece House, which has also been an argument because of its cost and where to put it. The rest of it, even Gavin Austin was complaining about at the time when he was there.

That was the only sort of location change. Basically I did not see anybody trying to develop anything. There was quite clearly a need for development of respite services for people who needed only brief containment, with perhaps the support of CAP, which would not then overload Spencer. The aim of that was people who need 24/48 hours and a bit more intense input can be contained and don't necessarily need an admission. That would actually function in the way that if you had somebody who went to Spencer who didn't seem to need the ward, but could be managed on an intermediate facility, they could go down to that and then out again. It effectively becomes a step up and step down facility. The north had one at a place called Rocherlea. The north-west has never had one at all.

There is a need to, as I go through the development agenda stuff at the back end, quite literally straight off what I had been planning. I was essentially setting out on doing this on two occasions and I would argue was obstructed by the management on both of these occasions. On the first occasion I got as far as recording all of the client data on a census day, apart from CAMS. CAMS I didn't manage to get into, which was actually unfortunate, but that was the one I didn't manage to get done.

The idea was then to go through and quite literally quantify how much of what you need where, so that you can get specific about it and you can say that you need a hostel for six female clients who are unable to protect themselves against sexual exploitation and it needs to be in the Devonport area. That is an example that's probably fairly true.

There is a need to look at all of these things. They don't all have to be provided by Mental Health Services; they should be provided in partnership with other community organisations and Mental Health Services would have a visiting role into those places to maintain that. Otherwise you get forced back into a situation where Mental Health Services simply becomes a symptom containment agency: you turn up, look at the problem, give people medicines, and you suppress and off you go because there's not much else you can do. The advantage of having of having

co-location of CSOs is it gets across the yawning gap between the two. You can then get to a situation where you can look at the lifestyle needs of clients in a much more extended way.

The idea would be that you would treat someone, identify their relapse signature, look at what their social inclusion and other needs are - such as work collective - and as a result the idea is you would then be able to pass people over from case management to them and they come back again if they are relapsing. They can then come back into treatment and go out again, so it is easy out, easy in. Then the case management focus doesn't become so much on long-term care as it starts becoming an assertive outreach. In other words you start dealing with the people who are difficult to follow up, who won't take their medicine for whatever reason, who give you an address that is under a motorway extension, so that you maintain the appropriate oversight and engagement on the hard-core group of people who become a revolving door.

To do that you have to do things such as negotiate with other people - which is what I was starting to do in the absence of anybody else doing it - with the Richmond Fellowship, which I was doing. The aim of that was no more than to produce a discussion paper that would at least get people thinking and talking about it.

CHAIR - So the Richmond Fellowship has a facility or branch up here, as well as in Hobart and probably Launceston?

Dr WAREING - Yes, they do. I am not qualified to talk about very much outside the north-west. That has been very much my focus since I've been here. They have a number of rehabilitation beds in Ulverstone. At one point the referral rate was falling off and they were getting a number of vacancies that were possibly going to put some of the funding in doubt. One of the issues was 'Let's prop you up and keep you going, and at the same time let's do something useful between Mental Health Services and the Richmond Fellowship and see if we could set up a respite facility'. The idea then was that they would run the facility and CAP would be co-located with that so they provide the input.

We have had a number of other occasions where this hasn't worked. There were a couple of houses - there was one at a place called Cannon Court, when I first came here, which did seem to be earmarked as a sort of respite facility. In practice, nobody supervised it, there were endless arguments about who cleaned it if somebody left it in a mess, and there wasn't the capacity to keep an eye on what was going on. As a result, it fell into disuse.

CHAIR - Not for the want of demand?

Dr WAREING - No, not for the want of demand. It was the lack of support and organisation ability to staff it and keep on attending to the people who were there. It was an outlying facility.

When I was first looking at crisis services in 1988 I was in Burwood in west Sydney. From my point view they had what was the ideal facility, which was where the respite facility was on the bottom floor and the CAP team were on the fop floor of the same house. As a result, you were on the site and you could deal with problems. For example, when I was doing that in West Auckland it was not unusual for me to visit somebody four times a day to ensure we were getting on top of someone's symptoms and they were progressing in the right direction. For that you have to be co-located. You cannot drive huge distances, looking for things and people to do that. It does not work.

CHAIR - Are you happy with going into questions?

Dr WAREING - Yes. I am explaining what my background is to it. Otherwise, what I have done was to mention what my impetus is here and a sense of feeling obstructed by it. I do not want to go into a great deal of detail about the personal trials and tribulations with certain individuals who I would not be prepared to name in an outside and in camera situation but if I have said it and it is in there, the evidence exists. There are lever arch files that long on shelves about this.

CHAIR - Our focus is about the current projected state demand for Acute Health Services, as the terms of reference point out, factors impacting on the capacity of each hospital to meet the current projected demand, et cetera. It is more on the operational side and personal stories are important to listen to. We are not a tribunal. We do not have the capacity to take that further. We are interested in the mechanics of it. I have questions -

Dr WAREING - My main impetus about all this is, where do we go from here or how do we solve the problems we have, some of which are blindingly obvious.

Ms FORREST - I would like to hear about the solutions.

CHAIR - That is right, and you mentioned a couple in here.

Mr FINCH - I wanted to clarify, when you were talking about Mental Health Services teaming up with Richmond Fellowship, the opportunity for case management and oversight and those things, the funding for that sort of operation, how did that come about, or why didn't it come about, or was Commonwealth funding involved along with state funding?

Dr WAREING - I am not a terribly good person to check that out with. That has fallen, more legitimately, under the direction of managers and funding than it has under me. Remember, I am a clinician and psychiatrist. The situation has been that a lot of funding from a federal level appears to have gone away from what might be loosely called statutory services and more into community service organisations. There has been a yawning gap between the two, and I do not think they relate well. There is a sense of discontinuity in that area. The co-location idea I had was a means of getting over that.

The other issue is, what are the contracts with the community services organisations and what are they contracted to do. We are not going to go into a period of a sudden increase in funding for statutory organisations. I do not see that happening. Re-prioritising the funding available to CSOs is probably the area to look in. The idea is to try to find the means by which that can be moved into being a cooperative exercise rather than not, which at present it is not.

Mr FINCH - The Richmond Fellowship now, how is that placed in Tasmania? Is it operating here in the north-west?

Dr WAREING - It is.

Mr FINCH - Successfully?

Dr WAREING - Yes. We only have two real residential options available here and they do not meet the range of needs that I am suggesting. There is that and there is Curramore. This is

long before my time, so correct me if I am wrong, but the impression I have always had of Curramore is that when the Royal Derwent, which was the state asylum, for want of a better word, was closed, one of the ideas was that people would be resighted in various places and Curramore took the decanted population from there that arrived here. That population has got older, died, passed on, et cetera. As a result, it tends to take a very limited number of people. It doesn't deal with people who present long-term, slow rehabilitation problems and there is a persistent bottleneck because there is an attempt to do that through Millbrook Rise on the New Norfolk site.

Trying to get somebody in there is like the mating of elephants - there's lots of roaring and trumpeting, it takes place at high level and it takes you two years to get a result. That is about accurate, by the time you have got somebody accepted. After all the battle to try to get somebody in there, by that time the person has either fled the state or some other process has been generated. No-one has done a needs assessment of that, no-one seems to know.

Ms FORREST - Or a cost assessment.

Dr WAREING - A needs assessment and a cost assessment. They are both allied as far as I am concerned. Unless you look at the funding structures available to cost these things, you won't get anywhere anyway. You have to know at least the size of what you want, and where, to be able to work out what the funding is to match, otherwise you can't even start to ask the question.

Ms FORREST - I want to talk about a few of the things you have mentioned in your submission but also in broad terms of solutions. Some of what you identified were also identified in the Integrity Commission report, such as the toxic culture within the department. That's not limited necessarily to the north-west, I believe, from what we hear.

Dr WAREING - That would be my impression, too. To some extent the north-west has suffered from the fact it hasn't been. We have had a lot of occasions when the north-west has been run by people from the north, and on occasion the motivation for some of that has been somewhat questionable.

Ms FORREST - Do you see that that has changed, is changing, or needs to change for the necessary change to be made? I guess there are many processes that need to occur. Is that still a problem?

Dr WAREING - Yes, it is very alive and well.

Ms FORREST - How do you address that? Unless you change the culture - and it does take time to change a culture - how can you bring in changes that are necessary? The people who are making the decisions may not see the need for change or be reluctant to change because of that culture that is built around them.

Dr WAREING - The idea of this was partly what had led to my consideration of the Oregon health care plan. The issue is that management is perceived as having steamrolled everything and everybody and been extraordinarily unreceptive to clinical standpoints and views that are different. For example, the battle over blood alcohol and the casualty department has just gone on and on. It is like dealing with a hydra - you lop one head off and another talking head pops up saying the same thing, so you lop that head off, and then you get another one. What I am saying there is blatantly true: you cannot safely assess the intoxicated just to clear them out of the casualty department for someone's convenience. That is what it has all boiled down to.

There has been tendencies for managers to get involved in those sorts of issues, in which frankly they have no business. This is about clinical need and care for people and prevention of suicide. There is a suicide rate in people who are seen when inappropriately intoxicated, who are then dismissed from the casualty department. You wait until it drops down to 0.05 per cent. A certain number go into withdrawal, but not very many; it is usually overstated. There is a small number in which that happens, in which case that's the safest place to do it and get it treated. With the others, what you find is that most of them are deeply apologetic about what they have done and feel very upset about what they have done. The problem is they then go and do it again and there is no incentive to stop that from happening, or disincentive and that is one of the loads on the casualty department. The solution isn't just simply to find a means of turfing them into mental health.

The reason I was talking about the Oregon Health Care Plan was that it then introduces a large amount of community participation. The community involved in its own health care has a way of putting checks and balances on extremes of anybody's statements or attempts to steamroll or anything. I do see that as quite a useful potential development.

Rob Pegram, who is up here as the Director of Medical Services, probably has an even better knowledge of the Oregon Plan than I do.

Ms FORREST - Dealing with people with an elevated blood alcohol level in the DEM, we have not actually talked to the DEM staff on the record at all in here, but is that a significant blocker of patient throughput the DEM that you are aware of?

Dr WAREING - Put it this way if somebody comes in with a substantial blood alcohol, there is a given rate at which you can reckon they will process and metabolise the alcohol. For most people who come in at a given rate you have a fair idea as to how long the period will be before they become appropriately assessable.

Ms FORREST - What do you do with them in the meantime?

Dr WAREING - What you do in the meantime is you end up keeping them in the DEM, because there is nowhere else to put them. You certainly can't put them in the acute ward in that they are likely to engage in various forms of disturbed behaviour. Otherwise they just simply go to sleep and are not a problem and you can park them in a corner and wait until they sober up.

The bigger problem is the problem with ice, where people behave extremely badly and in fact can become quite dangerous. The issue with them is a different issue. The issue with them is it usually Midazolam will contain the symptoms. Yet again waiting for whether or not that will leave you with somebody who will simply be treated for intoxication in which case that is what it was. If they are actually ice psychotic, then it may lead to an admission.

Ms FORREST - Can you give them Midazolam and leave them in the waiting room though?

Dr WAREING - You couldn't really give Midazolam in the waiting room no, because if you give people Midazolam and large amounts of Benzodiazepines the chance of producing respiratory depression exists and it is dangerous to do. That is why we will not do Midazolam in Spencer because they do not have the resuscitation training equipment. To manage all of that it is probably fairly appropriate that we don't. I banned Midazolam from Spencer because it is just too

dangerous. If you are into that sort of treatment then you are by definition into the casualty department.

We did advocate for, which was a point at which the casualty department and ourselves agreed, the idea of having side wards, and having somewhere where you could put someone. The problem was much less at the Mersey where they could be in a side ward for an extended period of time. As a result it became known that is what you could do. The amount of angst, tension, attempts to move people somewhere else, at the Mersey basically wasn't a problem. The problem was only at Burnie where there wasn't one.

Ms FORREST - Did they use the MU for that or what did they use? Which side ward are you referring to at the Mersey?

Dr WAREING - The side ward that I was referring to was the side ward that they use on the end of the casualty department at the Mersey. I think they called it some short stay unit. The terminology I am not the best on. I always knew what it was because I saw it when I went there. That kind of thing worked. There would be a limited number of beds at Burnie, but they are very limited.

Ms FORREST - As an offshoot of the DEM, so they have a facility there, but it is not adequate. Is that what you are saying?

Dr WAREING - I am saying that, yes, and they have only just got it and it is only has about four beds, which is inadequate for the demands placed upon it, which we knew very well it would be.

CHAIR - The four beds are in?

Dr WAREING - The four beds are in Burnie and they are attached on the side of the Department of Emergency Medicine. They seem to have built a fairly large Department of Emergency Medicine, but without managing to get the funding for possibly the recruitment of experienced people to run that as part of it. I think it has been staffing that has probably been the limitation from what I hear. That is probably better heard directly from them than me, but that is the impression I have.

Ms FORREST - On the staffing issue, in your submission and in your opening comments, you talked about the attraction of specialist staff and retention. I know from living in this area that it has been a constant battle. The development of the one Tasmanian Health Service was designed to take greatest ability, and it has done in some areas with the Burnie and Mersey hospitals being more uniformly operated - I am trying to think of the right word. In obstetrics, for example, gynae/obstetrics has managed to secure five obstetricians and gynaecologists, and that is the first time since I have been working. So that is positive.

But in psychiatry, which has its acute care aspect as well as the community-based care, what are the barriers there?

Dr WAREING - The barriers there have been what I have said they have been. One has been a pay barrier in that they are not paying at a competitive basis, something that has been acknowledged by other people besides me. Rob Pegram acknowledges that if you talk to him. So one is the pay issue.

The second issue is the toxic management issues and the history of management relationships with psychiatrists in which psychiatrists have been put under general managers, which has not been a good idea. That has been a problem. If you ring the recruitment agents they will tell you quite openly - they talk about Burnie as a toxic environment where they don't like sending people to, and in which recruitment is very difficult.

What happened with the SIMG situation that I was talking about is that it tightened up and it became less fluid. The colleges started making it more and more difficult - at the Royal College of Psychiatrists to recruit people. Then they tried to impose more standards. The last go I had at this, which was about last April, we had a couple of English consultants lined up. Basically the college insisted that instead of doing a phone interview, which we had done before on one of those things, they had to fly in and the college had to interview them. Who is going to do that without the fares being reimbursed? It is a substantial expense. As a result, only one person flew in, who I did see in Hobart and I tried like hell to hang on to. The college then came up with even more difficult rules and regulations, which is why I say one of the issues is diminishing the college influence on all of this, because I think it has become disproportionate and obstructive.

The other issue is APRA. We do not have the SIMG problems as far as I know. They do not exist in New Zealand because it retains its medical board - or the New Zealand Medical Council, whatever the exact terminology is, but it retains one. As a result they do not impose all these conditions. So if they want to hire somebody, they do it very quickly.

Ms FORREST - APRA is established under national law.

Dr WAREING - It may be but my understanding is there may be objections in various places. I understand various states have complained about that.

Ms FORREST - It is a complex process to change that because you have to have the majority of the states agree that it is a common problem.

Dr WAREING - In this process we have shot ourselves very firmly in the foot.

Ms FORREST - How do we fix the clinical leadership? You say the managements were interfering -

Dr WAREING - We fix the clinical leadership issues by one, stopping the process by which clinicians are subordinate to managers. That needs to be on an equal basis and it also needs to be two people who are then forced to get on with each other in one way or another. If you try and be liked, you always get two against one. If you only have two individuals, one is clinical, one is managerial and they, in that sense, forced to negotiate and work with each other. There was a situation when I used to work for Odyssey House in New Zealand in 1983 and that model worked well.

CHAIR - You mentioned in your submission how you bring the community into some of the decision-making. I would like to get a bit of that on the record. Then I would like to have brief understanding of the cohort of people who are causing most of the issues in terms of the age range and whether it is growing into younger people or otherwise. Can you address your model, how you see the management being improved? I would appreciate that.

Dr WAREING - I can see the management being improved, one is that way and the other of which is very much the involvement of the community along the lines of what I was saying. In terms of the development methodology, I was including the stuff I have done. I know it works, been there and done it.

The issue would be, invite everybody in and encourage them to develop their own structures so they develop their own steering committee, and that feeds into the management and clinical director structure so they become, in a way, accountable to the community as well. That ensures there is an appropriate level of community participation.

What is happening at the moment is, you get a number of people who pop up, saying, 'I am a community representative', and you wonder from where, representing whom and what, and you never know. I had the experience not long ago with somebody claiming to be the carer's representative who did not know what Huntington's chorea was and had to have it explained to them in the middle of a management meeting. Given the extent of Huntington's chorea in the population around here - there are about 37 clients, which is high. I think some of the older generation have died off and it has now gone down to 29. The saddest case we had was somebody diagnosed with it at the age of 10. They did not know that information and they should know that information to participate.

The issues are how to encourage them to participate along the model I was suggesting and eventually by building what amounts to a steering committee.

CHAIR - The cohort of the people presenting for attention and treatment, is that changing?

Dr WAREING - Do mean is the population group that Mental Health Services have to give attention to changing?

CHAIR - Yes.

Dr WAREING - It has to because the area population is changing because disorders common in the elderly are going to present more frequently. That is the nature of the demographic change in this population; it is getting older.

CHAIR - Is ice, which seems to be in the headlines more of late, bringing in a different age range of people?

Dr WAREING - Yes. That is the second thing I was going to say. I hear that ice usage or experience is spreading down to 12- and 13-year olds. As a result, that is going to cause presentations at drug and alcohol services and community child and family services. All those are going to be increased to some extent.

The other problem is, I don't notice a terrible coherent philosophy for dealing with drug abuse around here at all. There have been drug and alcohol services but they frequently get led by somebody who is either drug or alcohol. This one is being led by alcohol and the drug side of it does not appear to have been given an awful lot of attention. If it was down to me, I would be asking Odyssey House in Melbourne to look at considering establishing a branch in north Tasmania.

Ms FORREST - Who do both drugs and alcohol and look after them.

Mr FINCH - In the paper you presented to us, at point 7, the conclusions you have come to, I want to explore your number one item there in respect of what goes on in Oregon. What you have written here, does that thought still apply? Do you still feel there are things that go on in a place such as Oregon, which you suggest is similar to Tasmania, that might be applicable here? Is it being progressed anywhere else in Australia?

Dr WAREING - I am aware it has been under consideration in other places in Australia. I know from conversations with Rob Pegram, the current director of Medical Services at the North-West Regional Hospital, and at one point they were considering bits of it in some of his previous areas of employment. I am not sure whether that was Queensland or South Australia.

The situation in Oregon is as I spelt out, as simply as I can. Oregon is very similar to Tasmania. It is largely a primary process state; it exports logs and it does not value-add and export furniture. It has a population that is fairly scattered across the state. They found themselves in the situation where about 22 per cent of the health budget was going in contract administration costs, that 24 per cent of the population was in the wealthy-poor gap - in other words, they are not poor enough to end up in the medicare scheme in the states, which is not to be confused with the Medicare scheme here. It is the same name but the functions and the way it operates are different.

They decided to address all this by calling in the Kaiser Permanente Insurance Company and doing an actuarial analysis of things. What they looked at was the range of illnesses and likely treatments across the board as diagnosis treatment pairings, which is fair enough - and I have given a couple of examples of it. I do not think it is necessary that everybody goes back and starts at the beginning. I would have thought that actuarial analysis of treatment pairings would be fairly internationally translatable. I don't think you necessarily have to start with that. It would be interesting to start with that list and then look at the weightings the community placed on it. I have copies of the calculations because I was in Oregon in 1992 and was involved in balancing up with a small group of people some of the anomalies in funding and diagnosis.

The first area I am talking about was in terms of Mental Health Services. We had a look at that and it became clear as a model that it had a range of advantages. I do not think you have to go right back to the beginning of doing the actuarial analysis again. I have the calculations so I know what factors they took into account.

CHAIR - Do you have a contact in Oregon with regard to that particular system?

Dr WAREING - Not at present - 1992 was quite a long time ago. The person who was very much in charge of the Oregon Health Services Commission at the time was Paige Sipes-Metzler, who I used to deal with, but I would imagine she is long gone. The best person to talk with is probably Rob Pegram who is closer to those sorts of contact.

CHAIR - Thank you very much for your presentation today. Your submission covered a lot of ground and it has been quite valuable. I remind you about parliamentary privilege and whatever you say outside is not covered.

THE WITNESS WITHDREW.