THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON THE PUBLIC HOSPITAL SYSTEM MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON MONDAY 6 APRIL 2009.

Dr GRAEME ALEXANDER WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Thank you very much for you attendance, Doctor. You have given us a detailed submission and we have now gone through that. What I need to probably say is that if at any stage during the proceedings today you would feel more comfortable and you feel that you would like to go in camera to give the evidence then, please, make that request and we will make a determination on that. You might feel that that is a better way to do it. I noticed in your submission that you have not referred to any persons, you have simply referred to cases. That may well be sufficient. But if you feel uncomfortable then certainly we can make a decision on that.

Today's hearing will be recorded of course in *Hansard*. You have parliamentary privilege so you are able to freely speak on any issues that you wish to. Following the hearing you are entitled to talk generally about the evidence that you have given but be a little careful in referring to specific detail if you are talking publicly about your attendance here today.

Doctor, we have read you submission. At this stage I will give you the opportunity to raise any issues with us, to make a further submission to us, if you wish, and then we will ask you questions.

Dr ALEXANDER - As I mentioned, I have been a GP for 20-something years plus three years of hospital experience. Over the last five or six years I have presented to the Senate, the Productivity Commission et cetera. Every now and again I have a moment of, 'Why do I keep doing this?' When I heard this committee was first being organised my initial reaction was that I was not going to do it. I was persuaded a little bit by some statements that were made that people are generally sick of hearing, 'Why isn't health being fixed when it can be fixed?' Whether it be media, politicians but more particularly patients, people constantly say - and I am sure the office of everyone here has been flooded with patients saying - 'Why can't this be fixed?'

Together with some Legislative Councillors, who are not here, some other politicians of both sides of Parliament, I changed my mind and I did put in a submission. That is why I am here. I do not claim to represent anyone other than someone who has worked for 20-odd years within the health system. GPs - and I assume you will find this out - are poorly represented by people who I suppose at times claim to represent GPs. We are a fairly diffuse group, a quiet worker who goes about their work, trying to do the best they can. I then said I will be here and that is why I am here really, to try to put the case that I think GPs are probably the best group of any to see the problems that ail our health system. Every day we interact with State Government, Federal Government, pharmacy, disability, aged care, mental health, nurses, podiatrists, allied health people - you name it - and more particularly, everyday patients. That is what this should all be about. I am sure at times I will commit the same sin of casting around numbers but every one of

those numbers is a patient and for every one of those patients there is a family. This, for this State, is huge and I think we should work and start to try to fix the system.

The two things that it will come down to over and over again is leadership, and it has been sadly lacking in every aspect of health care, and the second is work force.

CHAIR - Thank you, Doctor, for that. We will go straight into questions.

Ms FORREST - You have said that GPs are unrepresented in this whole debate and you have seen in the terms of reference that it refers to the public hospital system. Our health plan was prepared nearly two years ago, I guess it is now. It was done in isolation with the primary health and the clinical services initially; the plan seemed to draw them together. Do you think that is a way forward? Are we integrating well enough and should there be more integration between the primary health and the public hospital system, the acute services?

Dr ALEXANDER - Absolutely there should be more integration but I think the gap has never been wider.

Ms FORREST - How do we fix that then?

Dr ALEXANDER - Communication must be number one. Communication between the public hospital system and the system that I work in has never been worse. It is just appalling. We can go three months without getting a letter back from a patient who may have waited a year to get into a clinic. The patient may front to us two or three times before that. If we want results, it takes months and months to get results. Again the patient waits. I was staggered last week to be rung by a doctor from the Royal, and I commended him for it, from the Hyperbaric Unit. It was the first call I had received about a patient of mine within hospital for months and months. Think how much we could shorten stays in hospitals. We could stop mishaps in hospitals by adding information we have accumulated in our practice for decades. To find the person responsible for the patient in the hospital, or if you want to admit someone, it is almost impossible. It frequently would take a dozen phone calls, faxes and faxes and faxes. We are literally in general practice wading through mud trying to work but we cannot work. We were thinking of donating a set of carrier pigeons to the Royal - it is funny but it is true. I sit with a state-of-the-art computer on my desk, with encrypted information - you name it. The whole file is there at the push of a button and I can no more communicate really to any of the doctors in the hospital than fly to the moon.

Ms FORREST - Are you aware of the progress that is being made in the north-west region in this regard, with GPs basically commencing the discharge planning on starting a patient through that process?

Dr ALEXANDER - I am aware that there has been, and this is not being disrespectful, lots of trials, lots of programs but to us it is not that hard.

Ms FORREST - If you aware of that situation, do you think it could that the GP has that much more integral approach, they are much more engaged with the patient as they make their way from the primary health setting to an acute health setting and then back again? The GP is going to follow that patient up once they leave the acute health setting which is

where that acute event should occur and then the ongoing post-operative care or whatever should be back with the GP.

Dr ALEXANDER - I am aware of those programs and, yes, any input I think general practitioners can have. We have had patients whom we have looked after die in a hospital and we have never been notified about them. The first notification that the GP gets is the family coming to a consultation and we are totally unaware of it. It happens all the time.

Ms FORREST - So there is a breakdown with your discharge planning here. When a patient dies obviously they are discharged. I cannot see how the system cannot work that you can get an electronic discharge summary. Why is that not happening?

Dr ALEXANDER - I do not know. As GPs it just baffles us and it is irregular, frequently unreadable. It is often handwritten in a hurry, weeks and weeks afterwards. Often during the stay there are significant changes to that patient's management or medications or follow-up. I cannot explain why it does not happen, but it should happen and in 2009 it should not be that hard.

Ms FORREST - Whose responsibility is it?

Dr ALEXANDER - The problem comes from way back. If you look at our hospitals at the moment they are cramped, they are poorly computerised. Where do you fit on the ward to sit and ring your GP? I think the problem starts from way back.

Ms FORREST - The design of the hospital or around the design?

Dr ALEXANDER - I am not just talking about the Royal; I am talking about all our hospitals. They are archaic, they are out of date, they are rushed. The doctors are busily trying to survive in their clinics. Do I look after the next patient that I am trying to squeeze in while this person is going out of that bed or do I get time to ring or do a discharge summary? That is the mechanics of it.

Ms FORREST - Should it be the consultant, the registrar or the resident?

Dr ALEXANDER - The resident.

Ms FORREST - So it should be the resident.

Dr ALEXANDER - In my day - and I know it is getting on a bit - it was the intern's job. The registrar supervised the discharge summary and the consultant was responsible and every now and again would scan what you had done or had not done. I cannot imagine that that process is still happening.

Ms FORREST - So it is either the intern or the resident's job that you believe should do that?

Dr ALEXANDER - It should be the person who is looking after that patient within the hospital. But it should be even more than that. With the call I was rung about the other day the doctor concerned wanted to know the patient's renal function. With one button I knew I could tell him what that patient's renal function was. It saves a test, it saves

waiting, right through - one button. So it is not just at the end. I think it is the whole way through.

Ms FORREST - So that was an incident where it obviously worked. The doctor in a hospital rang you, knowing you were the GP, for the patient's renal function.

Dr ALEXANDER - It worked and he had thought it through and, yes, it was the simplest and quickest. One of the problems we then have is the way that GPs work and the way they or their practice is remunerated. It is zero for phone calls and faxes. Constantly I will come back to that. We get zero.

I brought this along today, just for interest to show you later. This is the new bible. That is last year's, and this is this year's abridged version from Nicola Roxon. This is the one she waved around during the election campaign and said, 'I am going to do something about this when I get into Government'. 'It is like a phone book'; that was her description. It stifles preventive medicine. It is complex and difficult for GPs to understand. Well this is the new one, which we have to now pay for - we did not pay for this one. The changes that have been made are, one, it is in black and white; two, we pay for it; three, it has gone from a Tasmanian phone book to a New South Wales phone book. I do not understand this book. If I get this wrong or the staff get this wrong, the only thing that the Government introduced in their first Budget - the only thing - was that if GPs get it wrong they will be investigated.

I do not understand it, not because I am unintelligent; no-one understands it and no-one knows if we are doing the right thing.

Ms FORREST - What are the fundamental changes between that phone book and this phone book?

Dr ALEXANDER - More item numbers, more of 'Which item number do we do for what, for where, and how do we do it?' The thing that we wanted to do was to simplify the item numbers that we normally work through. These allow us to do prevention and look after the chronically ill and the elderly with multiple problems, which is what features in Tasmania. We are the oldest population, with the highest level of chronic disease and yet we have a book now where I can maximise my practice's income by seeing a patient every five minutes. When they went from this to this and they investigate, the one thing that has happened is that GPs have stopped doing longer consultations. They have stopped doing preventions and the statistics are out there now.

CHAIR - So what is the result from that?

Dr ALEXANDER - Nothing. We are still out there under this book. The reason I am pointing this out is that an opposition can criticise this and the Government gives us this, but there is a change when decision-makers come into government.

Dr Webber of the Professional Services Review, a government organisation, reviewed this book to try to explain to us how we should apply this to general practice. The first way we should apply it is not to see a patient with more than one problem on one day. In a background of an absolute work force crisis, the Professional Services Review tells me that if a patient comes to me with three or four problems then I would say, 'You have

only got one problem today, come back tomorrow', then I will be safe. We should not do prevention because it is not covered in it. If a mother comes with two sick children, for a GP to be completely safe we should tell her to bring the second sick child back the next day. This is the Federal Government's Professional Services Review, and people wonder why GPs get so frustrated. We're not well represented by the AMA; we are not well represented by colleges or the division network, which is a Federal government organisation. What GPs do when this amount of frustration gets them is quietly go away and do something else. That's what we are seeing. They don't want to do rural practice because rural practice is harder; it's more difficult. There is less support, fewer investigations, less specialist support, so it is complex and it is slow. This book punishes rural GPs, and then the Federal Government gets up and says, 'Why don't we have GPs on the north-west coast? Why do we rely on an overseas-trained work force?' To us it is mystifying because pre-election this is dreadful, yet post-election it's worse.

Mr HARRISS - I understand that there are plenty of computer programs around, one in particular, Securenet, which allows the GP to properly and broadly communicate with everybody through the chain once you've dealt with your patient. They might end up in the public hospital system - bearing in mind that's the nub of this inquiry. Ruth then went to the question with you as to who should pay for that. I understand there's been some reluctance in this State to broadly pick up that process, which operates in places like the Northern Territory and other places in the world. I hear from your evidence there's a crying need for something like that to be introduced almost immediately so that our public hospital system can operate properly and more efficiently. Who should pay for it, and shouldn't there be some contribution by the Federal and State governments to get that in place pronto so that we can properly track health care of our patients?

Dr ALEXANDER - We do come to the argument about whether two people should be running the health system. You are looking at someone who has said for six years that the Federal Government will run our health system. It's a matter of when, because it cannot continue to collapse like it is. We will get to that stage fairly soon when that will happen. If we look at other States like New South Wales, they are getting close to it and they are giving up bits of it. I think if the pressure came on they would say, 'Please, here, have it'. So someone should pay for it, and it should be done now. I can't for the life of me see why it's that hard.

Mr HARRISS - The public hospital system needs it for the reasons you've given in your evidence. Private practitioners need to be paying their way as well so that they are tapped into the system. If the system is going to properly track health care then that needs to be actioned immediately.

Governments of all persuasions over so many years have looked at the whole of the health system. You have said there is a whole heap of things that need attention, but we always seem to say that our health system needs attention and we look at it from the big picture. Why don't we take some bite sizes? Why doesn't a government simply say, 'A and E needs dramatic attention and has to be fixed now'. We fix it and we stop taking the macro view, and get some wins in the areas that desperately need wins. Ought that be adopted? It just seems to me that it has never been adopted.

Dr ALEXANDER - You will constantly come back to two terms: leadership and work force. I have no politics here and have a record of questioning the Howard Government. We

always hope with new governments that we will get changes, but it just doesn't come. Still for some reason the Health portfolio is considered the poisoned chalice. If we look at leadership, then track our State Premier. How many times has he mentioned the word 'health' since he has been our Premier? Then compare it to 'education' or any other thing, it is the word you don't utter in case you are tarnished with it. Look at Mr Rudd - every pre-election November 2007 poll I saw, every single one across the country, had health at number one. The only exit polls I saw on election day had health number one. He only said to one portfolio, 'The buck will stop with me' - Health. How many times in 18 months has Kevin Rudd asked, mentioned, questioned the word 'health'? I could count them on one hand. He talks about his mandate to do various things - IR legislation, mandate for this - if you ask me, he was given one mandate and that was to fix everything we are going to be here talking about. But has it got a mention? Today we are seeing the start of $42 billion being showered on this country. You have to be careful not to be hit by a gold bar or a diamond at the moment, but not a dollar for health care. To me, why we are not getting anywhere is obvious - there is no leadership. If you combined Premier Bartlett and Prime Minister Rudd you could not count their input other than the odd ribbon-cutting ceremony, you could not count on one hand their interest in this debate that we are talking about. I know our Prime Minister should have a focus on overseas issues but their record in 18 months of turning their back on the issue most important to 20 million Australian - health care - is appalling. I said previously that I thought the Howard Government was the most out of touch on this issue but in 18 months we have gone a quantum leap in a Federal government being out of touch with its people. I would ask everyone to think when Kevin Rudd has mentioned the word 'health' in 18 months. It was such an important issue in the lead-up to the election. In Queensland recently there was a 4 per cent swing; 98 per cent of the people who swung their vote swung it on health.

Mr WING - On the question of the knowledge of the Government, how much of that recent larger of the two documents you have presented do you expect the minister would understand?

Dr ALEXANDER - None - not its impact.

Mr WING - Maybe she should be interviewed on television a few times, in the way John Hewson was about the GST and got mixed up with the birthday cakes and things such as that, and that was the end of the GST.

Dr ALEXANDER - I would like the interview to be done by some patients. We talked about patients. Last Wednesday I saw a patient of mine. He is 78 years old and is on no medication, he has no problems, no illness. About a year ago he came to me, as he always did once every three or four years for something minor, to apologise for taking up my time. He is one of those patients; I am sure you can think of the type of patient. He had excruciating pain in his hip for three months before he thought he would bother me. I X-rayed his hip and he obviously needs a hip replacement. I then referred him to the hospital. After two months I had heard nothing back but the patient received a letter that said, 'Your doctor has marked your referral "semi urgent". As it is not urgent, we will have to wait for an appointment'. I then rang - there is no item number for ringing or faxing - and I faxed it and said, 'He needs to be seen'. After four months he received an appointment date, not for his hip surgery but to see a specialist, for three months further on. The specialist saw him and said, 'Dr Alexander, this man needs a hip replacement'. I

saw him on Wednesday because he has been sent back. He has been having physio at the Royal and has been sent to me for anti-inflammatory medication, analgesics and monitoring. I thought while he was there I would ring and find out what the expected wait would be for his hip replacement. The answer, 'Three years'. He is 78, has already been waiting nearly a year and he has another three years. I hung up and said to him, 'I will deal with this later and I will see what I can do', so I rang back and I got a very helpful person - and I mean that - who said, 'One of the other lists is 18 months and another is a 12-month wait for hip surgery'. I then said, 'Can I swap him over?' and they said, 'Not without a new referral', so I said, 'It took him seven months to get there in the first place' and she said, 'That's the way it is and there's partly a reason for this that is very important about cost shifting'. She then said as I was about to hang up the phone, 'But don't send it now because we can't look at it for 12 months', and I said, 'What do you mean you can't look at it for 12 months?' She said, 'When someone shifts from one ortho clinic to another we don't allow the referral to be looked at for 12 months'. So 12 months, seven months, 12 months, you may as well stay on the three-year one.

Ms FORREST - How is that cost shifting?

Dr ALEXANDER - I referred to it and I wanted to explain it. Patients have come into my room and said, 'I've had no correspondence from the Royal whatsoever. I need a referral to the ENT clinic for billing reasons' and I say, 'What billing reasons?' and I am told, 'I don't know, that's just what they said'. The reason there are billing reasons is I write a referral which is an external referral from the Federal Government and they can then claim a visit on the Federal Government so the patient is sent out to me so that they can then generate a bill to the Federal Government through Medicare. Equally, GPs are constantly blamed by the Health minister that somehow it's all our fault and we're flooding patients into A&E. You can already see the burden that a hospital not functioning properly has on general practice, we have no say whatsoever in when our patients get operated on, whether they get seen in A&E. I could make a dozen phone calls and it would not expedite their transfer through A&E. I could write the most beautiful letter and I said that we, at times, write 'urgent' in letters that big at the bottom so that someone will see it. That is the level that we have got to.

Mr WING - They may not be able to deal with it for 12 months but read it.

Dr ALEXANDER - Equally, clinics now refer patients out of clinic to us for us to order the investigations so here is a wasted appointment. We order the investigations whether they be X-rays or bloods. Why? The Federal Government pays for it and not the State Government. There is this constant system of referrals and referrals in so that the State Government public hospital system can cost shift to the Federal Government.

Mr WING - Do you believe that is a State policy?

Dr ALEXANDER - I would love to know if that behaviour gets taken into account when our State public hospital systems talk about their under funding because an increase in the amount is cost shifted into the private system or primary health care.

Mrs JAMIESON - I can understand exactly where you are coming from but have you also had problems with patients who have actually gone through the procedure and then just

about got to the theatre to find that it was the wrong hip or the wrong knee and then have had to go right back through the system and two years later they might be treated?

Dr ALEXANDER - Recently there has been an announcement - I am addressing this question - that we are going to do I think 1 000 cataract operations. Some of those will be my patients so good, but no-one has raised the question of why the Royal isn't doing them. What's the hospital's reason for not doing these things? The answer that they do not want to verbalise is that there are no doctors, there is no system, there are no beds, although a cataract operation probably would not need a bed. We are doing 1 000 cataracts because they are quick and easy and they do not need a bed. A good question to the hospital is how many neurosurgical lists were cancelled in 2008? You will be horrified.

Ms FORREST - Whole lists or patients?

Dr ALEXANDER - Whole lists, people who have waited more than a year for their initial appointment and goodness knows how long for their surgery - this is neurosurgery. They would not give it to me but ask the public hospital how many neurosurgical lists were cancelled. How many hip replacements or knee replacements have been performed in the Royal Hobart Hospital this year? I reckon we would probably count them on one hand too.

Mr WING - Is that to have an effect on the waiting lists do you think because they take longer?

Dr ALEXANDER - Yes. The big one is that they take beds. Why are we doing 1 000 cataracts? Because they are quick and easy and they will drop the waiting list for the hospital probably from 10 000 to 9 000 about one month prior to the next State election. That is what it is about.

CHAIR - We have had evidence that there has been a position or strategy within the system that, yes, the easy and the quick patients would be done, specifically to decrease that elective surgery waiting list, so you would support that position?

Dr ALEXANDER - Absolutely. I will put a face to the hip. Imagine being your GP, talking to that patient whom you have known and then talking to his wife and imagine talking to the cardiac patients and their wives and families. Imagine talking to - and I do not mean to be disrespectful by this - the person who has become unemployed because they cannot get surgery. There are hundreds and hundreds of them in this State, and their families. They become unemployed or they are, especially in today's climate, unemployable because they might have to, at any time, go in for surgery. So should we do the thousand cataracts if we can? Yes, we should but why are we doing it?

We have made progress in some areas on various issues. After a four-year campaign we have raised the number of GP training positions. I can assure you that was a very long, hard-fought campaign. Why did we win in the end? We won solely on one thing - it got into the media. Whoever sits here today could have the best reasons, the best planning, the best ideas, but the chances of them being implemented are virtually zero. The only thing that works, sadly, is the media.

I will look at your two earlier inquiries. You have an A&E consultant from LGH telling you about his problems - and this was in the media so that is why I am talking about it. The next day, what happens? The CEO comes out and virtually says, 'There are no problems'. The day after that, the LGH gets a large sum of money delivered by our Premier. That is how it works to date and that is why it is a dog's breakfast.

Mr WING - In your submission you say that communications between the Royal Hobart Hospital and GPs has never been worse. Are you in a position to say whether or not the lack of communication between GPs and the Royal is similar within the Royal, between different sections of it, between specialist in different areas dealing with the same patient?

Dr ALEXANDER - I could not say it is same level but it is certainly not good. If you have one clinic and a patient needs two clinics, it is back to me for re-referral to the other clinic. I suspect, again, there is cost-shifting. It makes sense that that is what it is about. Communication within the hospital is not what it was.

Mr WING - I am aware of one case where a patient has been in a coma for approximately one month and in assessing what is to happen the family became aware that there is virtually no communication between two or three specialists who really have a role in making that decision. Would that be common or is that unusual?

Dr ALEXANDER - I think it might be common and it will become increasingly common in the private system as well, now that we are losing our general physicians, which is going to be a major problem for admissions to hospitals in the private sector as well.

Mr WING - What is the atmosphere like within the Royal?

Dr ALEXANDER - Appalling.

Mr WING - Between the various sections of it and generally?

Dr ALEXANDER - If we ask the Royal, there will be a 'bureaucrat' announcing that it has never been better. I am sure, at times, it may dip lower. I made reference to a meeting that I was asked to attend in 2005 and I have never seen more frustrated and angry people than that room full of doctors. They were there asking for a desk to sit at, or a secretary, or a computer.

One of the real problems for our work force is our medical students because, like most things, you have to start somewhere. The medical school no doubt will be here later today and they will come in and say it is fabulous: 'We have never been better funded, we have never had more overseas fee-paying students'. What is the purpose of that medical school? The purpose of that medical school and the reason it was created was to provide doctors for this State. On record, if you get a Tasmanian-born person who goes through our medical school their chances of staying here are massively higher. If they happen to come from the north-west or the north-east they are massively more likely to head back to the north-west and the north-east. Our universities are growing fat on the money that they can take from overseas-trained students. They will argue we have a responsibility to train them. Maybe we do, but the bizarre situation is that we have this

so-called responsibility to do that and then we go into third-world countries and steal their doctors. It just does not make sense.

On the medical student issue, you cannot become a doctor until you have been an intern. The Nursing Federation and Neroli Ellis will do a much better job at presenting this than I can. You must have clinical placements to be a doctor. At the moment we have 58 intern positions in this State. The reason I am getting to this is in relation to the attitude of medical students and medical staff to working in those hospitals. They find them appalling so they are not staying. They are not even staying to do their intern year. We are importing. The North West Regional Hospital is a classic. Of eight positions for interns, only two will be filled by Tasmanians. The long-term future of that is that the north-west will not have doctors. The LGH is similar: of 21, six are Tasmanians. They are being filled by mainlanders who have got their act together much better at replacing their work force. In a few years, increased numbers will come through of what I would argue will be poorly trained medical students compared to what we have had historically. Why? Because the hospitals are just not working. Imagine clinics and things where the clinicians and the specialists cannot get to their patients. What is the one thing that must be missing? It is teaching. The medical students are not allowed to speak out for themselves. They are told that through and through. They often contact people like me about the appalling level of teaching they are getting within our hospitals.

Mr WING - In relation to teaching, what comparison would you make between the Royal Hobart Hospital and the Launceston General Hospital?

Dr ALEXANDER - It seems to vary a little bit with whom you talk to. Some people enjoy going to the LGH because they seem to get to do more. But equally, if you take again the North-West Regional, I have heard there must be serious questions raised about whether they will be accredited to teach in some areas, for example general practice. Once that happens a fiasco will occur in the north-west of this State for doctors. We already know that they are very reliant on an overseas-trained work force. We do this bizarre thing of not looking after our own medical students and then spend massive amounts of money retraining overseas people. I do not understand that.

Ms FORREST - Historically you would be aware that there was a Federal Government initiative some years ago that we had too many training positions for doctors so they cut them right back.

Dr ALEXANDER - I cried that day.

Laughter.

Ms FORREST - Yes, and in the great wisdom of that decision a few years down the track we actually do not have enough. In more recent years we have had a great increase in the number of medical students going through to the point that in a couple of years we will not be able to place all our Tasmanian-trained interns. Because it has happened around the country they will not be able to get intern placements in other parts of the country either. What you are saying is an issue now will then be almost the complete opposite and we will actually lose them for another reason.

Dr ALEXANDER - I was coming to that. I think it is in 2010 that something like one-quarter won't have a job, and then it goes to one-third. There is no planning or leadership in any of this. One of the problem we have as GPs is that we have a feminised work force, which is great, but although there might be more doctors on the ground, many are part-timers. We train our GPs and in this country it is legislated that they see a patient every 15 minutes. This maximises their income at five minutes. The pressure is massive when they get out there. What do they do? I equate it similarly to teachers. If you train a teacher to have 30 in a class and all of a sudden you have 90, that is what it's like. We wouldn't let it happen but that is really the level that we are getting at.

I will pick Scottsdale just briefly. I know nothing - and I don't even want to get involved or know what is going on up there - but the doctor concerned, from all I read - and it must be close because there were 1 500 in the march - has 3 000 patients on his books. The recommendation at the moment is somewhere between 1 200 and 1 500. That means we are looking at roughly for the Scottsdale area of finding three full-time-equivalent doctors. Our training program puts out at the moment, and we have recently worked hard to get it increased to 22, so a modern GP works about half-time. We are looking at six doctors to replace one doctor. Whatever the reasons and issues that have been raised, the only thing I would point out - and he might work for many years - is that he is 68, which is really the profile of rural GPs. I am an urban GP, grey-haired and ageing at 51, and I am a young urban GP. Statistically I am in the young half. If I were a rural GP, I am 10 years younger than the average rural GP. It is a horrifying situation. The replacement work force we are going to look for is massive and we are doing nothing. We are not even treading water at the moment.

Mr WING - In terms of training GPs you mean?

Dr ALEXANDER - Yes. As I said, we fought very hard at a superclinic meeting where I questioned the Deputy Premier and the Federal member for Franklin about this issue. I held onto the microphone for quite an embarrassing amount of time, repeatedly asking the same question as to why she wouldn't raise the number from 16 to 22. The result of that - and this is how it works - was that it got on Radio National and was fanned across the country. It ended up in Roxon's office and all of a sudden we were asking for six new positions because we happened to have six GPs Tasmanian-born, Tasmanian-trained who wanted the job. That is unheard of, but the State and Federal governments were saying, 'No, we don't want you'. Eventually Nicola Roxon made 175 new positions and, by coincidence, Tasmania got its six. That was a response to media pressure. It was nothing smart from anyone, it was a response to media pressure, and not only on a State level but a Federal level. That is how health decisions are being made. I made reference to the Royal in there. I could go on, but it is the same. Just look at how the decision-making has been made on the Royal and where we are now with it.

Mrs JAMIESON - I noticed in your work force comments you are saying we need to pay particular attention to our younger GPs and support and shield them. If you had your way, how would you support, shield and train your younger GPs and younger doctors going through the hospital system? What are your comments on nurse practitioners and physician assistants?

Dr ALEXANDER - If we are going to do these numbers, they will not be able, in a practical way, to get experience. We will have to get smart here and they will have to get out into

some of the better-accredited general practices and get experience early. There is this bizarre system of the doctors that worry us most - overseas doctors who need the most work - work unsupervised because it is called an area of need. It should be called an area of neglect, not an area of need. They should be in the office next to mine, or something like that, for a period of time.

There is so much unsupervised work being done at the moment. Is this bagging overseas trained doctors? No, I am not. We would not have survived without them but we continue to trawl the world and our governments are allowed to say over and over again, 'But there's world wide shortage'. We have all heard that. What has that got to do with Australia? If there is a shortage in Sudan, what has that got to do with it? Absolutely nothing. It is a throwaway line to take pressure off governments. The reason we have a shortage here has nothing to do with the shortage anywhere else. The reason we have a shortage here is bad planning.

Mr WING - Even Cuba is training doctors to go to some of these countries to help, and we could even be playing that role once we have an adequate number here.

Which government was it that decided to cut back on training GPs?

Dr ALEXANDER - It is a bit of a crossover, from my understanding. I might be wrong here. Training positions for general practitioners is a bit of a crossover. I think some of the work was done just prior to the Howard Government taking office and then I think the actual decision, the fall of the hammer, if you like, was the Howard Government. But at the time we were advertising everywhere.

CHAIR - I am going to have to bring this session to a close unfortunately but there is one question I wanted to ask you, Doctor, and you may not want to answer it. One reads the horrific headlines coming out of the mainland and in Victoria in the last two weeks in relation to people who have been on waiting lists and those who have become deceased. I think in the last five years 2 356 people have died in that State whilst on waiting lists. Do you believe that in this State with our waiting lists we could be seeing some similar problems arising from the way we are currently operating and working on our waiting lists?

Dr ALEXANDER - Yes, it must be happening. There are other issues here. I do not like normally to talk anecdotally but I put cases in there to try to put a face to some of these issues.

The prostate cancer one is a classic. Who wants to be sitting on that diagnosis, who wants to be telling that patient? 'You have told me, doctor, I have prostate cancer but no-one is doing anything'. Regarding gastroscopies and endoscopies, patients who we are fairly convinced have a gastric cancer, imagine the family. It is not until probably they manage - and I use that term loosely - to get to the palliative care situation that things seem to rally round, but to get investigations, treatments in what is the last maybe short period of quality of life is appalling.

CHAIR - The prostate cancer one is a very interesting one and I read that with interest as the others would have done as well. Quite obviously any delay there will, I guess, aggravate that problem. I do not know, you could tell me to the extent it would aggravate at, say, a

six-month wait or a 12-month wait, which would then obviously entail greater surgery, greater care, probably greater hospitalisation. Am I on the right track there?

Dr ALEXANDER - It has to be. Then we have patients waiting on the cardiac lists. We have patients waiting for endarterectomies who wonder if they will have a stroke today or tomorrow. Months and months and months of waiting.

Ms FORREST - I guess you would say those numbers need to be considered with caution, though, because some people might die for a reason unrelated to the reason they are waiting. So you cannot always have a direct relationship.

Dr ALEXANDER - It is why my answer was just yes, are there some? There must be.

Mrs JAMIESON - You did not get a chance to comment on the use of nurse practitioner positions.

Dr ALEXANDER - Oh, sorry. It mystifies me. The word 'reform' gets thrown around all the time and 'teams'. We have always worked in teams. I have worked happily with sisters for 20-odd years. We have always done it. My concern is what the governments do. When we say we need more GPs they then say, 'We are giving you something else'. We all work together. We always have done. The next thing is where are these nurses coming from? The only way we can get nurses to replace us is to take them out of the hospital at the moment.

CHAIR - Doctor, sorry to cut you off there. I wanted to quickly go back to the prostate cancer case just to bring the circumstances and the details out at the time frames involved there. So can you go through that? It is in your submission.

Mr WING - The first case.

CHAIR - Without the identification, quite obviously, of the person and then we are going to have to call a session to a halt.

Dr ALEXANDER - Again, I want everyone to think back to this thing as well. There are no faxes, there is no phone call item number here. But, again, the most important thing is the patient. Sometimes, as a GP, you are unsure and what you need is a biopsy. Sometimes, as a GP, you know - and this was clinically as obvious as you could possibly find from pathology readings and from examinations - so I did what I had to do and I informed the patient. It is no good doing anything different - I faxed a referral. He was given an appointment after I examined him.

Mr WING - When did you tell him that? You have it in your submission but it is not dated.

Dr ALEXANDER - It would have been May 2008, yes. So I write that in my referral - 'This patient has prostate cancer'. The clinic appointment comes back in January 2009, so it was roughly an eight-month or more wait. Frequently clinic appointments that you are given are then delayed later on so the January 2009 still has a huge question mark against it - he knows it, I know it - so it could be postponed many, many times before you actually get there.

This is a patient who does not have money, who is not privately insured, so we have a problem. The only way that I can get around that is ringing, privately, faxing, begging and that is how we got around this case. The patient was initially seen privately so I could short-cut the outpatient wait - but I could not completely short-cut the surgery wait. In other words, I had him to someone who works privately and at public, who knew the diagnosis, who knew the significance of the diagnosis and therefore could expedite him up the list.

It was not an option to do surgery in private because that is vastly too expensive for a lot of people, but it is certainly a way that we have around it - that we use favours amongst the consultants that we have access to to expedite the outpatient wait.

I have had doctors at the Royal and letters telling me, 'Do not send patients here - do not do it'. I keep those letters - in their letters they say, 'The system does not work. In future can you send this sort of patient to me in private?'

Mr WING - In this case of the prostate diagnosis, your action reduced the waiting time from nine months to seven months, I think you say in your submission.

Dr ALEXANDER - To surgery.

Mr WING - For surgery.

Dr ALEXANDER - But the nine months, as I said, is an arbitrary, fictitious figure anyway. It could have been anything.

Mr WING - Longer.

CHAIR - So we are still waiting, in that case, to see if it happens.

Dr ALEXANDER - No, he has had surgery.

CHAIR - Doctor, I am going to have to draw this matter to a conclusion, unfortunately. I think there are a lot more questions and there are a lot of other areas in your submission that I would certainly like to go through I think other members would as well. So, if you were able to, I think that the committee may well make that decision to ask that you come back, if you would, obviously at a convenient time for all of us to do that.

So, doctor, we thank you very much for your evidence to the committee today.

Dr ALEXANDER - Thank you for listening.

THE WITNESS WITHDREW.

Professor JUDITH HALLAM WALKER WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - We thank you very much for coming here today, Professor. Just before we start, I indicate that parliamentary privilege applies here today - you have that protection. However, if at any stage - and there probably won't be - you wish to go in camera for the purposes of bringing forward some evidence, then we would certainly consider that and we will leave that to you to make that judgment at the time.

The conversation will be recorded on *Hansard*, and at the end of it you are entitled to discuss generally the evidence that you've given to this committee, but you just need to be a little careful with going into specific detail of some matters that may well have come up. Professor, at this stage I will leave it open to you if you would like to go through and bring forward any information and evidence that you would like to give us and, if you don't mind, perhaps it might be better if we asked questions going through. Is that the way you would like to handle it?

Prof. WALKER - Sure.

CHAIR - Thank you very much.

Prof. WALKER - I had better explain the sort of hats I am wearing today, because I have a few. I am here as acting Dean of the Faculty of Health Science; Professor Carmichael is on well-deserved leave at the moment. As most of you know, I also hold the chair of rural health at the University of Tasmania, and in that position I actually head up the clinical school in north-west - the rural clinical school. Excuse my funny voice, but I have been doing a lot of travelling recently and it catches up with you with all those smoky airports and things like that.

I would really like to thank you for the opportunity, I did not put in a submission. I was obviously aware of this hearing into the public hospital system, so I was very pleased to be asked to come and talk with you today. I would like to specifically address term of reference number five, which is around the work force planning strategies, if that's okay. That is where my knowledge and areas of expertise are, rather than in some of the other areas.

The University of Tasmania of course is one of the main providers of health professional education in the State. Traditionally it has been mostly involved in under-graduate education. As you are aware, we have a medical school, we have a nursing and midwifery school, we have a pharmacy school, and we also have the school of human life science. When you work across the whole university, there's a wealth of areas that are appropriate to health professional training - it doesn't just rest in the Faculty of Health Science. Increasingly we are moving now towards post-graduate training, and I will just unpack that a little bit further on.

One of the things you may not be so familiar with is the fact that there is a partnership arrangement between the university Faculty of Health Science and the Department of Health and Human Services, and if it is appropriate I will just table this document for your information, mainly because it provides pointers to more information, if you require

it. I have just done a shot of the web site for partners in health. The reason I mention it is because it is unique, I think we were one of the very first in Australia to have a formal partnership arrangement between the university and the health department, and following our lead other States and Territories have made similar arrangements.

Our partnership agreement is now part of the wider partnership agreement between the State Government and the University of Tasmania, so it has been recognised as being important. You will see on the back of that one or two pages that there's reference to a new document which is actually called *Guess What Future Directions* because what has happened is that the partnership is going through a revitalisation process and that is in recognition that things are changing enormously and that you cannot just rest on structures and processes that were appropriate 10 years ago, you have to move with the times. I am sure you have heard all about the changing demographics, the epidemiology in Tasmania and you will have heard about the health reform processes that are going on. Likewise, within the university and particularly within health professional training, contrary to perhaps some of the things you may have heard, there are enormous changes going on in the way in which we train. So that is the partners in health arrangement and you will see six strategic objectives of the revitalised partnership and it is very much about recognising that you have to work together. It cannot just be training provider, on the one hand, doing what it thinks is the right thing to do and it cannot just be the provider of health services, whether they are public or private. It has to be a partnership arrangement because if we are to be truly responsive to training health needs, then we certainly cannot do it on our own.

There are other documents I would like to table but I do not know if this is permissible. I have just been in South Australia doing a keynote presentation at a conference for South Australian Health and it struck when I was preparing for this session that the sorts of things I was talking about there were incredibly relevant to this particular hearing. So I have taken the liberty, if you do not mind, of just copying off the PowerPoint presentation because I would like to point to a couple of slides just to act as a bit of an example of what I am talking about. Is that okay?

CHAIR - Yes, it is. Thank you very much.

Prof. WALKER - Hopefully this will help to explain the very important linkage which has not always been made between health work force planning and development and education and training. It may sound a bit odd to say this but I really do not think that in the past that linkage has been recognised. Work force development and work force issues have been seen to be the domain of the health service providers and the education and training the domain of the universities or the TAFEs or Polytechnics, as we must now say -

CHAIR - A popular word at the present time, polytechnic.

Prof. WALKER - But in actual fact, there is a very strong linkage. I am not going to go through this and give you a keynote speech. But you see those key messages, that is one of the things I was trying to get across. If you look at that second dot point, 'Education and research contribute to a culture and an environment of inquiry, learning and reflection which is crucial to service quality.'

I would also like to stress the importance of workplace-based training. Some of you around this table may have trained in situations where it was not truly workplace based and then, as so often happens, the strange journey of education and training and perhaps it was not necessarily the best thing to move, for example, nurse training out of the clinical environment solely into the university environment. But we have, I think, come more or less full circle now and workplace-based training is the way in which we do things. But, of course, that way is -

Mr WING - Does that apply to nursing as well?

Prof. WALKER - Yes, absolutely.

Mr WING - Sorry, I thought you were referring to medical students.

Prof. WALKER - I was referring more to nursing because I think it is more of an example there of when nurse training moved out of the hospital system into the university system, that it was not necessarily most appropriate that it did not have workplace-based training involved. As I say, the circle has turned now and the reason I mentioned this is that there is a codependence on the fact that you have to have clinical placements available in order to train. This is why we need partnerships between public and private health services and the training providers so that those very important clinical placements are available.

Ms FORREST - To clarify that point, are you saying that where we are now with nurse education and nurse training in the university with the clinical component is right?

Prof. WALKER - I would say it is much more appropriate than it was in the past when it was totally classroom-based. There is enormous change going on at the moment and we need to be in a situation where we can respond to those changes. It may mean that there need to be changes in the way in which we do the teaching, so the pendulum went one way and then the other way. I am not saying it is necessarily totally right at the moment. It depends on the circumstances involved as well and what type of speciality area you may be looking at. But certainly in all our health professional training now there is a recognition that there must be adequate clinical places for training.

Ms FORREST - You are not suggesting that it all goes back into a hospital setting; you are suggesting that there needs to be the right balance?

Prof. WALKER - There needs to be the right balance. I would argue as well very forcefully that hospitals are not the only places where we train future health professionals, particularly as we move into a changing demographic and changing illness patterns with far more chronic disease. It is also very important that we train our future health professionals in the environments which are going to make them fit the purpose for the future. If we are looking at an increased number of elderly people, people who have chronic illnesses, then we need to be training the next generation of health professionals in those environments for those particular purposes.

CHAIR - So the training period will still be the same but you are moving a lot of that out of the classroom into the workplace.

Prof. WALKER - I am not necessarily saying that the training period needs to be the same because we are doing things in different ways to be responsive. For example, Tasmania was one of the first States to move to a fast-track nurse training program, so in addition to the traditional three-year training there was the option. If they so desired people could take a fast-track route and actually train in two years.

Ms FORREST - But it meant working over summer as well; you did not get a break. You did not have less time; you just did it more intensively.

Prof. WALKER - That is right.

CHAIR - Are the hospitals able to accommodate all of this workplace training? I guess it takes time from their other duties and functions as well, so what is happening in that regard?

Prof. WALKER - Absolutely. That is an excellent segue into what I would like to draw your attention to. If you look on the second page you will see that the University of Tasmania has actually developed what we are calling the Health Services and Work Force Education Unit. We are very conscious of the fact that if we are to train appropriately for the future then I predict that we may be training for different types of roles, different scopes of practice, and that may mean different lengths of training.

Mrs JAMIESON - Could that be, say, a shorter general training and then you specialise?

Prof. WALKER - Exactly so and you will find it in a number of health professional courses now, particularly in the allied health professions. One of the pathways now is through a general initial undergraduate degree and then into a postgraduate specialisation like physiotherapy or clinical psychology.

The unit was born about half way through last year mainly because we became very aware that it was in danger of becoming a hit and miss affair. The university needs to plan and work in partnership with the health providers. It needs to take account of the changes that are going on in health services reform and needs to provide appropriate education and training. These things just don't happen overnight, as you know. We also have to be responsive to the numbers game, and that includes the capacity of hospitals and other environments in the community to train.

You will see that the unit has three portfolio areas. Those three portfolio areas are very similar to the portfolio areas in what will be the new national health work force agency, which is being developed. At the moment it has the glorious name of 'health work force task force'. The Council of Australian Governments at their meeting on 29 November announced a very considerable health reform package which had megadollars attached to work force training.

What we have tried to do with our Health Services and Work Force Education Unit is make it the same sort of shape as the national health work force agency will take on. I think it is really important that we in Tasmania, and in all the other States and Territories, don't try to do something at too much of a variance. We need to meet the needs of our particular communities, hospitals and other health service environments but we need to do it in such a way that minimises the great divides across State and Territory

boundaries. We are working towards national registration of most of the health professions so we need to make sure that in our future planning we take this into account.

The three portfolio areas are outlined on page 3. The first one is what we are calling the 'planning and modelling portfolio'. That is really about building the evidence base that we need in order to be responsive to the needs of the future health work force. A lot of it in the past has been hit and miss. You have heard, I'm sure, about reductions to training places, increases to training places - it is a bit like a merry-go-round. It hasn't been scientifically based, in my opinion. We are in an era now where an evidence base is extremely important to what we do, whether it is in medicine or planning for the health work force. That portfolio area is working not only within the university but also across the whole training continuum. Another really important point is that we cannot look at our health profession training from one perspective. We have to look across the whole pathway. We have to look at the emergence of new roles of health assistance, people who need to have a career pathway into other health professional roles if that is what they desire. There is no good for the University of Tasmania planning to be on its own. We need to be planning with the vocational education and training sector and with the postgraduate sector, particularly with the professional colleges. This is the scope that this particular portfolio area will take on.

The unit is not there to do the doing; the unit is there to drive and coordinate the university's response. For example, the School of Nursing and Midwifery is obviously responsible for nurse and midwifery education and training and the School of Medicine is responsible for medical training. However, you will find that those school barriers are beginning to be much less rigid. We are working across those boundaries to produce those health professional teams that work in an inter-professional way. It is still important to point out that the professional training is the domain of the professional schools and colleges, although I think the way in which we are doing that training now is much more appropriate because there is a stronger interprofessional base. The second portfolio was called 'innovation and improvement'. This is really about bearing in mind we are looking at not only recruitment and new health professionals coming into the workplace but also at working with the existing health work force to make sure that they remain appropriately skilled for the changes that are around. This, I think, is the most exciting area because it is the portfolio area where we can try things out, where we can test things, where we can look at different models and different roles and actually see if they are appropriate to the need.

We are looking, for example, in this State at integrated care centres. There is one for Launceston, as I am sure you are aware. There are two or three in Hobart. These are different models of delivering health services. We need to make sure that we are producing people who can work in those integrated care centres. We also need to be looking at all aspects of health services as training facilities. So when you ask 'do the hospitals have the capacity to take on increased numbers of students, to provide that important work force development for the existing work force,' I would say 'yes' - provided we support all training environments.

In the past we have been focused very much on hospitals and that was probably appropriate because that is where people went when they were ill. Now we are much more focused on keeping people out of hospitals, that you only go to hospitals when you are really sick. We need to be developing the future health work force with that in mind.

That means we must train in environments right across the community sector as well as in the hospital sector. Again, it is a balancing act. I think that in the past we have not taken advantage of that wealth of training opportunity in general practice in community health centres and particularly now in aged care facilities where we need to be training and where we need to be supporting the existing health work force. Does that make sense?

CHAIR - Yes.

Mrs JAMIESON - I would like to follow that because how do you envisage actually supporting - we keep hearing the term and not just from you, from others too that we have to support our work force - somebody who is having a few qualms about whether they will continue, for example, and may eventually drop out? Do we have any indication how many nurses, for example, do drop out of their training before it is completed?

Prof. WALKER - Again, this is where the unit will come into its own, because it will be the repository of this sort of data so that we can provide you with those informed answers. At the moment I think you would probably get quite a number of different responses to that question. One of the reforms that we have made through the Faculty of Health Science - and it is now lodged in this unit - is the student placement management system, which is a very sophisticated electronic database that allows us to plan and to monitor clinical placements across the spectrum in all areas of training.

We just did not have that two years ago and the university has made a pretty sizeable investment in that so that the hospital sectors will know in advance how many students of different persuasions are going to which areas so that we can actually plan and know in advance and thus be able to support the work force in, for example, the ward where there are *x* numbers of students coming that we know about in advance. We need to be providing preceptor training. It is not automatic that people who are health professionals are automatically excellent teachers. We need to help them to be excellent teachers.

The other area where I think we have not worked well and we have not had the partnerships to do it is in actually supporting educationally people in the work force. For example, clinicians have never traditionally been trained for leadership roles. A clinician tended to go into leadership, which was perhaps code for administration when he or she was seen to be past their clinical life. There is a lot of evidence worldwide now that if you look at health care organisations that are actually performing well, and where adverse events are considerably reduced, it is in areas where clinicians are taking leadership roles. Gone are the days when clinicians only provided services and administrators administrated. These days we need to have a clinical work force that has leadership competencies, and is able to take those important roles so that patient safety in particular is absolutely paramount.

So we are now, for example, providing post-graduate programs in clinical supervision and clinical leadership which are available to the people within the work force. These are ways in which we can support the work force better. The evidence, particularly from European countries and from the UK, is that with skills and a continually trained work force, you have a more satisfied work force and people tend not to leave.

Mrs JAMIESON - So while you're doing your professional development, and so on, have we got enough staff? If you're going to have mandatory professional development, and so on, to maintain your competencies, have we got enough staff to support them while they're away, if they are working away, for example, or if they're doing extra studies?

Prof. WALKER - To get back to the comments at the beginning, I would suggest that professional development is very much a workplace issue. Again, traditionally we have separated out education from service delivery, whereas in fact we need to integrate and mesh them together.

Ms FORREST - In relation to the nurse practitioner project, I understand that Tasmania is perhaps one of the few States - and I may be wrong on this - that require a masters degree for all nurse practitioners. Is that the case in other States, and are we expecting too much and putting up barriers that need not be there?

Prof. WALKER - Advanced nurse practitioners all require masters level training - that is my understanding.

Ms FORREST - In every jurisdiction in the country?

Prof. WALKER - It is my understanding, yes. I would just like to say something about the nature of training, and I can give personal examples from the rural clinical school in the north-west of the State. I think it's really important that you have a balanced understanding about the outcomes of the changes to health professional education and training, and I guess medicine is a good example. At the University of Tasmania we have a new medical course which is a five-year medical course as opposed to a six-year one. The nature of that course is that its approach is quite different - it is very much hands on clinically oriented. Students enter the clinical environment from year one.

In terms of my school, it actually has the last students who were in the last two years of the course. At the moment we are in a transition - this year half the students are from the old course and half from the new, and it is very interesting to see the difference. We have pioneered an integrated approach where we are very much working hand in hand with the new roll-out of the north-west area health service which, as you are aware, is the first of the area health services to be rolled out in Tasmania. It is about the integration of acute and primary care, so what we are doing - and this is where the portfolio areas come into it - is redesigning the way in which we run the medical course to take into account the fact that the area health service characteristics are changing. For example, our fourth-year medical students - and that is the penultimate year - no longer have a GP attachment for five or six weeks. All students are attached to a general practice which we call an integrated primary care attachment because it is not just general practice, it is the whole spectrum of primary care. They are attached to that practice or health centre for the entire year. So they build up a relationship over the year rather than a block of teaching and you will find that this is what is happening across the health professional training spectrum.

In terms of the output, I will give some statistics. In 2002, which is the first year of the north-west rural clinical school, we had four medical students. In 2008 we had 27. In 2009 we have 41 medical students based in the north-west and it is across the whole region and includes the Mersey Community Hospital as well as the North West Regional

Hospital. We will have 50 next year and we will peak at 55 in 2010. This is one of the ways in which we are managing the increase in medical student numbers. There was not a clinical school in the north-west in the past. There is a clinical school now.

In terms of output, in 2007, we had no domestic graduates as filling any of the eight intern places at the North West Regional Hospital. Last year, 2008, 50 per cent of the interns were graduates from the rural clinical school. So four out of the eight positions were filled by interns. This year, five out of the eight were domestic UTas graduates and the sixth one was from the University of Melbourne. So six of the eight interns were domestic students and only two were international medical graduates.

Ms FORREST - The majority of those would have been students who grew up on the north-west coast, which is even better?

Prof. WALKER - That is right. So here were are talking about the fact that if you have training based locally the evidence is there that people will return and practise. This year we have one GP registrar who happened while he was at the rural clinical school to marry one of the other students, who is also back on the coast as an anaesthetics registrar. We have a paediatrics registrar who went through the rural clinical school and an O and G, advance registrar.

CHAIR - Professor, I am going to have to end this session, unfortunately. It is very interesting. Certainly our terms of reference cover that and it is heartening, I think, to see that these changes are being made because I think it was fairly clear that the way it was previously going with the training of the nursing staff, in particular, probably was not right. But I think that is reflected in the changes you are now making. So, Professor, I would thank you very much for coming today and presenting to us. As I said, it was an important part of our terms of reference.

If there is any more information that you would like to provide to this committee, then you can certainly forward it on to us in written form and the committee can still receive it in that situation. So, if there is any matter that you have not had time to expand on, please do that and I invite you to do that.

Prof. WALKER - Thank you very much.

THE WITNESS WITHDREW.

Dr GEOFFREY ALLAN COUSER WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Welcome, Dr Couser. Just quickly before we start, Doctor, parliamentary privilege applies to the evidence that you give today. However, having said that, if it comes to a stage where you would like to present evidence to the committee in camera then we would certainly listen to that position which might make it more comfortable for you if you want to refer to particular cases or some other evidence that might identify a particular person. We would be very happy to consider that at the appropriate time.

Dr COUSER - Thank you, but I think I will endeavour to keep it general.

CHAIR - Thank you for that, and the evidence is being committed to writing in *Hansard* and at the end of the whole process you can feel free to talk about it generally publicly but just be a little careful in talking about specific issues that might well come out during the committee.

Dr COUSER - I will look for it on *Hansard*.

CHAIR - At this stage we will leave it open to you to make a verbal submission to us and if you do not mind, throughout that process it might be more convenient to ask questions or would you prefer to go through it first of all?

Dr COUSER - Certainly, I am at the committee's discretion. I have looked at your terms of reference and I must say that they are very broad and it is almost a bit hard to know where to start and I think that is how many people feel when they look at the health system.

CHAIR - Those terms of reference could have been a lot broader but we tried to restrict it as best we could.

Dr COUSER - I certainly commend you for looking into it because it is very important.

Perhaps if I could start by giving a bit of background as to where I am coming from and where my area of expertise may be and the committee may wish to interrogate me relating to that. I am an emergency physician. I am a salaried staff specialist at the Royal Hobart Hospital and I have been since the year 2000 when we moved to Tasmania. My wife and I got a bit fed up with Queensland summers and -

Ms FORREST - I am glad that we have sorted you out then.

Dr COUSER - Absolutely, it is good to be here.

I have also long been an advocate and had a long interest in education and training in the work force and through that I was very much involved in it being a core member of the new curriculum working group which wrote the new medical course for the University of Tasmania. I spent some three years doing that. I was director of the overseas trained doctors project at the Post Graduate Medical Institute of Tasmania where I was

responsible for providing support and designing programs for international medical graduates in Tasmania and I am also an Australian Medical Council examiner. I have also been very committed to the role of emergency medicine in undergraduate and postgraduate medical education, having designed curricula for emergency medicine at the Royal Hobart Hospital and beyond as well as developing programs for junior medical staff in acute care. By acute care I am referring to emergency medicine and intensive care - the pointy end, I guess, rather than chronic care.

I am very committed to education and training and I think through my years of very much a hands-on role but coming from the clinician perspective I have only ever had a clinical title at the University of Tasmania so I have always been employed by the Department of Health and Human Services at the Royal Hobart. I think the words are 'pro bono' - I have not actually been employed by the University of Tasmania to teach and that is the way that, as you might be aware, it relies on the work force to deliver a lot of training. There needs to be that very close connection between the hospital system, the work force in general and the university. I have just heard the end of Professor Walker's submission and I have worked very closely with Judy over the years as well so hearing some very familiar things there, but I guess I am coming from the clinical side. I have always been a clinician who does some teaching rather than a teacher who does a little bit of clinical work.

CHAIR - It seems to be the side that is left out at times from the clinical perspective and their side of things.

Dr COUSER - I think that is one of the issues and certainly I am happy to go down that path if you would like to talk about it because certainly the University of Tasmania, with all due respect to what Professor Walker was talking about, can design and write curricula, and can develop programs, but without the practical support of the work force they just cannot be delivered. That is not just in medical areas, which is where I am coming from, but it is also in nursing and a range of other things. Without that tangible support of clinicians working not just in the State public hospital system but also with general practice in the community, in aged care providers - a whole range of things - you can't deliver programs because the university just does not have the capacity to deliver training programs. Yet that is where you go to become a nurse, a doctor and any other future health professional that is yet to be properly defined.

Certainly Queensland is off the mark this year by developing a physician assistant program through the University of Queensland. Obviously that is a very work force-based profession but it is going to need the support, and it does have the support of Queensland Health to do that.

The general point I am making is that you can have great intentions about interprofessional learning and you can talk about integrated care and everything, but without the support of the work force it is just not going to happen. I think if you were to ask any medical student what their experience is like at the Royal Hobart, they would said, 'Look, the teachers are great but 50 per cent of the time tutorials are cancelled because they are too busy'.

CHAIR - I think that was the reason I asked Professor Walker how that would be delivered within the workplace, to have the people there to deliver that, and that is the point you are now getting to.

Dr COUSER - So much of it is delivered on goodwill because I and a range of others are really committed to this system. I love being a staff specialist in a public hospital system. It is interesting, I get to be around medical students, the junior staff, registrars - it keeps me active. My brain would go all fuzzy if I didn't have my registrars, residents and medical students keeping me on my toes and I think a lot of us do get great satisfaction from that. But there is only so much that you can gain satisfaction from in doing it in your own time and putting other things aside.

I think the infrastructure is catching up but it still has a long way to go, particularly when there are approximately 120 students in the first year at UTas this year, which is a huge amount when you consider there may be 60 intern positions in the State. There is going to be a bit of a gap between who is graduating and who has jobs in a few years, and that is Australia-wide, as you should be aware.

Ms FORREST - We have heard that. I have supervised and educated many residents and registrars over my time as a midwife. You do it because you have a passion for it and you want them to be good at what they do. I think you are alluding to being freed up to provide this sort of support and education and ensure that lectures are not cancelled and the rounds are not held up or anything like that when there is another teaching tool. That obviously comes with a cost, so how should this cost be met?

Dr COUSER - Yes, this is the problem when you have public hospitals run by the State. You have universities funded federally, you have general practice which is backed by Medicare, you have aged care which is a federal concern, you have a range of different funding sources and I do not know whether any one system is better than any other system at delivering it. But it does make it a bit harder to cross those barriers. They are breaking down. I think in a place like Tasmania, the potential to break down those barriers is there because everybody knows everybody.

Mrs JAMIESON - It is a lot smaller too.

Dr COUSER - Yes, it is.

Ms FORREST - So do you think that it would be easier if we had the Federal Government taking over health everywhere. Either that they take it over as a nation or they take it over within the State and are responsible for general practice, acute service, primary health and aged care and then the State could administer it, potentially. But you have one bucket of money that is funding those services. Is that how we should be progressing? What would you suggest in that area?

Dr COUSER - That is a wonderful question and I do have some very strong opinions on that. There has been a lot of interesting work done in recent years by John Menadue and Professor John Dwyer from the Public Hospital Task Force and also the Centre for Policy Development. I am not sure if you have read much of their work. John Menadue is certainly a very intelligent man with some great ideas whom I have been privileged to hear speak on a couple of occasions and I am really attracted to some of their ideas. It is

almost like having a universal theory which would basically involve throwing out everything we have at the moment and grabbing more efficiencies out of our whole system because there are a lot of inefficiencies. I do not think that all in the Federal sphere or all in the State sphere is the answer because a lot of things are really entrenched. We do have a Federal government at the moment which claims to be very interested in health care reform. We have the National Hospitals and Health Reform Commission. I think the present financial situation may grind a lot of that reform to a halt.

There needs to be a way of bringing into alignment health spending with community outcomes. At the moment you have what is sometimes referred to as a private system when really I think we should refer to it as the Federal public system because there is not a lot of private money in private health. It is underpinned by Medicare and health care rebates. It is a bit of private money but it is a Federal public system. It is still public money going into private health care out at Calvary and Hobart Private and we should not think that because it is private they can go and do what they want. It is public money and I think you have a responsibility as legislators to direct where that goes in the community interest.

We are talking about a lot of vested interests here, not just the usual suspects of doctors and the AMA but also private health funds, a lot of entrenched attitudes and a range of things. There is a lot of good writing in the last few years about health care reform and I think you see this in a range of different areas. We have the Federal system with Medicare and a large amount of Federal money. You have the State governments. How do you bring them together? There is almost a good argument for bringing in a third-party system that can actually collate that. Tasmania would be a really good place for this, I have to say, because we are small enough. You have a third party which says, 'We are going to take all the Federal money and all the State money coming in and we are going to direct the funding to the model of care that gets us the best outcomes as a community'.

Ms FORREST - Encompassing all of those health services.

Dr COUSER - Encompassing everything. That way you are not pulling down the Federal system or the State system or any other system that may be there. It is actually a way of co-ordinating tens of billions of dollars every year.

Mrs SMITH - How would you answer the argument that that is another level of bureaucracy so that puts in more administration and still less for patient care?

Dr COUSER - I think that is a very fair question as well and that is certainly a way it can be interpreted. If I could just go off topic for a little bit, in my other life I am quite involved in environmental issues. I am the vice-president of the Tasmanian Land Conservancy. We purchase land of high conservation value and manage it. We draw funds from private areas, from Federal money, from State Government programs, from our own resources. We collate it and then we send it to where we think it needs to go. A similar sort of model would work in the health system because there are a lot of disjointed things happening there. Who is to say that somebody, just because they have private health insurance, should have something just because they have an ability to pay? They can get in next week to have an operation whereas a similar person who needs a hip replacement

is on a two-year waiting list. They are getting community support and services and frequent hospitalisation just because they cannot walk around on their leg. I am not saying that it is necessarily the answer.

Ms FORREST - Two points there. There is the issue of cost-shifting, which happens quite a lot now when you have different billing practices. If I go to a GP and I need some blood tests and an X-ray prior to surgery, then if I have it done with a GP it is funded by the Federal Government. If I go to the hospital and have them done there as a pre-operative procedure under my admission then the costs are a State Government responsibility. Could a system such as you describe deal with some of that cost-shifting?

Dr COUSER - I think it could. It is just a way of bringing it into alignment because at the moment they are out of alignment. There is more thinking about the cost-shifting than the process of how a GP gets somebody in who needs to be seen urgently. If they have private health insurance they can go that way because that might work but it does not lead to good outcomes for the community as a whole. Cost-shifting is a concern, and that is what comes when you have two separate systems. The potential savings, looking at some of the arguments, are a bit hard to quantify. There is the argument that you would be creating another bureaucracy, and as a front-line clinician that is something I am not keen to do, but the savings are probably almost hidden.

Mrs SMITH - Would you like to consider the pluses and the minuses of a federally funded and managed system and the States taken totally out of the health care regime?

Dr COUSER - I think this is going back to the training system. It could work quite well because if you were to offer, say, a hub-and-spoke model where you have the hospitals, the general practice and community care and then students can move freely between them and everyone is paid in a similar sort of way and you have the training incentive. I think the training for education needs to be made a core business of any health-care system. It is usually something that is just tacked on the side. But take the States out of it. It is good to have that local input as well. At the end of the day it is just a way of running something. I don't think there is necessarily any great advantage having it all just one Federal system. New Zealand has a Federal system and they are a lot smaller but they have the benefit of not having States, so it is a bit easier. I don't know if I am capable of answering that with any great deal of knowledge or conviction.

Mrs SMITH - You stated earlier you came from Queensland. Did you work as an emergency physician specialist in Queensland?

Dr COUSER - Yes, I was a trainee at the Royal Brisbane Hospital.

Mrs SMITH - Would you like to make some comment on the comparisons of patient service between the Queensland and Tasmanian systems?

Dr COUSER - I trained in emergency medicine at the Royal Brisbane Hospital and did rotations at Rockhampton, Nambour and other places. I guess it is quite different because obviously we're talking really big areas, but somebody who is on the east coast of Tasmania, say at Bicheno, is as far away from Hobart as someone at Quilpie is from Brisbane effectively. It is just a different scale. You still have a lot of the similar sort of problems. We do have a very decentralised population here in Tasmania. Even though

they are smaller distances, it is a long way. I do retrieval coordination once a fortnight and I am often on the phone to the nurse at Cape Barren Island or someone at Queenstown organising planes, retrieval teams and the like. It takes a long time to organise that so it does have things in common with Queensland.

Mrs SMITH - Are we better or worse at it?

Dr COUSER - I don't think we are necessarily any worse at it; I don't think we are necessarily any better. People talk about the issues at the Royal Hobart Hospital and a lot of our other hospitals but they are no different from a lot of the pressures that public hospitals are under generally Australia-wide. There are the work force issues, the training issues. Obviously there is a bigger critical mass in Brisbane so we have suffered for a long time from only having one person who can do something. That was the reason a few years ago a particular neurologist who was the last one standing left just as the hospital announced they had set up a stroke unit. That would be interesting given that the last neurologist at the hospital had left. Now we have four, maybe five neurologists and that is great, but you do need that critical mass if you're going to offer that tertiary level service.

Mr WING - Do you feel the morale at the Royal Hobart Hospital, which we have been told is very low, is the same as in most other hospitals?

Dr COUSER - I think so. I keep in pretty close touch with my colleagues at the Royal Brisbane and I would have to agree with that. I think it comes and goes.

Mr WING - Among the professional staff it doesn't seem to exist at Launceston, although there is a lack of funding and great pressures. But within the hospital the morale seems to be greater than at the Royal. Is that your impression?

Dr COUSER - Sorry, the morale at the LGH is greater?

Mr WING - It seems to be better among the professional and other staff than it is at the Royal. Would that be your impression?

Dr COUSER - In general, as a hospital as a whole, they do always seem to be pretty upbeat in Launceston. I speak to people in intensive care and the retrieval service there. However, I would have to say regarding morale in the Emergency Department at LGH, they are very much under pressure. They are at the verge of breaking point, I would have to say, so I would have to say their morale is very low.

Mr WING - I think all departments have their problems but there seems to be a greater degree of teamwork within than there is at the Royal.

Dr COUSER - I think when you put a title 'Royal' in front of a hospital that automatically means a range of different hospitals. Everyone has their empires and we talk about the generic 'royal' important hospital. You break down those barriers just by personal interaction and getting to know people. For example, last year I created a bit of a minor war when I started sedating for colonoscopies for the gastroenterologists. I am an emergency physician, I am not an anaesthetist but I do sedation as a matter of course in the Emergency Department but the gastroenterologists had a big waiting list on

colonoscopies and they said to the anaesthetist, 'Okay, we need to work through this' and they said, 'We can't help' so they asked me if I could help and I did and that of course created a massive riot.

Ms FORREST - You stepped over that line, didn't you?

Dr COUSER - I stepped over that line, but it is not rocket science.

Mrs SMITH - Let us talk about that line. Are you of the opinion that that line, that culture amongst specialists, is some of the problem in our being able to address some of these situations? You found a perfectly safe solution to assisting and yet the culture of other colleagues said, 'No, go back to where you belong'.

Dr COUSER - I think that is very much the case in medicine but I think history shows that they are very readily broken down. Thirty years ago defribillators were a secret research tool and they were only in special coronary-care ambulances and then of course in the early 1990s Kerry Packer had his infarct and he arrested just as one was driving past. The ambulance was there and it was out with the defibrillator and now there are automatic external defibrillators and there is one at the Salamanca Bakery, and another at the MCG - things move down. Intubation, which is a skill that previously was secret anaesthetist business, is now done out in the field by paramedics.

CHAIR - It normally takes an emergency or a crisis for that to occur, unfortunately, doesn't it.

Dr COUSER - It does, that is right, so things do evolve.

Ms FORREST - Going back to your proposed structure for how things could work on a funding basis, I had two comments. I did have a fear perhaps that that would completely undermine the private health system - it obviously needs to be worked out a bit further - but, say, someone comes in with a capacity to pay as a private patient and you have a public patient who can get exactly the same time frame of treatment, why would you pay your private cover?

Dr COUSER - In which case make it a truly private system then. If you have the capacity to pay for it, make it a true private system. We are still talking public money here. I could not tell you what the figures are but most procedures are underpinned by Medicare which is 75 per cent of the doctor's cost, there is the health-care rebate which I think nationally costs in the order of $4 billion to $5 billion a year now, that sort of thing, and it is growing because it is uncapped.

Ms FORREST - My point is that if you undermine the private health system then you put even more pressure on the public.

Dr COUSER - What I would say, though, is I think we need to look at what system does what well. I would put to you that regarding the public system as it stands at the moment or the State public system, the Royal Hobart Hospital does acute medicine very well. We have the capacity; we do not always have the fat in the system, although that is probably not the best word, the built-in systemic redundancy might be even a better term, but you know what I mean, hospitals run well when they are at 85 per cent capacity but if they

are at 86 per cent then you have your access block and things fall down. Unfortunately, the Royal Hobart has been running much higher and it is certainly the same with Launceston and the like so you need to have that built-in redundancy so things can deal with the peaks and troughs.

The public system can deal with that because it is geared towards acute medicine. The private system on the other hand or the Federal public system does elective surgery very well. I would dare to suggest that it does that a lot better than the public hospital system because they have a bit of a business approach to it. If they do not go and do those five hip replacements on this afternoon's list, all sorts of things will happen. They will not get their throughput, they will have an empty bed and that is uneconomic, they will avoid the orthopaedic surgeon who will go to that other public-private hospital. There are a lot of different pressures, so I think with that bit of a private business case they are very good at doing elective surgery, whereas it does not matter at the moment if you have private health insurance and you are involved in a nasty road crash on the Brooker Highway; it does not matter what you have, you are coming to the Royal. So let us build on the strengths that different systems have. The public hospital is good at that acute, at the hot medicine. Private hospitals try to do hot medicine and a lot of the time they do but they are not really geared towards, 'Oh, let's cancel that list and let's do an urgent operation now' because they have their elective surgery that they are working through, and that is fine, that is their core business.

Ms FORREST - Only when they have obstetrics on site that happens. That is the only time.

Dr COUSER - That is right. That is true.

Ms FORREST - To go back to the question of who should pay for the backfill for education of students, where do you think that fits in? We did not actually get to the answer, I think.

Dr COUSER - No. I think there has to be an acknowledgment that training and education is actually a very powerful recruitment and retention tool. Again, hearing the end of Judy Walker's evidence, if you can create a positive training environment people like to stay at that hospital. If they feel they are supported then there is chance they will train there even more. Then they will stay there once they finish their training and that is good for everybody and then it creates that culture.

One of the things I can comment on about Queensland is that interns only have a choice of three hospitals here and in Queensland they have a lot more. If there were not a training infrastructure at a particular hospital then there is no way students and interns would go there. Then the whole thing collapses and it requires a whole lot of panicking and putting money in and crisis management to get people in and then it builds up. It goes in cycles. I think sometimes it is the same here. The Royal Hobart Hospital is on a bit of high, LGH is on a low, but it might swing because the house of cards can fall down.

Ms FORREST - Should the Department of Health put this money in as a separate budget allocation or should it be the universities that provide for it, because their students need to be educated and supported?

Dr COUSER - That is where a lot of the problem has come from. I would love to work for the university because I really quite enjoy that student interaction. It is the award structure and it is just not there.

Ms FORREST - But unless we fix it, it is not going to happen. Unless we deal with this, we are going to have people like you getting sick of doing too much in your own time and the students are not going to get the support they need, particularly with the great number we have coming out. So how do we fix it?

Dr COUSER - Without necessarily ripping down both systems, I think it may be that the Department of Health has to say, 'Look, we recognise that we benefit from having the university there. We benefit from having students. We benefit from having committed teachers and we know that good teaching and training translates into good patient care. So when we employ somebody we are going to get a contractual obligation'. My contract says that I will do teaching and I will do that, but it is very soft. It is a general statement. But if we could have it as a mandatory, enforceable part of the contract -

Ms FORREST - For so many hours a week of dedicated teaching?

Dr COUSER - Yes. You are going to have 10 hours a fortnight where you will be doing teaching. That is important because I will do that easily and it is a way of my saying to the hospital that I am contracted to do 10 hours of teaching a fortnight.

Ms FORREST - So, someone has to cover me in the DEM today?

Dr COUSER - And you have to increase staffing to do that. One of the programs that I developed about nine years ago - I do not run it now because I have just moved on - is called the acute care program, which is for second and third-year residents at the Royal Hobart Hospital to come and get good teaching and good turns. I negotiated with medical staffing that we would have turns in emergency medicine, anaesthetics, intensive care, paediatrics, obstetrics and gynaecology, and also linked in with a general practice turn. I said, 'In return for that, every fortnight can I have these residents for two hours. I will give them a structured curriculum that I wrote and developed and I have since published and we will have a really good feel for that'. I received 44 applicants for the eight positions. That is a pretty standard thing every year because people want to be on that program. One of the residents whom I had on the program in the year 2001 started work as a staff specialist 12 months ago.

Ms FORREST - Do they have to pay to do the course?

Dr COUSER - No, you apply as a resident and say you would like to be on the acute care program.

Ms FORREST - Are you freed up to do it?

Dr COUSER - I have non-clinical time but that is variable because I work different hours. I would get other people to do it. It was not sustainable in that, if I was off and could not get somebody to do it or if I was unwell or if I had a clinical shift and could not swap hours, then it just did not get done. So there needs to be systemic support to support that education and training.

Mrs SMITH - The university partnership between the State and the university is now 11 years old and yet it sounds like it is not getting -

Dr COUSER - Are you talking about Partners in Health?

Mrs SMITH - The partnership between your university, your teaching arm and your Health department was formed in 1998. Eleven years on you still have not -

Dr COUSER - I think you are referring to Partners in Health. I think it is a nice document and it sounds good but I do not think it has any practical advantage. It is probably one of the more meaningless things I have ever heard in my life, to be honest. As a clinician at the Royal Hobart Hospital, it means nothing to me. It is just a nice little statement. I am sure some people feel good about it.

Ms FORREST - It is a web site.

Dr COUSER - Somebody once rang me up when I was running the overseas-trained doctors project and they said, 'Hi, I am from Partners in Health, I have to write a report about how we are working well together'. I said, 'Who are you?' It sounds good and I have sat on TaSMAC, the School of Medicine Advisory Committee. Depending on who is on it at the time, there is talk about how we have to integrate this but it does not really happen. It sounds great and it is a nice web site but, no, it does not really do a lot.

Mrs JAMIESON - Could I go back to physician assistants in Queensland. Any chance Tasmania is going to start training? Would you like to expand on the role and how well they fit in with the AMA's objectives?

Dr COUSER - I am not a member of the AMA so I can't really speak for the AMA. I would really like a couple of physician assistants working with me when I am working on the floor at the Royal Hobart Hospital.

Mrs JAMIESON - Could you expand on their role?

Dr COUSER - A physician assistant is somebody who has training and is task-directed and who can work under the direction of a physician. It would be like having an extension of me. I am an emergency physician. I did six years of medical school to get a basic medical degree, two or three years as a junior doctor, and then five years specialising. Without wanting to sound arrogant, it's really not worth my time to be out the back stitching somebody up for half an hour. My role as an emergency physician is diagnosis and management, making sure the interns aren't killing the patients, making sure the department is flowing, making sure the patients are being referred, taking control of critical resuscitation, doing that sort of thing. I would really love to have somebody who is able to present to me and say, 'This person's got this laceration there', and I could say, 'Do some stitches and that's fine'. That does not have to be a doctor. This is what happened when I started writing the new course - I realised what defines a doctor. If you are going to tie yourself to a skill, you are going to find yourself redundant pretty quickly. Intubation was secret anaesthetists' business, now it's paramedics' business. Defibrillation was secret cardiologists' business, now it's the machine at the MCG. Come and work with me in the emergency department and we will get you doing stuff.

Skills are great; you teach people and they learn and they present stories and it's a wonderful thing. I really get a buzz out of teaching people stuff, but it's not really worth my while to keep doing stuff, and that's why a physician assistant or a nurse practitioner model would be worthwhile. Personally I would like to see the nurses. The nurses are capable of stepping up to the plate and I think there's a lot of potential for that.

Mr WING - Is it a fact that there is a lack of liaison and cooperation between practitioners and medical staff at the Royal in different disciplines?

Ms FORREST - GPs, do you mean?

Mr WING - No, specialists and medical practitioners.

Dr COUSER - I haven't experienced that. I have quite cordial relationships with a lot of my colleagues. I don't always see them, but the ones that I do know quite well work very well together. For example, going back to gastroenterology, we have a great working relationship with them, not just because I am breaking down some barriers and doing some sedation, but I'm bringing them down to the emergency department to do procedures and working closely with them to get good patient outcomes.

Mr WING - There seems to be a body of opinion that disagrees with you, but perhaps to test that out I will refer to a specific case of a patient currently in the Royal in the intensive care section who has been in a coma for a month. In discussions about whether life support should be continued or not, the discussions were proceeding without reference to the neurology department, which had a very significant role. Would that be unusual or would you think that was common?

Dr COUSER - I am not familiar with the specific case. Certainly it all depends on how the intensive care unit would be run. I would have to say that the intensive care specialists have a great deal of experience and expertise in managing patients who may be palliating, for example, or may have problems with their brain function or if they're trying to do an assessment. Sometimes it may not always be obvious. They may call upon the neurologist, they may be making that call themselves, so there is a bit of an overlap. I don't know whether it's necessarily because there's a systemic breakdown.

Mr WING - In the case of somebody in a coma for a month, would it not be essential to consult with the neurologist before making recommendations to family?

Dr COUSER - On one level, I would agree with you. I think a neurologist is the one who does the EEGs, the brainwave tests, and they are able to interpret that.

Mr WING - On any level, not just one level - on any level - in a situation such as that wouldn't you agree that neurology was an essential ingredient in decision-making?

Dr COUSER - It depends. The patient may have a severe neurosurgical condition, in which case they may well be liaising with the neurosurgical unit.

Mr WING - Who makes the decision as to whether life support is withdrawn or continued?

Dr COUSER - I have done that myself in the Emergency Department.

Mr WING - Is it not the family's responsibility?

Dr COUSER - I would disagree with that.

CHAIR - I am a little bit conscious of the fact that we, I think, are going into a specific case where identification could occur and I think it might not be appropriate, Mr Wing, in the circumstances.

Dr COUSER - I can answer in general, though, if you like.

Mr WING - I am testing the system in situations such as that.

Dr COUSER - There are different reasons you make the call. It is not always necessarily related specifically to the brain; there may be other conditions going on. As I said, I have sometimes made the call when, for example, a patient comes in with a ruptured aortic aneurism and you are doing CPR. I have put the ultrasound on, which is another breaking down a barrier which causes all sorts of problems, and I can see there is a big aorta and I know that is what is going on, I know this is an unsurviveable condition.

Similarly, somebody came in with a massive haemorrhagic stroke - a large intercerebral bleed - and I have incubated the patient, done the CT scan and I know that this is somebody who is elderly, has had a massive intercerebral bleed; I know that this is unsurviveable. I have made that call, there and then, because -

Mr WING - So you have made the decision yourself, rather than a family member?

Dr COUSER - I involve the family and sometimes it is very tricky. You need to explain to them, show them the scan and say, 'This is the situation, I can't offer you anything'.

Mr WING - I see.

Dr COUSER - So it is not necessarily the family's call. If the family were to say, 'We want everything done', I think I have a responsibility to the patient and - I hope this doesn't get taken the wrong way - I think I have a responsibility to the system as well to make the call in the interests of not just the patient but the system as well because I know that if I send this person who I know has an unsurviveable brain injury to the intensive care unit, with no treatment goal in sight, it is basically delaying a decision, I know that I am not going to have an intensive care bed later when somebody else comes in who needs that intensive care bed and for whom I can do something.

Mr WING - So what -

CHAIR - Mr Wing, I am wondering whether we can get it into the terms of reference. I am not quite sure that it fits in there.

Dr COUSER - But, in general, I could say that we do consult with others where appropriate as well.

Mr WING - You mentioned the need for a bed for other patients. To what extent is that a factor in determining whether life support comes into it?

Dr COUSER - I am not rationing, but even if I had beds I think I would have responsibility to the patient and their family of not prolonging things if it is futile.

Mr WING - There are many cases where people are in a coma for some months and then make a remarkable recovery, aren't there? It must be a very difficult decision.

Dr COUSER - There are and everyone seems to be able to quote these cases but that is not often the case as well. Then again, I think you do have to bring some rationing into it, if I can be brutally honest with you. You are putting in a huge amount of resources. I think doctors and people in the health profession in general have to have the courage and also the knowledge and the support to be able to diagnose dying and sometimes -

CHAIR - We need to draw this session to a conclusion. We are well over time. Your evidence is very interesting and informative for us and that is why we have kept you going but if there are not any other issues, doctor, we want to thank you very much for your evidence.

If there are any other issues that you believe that we should know more about, then I would invite you to provide that to us, if you could, in writing and we will certainly receive that.

Dr COUSER - It would be a pleasure.

CHAIR - The committee will further discuss your position. We might even invite you back again because of the very interesting issues that you have been referring to.

Dr COUSER - There are a lot of issues and I wish you well in your deliberations.

CHAIR - I would have liked to give you time to sum up for us but we do not have that time right now, unfortunately. Doctor, I would like to thank you very much for coming here today, for the evidence you have given us and we will be in contact with you.

Dr COUSER - Thank you very much. I will be on the floor at 3 p.m. this afternoon so I hope not to see any of you there.

Mrs JAMIESON - We hope not too.

Laughter.

THE WITNESS WITHDREW.

Mr SIMON ALLSTON AND **Ms PHILIPPA WHYTE** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - Thank you very much for being here today. Simon is here in his role of Health Complaints Commissioner, I need to get that right, not the Ombudsman, and Philippa is here in support of Simon, I take it.

Mr WING - In her capacity as Principal Officer of Health Complaints.

CHAIR - Yes. Thank you both very much for being here. We have received your submission, Simon, and we give an opportunity at this stage for both of you to go briefly through any issues that you want to and then there will be questions from the committee.

Mr ALLSTON - Thank you. I brought Pip along because, as you all know, I have a lot of jurisdictions and I do not carry a lot of the fact in my head, whereas Pip is the senior staffer in charge of this area and she has been working in the office as a conciliator for -

Ms WHYTE - Six or seven years.

Mr ALLSTON - So she has a lot of experience with the cases over a good period of time. She has now been managing that area for me for just over a year, I think, and is helping with reforms in the area too, which has been really constructive.

As I indicated in the letter that I sent to you, I thought I could best help the committee by giving examples of cases which fell within your terms of reference and obviously I have not covered all your terms of reference.

There have been some changes since I wrote the submission, which are probably helpful for me to mention now. On the third page of the submission where I deal with the waiting times in A&E and case 08.09.026, I mentioned there that at the time three changes in practice came up - this is towards the bottom of the page - which were proposed to address some of the problems which arose in the case and I have mentioned those three there. Briefly, this was an elderly woman who suffered a fall, came into A&E at the Launceston General Hospital at 11 a.m., was not seen until 5 p.m. that evening, and ended up having to be kept in overnight. There were all sorts of sequelae that I do not need to mention here. The major concern in this particular case was, of course, the failure to get due care promptly. The case went to conciliation. Pip was the conciliator. Whereas once upon a time it was common for us to write an investigation report to try to bring about change, nowadays we are finding that if we conciliate a case, often the body concerned will come forward with intentions for change. Those are elaborated through the conciliation process. Then I need to follow up subsequently to find out what happened. In this particular case the hospital came forward with three main areas for change - actually there were five, but I mentioned three there for you - and I followed up by letter with the hospital subsequently and that letter has since come in. It seemed to me that the committee might be helped if I gave you subsequently a de-identified copy of this letter because you can see what has happened. Briefly, they have reviewed the triage policy and they say:

'In general, patients in the most urgent categories - 1 and 2 - are not kept in the waiting room in any circumstance. In line with the amended policy, patients in category 3' -

which is what this lady was in -

'are to be reviewed every 30 minutes until they can be accommodated within the Emergency Department. These reviews are to be documented on the standard observation sheets so that a compliance audit can be conducted when the policy has been in effect for 12 months.'

That is a good change. Then there was a proposal - it is the third dot point on the next page of my letter to you - about changing the signage. They had a go at this. What was said to me in the response was:

'An initial trial of this signage was unsuccessful. The problem was that a bald statement of triage categories and expected waiting times actually increased patient anxiety and aggression in situations where meeting the standards was just not possible.

The hospital is developing an amended sign, which includes not only the triage category but also a statement of intent and explanation regarding situations where the department workload cannot accommodate the triage benchmarks. It will also advise patients of the procedure where they have been waiting beyond the accepted time.'

So that is the advance in that area. The first dot point that I mentioned was the idea of a sort of transit lounge where patients might be better assessed and where also, as I understand it, discharge might be dealt with. I have not received any feedback on that proposal but one might imagine that it is being dealt with as part of the new A&E department that has been announced, so one would hope that that will be attended to there.

Towards the end of my submission I expressed concern about the pattern of problems at the A&E department at the North West Regional Hospital which we had detected, where in essence there had been a failure to diagnose a serious condition that had come forward. I have mentioned four cases there. I also said to you that the problem had not resurfaced in complaints since 2006. Actually we have had two more from that hospital since and we have also had one from the Mersey.

CHAIR - How recent were those cases?

Ms WHYTE - Since December last year.

Mr ALLSTON - That is not when the failure of due treatment took place, is it?

Ms WHYTE - No, but we have received the complaint in the last six months.

Mr ALLSTON - Yes. This is the same pattern coming up where essentially the doctors in A&E have not detected a serious condition. They have only woken up to this after

multiple re-presentation, and this is a matter of some concern. Pip and I met with the previous CEO, Ken Campbell, about 18 months ago to talk to him about this issue. At that time he was about to leave the hospital but I have to say there have been a number of changes, to our knowledge, to try to improve matters but there is still this pattern. One imagines that it has something to do with the fact that this is an outlying hospital which doesn't obtain the skills that are available in the metropolitan hospital.

Ms FORREST - Simon, do we know whether these patients were assessed by a physician or an emergency specialist? What level are we talking about where the assessment failed?

Ms WHYTE - With two of them they would have gone through the general come in and see not the intern but the registrar. There is a policy in place, which came out as a consequence of an investigation that we did a few years ago, where now, if they come back, they are assessed by someone at a higher level and a higher level and a higher level. Just to correct, with one of the ones that we are talking about probably the patient was admitted so it was not a question of their being sent home but the other two were situations where they had come in with pain. There seems to be a tendency, I suppose, to treat the symptoms rather than look at the underlying cause and the subject of the complaint to us is, 'Yes, we knew we were in pain but we wanted to know why'. As it turned out, one of them was serious but ended up being okay and with the other it would not really have made any difference other than avoided ongoing pain but the fact was that the diagnosis was not made in two or three and it is a recurring thing because it is not the first time.

Ms FORREST - Are we finding that in the more remote hospitals where we provide accident and emergency services they are not being staffed by suitably experienced medical staff?

Ms WHYTE - It comes down to the opinion that we received in relation to an earlier matter which is along the lines that A&E perhaps - and I do not know so I need to be very careful if I am actually giving evidence - is staffed by junior doctors. There are not a lot of A&E specialists, physicians, and I think we are very lucky to have the ones that we do have but I think of one in the North West Regional, for example, and he has to take time off. Being ill is a 24-hour thing and you cannot provide a 24-hour service, or one person cannot.

Ms FORREST - We have also had evidence that the North West Regional Hospital has had a high percentage of overseas-trained interns and residents. Do you think this is a factor? It is terrible to have these things happening so many times and recurring again in recent times, should there be a situation where there is a mandatory requirement to have a level of staffing in the DEM at all times regardless of what hour of the day it is because we know that often the sickest people actually present in the middle of the night for multiple traumas and things like that and if you only have one emergency specialist then obviously they tend to work during the day and they do not want to be called in every night. You have some intensivists up there, you have a highly skilled anaesthetist, you have a whole range of supports but if this is the front line where people are being assessed, is there a breakdown there with a junior and perhaps inexperienced medical staff perhaps not referring to those people? I guess do they happen more in the night, do they happen more after hours? Is that a matter that really needs to be looked at in ensuring that we have a good service?

Ms WHYTE - It is something which certainly comes out of the Garling Report in relation to New South Wales and he certainly made some extremely useful comments about that type of thing. Whether specifically it is occurring here in Tasmania, it is very difficult for me to say, 'Yes, it is', but certainly obviously you have more specialists in Hobart.

Ms FORREST - It comes down to what is a safe service, doesn't it, and this is a real challenge. People think that if institutions have some medical staff there that is a safe service.

Mr ALLSTON - I think it is the case that the more skilled people tend to gravitate towards the Royal Hobart Hospital and that is likely to be so. I do not think in the cases that we have listed there has been a feature of overseas-trained doctors being the problem, it is more a case of probably the patients being seen by junior doctors and an inadequacy of referral to people who are more senior and more experienced.

In the second of the four cases that I have mentioned at the bottom of page 4 of my letter to the committee, we went to Bryan Walpole, who used to be the head of the Emergency Department at the Royal, for advice about that case, an analysis, and again it may be helpful if I provide this to the committee. I will not provide the full report. I think it is probably best that I provide the comment at the end which it goes to the very issue of junior doctors. The protocol is not in place to promote referral to the more experienced people, especially where the patient keeps on re-presenting and the cause has not been discovered.

Ms WHYTE - That change was an implement.

Mr ALLSTON - It was and that is one I mentioned earlier.

Ms WHYTE - I think it is important to stress one thing - that these cases we are talking about, each of them involved a rare diagnosis. It was not something that was common. It was something that even the most experienced doctor was probably going to have some difficulty with.

Mr WING - In the fourth case, dealing with the woman who was discharged without diagnosis who was suffering from septicemia, did she survive?

Ms WHYTE - Is that the last case?

Mr WING - Yes.

Ms WHYTE - Yes, she did. She was caught in time.

Mrs JAMIESON - I have quite a number of people who have a bit of complaint about overseas-trained staff and comprehension, particularly in A&E or if they are elderly, in not quite understanding what is being said. I was not sure whether these complaints were coming through because I have suggested that they contact you. Can you give me any indication as to whether you are getting complaints at all from patients regarding overseas-trained staff in relation to comprehension and understanding what they are saying or value systems being different?

Ms WHYTE - There is a possibility that some of them have come through, but it is not the key thing. It would be an underlying factor.

Mrs JAMIESON - What about staff attitudes, particularly for people who, in their own eyes, of course, have a real problem and very often do have, but it is not perceived that way by the staff, particularly at admission and they are constantly returning to A&E because they cannot get their GP? Do you get any complaints?

Ms WHYTE - Not with A&E.

Mrs JAMIESON - I am just thinking of two or three people in particular. One is a 23-year-old who has a lot of chronic conditions and the staff say, 'Not you again.' Immediately there is a breakdown in that relationship.

Ms WHYTE - Having said that, there might well be one that has been resolved very quickly.

Mrs JAMIESON - Probably because they are put off by having to come to an authority.

CHAIR - In relation to the misdiagnosis or failure to diagnose, are you reasonably satisfied now with your involvement and the investigation of some of these issues that we are likely to see less of that occurring or improvements in that area?

Ms WHYTE - The cases that we have listed here go back quite some time and the hospital - and obviously we are talking about North West Regional Hospital - have put strategies in place to try to address this issue. But notwithstanding that, there are times where they are going to be confronted with a presentation which, with the benefit of hindsight, turns out to be rare. The question is whether a more experienced doctor would have picked it up. Would referring it up the line have the right outcome? So we cannot be categorical with that.

CHAIR - As a layman looking at this, I would have thought that if a patient presents to a hospital in that situation with severe pain or whatever it might be and a diagnosis cannot be made, it would have been obvious to refer them to a specialist there and then or very quickly? But that is not the case, obviously.

Ms WHYTE - I think the situation is that they entertain differential diagnoses. So if you have somebody who comes in with a headache, it might be sub-right lobe haemorrhage, it might be a migraine or it might be just a headache. It is a question of whether it is an inappropriate diagnosis that they are entertaining. Do you give an MRI to everybody who attends an A&E department with a headache? No, not in the North West Regional, because you do not have one.

Ms FORREST - But do you in Hobart just because there is one?

Ms WHYTE - No, you do not and that is the point and nor should you. So I think this is where you get a balance -

CHAIR - The point I was making here is, I guess, in these cases there are some serious situations and who knows what would have occurred between then and when finally treatment was provided. So it is a pretty ordinary situation.

Mrs SMITH - In your 2007-08 Health Complaints Commissioner's report, in total there are 522 complaints and they are split up into different categories. This was up on the 2005-06 figure, then it went down and climbed again. Nothing that I can see in here shows any sort of distinction in areas. We accept that there are three major areas in the State - the south, the north and the north west. Nothing in here shows out of those 522 complaints any sort of breakdown into areas. Is that a difficulty?

Ms WHYTE - I think there is.

Mr ALLSTON - I am not sure that we have got it in the report. Certainly in the Ombudsman's report we do break the complaints down into areas. Experience is that by far the greater number of complaints are made in the south and I would expect it to be the same in that jurisdiction too, probably because of the nature of the population. We are a public service town for instance and there probably is -

Mrs SMITH - Everyone knows where to go.

Mr ALLSTON - Yes, that is right and it is probably more likely that people will speak up. I do not know but that is certainly is the experience in the Ombudsman's jurisdiction. We ought to track that. We certainly have the data available to us if we want to pull it out.

Mrs SMITH - I think it would be interesting. We are looking at public hospital systems and there are 38 complaints there, so it would be interesting to know the balance of those 38 complaints if you have it in your data system.

Mr ALLSTON - Yes, we do.

CHAIR - If you are able to provide that information to Dr Colin Huntly that would be good.

Are there any other issues?

Ms FORREST - Just a broad one. As you know the terms of reference are very broad, but we hear criticism all the time that the health system is broken, things do not work, people are not getting surgery when they want or when they need it and the whole bit. As the Health Complaints Commissioner, does anything stand out in your mind or a direction that we should take that could resolve some of these issues?

Mr ALLSTON - I might leave that for Pip, but I would like to say one thing. I was contemplating this earlier today. You know the old adage that people do not go to work to do a bad job and that is definitely not the case in the Health Department. We experience people, like us, constantly wanting to improve the systems that are available for the public and I suppose there are limitations of resources, there is just human frailty, there are all sorts of reasons why it does not come about, but it is the case that people in the health system are really trying to do the best they can. When we come to our conciliations, for instance, there is a real endeavour to try to resolve the matter and come up with solutions to make sure that the same misadventure does not occur again.

Ms FORREST - Do you think communication is one of the big issues?

Mr ALLSTON - It is a big issue.

Ms FORREST - Or lack thereof, more likely.

Mr ALLSTON - I think that is probably true across human society generally. One really good feature that is coming through at the moment is the move towards open disclosure, which is to have discussions with a person who has suffered a misadventure as early as possible after it has taken place. Not to hide the cause or what happened under the carpet but to bring it out, discuss it, discuss the consequence and, particularly and most importantly, discuss what changes are going to be put in place to make sure it does not happen again.

Mrs JAMIESON - Do you keep those figures? How many changes have actually occurred to benefit the patients and the system generally?

Mr ALLSTON - We are tracking them and we go back and make sure that people are followed up on what has come out.

Ms WHYTE - That is from our conciliation.

Mrs JAMIESON - Would you have any idea of how many policies may have changed because of your involvement?

Mr ALLSTON - That would a really hard thing to track, Norma. One thing that is in contemplation - and it is a resourcing thing for us really - is under section 66 of the Health Complaints Act, it is possible for a regulation to made which requires public hospitals to report the complaint management history to the Health Complaints Commissioner so that I can develop an overarching report about complaints to the health system. It is something I have been thinking of doing. It is another burden upon the office, which we probably don't need at the moment, but it is something that is on my list of things to do.

Mr WING - Do you have a deputy?

Mr ALLSTON - I wish!

Ms FORREST - Do you want to say anything about my question first? Did you want to make any comment on the question I asked about the broad sort of -

Ms WHYTE - Yes, I was talking with Simon before, and I think one of the themes that comes from the A&E situation is simply that they do so much GP-type work. That seems to be because you can't get a GP at certain times. Just from personal experience, I tried to get one and couldn't get an appointment for three days to get an antibiotic. The option is you go down to A&E and wait. If everybody is doing that, instead of a hospital being somewhere you go for an emergency, you are just going there for routine medical treatment. It seems that it is something that could be overcome. Some of our complainants are people who have been referred to the hospital by their GP. The GP has seen them and said, 'We're worried about you. Go to hospital' or they get an ambulance for them. They arrive at A&E and then go through the same process as everybody else in A&E. They get triaged, and presumably appropriately triaged. Whereas if I am sitting

there waiting for an antibiotic I wouldn't expect to be seen within the day. It seems that the system is being clogged by that very routine-type general practitioner work.

Ms FORREST - Evidence from our DEM people would dispute that. They say the GP work they do is a very small percentage of the work they undertake.

Ms WHYTE - Does that come from the North West Regional Hospital?

Ms FORREST - We haven't heard from the North West Regional yet.

Ms WHYTE - I think when we had our meeting with Ken Campbell some time ago he said that the number of presentations they have up there -

Ms FORREST - I think it could be different there.

CHAIR - Thank you, Simon and Pip, for your attendance today and the information and evidence you have provided to us.

THE WITNESSES WITHDREW.

Mr MICHAEL PERVAN WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

DEPUTY CHAIR (Mr Wing) - Welcome, Michael. You have not submitted a written submission so we look forward to hearing your views about any matters that come within our terms of reference.

Mr PERVAN - Would you like me to make a general statement?

DEPUTY CHAIR - Yes, if you would, please, and tell us your main views.

Mr PERVAN - Without knowing any detailed issues that the committee would like to discuss with me in my capacity as the acting CEO of the Royal Hobart Hospital, I would say at the outset that inquiries such as this are always welcome. Health is a frantically busy affair, particularly after lots of very high-level and detailed discussions were had as part of the COAG process around health reform that did not have the benefit that the States and Territories were all hoping for. What we have seen is not much reform and a lot of discussion and some commitments to money to drive a system, the architecture of which is now getting on for 200 years old. By architecture I don't mean the buildings, although of course parts of the Royal are getting on. It is more the work force structure, how services are delivered, the domination of services being delivered from acute care hospitals and general practice, a system that we inherited from the UK at first settlement. What is interesting is trying to talk about a system when part of it is really what is of interest to the committee, which is public hospitals, because the health system covers of course general practice, aged care facilities and a number of other services, in particular the non-government organisations, all of which work together to greater or lesser degrees of success.

As I am sure my colleague, John Kirwan, in Launceston would confirm, if all parts of the system are not working then the first place you know about the system failure is in your public hospital. If aged care cannot provide places, if the GPs are not there, then all roads lead to one place and that is your front door.

I guess I am in a particularly privileged position also because exactly 10 years ago I won a Churchill Fellowship to study access to elective surgery and emergency medical services in a number of other countries. The challenges confronting Tasmania and Australia generally are common to those being seen worldwide. The responses to those challenges are different from country to country but all of them have had very varying success. So while I would like to sit here and say the answer lies in Canada or the United Kingdom or Croatia, the absolute truth is that we are seeing a change in the way that people want to access health and in what the health system can provide for people. It changes on a daily basis, be it through medication or through treatment or just through the relationships between clinicians. That has an impact on your overall capacity and on demand.

I guess what is of concern to me most is that - as is demonstrated by the Booz Allen Hamilton Report in New South Wales and the Garling inquiry - what we are seeing in the Royal and Launceston General is an increase in demand that is not related to age or illness or any predictable indicator. It is sociological. More and more people, and in

particular the age group around 18 to 28, are choosing public emergency departments as their primary care provider. We have a lot of regulars. We have people who come back two and three times a week. What is of greater concern is that a lot of them are actually referred to us by GPs, not because they are in need of urgent specialist care but because GPs are feeling less and less confident to deal with people with complex problems - not necessarily urgent - or ones that they do not feel confident to deal with, something I have had personal experience with recently with my own children. The GP actually told us to go to the Royal for what would have possibly been considered a primary care consult in years gone by. So the pressure is mounting. We are doing everything we can to meet that pressure and meet those demands head on. That is a constant process. It is not going to be something where you just put an additional few staff members into our emergency department or change the pathway of the patient through elective surgery.

Ms FORREST - With the issue about the GP lacking in confidence to deal with a particular situation that you saw as a primary health issue, is there a real problem there? Do we need to look at how GPs are trained and how they are supported in their up-skilling particularly? The average age of GPs is in the 50s and a lot has changed in recent times. How are we, or how are we not, supporting GPs to update and to have this level of confidence to deal with whatever primary health issue could come through their door?

Mr PERVAN - I think part of it goes to training and part of it goes to support. We have some amazing GPs in Tasmania and of course there is a rising incidence of GPs with special interests. We have GPs who are trained by endocrinologists at the Royal for the management of diabetes. We have GPs with a special interest in skin cancer and things like that. The range of things that a general practitioner is now expected to deal with is such that many of them, I believe, find it very challenging, particularly the younger ones. In my experience it was a younger GP who just said, 'I am sorry, I do not deal with children. The risks are too high. You are better off going to the emergency department'.

Ms FORREST - The risks being litigation?

Mr PERVAN - Perhaps. That particular GP didn't elaborate. It could have been litigation, it could have been just concern for the patient, because a 12-month-old child with a temperature and a fever could be one of many things. Just in the interests of safety - and I guess that does go to support - the GP would rather you went somewhere where if there was something wrong they could deal with it immediately.

Ms FORREST - Do you feel that the GPs have enough support if someone does present, a child or someone who is a little bit more complex, and we are getting more and more of those sorts of patients, particularly in the elderly population? Do they have a direct person they can call? I know this is being looked at in the North West Regional Hospital, and it would be an ideal outcome in that area. Is that being considered down here, to have a direct link for that GP to ring and not go through the intern and the resident and the registrar and then finally get to a consultant, but to go straight to an emergency specialist?

Mr PERVAN - We are certainly looking at services like that in respect to things that you want urgent support on - like chest pain. It's just not possible to do it for every single health issue and health concern. The network that has been built up by the endocrinologist is formidable, to say the least, in that they now have a large number of

GPs whom they relate to on a daily basis. Of course the upshot is the patient gets better and more comprehensive care and they spend less time in hospital, which is really what everyone wants. They stay better longer.

Ms FORREST - Can GPs in the Hobart and broader southern area ring directly into the emergency department at the Royal?

Mr PERVAN - They can ring the emergency department, yes.

Ms FORREST - Will they get to speak to an emergency physician or someone higher up the chain, because if they're a GP they've already got skills, probably more than one of the residents would have.

Mr PERVAN - Yes, many will.

Ms FORREST - Potentially?

Mr PERVAN - Potentially, yes.

Ms FORREST - So they don't want to talk to someone who has as much knowledge or less than them; they want to go a bit higher than that. Is that possible and does it work?

Mr PERVAN - It is possible and it does work. They have to wait, of course, it depends on how many patients the emergency consultants are seeing at any given time, but they will get to talk to a consultant. Similarly, if they ask to be referred onto someone else, they will go to an on-call consultant. Many of the GPs don't. They try to speed up things for the patient and just send the patient straight into the DEM. That's why we're getting the increased number of GP referrals, because it's still faster for the patient to come in if their need is urgent rather than waiting in the GP room to confirm that the need is urgent and then coming through.

CHAIR - We have had evidence given to us by GPs that in fact they are treating patients that they ought not be treating, who should really be coming into the public hospital system. Have you any knowledge of that?

Mr PERVAN - A little of it. I think it's a very mixed bag. It's very hard to describe whether this is an asset or something else - I think it's an asset - in that so many of the GPs that work in Tasmania were born and trained here. They have an extensive personal network through the hospitals, so they know exactly who to ring for whatever problem. As I said, the challenge is for the younger GPs coming through or the ones that come from the mainland or overseas who don't know anyone here. You can track the years of training through the referral patterns, by whom they refer to, because they're the people they went to university with.

Mr WING - We heard from one GP in Hobart and he was not sure who he should be phoning to check on the condition of his patients in the Royal.

Ms FORREST - Once they're admitted.

Mr WING - That's right.

Mr PERVAN - We are about to roll out an electronic discharge summary system so that all of the information goes with the patient when they go back to the GP. While they are staying with us the best person to talk to would be the emergency department after hours, or the chief or deputy chief medical officers, if they want to keep tabs on their patient.

Mrs SMITH - How far away is this roll out, because that's been a significant issue, the lack of communication or the time it takes to communicate. Are we three months, six months -

Mr PERVAN - Three months. The application has been fully developed and then testing and refinement with the actual clinicians who are going to be using it.

Ms FORREST - Whose responsibility would it be to complete the discharge summary and will it be sent electronically on every instance?

Mr PERVAN - The responsibility rests with the discharging doctor at the moment.

Ms FORREST - The resident?

Mr PERVAN - If that's the discharging doctor, yes, it would be a resident. It could be a consultant. It can be sent electronically or will be if that option is available. Some GPs still do not have fax machines or computers.

Ms FORREST - When you say electronically, is e-mail an option then?

Mr PERVAN - Yes, secure e-mail is an option.

Ms FORREST - One of the criticisms has been they cannot read them when they get them, so if it is an e-mail that should be able to be read.

Mr PERVAN - Yes, if it is an e-mail.

Ms FORREST - As opposed to handwritten then faxed.

Mr PERVAN - It will be faxed if there is no option but the preference is e-mail and certainly there are a number of options for backing that up if there is no possibility to e-mail or fax it. The idea is to get better information to the GPs as quickly as possible.

CHAIR - We are told that the system is not working at the present time and there need to be big changes in communications from the public hospitals back to the general practitioners. You have told us that there are changes that we can look forward to in that area. Can we be satisfied that those changes will address those communication breakdowns that we are now told are occurring and which are causing some doctors a lot of concern and stress because they are not being advised of what is happening with their patients? One doctor was telling us that one of his patients had deceased and was not told about it, so can we be sure that all of that will be addressed with this new system?

Mr PERVAN - Certainly the objectives of the system are to do that. The only way to be assured that will happen is for the system to be evaluated probably at six and at

12 months after it is implemented and for the details of that evaluation to be made public. I could see no reason why we would not want people to know how well this kind of change is working and to promote it. I think it is a major step forward.

Mrs JAMIESON - Would this also include people whose appointments have been changed, delayed or postponed and they have to go back to their GP and then we have an endless circle?

Mr PERVAN - If they have been discharged from our care -

Mrs JAMIESON - But they might not have been at care. Sometimes people on the north-west coast come down to Hobart and arrive only to be told it is cancelled.

Mr PERVAN - It will not deal with cancellations; it is a discharge summary

CHAIR - I do not want to harp on the point but the evidence given was that communication has never been worse.

Mr WING - Between the Royal and the general practitioner.

CHAIR - Yes, between the Royal Hobart Hospital and the general practitioners. It has reached a point where something must occur immediately for the benefit of the patients. We are told that patients were released from A&E without any knowledge of the general practitioners. They were left not knowing what is going on or what needed to be done.

Mr PERVAN - Given the requirement to speak in a purely evidentiary way, in nearly eight months as acting CEO not a single GP has ever raised a concern with me about communication. It is not an issue that I was aware was of such concern until I sat in this committee hearing.

In terms of my own experience, when my children had to go to the ED our GP in Lauderdale received a discharge summary within 24 hours and followed up with us within 24 hours. I can only respond about what I know and no-one has raised it with me, otherwise we would have been doing something about it.

CHAIR - So you would have expected any complaints to come to you for your personal attention?

Mr PERVAN - Every complaint comes to me, as does every compliment.

CHAIR - Is that the normal procedure within the system, that if a complaint is made it must go to you for your attention or for your consideration?

Mr PERVAN - Yes, we have a complaints management system and it is all logged and we watch it very carefully.

Mrs SMITH - How long have you been CEO?

Mr PERVAN - I have been acting CEO since 8 September last year.

Ms FORREST - There are also some questions about whole lists being cancelled at times, particularly neurosurgical lists. Are you able to provide for the last three or four years how often a list was cancelled and in which areas? I am not talking about a case being put off because there was an emergency, but a whole list being cancelled. Why would a whole list be cancelled?

Mr PERVAN - It would depend entirely on the list. If it were a list of cases that were complex - orthopaedic surgery, neurosurgery - in the case of neurosurgery the list would more than likely be cancelled due to a lack of ICU beds for recovery because of the risk of the risk to the patient. So you wouldn't start an operation. I will see if I can do that and provide it to the committee.

Ms FORREST - And provide the reasons as to why that list was cancelled.

Mr PERVAN - I am unsure if the system records the reasons. It will record the cancellation, but if it does record the reasons then I am happy to provide that.

Mrs JAMIESON - Do you have enough anaesthetists, if the anaesthetist who is doing the whole list went on the blink? Would that be a reason why a list would be cancelled?

Mr PERVAN - No, the only reason we would cancel a whole list is lack of ICU beds or some catastrophe on the part of a surgeon. If a surgeon had a motor vehicle accident, as happened in the north-west about 12 months ago, we would cancel the list.

CHAIR - I want to go back to contact between the Royal Hobart Hospital and GPs in the local area. Do you have a system where you go out to or make contact with GPs in the area to identify any issues or concerns they might have or areas where they might be able to recommend and support improvements?

Mr PERVAN - Absolutely. We have a monthly meeting with the local division of general practice where they raise any issues of concern to us. This issue that is being raised with me now has never been raised in any of those meetings. They are very constructive and cordial and we do what we can to respond to the needs raised. As I said, it is not in our interests to have anything but a very positive relationship with the GPs. It has never been raised with me in nearly eight months.

Mrs SMITH - Is there a standard acceptable waiting-time benchmark for hospitals around Australia? How do we compare in the different electives? One lot of evidence given was that a patient facing a knee reconstruction was advised by a specialist to commence private health insurance and wait 12 months as it would be years before surgery happened at the Royal Hobart Hospital. Do we have a national benchmark and are we meeting that in comparison with other States or is it so different from State to State?

Mr PERVAN - We report nationally on three urgency categories for elective surgery. Category 1 is they must have the surgery within 30 days; category 2, from memory, is 90 days; and category 3 is 12 months or more. Those categories are all determined by the clinician, so if it is clear to the clinician that someone is in extreme pain, has no mobility and has a number of reasons why they need the knee reconstruction or a knee replacement then they can make them an urgent patient. They determine the urgency of

the case. Our performance on elective surgery at the Royal Hobart Hospital has been lacklustre to say the least but has dramatically improved in the last six months.

Mrs SMITH - And the reason for that?

Mr PERVAN - There are many reasons. There is a new team running surgery, led by Mr Craig Quarmby. We have done a lot of work around scheduling and starting and finishing times. They are all very basic management things but things which needed to be done. As a result of we have increased the number of procedures, or the throughput, through our surgery area by around 10-15 per cent and we have halved the number of cancellations.

Mrs SMITH - If I might look at the 10-15 per cent issue on the number of procedures, there has been continuing mumbling in the community about waiting lists. If you have waiting lists you can do *x* number of operations in a day, but when you come to things such as a hip replacement you might do half the total. Do you separate out your lists so that we could be assured that when public lists say we have improved our lot it isn't because we have been doing minor surgery and allowing larger surgery to wait?

Mr PERVAN - No. I can provide that information. We have increased throughput right across the board. As a result of a lot of the changes that have been made, three orthopaedic surgeons who had previously refused to work at the Royal are now back with us - Michael Pritchard being the most notable. It is a matter of balancing what goes through the theatres to make sure that there are sufficient but the waiting list, particularly for orthopaedics at the Royal, was quite staggering. It had built up over many, many years so it is going to take a long time for us to work our way through the people who have been waiting.

Ms FORREST - Regarding the improvements that you have alluded to and the improvements in productivity or the number of patients you have through the reduction in cancellations, has that been partly driven by the Federal Government's however many million dollars was given for elective surgery? Is that one of the driving forces there? I understand that that had to include a number of hips, a number of eyes, a number of this and a number of that.

Mr PERVAN - It was not nearly that detailed.

Ms FORREST - Wasn't it? Okay.

Mr PERVAN - No, the Commonwealth money was just for elective surgery and it was up to the States to determine what they would do for it and how they would do it. It was for procedures across the entire scope of elective surgery.

No, I would say the biggest driver of the improvements at the Royal is the staff in the surgery division taking ownership and wanting to do a better job. That is all it comes down to.

In terms of the Commonwealth target and in fact the State activity targets that come with the funding, we met all those last year and, as at 8 December, had blitzed the target by 214 cases.

Ms FORREST - In those cases you have conducted a range of surgery, not just -

Mr PERVAN - Not just the easy ones, not just day surgery.

Ms FORREST - You have done intraocular lens transplants, you have done some hips, you have done some knees, you have done - I don't know what else you want to do.

Mr PERVAN - Everything across the board. But we can provide a breakdown of the cases that were done under the Commonwealth or just general activity.

Ms FORREST - Can you provide those for the committee then?

Mr PERVAN - Yes.

Mr WING - How would you describe the morale at the Royal among the medical and other staff, especially the medical staff?

Mr PERVAN - I would say the morale has improved dramatically in the last few months, in particular with respect to people wanting their tenure renewed or wanting to increase the work that they are doing at the Royal. One of the other good indicators is their active engagement in research and wanting to expand that. It is always a good thing for a teaching hospital to do and part of the life of any good tertiary facility.

The morale, when I arrived, was very depressed, basically, for all sorts of reasons. The Royal has an enormous history behind it and a lot of troubled times in the past. There is still a huge corporate memory of budget decisions that were made in the late 1980s when things were very tight and most of the hospital was sold and leased back, including our crockery. So people are very wary about tight times with the global financial crises and things like that.

There was also a need to engage directly with the clinical staff - that is, to get down into the wards, find out what was happening and start to change things. There are a lot of things that have been changed and improved that only required a mandate - they required someone to say, 'Yes, you can' - and what has been of immense pleasure to me is seeing how many people have taken ownership of the issues that they got to deal with and have stepped up and fixed them. I would highlight people like Craig Quarmby in that. Tony Lawler in the Emergency Department is another one. The improvements that have been made in those areas of the hospital have nothing to do with who the CEO or acting CEO is -

Mr WING - That's very modest.

Laughter.

Mr PERVAN - and entirely due to some of those brilliant clinicians and the work that they have done with their staff.

Mr WING - What is the relationship between the various medical sections - emergency, intensive care, cardiology and the various departments - and the senior staff there, particularly, because there have been problems there?

Mr PERVAN - There is a bit of healthy competition in there.

Laughter.

Mr WING - Healthy for the patients?

Mr PERVAN - Yes, by and large, it actually is because they challenge each other's thinking but there will always be - and this is one of the dilemmas of any tertiary hospital in Australia - a tension between the chaos that drives out of an emergency department and its need for beds, which could be through the roof one day and non-existent the next, and the need for surgery, particularly elective surgery, to have an absolute number of guaranteeable, certain beds that they need to plan their theatre sessions around and that is certainly what challenges us come winter when we have a lot of respiratory illness.

I will single out another clinician whose brilliance keeps the Royal and that would be Dr Alastair McGregor, who has just finished his term as head of department for Infectious Diseases and Microbiology. Last year when we had influenza A and B outbreaks in Hobart - and this is the sort of thing that can cripple a hospital very quickly - Alastair and his team contained and managed it; they immunised the patients, everyone who had been exposed to influenza, and controlled it such that we maintained surgical activity and medical throughput. A lot of other hospitals got so tight that they could not function and were going on by-pass. One of the things about the Royal is we do not have that option so we just had to keep going and we were lucky to have people of that calibre to help us do it.

Mrs JAMIESON - Just to follow that. If you had a major pandemic of any sort, how would the hospital cope? Most of the patients would probably end up down here.

Mr PERVAN - The hospital would have to cope because there would not be an option. We do have a substantial pandemic influenza plan that would guide how we work with the private sector, how we increase capacity, the people we immunise first so that we can keep services going. That is the big impact in winter. It is not so much the demand on services, it is the fact that most of your staff either get sick themselves or have to care for someone who is. At the moment we are immunising all of our staff and I have actually offered it to the families of people that work in the ICU and the Department of Emergency Medicine for that very reason.

Mrs JAMIESON - I have another question on a completely different subject. Have you ever worked with physician assistants?

Mr PERVAN - No, but I have seen them working overseas.

Mrs JAMIESON - Would you endorse the idea of them being included in our staff here?

Mr PERVAN - I think that bringing in physician assistants is a very innovative approach to increasing the capacity across the physician work force. The difficulty I have in giving

you a clear answer is that we actually have a good body of physicians at the Royal Hobart Hospital, so that is not where we get pressure from. It may be something of more benefit to Launceston for instance and particularly for our private sector friends who have much bigger problems recruiting physicians. I think physician assistants or any diversity of work force such that you get increased capacity is a good idea. In the United States I saw it through to nurses and ethicists and that was not a nurse working as a technician, it was a nurse delivering. It was not a nurse practitioner either - it was a nurse - and I think that within the scope of the work force that we have, within the current medical and nursing structure, there is a lot more that we can do to increase the flexibility and capacity of our work force.

Mrs JAMIESON - So perhaps it would be worth exploring in Tasmania's situation, particularly when you have such a rural spread of people too.

Mr PERVAN - Absolutely. And places like providing outreach or inreach, depending on what jargon you like, into nursing homes. I know I am doing this a lot but these are very good people. We would be absolutely lost without Dr Jane Tolman. Jane actually goes out there herself and delivers those services. Physician assistants would be of immense benefit in the aged care sector, even coming from the Royal and working out into that sector.

CHAIR - I need to draw this session to a conclusion as well. In relation to elective surgery - and you might have to provide this information to us - are you able to provide us with the number of, say, knee and hip surgeries that have occurred this year? We would like to get the number of elective surgery cases -

Mr PERVAN - I have already said that for the last three years.

CHAIR - And neuro-surgical, did you cover that?

Mr PERVAN - Yes, all of that.

CHAIR - Thank you, so we have got that.

Mrs SMITH - Do you have any comments to make about the issue of appointment of staff? We have had some comments from other areas about the time it takes, the bureaucratic process, the best people to know, whether the qualified people you want in the hospital are yourselves and yet by the time you go through the system more often than not people have moved on. Would you like to make a comment on that?

Mr PERVAN - Once again I can only speak from personal experience and when we have had a really well qualified applicant that we needed to appoint urgently, I have had no problems with the time it has taken or the speed of the bureaucracy moving to make the appointment. Other people may have had difficulty but I seem to have had a really good run.

Mrs SMITH - How many would you have appointed since 8 September last year?

Mr PERVAN - Clinical staff? Probably in the order of 30 or 40.

Mrs SMITH - How many of them would you have classified as urgent and you wanted quick responses?

Mr PERVAN - Two. Once again, as I said, only in terms of my personal experience with regard to the rest of them, they move through at their normal speed, and certainly none of the heads of clinical departments came forward and said it was taking too long, or the department was dragging its feet. No-one has raised it with me as an issue. I've heard the same thing that you've heard.

Mrs SMITH - My last question - and you don't have to answer this if you feel it might compromise you; I will ask it of the department. You have been acting CEO since 8 September. Is there some reason why seven months on we haven't progressed to -

Mr PERVAN - The job was advertised at the weekend.

Mrs SMITH - Okay, thank you. That wasn't urgent evidently.

Laughter.

Mr HARRISS - At what percentage of capacity are the theatres operating within the hospital? Can you tell me that?

Mr PERVAN - For a number of reasons, at the moment we're probably running at about 70 per cent. I am only saying probably, because I haven't checked today. The reasons they don't operate at 100 per cent capacity go to access to beds at the other end - you need somewhere for the patient to go before you start the operation - and changeover times, cleaning and things like that. So they are running a lot better and more efficiently than they were, but there's some improvement to go yet. This is the case even in the private sector, in hospitals where they only do elective surgery. I will give you two examples. In New South Wales the John Hunter Hospital is co-located with the Royal in Newcastle. In one they look after medical patients in the emergency department, and the other is just elective surgery. Even where you have beds which are only for surgical patients in a hospital that only does surgery, they still only run at about 80 per cent to 85 per cent capacity in their theatres. It is a matter of changeover, cleaning, rostering, and all sorts of other issues.

Mr HARRISS - During your time in the position, has there been any major incidence of scheduled surgery which has been cancelled at, say, the end of a working day, particularly for cost-saving or cost-cutting measures in that people might be required to work overtime if you proceeded with that surgical procedure at the end of the day?

Mr PERVAN - There is a history of those sorts of decisions being made at the Royal, but since Craig Quarmby was appointed Director of Surgery no cancellation has occurred for financial reasons.

Mr HARRISS - Then my observation about that would be, given your response, that there has been a history of that. My observation then would be that by some modest or moderate negotiation you could have proceeded with those scheduled surgical procedures at minimal cost, and good outcomes achieved, given that there must have been beds at the other end already identified.

Mr PERVAN - And that is what we've done, and that's what Craig and his team have done in surgery. Where there has been a problem with surgery heading towards the end of the day, and need for overtime, or even where there's just not been room to fit the whole list for a particular set of procedures on the general Monday to Friday roster, some of the solutions that have been entered into are staff swapping their days off so that they take Wednesday off and then work on Saturdays. You get their list done then. Generally, as he said, sitting down with people and having a fairly focused conversation has been enough to get the work done, and the change in attitude and morale in surgery is absolutely staggering.

It is often said that cancellation used to be the default position. If there were any problem with budget, with staffing, with anaesthetists being late or a theatre nurse not showing up, or for other reasons, they would cancel that procedure. Now they do everything they can to find a solution to the issue before cancellation, which is the last resort.

Mr HARRISS - You indicated there's been a history. How longstanding was that history?

Mr PERVAN - I couldn't comment on that, I've only been in Tasmania myself for about 18 months, but I gather from previous reports and other issues that it goes back three or five years or even longer.

CHAIR - Thanks, Paul. I am going to have to draw this session to a conclusion, I think we've a lot more questions that we would like to ask but we may well be able to do that at another time, or perhaps ask you to respond to some questions in writing to us.

Mr PERVAN - Absolutely. I'd be more than happy to take any questions in writing.

CHAIR - Thank you very much for that, Michael. We look forward to getting the information that you have indicated you can provide to us. I again apologise for keeping you beyond your time; you are busy person but we do thank you very much for your input.

Mr PERVAN - My pleasure to help.

CHAIR - Thank you.

THE WITNESS WITHDREW.

Mr BRETT WHITELEY LIBERAL PARTY MEMBER OF STATE PARLIAMENT WAS CALLED AND EXAMINED.

CHAIR - Brett, you have provided us with a written submission. Now there is an opportunity for you to go through whatever you want to and then there will be an opportunity for us to ask questions. I realise, too, that you have to be away by 2 o'clock.

Mr WHITELEY - Thank you, Mr Chairman, and thank you honourable members for this opportunity. As you have quite correctly said, we did provide a submission, which I do not need to encourage you to read because I am sure that you all would have diligently read it. Can I just make this comment though, obviously being a shadow minister for health fronting a committee on a very wide referenced public hospital inquiry, I want to put it on the record that it is not my intention to politicise this matter at all. I want to come before the committee today with the facts and the views that we have come to a conclusion on in a number of areas. I think it would be fair to say that, when it comes to the politicisation, I and we as a party have tried where possible over the last few years to be as supportive as we can be where needed and where justified. I think the case in point, being the Mersey Community Hospital in my own electorate, where we demonstrated that willingness to participate in a bipartisan way where appropriate.

I am not a clinician. I noticed, Mr Chairman, you said you were not either. That is good. I understand the evidence that has been given has been passionate, in many cases expressing absolute frustration - the expression of views that I think are soundly grounded in the day-to-day experiences of very dedicated professionals. Can I also say, before I just move into my written submission today, that we have very, very good people working in what I would summarise as failing and discredited systems. So my submission today to this committee will not be hopefully taken as an affront to the very hardworking professionals in our health service, but rather the systems which are supposed to support those people.

Our Liberal submission is centred on endless waiting lists for surgery and also the less-publicised issue of the time between seeing a GP in this State and getting to the door or the reception area of a specialist, which is a big issue. Our submission also centres on whether the current plan to reduce elective surgery lists has got it right, how timely access to medical treatment can impact on the whole health system and the need for strategic planning in the whole health and hospital systems. Our submission poses a number of questions for this committee and I am sure you will deal with most of those because they are not such a special set of questions. They are rather the questions that all of us as members of parliament would be confronted with each and every day in our electorate offices. So today I am not going to even attempt to provide solutions to the committee. I have formed my own view on the future direction of health in many ways in this State and no doubt, as a political party, we will have something to say about those things in the coming months.

The purpose of my appearing before the committee today is to point out the revolving door in this State where patients are getting sicker even before they get to hospital and how that impacts on every level of not only the health system but also our community at large. We have all heard the minister say, quite correctly, that we cannot keep spending to the level we are on hospitals. We know that hospital funding has doubled over the

past decade but yet waiting lists are longer, unplanned hospital readmissions have tripled and there are ongoing problems in accessing hospital care. We acknowledge also that we have an ageing community. We also acknowledge the links between lower socioeconomic status and poor health outcomes. But we also know the failure to promptly diagnose and treat medical conditions can lead to increased hospitalisations, can mean people are sicker when they get to hospital and this can result in a longer stay or an unplanned readmission once discharged or that people, waiting endlessly, will often re-present to emergency departments as urgent cases. This in turn impacts on all levels of the hospital system, clogging up emergency departments, causing cancellation of elective surgery because emergencies take precedence over a longer stay and unplanned readmissions mean less access to hospital beds.

Access problems, in turn, might result in patients being discharged early, again leading to unplanned hospital readmission. This is also a major problem when there is a lack of support for those people who are discharged back into their homes and community without the family network and community networks that many of us would probably enjoy.

This is what we have called, and I continue to call, the revolving door of health care in the State. Here are two very quick examples as case studies. An elderly patient in a rural hospital needed an appointment at the outpatients' wound clinic. The problem was beyond the scope of the hospital and the local GP but it would have been considerably worse if the patient had waited four months, as they were told they would need to, leading to adverse outcomes to the patient, more work for the rural GP and perhaps hospitalisation eventually in a major acute hospital, when it was necessary at all.

The second example was a woman waiting beyond the clinical time frame for hip surgery. She contacted us after waiting 12 months. She was told she would be waiting another 19 months. She had her surgery cancelled four times. Her husband lost time at work each time in having to care for her. She was admitted twice to a rural hospital so that her husband could have respite, and was on very strong medication which did, in fact, affect her overall health.

In the community, those who are not diagnosed and treated in a timely way or who are waiting to see a specialist, have to rely on their GPs. A third of GP practices have patient access restrictions or closed books and some GPs have told us that one of the positive impacts from GP patients getting timely access to specialist health care may be GPs opening up their books to new patients, if we could get through that problem. As I have said, it can also lead to an over-reliance on pharmaceuticals, which impacts on the PBS, which in turn is costly to the patient, not good for their health, costly to the taxpayer and the Federal Government and costly to the State in the terms of lost productivity. The revolving door continues.

We talked in our submission about elective surgery wait times and how linking financial incentives to the State tackling long-wait patients may result in the State completing the simple, less complex surgical cases. As the committee is aware, stage three of the Federal Government's elective surgery waiting reduction plan provides up to $300 million in dividend payments for States and Territories who have improved their performance by dramatically increasing the number of patients treated within the clinically recommended time frames.

Since we wrote our submission two matters have come to light. Firstly, we have been sent a copy of a letter from the hospital to a GP in relation to a patient in the north of the State. This letter states very clearly that the specialist is unable to get theatre time for more complex surgical cases. The letter states and I quote:

> 'He is not the only person in this situation. We have many patients on the waiting list for as long and sometimes longer than him, with very similar problems. The resources are such that we can only get one of these cases done per week due to the length of the surgery.'

In raising this with the minister, she said the hospital was wrong to describe the situation in the way that it did. So who is right? The patient is told one thing. The GP understands another. The minister says another. We are just doing the simple surgeries, we believe, and leaving those waiting for longer, more complex surgery, on waiting lists. Is there a danger in providing financial incentives to reduce waiting lists? It is a question, I suppose, that will linger for a while.

Also since our submission we have received a copy of a departmental document on improving elective surgery. The document we received contained departmental figures on the number of people who do not have their elective surgery on time or within the clinically recommended time in this State. Interestingly, we had it given to us in draft form, but when it was eventually published and available publicly these figures were not included. I am happy now to share those figures with this committee. The document shows that as at 30 June 2008 there were 8 622 patients on public hospital waiting lists comprising 579 category 1, 4 174 category 2 and 3 869 category 3. Of those patients, 51.9 per cent were waiting at the Royal, 31.7 at the LGH and 16.4 at the North West Regional. In 2007-08 only 75 per cent of category 1 patients were admitted within the clinically recommended time frames; just 47 per cent of category 2 were admitted on time and 70 per cent of category 3. At the Royal Hobart Hospital only 63 per cent of category 1 patients were seen on time, 40 per cent of category 2 and 52 per cent of category 3 patients. At the Launceston General Hospital, 98 per cent of category 1 patients were seen on time, 58 per cent of category 2 patients and 70 per cent of category 3. I know these are a lot of figures but they are interesting. I am happy to provide them for you. At the North West Regional Hospital 80 per cent of category 1 patients, 44 per cent of category 2 and 86 per cent of category 3 patients were seen within clinically recommended time frames. Just for reaffirmation, 30 days is the recommended time frame for category 1, 90 days for category 2 and 365 for category 3.

Further, it shows that in the years between 2001 and 2008 there was an overall decline in performance for all categories at the Royal, an improvement at the Launceston General Hospital for category 1 patients and pretty constant results for others at the Launceston General Hospital, and fluctuations altogether in Burnie. Of real concern, however, is the number of patients waiting longer than a year. The differential in the wait times between regions is also very interesting to watch - and between hospitals for all categories of patients. For example, for admitted patients, category 1 patients waited from nine days at the Launceston General to 38 days at the Royal - note the differential. Category 2 patients ranged from 107 days at Launceston to 223 days at the Royal and category 3 patients ranged from 196 days at Burnie to 375 days at the Royal. For patients on waiting lists for surgery, category 1 patients ranged from 10 days at the Launceston

General to 102 days at Burnie. Category 2 patients ranged from 144 days at the Launceston General to 380 days at the Royal. Category 3 patients ranged from 302 days at the Launceston General to 592 days in Burnie. The document shows that patients waited longer for cardiothoracic, ENT and ophthalmology surgery at the Royal, plastic and orthopaedic surgery at the Launceston General, and ophthalmology, gynaecology and orthopaedic surgery in Burnie, showing clearly that simple surgeries, we believe, are taking precedence over more lengthy surgeries, despite a patient's categorisation on the waiting list. That is our conclusion.

At 30 June 2008 a total of 1 733 patients in Tasmania had waited longer than 500 days for their surgery. There were 2 886 who had waited longer than a year. At the Royal Hobart there were 1 582 patients waiting longer than a year and 946 waiting longer than 500 days. In Launceston, 613 patients waited longer than a year and 299 patients waited longer than 500 days. On the north-west coast there were 691 waiting longer than a year and 488 waiting longer than 500 days. Of concern in these figures is the number of category 1 patients waiting longer than a year. Do not forget, category 1 patients should have been seen within 30 days. At the Royal Hobart Hospital there were seven category 1 patients waiting longer than a year. In Launceston, thank goodness, there were none. In Burnie there were 10 category 1 patients waiting longer than a year and three category 1 patients waiting longer that 500 days.

What this document clearly shows in relation to elective surgery waiting lists is that endless waiting is very, very real for thousands of Tasmanian patients. The impact of the wait on patients, on their families, on our hospitals themselves and on the general community, cannot be underestimated. Unless we change policy, unless we see structural change, nothing will change.

I would like to quickly move on to the issue of the relationship with private hospitals if I could. One issue I did not raise in our initial submission was the increasing reliance by our public hospitals on private patient revenue. I have just read out the figures to the end of June 2008 of the number of Tasmanian public hospital patients waiting more than a year for their elective surgery. However, in the same year it was astounding to note that there were 12 193 patients with private health insurance who were admitted to Tasmanian public hospitals, an increase of 1 388, or 12.8 per cent, just on the previous year alone. These 12 193 patients, occupied 42 263 bed days and this is the equivalent to there being on average in any day in hospital in Tasmania 115 private patients occupying beds in the public hospital system.

These figures, Mr Chairman, do not include DVA patients, third party compensable patients and the self-insured, which we believe would increase this figure by probably 20 per cent. So we have nearly 9 000 people without medical insurance on waiting lists to go into our public hospital system and we have over here, Mr Chairman, 12 000 plus with private health insurance being admitted to our public hospital system. It has been put to me that we could abolish the entire waiting list if we redirected back to the private hospital system just 70 per cent of privately insured patients. It would cost our public hospital system $8.5 million in lost revenue which is what they are currently earning from private health patients, the equivalent you could say of what the Commonwealth are now giving us to reduce but not abolish entirely our waiting lists.

Some 57.1 per cent of Tasmanians do not have private health insurance yet they are competing we believe with private patients for beds in our public hospitals. Some would say they get preference over these beds because they are paying their way. Is this, Mr Chairman, the most equitable situation for those who cannot afford private health insurance and, in fact, is it not unfair to the private sector which, at any given point in time, as we have seen from recent announcements, are constantly reviewing their viability in this State? Without the private health system, whatever people may think of it, whatever their ideological view of it is, this State would be in far worse shape without the assistance of and the partnership with, where it is appropriate, the private health sector. We should not in my view being doing anything to undermine their viability. We are not awash with private hospital operators in this State and they do play a significant part and they are an integral part in the overall solutions to the Tasmanian health problem.

I asked the Minister for Health recently about this practice in question time. The minister's only defence was that private health insurance patients sometimes have had no choice but to attend a public hospital - such as when they need open-heart surgery. The committee will also find this interesting, I am sure. This is the fact. Of the 660 diagnostic categories of patients treated in acute hospital systems, private hospitals in this State can treat 653 of them. Further, we are informed the Tasmanian clinicians believe at least 70 per cent of the private patients in Tasmanian public hospitals could be treated in a clinically appropriate way in the private hospital system. So for anyone to suggest that the private hospital system cannot provide a significant part of the solution to the problem, I think they may be ill informed.

Another argument the minister uses is that public hospitals do not have any choice. A hospital cannot reject a patient simply because they have private health insurance. Mr Chairman, that is true but other public hospitals on the mainland for some time now have implemented what they call demand management strategies to great effect by simply asking patients whether they would like to be referred to a private hospital, not a practice that I believe is at the top of the agenda in Tasmania.

What is clear from these figures is that public patients are being asked to wait too long and we need to be asking whether the large number of privately-insured patients in our public hospitals is one of the reasons for this and why.

If I could quick move on to bed numbers, Mr Chairman, we mentioned in our submission the problems of access block and bed numbers -

CHAIR - I would like to leave time for some questions at the end.

Mr WHITELEY - Yes, we can. We know that the Royal Hobart Hospital has 540 beds, 437 overnight and 103 day beds. Launceston has 342 beds which are made of 296 overnight and 46 day. The North West Regional, or Burnie in particular, has 179 beds, 146 overnight and 33 day, and the Mersey has 115 beds, 96 of which are overnight. What we do not know is how many of those are closed for cost-cutting measures at any given time. The minister told an Estimates committee last year that she supports the practice of closing beds to save money in hospitals, yet we have national reports stating that high occupancy levels contribute to 1 500 patient deaths a year, more than the number of people who currently die across the nation in road accidents. We need to know not how many beds we have but how many beds

are available. I also made a note of the previous witness's submission, that one of the reasons theatre time was at 70 per cent was access to beds.

So we need to know how many beds are actually available to Tasmanians, on average, each year, whether closure is related to a lack of funding of nursing positions and whether we do, in fact, have sufficient beds, if they remain open, or we need to push for the Federal Government to increase hospital beds in this State.

The Liberal's submission comments on the over-reliance on locums and agency staff, the need for transitional and rehab beds, especially in the north and north-west, and poor support for the management of chronic disease in our community. Do we have equity in this State between regions in relation to hospital funding based on demand and the need for work force succession planning in view of our ageing population base?

Since making that submission, we have learned that Tasmanian nurses who are no longer working in the profession and who do want to make use of the Prime Minister's $6 000 initiative to re-enter the work force cannot access refresher courses in this State.

We have learned from this inquiry that the process of hiring new doctors takes so long that good doctors often get sick of waiting and take jobs elsewhere. Only last week in my street in a casual discussion with a senior clinician from Burnie this very issue is still relevant, even though we have been given the impression that it has all been fixed. I think an editorial in the *Mercury* some year or two ago talked about 22 levels that you had, or 23 hoops you had to go through, before you could get approval. This man, who will remain nameless, is extremely worried that the fish he has on his hook may in fact disappear because the time has been quite unacceptable. I do not believe for one moment this matter has been rectified and it is a massive issue for those looking to hire professionals in our system. The decision-making in the Department of Health and Human Services is not timely. It interferes with the efficient running of hospitals and is certainly not devolved, as we have been given to believe, to our local hospitals.

The health bureaucracy must get out of the way of decision-making. While the minister will say hospitals are free to make their own decisions, it is certainly not my experience as I speak to clinicians around the State that this is in fact the practice.

One of the areas that we have not referred to is the issue of technology. I cannot work out why on Saturday night millions of Australians will pick up to 20-odd numbers for Tattslotto and basically, by the end of the night, we know every division winner across the country - literally within seconds - yet we have communication systems in our health area that are continuously failing GPs, registrars, interns, outpatients, specialists. It is not acceptable in 2009. We have to be big enough and mature enough to accept that if people across the country, but more particularly here in Tasmania, want better efficiencies in our health system then we need to be brave and bold enough to tackle the issue of technology, the access to people's information available where appropriate to appropriately qualified people so that we can start to remove some of the massive blockages in our current health system.

CHAIR - Thank you very much for that comprehensive oversight of your submission.

Mrs SMITH - There has been some debate on whether or not our health system can be better placed with one level of government, either Federal or State. In fact, I think Mr Rudd did threaten at one stage and it has been very quiet since. Does the Liberal Party have a policy on whether or not they believe the health system would be better placed if it were under one management stream financially et cetera, rather than the cross-blaming that we see at the moment?

Mr WHITELEY - Not an announced public policy.

Mrs SMITH - Just a personal opinion?

Mr WHITELEY - It is the first time I have ever fronted a committee like this. I am not sure a personal opinion is appropriate. There is, no doubt, a big problem with the funding avenues or the funding streams between Federal and State. But what I can say, and this is a bold private statement, is that if we, as a State, tomorrow were to roll over on probably the single provision of services that we provide as a State government to the people of Tasmania, that being Health and Human Services, but more particularly Health, then you would have to question why, in fact, we exist. Having said that, we just need better systems in place that allow for those who are working on the ground - clinicians, nurses and primary health providers - to have far more say and decision-making capacity within the current health system.

Getting right back to Mrs Smith's point, there could be a better way to bring the funding streams together. There are models out there that lead us to a place where two streams of funding continue but they are placed in one bucket of funds and managed by a health commission. That is not Liberal Party policy nor is it my private leaning, but there are plenty of examples in the world where such systems work. Places like Canada have made some significant inroads into the way in which they provide funding, but they do not have the same challenges that we do. So there are some big problems there, there is no question and the blame game continues.

Ms FORREST - Are you looking at potentially a system where both -

Mr WHITELEY - I am not looking at a system. I am saying that people have looked at systems where the Federal Government's funding and the State taxes are put into a bucket and then Federal and State entities are moved aside and a health commission is put in place.

Ms FORREST - Do you agree that that sort of model, if it was ever considered, would need to encompass the whole of health, the GP service, primary health, acute services, aged care - the whole bit?

Mr WHITELEY - Absolutely. You are asking a hypothetical question and I am giving a hypothetical answer, because it is neither Liberal Party policy nor my policy. There is a lot of merit in having the discussion and being brave enough and bold enough to say there should be no taboos. When the health system is in the condition that it is, there should be no taboos. We should be big enough and ugly enough to talk about all the appropriate possibilities. I would like to think by the time we make any further announcement we will have been big enough and ugly enough to do that.

Mrs SMITH - There are some who say that Health takes a significant amount of our budgeted funds in the State and that it is enough money, but it is too top heavy in administration, with not enough on the ground.

Mr WHITELEY - I agree.

Mrs SMITH - Do you accept there is enough money in the system or do you think we need more funding?

Mr WHITELEY - I think there is more evidence of failures and inefficiencies in the system than there is evidence that we need lots more money. I wrote some earlier notes about the link between Treasury and Health and the need to understand the concept of preventive economics. There is no question, Treasury runs all the departments of government. There is no doubt about that. What is failing amongst senior officials in government of all persuasions, and it probably failed when it was under a Liberal government so let us move all that to one side, is that there is too much short-term thinking, probably electoral-cycle thinking, and we need to be looking at preventive economics.

It was put to me the other day - and this is not a shot at Ms Giddings - that we should have a minister for ill health because that is predominantly where we pay most of our attention and put most of our funds. That is instead of looking at what we need to do in a preventive economic sense to ensure that the next generation at least are going to end up healthier in a better system. Having said that, I add that there is going to be an overlap for the next 15 years probably while we clean up the mess of the last 20 years. We could spend the money that we currently have far better, far more wisely. We can remove a number of layers of bureaucracy and administrative hurdles within the system and get that money devolved down into local hospitals. You have been given evidence by people who are more than qualified to give good wisdom and leadership on the expenditure of those funds. Does that mean that we do not need a health bureaucracy? No it doesn't. Does it mean that we don't need one as big as we have? Yes, it does.

CHAIR - It was suggested to us by a witness that we ought to look at bringing in a third tier to control and handle all of the money that comes into the system.

Mr WHITELEY - The third tier is the health commission model where the funds, as I said, are put into a central bucket. State and Federal players take their hands off the bucket and leave it to people that, supposedly, know what they are doing. As I said, that is not our policy. I think it is an interesting model; it is one that should not be dismissed but I do worry about the centralisation of health to Canberra. That would concern me. In the overall equation, with 500 000 people in 22 million, we could end up being a very poor cousin.

Mr WING - That is the risk, isn't it, a big risk?

Mr WHITELEY - Yes. I think we should get our own house in order first before that threat even hangs over our heads.

Mr WING - It is difficult enough for regional hospitals to fare well under the State-controlled system.

Mr WHITELEY - There certainly is evidence to suggest that some decision-making processes have been devolved to regional hospitals. We are talking about mainly two hospital systems - the Launceston General and the North West. There is evidence of some and I would not be telling the truth if I said otherwise. However, there is a long journey to be travelled yet with the devolution of decision-making and learning to trust the people on the ground in our local areas. There is a lack of trust from the top by people who think they are the founts of all knowledge. It would be my experience that there could be nothing further from the truth.

Mrs JAMIESON - Would you consider the idea of returning to the old regional board idea that we had before so that you were responsible for your own parcel of money?

Mr WHITELEY - To a degree. Our policy is that we would move back to utilisation of the skills of people in a regionalised sense. There is no doubt about that. We may have a bit more to say about what the authoritarian model of that would be in the overall context, but certainly yes.

CHAIR - I want to go to the elective surgery side and you refer to that quite a lot in your submission and you have done again today. You have read the facts and figures and details about elective surgery and the lists and some of the ramifications. The concern of the people in this State is whether they are accurate, are they being misused, are people not being put there where they should be and so on? Is your party satisfied that that is right at the present time, that we have that right?

Mr WHITELEY - I would not say that we would be fully satisfied, nor would I want to give any inference whatsoever that I believe that good public servants are not telling the truth. That is not what I am saying. However, we saw recently on the north-west coast, probably 12 months ago or less, where 800 people turned up. I do not believe for one moment that there was any intention necessarily to withhold information, but the systems broke down and we suddenly found on the news that we had 800 more people on the list because specialists had been holding their own lists.

The stuff coming out of the mainland at the moment is concerning but I could not sit here and say that I was fully satisfied that the information was totally correct.

Mrs SMITH - You gave some figures, Brett, about privately insured people - 12 196 - and that 70 per cent could be treated in private hospital. Am I to take it that you anticipate 30 per cent are accident and emergency people? On the north-west coast the only place they will take you to is Burnie hospital, if you are private or otherwise. Is that how you see the break-up?

Mr WHITELEY - Yes, I do. The 30 per cent would include a significant number of people who would fit the seven categories that private hospitals don't undertake. I think that is a good assessment, Sue. The feedback to us - and I don't believe it has been driven by any financial incentive - is from people saying, 'For goodness sake, we have 12 000-odd people' - and I have used the word and I will use it in the committee - 'being "seduced" into the public system'. The minister takes exception to that and that's fine because they do get revenue from it. They are basically agreeing to do it at the scheduled fee within the public hospital system, so that they do those procedures - one of the 660 - but they

then bill Medicare. There is $8.5 million in revenue there. It is a pretty sad state of affairs for $8.5 million - nothing in the overall context of the Health budget - and it is a bit of a problem to us. As I said, it doesn't matter what you think of the private health system. I am not here as an advocate for the private health system; I am here as an advocate for solutions. If we have the private health sector able to take the 12 000 that are currently being held within the public hospital system while 9 000 people are waiting, it might not be as simplistic as this but even if half were to be redirected then that is 6 000 people in a year. It would go an awful long way to easing the pain in the public hospital system.

Ms FORREST - Another way of looking at that would be the number of patients who are privately insured who elect to use the public system. They go in as a public patient and have elective surgery. That may be because there hasn't been a choice of doctors so why use their private health cover.

Mr WHITELEY - I think you're spot on and I think there could be some of that. Again, the feedback we get suggests there is a portion of that but there is a significant number of people who aren't being given the -

Ms FORREST - But I don't think the Government will necessarily support my suggestion that those people perhaps shouldn't be there -

Mr WHITELEY - Certainly not.

Ms FORREST - because they bring in quite an amount of revenue.

Mr WHITELEY - It is $8.5 million of revenue that the Department of Health receives from Medicare. All I am doing is putting the facts before the committee. They are the facts that have been provided to us: 12 193 privately-insured patients in a public hospital system, for whatever reason, per year and 9 000-odd over here as of June 2008, too many of them waiting outside clinically recommended times on a public hospital waiting list.

Mrs SMITH - And yet at the same time we have received evidence - and I have had some private evidence on this - that specialists are suggesting to people that they ought to take up private health cover because after 12 months they can get into the private system to have an operation, whereas they will wait years in the public system.

Mr WHITELEY - I think all members of parliament would have had that feedback.

Mrs SMITH - Does that tell us that the private system has some capacity to do some public work, so if we can't facilitate everything in the public hospital we could be buying in services from the public system?

Mr WHITELEY - With respect to the questioner, that would be an understatement. They do have capacity.

Ms FORREST - They currently do it.

Mr WHITELEY - And they are about to do more. We read in a press release a week or two ago that the minister has engaged in a relationship with private health providers for 1 000

cataract operations. The private health sector are not going to sign up for that unless they know absolutely that they can do the job. The last thing we want to get into is a bun fight amongst ourselves about the ideological benefits or disbenefits of private versus public. We have to put that to one side. We have an almighty problem within our health system with thousands waiting outside clinically recommended times, many of them 500 days and over a year. I am not up for a fight between ideological positions on private and public.

We have three providers in the State. They are very capable, have massive capacity available, are willing, waiting, wanting to be a part of the solution. You can question why they want to do that and that is your right but at the end of the day I just want what is best for the patient. If we can get them through and get them back into good health then we will loosen up the doors of our GP surgeries, and we will lessen the number of people on heavy medication that is affecting their work and productivity. It is a revolving-door problem. More partnerships with the private sector is a major part of the solution - not the only part.

Ms FORREST - I have had a concern for many years working in a system where a private operator was providing a public service under contract.

Mr WHITELEY - Are you talking about the birthing clinic?

Ms FORREST - Yes, the obstetrics services at North West Private Hospital under contract for the Government. They are paying a premium for that. I have not done the figures so I do not know. I think it a question worth asking. How much is actually being paid to deliver that service? How much would the same service cost taxpayers if it were delivered in a public system? If we are paying more in a private system to deliver a service that could be reasonably provided in the public sector then we should be very cautious about taking that path.

Mr WHITELEY - I think that was more a statement than a question.

Laughter.

Ms FORREST - But is it an issue here?

Mr WHITELEY - I think that all questions are good questions and that is a question that you should ask to a departmental official under oath because I think a lot of people would like to know the answer to that question. I do not have it.

Ms FORREST - I do not expect you to have the answers.

Mr WHITELEY - Without a swipe at my good friend, Ms Forrest, I am really not about trying to find ways that we can value or devalue the responsibility of public or private. We are too deeply involved in a mess at the moment to worry too much about that as a distraction. Let us just work together and get ourselves out of the mess that we are in and then maybe some of those others matters may -

Ms FORREST - The point is that we do not really want to be paying a premium cost for a service that could be provided more cheaply in the public system.

Mr WHITELEY - I am a Liberal.

Mrs JAMIESON - You were not going to get political, remember.

Mr WHITELEY - No, no, but that is a good question. By the same token I think the private health operators in this State are up for the game and I think they understand their role in it. They would be foolish to abuse any opportunities that they may be given by this Government or any future government. It is a small State and we have all to work and pull together. I think with a concerted effort over a couple of years involving all players fairly and getting on with it we can make a big improvement in where we are at.

Mrs JAMIESON - I want you to expand on transitional care and palliative care please.

Mr WHITELEY - I think the report we had commissioned 18 months ago now was very clear. The Government withheld that report. You are asking questions now that lead me to make statements that are probably not so kind. The transitional care issue and the rehab beds particularly are a disgrace as far as numbers go and the comparisons of those numbers between the north of the State and the south - totally unacceptable. Do I think the south should have less? Certainly not, but it is about time that the Government took seriously the issue of rehab beds and transitional care beds in the north of the State. We could release some of the pressure in our acute beds, one of the major problems and one of the reasons why our theatres are not operating at efficiencies better than 70 per cent.

Mr WING - Do you feel the same about hospice beds?

Mr WHITELEY - Absolutely, and aged care. There are some issues there that we can talk about too. It is not in your range, I know, but there is aged care, transitional, hospice, rehab -

Mrs JAMIESON - It is related in that we have blocked beds.

Mr WING - And term of reference 3(a) deals with that.

Mr WHITELEY - The acting CEO, who I think is a very decent individual, made a comment about the issue of 18- to 28-year-olds being over represented in A&E. That is a very interesting point of evidence because normally 18- to 28-year-olds would be in the healthy category. We have to ask ourselves why GPs are saying, 'Not for me thank you; you're more appropriately entertained over here'. I subtly recommend you to pursue what those presentations are. I would suggest to you they are multiple issues, more closely linked to alcohol and drug problems and over-represented in mental health issues.

CHAIR - Has the Liberal Party looked at any other hospital systems throughout Australia or around the world that they believe sets a good model and a good benchmark for moving forward with the hospital system?

Mr WHITELEY - Yes. I alluded to them. There is some great work happening, for example, in Canada. I do not think that the UK is the best model for us to be looking at. They are obviously trying hard at the moment to rectify a generation of difficulties but I

would also submit that there seems to be a little preoccupation here lately with the health system in the UK. That would not be where I would go to get my first reference point.

THE WITNESS WITHDREW.

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

CHAIR - John, you are protected in giving evidence here by parliamentary privilege. At the end of the whole process you are able to speak about it publicly, but just be careful about identifying a specific item or matter that has been referred to during the committee. If at any time during the hearing you want to give evidence in camera then the committee can make a decision on that.

Mr SMITH - I do not have a submission as such. I am director of Corporate Planning and Performance with the Department of Health and Human Services.

My unit looks after the corporate planning of the department, which is developing the strategic plan and the associated business plans of the operational units, including the hospitals. We also look after the performance reporting. The submission that came from the department had quite a few facts and figures on elective surgery performance, the Department of Emergency Medicine and hospital activity. We coordinate the major reporting to the public arena through the Health and Community Services progress chart. We also provide various data sets to the Commonwealth for their various publications, such as the Australian Institute of Health and Welfare, and State submissions to the hospital statistics report. We are the reporting arm, but not the financial arm. We don't look after the financial side.

CHAIR - Where are you with planning within the public hospital system and what is happening in that area?

Mr SMITH - We have just completed our strategic directions document, which is the department's higher-level document. That will be released, I think, later this month. Five key objectives have been developed and out of that the department will identify some key priorities. The hospitals will then go through a planning process themselves. They will do their own business plans, having regard to the priorities that the department sets. Those priorities are based on things that are coming out of the Australian health agreements and various State priorities. My unit doesn't participate in the business planning process of the hospitals. We assist and we have an agreement with them about the priorities from the department's perspective that we would like them to achieve - elective surgery targets, emergency medicine targets, activity targets and things such as that.

CHAIR - So you're saying that you set the broader strategic directions of the department?

Mr SMITH - Yes.

CHAIR - And the hospitals look at that to do their business and work plans.

Mr SMITH - The department has an agreement with each of the hospitals, which is called a resource and performance agreement. It includes things such as budgets and what resources the hospital has and what they are expected to provide in activity and also performance indicators.

CHAIR - In setting those strategic directions for DHHS, what consultation do you have with, say, senior people within the public hospitals in determining them? Is there a committee? Do they make up a committee?

Mr SMITH - The process is agreed by the department's executive team, which is a departmental team. We work with them. The department largely determines what its priorities are and then they are promulgated out to the hospitals which then determine how they will deliver on those priorities. We didn't go through a process of consulting in detail with the hospitals. We met with certain key people in the hospitals and explained what the process was and went through a consultation process in that way, but it is the department executive that determines the strategic directions.

CHAIR - After the hospitals complete their plans, taking direction from your strategic plan, do you then look at that after it is done to see whether it works in with the strategic directions as set? Do you offer advice from there?

Mr SMITH - Yes. Each of the hospitals will develop a business plan. We are changing the process a bit to align better the planning process between the hospitals and the department. It is changing slightly this year. Each hospital will do a business plan. The department will work with them and have an agreed business plan around the key priorities that the hospitals need to meet. As I mentioned, there is a contractual arrangement, a resource and performance agreement, between the department and each of the hospitals that will specify certain performance criteria by which the hospitals will be judged in having met those priorities.

Mrs JAMIESON - Do you become involved in primary and community health strategic planning and performance indicators?

Mr SMITH - Yes, across the department.

Mrs JAMIESON - So it is right across the whole department; you have only mentioned hospitals.

Mr SMITH - Sorry, I was addressing the hospital aide of it, but it is across the whole department.

Mrs JAMIESON - Would that also include the accreditation of hospitals? Do you help them with their planning towards accreditation?

Mr SMITH - We would provide information to them that they would use in the accreditation process. They would be required to provide a certain amount of detail, which we provide.

CHAIR - In setting those strategic directions that the hospital is required to meet in doing their plans, obviously you do it having regard to the budget, the moneys that are made available in DHHS. You then set up, as you said, the very broad parameters, having regard to the confines or the moneys made available in the budget.

Mr SMITH - The strategic direction is very high level. Basically they have come out of the strategic plans, like the Tasmanian Health Plan and other plans across the department in

housing and other areas. So the strategic directions are basically common themes which are in all those existing plans. So it is a very high level document. It is not really addressing budget requirements. That is taken at the next level down as to how the hospitals can meet those directions.

CHAIR - Would you have a document there that you have prepared, the current one? I guess that it would be available in the annual report anyway?

Mr SMITH - No, I have not because it has not been released as yet. The department's executive are still considering it, so the strategic directions document will be available later this month.

Mrs SMITH - In the department's submission to the committee they talk about the strategic plan and the business plans et cetera. One of the issues that is frustrating to some hospitals is staffing. Does their business plan allow them to decide their levels of staffing if they fit within the financial criteria, and the appointment of staff directly, or does that still have to go through the department?

Mr SMITH - No, the hospitals can determine their own staffing levels within their existing budgets.

Mrs SMITH - People gave us evidence that it took seven months to get the tick-off for Dr So-and-so and by then he had moved to Ballarat and we had lost him. That will not happen any more because if they lose him it is their own fault because they have not interviewed et cetera?

Mr SMITH - I could not say that would not happen anymore. There may have been a number of reasons for delays but basically the hospitals, for most appointments, have the authority to employ within their existing allocations.

Mrs SMITH - For most appointments. You would not expect a CEO to -

Mr SMITH - I am not an HR expert so it is outside my area a little bit.

Mrs SMITH - These words are about operational units and business plans - it sounds all very Treasury-like to me. There is nothing wrong with having to meet performance measures but if a hospital loses a doctor and cannot meet their performance measures because, outside of their control, there have been issues in getting the sign-off to employ certain people then your whole business plan, strategic plan et cetera fall over.

Mr SMITH - As I mentioned, I am not the best person to talk about HR systems but as a general principle the hospitals can employ within their existing budgets. They do have the delegations and the authority as a general principle to employ. If you wanted more detailed specifics about employment and HR processes you would probably need to speak to someone with that background.

Mrs SMITH - What is the requirement of the department's strategic plan that you have been involved in? Is it a rolling plan; is it reviewed every five years?

Mr SMITH - It is a three-year plan which will be reviewed annually. The department has not had a strategic plan for the last two or three years. There was a Fit program, which was implemented by a former secretary, and the current secretary re-implemented a strategic planning process. As I mentioned, most of the strategic plans exist through the Tasmanian Health Plan and plans like this, so this is really bringing together those existing documents.

Mrs SMITH - So we have had strategic plans but not for the last three years. What will make this system better to make sure that things improve rather than stay where they are or go backwards? What is the difference in this - the benchmarks?

Mr SMITH - I think this is a more thorough planning process. We have drawn together the various documents around the department that have been put out - various strategic plans. I think this draws them together so we have an overarching document which will then enable the planning process to have a reference point in terms of having a strategic document. As I mentioned, there hasn't been a formal one as such for the last two or three years, and hopefully this will provide a reference point for people doing planning.

Mrs SMITH - And will these business plans and this new annual resource performance agreement be audited?

Mr SMITH - Audited by whom?

Mrs SMITH - The department or the Auditor-General or someone. I ask the question in light of what has happened in Victoria. This one is to cover patient access, hospital activity, waiting list management et cetera, but note what is evolving in Victoria at the moment. We want to make sure that whatever we put in place has some capacity to be audited to make sure we are not fudging figures, to put it plainly.

Mr SMITH - Certainly the department would be monitoring those plans. Victoria has had a different funding process. They are actually an activity-based funding process, so they have had a different funding allocation process. We do not have an activity-based funding allocation as such, so there are some slightly different incentives, I suppose, in the different systems. But we certainly have a coding auditor position. We have a range of processes we go through to ensure that the coding of records is accurate, and those resource performance agreements would certainly be monitored within the department. Whether the Auditor-General looks at them, I don't know, but we will certainly be monitoring them and using them as an accountability document on both sides of the department and the hospitals.

Mrs SMITH - Can you give me some indication of how long it has taken to bring together all of these plans into a strategic plan?

Mr SMITH - The unit which I am heading up was only configured last December, so we have been working on it. Prior to then there was work under way, so it has been since this financial year. We are looking at starting in 2009-10, with the new planning process from July 2009.

Mrs SMITH - So your benchmark of success is if the business plans get up, are operational and stay within their budgets but provide top-line service. Is that the way we would look at it?

Mr SMITH - I suppose that would be it in a nutshell, but there are certain standards and targets which we would expect the hospitals - or business units, but here we are probably talking about hospitals - to meet around elective surgery, emergency departments, various safety and quality areas, and conversely they would be requiring certain things of the department. We have gone through a process where we are introducing a range of tools to enable hospitals to access the data to enable them to manage better, for example, so there would be an expectation that we will be able to live up to those demands too.

Mrs SMITH - So do I presume that we have had a system in place before, but it has just proved to be not appropriate, or have we had no system in place before and we are just putting one in now to ensure these benchmarks are met?

Mr SMITH - There has been a system in place but it probably has not worked as well as it could have done, and it probably was not up to contemporary standards, nor our performance monitoring systems. The hospitals didn't have access to the information they need to manage on a daily basis. We have put in those two systems. There is Checklist, which is an elective surgery planning tool, which each hospital has now. We are also implementing another system called Clickview which will enable hospitals to actually access their activities and costing and HR and financial information where previously they have not had access to that apart from a hard copy, so it will enable them to actually interrogate and access that information themselves.

Ms FORREST - I would ask you to comment on the IT infrastructure that is available now. Has that been lacking to the point that they have only been able to access hard copies of some of these reports and that sort of thing? What sort of investment are we talking about here and what needs to be done in the future? We are hearing constantly that things like even electronic discharge summaries are still not available and perhaps will be soon. Something as basic as that is not currently available, so can you tell me where we are headed with that?

Mr SMITH - There is a new patient administration system which is being implemented across all three hospitals. I think the LGH is due to go live later this year. It was going to be July but it has been delayed. So the new patient information system will address a lot of those issues around patient records

Ms FORREST - You are getting rid of EDIS?

Mr SMITH - EDIS would be part of that. It is replacing the old HOMER system, as it is now known. On top of that, we are developing the other two systems I mentioned so that staff in hospitals can access their activity data. They can look at it ward by ward. There is information they need to manage effectively.

Ms FORREST - Work force management will be part of that?

Mr SMITH - Yes, there will be HR information, finance and activity information and, in the hospital environment, costing information, clinical costing and a separate module around elective surgery because that has a rather heavy focus at the moment.

Ms FORREST - Are you confident that the investment in IT is adequate to meet the needs of the next five to 10 years in this area?

Mr SMITH - The department at the moment is looking at an e-health strategy. I haven't been party to that. I would be confident that we are a lot better placed than we were but I don't know whether I could confidently say for the next five to 10 years, because I am not privy to what the e-health strategy is.

Ms FORREST - Who is heading up that area?

Mr SMITH - That would be Simon Barnsley.

Ms FORREST - There have been some concerns with the IT conversion from HOMER at the LGH, particularly the disaster recovery of the new system and the fact that there are a lot of users who may not be competent.

Mrs SMITH - Simon would be the best one to talk to about that.

Ms FORREST - The nine-digit UR number is presenting some challenges. Are you involved in that or is that another area?

Mr SMITH - No, that would be best dealt with through Simon's area. My area is involved in that as well but once we get the new PAS system on we will be able to look at moving to the nine-digit number - the statewide number - depending on the new system being implemented.

Ms FORREST - When is that likely to happen?

Mr SMITH - The LGH was going to be July this year, and it has been put back for a while, and then the other hospitals will progressively come on after that. The LGH will be later this year, then the North West and then the Royal is scheduled for early next year. Simon or someone in that area would be best to provide that detail.

Ms FORREST - When you're looking at developing the broad-brush strategic plan, do you look at other health systems in other parts of the country and the world? What have you done in that area?

Mr SMITH - We have done quite a bit of research in all jurisdictions. We have followed Victoria pretty closely. Victoria has a very well developed performance and monitoring system and their performance indicators are very well developed. We have also done quite a bit of research internationally. We have adopted quite a bit from the National Health Service, particularly around their planning documentation. It is trying to move to an output-based system as opposed to the former input-based system that we have had in the past. We have drawn on the NHS and the Victorian system very heavily. Looking around the other jurisdictions, all systems and all States have pretty similar systems.

There are strengths and weaknesses with each but we found that Victoria seemed to be pretty close to what we were looking at.

Ms FORREST - This is particularly for your hospitals. Outside of that, like for primary health, have you looked at other jurisdictions?

Mr SMITH - Yes. Primary health will become part of the area networks, so it is part of the north-west and it will be the Northern Area Health Service and the Southern Area Health Service. The planning we are doing covers right across the department, so the planning processes cover the Human Services area as well.

Mrs JAMIESON - Are you involved in the policy and planning development for a major pandemic, say if bird flu came in on a plane or a boat?

Mr SMITH - No - the chief health officer. That would be Craig White's area.

Mrs JAMIESON - Are you involved with the Feds at all in letting them know - hammering the point - that we have an ageing population problem here? How much influence and effect are you having with the Feds?

Mr SMITH - My area provides information and data. The argument is taking place in other areas of the department but suffice it to say that there is an ongoing debate. I actually had a meeting this morning with some people from the Commonwealth who are doing some modelling around Tasmania's ageing population impacts.

Mrs JAMIESON - And palliative care and all the other issues that come into that as well?

Mr SMITH - Yes.

Mrs JAMIESON - Did you ever think about the re-establishment of the regional hospital board system?

Mr SMITH - It is probably not something I would comment on. I think that would be better addressed by someone else. The area health networks are heading to a similar concept to when we had the regional structure but certainly there are not any regional health boards at the moment. Whether there are plans ahead for that I could not comment.

Mrs SMITH - The business plan centres on this performance agreement et cetera with financial targets and so forth. Have you any knowledge of whether the hospitals component will have the same budgets for their business plan?

Mr SMITH - At this stage we have no information on budgets.

Mrs SMITH - So the strategic plan is done but we cannot finalise the business plan until we have a budget process. It is no good giving them *x* amount of dollars and expecting them *x* plus one in performance, is it?

Mr SMITH - My area and I have not been involved. I do not get involved in the budget process so we have no individual budgets for hospitals as yet and I do not get involved in the budget process for the departments.

Mrs SMITH - But did you have any presumptions when you worked this process out that it would be at a stationary stage?

Mr SMITH - We will be setting priorities that we think the department or the hospitals need to concentrate on. The extent that they can deliver would be determined by budgets. If there are standards, like 80 per cent of all patients must be seen within clinically recommended times, then obviously to achieve that would depend on budgets but we have not got budgets at this stage.

Mrs SMITH - So the department will set the priorities, not the hospital that is working up the business plan?

Mr SMITH - The hospitals will be able to set their own priorities as well but the department will have certain priorities that it will want met. Those priorities are driven from Commonwealth largely.

Mrs SMITH - So it is big brother working its way down, even though according to this submission there is a $70 million per annum shortfall in the Australian Government financial contribution. That is my concern with business plans. We can put priorities there and the very people on the ground have their hands tied like that in attempting to meet them.

Mr SMITH - I take your point.

Mr WING - Is it part of your responsibility to deal with methods of the separate hospitals in purchasing new equipment?

Mr SMITH - No. I was involved in such a role previously but not now. I used to sit on a committee which actually looked at medical equipment purchases and requirements.

Mr WING - Up until when were you on that?

Mr SMITH - Until about October.

Mr WING - I see, so fairly recently.

Mr SMITH - Fairly recently we had a medical equipment committee as a department committee.

Mr WING - Do you know if there have been any significant changes or any changes in the procedures since then?

Mr SMITH - Penny Egan, the Chief Financial Officer, is now looking out for procurement. We used to have the medical equipment committee, which had representatives from each hospital and including oral health, primary health - quite a wide representation across the department and the various operational units. Our major aim was to look at the replacement schedules that hospitals had so that each hospital had an equipment replacement schedule so that we could attempt to plan what was coming forward with requirements and needs, matching against what funds were available.

Mr WING - So do you know if there have been any significant changes since last October?

Mr SMITH - No, not that I am aware of. Each of the hospitals developed a replacement schedule of equipment but I am not aware of what has happened.

Mr WING - We have had complaints about the unnecessarily tedious nature of getting approval to purchase new equipment and the need for a whole series of people to be involved before it can be signed off. Could you tell us what the procedure is if, say, the Launceston General Hospital wants some equipment worth $5 000?

Mr SMITH - There is legislation under the Government's procurement policy that anything over $10 000 requires three written quotes; anything over $100 000 is required to go to an open tender, unless the Treasurer gives an exemption from that process. So for something worth $5 000 a hospital would only need to demonstrate that it was achieving value for money.

Mr WING - So how many people do they need to demonstrate that fact to? What is the chain of operation? With the officer in charge of purchasing at the Launceston General Hospital, who does that officer contact and who does the next one contact?

Mr SMITH - It would depend on who had the financial delegation to spend the $5 000, but at that level I would have thought it would be quite well down the hospital chain.

Mr WING - Is each hospital given a budget to purchase smaller items such as that?

Mr SMITH - Hospitals within their budgets, I would imagine, have set aside some funds for equipment purchases. There are various other funds which come through centrally. Under the Commonwealth's elective surgery waiting list program the State was given $3.1 million, and the hospitals then formulated a way to utilise those funds. Each hospital would have in its budget allocation a component for equipment replacement.

Mr WING - So over $10 000, three quotes are needed - up to $100 000?

Mr SMITH - Yes, over $100 000 has to go to open tender.

Mr WING - But if the system hasn't changed then there would still be criticism within individual hospitals about the number of people who have to be involved at various stages before a decision can be made. Who is responsible for calling the tenders?

Mr SMITH - Each hospital or each unit would call its own tenders. It is State Government procurement policy and the Health department follows it, as does any other department. There is a period in doing each of the stages but I have never come across the types of delays that are anecdotally talked about, but then I don't purchase equipment on a day-to-day basis.

Mr WING - So if there were complaints would you be likely to be aware of them?

Mr SMITH - No, I wasn't involved. I chaired the medical equipment committee and prior to that I was on the State imaging equipment committee, but I wasn't in the area that looked after the procurement policy of the department.

Mr WING - So if a judgment had to be made whether some equipment was repaired or new equipment was purchased, who would make that decision, say in the case of some equipment worth $50 000?

Mr SMITH - It would be the hospital that would make the decision, depending on what funding was available. As I mentioned, the Commonwealth provided $3.1 million under the elective surgery program. There may be a source of funds which could meet purchasing that equipment. Otherwise, depending on the cost and the availability of funding, the hospital can look at purchasing or it may look at leasing.

Mr WING - The hospital itself makes that decision, does it?

Mr SMITH - Yes.

Mr WING - Are they given any guidelines under which to make that decision?

Mrs SMITH - Each of the hospitals has business managers who are familiar with the purchasing guidelines and processes. It is part of their jobs and job descriptions.

Mr WING - We had a criticism that if it was sensible to do something that would save a lot of money the guidelines didn't permit it because there was a requirement to do something else, which could cost a lot more money. I don't know if anybody remembers the details of that.

CHAIR - I can remember one witness saying that the rigmarole that they had to go through to get property replacement was nonsensical, and that the decision should be made closer to where that property is necessary and required. By the time a lot of these things were actioned the property was no longer wanted, had become redundant or was out of fashion or whatever. There were long periods of delay.

Mr SMITH - I don't look after the procurement side, so I am not familiar with the exact details.

Ms FORREST - As part of the strategic plan in that area, do you provide guidance to departments regarding their equipment replacement programs.

Mr SMITH - I used to in the role I had previously.

Ms FORREST - Is there still someone undertaking that role?

Mr SMITH - Penny Egan, the Chief Finance Officer, looks after the equipment requirements, so she has taken on that role. The medical equipment committee made sure each hospital had a replacement schedule and equipment requirement schedule for the coming year. The idea was to expand it out over seven years so that we knew what pieces of equipment were coming up for renewal. If there was a piece of equipment in one hospital there may well be the same equipment in other hospitals, so there may well

be sense in going to the market with the multiple purchases rather than one. So that was the idea of that committee.

Ms FORREST - Do you know currently how long that replacement program runs? Obviously the majority of expensive medical equipment has a fairly defined life, and you will know that after five, 10 or 15 years, depending on what it is, it would need to be replaced. Are we looking that far down the track so that Treasury knows that in 2020 they will be up for three MRI machines so they had better start looking now?

Mr SMITH - That was part of the role of having that replacement schedule so that we could see what was coming up in future years. I know that Penny Egan, the Chief Finance Officer, does have a project under way where they are continuing that process of trying to identify what the requirements might be in future years.

Ms FORREST - So that is still a work in progress, from what you understand?

Mr SMITH - It is an ongoing work in progress. It needs to be updated and monitored the whole time.

Mrs JAMIESON - What is the actual process? You set the parameters and the guidelines and the targets and all the rest of it for the different groups in the hospital. What is the process, then, if they don't meet those targets? Do you follow that up, or is that some other department that follows them up?

Mr SMITH - It is followed up through my department. We go through a process where we monitor the performance and provide reports to the department executive.

Mrs JAMIESON - And if they continually don't meet them, what happens then?

Mr SMITH - That is an issue for the secretary to resolve.

Mrs JAMIESON - But are there any penalties or any smacks on the wrist?

Mr SMITH - I have not been party to those discussions when the secretary may have discussed it.

Mrs JAMIESON - Have there been any examples where we have been grossly behind, put it that way, in meeting targets?

Mr SMITH - There have been cases where we are not meeting the targets, and I think any business would have that.

Mrs JAMIESON - I think that is fairly evident, yes.

Ms FORREST - We are seriously looking at having a plan that encompasses the major expenditure items so that there is a reasonable hope of budgeting in a meaningful way. Do you know where that is at?

Mr SMITH - Obviously the Tasmanian Health Plan is connected to that too and having a proper capital plan and service plan as we go into the future. But what was being looked

at was a system where it was able to identify those requirements as they come up, but of course they have to be identified by someone in the system. Also with the capital plan we know we are in a position where we might need, as you mentioned, an MRI in five years' time. CT scanners that have been put in in recent times probably have a five to seven-year life span, so it is a matter of getting that replacement schedule up. That extends to ambulance vehicles. There is an ongoing role for the replacement program that we can plan for.

Ms FORREST - Is that established or is it still not working?

Mr SMITH - I think it is established but I think there is always room for it to be refined further. I know that Penny is looking at the whole procurement process so I think that she would be trying to refine it further. But there is a process in place now.

CHAIR - The strategic directions they are set by the secretary?

Mr SMITH - Through the department executive, which is the secretary, yes.

CHAIR - They sit down and they set the direction with you and your group.

Mr SMITH - Most of the directions have come out of the plans that have been developed in recent years, such as the Tasmanian Health Plan,

CHAIR - The Clinical Services Plan and the like?

Mr SMITH - Yes. Those plans have been developed in recent years anyway so the strategic direction is a theme document which pulls out the common threads from those plans.

CHAIR - I thought that might be the case. There is the Clinical Services Plan, a document that has been done but it is a meaningless document. You are saying that is not right and that the strategic directions are set on that document and they will guide you.

Mr SMITH - With the Clinical Services Plan there is an ongoing implementation group which reports back regularly. There is a list of 70-odd projects that are required to be done, so the Clinical Services Plan is being implemented. Certain parts of the Clinical Services Plan, through no fault of the department or the Government, have been changed in recent years through various circumstances but the Clinical Services Plan is still current and is being implemented.

CHAIR - How many are in your team?

Mr SMITH - I have about 25 people.

CHAIR - So 25 people are set up to do this strategic plan.

Mr SMITH - We do the annual reports, the budget documents, the Health and Human Services progress chart as well as performance reporting on the operational units. We also have a role with providing information about hospitals' various data sets to the Commonwealth, which can be quite intensive. We also provide the data administration for a lot of the hospital information around the elective surgery system.

CHAIR - Do the CEOs of the individual hospitals have any say at all in the development of that document?

Mr SMITH - Of the strategic plan?

CHAIR - Strategic directions - the overall document.

Mr SMITH - There was some consultation with the various operational units, including Mental Health Services across all operational units. There was consultation about what the document was about and how it was drawing together the themes from the other documents that had been prepared. So in some regards it was nothing new; it was simply drawing on those existing themes.

Mr WING - I would just like to know every stage of the process of replacing equipment. Take an item of $50 000 that needs repairing or replacement. Could you take us through every stage of what the responsible officer at the Launceston General Hospital, for example, needs to do until it is delivered?

Mr SMITH - As I mentioned, I am not actually involved in that process. I could give you a step through on what I think the process would be but I might miss something.

Mr WING - But you were involved, weren't you, before?

Mr SMITH - I was involved in a committee that was establishing replacement schedules. The individual hospital business managers would go through and purchase the equipment.

Mr WING - I know that you did not purchase the equipment but you were responsible for the policy, resources and systems, weren't you?

Mr SMITH - Not with relation to equipment. The equipment purchases are covered by government policy and legislation.

Mr WING - So it has not been in your jurisdiction in either of your two recent positions?

Mr SMITH - No. It is under the Chief Finance Officer's role.

Mr WING - I see, right, thank you.

CHAIR - John, is there anything that you would like to say before we finish?

Mr SMITH - I know that there are a lot of areas that I have not been able to address that have been outside my scope and in those areas I have preferred not to say something that might not be accurate. So I hope I have been able to assist.

CHAIR - I understand that, John, and thank you very much.

THE WITNESS WITHDREW.